



Department
of Health

Expansion of Undergraduate Medical Education

Equalities Impact Assessment

August 2017

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1. Introduction

- 1.1. In considering the policy to increase medical school places in England, the Secretary of State must comply with the Public Sector Equality Duty (PSED) and consider the Family Test.

Public Sector Equality Duty (Section 149 Equality Act 2010)

- 1.2. The Public Sector Equality Duty within the Act comprises three equality objectives and requires public authorities, in the exercise of their functions, to have due regard to the need to:
 - eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010
 - advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
 - foster good relations between persons who share a relevant protected characteristic and persons who do not share it
- 1.3. The protected characteristics covered by this duty are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The protected characteristics of marriage and civil partnership is also covered by the first element of the duty – to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.
- 1.4. The impact of this duty on the policy and the responses to the public consultation has been considered within this Equality Analysis.

The Family Test

- 1.5. The Secretary of State must consider and, where sensible and proportionate, apply the Family Test. These questions have been considered:
 - What kind of impact might the policy have on family formation?
 - What kind of impact will the policy have on families going through key transitions such as becoming parents, getting married, fostering or adopting, bereavement, redundancy, new caring responsibilities or the onset of a long-term health condition?
 - What impact will the policy have on all family members' ability to play a full role in family life, including with respect to parenting and other caring responsibilities?
 - How does the policy impact families before, during and after couple separation?
 - How does the policy impact those families most at risk of deterioration of relationship quality and breakdown?
- 1.6. The impact of this duty on the policy has been considered within this Equality Analysis.

1.7. Any queries and comments about this Equality Analysis should be addressed to:

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What are the intended outcomes of this work?

The decision to expand undergraduate medical education in England is in part in response to forecasts of a growing and ageing population with far more complex conditions, and a projected global shortage of 2.3 million doctors by 2030¹.

The increased training capacity will widen participation and increase social mobility and begin to attract and produce graduates from a range of different backgrounds.

The resulting increase in a domestically trained medical workforce has several advantages:

- increase capacity to meet rising demand
- greater self-sufficiency by training more of the doctors we need here in England
- reduced reliance on expensive agency / locum staff
- reducing draw from countries overseas where the need is arguably greater than ours

Who would be affected?

Students wishing to study medicine in England will have an additional 1,000 medical school places to apply for, based on eligibility.

The Government will continue to fund clinical placements for international students commencing study at English universities in 2018-19 while it undertakes further cross-Government work on the implementing the change in 2019-20.

2. Data sources

- Office for National Statistics (ONS)

<http://www.ons.gov.uk/ons/index.html>

Source of data relating to the UK Population. Where possible, this report has used population estimates for mid-2014, as these are the closest available to the most recent equality monitoring data collection for NHS Bursary recipients. Where this is not possible, 2011 census data has been used.

- NHS Business Services Authority (BSA)

<http://www.nhsbsa.nhs.uk/>

Publishes annual reports containing Equality and Diversity data for current and past recipients of the NHS Bursary covering the following protected characteristics: Sex, Age, Sexual Orientation, Disability, Ethnicity and Religion/Belief.

- Higher Education Statistics Agency (HESA)

<https://hesa.ac.uk/>

HESA publish data on the population of students as a whole, allowing comparison between NHS Bursary recipients and the full student population.

- Higher Education Funding Council for England (HEFCE)

<http://www.hefce.ac.uk/>

HEFCE funds and regulates universities and colleges in England, and invests on behalf of students and the public to promote excellence and innovation in research, teaching and knowledge exchange.

- National Union of Students – No Place for Hate

<http://www.nusconnect.org.uk/resources/no-place-for-hate-religion-and-belief-report-may-2012>

Home Office-funded research exploring the extent and nature of hate crime and incidents on campus related to religion and belief – includes survey of the religious affiliation of around 10,000 students.

Data sources

- Universities and Colleges Admissions Service (UCAS)

<https://www.ucas.com/corporate/data-and-analysis>

Publishes data covering applications and admissions to full-time higher education in the UK.

- Any evidence supplied by responses to the consultation Expansion of Undergraduate Medical Education. There were just over 3,650 responses to the consultation.

