

Migration Advisory Committee Call for Evidence: EEA-workers in the UK labour market

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. The BMA is committed to safeguarding the future of NHS services, medical research and the medical profession following the UK's vote to leave the European Union.

The BMA welcomes the opportunity to provide evidence to the Migration Advisory Committee (MAC) on the impact the UK's exit from the European Union will have on the supply of doctors and the UK's ability to deliver safe and reliable healthcare services. We believe it is important to acknowledge the contribution made by migrants from the EEA and elsewhere, including doctors, in delivering and sustaining vital public services.

The BMA believes that employers must have the capacity to recruit overseas doctors where a clear workforce need exists. The immigration system must remain flexible enough to recruit doctors from outside the UK should the resident workforce be unable to produce suitable applicants to fill specialist or generalist vacant roles or if an individual has skills and knowledge that would benefit UK health services. This must be done ethically, in accordance with the UK Code of Conduct on International Recruitment¹. Importantly, the NHS must also undertake comprehensive workforce planning at a national level supported by high quality data and make serious efforts to recruit and retain staff at all levels of the system.

The UK thrives on the ability to attract, recruit and retain the best available talent in the world. To continue to be a world leader in the life sciences the UK must be able to continue to recruit in this way.

Our evidence will highlight the following key points:

- Overseas doctors, from the EEA and elsewhere, make up a significant portion of the medical workforce. They practice in all specialties, many of which are facing shortages including general practice, emergency medicine, paediatrics, occupational medicine, radiology and psychiatry. Any reduction in migration will have a destabilising effect and exacerbate existing workforce shortages. This could lead to adverse impacts on the quality of care and patient safety.
- Thousands of medical students from overseas are currently built in to national workforce planning and must be reassured of their futures in the UK or they may choose to leave their prospective careers in the NHS.

¹ <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment>



- A significant portion of clinical academic staff are from EEA countries and UK medical research depends upon and is enhanced by their contributions. Because of the highly specialised nature of medical research and the inherent benefit of sharing ideas and expertise across borders, it is important for UK companies, universities and research institutes to attract and retain top researchers from all over the world.
- Health services across the UK are facing increasing pressure at a time when there are severe workforce shortages in key specialties in hospitals and in GP practices.
- It is getting harder to recruit and retain doctors, which is leading to rota gaps and raising concerns about the ability of the NHS to deliver care in the same way in the future. The NHS relies on the inflow of EEA doctors and overseas recruitment where qualified UK doctors are not available to fill vacant posts and maintain a reliable and safe health service.
- Plans to increase the domestic supply of doctors will not address immediate workforce needs because of the length of time it takes to train a senior doctor. The NHS will therefore continue to rely on overseas recruitment for the foreseeable future.
- Doctors work alongside a wide range of individuals who make up the wider health and social care workforce, many of whom are from countries other than the UK. Any future immigration system must be responsive to the needs of the health and social care sector.

1. EEA and non-EEA doctors currently working in the UK

- 1.1. More than 186,000² doctors are employed by the national health services in England, Scotland, Wales and Northern Ireland but many also work in local authorities, independent medical services, private companies, research organisations and higher education institutions. Because of the high quality of medical education and training, research opportunities and healthcare services provided in the UK, students and doctors come from all over the world to study and work here.
- 1.2. The UK medical workforce includes doctors from all over the world who practice in more than 60 different specialties and is made up of:
 - General practitioners (GP)
 - Consultants
 - Junior doctors
 - Staff, associate specialist and specialty (SAS) doctors
 - Other non-consultant non-training (NCNT) doctors
- 1.3. The EU's policy of freedom of movement and the mutual recognition of professional qualifications within the EU has allowed many health and social care professionals from

² Based on figures reported by NHS digital, ISD, Stats Wales and DoH Northern Ireland.

countries within the EEA to work in the UK³.

1.4. In comparison, non-EEA doctors who migrate to the UK must do so on Tier 1, Tier 2, or Tier 5⁴ visas. Non-EEA medical students enter the UK on a Tier 4 student visa.

1.5. Approximately 135,000 (12%) of NHS staff in England are nationals of a country other than the UK. This includes 5.5% (just over 60,000) who are nationals of other EU countries.⁵ Approximately 22% of all doctors currently working in the NHS in England are from outside of the UK. This includes approximately 12,000 EEA doctors (7.7% of the NHS medical workforce) and nearly 23,000 from the rest of the world (14.6% of the NHS medical workforce)⁶ with additional staff working in public health and academic medicine. 2,124 hospital and community health services (HCHS) doctors in England are Irish⁷.

