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Rapid review on the ethical international recruitment of healthcare workers

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Summary ........................................................................................................................................3
Acknowledgements and funding .................................................................................................3
Background ..................................................................................................................................4
Methods .......................................................................................................................................8
  Identifying material for inclusion in the review ........................................................................8
  Patient and public involvement. ................................................................................................9
Findings .........................................................................................................................................10
  The ethics of the international recruitment of healthcare workers ........................................10
  Limitations of existing data .......................................................................................................12
    Nationality and migration status among NHS workers and nurses in adult social care ....13
    Using data from professional registers ..............................................................................14
    Improvements to data quality – doctors in South Africa ....................................................15
  Comparisons with approaches in other countries .................................................................15
  Effects of international recruitment on receiving countries ...................................................23
  Effects of international recruitment on sending countries ....................................................23
    Taking a more proactive approach .......................................................................................25
    Estimating the cost of international recruitment ...............................................................25
    Creating an over-supply of healthcare workers ....................................................................26
    Impact of unemployment ......................................................................................................27
    Role of education partnerships .............................................................................................27
    Government-to-government partnership agreements ...........................................................28
  Remittances ...............................................................................................................................29
  Recruitment agencies and recruitment fees ............................................................................30
  Effects on individuals ...............................................................................................................31
    Reactions to the decision to migrate .....................................................................................32
    Support for transition into the workplace ............................................................................33
    Discrimination and worker rights in receiving countries ....................................................34
Discussion ....................................................................................................................................36
Key messages ...............................................................................................................................38
References ....................................................................................................................................39
Summary

International recruitment is an important means by which healthcare services in England have sought to compensate for shortages of domestically trained healthcare workers. This has contributed to ethnic diversity within the workforce and created opportunities for valuable professional and personal exchange. However, there are concerns that international recruitment of workers from poor and middle income sending countries to richer receiving ones has a disproportionately severe effect on the health systems in the sending countries.

This rapid review sought evidence on threats to the ethical international recruitment of healthcare workers. Efforts to quantify and analyse the ethical aspects of international recruitment have been limited by the quality of administrative data, such as data collected by governments or by regulators. This review concluded that international recruitment was a symptom, not a cause, of challenges to the health systems in sending countries.

Receiving countries have varied in their approaches to international recruitment, and this has led to differences in their reliance on internationally recruited healthcare workers. Educational partnerships and trade agreements are two important ways in which sending and receiving countries try to use international recruitment in mutually beneficial ways. Remittances were an important source of income for sending countries but sometimes this was to the detriment of the personal finances of poorer paid internationally recruited workers. Discrimination in receiving countries and the failure to provide good induction and support systems were major barriers to ethical international recruitment.

The 2021 Code of Conduct for internationally recruited workers represents a comprehensive policy approach to successful ethical international recruitment but it will be important to see how well it is being implemented by employers.

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Background

There is a global shortage of healthcare workers which is expected to worsen as demand for healthcare outstrips supply (World Health Organization 2016). For many years, high income countries have sought to supplement their domestically trained workforces through international recruitment and in 2019 the global number of internationally recruited healthcare workers was estimated to have reached about 40-50 million (Yeates and Pillinger 2019b). The increased demand for skilled internationally recruited healthcare workers has occurred at a time when there has been a growth in all types of migration as a result of war, natural disaster, and changes to the viability of traditional ways of life through farming or fishing (Kerwin 2020). Globalisation has also changed the character of migration from the typically permanent migrations of the past to the circular or temporary migrations in current times (Hossin 2020). Existing shortfalls in the supply of healthcare workers have been exacerbated by the global COVID-19 pandemic and there are concerns that some high income countries will attempt to create a ‘quick fix’ through aggressive international recruitment from countries with less developed economies (Buchan and Catton 2020) and that the impact of the pandemic on migrant care workers will have implications for health and care services in receiving countries (Kuhlmann et al. 2020).

People have always moved from one country to another, hoping to improve their lives and escape economic and political instability. Freedom to emigrate was one of the key principles of the post-war international liberal economic and social order (Yeates and Pillinger 2019a). However, it soon became apparent that the uneven development of health systems across the world was creating imbalances in inward and outward migration. While healthcare workers in low and middle income countries moved to higher income countries, those in high income countries hardly ever moved to low or middle income countries. In the 1950s and 1960s, the term ‘brain drain’ became popular as a way of describing the movement of doctors from the United Kingdom (UK) to other jurisdictions, most notably the United States (US). Subsequently, the antonym ‘brain gain’ has been used to describe the gain for countries that benefit from internationally recruited workers’ skills and experiences. ‘Brain waste’ is also used when workers find that their skills are not being fully utilised in the country to which they have migrated.

Notwithstanding the above example of the UK as a ‘sending’ country for internationally recruited healthcare workers, the UK receives far more workers than it sends. The National Health Service (NHS) has relied on doctors and nurses who qualified overseas since its inception (Snow and Jones 2011), although the scale has increased markedly over the past decade. The UK is now second only to the US in the number of practising doctors who trained overseas (Organisation for Economic Co-operation and Development 2015) and is the third most popular destination for overseas nurses in the world (Gillin and Smith 2020).

Until the 21st century, the vast majority of internationally recruited healthcare workers in the UK came from countries with colonial links to Britain in the past and the Philippines. When NHS expansion at the end of the 1990s resulted in the need for a large influx of staff (Young 2013), the focus switched towards recruiting workers from the European Economic Area (EEA) (Young et al. 2014). Following the Brexit referendum in 2016, there has been a
notable shift away from active EEA recruitment and towards non-EEA countries, particularly the Philippines and India (Gillin and Smith 2020).

The rapid increase in active international recruitment during the NHS expansion in the late 1990s was largely uncontrolled. Responding to concerns about the effect this was having on health systems in the countries from which workers had been recruited, the then Department of Health (DH) issued guidance on the employment of internationally recruited doctors and dentists (1998) and nurses (1999). This was followed by publication of a Code of Practice for international recruitment which required NHS employers in England not to actively recruit from low income countries unless there was government-to-government agreement (DH 2001). The UK was the first country in the world to adopt a Code of Practice for international recruitment (Merkur 2014, Stievano et al. 2021). It was updated in 2004 (Buchan et al. 2009).

Another first came with the adoption of the Commonwealth Code of Practice for the International Recruitment of Healthcare Workers in May 2003. It was developed by representatives of Commonwealth health ministries and aimed to offset the effects of health worker international migration without imposing restrictions on freedom of movement (Commonwealth Secretariat 2021).

The implementation of these Codes of Practice at national and Commonwealth level helped contribute to an international impetus for action to reduce the amount of uncontrolled migration of healthcare workers from low and middle income to high income countries. An influential World Health Organization (WHO) (2006) report, Working Together for Health, highlighted its problematic nature by promoting the idea of a causative link between the sparsity of healthcare workers per head of population and poorer health outcomes (Yeates and Pillinger 2019b).

Publication of this report led to increased lobbying from Member States for the WHO to develop a global Code of Practice. The Global Code of Practice on the International Recruitment of Health Personnel (2010) expressed concern that the:

... severe shortage of health personnel, including highly educated and trained health personnel, in many Member States, constituted a major threat to the performance of health systems and undermined the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals.

(WHO, 2010: 1)

Instead, Member States should:

... establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel.

(ibid, 3)
Two influential paragraphs reinforced the interconnectedness between ethical international recruitment and making improvements to workforce planning, recruitment and retention, and data quality in sending and receiving countries:

[Member States should] strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. (ibid, 5)

[and they] should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base. (ibid, 8)

Implementation of the national Code of Practice in 2001 (Department of Health 2001, Department of Health 2004) and changes to the rules which made entry to professional registers more difficult had led to a fall in the number of internationally recruited healthcare workers in the NHS (Buchan et al. 2009). Another contributory factor was the economic crisis of 2008 which reduced the number of employers actively recruiting international workers, both in the UK and other countries such as the US (Ortiga 2020).

The ratification of the WHO Global Code of Practice in 2010 coincided with attempts by successive UK governments to introduce more stringent arrangements for immigration to the UK. In 2015, nurses, doctors, and allied health professionals (AHPs) were included on the shortage occupation list and the number of internationally recruited healthcare workers in England began to rise again (General Medical Council 2020, Nursing and Midwifery Council 2020, Martineau et al. 2020 unpublished).

In July 2020, policies aimed at immigration reform culminated in the publication of government plans for a points-based immigration system:

The Government welcomes the vital contributions which doctors, nurses and other health professionals from overseas make to the National Health Service (NHS) and wider Health and Care Sector. The Health and Care Visa is part of the Skilled Worker route. It will ensure individuals working in eligible health occupations with a job offer from the NHS, social care sector or employers and organisations which provide services to the NHS, who have good working English, are incentivised to come to the UK.

(Secretary of State for the Home Department 2020: para 60)

This was followed up in February 2021 when the Department for Health and Social Care (DHSC) issued new guidance for the Code of Practice for the international recruitment of health and social care personnel in England. It extended the Code to social care employers and confirmed the government’s commitment to ‘upholding the highest ethical standards in international recruitment’. It reinforced the guiding principle in the WHO Code of Practice (2010) that the:

... international migration of health and social care personnel can make a contribution to the development and strengthening of health and social
care systems to both countries of origin and destination countries if recruitment is managed properly.

(Department of Health and Social Care 2021)

The DHSC Code prohibits active recruitment from a list of ‘amber’ and ‘red’ countries considered to have the most vulnerable health systems. It is intended to minimise harm to the health and care systems of countries of origin while safeguarding the rights of health and social care personnel to migrate. It is also aimed at ensuring fair and just recruitment and employment practices. The devolved governments in Scotland, Wales and Northern Ireland have their own versions of the Code.

In the context of the changes to immigration rules and the publication of the 2021 Code of Practice, the DHSC commissioned the NIHR Policy Research Unit in Health and Social Care Workforce to undertake a review of the ethical international recruitment of healthcare workers. The remit requested information on:

1. Overview of available research focussing on healthcare workers;

2. Assessment of research findings covering impact on individual; impact on home country; impact on recruiting country;

3. Assessment of comparator country approaches to international recruitment.

The key question to be addressed in the review was to examine whether international recruitment of healthcare workers could be seen as ‘ethical and presenting a triple win scenario with benefits’ for internationally recruited individuals, sending, and receiving countries. The focus in the review was on healthcare workers with a professional qualification from their country of origin, even if the qualification was not recognised by regulatory bodies in the receiving country.

Draft reports were submitted in April and August 2021 and this revised version incorporates feedback from policy customers.
Methods

Identifying material for inclusion in the review

In keeping with the timescale for the review and the broad nature of the remit, we adopted a rapid review methodology to identify and synthesise material on the topic. Rapid reviews are a form of ‘knowledge synthesis for providing evidence to decision makers in a short timeframe’ (Khangura et al. 2012: 8, Tricco et al. 2015). The purpose of a rapid review is not to provide a definitive answer to a hypothesis nor determine the effectiveness of a particular intervention but to provide sufficient information on which to make decisions about what should happen next, including identifying whether further work is required and what form it should take (Taylor-Phillips et al. 2017). Rapid reviews can be used to highlight gaps in existing research, as well as summarising findings (Moriarty et al. 2019, Martineau et al. 2020 unpublished).

