

Migration of Healthcare Professionals in post-Brexit Britain

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The year 2020 has been a momentous year on many counts. The world has been devastated by the ravages of a pandemic like never before, brought to a standstill, the economy destroyed and then transformed into a digitally cohesive, connected world of scientific collaboration and innovation. Yet, behind all this is a momentous change that occurred as the bells were ringing in the New year. A historic act of divorce and separation of hearts and minds, is sealed finally with the completion of the Brexit transition. Great Britain exercised its right to self-determination and became an island nation once again, after four decades of economic and (by proxy and utmost reluctance), political alignment with a huge segment of the continent of Western Europe. It is being hailed as a great opportunity by a slender (but winning) margin of the populace, while for just the other (less than) half of the nation (Europhiles) it is a heart-wrenching end to the promise of a united, liberal dream of modern multinational collaboration. It is in this backdrop that this article explores the phenomenon of medical migration into Great Britain. What does the future hold for medical professionals in post-Brexit Britain? What should become of the 'English dream?'

During the Covid19 pandemic, a unique phenomenon was observed by the team supporting several international doctors who were in the UK for their licensing assessment, and had become stranded due to the 'lockdown' imposed by the UK and many international governments on travel and almost all activities. These doctors from 19 different countries had arrived in the UK chasing a dream of working and training as postgraduate doctors. When faced with the severe prospect of becoming stranded physically, emotionally and financially for an unspecified but prolonged period, the supporting team managed to negotiate some rescue flights back to their home countries. What came as a surprise was the apparent

reluctance of the stranded doctors to leave the UK, without accomplishing their goal of qualifying (for the licensing examination and work in the UK). These stranded doctors were willing to take incredible risks with their wellbeing, face huge hardships stranded without recourse to support nor sustenance, and appeared to be supported in their decisions by their families in their home countries. Although all the members of the support team were themselves, immigrant doctors, they found this observation almost unfathomable. Is this the dream of working in the UK health system the English equivalent of the 'American dream?' Although this did come as a surprise to the UK support team, this phenomenon is well-described among immigrant doctors in Australia and USA. (1,2)

Migration of groups of humans is a fact of evolution. An essential part of being a thinking animal. In fact, migration can even be considered a biological necessity, a mode of sustenance and survival. At least it has been described and understood stretching back to the earliest modelling of the existence of homo sapiens.

What drives migration? There are several theories ranging from the fundamental search for food, water, a suitable climate, safety and reproduction or propagation to one of chasing a dream. The most common reason for coming to the UK in 2016, was work. About 50% came for work, followed by those who came for study (27%) and 17% for family reasons. European Union (EU) citizens were more likely to report 'coming for work', while non-EU citizens were more likely to come for study or family.(3) The popular penetration of the English language and the legacy of the British Empire, in the nations of the Commonwealth, is perhaps one of the primary determinant of migrants choosing the UK as their favoured destination. The recent phenomenon of EU

citizens migrating to the UK is a direct result of the free movement of citizens policy.

There is, however, some fundamental differences in the migration of highly skilled versus low-skilled worker migration. What is common for all migration is that, (contrary to popular misconceptions), migrants overwhelmingly bring posterity to their adopted countries. In almost all circumstances there is a net 'brain gain' in adopted countries versus the 'brain drain' from originating countries. (4–6) Even in the time of nations with heavily reinforced borders, the phenomenon of migration continues to drive human beings to greater ingenuity, courage and even desperation in their attempts to emigrate.