1.6. Table 1. Medical workforce by type of doctor and nationality⁸.

	EEA	% of HCHS workforce	Non-EEA	% of HCHS workforce	Total HCHS overseas (EEA and non-EEA)	Total overseas as % of HCHS workforce
Consultants	4,250	3.7%	5,321	4.7%	9,571	8.4%
Junior doctors	5,165	4.6%	9,098	8.0%	14,263	12.6%
Staff, specialty and associate specialist doctors	1,256	1.1%	3,081	2.7%	4,337	3.8%
Other NCNT doctors	78	0.0%	69	0.0%	147	0.0%
Total HCHS doctors	10,749	-	17,569	-	28,318	-
	EEA	% of GP workforce	Non-EEA	% of GP workforce	Total GP overseas (EEA and non-EEA)	Total overseas as % of GP workforce
All GPs (excluding registrars, retainers and locums)	1,280	3.1%	5,081	12.1%	6,361	15.2%
Total medical workforce (HCHS and GP)	12,029	7.7%	22,650	14.6%	34,679	22.3%

³ King’s Fund, Five Big Issues for Health and Social Care after the Brexit Vote’, 30 June 2016

⁴ <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/immigration-rules-and-the-points-based-system/recruitment-into-medical-and-dental-posts/medical-training-initiative>

⁵ “NHS Staff from Overseas: Statistics.” House of Commons Library briefing paper No. 7783, 10 April 2017.

⁶ NHS Digital provisional workforce statistics, March 2017.

⁷ NHS Digital provisional workforce statistics, March 2017.

⁸ NHS Digital provisional workforce statistics, March 2017.

Scotland, Northern Ireland and Wales

1.7. 5.7% (1,139) of Scotland’s doctors are EEA graduates. It is estimated that there are around 60 doctors currently in Scotland on Tier 5 visas⁹. It is estimated that non-UK citizens account for approximately 5% of the total NHS workforce in Scotland, and around 6.8% of Scotland’s doctors¹⁰.

1.8. 8.8% (550) of Northern Ireland’s doctors are EEA graduates as are 6.4% (624) of doctors in Wales.

UK-wide

1.9. Figures from the GMC show that in 2016, more than 30,000 doctors who received their PMQ (Primary Medical Qualification) in another EEA country were registered to practice medicine in the UK. That figure jumps to over 100,000 when doctors from the rest of the world are included. The number of EEA doctors who graduated from a UK medical school is not counted, but this would add to the number of EEA doctors licensed to practice in the UK.

Table 2: Doctors by world region of primary medical qualification (PMQ)¹¹

PMQ World Region	No. of doctors	%	No. of GPs	%	No. of Specialists	%
EEA (excluding UK)	30,983	11.0%	4,116	6.1%	15,414	17.1%
International	73,081	26.0%	11,014	16.3%	22,534	25.0%
UK	177,376	63.0%	52,527	77.6%	52,362	58.0%
Total	281,440	100.0%	67,657	100.0%	90,310	100.00%

1.10. Non-UK qualified doctors work across all medical specialties. However, GMC figures show that obstetrics and gynaecology, paediatrics, ophthalmology and psychiatry are made up of a greater proportion of non-UK graduates. Radiology, anaesthetics and intensive care have decreased their reliance on non-UK graduates between 2011-2015. All other specialties have seen an increase in the proportion of non-UK PMQ doctors. The proportion of obstetricians and gynaecologists who are non-UK graduates has risen from 52% to 56%, making it the most reliant specialty.¹² Per the GMC, some specialties are only able to grow because of EEA graduates and international medical graduates (IMGs). For example, the number of medical specialists has increased by 15% overall between 2011-2015, but the

⁹ Scottish Government paper on International Medical Training Fellowships, Scottish Shape of Training Transitions Group meeting, 24 August 2017

¹⁰ [National Health and Social Care Workforce Planning: Discussion Document. Scottish Government, February 2017.](#)

¹¹ http://www.gmc-uk.org/doctors/register/search_stats.asp

¹² [The state of medical education and practice in the UK report: 2016, GMC.](#)

number of non-UK graduates has increased by 22%. Paediatrics grew by 13% overall during the same time but has 20% more non-UK graduates, and psychiatry did not grow overall but has 6% more non-UK graduates¹³.

