WORKFORCE REVIEW TEAM

10th INTERNATIONAL MEDICAL WORKFORCE CONFERENCE
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RETENTION AND RETIREMENT

CONTENTS

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1 Executive Summary/Abstract

This paper aims to synthesise current data and views on medical retirement and retention within the United Kingdom, drawing on recently published data and research from the countries of the United Kingdom. A clear understanding of current and potential future trends in medical retirement and retention is a vital component of effective medical workforce planning. In recent years there has been extensive devolution of political power within the UK making the four countries more responsible for their own health services including workforce planning.

Key Points in this Report

- Some rich and diverse data on retirement rates and intentions is available, but improvements in data and workforce planning are needed.
- There is no guarantee that the future will necessarily be similar to the past; many highly complex influences exist – some of which are contradictory.
- Both higher and lower than expected levels of retirement and retention will have their own impact.
- A tentative conclusion is that in overall terms across the UK, there is no significant evidence of a major problem caused by the 'haemorrhaging' of doctors retiring earlier than expected.
- Different challenges in specific geographical and service areas, encouraging local areas to proactively draw up strategies.
- Greater succession planning and mentoring of new consultants should be encouraged.
- There is a decline in retirement as a single act on a defined day; this reinforces the importance of good intelligence.
- Dramatic changes generally in the world of work are occurring; key differences between attitudes of 'traditionalists', 'baby boomers', 'Generation X' and 'Generation Y' have been identified.

The Workforce Review Team

The Workforce Review Team (WRT) is a national body providing expert workforce planning advice on behalf of the NHS in England.

WRT produces reliable data and intelligence about the workforce needed to deliver high quality modern health and social care, to meet changing demands. Our analysis is trusted and helps drive decision making and shape workforce strategies. We have a reputation for accuracy and impartiality.

2 Introduction

A clear understanding of current and potential future trends in medical retirement and retention is a vital component of effective medical workforce planning.

Both higher and lower than expected levels of retirement and retention, will have their own impact on the current workforce and therefore the provision of health services.

Increased numbers of retirees – for whatever reasons – may mean an unwanted loss of experience and lack of availability of sufficient numbers of suitable replacements. Fewer numbers of retirees may mean a lack of fresh blood, energy and ideas and a 'bottle neck' for aspiring consultants or general practitioners (GPs).

This paper aims to synthesise current data and views on medical retirement and retention - with particular focus on retirement - within the United Kingdom. It draws on recently published data and research from the countries of the United Kingdom, some of which is routinely available, some specially commissioned. Finally, it describes some aspects of potential approaches in a highly complex and volatile planning environment.

3 Background

3.1 Provision for Pensions

Within the UK, subject to specific qualifications, individuals can claim a basic state pension at the age of 65 for men and 60 for women (rising from 2010 to 65 for women by 2020).

Largely as a result of increasing longevity, the state pension age is set to increase, in stages, to 68 for both men and women by 2050.

The NHSs for England and Wales, Scotland and Northern Ireland each offer a virtually identical 'final salary' pension scheme. They currently enable a pension to be paid from the age of 50 (abated) or 60 (unabated). Broadly similar arrangements are in place for GPs who are, in the main, independent contractors rather than employees.

3.2 Characteristics of the UK Countries

Within the United Kingdom, recent years have been marked by extensive devolution of political power and authority so that now each of the four countries is responsible for its own health services.

