

Election briefing December 2019

Stopping the staff we need?

Migration choices in the 2019 general election

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The two main parties campaigning in the general election have recognised that health and social care staffing is a pivotal issue which threatens to undermine the UK's largest public service. But they have also outlined radical possible changes to migration, ending the free movement of workers for European citizens.

This briefing looks back at how migrants and migration policy have shaped the care workforce across the UK in recent decades, drawing on new figures obtained from the Office for National Statistics. It assesses the risks different parties' policies pose and how these could be addressed to ensure that we do not stop the staff we now need more than ever.

Key points

- NHS and social care services have depended heavily on migration over the last 20 years. Our analysis of new figures shows workers born outside the UK have accounted for 50% of the increase in care staff over the last decade. Their numbers have risen by 221,000 out of a total increase of 446,000.
- Reliance on migration is greatest in hospitals. Here the proportion of workers born outside the UK has now reached one in four.
- There is a risk that policies by the main parties to end the current system of free movement from the European Economic Area after Brexit will cause

a slowdown in migration, with no alternative way remaining to recruit these much-needed staff. If the effect was similar to the crackdown in immigration from outside the EEA around 2010, health and care could have 6,000 fewer extra staff each year.

- Any slowdown in migration could not come at a worse time. Health and social care already face major workforce shortages, yet will actually be called on to do more in the coming years as our population ages and political leaders inherit pledges to expand social care coverage. We have estimated that at least 5,000 nurses a year must be recruited from abroad.
- While both Labour and the Conservatives have discussed exemptions for NHS workers, it is very unclear who these would cover and whether a new system would still be more restrictive overall.
- Social care is the most exposed sector of all. Neither party has discussed exemptions for it, yet low-paid care workers are especially likely to be blocked off by a selective system.

The workforce situation

Health care

The NHS in England is facing around **100,000 vacancies** for permanent posts in trusts alone. The problem is particularly concentrated in nursing, which has nearly 40,000 vacancies. **Northern Ireland** appears to have an even worse problem relative to the size of its workforce, while the **NHS in Wales** has also seen rising reliance on temporary nurses.

With The King's Fund and the Health Foundation, we identified a **battery of measures** to address this situation through training more staff and convincing them to stay in the service, including grants for nursing students and restoring funding for professional development. Many of these policies have been taken up in election manifestos and in the recent **Interim NHS People Plan**.

However, our calculations showed that, even with all of these measures, the shortfall will actually worsen over the course of the next parliament without additional overseas recruitment of at least 5,000 nurses a year.

These calculations reflect the tendency of the NHS to constantly require more staff as the number of patients rises and new technologies expand what can be done. Recent announcements by Labour and the Conservatives mean the budget of the English health service will rise by 3–4% a year in real terms. But unless the workforce increases as well, these large sums will not translate into a difference for patients.

Social care

Social care services helping the elderly and disabled with everyday tasks also face mounting workforce problems, closely linked to the real terms cuts they have seen over the last decade. Vacancies have **now reached 8% in England**. The problem is particularly severe for nursing jobs within the social care sector.

Again, election pledges will intensify the need for staff still further. Our recent **election briefing** calculated that reforms to the failing English social care system would require at least 90,000 extra workers to care for older people whose needs currently go unmet.

In its report on European Economic Area (EEA) migration last year, the Migration Advisory Committee **concluded that** “unless working in social care becomes more desirable to UK workers, chiefly through higher wages, migrant workers will be necessary to continue delivering these services”. Yet social care workers, often poorly paid, are likely to find it particularly difficult to enter the country under a more restrictive migration system.

How migration has provided staff to health and social care

To understand how immigration supplies health and social care workers in the UK, and the effect different policies have had and will have, the Nuffield Trust requested **a dataset from the Office for National Statistics (ONS)** showing staff by country of birth. This covers every area of health and social care all across the UK and is based on the Annual Population Survey, with a sample size of 300,000. The data is split into two periods, one from 2000 to 2008 and the other from 2009 to 2019, due to a change in categorisation.

Narrower data sources are also available looking at the nationality of workers within the **English NHS** and **social care**, while registers for different professions list professionals based on where they have trained. We hope our data will give a more complete picture, by covering the whole pool of professionals wherever they work across all UK countries, and by capturing migrants who may have trained in the UK or adopted UK nationality.