Regional variation

1.11. We understand that the MAC is interested in regional variation in migration. NHS Digital data show the percentage of HCHS doctors in England from outside of the UK has the most uniform regional distribution of any NHS staff category¹⁴. Regional data is available for England only and does not include general practitioners.

Table 3. National origin of HCHS doctors by English region (2016)¹⁵

English region	British	EU	International (non-EU)
East Midlands	70%	8%	22%
East of England	67%	11%	22%
Kent, Surrey & Sussex	75%	10%	15%
London (N. C. & E.)	73%	14%	13%
London (N.W.)	74%	14%	12%
London (S.)	74%	13%	13%
North East	77%	7%	16%
North West	73%	8%	19%
South West	83%	8%	9%
Thames Valley	73%	11%	16%
Wessex	80%	9%	11%
West Midlands	73%	8%	19%
Yorkshire & the Humber	76%	7%	17%

1.12. Many areas of the UK have difficulty attracting and retaining sufficient numbers of trainees and doctors of all branches of practice. For example, the north of England (North East, North West, Yorkshire and the Humber) have experienced the lowest training fill rates in the country for multiple years indicating serious problems with recruitment in those regions¹⁶.

1.13. Regional visas have been suggested as a possible way to address recruitment concerns in under-doctored areas, giving regions more control over regional immigration policy to meet local need. Whilst this might increase workforce numbers in the short-term, evidence from Canada shows that it may not provide a sustainable long-term solution. The Canadian system includes elements of regional autonomy and their experience shows that immigrants decided not to settle in the area that had granted their visa when their earnings improved.

¹³ [The state of medical education and practice in the UK report: 2016, GMC.](#)

¹⁴ ["NHS Staff from Overseas: Statistics." House of Commons Library briefing paper No. 7783, 10 April 2017.](#)

¹⁵ ["NHS Staff from Overseas: Statistics." House of Commons Library briefing paper No. 7783, 10 April 2017.](#)

¹⁶ <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/state-of-medical-recruitment>

Other considerations, such as family connections or established immigrant communities may play a stronger role in influencing the decision to stay in the region permanently. Different immigration systems would be difficult to implement and enforce without establishing onerous internal checks to ensure that immigrants remained in the region which granted their visa.

Migration of EEA doctors over time

- 1.14. Data from the GMC show that the number of EEA doctors joining the medical register rose steadily from 2011 to 2014. However, in 2015, that number decreased by nearly half from a peak of 3,387 to 1,777 doctors¹⁷. According to the GMC, this follows the introduction of English language requirements in 2014.
- 1.15. Data from the European Commission’s regulated professions database show that between 1997-2016 more than 72,000 doctors from EU countries applied to work elsewhere in the EU. More than one third of those applied to work in the UK making it by far the largest receiver of applications during that timeframe¹⁸.

Medical students

- 1.16. Table 4. Number of EEA and non-EEA students at UK medical schools¹⁹

Nationality of applicant	2015		2016		2017	
	Applications	Acceptances	Applications	Acceptances	Applications	Acceptances
UK nationals	15,220	6,825	14,820	6,730	14,450	6,815
EU nationals (exc UK)	1,940	205	2,050	230	1,720	255
Non-EU nationals	3,230	650	3,240	705	3,040	755
Total	20,390	7,680	20,100	7,665	19,210	7,825

- 1.17. The higher education sector generated over £73 billion in output (direct and indirect) and contributed 2.8% of UK GDP in 2011/12,²⁰ and spreads UK influence and services across the globe. In 2014/15, almost half of all university revenue in the UK was derived from tuition fees and education contracts (£15.6 billion). Non-EU students contributed over a quarter of tuition fee income, paying fees of £4.3 billion²¹ while home and EU domiciled student course fees accounted for £10.5 billion of the overall income of UK higher education providers. The

¹⁷ GMC. “Our data about doctors with a European primary medical qualification”. February 2017.

¹⁸ Hervey, Ginger. “The EU exodus: When doctors and nurses follow the money,” Politico, 27 September 2017.