The respective populations of the four countries at the time of the 2001 Census were:

	Population at 2001[a]	Number of consultants in NHS	Number of GPs in NHS
England	49.1m	31,993[b]	35,944[b]
Scotland	5.1m	3,853[c]	4,637[c]
Wales	2.9m	1,584[d]	1,849[e]
Northern Ireland	1.7m	1,114[f]	1,084[f]
Total	58.8m	38,544	43,514

a Office of National Statistics 2001 Census
b Information Centre NHS (England) workforce census 2005, headcount
c ISD Scotland census 2006, headcount
d NHS Wales workforce FTE
e NHS Wales workforce headcount
f Northern Ireland Health & Personal Social Services Workforce Census 2005

Perhaps inevitably, distinct differences in philosophy and approach have emerged. Following the publication of the NHS Plan in 2000, England has focussed on:

- setting demanding targets for the improvement of access to services
- seeking improvements to life expectancy from the major killers such as cancer and coronary heart disease
- greater devolution; the most recent organisational change has seen the creation of 10 strategic health authorities[1] and 152 primary care trusts[2] together with a parallel programme of establishing foundation trusts[3]
- plurality of providers, coupled with introduction of a more market orientated approach to health services but services still free at the point of care
- pay reform for virtually all NHS staff including new contracts for GPs and consultants.

[1] Each responsible for managing the NHS locally and acting a key link between the Department of Health and the NHS.

[2] PCTs are responsible for:

- Assessing the health needs of all the people in their local area and developing an insight into the needs of their local community.
- Commissioning the right services, for instance from GP practices, hospitals and dentists, to meet these needs.
- Improving the overall health of their local communities.
- Listening to patients' views on services and acting on them.
- Making sure that the organisations providing these services, including social care organisations, are working together effectively.

[3] Foundation trusts are a new type of NHS hospital run by local managers, staff and members of the public which are tailored to the needs of the local population. They have been given much more financial and operational freedom than other NHS trusts. These trusts remain within the NHS and its performance inspection system.

In 2006/07, national funding in respect of workforce education and training has been 'top sliced' at national level and passed to SHAs with fewer conditions attached as to how it may be spent. At the same time, local health organisations – SHAs, PCTs, Trusts and Foundation Trusts – are being actively encouraged to take greater responsibility for their own affairs including workforce planning.

In Scotland, the strategic direction for health services is set out in *Delivering for Health* (Scottish Executive, 2005). The focus is on shifting the balance of care – reducing the reliance on episodic, acute care in hospitals; and increasing efforts to improve heath and well-being through preventative medicine and anticipatory care services. Targets are set nationally to improve delivery and performance of health services and the national clinical priorities are cancer, coronary heart disease and stroke, and mental health.

NHS Scotland is a single-tier system with 14 territorial health boards (and eight special health boards operating at national level on matters such as education, and clinical standards). Unlike England, there is no policy of plurality of provision or a market approach.

Within Wales, *'Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century'* published in 2005 describes a 10 year vision which aims to:

- Improve health and reduce, and where possible eliminate, inequalities in health
- Support the role of citizens in promoting their health, individually and collectively
- Develop the role of local communities in creating and sustaining health
- Promote independence, service user involvement and clinical and professional leadership
- Re-cast the role of all elements of health and social care so that the citizen will be seen and treated by high quality staff at home or locally – or passed quickly to excellent specialist care , where this is needed
- Provide quality assured clinical treatment and care appropriate to need, and based on evidence
- Strengthen accountability, developing a more corporate approach in NHS Wales so that organisations work together rather than separately
- Ensure full public health engagement at both local and national levels

'Designed to Work, a workforce strategy to deliver Designed for Life' was published in July 2006. One of its key recommendations in relation to workforce planning is that:

> "Regional HR and workforce networks involving social care and the voluntary and independent sectors will be established to ensure that workforce plans are developed to deliver *Designed for Life".*

4 Overview of Data

An important issue is an accepted definition of the term 'retirement'. Within the workforce planning context in the UK, it is generally taken to mean an individual of a minimum age who appears in a health service census in one year and then does not appear in the following year. This clearly has limitations in that the individual may have:

- taken a temporary leave of absence
- moved from being a consultant to a GP (thus not being included in the census in England and Wales)
- taken up an academic contract with the same effect.

Equally, a retiree may be defined as someone who has begun to draw their pension.

