Inward labour mobility in the Irish health- and social-care sector

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Abstract
In an effort to understand the factors that impinge on labour mobility in the health- and social-care sector in Ireland, an exploratory study was undertaken. This study involved key organizational stakeholders and individual practitioners in the health- and social-care environment. A qualitative design using purposive sampling was employed, involving face-to-face and telephone, semi-structured interviews. Four interviews were undertaken with representatives from the Irish Nurses’ Organization, the Health Services Executive, the Department of Health and Children, and the Association of Social Workers. Interviews were also undertaken with five health-care professionals who had relocated to Ireland. Notes were taken during all the interviews, and respondents were then sent copies of the transcripts to verify accuracy. Data analysis was guided by Burnard’s (1991) framework. The data were analysed according to emerging categories and subcategories. Data emerged in relation to reasons for work mobility, the factors that support mobility and the factors that inhibit it. The reasons for moving to Ireland were mostly personal, professional or economic. In addition, factors facilitating movement included having established contacts in the country, organizational support and the attractiveness of educational structures. Challenges included the recruitment process itself, organizational support structures, professional recognition, language barriers and social integration. The findings are discussed in terms of health and social policy.

Key words: Labour mobility ■ Migration ■ Nursing research ■ Professional issues

Recruitment retention as well as attrition have been cyclical challenges in the Irish health sector (Wells et al, 2000), and workforce planning has not been a prominent feature of health- or social-care systems until fairly recently (Department of Health and Children, 2002). Indeed, in England the Skills for Health (2008) Labour Market Intelligence Report indicates that 16% of establishments in the health sector were reporting skill gaps in June 2008. This level of skills gap contrasts with the Irish situation, where there has traditionally been an oversupply of nurses. A total of 106,273 whole-time equivalents (WTEs) were employed in the public health services in 2006. Of these, 36,737 WTEs were allocated to nursing posts and 7712 were in medical/dental grades, while 14,913 were categorized as health- and social-care professionals (Department of Health and Children, 2008).

Traditionally, universities in Ireland have had a high proportion of medical students from countries outside the European Union (EU), and relatively low numbers from within Europe. There is a strong reliance on non-national as well as non-EU students within the Irish schools of medicine (Government of Ireland, 2003). The oversupply of nurses has meant that many potential students for nursing programmes were lost to other health-care systems, principally the UK. Likewise, a high proportion of nurses emigrated when qualified, although in recent years that trend has been reversed. Social work has not experienced such a strong influx of practitioners, although this is also changing with 182 applications coming from outside Ireland in 2006, from 29 different countries (National Social Work Qualification Board, 2007). There is a consistent trend of low levels of labour mobility within Europe. Approximately 2% of the European population who are within the normal employability age range are living and working in a European country other than that in which they were born. This also applies to the health and social care sector (Care Flows, 2008).

The study
In an effort to understand the factors that impinge on labour mobility in the health- and social-care sector in Ireland, a study was undertaken involving representatives from key organizational stakeholders (staff organizations/representative bodies and health provider agencies) and individual practitioners in the Irish health and social care environment.

The aim was to explore the experience of the key stakeholders and individuals who had relocated to Ireland in relation to labour mobility in the health- and social-care sector in Ireland.

Method
A broad qualitative design using semi-structured interviews was used. The general interview schedule was based on one used in all the countries participating in the Care Flows project (Care Flows, 2008). Semi-structured interviews were undertaken with representatives from the Irish Nurses’ Organization, the Health Services Executive (HSE), the Department of Health and Children, and the National Social Work Qualification Board.
The influences in these categories were both positive and negative. As with most themes, while discrete, a dynamic element was evident between them.

Mobility influences
Mobility influences were seen during the decision-making stage before any selection of a country or specific location. The key subcategories included language, social mobility and forced movement or having choice in movement.

Language emerged as a factor in terms of initial mobility but also in terms of subsequent practice. Language was less of a concern for the individual practitioners than the key stakeholder group. Some respondents did report initial language difficulties, but mainly in terms of social integration and communication, as opposed to influencing the relocation decision. Another respondent described language and terminology as the main difficulty of working in Ireland. This difficulty related more to early stages of inter-collegial working, with respondents feeling that it was easier at first to talk to the patients. Difficulty was also reported in understanding certain accents, especially with older people, who may have stronger accents. One respondent said that talking in a different language is easier than writing in it and that it is difficult to think in another language:

‘What I found as well was the different accents – if someone came in from the [named area] I was completely lost. But it doesn’t take that long to pick it up and people are easy-going here. But it was stressful and difficult in the beginning – the first two or three weeks, I’d say after that it was ok.’ (R3)