¹⁹ https://www.ucas.com/file/84266/download?token=W_z_cSYX table DR3_016_01

²⁰ Universities UK: Higher education in numbers <http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2014/the-impact-of-universities-on-the-uk-economy.pdf>

²¹ House of Lords library note (October 2016) Leaving the European Union: funding for universities and scientific research

presence of students from across the world and from the rest of the EU helps financially underpin universities and UK medical schools.

Medical academic staff

1.18. Table 5. Number of medical academics from EEA countries²²

Nationality	Clinical academic doctors and dentists	Clinical academic nurses and midwives	Clinical academic health professions	Other clinical academic staff	Not clinical academic	Total (all staff in HEIs)	All clinical as % of total
EEA	745	25	30	115	44,845	45,760	2.0%
All	6,710	545	365	775	401,735	410,130	2.0%
EEA %	11.1%	4.6%	8.2%	14.8%	11.2%	11.2%	

2. Demands on the healthcare system

2.1. Doctors across the UK consistently report that their workload is increasing in intensity and complexity. In 2012, 59% of consultants and 86% of GPs reported that their workload had increased in intensity over the past year. Likewise, 40% of consultants and 77% of GPs reported that their work had become more complex. The findings were replicated among SAS doctors and junior doctors²³.

2.2. In the next five years, the general population is expected to rise by 3% while the number of patients aged over 65 is expected to increase by 12% (1.1 million) and those aged over 85 by 18% (300,000)²⁴. Their more complex and long-term health care needs are placing new demands on the NHS that doctors are struggling to cope with. This has a substantial effect on the frequency with which patients use the NHS and the time it takes to see them and as a result, there have been significant, foreseeable increases in NHS activity across the UK in recent years²⁵.

2.3. Several other factors that add further pressure to doctors working in today’s health service include rising levels of bureaucracy²⁶, higher public expectations and cuts to other support services such as local authority social care and community mental health services.

²² [Higher Education Statistics Agency, 2015-16.](#)

²³ BMA memorandum of evidence to the Review Body on Doctors’ and Dentists’ Remuneration, 2012.

²⁴ <https://www.parliament.uk/business/publications/research/key-issues-parliament-2015/social-change/ageing-population/>

²⁵ King’s Fund Hospital activity. Accessed on 11/04/16. www.kingsfund.org.uk/projects/nhs-in-a-nutshell/hospital-activity.

²⁶ In 2013, 97% of GPs reported bureaucracy and box ticking had increased since 2012 while nine out of 10 GPs felt this took them away from spending time with patients. A separate study found that clinical staff spent up

- 2.4. There have been significant increases in NHS activity across the UK in recent years. Hospitals across the UK have been getting busier, with increased numbers of emergency and elective admissions, and outpatient attendances. In England, from March 2016 to February 2017, there were 19.6 million ‘finished consultant episodes’, up from 19.2 million in 2015-16. There were 92.5 million outpatient attendances, compared to 89.4 million in the previous year. Over the same period, A&E attendances rose from 20.3 million to 20.9 million.²⁷
- 2.5. In Scotland, there were over one million outpatient attendances in the quarter ending March 2017 - a 9% increase in the last five years. During April 2017, there were 136,077 attendances at A&E services across Scotland, compared to 131,755 the previous April²⁸.
- 2.6. In Northern Ireland, the number of outpatient and inpatient appointments increased in 2015/16 compared to the previous year. The number of admissions to hospital has risen by 1.6% since 2011/12²⁹.
- 2.7. In Wales, the number of A&E attendances in the year to August 2017 (1,009,128) was up 0.7% on the previous year (1,016,592) and up 4.0% on the year to August 2013 (977,554). In the year to July 2017, 7,554 patients newly diagnosed with cancer via the urgent suspected cancer route started treatment, an increase of 43.7 per cent (2,298 patients) from the corresponding period 5 years ago and an increase of 7.1 per cent (501 patients) over the previous year. There were 1,073,518 closed patient pathways over the 12 months to July 2017, an increase of 2.8 per cent (29,360 pathways) compared to the previous 12 months³⁰.

3. UK medical workforce shortages

England

- 3.1. The England data from NHS Digital based on NHS Jobs website adverts shows a step-change increase from last year of around 6,000 medical and dental vacancies advertised in a quarter to a figure in 2015 of considerably over 8,000 WTE (whole time equivalent) vacancies. We have concerns that using adverts as a proxy understates the true level of vacancies therefore, the exact number may be higher still. This is because some jobs are not advertised, one advert may reflect several posts, or jobs may have been previously advertised but then remain unfilled. However, even on its own terms, the data show a substantial growth in vacancies over time. The Health Foundation has analysed Office for

to 10 hours a week collecting or checking data and that more than a third of the work was neither useful nor relevant to patient care.