As will be seen later in this paper, Scotland, Wales, and other organisations have carried out extensive research into the intentions of practitioners and, to a large extent, 'retirement' means what individuals want it to mean.

Within the UK, although data is mainly available for the four countries separately, there is strong commitment to the sharing of data between the countries as exemplified by the production of this paper.

5 Approach to Workforce Planning in the UK

Each of the four UK countries has arrangements in place to plan the future demand and supply of the medical workforce.

The essential building block for this work is the NHS Workforce Census which is carried out as a 'snapshot' on 30 September each year. This includes information on the age profile of the workforce.

Historical leaving rates in each of the 75 specialties are an important factor in predicting retirement trends although, of course, there can be no surety that the future will mirror the past. In England, discussions are held with the medical Royal Colleges to estimate a retirement age for each specialty. These are applied to each specialty's consultant workforce and age profile so that an estimate of retirements can be made for future years. In Scotland, historic trends averaged over five years are used.

NHS Wales has had an annual workforce planning process since 1988. The outcomes of the process have been used to inform education commissioning numbers for NHS professional staff groups and to monitor staffing targets.

A new process has been developed which aims to ensure that workforce planning is fully integrated with service and financial planning so that workforce plans can reflect the major changes in service delivery that are planned and anticipated for the future.

The new workforce planning arrangements involve national and local strategic planning together with employer operational workforce development plans, each of which forms an integral part of the new arrangements.

6 Selected Research and Work from within the UK

The geographical scope of each piece of work is indicated at the beginning of each section.

6.1 Retention and Retirements *(England and Wales)*

The Workforce Directorate Analysis Team (WDAT, part of Department of Health) has undertaken work on consultant retirements in England and Wales, to provide evidence to the doctors' and dentists' review body.

As well as drawing on the work of the Workforce Review Team and UK Medical Careers Research Group, WDAT has obtained data from the NHS pensions division on actual retirements in the period 1997 – 2005 which is summarised below.

Table 1: Consultant Retirements and Reasons for Retirement – England & Wales

Year end 31 March	Age	Ill-health	Deferred pension benefits	Redundancy	Unknown	Total pension awards
1997	258	58	31	27	32	406
1998	295	52	30	19	34	430
1999	275	57	22	18	37	409
2000	295	55	21	11	23	405
2001	338	66	34	11	26	475
2002	358	66	26	8	24	482
2003	327	60	16	7	30	440
2004	367	57	22	14	34	494
2005	363	46	20	9	36	474
Total	**2876**	**517**	**222**	**124**	**276**	**4015**

Although the total number of pension awards has generally increased, this reflects the rising size of the workforce rather than any change in rates.

Their work also quotes the findings of the Government Actuary's Department's most recent investigation of the NHS pension scheme which found that the average actual retirement age - as defined by those drawing a pension – for doctors contained within a larger staff grouping which includes non-doctors - was 63.3 years. This represents a small reduction from 63.9 years for the previous period.

In terms of retention of medical staff, the following table summarises the number and percentage of staff still practising medicine five years after qualification.

Table 2: Patterns of Retention – Five Years after Qualification

Year of qualification	Cohort size	Not practising medicine		Not practising medicine in the UK	
		Number	%	Number	%
1974	2344	131	5.6	339	14.5
1977	3130	184	5.9	395	12.6
1983	3841	204	5.3	357	9.3
1988	3731	307	8.2	514	13.8

1993	3639	188	5.2	322	8.8
1996	3836	182	4.7	302	7.9
1999	4180	195	4.7	308	7.4

The Government Actuary's Department also provides a commentary on consultant 'wastage rates' between 2004 and 2005. This is based on an analysis of doctors who appeared in the 2004 Census but not in the 2005 Census. In practice, of course, this wastage rate will generally be overstated in that it will incorporate those who have moved to other health employment eg becoming a GP, those on maternity leave or research programmes, and doctors from abroad who never intended to stay in the NHS for long periods.