3. Protected Characteristics

Disability

- 3.1. The profile of medical students that have been accepted on a medical undergraduate course via UCAS over the past 3 years compared to the wider student population and the UK population as a whole is set out below:

Disability	Medical Students			Students			UK Population
	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16	2014/15
Declared Disability	5.0%	5.3%	6.0%	8.0%	8.6%	9.4%	17%

- 3.2. The proportion of medical students who are disabled is smaller than the proportion of the UK population that is disabled.
- 3.3. If disabled people take up any of the additional medical places, this would help promote equality of opportunity between this group and others by enhancing their employment opportunities. Increasing opportunities in the medical profession would help foster good relations between this group and others by enabling them to form relations and links with patients. This reflects views from respondents that the increase in the number of undergraduate medical students could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.
- 3.4. Increasing the number of medical places and the additional capacity this provides will help NHS services to be provided more effectively. This will have a beneficial impact on the entire patient population, including groups with protected characteristics. The additional service capacity may facilitate more flexible working and therefore improve equality of opportunity in the medical profession.

Gender

- 3.5. The profile of medical students that have been accepted on a medical undergraduate course via UCAS over the past 3 years compared to the wider student population and the UK population as a whole is set out below:

Gender	Medical Students			Students			UK Population
	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16	2015
Male	45.0%	44.3%	43.9%	55.2%	55.6%	56.3%	49.3%
Female	55.0%	55.7%	56.1%	44.8%	44.4%	43.7%	50.7%

Protected Characteristics

- 3.6. The proportion of medical students who are female is slightly higher than the proportion in the UK population. Therefore, women are slightly more likely to benefit from the policy than men but this is justified because we need the additional places to increase our supply of doctors in order to continue to provide the best possible care to the nation. This policy can go no further to advance equality of opportunity since the higher proportion of women benefitting simply arises as a result of the composition of the medical student population.
- 3.7. Increasing the number of medical places and the additional capacity this provides will help NHS services to be provided more effectively. This will have a beneficial impact on the entire patient population, including groups with protected characteristics. The additional service capacity may facilitate more flexible working and therefore improve equality of opportunity in the medical profession. This reflects views from respondents that the increase in the number of undergraduate medical students could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.

Race

- 3.8. The profile of medical students that have been accepted on a medical undergraduate course via UCAS over the past 3 years compared to the wider student population and the UK population as a whole is set out below:

Ethnicity	Medical Students			Students			UK Population
	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16	2011
White	66.9%	65.6%	63.2%	75.6%	74.5%	73.6%	86%
Black, Ethnic Minority	28.5%	30.4%	32.1%	21.8%	22.8%	23.4%	14%
Other and Non-Declared	4.6%	4.0%	4.7%	2.7%	2.7%	3.0%	N/A

- 3.9. Medical students are a more ethnically diverse group than the wider student population or the general UK population. There is no evidence to suggest that increasing the number of medical school places will have an adverse effect on this and it will continue to support diversity as a result of the current composition of the medical student population.
- 3.10. Increasing the number of medical places and the additional capacity this provides will help NHS services to be provided more effectively. This will have a beneficial impact on the entire patient population, including groups with protected characteristics. The additional service capacity may facilitate more flexible working and therefore improve equality of opportunity in the medical profession. This reflects views from respondents that the increase in the number of undergraduate medical students could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.

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- 3.11. From the available evidence there is no reason to believe the increase in medical school places will have a disproportionate impact on people with this protected characteristic.