²⁷ NHS Digital, Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2015 to February 2016.

²⁸ ISD, Emergency Department Activity and Waiting Times data comparison, 7 June 2016

²⁹ <https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-inpatient-day-case-stats-15-16.pdf>

³⁰ Welsh Government statistical release – NHS Activity & Performance Summary: July/August 2017; and StatsWales website

National Statistics (ONS) unemployment data between 2013 and 2015 to show a 60% increase in doctor vacancies over that period.³¹

- 3.2. Nearly three quarters of all medical specialties faced under-recruitment in 2016.³² There are significant gaps in recruitment of consultants, particularly in psychiatric specialties³³, among physicians³⁴ and in emergency medicine³⁵. Some A&E departments have already had to impose temporary closures due to lack of medical staff³⁶. In a recent BMA survey, almost 50% of public health specialists reported that there had been between 1 and 5 vacancies in their department in the last 12 months, with nearly 60% of those respondents reporting that the vacancy had lasted more than 6 months³⁷.
- 3.3. A survey by GP magazine Pulse found that around 12% of GP posts are vacant, the highest ever level of unfilled posts³⁸. The Government has pledged to increase the number of GPs by 5,000 by 2020, but has faced difficulty filling the posts. In response, the NHS is seeking to recruit more than 2,000 GPs from overseas to meet its target (see paragraph 4.4).

Scotland

- 3.4. Long term (greater than six months) consultant vacancies in Scotland have increased by 17.4 WTE over a year to a total of 166.1 WTE in March 2016, which is considerably higher than the rate prior to 2015. We consider that the long-term vacancy rate is a good indicator of systematic staffing shortages, but the overall consultant vacancy rate at 6.5% is also considerably higher than rates seen prior to 2015. The Scotland data identifies clinical radiology, emergency medicine, psychiatry and general acute medicine as particular shortages³⁹.
- 3.5. For SAS doctors, who form a sizeable part of the secondary care workforce in Scotland, no vacancy data at all is collected.
- 3.6. In terms of junior doctor recruitment, some specialties and geographies remain challenging to fill, for example, the core psychiatry fill rate stands at 44% in the North Region. Challenges also remain for GP trainee recruitment and in certain diagnostic specialties. Fill

³¹ [BMA evidence to DDRB 2016](#)

³² ["The state of pre and post-graduate medical recruitment in England." BMA, 2017.](#)

³³ Kings Fund, Workforce planning in the NHS, p. 7

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Workforceplanning-NHS-Kings-Fund-Apr-15.pdf

³⁴ RCP (2016) Underfunded. Underdoctored. Overstretched.

³⁵ The Guardian, 10 August, 2016, <https://www.theguardian.com/society/2016/aug/10/hospital-a-and-e-crisis-shortage-emergencydoctors>

³⁶ Inews, 10 August 2016, <https://inews.co.uk/essentials/news/health/emergency-departments-closing-nhs-trusts-deficit/>

³⁷ BMA Public Health Survey 2017 (11 May 2017).

³⁸ Pulse, 29 April 2015, GP vacancy rate at highest ever, with 50% rise in empty posts

<http://www.pulsetoday.co.uk/your-practice/practicetopics/employment/gp-vacancy-rate-at-highest-ever-with-50-rise-in-empty-posts/20009835.fullarticle>

³⁹ [BMA evidence to DDRB 2016](#)

rates for diagnostic specialties, such as Medical Ophthalmology (50%), and Clinical Neurophysiology (67%), remain low⁴⁰.

- 3.7. The Scottish Government's 2015 GP Workforce Survey states that the estimated number of whole-time equivalent GPs has dropped since the 2013 survey, from 3,735 to 3,645. The report is clear that this decrease in numbers is against a backdrop of increasing demand on GP services and rising workload. The populations that GP practices serve have grown, with the average list size per practice having risen from 5,622 in 2013 to 5,920 in 2017 – a 5% increase (taken from the latest ISD data)⁴¹.
- 3.8. BMA Scotland has gathered GP vacancy data on a regular basis over the last 2 years. The results from the latest survey from June 2017, in which 53.6% of practices in Scotland took part, showed that 26.5% of responding GP practices had at least one GP vacancy open. This is an increase from the 17% of practices who reported at least one vacancy in March 2015⁴².