This rate stands at 5% - virtually unchanged over the past 10 years.

6.2 Medical Careers Research Group (MCRG) *(United Kingdom)*

Based at Oxford University under the leadership of Dr Michael Goldacre and funded by the Department of Health, the MCRG undertakes longitudinal studies of the careers of all doctors who graduated in particular years from UK medical schools.

Recent work includes testing the retirement intentions of doctors who qualified in 1977 (with a median age of 51). The 'headline' outcomes are summarised below and compared with similar data obtained from the 1974 cohort, when they were surveyed in 1998.

	1974 cohort	1977 cohort
Definite intention to retire early	25%	17%
Definitely/probably not stay until retirement age	51%	37%

It is, of course, the case that a declared intention is not necessarily realised and evidence indicates that there has been little actual increase in early retirements from the 1974 cohort. It is common in many professions for early retirement intentions to be overstated.

6.3 Working Time Directive Project *(England)*

The English Working Time Directive Stakeholder Group determined that it wished to understand better the retirement trends of the medical workforce and the impact these might have on workforce planning and health service delivery – particularly whether there was any specific threat to the achievement of Working time Directive (WTD)[4] compliance by 2009. Accordingly, it commissioned WRT to investigate the trends and assess anecdotal evidence. It should be noted that GPs fell outside the scope of the work and report.

[4] A directive to protect the health and safety of workers in the European Union, it lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. It has proved to be particularly challenging in respect of doctors in training within the UK who have historically worked very long hours.

As indicated earlier, ‘retirements’ were defined as leavers from the NHS in the age bands 55-60, 60-65 and over 65.

This section contains extracts from a lengthy report published in late 2006 which also contained reference to other research carried out in this field.

For this report, the data used has been obtained by WRT from its ‘all specialties’ proforma (modelling based on data from individual specialties) and from a previous piece of work that modelled the trends in ‘wastage’ among consultants. These sources were used to identify the past and future trends for consultants retiring from the workforce. WRT has also obtained bespoke data from the Health and Social Care Information Centre (HSCIC) for leavers from the workforce between the years 2003 and 2004 to give a view of the current picture.

Past Trends

Net wastage rates among hospital medical consultants

Fig.1 below shows the net wastage for four comparative years – 1992/3, 1993/4, 1998/99 and 1999/2000. Wastage here is calculated as:

$$\frac{\text{Leavers during the year} - \text{Joiners during the year}}{\text{Stocks at the start of the year}}$$