There is a growing recognition that policymakers need to monitor and understand the evidence base as a whole, including evidence gaps and evidence clusters. This helps facilitate the formulation of proactive research questions (O’Leary et al. 2017, Wolff et al. 2019). The term ‘evidence map’ is commonly used to describe this process but there is extensive variation in the way that maps are constructed and presented (Miake-Lye et al. 2016). They can be used either to give readers a baseline understanding of a body of evidence by describing the extent and distribution of literature on a topic, identifying gaps, and indicating areas for future research or to describe the range of study designs and methodological approaches used (Whyle and Olivier 2020). In this review, we are using the term ‘evidence map’ to summarise how evidence gaps and clusters were analysed thematically to answer the question, ‘Can the international recruitment of healthcare workers be ethical and create a triple win scenario with benefits for internationally recruited individuals and sending, and receiving countries?’

Searches were made using fixed term and free text phrases for combinations of international recruitment, migration, healthcare workers, nurses, ethics, and brain drain/brain gain. Sources consulted included the online platform Web of Science; the database CINAHL (nursing and allied health literature); internet; and Google Scholar searches. Separate searches were made of the Journal of Ethnic and Migration Studies and Nursing Ethics. The websites of the World Health Organization, Royal College of Nursing, International Council of Nurses and the International Labour Organization were consulted. We also examined government, regulatory and recruitment websites such as CGFNS International, Inc (2021) or the National Nursing Assessment Service (2021) to ascertain current arrangements for healthcare workers planning to emigrate to countries such as the US or Canada.

Just over 250 items were selected for full text retrieval. They consisted of journal and newspaper articles, web pages, books, and reports. As will become clear, there are limitations to the quality of routinely collected administrative data and many of the empirical studies retrieved for the review were small scale or limited in scope. This has consequences for the confidence with which each of the review questions can be answered. It is also important to note that the review sacrificed depth for breadth in terms of coverage of developments in different countries. Material more than 15 years old was excluded, except when it was cited in reference to past events or policies or to demonstrate that a problem was longstanding.
A final caveat must be made before discussing the findings. Healthcare in the UK is a devolved matter, but immigration is not. It is not always possible to obtain separate data for all four constituent countries in the UK. Care has been taken to make it clear when data from England and data from the whole of the UK are being presented. However, the lack of separate data for each country is a limitation, particularly when the proportion of migrants working in the NHS varies so much across different UK regions and countries, with London and the South-East of England recruiting more international healthcare workers than other parts of the UK (Alderwick and Allen 2019).

Patient and public involvement

The review was discussed at a meeting of the Unit’s Patient and Public Involvement and Engagement Advisory Group (PPIEAG) in March 2021. Members felt that this was an important topic for research and expressed their approval that the DHSC had commissioned it. They concurred with the emerging themes for the review identified by the researchers and offered further insights based on their personal experience. These included severe nursing shortages in two countries because of international recruitment and the difficulties that could arise from unethical recruitment practices. For example, some recruitment agencies listed nurse salaries in the UK without providing vital contextual information on taxation rates and how much was needed to pay for essentials such as utilities, housing, and food. The Advisory Group also highlighted the position of children who had been left behind in sending countries. They wanted internationally recruited nurses to have access to suitable training to smooth their adaptation to working in the UK and considered there was potential for developing more exchange schemes in which UK and internationally recruited nurses had opportunities to experience practice in each other’s countries of birth. Several members of the Group read and commented on the drafts.
Findings

The ethics of the international recruitment of healthcare workers

The ethics of health workforce migration are complex (Hawthorne 2014) and multifactorial (Buchan et al. 2014a). Discussion is sometimes polarised, ranging from the suggestion that the ‘active international recruitment of healthcare workers from Sudan should be a crime’ (Mills et al. 2008) to countervailing propositions about individuals’ rights to autonomy (Palese et al. 2016) and the moral permissibility ‘for an employer to actively recruit and hire a worker if the relevant employment contract is voluntary, fair, and no third party has an urgent moral claim against the contract’ (Hidalgo 2013). Runnels et al. (2011: 7) suggest that it may be more fruitful to analyse the ethics of the international recruitment of healthcare workers from within a framework of competing rights. ‘The right of healthcare workers to migrate, for example, may compete with the right of other individuals to have access to core health services.’ Such an approach has been endorsed by other commentators. Here, the emphasis is on the impossibility of offering absolutist guarantees about rights. Rather, each right must be constrained to fit within a system that workably realizes a full suite of human rights (Breakey et al. 2019).

Over time, a consensus has emerged that global shortages of health personnel are not caused by international recruitment but are rather a symptom of the multiple push and pull factors which operate in both sending and receiving countries (Buchan et al. 2014b, Li et al. 2014, Cabanda 2017, Walton-Roberts et al. 2017, Primeau et al. 2021, Roth et al. 2021, Stevano et al. 2021). There is also greater acceptance of the idea that international recruitment of healthcare workers is bound to continue, and the challenge is to find solutions to make it more ethical (Runnels et al. 2011, Cometto et al. 2013). Debates about the ethics of international recruitment also need to be considered in the context of each state’s responsibility to support its citizens (Palese et al. 2016, Pavolini and Kuhlmann 2016).

Figure 1 summarises the main messages from this review diagrammatically. The shapes in dark colours and white text indicate the topics for which there is a consensus (data quality, help adapting to new environments and discrimination in receiving countries). Those in light colours (role of recruitment agencies, effects on sending countries and workforce supply in receiving countries) summarise where evidence is more limited. Some of the evidence about the final topic, remittances, comes from data about remittances as a whole, not just those from healthcare workers. Research based on healthcare workers indicates the disadvantages experienced by women in less well-paid healthcare roles who may be disproportionately responsible for sending funds to their country of origin.

Overall, the material retrieved for this review suggested that ethical international recruitment of healthcare workers is possible but that it requires a number of safeguards, designed to protect both workers and the countries from which they are recruited, to be in place. When this protection is absent – for example when international recruitment is used to reduce domestic workers’ wages (Kidgell et al. 2020) or when internationally recruited workers experience discrimination in the receiving country (Iheduru-Anderson 2020) – then it is not.
Figure 1: Evidence map for themes covered in the review

The colours of the boxes represent the different themes identified in the review. The dark blue (data quality) and bright green boxes (induction) and larger font size indicate that these themes are comparatively well covered in the published literature. By contrast, the paler boxes and smaller font sizes indicate that there appear to be gaps in the published literature. There is comparatively little material on recruitment agencies (grey) and success in increasing the domestically trained workforce (pale green). The impact of international recruitment on smaller countries is under researched (cream). Remittances (orange) are often discussed in terms of the impact on national income but rarely in terms of their impact on individuals who have been internationally recruited. The evidence about experiences of racism and discrimination (purple) is compelling but comparatively few studies have systematically collected data on this topic.

Limitations in data quality are a barrier to accurate information on the scale of international recruitment of healthcare workers and its impact (for example, World Health Organization 2010, Buchan et al. 2014, Dumont et al. 2014, Buchan et al. 2019).

Some high income countries have been criticised for treating the international recruitment of healthcare workers as a permanent solution to their workforce shortages (World Health Organization 2010, Siyam and Dal Poz 2014, International Council of Nurses 2019). Efforts have been made to increase the number of workers in the domestically trained workforce with varying success (Hawthorne 2014, Alluhidan et al. 2020, Shaffer et al. 2020, Valdez et al. 2021).

Remittances enable resources to be transferred from receiving to sending countries (World Bank 2020) but some workers send remittances when they cannot afford them (Humphries et al. 2009). The gendered nature of remittances in which comparatively poor women send money home is often ignored (Bourgeault et al. 2021).

It is now generally accepted that international recruitment of health workers is a symptom not a cause of wider problems in the health systems of sending countries (Li et al. 2014, Stievano et al. 2021). Sending countries are affected in different ways. For example, India and the Philippines aim to produce a surplus of workers who can move abroad (Walton-Roberts et al. 2017, Ortiga 2020). Smaller countries, such as countries in the Caribbean can be proportionally more affected by international recruitment than more populous states (Tomblin Murphy et al. 2016, Rolle Sands et al. 2020) but this is not always recognised.

Empirical evidence about recruitment agencies is disproportionately weak compared with their influence on the process of international recruitment (Pittman et al. 2010, Runnels et al. 2011, Shaffer et al. 2020). This is an important gap because of their role in undertaking much international recruitment on behalf of sending states.

Good induction systems to help workers adapt to working in another country. There is substantial evidence from the UK and other countries about variation in the quality of support systems designed to help workers adapt to working in another country.

In the context of the pressures created by the COVID-19 pandemic on international recruitment, it has been suggested that digital technologies will become increasingly important as a way of facilitating international recruitment. The International Labour Organization (ILO) and the International Organization for Migration (IOM) have suggested that one possible outcome of digital recruitment platforms is that they could help promote ethical international recruitment by increasing transparency and reducing the influence of exploitative recruitment agencies. However, should these processes be unduly time consuming and cumbersome, they may encourage potential international recruited workers to try and bypass these systems and gain employment through informal networks (ILO/IOM, 2020).

In addition, ethical international recruitment needs to be conceptualised as a multi-staged process, beginning with ensuring that workers in sending countries can make fully informed choices about applying to work in another country and ending with an examination of how they are supported in making the transition to a new home and working environment. Outside the workplace, workers’ opportunities to acquire citizenship and settlement rights in receiving countries, should they choose, are another prism through which ethical recruitment should also be scrutinised.

In recent years, events such as Britain’s withdrawal from the European Union, the COVID-19 pandemic, and changes to immigration policy have all influenced the numbers of internationally recruited workers in health and social care and their countries of origin (Health Foundation 2021, Turnpenny and Hussein 2021). The addition of occupations to, or removal from, the Shortage Occupation List (GOV.UK 2022) acts as an incentive or disincentive to international recruitment.

Turning to the review findings in more detail, the remainder of the section on findings has been organised into the following themes:

- How limitations in the data make it difficult to measure the impact of policies designed to achieve ethical international recruitment of healthcare workers
- Approaches to international recruitment in comparator countries
- Effects on receiving countries
- Mitigating the impact of international recruitment on sending countries (trade agreements, partnerships, recruitment agencies, and remittances)
- Effects on individuals, including motivations for migration, integration into the workplace, and citizenship rights

Limitations of existing data

Evidence about the international recruitment of healthcare workers is hampered by poor data. There have been repeated calls to improve the availability and comparability of statistics on international migration of healthcare workers if policymakers are to be able to evaluate the impact of policies and programmes relating to international recruitment (Stilwell et al. 2003, Buchan and Sochalski 2004, Buchan 2010, Dumont et al. 2014, Organisation for Economic Co-operation and Development 2015, Buchan et al. 2019, International Council of Nurses 2019, Yeates and Pillinger 2019b, Williams et al. 2020, World Health Organization 2020). The absence of globally comparable data (Yeates and Pillinger 2019b) means that we are largely reliant upon national data from
receiving countries, but these are not necessarily collected the same way (Dumont et al. 2014) nor updated with the same regularity, making cross country comparisons more difficult (Organisation for Economic Co-operation and Development 2015). Estimates of the extent of international migration among healthcare workers have become harder to calculate with the proliferation of circular and temporary migration programmes which make it more difficult to calculate the total number of ‘inflows’ (the number of people moving to a country) and ‘outflows’ (the number of people leaving) (Yeates and Pillinger 2019b). The next two sub-sections use examples from the UK to illustrate why definitive answers to questions about ethical international recruitment are hampered by limitations in the way that data are collected and recorded.