Wales

- 3.9. Welsh vacancy rates have not been published officially since 2011, so have had to be obtained via freedom of information (FOI) requests. An FOI by the BBC showed a vacancy rate of 7.8% for doctors in Welsh health boards in December 2015, having risen sharply over the preceding year, and with significant variation across the boards. While this provides an indication of recruitment difficulties, the lack of an agreed and consistent definition makes comparisons within Wales and across the UK difficult. The BBC also discovered a 61% increased cost of overtime payments for consultants in Welsh hospitals over three years, which reflects existing staff having to undertake additional work to cover for vacancies and rota gaps.
- 3.10. The BMA has additionally collected data on locum consultant usage, which equates to 7.5% WTE consultant posts. While there are issues around when and for how long locum use is the most cost-effective solution, this does suggest the true vacancy rate will be higher than the headline figures. The NHS Wales Workforce Review confirmed this increase in locum use, with an increase in agency and locum spend (not just consultant) of 62% in 2014/15 to a figure of £88 million. Moreover, there appears to have been a fall in the numbers of doctors per head in Wales to 2.8 per thousand population from 3.1 last year⁴³.

Northern Ireland

- 3.11. Northern Ireland vacancy rates stood at 5.2% for medical and dental WTE staff in March 2015, compared with 4.4% a year earlier. The long-term rate has also increased from 2.4% in March 2014 to 3.2% in March 2015⁴⁴. A recent BMA survey of Northern Ireland local

⁴⁰ <http://www.scotmt.scot.nhs.uk/recruitment/recruitment-statistics.aspx>

⁴¹ <http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/>

⁴² <http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2016-06-14/2016-06-14-PrimaryCareWorkforceSurveyScotland2015-Report.pdf>

⁴³ [BMA evidence to DDRB 2016](#)

⁴⁴ [BMA evidence to DDRB 2016](#)

negotiating committees (LNCs) indicated that there were around 250 consultant vacancies across various specialties in August 2016, with 8% of these posts vacant for longer than a year, and shortages in radiology, anaesthetics, emergency medicine, psychiatry and laboratory medicine.

- 3.12. There has been an increase in locum use, with the Department of Health Northern Ireland quoting an overall 30% increase between 2010 and 2015, although again there is a lack of detailed data on numbers, grades, specialties and workplaces of locums.
- 3.13. A new e-recruitment system will be used to track job adverts, as in England, but no information on the exact content or timing is available, and work is ongoing as to whether the HR system in Northern Ireland could also be used to extract vacancy data. The Department of Health in Northern Ireland has recently undertaken overseas medical recruitment exercises to try to fill gaps in the workforce⁴⁵. In addition, Northern Ireland is unusually reliant on doctors and other healthcare staff crossing the border with the Republic of Ireland to work in the NHS.

UK-wide

- 3.14. To sum up, the BMA has serious concerns about recruitment and retention of medical staff in the NHS across the UK and the domestic supply of doctors is currently insufficient to adequately staff some health services. The number of people applying to UK medical schools has decreased by more than 13% since 2013⁴⁶ and there are fewer applicants to foundation and specialty training. Only 50% of FY (Foundation Year) 2 doctors are now progressing straight to specialty training⁴⁷. Almost half of GP practices (46%) reported that they had GPs in their workforce who were either intending to retire (37%) or leave the UK (9%)⁴⁸.
- 3.15. Rota gaps are frequently reported as a problem, with evidence showing that seven out of 10 doctors in training work on a rota with a permanent gap⁴⁹. In a recent BMA survey, two thirds of respondents reported that there are currently rota gaps in the department in which they work⁵⁰. The reasons behind the NHS's difficulty in recruiting and retaining medical staff are varied. A recent report by the BMA explores these issues in depth and offers some potential solutions to addressing short-medium term workforce gaps⁵¹.