Fig. 1 Wastage rates for hospital medical consultants aged over 50

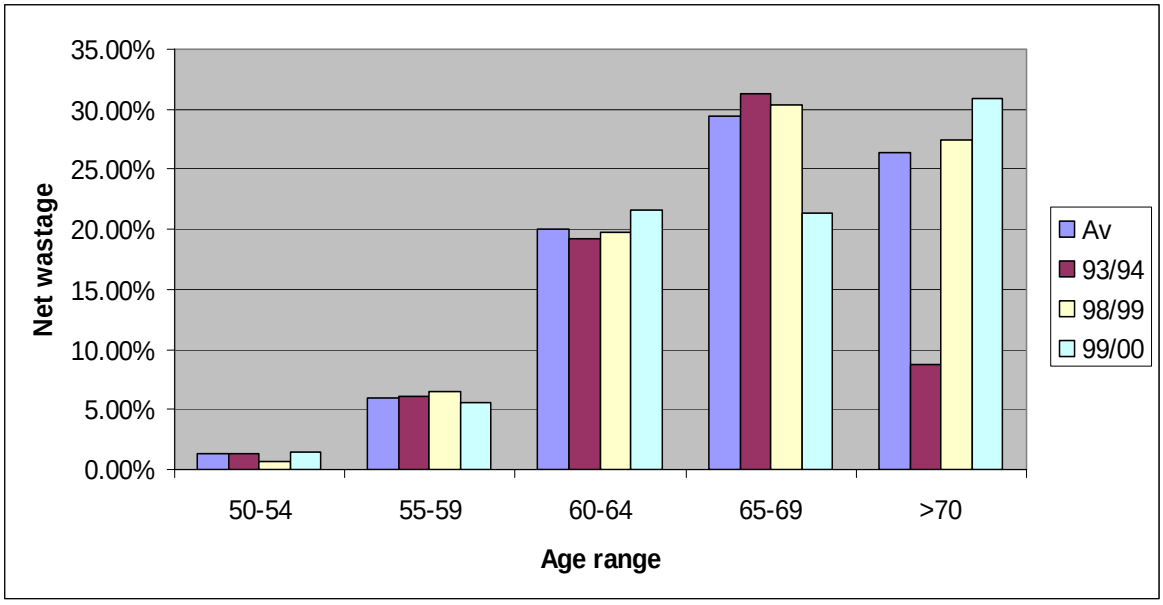


Fig.1 suggests that there is little overall difference in the wastage rates over the time period modelled. However, in order to obtain a more representative picture, the

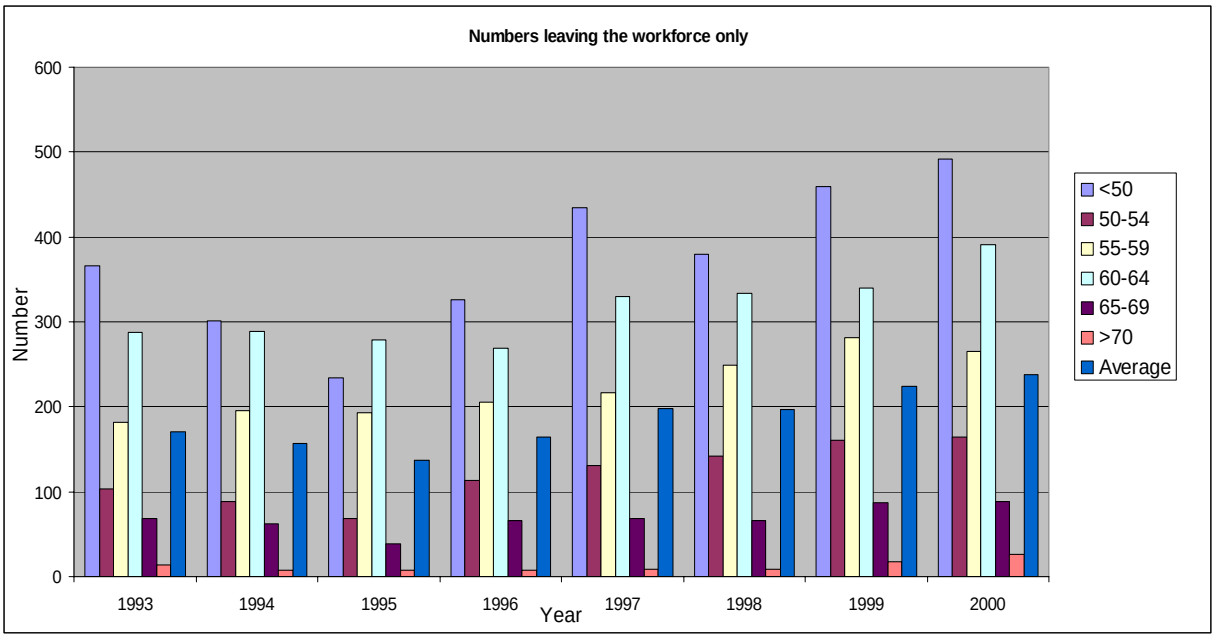
numbers *leaving the workforce only* need to be considered. The graph above takes into account the numbers joining the workforce, which can hide the number of leavers.

