RCN's submission to the WHO's Independent Stakeholder Reporting Instrument (2024)

About the Royal College of Nursing:
With a membership of over half a million registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world. The RCN works closely with wider professional bodies and trade unions, and lobbies governments and other bodies across the UK to develop, influence and implement policy that improves the quality of patient care.

Overview:
This document contains the RCN's full response to the WHO's Independent Stakeholder Reporting Instrument (2024).

Questions and responses:

1. What has been the trend in international migration and mobility of health personnel (e.g., increasing trend in migration of health personnel or increasing reliance on international health personnel) in the countries where you work in the past three years and its effects?

Reliance on international recruitment of health personnel:

The UK is increasingly reliant on international recruitment. The UK's Migration Advisory Committee have noted that the UK's over-reliance on international recruitment is high when compared with many other OECD countries.[1]

Both the number of internationally educated nurses and their proportion of the total registered nurse workforce has risen consecutively over the last three years.[i] The total number of internationally educated nurses on the UK register has risen from 122,340 in

[i] Note on use of NMC data: The UK's Nursing and Midwifery Council (NMC) publishes data on the country of initial training for nursing and midwifery staff joining the UK's professional register. However, country of initial training is reported as 'unknown' for a small proportion of registrants who did not receive their initial training in the UK, European Union or European Economic Area. For example, in March 2024, 4,957 registrants were recorded as having an unknown country of initial training out of a total of 190,217 registrants who received their initial training outside of the UK/EU/EEA. These registrants are included in calculations of total internationally educated registrants and percentage of internationally educated registrants as a proportion of all registrants. For analysis of migration from countries listed on the WHO health workforce support and safeguards list, registrants with an unknown country of initial training have been excluded from all calculations as it is not possible to determine whether they were trained in a listed country.

March 2021 to 190,217 in March 2024.[2] The proportion of internationally educated nurses on the UK register has increased from 16.7% in March 2021 to 22.7% in March 2024. As has been recognised by the UK Parliament's Health and Social Care Committee, in the context of a global shortage of health professionals such levels of international recruitment are both unethical and unsustainable.[3]

Recruitment from countries in the European Union / European Economic Area has seen little change. In the 6 months to March 2021, 394 nursing and midwifery professionals who had received their initial training in the EU/EEA joined the UK register. In the 6 months to March 2024, this figure had fallen slightly to 345. By contrast, international recruitment from countries outside the EU/EEA more than doubled in this period. In the 6 months to March 2021, 7,047 nursing and midwifery professionals who received their initial training outside the UK/EU/EEA joined the UK register. This figure rose to 14,248 in the 6 months to March 2024, the most recent period for which we have data.

Data from the NMC provide a helpful picture to understand the scale of international recruitment. However, without a comprehensive and transparent assessment of the impact of international recruitment on source countries, including an assessment of the levels of seniority of such recruits, it is difficult to assess the impact of the UK's recruitment trends.

Recruitment of nurses from countries designated for support and safeguards:

Total numbers of nursing and midwifery staff joining the UK register from countries on the WHO health workforce support and safeguards list have continued to rise since 2021.[4] The proportion of internationally educated nursing and midwifery staff joining the NMC register that received their initial training in a country on the WHO health workforce support and safeguards list has risen from 14.5% in the 6 months to March 2021 to 22.9% in the 6 months to March 2024.

The total number of nursing staff from countries on the health workforce support and safeguards list has risen from 11,682 in March 2021 to 32,595 in March 2024. This means that the total number of nursing and midwifery staff practicing in the UK that received their initial training from a country on the health workforce support and safeguards list has almost trebled since the UK Government aligned its own Code of practice for the international recruitment of health and social care personnel with the WHO list.

In the six months to March 2021, the number of nursing and midwifery staff recruited from countries on the WHO health workforce support and safeguards list was 1,084. Since then, recruitment from countries on the WHO health workforce support and safeguards list has risen steadily. In the six months to March 2024, over 3,347 nursing and midwifery staff joined the UK register from countries on the health workforce support and safeguards list. This represents more than 1 in 10 (11.2%) of all new joiners to the UK nursing and midwifery register in this period, including those who received their

initial training in the UK. Between March 2021 and March 2024, a total of 17,182 nursing and midwifery staff have joined the UK register who received their initial training in a country that was then on the WHO health workforce support and safeguards list.