Age

- 3.12. The profile of medical students that have been accepted on a medical undergraduate course via UCAS over the past 3 years compared to the wider student population and the UK population as a whole is set out below:

Age	Medical Students			Students			UK Population 2015
	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16	
Under 21	76.0%	74.0%	75.5%	78.7%	78.4%	78.5%	24.8%
21 and over	24.0%	26.0%	24.5%	21.3%	21.6%	21.5%	75.2%

- 3.13. The age profile of the medical student proportion is slightly different to the wider student population.
- 3.14. On the basis that a significantly higher proportion of medical students are likely to be under 21, under 21s are more likely to benefit from the policy than over 21s people. The higher proportion of under 21s benefitting arises as a result of the current composition of the medical student population and is justified because we need the additional places to increase our supply of doctors in order to continue to provide the best possible care to the nation.
- 3.15. Increasing the number of medical places and the additional capacity this provides will help NHS services to be provided more effectively. This will have a beneficial impact on the entire patient population and help improve equality of opportunity between people of different age groups.
- 3.16. An increase in the available number of training places and the increased system capacity has the potential to enable more flexible working patterns that would have a positive impact on the age profile of the medical profession.
- 3.17. Respondents noted that an increased supply of doctors would make it possible to increase flexibility of working patterns, for example accommodating part time employment and training. There is potential for increased part time employment to enable people to work later in their careers.
- 3.18. There is no evidence to suggest that increasing the number of medical school places will effect the age profile of medical students. The increased healthcare system capacity created by the increase in medical school places does have the potential to change the age profile of the medical profession which would increase the diversity of the workforce and advance equality of opportunity.

Gender reassignment (including transgender)

- 3.19. There is currently not sufficient data available to draw conclusions on the effect of the increase in medical school places on students sharing this characteristic. We will work with stakeholders to close this data gap and to ensure that any data published is robust.
- 3.20. Additional medical school places will be allocated on merit alone.
- 3.21. If people who have undergone gender reassignment take up any of the additional medical places, this would help promote equality of opportunity between this group and others by enhancing their employment opportunities. Increasing opportunities in the medical profession would help foster good relations between this group and others by enabling them to form relations and links with patients. This reflects views from respondents that the increase in the number of undergraduate medical students could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.

Sexual orientation

- 3.22. UCAS data does not include data on sexual orientation. We have therefore looked at the profile of medical students in receipt of an NHS Bursary over the past 3 years compared to the UK population as a whole:

Sexual Orientation	Medical Students			UK Population
	2013/14	2014/15	2015/16	2015
Heterosexual	84.3%	84.6%	85.0%	93.7%
Lesbian / Gay	1.9%	1.7%	2.1%	1.1%
Bisexual	0.6%	0.9%	1.1%	0.6%
Other	0.0%	0.0%	0.0%	0.4%
Prefer not to say / no response	13.2%	12.8%	11.8%	4.1%

- 3.23. There is currently not sufficient data available to draw conclusions on the effect of the increase in medical school places on students sharing this characteristic.
- 3.24. Additional medical school places will be allocated on merit alone.
- 3.25. Increasing the number of medical places and the additional capacity this provides will help NHS services to be provided more effectively. This will have a beneficial impact on the entire patient population and help improve equality of opportunity between people of different sexual orientations. Increasing opportunities in the medical profession would help foster good relations between this group and others by enabling them to form relations and links with patients. This reflects views from respondents that the increase in the number of undergraduate medical students could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.

Religion or belief

3.26. UCAS data does not include data on sexual information. We have therefore looked at the profile of medical students in receipt of an NHS Bursary over the past 3 years compared to the UK population as a whole:

Religion or belief	Medical Students			Students	UK Population
	2013/14	2014/15	2015/16	2012	2011
Christianity	29.3%	29.5%	28.5%	34.3%	59.3%
No religion / atheist	35.9%	34.5%	36.2%	50.0%	25.0%
Islam	7.7%	8.5%	8.9%	3.5%	4.8%
Hinduism	5.9%	6.8%	6.5%	1.3%	1.5%
Sikhism	1.2%	1.7%	1.5%	0.6%	0.8%
Buddhism	0.6%	0.7%	0.8%	0.9%	0.4%
Judaism	1.0%	0.8%	0.9%	0.7%	0.5%
Jainism	0.3%	0.4%	0.3%	-	-
Other	2.1%	1.7%	1.7%	5.1%	0.4%
Prefer not to say / not stated	15.9%	15.4%	14.8%	3.1%	7.2%