**Nationality and migration status among NHS workers and nurses in adult social care**

NHS Digital collects data on the nationality of people employed in the NHS in England. In 2020, 211 different nationalities were recorded in answer to a question about national identity. Of those staff for whom information was available, 86.2% were British and 13.8% were not. The latter largely consisted of people from one of the 27 European Union (EU) countries (5.5%), South Asia (2.8%), Southeast Asia (2.1%) and Sub-Saharan Africa (2%). The highest proportion of workers with a nationality other than British were doctors (29%). This compared with 17.9% of nurses and 10.4% of clinical support staff (Baker 2020). These data only include staff employed by the NHS and exclude catering and cleaning staff working for outsourced organisations. However, this sector is also known to employ high proportions of migrant workers (Equality and Human Rights Commission, 2014).

While these data aptly illustrate the sheer diversity of staff working in the NHS, they are imperfect as means of quantifying how many NHS workers were recruited internationally. In this instance, nationality was self-defined and may have reflected workers’ cultural heritage, not their citizenship or country of birth. Answers would also have been affected by the proportion of people completing the survey who had applied successfully for British citizenship. Without recording data on country of birth or changes to citizenship, it is not possible to distinguish between natal citizens and those who have migrated. In countries such as Canada, New Zealand and Australia, most migrants naturalise within 10 years of arrival. In other OECD countries, take up of citizenship may be as low as 50%. This creates challenges in calculating the extent of international migration on a cross country basis (Dumont et al. 2014).

A further limitation for policymakers and workforce planners in England is the lack of data about the estimated 36,000 registered nurses working in care homes with nursing. Skills for Care (2020) reports that 84% of the adult social care workforce has a British nationality, with 7% coming from the EU 27 and 9% from outside the EU 27. However, it is not known whether nurses employed in adult social care have a similar or different profile to NHS nurses and the wider adult social care workforce. There is scope to investigate the extent to which adult social care is a ‘stepping stone’ to the NHS or to other country destinations (Cornes and Manthorpe, 2022).

Studies have also shown that internationally recruited health and care workforces nearly always include migrants with a health qualification which does not meet the registration requirements for the relevant professional body in the country to which they have emigrated (Allan and Westwood 2016, Middleton et al. 2018, Fricke 2019, Munkejord and Tingvold 2019, Sekulová and Rogoz 2019) or who are have been unable to obtain paid employment in a post for which they are qualified (Batalova 2020). Some of these workers do eventually find paid employment as healthcare
professionals in the country to which they have moved, but others do not (Mosulela 2020, Calenda and Bellini 2021, Spiliopoulos et al. 2021).

The lack of information about the care home nurse workforce (Cornes and Manthorpe 2022) and the lack of evidence about the registered nurse workforce in other parts of social care also makes it hard to identify the extent to which it includes internationally recruited workers who could be upskilled to become registered nurses, the prevalence of discrimination, and the steps taken to counter it, and how social care employers are adapting to their requirements laid down in the Code of Practice when recruiting international workers.

*Using data from professional registers*

Registration data published by professional bodies provide information on the main ‘sending’ countries. It is less useful in providing evidence of ethical recruitment in terms of compliance with the requirement to recruit only from countries on the ‘green’ list, as laid out in the DHSC Code of Practice (2021).

A report from the House of Commons Library which was published before the revised Code of Practice in 2021 noted that:

*[General Medical Council (GMC)] data accessed on 16 December 2020 shows that where doctors qualified outside the UK, the top 5 countries are India (29,343), Pakistan (14,631), Nigeria (8,030), Egypt (7,201) and South Africa (5,108). All of these countries are on the banned list.*

(Macdonald 2020: 30)

The list of countries from which active recruitment is not permitted has been updated (Department of Health and Social Care 2021) and, of the five countries referenced above, only Nigeria and Pakistan remain on the ‘red’ list.

However, without knowing the year in which they registered, the presence of people from ‘red’ and ‘amber’ countries on registers held by professional bodies should not be taken as evidence that the Code of Practice is being contravened. Some doctors, nurses, and AHPs will have been recruited before the 2001 and 2021 Codes of Practice became operational. These data are also unable to differentiate between internationally recruited healthcare workers and registrants who have arrived via other immigration routes, such as family reunification or as refugees.

It is even harder to quantify the extent of international recruitment of nurses and AHPs from ‘amber’ and ‘red’ countries because the Nursing and Midwifery Council (NMC) (2020) only publishes data about international recruitment of nurses from the ‘Top Five’ sending countries and the Health Professions Council, which registers AHPs, only publishes the proportion of international registrants with no indication at all of the countries from which they were recruited. The paucity of information about internationally recruited AHPs has already been highlighted by researchers in the UK (Buchan et al. 2014a) and the US (Pittman et al. 2014).

A further complication is that international migration takes place for a number of reasons, not simply economic (Bleeker and Deonandan 2016, Cabanda 2017, Gea-Caballero et al. 2019). There has been a recent rise in health worker migration from people living in countries experiencing political volatility and instability (Williams et al. 2020). In such situations, the dilemma of recruiting
from countries on the DHSC’s Code of Practice’s (2021) red and amber lists needs to be balanced against the ethical imperative of preventing individuals’ lives from being endangered.

As mentioned above, data from professional registers may underestimate the extent of international migration of healthcare workers if people with qualifications but who are not registered with a professional body (Salami et al. 2014, Sekulová and Rogoz 2019) are excluded. In the final example in this section, we discuss the corollary, namely that not everybody registered with a professional body is available for paid employment. Taken together, these three examples lend support to the suggestion that improvements to patient care and workforce planning could be achieved internationally if all governments took a ‘joined up’ approach towards data on internationally recruited workers in health policy and health workforce planning (Kuhlmann et al. 2020).

**Improvements to data quality – doctors in South Africa**

Accurate data about international recruitment require information on both ‘inflows’ and ‘outflows’. It also needs to take account of circular and return migration. Inevitably, this requires access to multiple sources of data and is likely to require extensive data imputation (replacing missing data with substituted values) across datasets.

Tankwanchi et al. (2019) analysed data from the South Africa medical register, the National Reporting Instruments (NRI) (a publicly accessible online data repository managed by the WHO), the Organisation for Economic Co-operation and Development (OECD), and the GMC. While their results confirmed what was already known – that many doctors trained in South Africa practised overseas – they were also able to demonstrate that the rate of net migration had slowed, a trend which predated the adoption of the WHO Global Code of Practice (2010).

The study also provided new evidence on the diversity of the medical workforce in South Africa. Practising doctors in South Africa included people from nearly 100 different countries, the overwhelming majority in Africa, but also from OECD countries. Two new findings included a rise in doctors from Libya hoping to escape political instability in their own country and information on the number of returnees to South Africa. It also emerged that registrants included a number of people who were not practising. Not recognising that professional registers include people not practising risks inflated assumptions being made about the size of the workforce (Tankwanchi et al. 2019).

**Comparisons with approaches in other countries**

High income countries are the largest importer of healthcare workers (Smiley 2020) but globalisation has also produced an expansion of internationally recruited workers in some low-to-middle income countries. An expansion in the number of receiving countries for internationally recruited healthcare workers means that there is greater competition for internationally recruited health workers (Chisholm 2019) and a loosening of some of the traditional ties between sending and receiving countries, such as a common language or pre-existing family connections. For example, some Indian and Filipino nurses are now working in Norway (Munkejord and Tingvold 2019, Nortvedt et al. 2020, Solum et al. 2020).

Table 1 (overleaf) summarises the information that was obtained from items retrieved for the review which included information about different policy approaches towards international
recruitment and information about the processes for applying to work in a particular receiving country. It is important to recognise that immigration and health policies can be subject to rapid change so, despite our best efforts to cross check material, the information presented in this table may have changed from when these studies were published. The reason for including an entry for Wales was to feature a project aimed at recruiting nurses who trained overseas who were living and working locally but who could not work in a registered nurse role without financial and practical support (Middleton et al. 2018).

There are several important messages that can be drawn from Table 1. The first is that the sheer size of the US healthcare system means that the number of healthcare workers classified as ‘migrants’ is very large in absolute terms. However, the US’s actual share of internationally recruited healthcare professionals is actually smaller than those found in many other OECD countries (Batalova 2014).

This returns us to the opening theme of this review – the limitations of existing data. As Table 1 shows, information about migrant healthcare workers in the US is generally presented in terms of those workers who were not US born. As Batalova (2014) points out, this definition includes refugees, children who arrived in the US as undocumented child migrants, and people who arrived on family reunification or student visas. By definition, this is a much larger migrant healthcare workforce than the workforce consisting solely of people who were internationally recruited via employment routes. This makes the process of international comparison more difficult.

A second message from the data presented in Table 1 is the continuing failure in receiving countries to capture ‘outflows’ as well as ‘inflows’. With rare exceptions (for example, McGillis Hall et al. 2009, Vafeas and Hendricks 2018), this creates a lost opportunity to ascertain the extent to which decisions to move abroad among the domestically trained healthcare workforce are driven by personal aspirations or whether there is a more endemic dissatisfaction with working conditions and career progression.

A third message from Table 1 is the need to capture the extent of transit or onward migration from one country to another. Some internationally recruited health workers will settle permanently in the country to which they emigrate. Some will return to their country of origin in retirement. Others use international recruitment as a stepping-stone for moves to a third country (Dimaya et al. 2012, Brugha et al. 2015, Al-Dossary 2018). The potential for family reunification was an important reason why nurses from the Philippines wanted to move to the US (Dimaya et al. 2012). High rates of onward migration add to the costs of international recruitment and also make it harder for workforce planning (Al-Dossary 2018). It is not clear how far the possibility of naturalising or acquiring the right to permanent residency plays a part in influencing the rates of onward migration.

While the migration literature contrasts high income countries’ preference for encouraging skilled migration and discouraging migration from workers who are deemed to be ‘unskilled’, Table 1 illustrates that theoretical distinctions between skilled and unskilled migration are less clear cut in reality. This is shown by the Germany’s triple win approach which trains citizens in Serbia, Bosnia Herzegovina, Tunisia, and the Philippines who would not otherwise qualify for entry to Germany as skilled workers. They spend time in their own country acquiring the professional and language skills to work in health and care settings in Germany (Deutsche Gesellschaft für Internationale Zusammenarbeit 2021). By contrast, the Federal Skilled Worker program in Canada has been
criticised for not achieving better outcomes for workers in terms of helping them to adapt to workplace and wider societal settings in Canada (Kolawole 2009, Kaushik and Drolet 2018).