Visa data for nurses give the same picture. Since January 2021, 16,574 visas were granted to nurses from countries on the health workforce support and safeguards list.[5]

Since March 2021, nursing staff from Nigeria have accounted for more than half of all joiners to the UK nursing and midwifery register from countries on the WHO health workforce support and safeguards list (56.1%).[6] 9,642 nursing and midwifery staff who received their training in Nigeria have joined the register between March 2021 and March 2024. Visa data that takes account of the first quarter of 2024 reveals that a total of 9,356 visas have been granted to nurses from Nigeria since 2021, showing that recruitment from Nigeria is continuing.[7]

The recruitment of nursing and midwifery staff from Ghana has also risen dramatically in the past 3 years, with 842 new registrants in the 12 months to March 2022, 1,263 in the following 12 months, and then 1,736 in the year to March 2024. Since March 2021, 23.7% of all new joiners from countries on the WHO health workforce support and safeguards list received their initial training in Ghana.[8] Similarly, recent visa data show that recruitment from Ghana is also continuing, with a total of 3,527 visas granted to nurses from Ghana since 2021.[9]

Despite increased recruitment from Nigeria and Ghana, the UK has not agreed a memorandum of understanding with either country. From conversations with national nursing associations the RCN understands that the WHO health workforce support and safeguards list can present a risk to the safe migration of internationally recruited staff. In the absence of managed recruitment pathways, staff from countries on the health workforce support and safeguards list may be more susceptible to unscrupulous recruitment agencies.

Recruitment of care workers:

Since February 2022, a total of 112,537 visas have been granted to migrant care workers. This included 89,534 visas granted in 2023 alone. Of the total number of visas granted to care workers since February 2022, 69% (77,519) were granted to applicants from countries listed on the 2023 WHO health workforce support and safeguards list.[10]

Similarly to the international recruitment of nurses, many of these visas were granted to applicants from Nigeria and Ghana. 22,425 visas were granted to applicants from Nigeria, and 11,491 visas were granted to applicants from Ghana. 22,426 visas were also granted to applicants from Zimbabwe, though Zimbabwe was not added to the health workforce support and safeguards list until 2023.

2. What kind of measures for health and care workforce sustainability are countries taking and how effective are they?

The UK's health workforce crisis:

Across the UK, there is a deepening nursing workforce crisis with over 37,000 vacant nursing posts in the NHS across the UK.[11,12,13,14] Continued below inflation pay rises and failure to address recruitment and retention concerns has contributed to fewer going into and staying in the nursing profession.

An RCN report published in February 2023 revealed that tens of thousands of skilled and experienced nursing staff are leaving the profession, with many of those aged 21 to 50.[15] The report shows that between 2018 and 2022, nearly 43,000 people aged 21 to 50 left the Nursing and Midwifery Council (NMC) register. It also finds the number of nurses leaving the NMC register increased by 9% from 2020-21 on the previous year and increased by a further 3% in 2022. At the same time, recent UCAS figures highlight that there's not only a record number of experienced nurses leaving the NHS, but less joining the profession, leading to more vacancies in the future.[16]

NHS England Long-Term Workforce Plan:

The context for workforce planning differs across the UK. In June 2023, NHS England (which runs the National Health Service in England) published a Long-Term Workforce Plan (LTWP) for the NHS (the health system).[17] The LTWP included modelling of NHS workforce demand and supply over a 15-year period and the resulting shortfall and had a stated aim to reduce the reliance on international recruitment and temporary staffing from 2028/29 onwards once additional staff are being trained and recruited domestically.

The LTWP sets out actions to be taken to address the identified shortfall in addition to, and building on, actions and investment already committed over the next two years. It commits to regularly updating the model to inform operational and strategic planning as circumstances change. The LTWP sets out plans to grow the workforce and in relation to medical students to grow the number of students in areas where there are the greatest shortages, but while this is not specified in relation to nursing, the LTWP does recognise that "Other professional groups also require a more equitable spread of training opportunities, based on current and future patient need."

While the LTWP is a positive step in the right direction, the RCN has raised several concerns about the LTWP. This includes how realistic the plan was without sufficient investment in the existing nursing workforce to support retention, and greater financial support for those seeking to join the profession. There was a lack of funding

commitment – the interventions set out in the plan were not costed, nor was there an assessment of the impact of the proposed interventions on recruitment and retention. Our analysis at the time found that the relatively low level of overall funding did not align with the scale of ambition and growth outlined in the LTWP.

There is also a lack of detail on how nursing staff numbers would be increased. Recent data indicates that there has been a 26% collapse in the number of applicants to study nursing in England over the past two years so without significant action, the ambitions within the plan are unachievable. The lack of attention to retention and staff pay is concerning, given that over the last decade, nursing staff have faced a series of under inflation pay awards in parallel with increasing demands and additional responsibilities above their current pay grade and it is a key issue affecting recruitment and retention. Furthermore, the RCN has concerns that the ambitions for growth set out in the LTWP are still insufficient to bring into line with other counties e.g. France, Norway on nurse per population head per 1000.