This was reinforced by the key organizational stakeholders. One respondent from this cohort remarked on the distinctions between the use of English in social and professional contexts:

‘You can have English language but you mightn’t be able to communicate in medical terminology. You mightn’t be able to understand the colloquialisms. Or your accent might be so different and the people’s accents might be so different that you can’t communicate at all. So even if your English is good, it’s still an issue.’ (R6)

The north-west region of Europe was not seen as the primary area of labour mobility by the key stakeholders. The principal areas identified were the US, the UK, Australia, and New Zealand. At some levels, it seems strange that the only locations identified were English speaking countries. These countries were referred to as the ‘developed world’ and were identified mainly as destinations for emigration. It was agreed that there has been a traditional reliance on workers from outside the country to meet demands across the health sector, except in nursing, which used to be a net ‘exporter’ of labour, but in recent years there have also been difficulties in retaining nurses (Wells et al, 2000).

Choosing a country – pull and push factors
The second theme to emerge was choice of country. Two key subcategories emerged that contributed to country choice:

- Social ‘pull’ influences: Ireland’s reputation, life experience, education, promotion, culture or family reasons
- Social ‘push’ factors: such as forced economic migration, or aversive social reasons in country of origin.

Individual practitioners identified some expectations they had before moving to Ireland. Ireland had a reputation that many were aware of in terms of its economic performance and the state of the health- and social-care system. The quality of the education system in Ireland was cited as an attractive reason for making
the move, although practitioners had varying experiences of the educational system when they arrived. In one case it was suggested that children are put under pressure at school, while conversely, another respondent felt that the school was very supportive in helping children who moved with their families to settle in.

Economic reasons were identified by both key stakeholders and individual practitioners as an incentive to move. Individual participants pointed out that they earn more in Ireland than they would have earned in their country of origin; only one reported that the job being undertaken was not well paid. However, the additional remuneration was offset by the cost of living, which was seen as higher in Ireland. The lack of financial help with the cost of moving was also noted. The organizational stakeholders believed Ireland’s attraction related to both organizational structures and supports, the recruitment process, professional recognition and social integration.

Ethical concerns were raised in relation to some of the active international recruitment drives. For example, one respondent noted:

‘I think if you make a choice to move for experience, for education, for promotion, for culture, for anything else that’s fine. If you move because you have to move that’s a whole different thing and the countries’ [people] that are moving are moving because of economic reasons. They’re moving because of unemployment, they’re moving because they have to bring back money to their country and they’re moving because of actual problems with safety, like there’s abuse, there’s rape, there’s death there’s all sorts of conditions.’ (R6)

While this is a general concern, this contrasted with the reasons provided by those who had actually moved to Ireland from within the north-west region of Europe.

Choosing a specific location – discriminative factors

There were a number of discriminative factors associated with choosing specific locations. The key subcategories to contribute to this theme were: economic attractiveness, family reasons, health system reputation, cost of living, organizational structures and supports, the recruitment process, professional recognition and social integration. Distinctions between individual locations were noted:

‘Some different HSE areas are treated better than others, so some would say “right we’ll look after these people like in terms of accommodation or whatever”’, others haven’t, you’re on your own.’ (R9)

Therefore, it seems that while the presence or absence of organizational support with respect to integration is important, the consistency of approach across the health- and social-care sector is a factor in considering taking up employment. Individual practitioners identified a range of issues related to the process of both getting a job and starting work, including the recruitment process itself, organizational support structures, professional recognition, language and integration challenges.

Recruitment challenges

Some key elements of the recruitment process were identified as problematic. First, the apparent ‘rigidity’ of the interview process was cited, and the lack of support for applicants to come and appraise services. There was reliance on face-to-face interviews, which were established to suit the employer rather than potential foreign applicants, but which lacked sensitivity to applicants’ positions. For example, the interviews were organised at times to suit the employer, and not at times that might suit someone travelling from mainland Europe, or taking into consideration that they might have to organise considerable time off from their current employer.

Difficulties in securing interviews outside a ‘recruitment cycle’ were reported. One respondent from within Europe cited such difficulties, despite the fact that the hospital was in the process of recruiting nurses from the Philippines at the time. Another respondent also commented that she was asked to come for an interview mid-week, which would have involved taking 3 days off work. This was difficult for her as she had not yet given notice to her previous employer. In this situation she suggested that she might have a telephone interview, which was agreed. While the request was facilitated, the key issue in this regard was that the flexibility had to be prompted by the applicant and it did not seem to be part of the organizational culture. Neither of these respondents was offered financial assistance for attending for interview nor with relocating, which would have been the norm in the countries from which they were moving.