The final point worth noting from Table 1 is the role of trade agreements in Japan and Germany to address shortages in the healthcare workforce. There are important differences between the two countries in terms of immigration policy, but the contrast in the number of workers recruited via this route does help explain why commentators place such emphasis on ensuring that the health sector is fully involved in trade negotiations that involve people as well as goods (Hirano et al. 2020, Kidgell et al. 2020).
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<th>Country</th>
<th>Main sending countries</th>
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<th>Strategies for increasing the size of health and care workforce</th>
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<td>Australia</td>
<td>According to the OECD, 32% of doctors and 18% of nurses in Australia were trained in another country (Buchan et al. 2019). Australia has been a popular destination for nurses and doctors from the UK but there has been a decline in the number of internationally recruited healthcare workers from the UK. Apart from the UK, India and The Philippines are major sending countries. There has also been a rise in international recruitment from countries in Southeast Asia, including Malaysia, Singapore, and China (Hawthorne 2014).</td>
<td>There are six well-defined pathways for internationally recruited health workers: temporary sponsored migration; permanent skilled migration; the study-migration pathway; trans-Tasman migration from New Zealand; spouse and family migration; and humanitarian migration. The last two categories are the routes hardest to access (Breakey et al. 2019).</td>
<td>Australian federal government policy is aimed at achieving self-sufficiency in the health workforce. Migration policy has changed from historically more generous visa conditions – including a greater range of opportunities for conversion from temporary to permanent residency – in favour of a shift towards temporary-only visas with reduced opportunities for conversion to permanency (Breakey et al. 2019). However, despite increases in the numbers of nurses and doctors, it is still expected that international recruitment will be important (Hawthorne 2014). Although there was a shortage of doctors in the 2000s, a controversial report concluded that there were ‘too many GPs’ in Australia (Birrell 2013). An increase in the domestic supply of doctors has meant that internationally recruited doctors are only offered visas on condition they practise in rural areas or in specialisms where recruitment has been difficult (Breakey et al. 2019).</td>
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<td>Canada</td>
<td>According to OECD data, 24% of doctors and 8% of nurses in Canada were trained in another country (Buchan et al. 2019). Pakistan, India, South Africa, United States, and Egypt are major source countries for doctors. Doctors from the UK still make up a high proportion of internationally recruited doctors but there are fewer than in the past. The Philippines, UK, US, and India are the major source countries for nurses. More recently, nurses from China and Poland have also moved to Canada (Owusu and Sweetman 2014).</td>
<td>Applications to live in Canada are made through the Federal Skilled Worker programme. A number of qualified nurses have used temporary routes designed for care workers to acquire entry into Canada (Nourpanah 2021), some of these may obtain permanent residency at a later point. A new development has been to offer a route to permanent residency to health workers who are refugees and who have worked a minimum number of hours providing direct care to patients during the COVID-19 pandemic (Government of Canada 2021).</td>
<td>Healthcare worker vacancies in Canada are at a record high, particularly in rural areas (Bensadoun 2021). Canada’s health insurance system means that there is not a conventional labour market in the supply of doctors and insurance companies have rationed the number of doctors to control costs (Owusu and Sweetman 2014). There has been considerable criticism of the Temporary Foreign Worker and the now disbanded Live in Caregiver programmes because of the potential for abuse by employers (Salami et al. 2014, Strauss and McGrath 2017, Nourpanah 2021).</td>
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<td>Germany</td>
<td>According to OECD data, 7% of nurses and 10% of doctors in Germany were trained in another country (Buchan et al. 2019). Germany has become a centre for the global migration of health workers, but the majority come from countries with which Germany has bilateral trade agreements (Balkan states, the Philippines, and Vietnam) and EEA countries – in particular Romania (Kordes et al. 2020). Germany is a sending country for nurses and doctors, albeit on a much smaller scale (Ognyanova et al. 2014). EU 27 residents can work in Germany under EU rules based on mutual recognition between Member States of professional qualifications. Programmes such as MobiPro-EU targeted individuals aged 18-35 who were registered as unemployed in an EU member state and who were willing to take up employment in a shortage occupation (Kordes et al. 2020). The key entry route for non-EU 27 citizens has been through trade agreements of which the largest is the Triple Win (Deutsche Gesellschaft für Internationale Zusammenarbeit 2021). This involves bilateral agreements with Bosnia, Serbia, the Philippines, and Tunisia. A separate similar agreement has been reached with Vietnam. The ‘triple win’ refers to the advantage for Germany of recruiting additional nurses, the advantages for individuals in the sending countries where there are high levels of nurse unemployment, and the advantages for families and sending countries where money from remittances will contribute to family finances and the wider economy. A severe shortfall between demand for health and care and workforce supply in Germany is predicted. Hospitals, care homes, and home care agencies are already experiencing considerable recruitment problems (Kordes et al. 2020). By the year 2030, the total shortage of health professionals is expected to almost reach 1 million, including 165,000 doctors, 466,000 nurses and healthcare assistants and 334,000 other health workers (Ognyanova et al. 2014). In addition to increased demand, workforce shortages are partly caused by a deterioration in working conditions (Kordes et al. 2020, Roth et al. 2021) and the low status of nursing and care work which acts as a barrier to work in these occupations (Wichterich 2020). Policy responses to workforce shortages include measures to improve retention and working conditions, expand the recruitment base and target returners to the workforce (Roth et al. 2021). However, the federal government regards large scale international recruitment as a key solution to workforce shortages (Kordes et al. 2020). While the Triple Win has been praised by some as an example of ethical recruitment practice because it focuses on countries where there is a surplus of health workers (Mosulela 2020), there was criticism of plans to recruit Pflegekräfte (care workers) from Kosovo who would then be trained to work as Krankenpfleger (healthcare assistants) in hospitals (Fricke 2019).</td>
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<td>Ireland</td>
<td>42% of doctors in Ireland are trained overseas. Among OECD countries, only Israel (57%) and New Zealand (42%) have higher proportions of doctors trained overseas (Cullen 2018). Traditionally a sending country for nurses, Ireland is now also a receiving country, mainly for nurses from the Philippines and India (Humphries et al. 2008, EU 27 residents can work in Ireland under EU rules based on mutual recognition between Member States of professional qualifications. Non-EU 27 citizens usually apply for Critical Skills Employment Permits which are designed to attract highly skilled people into the Irish labour market with the aim of Ireland produces more medical graduates than anywhere else relative to its population (Cullen 2018). Although the data are imperfect, it appears that seeking improved working conditions and better career progression are the main reasons behind high exit rates among doctors (Brugha et al. 2015).</td>
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<td>Ireland</td>
<td>Humphries et al. 2009). Between 2000 and 2010, 35% of new recruits into the health system were non-EU migrant nurses, making Ireland more heavily reliant upon international nurse recruitment than the UK, New Zealand, or Australia. Ireland also experiences high levels of onward migration as internationally recruited health workers move on to countries such as Australia, Canada, the UK, and US (Brugha et al. 2015).</td>
<td>encouraging them to take up permanent residence. Nurses, midwives, doctors, pharmacists, and AHPs are all on the Critical Skills Occupations List. They need to have a job offer of at least two years and be earning more than €32,000 per year (Department of Enterprise, Trade and Employment Undated).</td>
<td>There have been criticisms of the quality of both workforce planning and data collection in Ireland. It has been suggested that international recruitment has been used as a short term solution and not enough information is collected on the number of health workers leaving Ireland each year (Humphries et al. 2012, Brugha et al. 2015). Many nurses left Ireland after the economic crisis in 2008 (Humphries et al. 2012). A campaign instituted by the Irish government to encourage Irish nurses working overseas to return to Ireland was disbanded after the scheme received just 120 applications (Gannon 2019).</td>
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<td>Japan</td>
<td>People who are not Japanese residents only account for about 2% of the population, much lower than other OECD countries (Soneta et al. 2021). The main source countries for nurses in Japan are Indonesia, the Philippines, and Vietnam. More recently there has been a rise in the number of Chinese nurses hired via private agencies (Hirano et al. 2020).</td>
<td>Internationally recruited health workers can enter Japan via Economic Partnership Agreements (EPA) signed with the Philippines in 2006, Indonesia in 2007 and Vietnam in 2008. Nurses from these countries are hired either as a candidate for a nurse (Kangoshi) or care worker (Kaigofukushishi) (Efendi et al. 2021). They have to take a Japanese national examination and a test to prove their proficiency in Japanese. As many as 20% of nurses return to their home countries even after passing the examination (Sato 2019).</td>
<td>Japan’s ageing population means that demand for healthcare is expected to increase. It is estimated that there will be a shortage of 270,000 nurses in Japan by 2025 (Efendi et al. 2021), with worse shortages in rural areas (Hirano et al. 2020). The success of bilateral agreements in increasing the workforce has been limited. As of January 2019, only 136 of the 1,300 candidates who entered Japan since 2008 remain (Hirano et al. 2020). As is well known, Japan has invested considerably in technological advances in automation and robotics as a way of meeting the needs of an ageing population (Hsu et al. 2020) but there is no clear evidence as to how much this could substitute for shortages in the healthcare workforce.</td>
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<td>Saudi Arabia</td>
<td>73% of doctors (Zawawi and Al-Rashed 2020) and 74% of nurses are trained abroad (Aboshaiqah 2016). The majority of internationally recruited nurses in Saudi Arabia are from the Philippines, India, and Malaysia (Alluhidan et al. 2020).</td>
<td>Work visas are available for people who have offers of employment and the required qualifications, but they do not offer permanent residence or citizenship to migrants (Bourgeault et al. 2021). Problems have also been experienced with the need to apply for exit/re-entry visas every time workers leave the country and in changing employers (Zawawi and Al-Rashed 2020). Saudi Arabia has developed the Musaned digital platform for the recruitment of domestic workers of all kinds, including nurses, housemaids, drivers, and cooks. It aims to improve the working conditions of domestic and internationally recruited workers in the home (ILO/IOM, 2020)</td>
<td>For many years the government has supported a policy of ‘Saudisation’, aimed at reducing unemployment and replacing the number of migrant works with Saudi citizens (Al-Hanawi et al. 2019). There are growing demands on the Saudi healthcare system that arise from a population that is both growing and ageing, and rising expectations of improved healthcare for all citizens (Alluhidan et al. 2020). Comparatively few nurses are trained in Saudi Arabia because of a reliance upon internationally recruited nurses. However, as part of the Vision 2030 programme, efforts are being made to increase the number of Saudi universities offering nurse training and increase the status of nursing and improve retention rates (Alsufyani et al. 2020). Turnover rates among internationally recruited nurses tend to be high, especially as many nurses move to work in countries such as the US, UK, Canada, Australia, and New Zealand once they have gained more experience (Al-Dossary 2018)</td>
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<td>United States</td>
<td>In 2018, 14.7 million people in the US worked in a healthcare occupation in 2018. Of these, more than 2.6 million people were born outside the US (nearly 18%), including 314,000 refugees. The number of doctors, registered nurses, and pharmacists born outside the US numbered 1.6 million (Batalova 2020). According to the OECD, 25% of doctors and 6% of nurses were trained outside the US (Buchan et al. 2019). Other estimates put the percentage of internationally recruited nurses as between 8-15% (Shaffer et al. 2020). The Philippines, Canada, and India account for the majority of internationally recruited</td>
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<td>Work visas are available for people who have offers of employment and the required qualifications, but they do not offer permanent residence or citizenship to migrants (Bourgeault et al. 2021). Problems have also been experienced with the need to apply for exit/re-entry visas every time workers leave the country and in changing employers (Zawawi and Al-Rashed 2020). Saudi Arabia has developed the Musaned digital platform for the recruitment of domestic workers of all kinds, including nurses, housemaids, drivers, and cooks. It aims to improve the working conditions of domestic and internationally recruited workers in the home (ILO/IOM, 2020)</td>
<td>Population growth and ageing and a greater insured population following the Affordable Care Act have all contributed to increased demand for healthcare in the US (Zhang et al. 2020). Nursing continues to be the largest and fastest-growing healthcare profession in the United States, but future supply and demand are expected to vary considerably between States, with some experiencing surpluses and others shortfalls. Until the 2000s, employers in the US were very reliant on nurses educated overseas but since then there has been a major shift to educating more US-born nurses (Shaffer et al. 2020). There is currently a shortage of doctors which is predicted to worsen considerably by 2030, with only North Eastern States experiencing a surplus (Zhang et al. 2020).</td>
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<td>nurses but other important sending countries include the UK, Nigeria, and South Korea (Spetz et al. 2014). 22% of doctors in the US come from India but other important sending countries include Canada, China, Iran, Korea, Pakistan, and the Philippines (Batalova 2014).</td>
<td>migrants in childhood to apply for a work permit. The number of people on employment routes varies. It is affected by visa retrogression when the number of green card applicants exceeds the number of applicants, leading to a backlog of applications (Shaffer et al. 2020). When the number of visa applications was reduced in 2007, followed by the economic crisis in 2008, this led to a dramatic fall in the number of internationally recruited healthcare workers (Abarcar and Theoharides 2020). Possession of a green card or naturalised status brings advantages in terms of family reunification. For example, the ultimate aim of many nurses from the Philippines is to be able to move to the US and they move to other countries with the express aim of acquiring the skills and experiences that will enable them to apply to be a legal permanent resident in the US (Dimaya et al. 2012).</td>
<td>There is a gender gap among internationally recruited workers in the US, with more men employed in better paid occupations in medicine while women are more likely to be employed in nursing and care work (Batalova 2020).</td>
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<td>Wales</td>
<td>Overall, 5% of NHS staff are from the EU 27 and 3% are from non-EU countries (Baker 2020). Wales is more reliant on non-EU 27 doctors than England, particularly doctors from India.</td>
<td>In all four UK countries, a Health and Care Worker visa allows professionals to come to or stay in the UK to do an eligible job with the NHS, an NHS supplier or in adult social care (GOV.UK Undated). The aim is to increase the speed at which suitably qualified healthcare workers can move to the UK.</td>
<td>The Welsh Government aims to create a sustainable workforce, with an emphasis on making work in health and social care a distinct and attractive brand (Portes et al. 2020). A scheme was developed by Aneurin Bevan University Health Board to support internationally educated nurses from outside the EEA who were living locally to meet the NMC registration requirements (Middleton et al. 2018).</td>
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Effects of international recruitment on receiving countries