Current nursing higher education finance policy is inconsistent and ineffective in incentivising more people to choose nursing:

In England, nursing students are currently required to self-fund their studies, and maintenance grants do not reflect the reality of costs of living. Before 2017 they received a bursary and nursing degree funding was provided by government via Health Education England.

Recent higher education finance reforms in England include lowering the repayment threshold, extending the repayment period by ten years and removing real interest rates during and after study which will result in nurses, and all low to middle income graduates paying more, for longer. This could be one reason why newly registered nurses are not practicing nursing after graduation. Completing their degree leaves them with high levels of debt, and they often turn to other sectors for higher rates of pay, less stress and better work-life balance.

The Government announced that all nursing students in England will receive maintenance grants of £5,000 to £8,000 from September 2020. While this provides some immediate support with living costs for this group, these grants do not address the biggest barrier preventing people from studying nursing: the prospect of a lifetime's worth of debt. This living costs fund hasn't increased in line with the recent cost of living crisis and remains at the amount announced in September 2019. This is alongside a backdrop of increased travel expenses, increasing cost of childcare support and more expensive mortgages and rent payments. To be effective, higher education funding models must be accompanied by a complete package for students including a living-costs grant that reflects the true cost of living and access to hardship payments.

Nursing students in higher education should have access to adequate financial support

for tuition and the cost of living – and fair pay for the work they do. Until this happens, this decline in interest in the profession is likely to continue.

Nursing and Midwifery Taskforce in Scotland:

In early 2023 RCN secured a significant pay deal from Scottish Government on NHS nurses' pay and conditions, including an average consolidated pay increase of at least 6.5%. Scottish Government also agreed to RCN's demand for the establishment of a Nursing and Midwifery Taskforce.[18] The pay deal and the taskforce are intended to support the establishment of a sustainable nursing workforce for the long term, which will also be supported by the implementation, from April 2024, of Scotland's safe staffing legislation: the Health and Care (Staffing) (Scotland) Act 2019.[19]

However, as RCN's latest annual Nursing Workforce in Scotland report of makes clear, we are some way off securing the sustainable nursing workforce that the report's ten recommendations would go a long way to securing, if acted upon.[20] The long-term trends highlighted in the report show that demand continues to outstrip supply. While the number of nursing staff employed by NHS Scotland has increased, crucially, the number of vacancies remains stubbornly high; and staff turnover and absences have increased. Within social care, particularly care homes for adults, the number of registered nurses employed declined further despite increasing clinical need. And for the third year in a row the number of people applying and accepted to study nursing has fallen.

Nursing and Midwifery Retention Initiative in Northern Ireland:

In Northern Ireland, the Department of Health published a regional nursing and midwifery retention strategy in 2022 that was co-produced with the RCN and others.[21] However, implementation has been negatively impacted by the absence of devolved government in Northern Ireland between February 2022 and February 2024. The same considerations have underpinned a reduction in the number of commissioned pre-registration nursing student places in 2023-2024 and 2024-2025, which in turn has undermined attempts to enhance the sustainability of the nursing workforce in Northern Ireland.

The RCN continues to work with the Department of Health and other stakeholders to secure the safe staffing legislation that was pledged by the Northern Ireland Executive in January 2020 following strike action by RCN members and other health workers. A consultation on the principles underpinning the legislation is scheduled to be launched later this month and the draft legislation will be brought before the Northern Ireland Assembly early in 2025. This will include a statutory commitment to workforce planning, an issue that the RCN has been highlighting for many years.

NHS Wales Nurse Retention Plan:

In April 2023, NHS Wales published its Nurse Retention Plan, as part of the National Workforce Implementation Plan introduced by the Welsh Government.[22] The retention plan cites the RCN report 'Retaining Nurses in the Profession: What matters? (2022)' as a foundational strategic driver behind the development of the plan.[23] The plan provides recommendations to support and address challenges around nurse retention in Wales and includes a self-assessment tool for employing organisations.

In June 2023, the Welsh Government began publishing NHS Wales vacancy statistics. This follows a long campaign by RCN Wales calling for this data to be published and easily accessible. It is a welcome step in ensuring data transparency and improved workforce planning. However, the Welsh Government has warned that because of their 'experimental' nature, these new NHS vacancy statistics are likely to underrepresent the true vacancy figure. Following a series of freedom of information requests for vacancy figures submitted by RCN Wales to regional health boards, RCN Wales estimates that registered nurse vacancies rose to 2,717 in 2023.

The Nurse Staffing Levels (Wales) Act 2016 was the first of its kind in Europe and put safe nurse staffing levels in legislation.[24] It ensures the Welsh government and local health boards must take responsibility for maintaining safe staffing levels through data capture and workforce planning. In November 2023, the RCN published a report on progress made since the legislation was introduced which found that the legislation has directly increased the number of nurses on wards, making patients safer. RCN's Nursing in Numbers report highlights a reliance on agency nursing, with a 21% increase in spending on nursing and midwifery staff since 2021-2022.[25] The report shows nursing staff are working 69,877 additional hours every week. This is the equivalent of an extra 1,863 full-time posts.