The world has seen a huge reversal of trends in immigration from the eastward travels of the Greek King Alexander, the Roman expansion, followed by Marco Polo, Vasco de Gama, Christopher Columbus, to the Victorian exploration (and economic exploitation) of the Americas, Africa, Asia and Australia mostly by European travellers. Perhaps with the exception of the fourteenth-century Mongolian migration from Central Asia to the Indian subcontinent by Gengis Khan and then settlement by the Mughal Emperor Babar, most of the migration has been originating from Europe.(7)

Hand in hand with immigration, exists the cycle of emigration. No other European country has a more diverse history of emigration than Great Britain. Besides the "usual" emigrants during the 19th and early 20th centuries, there were the early settlers in the 17th century to North America, the establishment of colonies around the world, the shipping of slaves to those colonies, as well as the transfer of prisoners to Australia. Already in the mid-16th century the British crown sent explorers to the New World. However, it took a few more decades for the first successful and permanent English settlement in America to be established in Jamestown, Virginia in 1607. The early British arriving in America were referred to as colonists or settlers. The term immigrant was officially first used in 1787.(8)

With the advent of America as a promised land, there was a new phenomenon seen with the movement of the Irish and many settlers from different parts of Europe. This is perhaps where the dream of settlement to a new life away from home, was born again. The emigration continued until the 20th century. From 1820 to 1920 over 2.5 million people emigrated from

England to the US making it the fifth largest emigration nation following Germany (5.5 million), Ireland (4.4 million), Italy (4.2 million) and Austria-Hungary (3.7 million).

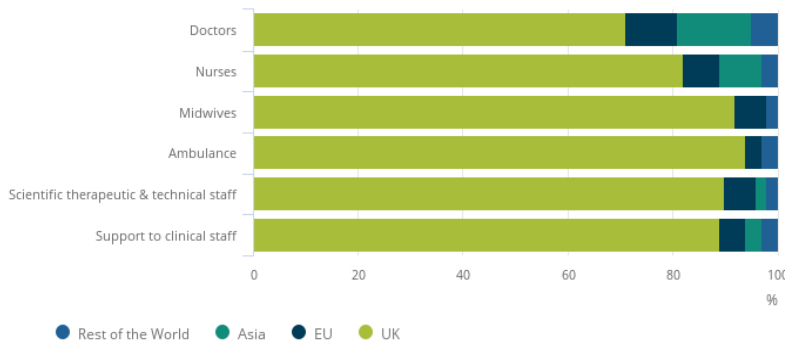
The Second World War and the long post-war European economic boom, which was fuelled by reconstruction and American investment, has been the creation of substantial immigrant communities in most West European countries. The war was a major pull factor stimulating migration. In Britain, the mobilisation of people in the armed forces, the expansion of the Merchant Navy and the harnessing of industry and agriculture for the war quickly caused serious labour shortages. These were only partly met by the recruitment of women, young people and Irish workers. Colonial workers were therefore recruited and brought to Britain, and others came voluntarily.

Since 1945, immigration to the United Kingdom under British nationality law has been significant, in particular from the Republic of Ireland and from the former British Empire especially India, Bangladesh, Pakistan, the Caribbean, South Africa, Nigeria, Ghana, Kenya and Hong Kong. Other immigrants have come from member states of the European Union, exercising one of the European Union's Four Freedoms, and a smaller number have come as asylum seekers, seeking protection as refugees. About 70% of the population increase between the 2001 and 2011 censuses was due to foreign-born immigration. Around 7.5 million people (11.9% of the population at the time) were born overseas, although the census gives no indication of their immigration status or intended length of stay.

In 2018, estimates show that there were approximately 1.9 million people employed in health care in the UK. Of these, 88% were British nationals, while 6% were EU nationals and 6% non-EU nationals. This is similar to the overall resident population wherein 2018, 6% were EU nationals and 4% non-EU nationals. Over the medium term, the proportion of non-British nationals in the healthcare workforce has remained broadly stable (Figure 1). At the same time, the numbers have increased from 155,000 to 227,000, with EU nationals accounting for the majority of the increase (from 56,000 in 2012 to 116,000 in 2018). Between 29% of doctors and 18% of nurses in the NHS were from non-British nationals. In primary care 1 in 5 General Practitioners and 1 in 4 GP Registrars were non-British nationals according to the immigration data from the UK Office of National Statistics. (9)