4. Current initiatives to address workforce shortages

⁴⁵ [BMA evidence to DDRB 2016](#)

⁴⁶ [UCAS data.](#)

⁴⁷ <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/state-of-medical-recruitment>

⁴⁸ <https://www.bma.org.uk/news/media-centre/press-releases/2016/march/almost-300-gp-practices-facing-closure>

⁴⁹ RCP: Underfunded, underdoctored, overstretched - the NHS in 2016, p.3

⁵⁰ [BMA Quarterly Survey Q2, 2017.](#)

⁵¹ <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/state-of-medical-recruitment>

Growing the domestic supply of doctors

- 4.1. The Government has announced it will fund the training of an additional 1,500 students at medical schools in England from 2018, with the intention of achieving self-sufficiency by expanding the supply of UK trained doctors, and reducing the NHS's reliance on doctors from overseas⁵². This initiative will not meet either the NHS's short or medium term workforce needs given the length of time taken to train a senior doctor (this new intake of medical students will not be practicing as GPs until 2028 at the earliest or as consultants by 2032 at the earliest) and the growing demand for health services. The NHS will need to continue recruiting doctors from within the EU and overseas to fill gaps in the workforce and ensure that the UK makes use of the best global talent available.

International recruitment initiatives

- 4.2. The NHS has long relied on overseas recruitment to fill posts in geographical areas or specialties where there are workforce shortages, mainly through the use of the Tier 2 (General) visa. More than two-thirds (69%) of all NHS trusts and health boards are seeking staff overseas. In England and Wales alone, the figure is nearly three-quarters of all trusts and health boards (74%)⁵³.
- 4.3. International recruitment schemes such as the Medical Training Initiative (MTI) aim to fill workforce gaps while at the same time providing the benefit of UK training to qualified overseas doctors. The MTI is a Government Authorised Exchange (GAE) and appointees enter the UK on a temporary Tier 5 visa allowing them to work for up to a maximum of 24 months. Appointees can work in most medical posts as long as these are designed to deliver training and education that will benefit the overseas-based appointee, and that they intend to return to their home country at the end. The scheme was re-launched in 2009 under the points based immigration rules⁵⁴.
- 4.4. This year, NHS England launched a targeted international recruitment scheme to recruit up to 2,000 GPs over the next three years to bridge the "gap between the number of doctors practices want, and the numbers they are successfully recruiting and retaining"⁵⁵. The initiative aims to help the Government reach its target of recruiting an additional 5,000 GPs by 2020.
- 4.5. In 2014, Health Education England partnered with the Royal College of Emergency Medicine to recruit overseas doctors to emergency medicine posts under the Overseas Development Programme. One of the stated aims of the programme was for recruits to work, learn and return to their home country with enhanced skills and qualifications in emergency medicine

⁵² [Expansion of Undergraduate Medical Education, Government response to consultation, August 2017.](#)

⁵³ <http://www.bbc.co.uk/news/health-35667939>

⁵⁴ [NHS Employers webpage: Medical Training Initiative.](#)

⁵⁵ <https://www.england.nhs.uk/gp/gp/v/workforce/building-the-general-practice-workforce/international-gp-recruitment/>

and was in response to the NHS's inability to fill more than half of its ST4 training posts for three years in a row⁵⁶.

- 4.6. In Scotland, the Royal College of Radiologists (RCR) is calling on the Scottish Government to recruit overseas doctors to fill vacant consultant radiologist posts. RCR notes that 8% of Scottish radiologist posts are currently unfilled and that 19% (nearly a fifth) of the current radiology consultant workforce will retire in the next five years⁵⁷.

5. Impact of reduced migration

Doctors

- 5.1. The UK relies on overseas doctors, from the EEA and elsewhere, to provide a reliable and safe health service in the face of widespread workforce shortages and rising demand. Because it takes more than 10 years to train a senior doctor, the ability of UK health services to retain and recruit qualified doctors from overseas is essential, particularly in the short-medium term until domestic supply is increased.
- 5.2. Many registered doctors with non-UK PMQs practice in specialties that are facing long-term workforce shortages including general practice, emergency medicine, paediatrics, occupational medicine, radiology and psychiatry. A reduction in the number of migrants, from the EEA or elsewhere, would have a destabilising effect on the medical workforce overall, but particularly in shortage specialties, and impact on the ability of the NHS to deliver care.