3. **Among the different mobility/migration pathways available for health personnel, which ones do they use most and why? What have been the advantages and disadvantages of different mobility pathways?**

The Health & Care Worker visa:

The primary visa route for internationally educated nurses and other migrant health workers coming to the UK is via a dedicated Health & Care Worker visa route.[26] Visa applicants are required to have a 'certificate of sponsorship' from an eligible employer in the health and social care sector. In February 2022, the visa route was expanded to include eligibility for care workers, care assistants and home care workers.

In year ending June 2022, 47,194 Health & Care Worker visas were granted to main applicants (i.e. health workers and not their dependants). In the year ending June 2023,

this figure had risen to 121,290, an increase of 157%, with Health & Care Worker visas representing 57% of all work visas issued that year.[27]

Over the same period, the number of dependant visas associated with Health & Care Worker visa main applicants also increased substantially. 48,973 dependant visas were issued to the families of Health & Care Worker visa holders in the year ending June 2022. This figure rose to 137,999 in the year ending 2023, an increase of 182%.

In an effort to cut net migration, the UK Government announced a series of measures in the second half of 2023 that would increase the costs of migrating to and settling in the UK.[28] Visa application costs for the Health & Care Worker visa were increased by 15%, while applications for Indefinite Leave to Remain (ILR) rose by 20% to £2,885 per person.[29] Care workers coming to the UK on the Health & Care visa route after March 2024 are now also ineligible to apply for dependent visas for their families, meaning they must come to the UK alone.

Such restrictions have had an impact on migration patterns and applications for the Health & Care Worker visa in the first quarter of 2024 have fallen dramatically to the lowest level on record.[30] From a high of 46,499 applications received in the third quarter of 2023 (before the immigration rules changes and visa fee increases had been announced), the number of Health & Care Worker visas granted to main applicants in the first quarter of 2024 have fallen to just 8,877 – a decline of more than 80%.

The decline was largest for care workers and home carers. From a high of 31,803 applications in the third quarter of 2023, the number of applications from care workers and home carers fell to just 2,922 in the first quarter of 2024 – a decline of over 90%. For nurses, the number of applications for the Health & Care Worker visa made in the first quarter of 2024 was less than half of the number of applications received by the Home Office in the same period the previous year.

There is an urgent need to address the dissonance in the policy making of the previous Government which created a hostile environment and disregarded the internationally trained staff which our health and care services rely so heavily on.

Rising visa costs:

In October 2023, the UK Government announced an increase in the cost of visa applications and renewals, the stated intention was in part to pay for public sector pay.[31] Migrant health and care workers applying for the health and care visa will now pay £284 GBP (an increase of 15%), and £551 GBP for more than three years. By comparison visa fee transparency data published by the Home Office, estimates the cost for processing health and care visa applications to be £129 GBP for overseas applicants and £151 GBP for in-country applicants.[32] If visa fees were to be capped at the processing cost, migrants would only be paying to cover the services that are being delivered.

The Government's Migration Advisory Committee (MAC) has stressed that increased visa costs are associated with a higher incidence of exploitation, particularly in lower paid areas, such as the social care sector. MAC findings have shown that unscrupulous employers leverage the knowledge of high charges, and the fact that lower paid migrants cannot afford to lose their role, to keep them in precarious and exploitative work.[33]

Recurring visa costs, specifically for large families, create a vicious cycle for people on lower incomes as they are not able to pay off any debts for previous fees and save for future ones. Qualitative and quantitative research has revealed that families resort to borrowing or lending money to cover costs, further facilitating exploitation of migrants on lower incomes.[34] For migrant health and care workers, total visa costs for a family of four are £1,136, and £2,272 for over three years, not including associated legal fees, or costs for settlement.

Indefinite Leave to Remain:

Restrictive migration polices continue to make it difficult for migrant health workers to attain permanent residency in the UK. Indefinite Leave to Remain (ILR) is often unattainable for migrants in the UK due to cost, and the required length of residence which is typically 5 years.

In October 2023, the UK Government increased the cost of ILR applications by 20%, taking the total cost to £2,885. UK Government estimates that the cost of processing is £646, meaning applicants pay a premium of £2,339 per application. There is no concession for children, meaning a family of four applying for settlement must pay £11,540. Such fees are often unaffordable for health and care workers and leave migrants subject to long-term immigration control.