As mentioned in the introduction, concern about the ethical aspects of international recruitment of healthcare workers stemmed from a realisation that high income receiving countries were net beneficiaries from the investment in professional qualifying education made by lower and middle income countries (Wright et al. 2008, Bradby 2014, Brugha and Crowe 2015). From a UK perspective, international recruitment has enabled shortages in the domestic supply of healthcare workers to be ameliorated (Buchan 2007), especially in regions in which vacancy rates are most severe (Buchan et al. 2004). As the UK population as a whole has become more ethnically diverse, diversity within the NHS workforce has enabled it to better reflect the communities it serves. International recruitment also offers opportunities for cultural exchange on a professional and personal basis (Beech et al. 2019). In terms of the wider economy, migration contributes to economic growth and entrepreneurship, especially in stagnant economies (Clemens 2017).

At a national level (as opposed to the impact on individuals which will be discussed separately later), the downside of international recruitment for receiving countries is short-termism and a failure to ensure that policies for international recruitment operate in tandem with policies intended to increase the supply of domestically trained workers (World Health Organization 2010, Siyam and Dal Poz 2014, Buchan et al. 2019, International Council of Nurses 2019). Bond et al. (2020) estimate that employers and sometimes nurses themselves might spend as much as £10,000 recruiting internationally educated nurses. This figure includes fees to recruitment agencies, advertising, verifying qualifications, and arranging visas. This is actually similar to the £9,169 which is reported to be the weighted median unit cost of pre-registration adult nurse education in England, excluding students’ living costs (KPMG 2017).

Effects of international recruitment on sending countries

Unlike receiving countries which overwhelmingly benefit from international migration, the impact of international recruitment on sending countries is thought to be more mixed, with some countries gaining more than others. Rolle Sands et al.’s (2020) scoping review of Caribbean nurse migration provides a clear example of the differences that can exist within the same region. They reported that countries such as Jamaica, Haiti, Trinidad and Tobago, and Guyana experienced much higher migration rates than other Caribbean countries such as The Bahamas or the Cayman Islands. Furthermore, both Jamaica and St Kitts have followed a policy of creating ‘nurses for export’ and, in turn, recruited nurses from India, Cuba and even Nigeria. This demonstrates neatly how countries can be receivers as well as donors in terms of internationally recruited workers.

The Caribbean also provides a good example of the uneven evidence base on which to examine the effects on sending countries. As noted in the previous section, reports for policymakers have tended to focus on countries such as India and the Philippines because of the large numbers of internationally recruited workers they provide. However, the effects on smaller sending countries may be more profound. There are three times as many nurses from the Caribbean practising outside the region as within it (Tomblin Murphy et al. 2016) but results from this review suggest that Caribbean – and Irish - nurse migration appears to be under-researched in comparison with the proportion of nurses of Caribbean and Irish nurses who have moved to another country.

With notable exceptions (Kirigia et al. 2006), few studies have attempted to quantify the effect of international recruitment in terms of the costs to the sending country of educating health
professionals and their loss of returns from investment when they migrate. Instead, we are reliant upon evidence about partnerships, trade agreements and remittances as examples of the ways in which countries have attempted to mitigate the worst effects of international recruitment and even create advantages for themselves. It is important to remember that progress is not always linear. The United Nations is especially concerned that gains in the form of trade, foreign investment and remittances are projected to decline by up to 40% in 2020 because of the impact of COVID-19 upon workers’ wages and ability to travel (United Nations 2020).

**Perverse subsidies and population health**

The World Health Organization (2006) *Working Together for Health* report promoted the idea of a causative link between the sparsity of healthcare professionals and poor population health outcomes. It also highlighted the ‘perverse subsidy’ in which higher income countries were the beneficiaries of healthcare workers whose education had been funded by lower income countries (Wright et al. 2008, Runnels et al. 2011, Bradby 2014, Brugha and Crowe 2015, Grenier 2015). The loss of large numbers of skilled workers was thought to have consequences for the wider economy in these countries and make it more likely that they would be reliant on foreign aid (Bleeker and Deonandan 2016) or expensive loans from organisations such as the International Monetary Fund (Likupe 2013). Among those who stay behind, the loss of workers is thought to lead to an increase in individual workloads, which would, in turn, contribute to a vicious cycle in which even more workers decide to leave (Kizito et al. 2015, Rolle Sands et al. 2020).

There is an alternative view which presents international migration as a virtuous cycle in which international migration and economic development are woven together because migration brings new technologies, skills, trade, investment to sending as well as receiving countries (Clemens 2017, Kerwin 2020). Furthermore:

> ... even if every last skilled emigrant from the poorest countries were obliged to return home, including those who grew up and gained skills abroad, this would erase just one tenth of the skill gap between those countries and the richest countries. That gap is principally determined by forces of long-term development much larger than migration.

(Clemens 2017: 7)

However, both Kerwin and Clemens are referring to migration as a whole and do not consider how this applies specifically to the international recruitment of healthcare workers.

Clemens also points out that, perhaps counter-intuitively, it is not the poorest countries that experience the greatest levels of migration but those that are becoming more developed. This pattern was also noted in a study analysing the relationship between doctors’ migration from developing source countries to more developed receiving countries and the developmental and global health profiles of source countries. Source countries with better human resources for health, more economic and developmental progress, and better health status appeared to lose proportionately more physicians than the more disadvantaged countries (Arah et al. 2008). More recent work would suggest that this may relate to infrastructure changes in the form of the greater presence of labour market intermediaries, such as recruitment agencies in low to middle income countries experiencing greater economic growth. These intermediaries are then able to facilitate
an increase in the number of internationally recruited healthcare workers (Kordes et al. 2020, Wichterich 2020).

Several commentators have pointed to links between the low numbers of health personnel and poor health outcomes for citizens in those countries. For example, Sierra Leone, Liberia, and Guinea are all currently on the DHSC (2021) ‘red’ list of countries from which active international recruitment of healthcare workers is not currently permitted. The full list of ‘red’ and ‘amber’ countries is listed in the Code: https://www.gov.uk/government/publications/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel/code-of-practice-for-the-international-recruitment-of-health-and-social-care-personnel-in-england.

However, in 2014 at the time of the Ebola outbreak, the scale of international migration from these countries to the UK and internationally was extensive, even though Sierra Leone had only 119 doctors serving a population of nearly six million people (a ratio of 50,000: 1). In Liberia and Guinea there was only one doctor for every 100,000 people. This compared to 100: 1 in the UK (Yeates and Pillinger, 2019b). The low numbers of workers compared with weak health systems is thought to have contributed substantially to the spread and severity of the Ebola virus in these countries.

**Taking a more proactive approach**

However, it is important to recognise that questions about the ethics of international migration need to recognise that different countries are affected in different ways. Sudan is regularly cited as a country which has been particularly adversely affected by international migration of healthcare workers. Like Guinea, Liberia, and Sierra Leone, it is also on the DHSC (2021) list of ‘red’ countries. Over half of Sudanese doctors practise abroad (particularly in the Gulf States, as well as traditional receiving countries such as the UK and Ireland) and new trends are showing that other health professionals are also migrating. Compared with the past, more Sudanese women healthcare workers are also choosing to migrate (Abuagla and Badr 2016).

The adoption of the WHO Global Code (2010) is thought to have acted as a catalyst for improvement. It helped encourage the Sudanese government to take a greater interest in the healthcare workforce in Sudan. As well as investing more in qualifying education for health professionals, the government has negotiated several bilateral agreements with receiving countries. Unfortunately, these agreements have not resulted in any payments to compensate for the loss of Sudanese healthcare workers moving abroad (Abuagla and Badr 2016).

**Estimating the cost of international recruitment**

Unlike Sudan, Kenya is an ‘amber’ country from which international recruitment is permitted but only in compliance with the terms of the government-to-government agreement. Over the years, Kenya has experienced extensive outward migration. Brownie and Oywer (2018) cite news sources in Kenya suggesting that one in every five Kenyan nurses applies to emigrate and around 30-40% of medical graduates leave on completion of their internships.