Medical students

- 5.3. It is unclear what immigration system will be put in place for EU students once the UK leaves the EU, but it is essential that EU students who are currently studying at UK medical schools are given certainty about their futures in the UK. Thousands of EEA and non-EEA medical students are factored into NHS workforce planning. The ongoing absence of certainty over their future rights to live in the UK and train and work in the NHS may force some EU medical students to leave their prospective careers in the NHS.
- 5.4. Unlike EEA students, international (non-EEA) medical students are currently subject to a 7.5% cap on numbers (the Government has announced the removal of this cap from 2019/20). In addition, starting in 2019-20, international medical students will be required to fund their own clinical placements as well as tuition fees and living expenses⁵⁸. This will undoubtedly make the UK a less attractive place to study for some international students, including those from the EEA.

⁵⁶ [BMJ "NHS increases efforts to recruit doctors from overseas." 21 February 2017](#)

⁵⁷ <https://www.rcr.ac.uk/posts/radiology-crisis-scotland-sustainable-solutions-are-needed-now>

⁵⁸ Expansion of undergraduate medical education, Government response to consultation.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/636527/Expansion_undergraduate_medical_education_consultation-response_2_.pdf

Medical academic staff

- 5.5. UK medical research depends upon and is enhanced by the contribution of international doctors. It is important for UK companies, universities and research institutes to attract and retain top researchers from all over the world. The employment of world class researchers helps to ensure that UK universities and companies involved in medical research maintain an internationally competitive edge and underpin the UK's position as one of the most productive countries for medical research⁵⁹.
- 5.6. The highly specialised nature of much medical research means that it can be difficult and unnecessarily restrictive to sustain research projects employing solely UK nationals. Experts within a specific field may simply be so few that there are none available domestically. The loss of top medical research and academic talent would impact adversely upon UK medical research activity and long-term economic success. If companies carrying out medical research find that in the UK they are unable to employ the best medical researchers from around the world, then they may move their operations abroad to countries where this is possible.

Wider health and social care workforce

- 5.7. Doctors work closely alongside a range of individuals, including nurses, paramedics, allied health professionals, clinical scientists, lab and theatre technicians, porters and cleaners, many of whom are likely to be EU nationals or from overseas⁶⁰. These individuals play an integral role in the efficient and safe running of the health service.
- 5.8. Migrant workers make up a large proportion of the adult social care workforce. One in five of the adult social care workforce in England were born outside of the UK⁶¹ and many social care professionals currently working in the UK come from other EU countries. In 2015, 6% of those working in adult social care were from other EU countries, equating to nearly 80,000 jobs⁶². The government must take steps to give EU nationals working in the health and social care sector certainty regarding their future status in the UK as quickly as possible to prevent any potential further reduction in the social care workforce.
- 5.9. Currently, immigration rules rely on salary levels, rather than taking account of need, as a filter to determine who is granted a visa. Shortage occupation lists (SOL) go some way towards trying to meet gaps in demand but these are not comprehensive or responsive enough to adequately measure need or take account of future changes in the workforce.

⁵⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/651174/uk-research-base-international-comparison-2016.pdf

⁶⁰ The BMA is a member of the Cavendish Coalition, a coalition of more than 30 health and social care organisations, which is seeking certainty for the current health and social care workforce originating from the European Economic Area (EEA) to remain in the UK.

⁶¹ Independent Age, Franklin & Urzi Brancati (2015) Moved to care: the impact of migration on the adult social care workforce.

⁶² Skills for Care (2016) Nationality of the adult social care workforce.

For example, general practitioners are not included on the SOL despite clear evidence of need⁶³.

- 5.10. Merely using salary levels is a crude measure and any future review of UK labour market policy, or potential immigration systems, must consider the needs of the health and social care sector for both skilled and unskilled labour. It should be based on the needs and demands of the service, ensuring gaps in workforce are filled where they cannot be met by UK nationals in the short to medium term. This will be vital in providing a high quality, reliable and safe service to patients.

6. Conclusion

- 6.1. Doctors and students from all over the world come to the UK to study and work in medicine. In addition to the thousands of other NHS staff who are from the UK and overseas, they provide a vital public service to the residents of the UK and contribute to the overall economy. They make up a substantial portion of the UK medical workforce and the NHS therefore relies on them to deliver safe and reliable health services. Vacancies persist in the NHS, even with current levels of migration and it is becoming increasingly difficult to recruit and retain doctors. A reduction in migration would exacerbate these shortages adversely impacting the quality of care and patient safety.

Published: 27 October 2017

⁶³ <https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/uk%20consultations/recent/bma%20response%20-%20mac%20tier%20%20call%20for%20evidence.pdf>.