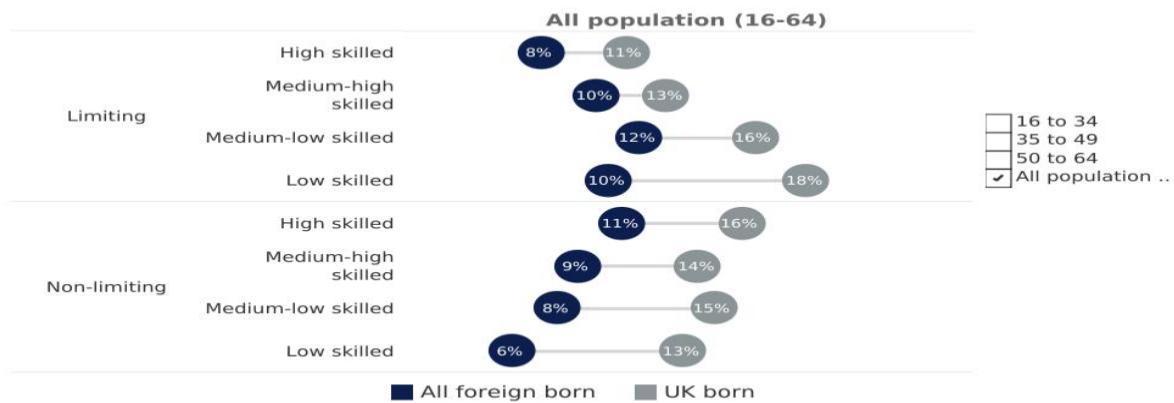
Figure 5: Higher proportions of doctors and nurses were non-British nationals than in other staff groups

NHS HCHS healthcare staff working in Trusts and CCGs by staff group and nationality, England, March 2019



Source: NHS Digital - NHS Workforce Statistics

Population with limiting and non-limiting health problems by job skills, age and country of birth, 2019
Employed population, age 16 to 64



Source: Migration Observatory analysis of the Labour Force Survey 2019 (average of four quarters)
Note: data on health problems lasting or expected to last at least 12 months. A health problem is considered limiting if it constrains respondents' ability to carry out day-to-day activities.



Hence, it is well-established that non-UK nationals make up a substantial proportion of the healthcare workforce. These are represented predominantly by nurses and doctors and tend to be younger and healthier than their British born peers.(10)

What is the experience of migrant healthcare workers? How might this change following Brexit?

Research focussing on professionals who 'have made it through the system' – acknowledge not only difficulties and challenges but also positive experiences. Pierre Bourdieu's theory of the 'Cultural Capital' describes culture as a non-financial resource

that people 'inherit' (e.g. from the family) or consciously acquire over time (e.g. through formal education). While formal/institutionalised cultural capital is acquired or attributed to education, accredited professional training or recognised work experience, informal cultural capital is acquired from social and professional networks both in their country of origin and the host country, as well as the work ethics they bring along.

Cultural Capital

The cultural capital that the immigrant population or professionals bring to their adopted country has never

really been recognised or valued. The dominant system has focussed on acculturation and harmonising. While the benefits of harmonisation is understandable in order to smoothen the complexities of people facing healthcare delivery roles, there are tensions that build up. Ultimately, where diversity is under-valued there is always the potential for discrimination and inequality. None of this is for the benefit of the immigrant nor of the host systems. (11) (12,13) For immigrant health workers, career trajectories are shaped by their use or not, of cultural capital which involves their self-worth. When it comes to motivations, practising in an advanced and less hierarchical healthcare system is more important than simply being in a job that pays well. Also, being able to participate in planning and decision-making in one's area of expertise is more important than merely holding a prestigious post. The exploration of the role of cultural capital in the experiences and views of migrant doctors is an interesting and fruitful approach in considering the influence of both the personal or structural barriers and facilitators of their participation in professional life in their adopted countries. (14)