It appears to be surprisingly rare for researchers to have attempted to calculate the impact on receiving countries of high rates of health worker migration. In 2006, Kirigia et al. (2006) estimated that the total cost of educating each Kenyan doctor from primary school through to medical school was US$ 65,997. An estimated lost return on investment of approximately US$ 517,931 was
incurred for every doctor who then emigrated. The total cost of educating a nurse from primary school to graduation was estimated to be US$ 43,180, with an equivalent loss on investment to migration of US$ 338,868.

The Kenyan government has made attempts to reduce the scale of migration (Brownie and Oywer 2018) but it has also faced a number of factors that have made this more difficult. These include the considerable variation in the geographical density of nurses per head of population (Wakaba et al. 2014) and Kenya’s geographical location near countries experiencing considerable political instability such as Somalia, Sudan, Ethiopia, the Democratic Republic of the Congo, and Burundi. This has led to substantial increases in the number of refugees and the establishment of several large refugee camps (Mwakubo 2020). Situations such as these require sending and receiving countries to develop policies that recognise the impact of forced migration and refugee displacement alongside those aimed at mutually beneficial systems for regulating ethical international migration.

Creating an over-supply of healthcare workers

Some countries have attempted to reduce the loss of capital created by international migration in countries such as Kenya (Kirigia et al. 2006) or Malawi (Record and Mohiddin 2006) by introducing time limits preventing nurses and doctors whose education has been paid for by public funds from leaving once they have completed their studies. This system is known as ‘bonding’ and the bonding period usually amounts to the same time as the workers intending to emigrate had spent in qualifying education (Zimbudzi 2013). Cabanda (2017) cites Zimbabwe, Ghana, South Africa, and India as countries who have all tried this approach. However, some recruitment companies have sought to bypass this restriction by paying off the bonds of the workers they have recruited (Rolle Sands et al. 2020).

Other countries, such as the Philippines, India, and Singapore, have used the expansion of private universities to transfer the costs of educating health professionals onto individuals themselves. The Philippines and India also provide the best known examples of policies designed to mitigate the effects of international migration by producing more doctors and nurses than can be employed within their health systems. The Philippines, in particular, has been studied extensively in terms of the development of curricula which align closely with training programmes in the main receiving countries, particularly the US (Abarcar and Theoharides 2020) and a focus on employability and transferable skills (Ortiga 2020). This approach has been designed to be as resilient as possible to changes in demand for healthcare workers and in immigration policies in receiving countries (Ortiga 2020). By marketizing its model of nurse education through the development of education hubs on the basis that a nursing qualification from the Philippines will make an individual more desirable to international recruiters, the Philippines has attracted international nursing students from South Korea, India, and the Middle East (Ortiga 2018). Unlike other states, which often rely on informal networks in the receiving country from which to ensure fair treatment for their citizens, the Philippines has also created structures from which to monitor what happens to its nurses who emigrate overseas (Dimaya et al. 2012, Lee 2019), although this cannot protect all its citizens from discrimination (Salami et al. 2014, Jenkins and Huntington 2016). By contrast, policy in India has been less clear cut and there is less control over what happens in the private sector which is increasingly responsible for the qualifying education of health professionals (Walton-Roberts et al. 2017).
Impact of unemployment

International recruitment can help sending countries and individuals who would otherwise face unemployment. Debates about the ethical impact of the international recruitment of healthcare workers are often predicated on the assumption that all internationally recruited workers will already be in paid employment but plan to achieve better paid work and greater career progression by moving. The economic downturn of 2008 led to large numbers of unemployed Italian (Palese et al. 2016) and Spanish (Gea-Caballero et al. 2019) nurses deciding to move elsewhere, particularly the UK. Until then, neither Spain nor Italy had particularly high levels of outward migration, demonstrating the dynamic nature of sending and receiving countries.

Role of education partnerships

Evidence from research into education partnerships is that they bring benefits for sending and receiving countries and for the individuals involved in delivering and studying on programmes. It is therefore unsurprising that the DHSC (2021) Code of Practice and the United Nations Sustainable Development Goals (Undated-b) both emphasise their role in creating capacity and reducing developing countries’ reliance on loans and international aid.

Nishimi and Street (2020) identified a total of 28 international nursing education partnerships between high income and low income countries using a combination of peer-reviewed literature, grey literature, programme websites, and web announcements. Twenty-one of these involved US institutions. The other high income countries involved were Australia (n=3), Canada (n=3) and the UK (n=2). The latter consisted of a collaborative partnership between academic institutions in Malawi, the UK, Ireland, and the US to include nursing informatics in the curriculum and develop educational materials that could be used to teach it (O’Connor et al. 2016) and a partnership to improve nurse education capacity in Andhra Pradesh between a UK university and seven local institutions (Evans et al. 2013).

Overall, Nishimi and Street (2020) concluded that there were barriers and challenges in developing partnerships, including cultural differences, language barriers and limited resources. Set against this, partners in low income countries identified improved nurse education and strengthened healthcare capacity. Partners from high income countries identified the benefits of international links for faculty and students, including enriching clinical practice and improving cultural competence. They did not appear to have identified any studies into the cost effectiveness of these sorts of partnership.

The ‘Supporting Internationalisation of Traineeships in the Healthcare Sector’ project (Morley and Cunningham 2021), which reported after Nishimi and Street published their review, brought together nine international partners from Finland, Poland, Spain, and the UK to develop international placements for students on pre-registration nursing programmes. As well as echoing the benefits of greater cultural competence reported by Nishimi and Street among those who undertook international placements, Morley and Cunningham (2021) concluded that there were benefits for the global health workforce in terms of achieving greater standardisation across programmes and in preparing nurses to work across increasingly mobile settings.

Outside the UK, the Australia Awards offer scholarships and short courses to individuals from 20 developing countries. In 2021, funding for this programme totalled AU$ 225 million (Australian
Government 2021). Funding from a predecessor programme, the Australian Award Fellowship (AAF) Programme was used to create a leadership and mentoring programme for nurses and midwives from small island states in the Pacific. Although small in scale, Fellows on the programme considered it beneficial and felt that it had been invaluable in developing projects aimed at achieving health improvements in their own practice. Regrettably, funding was not available to follow up participants to see if these initiatives had created long term improvements (Rumsey et al. 2017).

In addition to empirical research, the grey literature included in this review also provided some accounts of partnerships designed to benefit sending and receiving countries and individuals themselves. For example, in England the voluntary organisation THET reported on the *Earn, Learn, Return* partnership between Leeds Teaching Hospital and the Jamaican Ministry of Health. This allowed Jamaican nurses to spend time working in Leeds on a programme of structured placements with the support of a mentor. The scheme is to be evaluated by Health Education England (Chisholm 2019). A similar scheme *Earn, Learn and Return* scheme has been set up for radiologists working outside the UK (Royal College of Radiologists 2021).

**Government-to-government partnership agreements**

Unlike traditional international recruitment, which has often been seen as primarily benefiting receiving countries and, to a variable extent, individuals themselves, government-to-government partnership agreements are often cited as an example of a triple win situation for all parties (Yeates and Pillinger 2019b):

> ... in which benefits are provided for all involved: countries of origin (by increasing the potential pool of skills); the destination country (by facilitating access to skills in demand); and migrants (by enabling them to acquire and market new skills).

(OECD Organisation for Economic Co-operation and Development 2018: 1)

An agreement signed between Cuba and South Africa that enabled Cuban doctors to work in South Africa and South African doctors to gain experience in Cuba is often cited as an example of an arrangement that benefited both countries while it was in operation (Squires et al. 2020). When agreements involve funding from the receiving country to compensate for reductions in their domestic costs of training or to pay towards the costs of training in the sending country, then there are additional financial benefits for both sending and receiving countries.

A jointly written paper by staff from the World Health Organization and the World Trade Organization (Carzaniga et al. 2019) argued that the number of trade agreements involving health worker mobility was growing but their importance was often underestimated. They argued that such agreements could promote more ethical recruitment practices by strengthening the voice of the health sector in international trade and lead to improved health systems.

However, other commentators are less convinced of the validity of this argument. Here, the counter arguments include the lack of consultation with public health and health professionals in trade negotiations (Hirano et al. 2020), the risks to governments of losing control over domestic health policy, and an increase in temporary migration with consequences for the citizenship and settlement rights of internationally recruited healthcare workers in receiving countries (Kidgell et al. 2020). In addition, Yeates and Pillinger (2019b) suggest that the influence of trade and
corporate led approaches means that health worker migration will move further away from the UN
normative system which underpins human rights approaches to migration. These views are echoed
by Public Services International, the global union federation for workers in public services, which
has pointed to the need for government-to-government partnerships to strengthen workers’ rights,
including the portability of benefits (Public Services International 2020).

There is a need for greater research evidence that would provide a clearer answer to the question
of the extent to which government-to-government partnership arrangements facilitate or hamper
more ethical recruitment of migrant healthcare workers (Kidgell et al. 2020). This review did
identify two studies of Indonesian nurses who had moved (Sato et al. 2016) or were planning to
move (Efendi et al. 2021) to Japan under the Economic Partnership Agreement but these focused
on the effects on individuals, rather than the effects upon Indonesia as a sending country and so
will be discussed later.

**Remittances**

Over the past 20 years, there has been much greater recognition of the role of remittances and
their impact on sending and receiving countries and on individuals themselves and their families.
The proportion of gross domestic product (GDP) received through remittances varies between
different individual states but in 2004 the Central Bank of the Philippines reported total remittances
of US$ 8.5 billion, amounting to 10% of the country’s GDP (WHO 2006). At a global level, before
the COVID-19 pandemic, it was projected that as much as US$6.5 trillion would be sent to
developing countries between 2015-2030 (United Nations Undated-a). However, the World Bank
(2020) has predicted that unemployment and reductions in wages for migrant workers in host
countries could lead to a 20% reduction in remittances sent to middle and low income countries.
Remittances benefit sending countries and the families of internationally recruited workers because
they enable families to meet their immediate needs, such as food, and also enable them to set
aside money for other purposes, such as savings or education. It is estimated that about 75% of the
funds received through remittances go towards immediate needs, while the rest can be allocated
for other purposes (United Nations Undated-a).

*Studies show that remittances alleviate poverty in lower- and middle-income
countries, improve nutritional outcomes, are associated with higher spending on
education, and reduce child labor in disadvantaged households. A fall in
remittances affect families’ ability to spend on these areas as more of their
finances will be directed to solve food shortages and immediate livelihoods needs.*

(World Bank 2020)

Of course, these data refer to remittances from all migrant workers. Much less is known specifically
about remittances from internationally recruited healthcare workers. Two empirical studies about
nurses’ remittances (Humphries et al. 2009, Bourgeault et al. 2021) and one review (Squires and
Amico 2015) were identified for this report. These showed that a conflict could exist between the
interests of individuals and the interests of the sending state. For example, migrant nurses in
Ireland often felt under pressure to send remittances, even when they could not afford them
(Humphries et al. 2009). There was also a gender related dimension to remittances, with Squires
and Amico (2015) noting that male nurses tended to report that their remittances were spent on
things from which they ultimately hoped to benefit, such as building houses, while female nurses
were more likely to send remittances to help fund children’s education or on medical treatment for sick or disabled relatives.