A more concerning issue emerged in relation to perceived bias. One respondent felt that nationality was an issue in relation to employment. While the participant secured employment, it was argued that:

‘I knew that only if an Irish applicant did not turn up then I wouldn’t be considered.’ (R1)

This personal experience was not reported by anyone else and seems at odds with the data collected from the key stakeholder organizations, where strong emphasis was placed on the value of labour mobility, the necessity for inward migration and the support they believed was offered to achieve this. One of the key stakeholders noted that:

‘There’s been a fair amount of energy put into that side of things ensuring that there was appropriate visa, permit schemes etc., because we wanted to encourage it.’ (R7)

A strong belief emerged that there was an inordinate and inexplicable delay between the selection process, being offered a position and commencing work. One participant recounted receiving verbal confirmation of getting the new job, but a delay of some 2 months before being able to take up work, because the human resources department seemed to be very slow with the ‘paperwork’.
Professional recognition
Another key area to emerge related to registration of qualifications and professional recognition. Among the key stakeholder cohort, it was argued that the issue of registration was of vital importance for the protection of the profession and the public and also the maintenance of standards of practice. One key stakeholder noted:

‘We are going to have problems with eastern countries coming to the west and their different systems of training and their different competency levels.’ (R6)

Registration of all professionals was seen as a means of contributing to this process of standard-setting and quality assurance. While a laudable aim, some individual practitioners had particular problems with the process of registering their qualifications in Ireland:

‘First of all, it took me a while to get all the papers together…and then it took about 3 months or so after I sent it off. I don’t know what caused the hold up then because I didn’t have anything to do with it but I found that very difficult and very long and you know the way you have to give your employer notice and I didn’t know when I was going to go and I found that difficult.’ (R3)

This was a source of irritation among practitioners and it prompted questions of either lack of awareness or compliance with European legislation:

‘Actually all the official bodies involved in Ireland are not only awkward but are not aware what European law is. I think the difficulty is that it is probably rather new for them to have European citizens coming into Ireland as opposed to leaving Ireland, they are not familiar with the procedures.’ (R1)

Respondents reported a lack of structure about the start to their new job. The process of induction seemed erratic and unstructured. Only two practitioners had any structured induction programme. One comprised an informal 1-day programme for all new staff while the other had a 2-week formal programme, but otherwise the most frequent system of induction seems to have been ‘on the job’ induction.

The experience of integrating into the health- and social-care system was not easy, but there seems to have been understanding that this was not any individual’s fault, but rather more a systems issue, although there was ample opportunity to forward plan for good induction. Ongoing support and an ‘appropriate mix’ of indigenous and foreign workers was also seen as important to ensure standards, address language or cultural issues and facilitate integration:

‘If you’re recruiting a lot of overseas nurses then it would be good to have a spread so that you would have a percentage, a small percentage of overseas nurses with a fairly bigger percentage of say 25% overseas nurses and 75% local nurses in any one area. But if you have a very large percentage of overseas nurses then it leaves a lot of pressure on the one or two Irish or local nurses that are working because they have the responsibility of ensuring these nurses are trained and ready to take over and that puts huge pressure on our system. And it’s not good for anybody, it means that there’s no mentoring of the people that are coming in and there’s no support.’ (R6)

Three of the individual practitioners had moved to Ireland because of family reasons. In this respect, no significant difficulties emerged in relation to social integration. In terms of occupational integration, all practitioners found their work setting a sociable place. Integration was helped by inclusion in social occasions. While participants reported their own integration as having been largely uneventful, some participants were aware of difficulties encountered by others in similar situations.

Discussion
The results of this study indicate that there are multifaceted reasons influencing labour mobility in the health sector in Ireland, in particular inward mobility. This small scale study has identified both personal and professional reasons that influence practitioners in making choices about relocating. Despite efforts to address mobility to and from Ireland, participants in the study focused their responses on issues relating to immigration rather than emigration. Varying views were expressed in relation to whether or not inward or outward mobility was the greatest challenge. The findings suggest that the reasons for movement and choice of country seem to be largely influenced by macro considerations, while the choice of specific location is influenced by a wide range of micro level considerations, but all combine to influence mobility (Figure 1).

Figure 1. Emerging themes — factors affecting mobility.
There continues to be a strong dependence on inward labour mobility in many occupations in the Irish health and social care sector (Government of Ireland, 2003), although in the current recently altered economic global climate, it is unclear what the implications will be in relation to labour mobility. In any event, workplace planning also continues to be somewhat problematic (Ryan, 1999; Wells et al, 2000), with acknowledged potential for improvement (Department of Health and Children, 2002). Understanding the factors that influence mobility is one key component to addressing workforce planning issues, which is as true for any country as it is for Ireland. Many of the participants made choices for personal or professional reasons to relocate to Ireland and were happy with the outcome of their choice. Challenges as well as opportunities were identified in terms of facilitating inward mobility within the sector. The changing demographic profile of Irish society means that the health services must be able to understand and respond appropriately to the health and social care needs of an increasingly diverse and aging society (Ryan et al, 2006; Ryan and ahon, 2008). Thus, attracting and facilitating foreign labour into the sector becomes an imperative for health and social service employers.