Architects of the NHS

Locally trained doctors tend not to want to work in areas of high deprivation and need, and we continue to rely on foreign-trained doctors to fill massive gaps. Medicine should acknowledge this historical trend and tackle the dysfunction arising from its contemporary manifestations, writes Julian Simpson. (15) Medical migration from the former British empire in South Asia was a fundamental aspect of the working-class experience of healthcare in Britain in the period from the 1940s to the 1980s and beyond. By the end of the 1980s, although about 16% of GPs in England and Wales were from South Asia, their distribution was hugely uneven. Few South Asian doctors practised in areas that were generally more middle class and rural. GPs from the Indian subcontinent were largely catering to the residents of generally working-class and industrial areas. This is all the more important because of the central role that general practice gradually took on in the NHS, with care increasingly delivered in community settings, and GPs acting as gatekeepers to secondary care.

In effect, South Asian GPs were the first point of contact with the NHS for millions of patients.

In his book *Migrant Architects of the NHS* (16) Simpson argues that the core principle of the NHS is, that it provides care without charge at the point of delivery. This means that, at least in theory, social and financial status should not affect patients' ability to access care. But of course, to deliver on this promise, one needs

enough doctors or nurses to provide care. It was South Asian doctors and nurses from India, Philippines and the West Indies, who made it possible for the NHS to develop as a system built around primary care. Serving a population who historically had struggled to afford to see a doctor. They should therefore be seen as architects of the NHS in the same way that Aneurin Bevan and William Beveridge are.

The usual narrative in relation to medical migration is that the work of doctors like these helps to compensate for doctor shortages. But what does this expression mean? The huge variations in the proportion of South Asian doctors in the GP population indicate a wider issue. They helped staff general practice, which was at the time seen as an unpopular career option by many UK graduates. And the doctor shortages were also specific to particular geographical areas. The problem was not just a shortage of doctors in the UK, but also a shortage of doctors willing to take on particular roles, in deprived areas or geographical remote locations. During the same period, as thousands of South Asian medical graduates settled in Britain, thousands of their British trained counterparts chose to pursue careers in places like Australia, New Zealand, South Africa, the US, and Canada rather than take up the positions that South Asian doctors did.

Essentially, the history of general practice in the first 40 years of the NHS is also the history of a lack of alignment between the aims and needs of the NHS, and the social and professional aspirations of doctors trained in British medical schools. British general practice today continues to be shaped by these dynamics: much of the GP workforce comprises non-UK-qualified GPs who work longer hours and serve a larger number of patients in deprived areas. This has wider implications for medicine and healthcare. This phenomenon is not confined to the UK; nor is it exclusive to general practice. The so-called lower status roles in locations viewed as less glamorous have provided career opportunities for incomers, who lack local networks and have historically been subject to discrimination. Over half the doctors who had become NHS consultants in learning disability between 1964 and 1991, for instance, were non-white and trained abroad, while for the then lucrative field of cardiothoracic surgery, it was 6.5%.

Similar processes occur in other countries. Overseas trained doctors are crucial to provision in remote and rural settings in Australia and in care for Aboriginal patients. In practice, this means that the highest need and vulnerable populations—poor, elderly, disabled, and mentally ill patients—are more likely to be cared for by migrant practitioners. Forty-seven years ago, Julian Tudor Hart formulated the '*inverse care law*',

which says that the availability of medical care tends to vary inversely with the needs of the population served. It has an additional dimension: the proportion of locally trained doctors tends also to vary inversely with the need of the population served. The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is considered a primitive and historically outdated social theory, and any return to it would further exaggerate the maldistribution of medical resources.(17)

End of Permit Free Training

UK immigration rules were changed in 2006, requiring doctors who trained outside the European Union to apply for a work permit. This brought to an end the previously existing permit-free training arrangements for international doctors. Trusts that wanted to employ such a doctor had to prove, before hiring, to the work permits department of the Home Office that they could not find a good enough candidate in the UK or European Union. (18) This policy created a huge degree of resentment, many doctors who had already committed years of their professional lives to the UK NHS found it nigh impossible to secure jobs and there was a massive exodus of doctors. Unbeknown to the Home Office, the NHS Trusts struggled to fill their vacancies, particularly in geographical outfields and areas of social deprivation (inner cities and industrial wastelands). This policy was certainly successful in undermining the high regard that UK postgraduate training and the fairness of the universal care system of the NHS, was held in the eyes of professionals in many countries in the world.