Lack of consideration for men and women’s different experiences with remittances is illustrative of a wider failure to consider the gendered aspects of international recruitment (Yeates and Pillinger 2019b, Bourgeault et al. 2021). Taken as a whole, the evidence suggests that remittances should not be viewed as an unequivocal triple win but that they should be acknowledged as an important way of transferring some of the gains of international recruitment for receiving countries onto those left behind in sending countries.

Recruitment agencies and recruitment fees

In high income countries, much of the practicalities of international recruitment are outsourced to agencies, meaning that international recruitment has become an industry in itself (Pittman et al. 2010, Shaffer et al. 2020, Calenda and Bellini 2021). The DHSC Code of Practice states that health and social care employers should only use agencies which operate in accordance with the Code of Practice and are included on the Code of Practice agency list. Despite the centrality of recruitment agencies to international recruitment in sending and receiving countries, the perspectives and practices of recruitment agencies remain under-researched (Runnels et al. 2011, Rolle Sands et al. 2020).

Even where regulation of recruitment agencies exists, it is still possible for unscrupulous agencies to operate because they are subject to limited oversight (Squires 2008, Runnels et al. 2011, Strauss and McGrath 2017, Shaffer et al. 2020). For example, many governments in receiving countries pay placement fees to agencies for recruiting workers on their behalf (Mosulela 2020). In countries such as Canada, it is illegal to charge workers a fee for arranging their employment (Strauss and McGrath 2017). However, a report by the International Labour Organization (ILO) (2020) covering all types of migration, not just that of healthcare workers, found significant differences between the rhetoric of law and policy and the reality of what workers had to pay for their recruitment. The ILO report did not specifically mention any UK examples and it cited the UK as one of the countries with the clearest policies regarding recruitment agency fees.

Percot (2006) undertook extended fieldwork with nurses from Kerala working in Gulf States. She reported that the brother of one nurse paid a fee of 70,000 rupees to an agency in Muscat to cover the costs of his sister’s contract, plane ticket, and visa. This is about £680 at current rates of exchange and the equivalent of almost six months of the average annual salary in Kerala at today’s prices (Payscale Undated). When this nurse eventually got a visa to work in the US, she had to save for three months to repay compensation to the agency for leaving her job and then save for a further four months to cover the cost of her flight to the US. Percot also noted that in some instances, salaries were not paid directly to nurses themselves, but to the agency, which then deducted a fee before paying the nurses. This practice is known as ‘garnishing’.

Set against this picture, other accounts conclude that recruitment agencies can play a positive role in helping with practical aspects of international migration, such as applying for jobs and arranging visas (Likupe 2013, Mosulela 2020). Nevertheless, there may be limits to the extent to which agency owners and employees regard it as part of their duty to act in an ethical way. Runnels et al. (2011) interviewed 26 people responsible for recruiting doctors, nurses and AHPs for publicly funded acute healthcare organisations in Canada. Participants reported that they rarely recruited
directly from sending countries but that they did recruit from agencies who undertook recruitment in sending countries such as the Philippines. The researchers concluded that those they spoke to were ‘conscientious, caring and professional’, but that they rarely had either the time or resources to consider the ethical aspects of their work, except in terms of avoiding scandals or negative publicity.

Another factor which can act as a barrier to ethical recruitment is the extent to which recruitment agencies are responsible for ensuring workers have received sufficient training to work in healthcare services in the country to which they have moved. A small scale qualitative study of nurses from EU 27 countries working in Norway found that participants felt they had received neither enough training for adapting to work in Norway nor enough help learning Norwegian. They also had to spend a year under contract to the recruitment agencies, which gave them little choice about the geographical area or clinical specialism in which they worked (Solum et al. 2020).

The degree to which recruitment agencies present an accurate picture of life in and outside work in the receiving country is another factor that needs to be considered in terms of ethical recruitment. A study of nurses from India and the Philippines working in the UK found that nurses who had been recruited via the NHS, rather than an agency, tended to be more satisfied with their working conditions because there was less of a mismatch between expectations and reality (Calenda and Bellini 2021).

Faced with this degree of variation in the standards of recruitment agencies, it is not surprising that many internationally recruited healthcare workers have sought to use social networks in receiving countries as a way of bypassing recruitment agencies. Rolle Sands et al.’s (2020) review of nurse migration from the Caribbean suggested that this was particularly true of nurses wishing to work in Canada or the US.

**Effects on individuals**

Experiences of recruitment agencies lead onto the penultimate section of this review, which is about the effects of international recruitment on individuals. The three key themes are:

- Personal and career advancement versus feelings of homesickness and effects on existing social networks
- The quality of induction and support as a determinant for successful transition into a workplace in another country
- Experiences of discrimination in the receiving country

As will be seen, empirical data based on individuals’ personal and collective experiences are dominated by studies of nurses, with some exceptions (for example, Bourgeault et al. 2021). These show that the positive gains for individuals of working in a different country and acquiring new skills and an improved working environment might be compromised by inadequate support in adapting to a new working environment and their experiences of discrimination.

Perhaps surprisingly, we were only able to identify one study (Vafeas and Hendricks 2018) based on the experiences of UK citizens who had moved overseas. This showed that British nurses who had moved to Western Australia experienced similar emotions and experiences (such as homesickness
or needing time to adapt to living in another country) to those reported in studies of nurses who had moved to the UK (for example, Likupe 2013, Adhikari and Melia 2015, Bond et al. 2020, Calenda and Bellini 2021) or to another country (for example, Salami et al. 2014, Bleeker and Deonandan 2016, Mowat and Haar 2018, Nortvedt et al. 2020).

There are methodological problems in answering questions about the ethics of international recruitment on individuals because the overwhelming majority of research, with a few exceptions (for example, Percot 2006), is with migrant healthcare workers who have chosen to remain in the receiving country and not those who decide to return home. Some studies have asked workers in sending countries about intentions to migrate (Kizito et al. 2015, Hashish and Ashour 2020, Efendi et al. 2021) but these are cross-sectional studies which have not been able to differentiate between those considering moving and those who actually do so. The extent of circulatory migration may also be underestimated in studies of internationally recruited healthcare workers unless specific recruitment strategies have been developed to include workers who divide their time between their country of origin and the country to which they have moved.

Reactions to the decision to migrate

Decisions to migrate are rarely made for a single reason. This means that the effects on individuals cannot simply be measured in terms of a better income or improved working conditions but that they relate to a combination of different personal, political, social, and other factors, the importance of which will vary between individuals. Bourgeault et al. (2021) have pointed out that what are often presented as economic motivations for migration are really an expression of cultural expectations about family responsibilities because the primary intention is to earn more to support family members.

Most studies have reported mixed feelings among internationally recruited healthcare workers about their decision to migrate. They expressed regret about leaving their country of origin but also acknowledged that, overall, it had brought opportunities for personal and professional advancement for themselves and their families (Dywili et al. 2013, Likupe 2013, Young et al. 2014, Bleeker and Deonandan 2016, Mowat and Haar 2018, Tankwanchi et al. 2019, Rolle Sands et al. 2020, Primeau et al. 2021). For some workers, particularly women, migration was seen as a route to leading more autonomous lives (Percot 2006, Likupe 2013, Bourgeault et al. 2021). This did not mean that they did not continue to have very close contacts with family and friends in their country of origin (Likupe 2013). As well as telephone or online contact and visits home, this could also include taking part in knowledge exchange activities in the sending country on a voluntary basis (Bleeker and Deonandan 2016). However, these types of contact were not always enough to prevent homesickness (Mowat and Haar 2018, Vafeas and Hendricks 2018, Nortvedt et al. 2020).

Studies of migrant workers as a whole have shown that parental migration is generally detrimental to the health of left-behind children (Fellmeth et al. 2018). In this review, the only reference to left-behind children among healthcare workers in England that we identified was a 20-year-old study of Filipino nurses (Daniel et al. 2001). By contrast, 11 of the 14 participants in a more recent study of health and care workers in two English rural communities had children who lived with them. The remainder were not parents (Spiliopoulos et al. 2021). Without more attention to parenthood among studies of internationally recruited healthcare workers, it is impossible to know whether they find it easier than unskilled workers to emigrate along with their children or whether they tend to emigrate at an earlier age before giving birth or becoming a parent.
An exception to feelings of regret was reported in a study of Italian nurses moving to the UK. These nurses felt unhappy that high levels of unemployment had left them with little choice but to move. They did not feel under any ethical obligation to remain in Italy because they considered it had encouraged and funded their qualifying education without offering them employment and opportunities to progress in their careers as nurses in their home country (Palese et al. 2016).

Support for transition into the workplace

The DHSC Code of Practice (2021) specifies appropriate support and induction as one of the requirements for achieving ethical international recruitment. Funding has been made available for employers to assist with this process (NHS England and NHS Improvement 2020):

> All newly appointed international health and social care personnel will be offered appropriate support and induction. As part of this employers and contracting bodies should undertake pre-employment and placement preparation activity to ensure a respectful working environment for all.

(DHSC, 2021)

The data reported here about transition into a new workplace pre-dated the 2021 Code of Conduct and include evidence from countries outside the UK. However, it was the most frequently reported theme reported in this review, suggesting that it was an essential component of ethical international recruitment and another example where gaps existed between rhetoric and reality.

Bond et al. (2020) undertook a qualitative synthesis of the experiences of international nurses and transitioning to work in the UK. Their search strategies also included midwives, but they did not identify any material that met their quality inclusion criteria. Participants across the six studies included in their final review (Okougha and Tilki 2010, Likupe 2013, Alexis and Shillingford 2015, Allan and Westwood 2016, Stubbs 2017) reported difficulties adapting to their new life in the UK, including their role as a nurse and in finding and building positive relationships that would help to ease their transition. Instances of discrimination, an undervaluing of internationally recruited nurses’ skillset, and problems around communication were all detrimental to this process. Overall, the authors suggested, progress had been slow in improving international nurses’ experiences of the transition into work in the UK. These themes are similar to those reported in the only study we identified about how internationally recruited doctors adapted to working in the NHS (Jalal et al. 2019).

The perception that employers and colleagues undervalued their skills was reported in studies from the UK (Adhikari and Melia 2015, Al-Hamdan et al. 2015, Calenda and Bellini 2021) and in other countries (Kolawole 2009, Stievano et al. 2017, Iheduru-Anderson 2020). At the same time, newly recruited nurses were often given little support with practices that were different to those in the country in which they had trained (Percot 2006, Likupe 2013, Chun Tie et al. 2017, Dywili et al. 2021, Valdez et al. 2021, Zanjani et al. 2021). For example, a study of Jordanian nurses working in the UK highlighted the greater attention paid to procedures and record keeping in the UK compared with Jordan (Al-Hamdan et al. 2015).

Recognising the increasing ethnic and cultural diversity within countries, it is also important for internationally recruited healthcare workers to have training in recognising different cultural
expectations. This includes activities such as breaking bad news (Semlali et al., 2020) or delivering intimate personal care (Thompson et al., 2021).