It will also include some people who were born abroad but have always been UK citizens, for example to parents in the British armed forces. Some might not consider these people migrants.

The EEA data here includes all 27 other EU member states plus Norway, Iceland and Liechtenstein. It counts people from countries which joined the EU during this time, like Poland, as coming from the EEA all along in order to prevent an artificial spike when they are reclassified.

A twenty-year bailout

In the periods both before 2008 and after 2009, the health and social care workforce expanded rapidly, and migration made a very significant contribution to this.

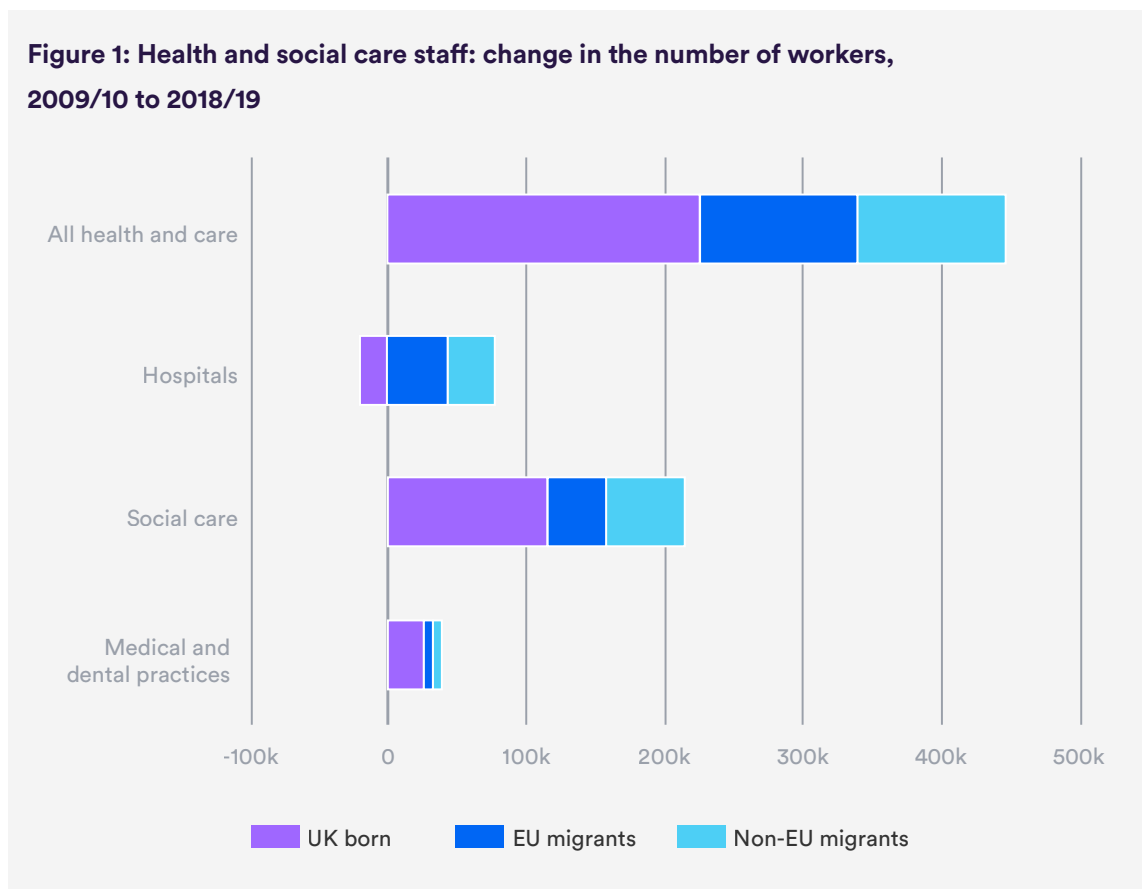
From 2001/02 to 2007/08, the workforce increased by 574,000. More than a third of this, 36%, was accounted for by an increase of 209,000 in the number of staff born outside the UK.

From 2009/10 to 2018/19, the health and social care workforce grew by 446,000. Almost half of this was accounted for by a rise of 221,000 in the number of staff born outside the UK. Figure 1 shows the changes in this latter period both as a whole, and broken out into the major categories within the sector. It shows people born elsewhere in the EEA and in the rest of the world each accounted for around a quarter of the increase.