Understanding the experiences of those who have engaged in inward movement, as well as representative groups who have both a sectoral knowledge and a vested interest in supporting labour mobility, is important. This study provided some interesting insight into the challenges of inward mobility, which occur at both a macro and micro level. This finding is consistent with the work of Stone et al (2007), which notes that the integration of migrant labour within a host country is not solely an issue for individual organizations or employers. Labour mobility can potentially enrich the cultural and economic life of host countries, as well as contribute to necessary skill sets. However, balancing integration into the host society with appropriate accommodation of cultural distinctiveness and recognition of need is challenging (Syed, 2008).

In a period of economic boom in the early part of the 21st century, it was estimated that migrant labour contributed to an approximately 3% increase in gross national product (McDonald, 2007). However, if labour mobility is to continue to be encouraged in a rapidly changing economic climate, then the accommodation of cultural differences, as well as factors that may negatively discriminate against minorities within dominant cultures, need to be addressed at a broader societal, political, and legal level (Syed, 2008).

Irish society has been transformed in the past 10–15 years. The Central Statistics Office (2008) noted that Ireland is now host to a total of 188 different nationalities. While arguing that the increasingly multicultural nature of the population means that labour mobility is an important policy issue for health service employers, it is also a potential concern that Ireland may be contributing to the so-called ‘brain drain’ from developing countries and therefore increasing the disparity between developed and developing countries (Geesen, 1998). This is something that clearly must be avoided, especially in the health– and social-care sectors, where the denuding of human capital from these sectors in developing countries could have potentially devastating effects on their care systems.

Therefore, a balance must be struck between facilitating and encouraging labour movement and discouraging a haemorrhage of key human capital from developing countries. This is, and should be, more than an ideological or intellectual discourse. There are considerable ethical dilemmas that need to be addressed through international dialogue and, in this respect, the position paper on ethical recruitment (International Council of Nurses, 2001) suggests that active management strategies need to be adopted. This is because the problem is extremely complex, with a range of competing and interlinked issues relating to societal needs as well as individual rights (Buchan and Calman, 2005).

**Limitations**

There are clearly a number of limitations to the current study. First, the sample of individual participants was limited to those who had successfully gained employment in the health- and/or social-care sector in Ireland. Therefore, the ‘voices’ of those who may be appropriately qualified but who have not obtained employment in the sector are not included. Their thoughts should clearly be addressed in further work. Likewise, the sample size of this study is small, but it should be remembered that data were being collected simultaneously in other countries and the sampling was influenced by the selection criteria of countries also engaged in the Care Flows project. However, investigations of this type have not previously been undertaken in Ireland; therefore, the findings provide an interesting point of departure for further study in this area. It is recommended that policy makers and health service providers collaborate to manage their human capital needs and match skills requirements with service user need through a coordinated and managed approach to workforce planning that takes account of labour mobility.

**Conclusion**

The potential negative impact of dramatically altered economic circumstances from 2008 has not yet been evaluated, though recent news reports of protests in Britain, relating to foreign recruitment in the construction sector, suggest that the strategic management of labour mobility should be a high policy priority across Europe. If policy positions are to be effective, they must be informed by the type of understanding provided by this study.

Ireland has experienced significant inward mobility in the past 10 years, which was linked with its economic growth and development. Much of this inward mobility came from mainland European countries and new EU states. This labour mobility was seen as contributing positively to Ireland’s growth and development. At an EU level, the potential for inter-country labour movement is not only allowed, but has been encouraged. If host countries are to facilitate greater labour mobility, then collaboration between policy makers, employers, representative organizations as well as at an individual level is necessary.
O’Neill P (2002) A qualitative study into the health needs of adults with psoriasis and how they are met by the National Health Service. Unpublished M.Phil Thesis. University of Teeside
Ryan D (2007) *The Role of Nurses at ADON Level in Irish Mental Health Services: A National Study*. University of Limerick, Limerick

**PROFESSIONAL ISSUES**

**KEY POINTS**

- Achieving greater labour mobility is a key priority area across Europe.
- Labour mobility in the health- and social-care sector within European countries is traditionally very low.
- The health- and social-care sector has experienced cyclical flows in labour demand and availability.
- Both personal as well as organizational influences impinge on the experience of inward labour movement.