Numbers leaving the workforce

Fig.2 below shows the numbers of hospital consultants in a variety of age groups that leave the NHS in England. For the purpose of this research, 'leaving the NHS' is defined as hospital medical consultants appearing in the census at the start of the year who were not in the NHS hospital, public health medicine or community health service (HCHS) sector at all in the following year. However, as discussed elsewhere, it is possible that these consultants reappear in the workforce in future years.

The graph shows a rise in numbers leaving the NHS in the below 50 and 50-54 age group, which cannot be attributed to traditional 'retirement' – these numbers are leaving for other reasons. These were explored in the literature review. Other age groups show small year on year rises but this could be attributed to demography.

Fig. 2 Number of consultants leaving the workforce



Current trends

For the purpose of this section of the report, WRT obtained current data from the HSCIC regarding assumed leavers from the NHS workforce. The data compares the NHS censuses of 2003 and 2004 and other workforce information to identify leavers from the age groups of 60 and over and also 65 and over. The findings should give a good idea of the retirement numbers, as it is less likely that doctors from these age groups would take a career break.

The data was then interrogated to produce results based on SHA and specialty.

On average, SHAs can expect to lose around 0.5% pa of their current consultant workforce through early retirement (ie not retiring at 65). 'Normal' retirement (at 65) results in a similar loss of just under 0.5% pa of the workforce; over 60s data includes the over 65 cohort, so a value is obtained by subtracting the over 65 from the over 60 data.

Overall from the over 60s group, SHAs can expect to lose around 1% pa of their workforce. The new SHAs will have to ensure that doctor hours under WTD are sufficient to cover this. As a result of WTD, doctors will have worked a maximum 48 hour week throughout training, meaning existing consultants that regularly work a 60 hour week are replaced by doctors who have little intention of working more than the hours they are used to (Curson, 2006). Evidence of this is already beginning to emerge with college surveys beginning to show a significant decrease in the average working week of consultants. These results are also consistent with the data obtained from the 2004-05 Censuses. Initial analysis suggests similar retirement percentages for both age groups (around 1% pa for the over 60s, and around 0.5% pa for the over 65s, thus around 0.5% pa for both groups). This suggests, in the short term at least, that retirements tend to be at consistent levels with no 'boom-and-bust' cycle.

Future Predictions

As already indicated, future predictions are taken from the WRT 'all specialties' proforma and previous WRT modelling done to identify wastage rates, which has been modified to give a future trend of the original findings. The WRT all specialties proforma contains the combined information from every medical specialty that WRT reviews. Information comes from a variety of sources including Royal Colleges, professional bodies and specialty representatives so should give a robust representation of the retirement situation. These figures are for the consultant workforce only.

Fig. 4 Predicted retirements of the consultant workforce using WRT proforma modelling