The RCN considers that settled status would reduce the risk of exploitation, as staff would no longer be reliant on single employers to uphold their sponsorship. The Government's Migration Advisory Committee has called for a review of the cost and route to settlement, specifically stating that lower fees for ILR, and easier routes, can reduce exploitation, as an individual's stay is no longer conditional on employment.[35]

No recourse to public funds:

Migrant workers without indefinite leave to remain are excluded from public safety nets. A 'no recourse to public funds' condition is applied on most work visas in the UK, and prohibits migrants from accessing public benefits, despite paying the same taxes and national insurance contributions as their UK-educated colleagues.

The Migration Observatory estimates that at the end of 2022, as many as 2.6 million people in the UK held visas that typically have a 'no recourse to public funds' (NRPF) condition.[36]

RCN (unpublished) research finds that internationally educated members face difficulties navigating their living costs without state funded support. RCN members who are internationally educated report struggling more with finding adequate housing, childcare costs, and general household expenditure, compared to their UK-educated counterparts.

Family visas:

Internationally educated nurses also face difficulties in bringing their family members to the UK due to the high burden of evidence that is required by the Home Office. Members often report difficulties in bringing their children to the UK particularly in cases where parents are separated with one parent outside of the UK with no plans to migrate. Legal custody arrangements, for example, are insufficient evidence to prove Sole Responsibility. Member cases also suggest that the Home Office makes false assumptions that children who are temporarily staying with extended family members can continue to do so, and these decisions leave staff separated from their children for extended periods.

RCN members also report challenges in bringing their adult dependents to the UK through the Adult Dependent Relative (ADR) route.[37] Nurses and other healthcare workers can provide expert levels of care to their loved ones, and as such will often be the most suitable member of the family to look after an adult dependent relative in need of care. The RCN is aware of at least one case where a registered nurse was initially refused a visa through ADR on the basis that they could leave the UK to care for their parent in-country.

4. **From the health workers' perspective, how are the arrangements (and implementation) for the migrant health personnel in terms of:**
    - Recruitment process in source countries
    - Safe migration and integration in destination countries
    - Remuneration, working conditions, and opportunities for education and career development of migrant health personnel (as compared to domestic health personnel)
    - Labour standards and health worker rights in the destination country
    - Return to source country and reintegration to source country labour market (e.g., facilitators and barriers to finding employment opportunities)
    - Other arrangements (e.g., special considerations for the gender aspects)

Exploitation in the care sector:

The RCN has received increasing reports of unethical and exploitative employment practices faced by internationally recruited staff in the care sector. These include reports of repayment fees, which RCN members have reported to be as high as £16,000 charged to workers attempting to leave their employment before a specified time.

The RCN is aware of cases where passports have been taken and wages withheld in order to enforce payment of these fees. Internationally educated members also report being offered fraudulent job offers. In some cases, nursing staff have been scammed into paying up to £20,000 in illegal work finding fees.

Unseen UK, which runs a helpline for victims of modern slavery & exploitation, reported a sixfold increase in the number of modern slavery cases in the care sector between 2021 and 2022.[38] The care sector accounted for 18% of all potential victims that called the helpline in 2022, over 700 individuals.

The Gangmasters Labour Abuse Authority (GLAA) has also found evidence of labour abuse in the sector, including overcrowded accommodation, payment below minimum wage, and debt bondage. In 2023, the GLAA received 123 reports of modern slavery and human trafficking within the care sector, with the sector representing between 26% and 48% of all referrals made in each quarter.[39,40,41,42]

The Director for Labour Market Enforcement, which sits above the GLAA, assessed the care sector as high risk, given the prevalence of non-compliance with labour standards and cases of modern slavery.[43,44] Most recently, in its 2024 report, it was found that non-compliance with the National Minimum Wage and non-payment was endemic in the care sector.[45]

Due to the widespread use of repayment clauses in the employment contracts of migrant health personnel, in conjunction with a visa system that requires migrants to be sponsored by an individual employer, the RCN also considers that there is a significant risk that internationally recruited nurses may feel that they have no choice but to stay in employment or domestic situations which might cause them physical or psychological harm.

Education and career development for migrant health personnel:

Internationally trained nurses bring a wealth of diverse experience and extensive knowledge that is often not recognised by UK employers or rewarded financially. Many internationally educated nursing staff may have been employed in senior roles in their home countries but their international experience is often unrecognised. Internationally recruited nurses have also reported feeling undervalued and experiencing fewer opportunities for career progression and promotion than UK educated colleagues,

including a lack of support from their employers in accessing continuing professional development.[46]

There is also significant variation in onboarding. Inadequate inductions can contribute to a difficult experience of transitioning to life and work in the UK. Induction and pastoral support are crucial in making staff feel welcome in their new communities, highlighting career development pathways, and signposting to trade unions and other sources of external support.