- 3.27. The medical student population is distributed slightly differently across religious groups compared with the general UK population.
- 3.28. This means that some religious groups are likely to benefit from the policy more than others but this is justified because we need the additional places to increase our supply of doctors in order to continue to provide the best possible care to the nation. This policy can go no further to advance equality of opportunity since the higher proportion of medical students from some religious groups benefitting from this policy simply arises as a result of the composition of the medical student population.
- 3.29. There is no evidence to suggest that increasing the number of medical school places will have an adverse effect on people from different religious groups and it would ensure this valued diversity continues.
- 3.30. Increasing the number of medical places and the additional capacity this provides will help NHS services to be provided more effectively. This will have a beneficial impact on the entire patient population and will help improve equality of opportunity and foster good relations between different religious groups.
- 3.31. This reflects views from respondents that the increase in the number of undergraduate medical students could be used as a catalyst to increase numbers from some, for example disadvantaged, groups.

4. Family Test (including consideration of pregnancy and maternity as protected characteristic)

- 4.1. The following questions have been considered when assessing the impact of the expansion of undergraduate medical education on families, including pregnancy and maternity.
- What kind of impact might the policy have on family formation?
 - What kind of impact will the policy have on families going through key transitions such as becoming parents, getting married, fostering or adopting, bereavement, redundancy, new caring responsibilities or the onset of a long-term health condition?
 - What impact will the policy have on all family members' ability to play a full role in family life, including with respect to parenting and other caring responsibilities?
 - How does the policy impact families before, during and after couple separation?
 - How does the policy impact those families most at risk of deterioration of relationship quality and breakdown?
- 4.2. When looking at the impact of medical expansion on families, the impact on families of medical students and families of wider society must be considered.

Impact on families of medical students

- 4.3. While medical students' circumstances may be broadly similar if they pursue a medical qualification straight after leaving school, during the course of their medical education (7 years), their circumstances may change: they may develop relationships leading to civil partnership or marriage, take on caring responsibilities (either parental or childcare) and some of these relationships may not last leading to either separation or divorce.
- 4.4. Some respondents to the consultation suggested that the additional training capacity required to meet the medical expansion could present opportunities for more flexible study (but this would require significant buy in from senior NHS management) by the introduction of more part time working and study. By adopting a more flexible approach, this would be beneficial to some students depending on their individual circumstances.
- 4.5. However, some respondents highlighted issues with clinical placements, for example needing to travel long distances between posts. They believed this could have a negative impact on family life.
- 4.6. There were some comments about the impact of minimum service contribution and the impact of family life. These were essentially questions of clarification about how such a regime may work and what the implications of part time working may be. For example whether the requirement would be set in hours and if set in years or months whether it would be pro rota for part time workers.
- 4.7. In conclusion, when looking at the impact of medical expansion on the medical students themselves, it is difficult to draw specific conclusions because medical students' circumstances are varied and may change during the course of study.

Impact of families of the wider community

- 4.8. In general, respondents suggested that medical expansion would lead to increased levels of service, which may be more flexible to patients. Other respondents pointed out the full impact felt by patients from the medical expansion may take some time to materialise given the length of time the training takes and that there will be other factors to take into account, for example the potential impact of service reconfiguration and negotiations for exiting the European Union.
- 4.9. In conclusion, the impact on the family life of the wider community varies depending on the circumstances of individual families and the reason for their interaction with health services which could be at maternity or end of life and any range of issues in between.

5. Engagement and involvement

5.1. Q: Was this work subject to the requirements of the cross-government Code of Practice on Consultation?

A: YES

5.2. Q: How have you engaged stakeholders in gathering evidence or testing the evidence available?

A: The public consultation, which was open from 14 March to 02 June 2017 has been used as the main source of engagement with stakeholders and has fed into further analysis of the impact of these changes, informing both the economic and equality impact assessments and the government response to the consultation.

5.3. Q: How have you engaged stakeholders in testing the policy or programme proposals?

A: The public consultation was used to test with stakeholders how the reforms can be successfully delivered.

5.4. Q: For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

A: The public consultation was used to test with stakeholders how the reforms can be successfully delivered.

ⁱ Global strategy on human resources for health: Workforce 2030 – World Health Organisation, 2016.