Migrants make a particularly important contribution in the hospital sector, where the number of UK-born staff has actually fallen over the last 10 years. In 2018/19 these figures show that 23%, almost a quarter, of all hospital workers were born outside the UK. This is a considerably higher figure than staff with non-UK nationality shown in **statistics of English NHS trusts**, where they are recorded as making up 13% of those with a recorded nationality. The

discrepancy may be partly because nationality as a measure fails to capture many people born abroad.

In medical and dental practices, however, migrants make up a smaller proportion of the increase and a smaller proportion of the workforce overall (17%). Although the ONS data does not pick out specific countries, **English data for NHS trusts** suggests that the most common nationality for staff from elsewhere in the EEA was Irish followed by Polish, with Portuguese and Spanish nationals especially represented as nurses. Among non-EEA staff, Indian nationals were most common. **In social care**, Romanian and Nigerian are the most common EEA and non-EEA staff nationalities, respectively.



Source: Nuffield Trust analysis of Office for National Statistics data

Does this reflect migrants contributing to dealing with an undersupply of staff, or outcompeting people born in the UK in a context of competition for scarce jobs?

Analyses of the workforce have tended to conclude that migrant workers are pulled into the sector, especially the NHS, to compensate for repeated failures

in the UK to anticipate how many staff will be needed and to train enough domestically. The period to 2008 was largely one of **very rapid growth** in NHS funding, which was associated by a rapid expansion of the workforce far exceeding plans, **enabled by international recruitment**.

By contrast, the period since 2009 has been marked by unusually slow funding increases. Yet **assumptions** about the number of NHS staff needed still turned out to be too low, while the heavily cut social care sector saw growing problems attracting enough staff. As a result workforce shortfalls have emerged again and **reliance on international migration continues**.

Out of proportion

Of course, migration from the rest of the world also increases the number of patients the NHS must treat. However, across all of health and social care, these figures show people born outside the UK make up 19% of workers – a higher proportion than in the general population, of which **they make up** 14%. This may reflect the sector's chronic failures to obtain enough staff domestically, which means it is particularly keen to obtain them from abroad, relative to other sectors.

Research by the Nuffield Trust on cohorts of migrants who arrived in England during the 2000s also finds that they also use hospital services much less than other people of the same age and sex. This may be because seriously ill people are less likely to emigrate, because migrants' access to services is worse, or because they prefer to go back home for treatment.

Before and after

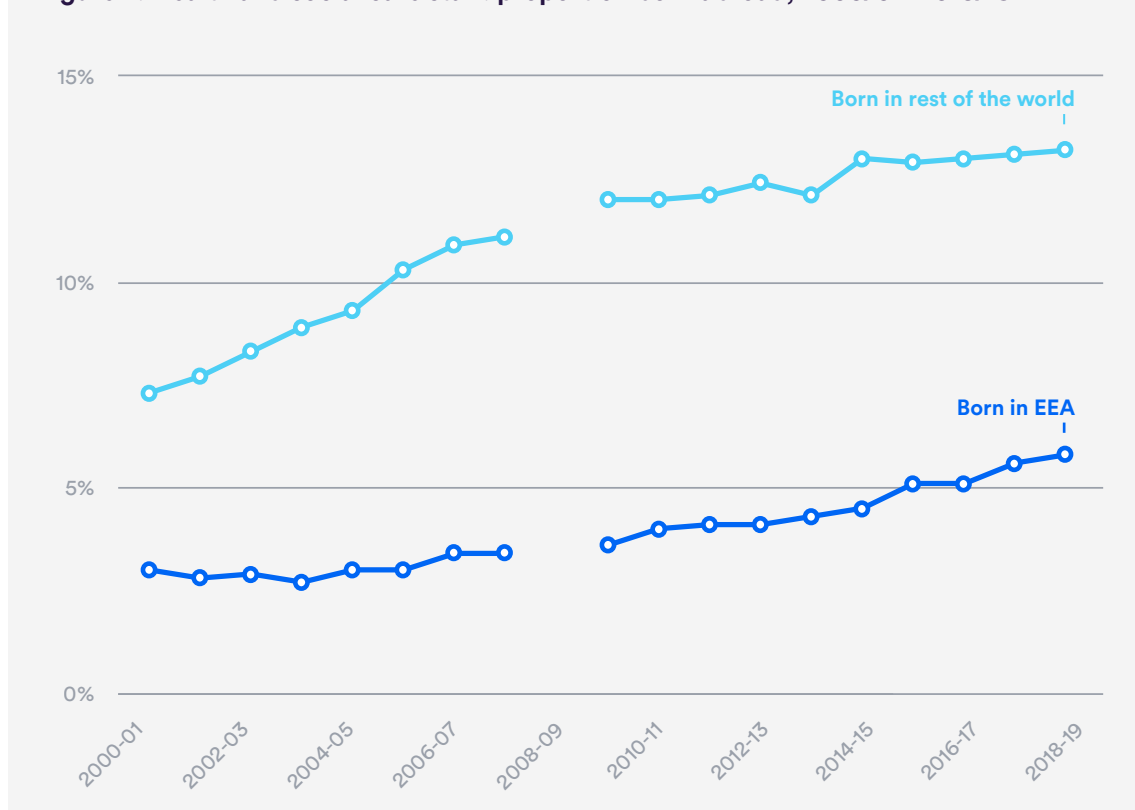
The sources of migration in the period up to 2008 and the period after 2009 were quite different, as Figure 2 shows. The earlier period saw a very rapid increase in the proportion of staff from outside the EEA, going from 7% to 11% in just seven years. From 2009/10, though, although there remains a slight increase it goes only from 12% to 13% over a longer period of nine years.