The UK as a 'staging post':

The UK-based Health Foundation has recently published data that shows the UK is at risk of becoming a 'staging post' in the careers of internationally educated nurses.[47] Whilst the UK remains a popular destination for nursing practice, it is also clear that a growing number of internationally educated nurses are considering leaving the UK.

Nurses on the UK register for nursing and midwifery professionals can apply for a Certificate of Current Professional Status (CCPS) from the UK Nursing and Midwifery Council to prove their practising status when applying for roles in other countries. Data from the Nursing and Midwifery Council shows that applications for these certificates recently reached the highest on record, with 7 in 10 of these applications coming from internationally educated nurses.

In 2022/23, 8,931 applications for CCPS were received from internationally educated nurses, more than 14 times higher than in 2018/2019. These findings demonstrate the extent to which internationally educated nurses have been undervalued by UK health and care systems and treated unfairly by punitive immigration policies.

5. How have source countries benefitted from international migration of health personnel?

Bilateral Labour Agreements:

The UK has signed bilateral labour agreements on the migration of health and care workers with six different countries: Philippines, Malaysia, Kenya, Sri Lanka, India and Nepal.[48] Of the six countries, only Nepal is listed on the WHO health workforce support and safeguards list. The UK-Nepal agreement was signed in August 2022. Between September 2022 - March 2024, NMC data shows that 820 nursing and midwifery staff joined the UK register from Nepal.[49]

Despite sustained high levels of recruitment from countries such as Nigeria and Ghana

the UK does not have any bilateral labour agreements with either country. Existing bilateral labour agreements signed by the UK have not included UK trade unions or nursing associations in discussions, which limits our capacity to ensure that agreements are genuinely mutually beneficial. It's also imperative that the implementation of bilateral labour agreements is monitored by independent stakeholders to assure full compliance by all parties.

The RCN is also concerned that the UK's existing bilateral agreements do not include necessary provisions included in the updated WHO (2024) guidance on bilateral agreements.[50] Provisions on data collection and monitoring, specifically on implementation and evaluation of existing agreements, are not specified in the UK's bilateral agreements. Enhanced data collection, monitoring and information sharing between countries would allow for more accurate monitoring of how such agreements are being implemented, and the respective impact on health systems in destination and origin countries.

Gender considerations are also absent from UK agreements, despite the global nursing workforce being an overwhelmingly female occupation. The WHO guidance makes clear that female migrants are also acutely vulnerable during the migration process and raises global concerns about the lack of a gendered lens in the creation of bilateral agreements. UK agreements must include gender-specific provisions, and make provisions for other protected characteristics.

Official Development Assistance and Migrant Remittances:

In 2020 the UK Government announced a temporary reduction in Official Development Assistance (ODA) spending from 0.7% to 0.5% of GNI, cutting aid at a time when investment in health systems was needed more than ever. It was announced that the UK would return to the 0.7% target when the fiscal situation allowed, with ODA spending standing at 0.58% for 2023.[51]

WHO data estimates that an additional 4.8 million nurses and midwives will be needed by 2030 to deliver Universal Health Coverage[52] but in 2022 just 2% of the UK's health-related ODA spend was allocated to developing the global health workforce.[53] Cuts to UK aid are happening when investment in the global nursing workforce is critical in post-pandemic recovery and to achieve global health goals.

In May 2023, the UK Government announced the allocation of £15 million pounds to support the development of the global health workforce.[54] £6 million pounds was promised to the WHO to work with governments to support workforce planning, management and policy. In September 2023, the remaining £9 million pounds was awarded to Tropical Health and Education Trust (THET) to coordinate the delivery of partnership work. The programme will target specific workforce needs in Ghana, Kenya and Nigeria identified through a scoping assessment in partnership with national

governments and in liaison with WHO country offices.[55]

Data is not available for remittances sent to source countries by migrant health personnel working in the UK. However, despite the Sustainable Development Goals target to reduce the cost of remittance transactions to 3% by 2030, the cost of sending remittances from the UK stood at 7.12% in 2019.[56]

6. How have destination countries benefitted from migration of health personnel?

Benefits of migration of health personnel to the UK:

UK health and care systems are highly reliant on international recruitment to meet workforce needs. In the 12 months to March 2024, almost half (49.4%) of all new registrants joining the NMC register for the first time (new joiners) were internationally educated.[57]

There is a significant economic benefit to the UK from recruiting internationally. In the 12 months to March 2024, the most common country of initial training for new joiners to the NMC register other than the UK was India (14,615 new joiners in this period received their initial training in India). Recent estimates of the cost of recruiting a nurse from India put the figure at between £10,000 and £12,000.[58] By contrast, a study conducted by researchers at the University of Kent found that the typical cost of educating a nurse in the UK was £71,582.[59]

International recruitment also brings other benefits to the UK health and care systems, including the exchange of experience and expertise of nursing staff from around the world. As has already been mentioned, many internationally educated nurses joining the UK workforce have previously been employed in senior roles, bringing a wealth of experience in leadership and management to UK health systems. A diverse nursing workforce can also help to ensure the delivery of culturally competent care.