Challenges to Self-sufficiency

The question of why that continues to be the case, and how to adjust the running of healthcare systems to reflect these facts, should be a central concern for policymakers. It has profound, but largely unacknowledged, implications for the way medical systems are run. History should help us understand one of the paradoxes at the heart of this problem: training more doctors is not alone an adequate response to “doctor shortages.” Once doctors have qualified they are in an international jobs market. If nothing is done to tackle the fact that British doctors have tended to migrate rather than take jobs that they

deem undesirable, the government’s aim to achieve medical self-sufficiency by producing more medical graduates will most likely mainly serve to boost the healthcare systems of other countries in years to come.

Reducing dependency on medical migrants requires measures such as changing the recruitment processes and culture of British medical schools. They should look at the diversity of their recruitment on a range of criteria—not simply gender and ethnicity but also social background. A recent report by the UK government’s Social Mobility Commission found that professions such as medicine “remain dominated by the privileged.” This surely perpetuates the historical flight from working-class areas.(19)

A training system that produces graduates who disproportionately aspire to work in middle-class areas or take on roles that are perceived as heroic can only be described as dysfunctional. That is unless the medical profession thinks it appropriate not to train enough physicians willing to cater for all conditions and all sections of the population.

Benefits of Migrant Professionals

Until radical cultural shift occurs, modern healthcare systems will remain reliant on migrant doctors. There should therefore be greater recognition of the specific work medical migrants tend to do and reflection on what support they require. This should include measures to tackle the racism and discrimination in medicine that shapes doctors’ career paths (not least when it comes to their concentration in particular specialities and geographical areas) and affects their ability to realise their full potential as professionals.

We also need to develop a greater understanding of migrant doctors as vectors of culture and professional practices. This is about linguistic skills that can benefit patients (when doctors speak the same language as migrant or ethnic minority patients), approaches to care that the host healthcare system might learn from (currently, the burden tends to be on migrants to adapt), and, say, how imported religious beliefs or social attitudes might shape patient care, for better or for worse. Paradoxically, we have little understanding of the effect of medical migration, even though it is a key aspect of modern healthcare.

The little island of ‘Great Britain’ stands again at the cross-roads of its future as the last bells ring in the new year of 2021. As it ventures out on its own again after 40 years of sharing a common destiny with the

continent and people of Western Europe, now is the time to make the right policy choices. We have heard the current Home Secretary talk of adopting an ‘Australian style’ managed migration and point-based system of deciding who should be allowed to come to Britain. This policy, seen as ‘draconian’ by many scientists, liberals and cultural pundits, is fraught with danger. (20) The Australian managed migration has devastating consequences on the lives of generations of highly skilled migrants, (21) many of whom have had to endure dashed hopes, racism and destitution.

The NHS needs the vital contribution of migrant health professionals now and will do so for generations to come. There are currently over 100,000 vacancies for nurses and several thousand for doctors. A hostile immigration policy, severe mismatch of aspirations (for high-quality postgraduate training in chosen specialities), discrimination in recruitment, career progression, examinations and unfair treatment within employment creates a toxic mix which can only be detrimental to the UK (or any host country) as well as being devastating to the migrants. If 2020 has taught us anything, it is the value of human capital, the selfless dedication of the key workers and how much nation-states, their people and their fragile economies depend on the wealth that immigration brings. It is therefore time that people, our elected representatives and the pundits realise their worth and work together to make it a fairer world for all. It is only through this that the country can prosper in wealth and health of the nation can be enhanced.

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