One possible conclusion would be that this reflects the extensive changes to the system for non-EEA migrants at the start of this period, especially those coming to work. These took place initially under Labour and then more

extensively under the Coalition government and included, among several other measures:

- a **new requirement** for certificates of sponsorship for skilled migrants on the 'tier 2' route (from April 2010)
- the **restriction** of the tier 2 route to graduate level jobs (from April 2011)
- the **introduction of a numerical cap** on tier 2 migrants overall, and the use of a points-based system to allocate places as the cap was reached (from April 2011)
- the **abolition** of the general 'tier 1' route which allowed workers to come to the UK without a job offer (from April 2011).

Figure 2: Health and social care staff: proportion born abroad, 2000/01–2018/19



Source: Nuffield Trust analysis of Office for National Statistics data

Migration from the EEA was not affected by these changes, with free movement of labour remaining in place throughout this period. The contribution of staff from the EEA shows the opposite pattern. It was relatively flat as a proportion in the earlier period, but has risen from 4% to 6% over the last decade.

In absolute terms, the average yearly expansion in the EEA workforce went from around 4,000 to around 13,000. Meanwhile, the average yearly change in non-EEA migrants working in health and social care fell from an increase of around 25,000 in the first period to an increase of around 12,000 in the second.

This absolute change among non-EEA staff will partly simply reflect slower overall growth in the workforce over a period of less generous NHS funding, with the total rate of migrant workforce expansion having slowed from an average of 30,000 a year to 25,000 a year.

But the shortages that we know emerged during the recent period; the change in the trend of proportion; and the very different trend seen in EEA staff during this period all suggest constraints on migration played a significant role.

In so far as NHS and social care organisations are able to affect what sorts of migrant workers join them, for example by using recruitment agencies to bring in staff, **as was common in the 2000s**, this seems consistent with a substitution effect where they turned to staff from the continent after previous sources of workers became less available. Consistent with a pattern of substitution, after taking evidence from the health sector in 2016 the Migration Advisory Committee reported that organisations preferred to recruit nurses from outside the EEA **where they were able to**, because they spoke better English and were more likely to stay at one employer. However, they have recently had to turn to the EEA.

It is likely that the eurozone crisis and accompanying austerity may also have played a role in making more staff available from some European countries. However, it should be noted that the biggest apparent uptick happens not during the period of eurozone recession in 2011 and 2012, but later in the decade. This mirrors figures kept by the Nursing and Midwifery Council which show 2015/16 as being a peak year for nurses joining the register **from the EEA**.

These figures also show a pattern of non-EEA registration that seems quite responsive to policy change. Registration from the rest of the world tripled in the year starting April 2018, the year that also saw the **government exempt NHS nurses from the numerical cap** on tier 2 visas. There is a lesser increase around 2014/15, when nurses were made a shortage occupation lowering some barriers.

Election pledges and their consequences

Migration policy has been a significant theme in the 2019 general election campaign, with both main parties pledging policy change and describing specific measures for NHS staff. What sort of effect might we see on health and social care staffing?