The extent to which different national governments across the UK rely on the recruitment of international nurses differ due to workforce issues, vacancy rates, and policy decisions.

International recruitment across the UK:

England has the highest rates of international recruitment in the UK with 21.2% of NMC registrants having trained overseas in March 2024. In 2019 the Government committed to increasing the number of registered nurses working in NHS England by 50,000. This was achieved in 2024, with 42,000-61,000 additional FTE nurses in the NHS compared to March 2019. However, 93% of this target has been met through the recruitment of

international nurses, reflecting the Government's strategy of filling workforce gaps with increased international recruitment.[60]

In April 2022, the Scottish Government announced that it had recruited over 1,000 additional healthcare support staff and 191 registered nurses internationally. Following the announcement of an additional £8 million in recruitment funding from October 2022, in June 2023 the Scottish Government celebrated the recruitment of an additional 800 nurses, midwives and allied health professionals from overseas.[61] Overall, international recruitment in Scotland is accelerating, with 5.3% of the NMC register in Scotland being educated internationally in March 2024.[62]

In Wales, recruitment of international health and care staff was traditionally conducted on a health board basis, with specific areas responding to workforce needs through international recruitment. However, in 2022, the Chief Nursing Officer for Wales outlined a 'Once for Wales' approach with backing from the Welsh Government, aiming to fill service needs by recruiting a further 400 nurses from overseas.[63] In March 2024, 10.8% of the NMC register in Wales had been educated overseas.[64]

In Northern Ireland, the Department of Health Nursing and Midwifery Task Group [NMTG][65] on which the RCN was represented, was established with the core aim of developing a roadmap to provide direction in achieving world class nursing and midwifery services in a reconfigured HSC system over the next 10-15 years. As of 31 July 2022, the project had recruited 1,209 nurses, of which 1,121 remained in post at that point. The following month, the Department of Health confirmed that funding had been secured for the remainder of 2022-2023. This equated to approximately 350 new recruits by the end of March 2023. In response to a question raised in the Northern Island Assembly in May 2024, the Minister of Health shared that 1,666 international nurses had been recruited through the International Nurse Recruitment project across Northern Ireland's Health & Social Care Trusts.[66] In March 2024, 15.0% of NMC registrants in Northern Ireland had been educated overseas.[67]

7. **How have national/sub-national data and research on health personnel (including health personnel information systems, migration data) been used to inform policies and plans?**

N/A

8. **How have countries, international organizations, donors, and other stakeholders used the WHO health workforce support and safeguards list?**

In the UK, the Code of practice for the international recruitment of health and social care personnel sets out the policy for international recruitment in the UK.[68] Devolved administrations adhere to the principles of The Code but hold their own

Code to reflect the different organisational structures in each nation.

The UK's Code is closely aligned with the WHO's Global Code. It includes reference to a RAG rating system for international recruitment, with 'green list' countries approved for active recruitment, 'amber list' countries approved for active recruitment only where it take place under the terms of a bilateral labour agreement (as is the case for Kenya and Nepal) and the 'red list', a list of countries that should not be target for active recruitment. In February 2021, the UK aligned its 'red list' of countries that should not be targeted for active recruitment with the countries named on the WHO's health workforce support and safeguards list (2020).[69]

The RCN supports the principles set out in the Code, however we have concerns regarding compliance and implementation. Since the UK's alignment with the WHO health workforce support and safeguards list, the RCN has raised concerns that continuing high levels of recruitment from countries on the list indicate that active recruitment is still taking place, contravening the Code. The RCN would welcome increased transparency on how active recruitment from red list countries is monitored including the data sources used.[70]

The Code requires compliance by all agencies and employers recruiting from overseas, however this requirement is not set out by legislation. It is evident that unscrupulous employers and agencies continue to operate against the principles of the Code. Enshrining principles of the Code through legislation would be a positive step to ensure compliance.

The RCN also has specific concerns around the levels of information that are being made available to internationally educated nurses as part of the recruitment process when considering coming to the UK. A number of RCN members have reported experiences where some recruitment agencies have allegedly underplayed the difficulty of bringing family and dependents to the UK, and not provided adequate information to applicants regarding the complexities of the UK's immigration system. Where this occurs, this increases the risk that any individual is able to make fully informed decisions on whether to migrate and can result in families being separated.