Mentoring programmes can also help with the process of adaptation. The JCORE’s Refugee Doctor Mentoring scheme (JCORE 2022) links up UK-trained doctors and refugee doctors to help mentees develop professional development plans and enable them to build confidence and self-esteem as well as meet their professional goals. By contrast, nurses from India who were working in London and had undertaken an Overseas Nurses Programme reported that they would have valued a mentor, especially one familiar with their culture, to help with the transition process (Stubbs 2017).

In one study of Indonesian nurses working in Japan, the pressure of having to pass the qualification that would enable them to remain working in Japan was such that nurses in the study were at risk of developing mental health problems. Women nurses also experienced more symptoms of anxiety and depression (Sato et al., 2016). A mismatch between expectations and reality in the workplace may also influence the success with which internationally recruited healthcare workers adjust to living in a different country (Roth et al., 2021).

Set against these accounts of negative experiences, findings from a study set in a Norwegian nursing home suggested that being in an environment where the emphasis was on mutual respect and collective responsibility for learning had benefits for the whole workforce, not just those who were internationally recruited (Munkejord and Tingvold 2019). Similar findings emerged in a study of internationally recruited nurses in Australia which concluded that a supportive work environment reduced stress and increased job satisfaction. Conversely, a stressful, unsupportive work environment delayed adjustment and undermined their mental health, ultimately compromising patient care (Zanjani et al., 2021).

The importance of help with language skills was mentioned in several studies (Okougha and Tilki, 2010, Stubbs, 2017, Jalal et al., 2019, Solum et al., 2020). This included recognition of subtleties in language that are generally only understood by native speakers or those who have been resident in another country for many years, such as euphemisms for health problems or parts of the body (Jalal et al., 2019), informal language, such as ‘loo’, and the role of politeness markers, such as ‘please’ or ‘thank you’ which may not have equivalents in all languages (Okougha and Tilki, 2010).

Discrimination and worker rights in receiving countries

Discrimination is a major threat to ethical international recruitment and was often mentioned as a barrier to adapting successfully to a new workplace or country in research from the UK and elsewhere (Okougha and Tilki, 2010, Walani, 2015, Allan and Westwood, 2016, Bleecker and Deonandan, 2016, Chun Tie et al., 2017, Mosulela, 2020, Rolle Sands et al., 2020, Dywili et al., 2021). Bullying was an additional problem reported in a review of internationally recruited doctors’ experiences in the NHS. This review also identified the over representation of internationally recruited doctors among fitness to practise referrals to the GMC (Jalal et al., 2019).

Alongside direct examples of discrimination, concerns also exist that global inequalities may be replicated for individuals working in receiving countries (Likupe, 2013, Bleecker and Deonandan, 2016, Hajian et al., 2020, Rolle Sands et al., 2020). Examples of this include restrictions on the parts of the country in which internationally recruited workers are able to live and work (Neumayer, 2006), their employment in parts of the labour market that are deemed to be more risky and less
desirable (McKay et al. 2006) or the permanent exclusion of workers from rights to social protection in the country to which they have moved (Public Services International 2020). Other workers may only have temporary rights to live and work in a country. Valdez et al (2021) reported concerns among internationally recruited nurses in Oman that the policy of ‘Omanisation’ (to replace internationally recruited workers with workers from Oman) would lead to them being asked to leave. Other rights that might be affected by international migration include the right to worship and religious expression. Percot (2006) reported that many nurses from Kerala working in Saudi Arabia had concerns about being able to practise their Christianity.

Circular migration is often presented as a triple win situation for sending and receiving countries and for individuals themselves because it enables workers to benefit from higher wages in in receiving countries while still maintaining close links with their sending country (Weber and Frenzel 2014, Joint Action Health Workforce Planning and Forcecasting 2016). Set against this is the risk that workers employed on a series of temporary contracts will experience precarity and be unable to choose more secure employment and rights to social protection. As it stands, while there is a growing literature about circular migration and care work (for example, Chau et al. 2018), some of which will also include workers with a health qualification that is not recognised in the country to which they migrate temporarily (Sekulová and Rogoz 2019), this review did not identify any studies about the extent to which circular migrants were employed in medical, nursing or AHP roles, which is an obvious gap in the literature.
It is important to preface this discussion by acknowledging the limitations of this review. It was undertaken in a comparatively short time, and it is possible that some relevant material may not have been included. The review scope was broad, covering all countries and all types of healthcare worker so there is scope to undertake new, more focused reviews with narrower inclusion criteria and more exhaustive searching. It is also important to note that much of the material cited in the review was published before the COVID-19 pandemic and it is not clear what its long term effects on international recruitment will be. The review has drawn attention to its negative impact on remittances (World Bank 2020) but there are other potential effects, such as the impact of restrictions on cross border travel on circular migration.

In the same way, much of the review material was published before 31 December 2020 which marked the end of the transition period following UK withdrawal from the European Union. Data on the nationality of NHS staff shows that since 2016 there has been a drop in the proportion of staff from the EU and a corresponding rise in the proportion of staff from non-EU countries (Baker 2021).

In terms of answering the question about whether international recruitment of healthcare workers could be a triple win solution, the review highlighted that there were a number of stages to international recruitment, all of which could be compromised, creating ethical dilemmas. As Kerwin writes:

> The challenges facing international workers and migrants underscore a set of conditions—education, job training, timely information, security, legal migration options, lifelong learning opportunities, portable benefits, housing, and healthcare—that need to be universally available for persons to thrive in the global economy. These conditions provide the foundation for creating ethical, person-centered migration and labor systems at a time of rapid change and uncertainty.

(Kerwin 2020: 129)

There is no doubt that there are ethical challenges in balancing the interests of lower and middle income countries who risk losing much needed members of their healthcare workforce though international migration and the rights of individuals to take up offers of career advancement and create new opportunities for themselves and their families in a different country.

The review has confirmed the complex and multi-faceted nature of international migration which encompasses situations as disparate as nurses from Kerala who are part of a diaspora stretching back three generations in the Gulf states, doctors hoping to escape from political instability in Libya by moving to South Africa (Tankwanchi et al. 2019) and nurses from Italy (Palese et al. 2016) and Spain (Gea-Caballero et al. 2019) moving to the UK to avoid unemployment. Such diverse circumstances mean that the ethical dimension of the process by which they were recruited will vary. It is also important to recognise the dynamic nature of the process of migration, which means that a historically ‘sending’ country, such as Ireland, can become a ‘receiving’ one (Humphries et al. 2008).
Too often economists, and employers analyse the international recruitment of healthcare workers solely in terms of the desire to achieve better salaries and improved working conditions. These are important ‘push’ factors why healthcare workers in sending countries decide to move but they do not operate in isolation. Intentions may be hardened by factors such as corruption and political instability, especially if workers feel that they directly impact upon their opportunities for career progression (Likupe 2013, Squires and Amico 2015, Bleeker and Deonandan 2016). There is evidence of greater international mobility among healthcare workers in countries experiencing conflict and instability (Williams et al. 2020), highlighting the way in which distinctions between economic and humanitarian migration can become blurred.

The material identified for this review has reinforced the message that consideration of the ethical aspects of the international recruitment of healthcare workers needs to encompass not just what happens to the sending country but also what happens in the receiving country and the need to ensure that good induction procedures and training are in place to achieve a smooth transition (Likupe 2013, Adhikari and Melia 2015, Chun Tie et al. 2017, Bond et al. 2020, Calenda and Bellini 2021). It has also indicated how experience of discrimination in the receiving country can make the process of transition harder or influence decisions about onward migration or a return to one’s country of birth (Likupe 2013, Chun Tie et al. 2017, Iheduru-Anderson 2020, Dywili et al. 2021).

In terms of future work, when people from over 200 nationalities are represented in the NHS workforce in England (Baker 2020), it is clear that it would be a mammoth task to attempt to catalogue the effects of international recruitment on all sending countries. There is more material about nurses from the Philippines (Daniel et al. 2001, Humphries et al. 2008, Dimaya et al. 2012, Ortiga 2018, Lee 2019, Abarcar and Theoharides 2020, Ortiga 2020) than elsewhere. This reflects the importance of the Philippines as a source of internationally recruited healthcare workers across the world. By contrast, despite their similar importance as sending countries, there appears to be much less published evidence about the Caribbean (Mortley 2009, Lofters 2012, Bleeker and Deonandan 2016, Rolle Sands et al. 2020), especially in terms of the diversity that exists between international recruitment in different islands (Rolle Sands et al. 2020), or about Ireland (Humphries et al. 2008, Humphries et al. 2009).

Much has been written about the limitations of existing administrative data collection in relation to the making of policy decisions about international recruitment (Buchan 2007, Humphries et al. 2008, Buchan et al. 2009, Macdonald 2020). As things stand, not only is it impossible to know when and how healthcare workers were internationally recruited, it is impossible to measure the extent of circulatory migration or permanent moves back to the sending country (Tankwanchi et al. 2019). Given that a reliance upon international recruitment is likely to continue in healthcare in England, time taken to review current data collection and recording systems is likely to prove productive.

The review highlighted the comparative paucity of empirical research about the role of recruitment agencies. Given their central role in all stages of the recruitment process, it is important to understand more about the process by which agencies comply with the 2021 Code of Practice.
Key messages

- It is possible to make international recruitment more ethical when it is accompanied by strategies to increase the supply of domestically recruited healthcare workers; to do so requires international cooperation and better quality data from sending and receiving countries over the long-term.

- There is a consensus that codes of ethical practice are in themselves insufficient to control the international recruitment of nurses. Codes need to operate within a transparent and fair immigration policy and to be underpinned by good recruitment practices which give potential international recruits all the information necessary to make informed decisions about whether to move to another country or remain in their country of birth.

- Policies aimed at achieving more ethical international recruitment practices need to recognise the multiplicity of reasons why healthcare workers choose to move to higher income countries because international migration is not driven solely by economic reasons. Little is known about onward migration, the numbers of internationally recruited healthcare workers who move to one country and then another. It is also important to document the number of internationally recruited health care workers in care homes.

- The role of digital platforms in contributing to ethical international recruitment should be monitored. They increase transparency about application systems and may potentially reduce the costs of recruitment for individuals and employers.

- There is potential to enhance the willingness of internationally recruited healthcare workers to maintain contact with their source country and to seek to enrol their help in knowledge exchange and capacity building activities.

- Some internationally recruited healthcare workers have experienced discrimination after moving to work as a nurse in another country and/or inadequate help in adjusting to work in another country. Systems are needed to ensure that they are given better support. Examples of leadership and role models may help to provide other narratives alongside workplace race equality schemes.

- There is scope to extend the financial support available to NHS Trusts or Integrated Care Systems to support the induction and onboarding of internationally recruited nurses to employers of internationally recruited nurses working in local care homes and other parts of the social care sector.

- There is potential to commission new empirical research on the effectiveness of programmes developed to support the induction and onboarding of internationally recruited health workers.

- There are limitations in the quality of existing administrative data about international recruitment which make it harder to monitor the number of international recruits and, in particular, to provide reliable data on health workers recruited from red and amber sending countries.


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