Commitments from the main parties

The Conservatives have a policy of a ‘points-based migration’ system to apply to both EEA and non-EEA migrants, which the Home Secretary has said will reduce overall immigration. They have also announced an ‘NHS visa’ policy, where extra points will be awarded for coming to work in the NHS; staff will not be automatically excluded by ‘salary limits’; and fees will be lower.

Labour have a policy of a second referendum on leaving or remaining in the European Union. In the event of leaving, their migration policy for EEA workers is unclear but appears to involve the end of free movement of labour in its current form. Their manifesto is ambiguous, promising to protect rights but in language which commits only to people who have already migrated. The party’s Shadow Foreign Secretary has said, more clearly, that a policy of “managed migration” with “fair rules” will apply. The Shadow Health Secretary has said in a speech that migrant doctors and nurses recruited by NHS trusts “will be allowed to come to this country” but there are no details of this policy in their manifesto. The party has not announced any changes to the system of non-EEA migration for people coming to work.

Bending the line?

Based on the trends over the last 20 years, an obvious concern is that these migration changes for people from the EEA will result in a slowdown in the migration of staff similar to that seen with non-EEA migrants after the tightening around 2010.

If the annual increase in health and care staff from the EU were to fall by half, as happened with non-EEA staff, this would mean around 6,000 fewer net migrants each year, or 30,000 over a five-year parliament. This would be a major problem given that our analysis shows that an acceleration of international recruitment is needed for nursing and social care if services are to meet people’s needs in the coming years.

The silenced majority

The promised exemptions for doctors and nurses are a positive step in addressing this. But the basic points of how they would work and who they would cover remain unclear. Changes to migration policy over the last 10 years to make it easier for nurses to enter the country have had relatively unpredictable effects. For example, as discussed above, the **figures from the Nursing and Midwifery Council** for registered nurses suggest that shortage occupation status (2014/15) seemed to make a relatively small difference, whereas the relaxation of the numerical cap (in 2018/19) possibly had more impact.

Labour's apparent exemption for those recruited by trusts would be positive. However, it is important to note that the restriction of skilled migrants to those holding a particular job offer was one of the changes made around 2010 for non-EEA migrants which seemed to lead to the subsequent slowdown.

The Conservatives' 'NHS visa' raises the same issue. It also remains completely unclear how many points will be awarded under it or how many will be needed to clear a threshold, making it impossible to tell whether it will be more or less open in effect than the current system.

Both announcements focus heavily on doctors, nurses and other clinical professionals recruited by NHS organisations. But it is important to remember that this is a minority of the health and social care workforce. While Labour's policy refers to 'NHS trusts' and the Conservatives' covers 'NHS bodies', many doctors and nurses work for nursing homes, hospices, charities, and privately owned companies and GP practices under contract to the health service. Even those working in the entirely private sector are part of a single workforce pool across the whole of the UK.

Moreover, most people working in health and social care do not belong to these professional groups. Even including **dentists** and **pharmacists** as well as **doctors, nurses, midwives** and **allied professionals**, the total number registered is 1.5 million, just 35% of a total health and social care workforce of 4.3 million based on the ONS data.

Within this wider pool sit the vast majority of social care workers – a sector we know faces growing shortages and yet one we need to sharply expand if funding reforms are going to help people who currently do not receive the care

they need. Migrants in this sector have low salaries and limited qualifications, and typically do not come for a particular job offer. This means they are among the most likely to be barred in any system of managed migration based on points or job offers.

Social care was overlooked for funding and reform for many years, with disastrous results the political parties are only now coming to address. It would be very regrettable if at this moment it is now overlooked in immigration policy so that additional funding fails to have the desired effect.

Conclusion

There is a very real risk that the migration policies proposed in the 2019 general election will make it more difficult to bring staff into the NHS and social care from the European Economic Area. This could not come at a worse time: both sectors have both deep staffing shortages and expanding demand, which means numbers of workers will need to steadily increase. When a crackdown on migration for work took place around 2010, health and social care were able to compensate by bringing in more staff from within the EEA. This time, there is no escape valve available.

Parties should tread carefully with their migration policies. Options to provide reassurance about their impact on health and social care would include more clarity about exemptions for NHS workers; the expansion of these to social care; and a specific commitment to design and adjust these new systems so that the actual rate of migration into health and social care remains stable for the initial years and will increase where this is needed.

Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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