Under the previous UK Government, the RCN had the opportunity provide feedback on the Code.[71] The UK's newly established Labour Government has indicated that they will be looking into exploitation of staff and labour rights more generally. They have also committed to reduce the UK's dependence on international recruitment to meet its health workforce needs.[72] This could lead to a reduction in recruitment of health and care personnel from countries listed on the WHO health workforce support and safeguards list, with positive impacts for countries facing critical workforce shortages. We will look for opportunities to work with the Government and to raise our concerns regarding implementation of the UK's Code of Practice.

9. **Please provide reflection on the past 14 years since the resolution on the Code in the country(ies) where you work or support (e.g., the Code's relevance, achievements, and challenges; alignment of the Code with other global instruments such as the United Nations Global Compact on Migration, international labour standards etc.; contribution of the Code to achieving the Sustainable Development Goals, etc.)**

Nursing and Midwifery Council Data:

The UK Nursing Midwifery Council publish data reports from the nursing and midwifery register every six months. This data shows the number of nurses and midwives that are currently able to practice, as well as other information including the country in which they received their initial training. The Nursing and Midwifery Council publishes registration data on its website going back to 2016.[73] The publication of this data has improved the ability of stakeholders to monitor the UK's reliance on international recruitment and identify trends of unethical recruitment from countries on the WHO health workforce support and safeguards list.

Adoption of the WHO health workforce support and safeguards list:

In February 2021, the UK aligned its 'red list' of countries that should not be targeted for active recruitment with the countries named on the WHO's health workforce support and safeguards list. However, this move marked a downgraded commitment by the UK, which previously maintained their own more extensive list.[74]

The UK's previous list was compiled in partnership with the former Department for International Development and based on the Organisation for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC) list of countries eligible to receive official development assistance (ODA).[75] This list included of 152 countries, including all 47 countries on the 2020 WHO health workforce support and safeguards list. In the UK context, alignment with the universal standard established by the17mployh workforce support and safeguards list effectively allowed UK employers to recruit from an additional 86 countries.

To take one example, Zimbabwe had previously been identified by the UK's own list as a country that should not be targeted for international recruitment. In the 6 months to September 2020, just 51 nurses and midwives who had received their initial training in Zimbabwe joined the UK register.[76] For the same period in 2021, following alignment with the WHO health workforce support and safeguards list (2020) and the removal of Zimbabwe from the UK 'red list', this figure was over 9 times higher, at 463. Despite the later addition of Zimbabwe to the updated WHO health workforce support and safeguards list in 2023, around 30,000 Health & Care Worker visas have been granted to Zimbabwean nationals since 2022.[77]

WHO guidance stresses that it is good practice for high-income countries to extend the safeguarding approach to additional low- and middle-income countries beyond those specified by the list.[78] As a high-income country with a relatively strong health system, the UK's full adherence to the spirit of the health workforce support and safeguards list should encompass setting a higher threshold for its own international recruitment and role modelling the standards appropriate to comparable countries. However, the example of the UK highlights the need for additional guidance from WHO for high-income countries that encourages them to exceed the universal minimum standard established by the health workforce support and safeguards list.

Trends in Unethical International Recruitment since 2016:

International recruitment, including from countries identified as facing pressing workforce shortages, has increased year on year despite the introduction of the WHO's health workforce support and safeguards list. Between September 2020 and September 2021, during which time the UK first aligned its Code of Practice with the health workforce support and safeguards list, 3431 nurses and midwives who received their initial training in one of these countries joined the UK register. In the 12 months to March 2024, the most recent period for which we have date, this figure rose to 6625. By comparison, in the 12 months to September 2016, just 68 nurses and midwives who received their initial training in a country on the current (2023) health workforce support and safeguards list joined the UK register for the first time.[79]

The policy context for this dramatic increase in recruitment from countries designated as requiring support and safeguards include the UK's departure from the European Union and the subsequent introduction of the Health & Care Worker visa as a relatively low-cost visa route to ensure health and care workforce supply. However, it is evident that the UK Government's alignment with the WHO Global Code of Practice and the WHO health workforce support and safeguards list has not been effective in reducing the number of nurses and midwives from listed countries taking 18mployyment in the UK.

Official Development Assistance:

Despite the UK's reliance on international recruitment to fill domestic workforce gaps, efforts to health workforce strengthening overseas have been hindered by the previous UK Government's decision to temporarily reduce Official Development Assistance (ODA) spending from the United Nations target of 0.7% of gross national income (GNI) to just 0.5% of GNI. The cut to ODA spending was announced at a time when investment in strengthening and building a resilient nursing workforce was needed more than ever.

Had the target of 0.7% of GNI been maintained, an additional £9,188 million would have been available to fund vital development projects around the world between 2021 and 2022. This downgraded commitment to sustainable development has had stark consequences for spending on health-related initiatives. Between 2020 and 2022, the UK's ODA spending on health fell by 38.6% to just 7.6% of total spend in 2022.[80]

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