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Brexit adds further complexity to the health and care staffing crisis

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Health systems in the UK have a long standing dependency on international staff, and over the decades this has tended to intensify at times of shortage. Today is no exception, but this period of shortfall coincides with departure from the European Union (EU)—causing rapid, and at times, concerning changes in patterns of recruitment.

International staff have and continue to make invaluable contributions to the system. However, it is evident this influx also partly attempts to compensate for relatively low numbers in doctors, nurses, and care workers. Yet there is no long term strategy to train, recruit, adequately pay, and retain domestic health and care workers. How has Brexit affected the situation?

Looking beyond Europe?

Brexit seems to have both provoked a shift towards seeking international workers from beyond the EU, and an exacerbation of existing issues.

In our latest report from the Nuffield Trust, we look more specifically at doctors.[1] While the overall number of EU and European Free Trade Association (EFTA) doctors appeared relatively stable, we selected individual specialties where the number and/or proportion of EU doctors was highest and there was a known shortage. Across these specialties, the numbers of EU or EFTA doctors plateaued or even tailed off, and any increase in doctors from the rest of the world did not make up for staffing gaps.

This was the case for anaesthetics, for example, which has the highest EU/EFTA numbers in England at just under 2,000. It has seen a very slight drop in EU doctors over the last two years, and still struggles with generating sufficient training places at home. In cardio-thoracic surgery, the number of EU consultants in the UK increased by 100% between 2007 and 2014, overtaking UK consultants, but has since tailed off, whereas there are still more junior UK and rest of world cardio-thoracic surgeons in England, which again suggests issues with progression pathways.

More widely across medicine, nursing and the broader UK workforce, EU migration has fallen away after the referendum while migration from other countries has risen to record highs. This trend is most dramatic for EU nurses, who have not only stopped joining but have started to leave the NHS. Between September 2016 and 2021, the NHS lost 11 000 EU or EFTA nurses, and gained 30 000 nurses from the rest of the world. Yet these numbers will be insufficient to compensate for severe shortages and rises in domestic demand in the coming decade.[2]

Other crucial areas have failed to make up with staff from elsewhere in the world for the workers they once relied on receiving from Europe. Social care vacancies have increased since the beginning of the pandemic: pay and working conditions are significantly poorer than in the NHS—where a number of foreign care workers eventually seek to be employed via the care sector. In dentistry, the problem appears to be a lack of training posts. In both cases, EU migration is down, but liberalising immigration rules has not closed the vacancy gap with staff from other countries.

Not just a numbers game

Meanwhile, our data for NHS England trusts show a strong increase in recruitment from so-called "red list" lower-income countries (such as Nigeria or Pakistan), which the World Health Organisation recommends not actively hiring from as this would compromise their health systems. Some trusts are open about these recruitment drives. Our interviews also raised very concerning employment practices from private recruitment agencies involving exploitative contract clauses and working conditions, which may be enabled by poor enforcement and regulation of the guidelines.

These findings suggest, first of all, a need to look behind aggregate numbers to assess the impact of policies that affect staff migration, and to understand health and care staff as individual decision makers.

There will be many considerations – such as pay, family, or training posts—in each decision to join or leave the NHS. Brexit has added to the cost and bureaucratic burden of EU workers coming to the UK. In terms of data, focusing on simply increasing overall numbers might mask shortages that require a more specific approach to recruitment. Similarly, drilling down into individual trusts shows that spikes in red list recruitment are more significant in a smaller number of institutions, which suggests a level of organised hiring as well as an overall trend.

Conversely, individual trends will affect the system as a whole. Health specialties do not operate in a vacuum. They will rely on each other as well as their support teams, and will be impacted by shortages in nursing and social care and pressures on the wider system. Organised hires of international workers can also shift the problem onto more vulnerable countries. These trends suggest that Brexit has added to existing long term problems, but that the solutions are poorly thought through.

There is an ever more urgent need for a strategy for national recruitment and retention that understands constraints and conditions in each health profession, the connectedness of the health system, and the ethical implications of its staffing solutions.

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1 McCarey M, Dayan M, Jarman H, Hervey T, Fahy N, Bristow D. Scott L Greer. Health and Brexit: six years on. Nuffield Trust. December 2022. https://www.nuffieldtrust.org.uk/files/2022-12/16711995514-health-and-brexit-web.pdf

2 Shembavnekar N, Buchan J, Bazeer N, et al. NHS workforce projections 2022. The Health Foundation. https://www.health.org.uk/publications/nhs-workforce-projections-2022