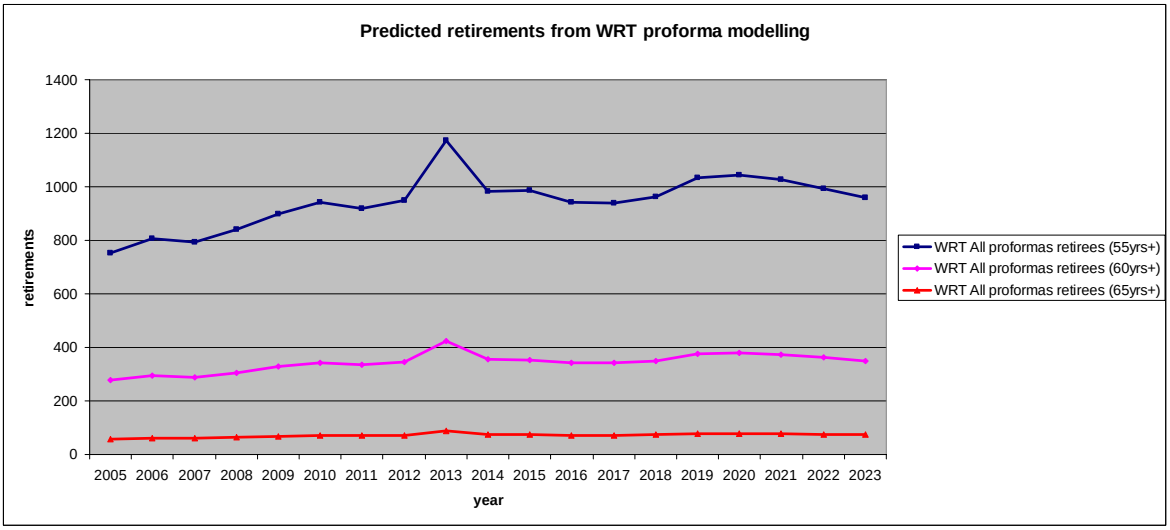


Figure 4 shows the predicted numbers of consultant retirements based on three age groups; 55 and over, 60 and over, and 65 and over. The WRT 'all specialties' proforma provides estimated numbers of retirements and younger leavers by year, wherein a person who leaves the workforce and is 55 and over is deemed to be retiring, and all other persons are younger leavers.

For the purposes of this paper, the number of leavers who are 60+ and 65+ has been derived from the proforma data using the age profile for trained specialists which is also available in the WRT 'all specialties' proforma. It is assumed that the age profile for trained specialists aged 55 and over does not change. The levels of each category remain fairly constant with the exception of around the year 2013. This spike represents potential changes to the final salary pension scheme – thus the high number, due to the increased numbers of doctors that are estimated to retire to obtain a final salary pension. However, this prediction is a 'worst case scenario'. At present, it is impossible to predict confidently whether this will occur or not and this will need to be kept under review.

These figures are calculated taking into account various factors such as the age of the current workforce and specific views from specialty representatives. With the exception of the spike around 2013 the profiles for all three categories are relatively smooth suggesting that a 'boom and bust' scenario will not occur. This may benefit the succession planning process.

6.4 National Survey of Non-training Grade Doctors in NHS Scotland (*Scotland)*

In 2006, NHS Education for Scotland (North Deanery) and the Health Economics Research Unit, University of Aberdeen were commissioned by the Scottish Health Department to carry out a second wide-ranging survey of all consultants, GPs and staff and associate specialist doctors[5] with the objective of ascertaining their future plans including retirement. This followed the first survey which was carried out in 2001 with a broadly similar remit. The aim of this research was to help gain greater understanding of job satisfaction and, of relevance to this paper, to give insight to issues of recruitment and retention of doctors in Scotland.

Results from the Consultant Survey

A total of 1744 consultants (56%) responded to questions such as intended retirement age, degree of certainty and plans to leave the NHS within the next year for reasons other than for retirement. The data has been analysed by gender, age group, contract type and specialty.

In summary, the mean retirement age was 60.3 years with the gender split as follows:

Female	59.1 years
Male	60.8 years

70% of all respondents thought that their planned retirement age was 'very likely' or 'quite likely'. The split by specialty showed that all were contained in the range 59.9 – 61.3 with the exception of psychiatry which had a figure of 57.9 years.

[5] Fully GMC registered doctors, trained as specialists but not to the same level as consultants

2% of respondents had plans to leave the NHS in the following year other than for reasons of retirement with a further 5% unsure of their plans.

In comparing the results of the two surveys, two questions are identical:

- At what age do you plan to retire? The mean average has increased slightly but significantly from 59.7 years (2001) to 60.3 years (2006).
- What is the likelihood of this happening? The perceived likelihood of retiring at planned age has remained fairly constant.

Results from the General Practitioner Survey
The responses from GPs (2282, 52%) showed a mean planned retirement age of 60.2 years with the gender split as follows:

Female	59.8 years
Male	60.7 years

This shows a significant increase from 58.8 years, the mean average from the 2002 survey. Respondents were slightly, but significantly, more likely to think that this was definite in 2002 compared to 2006.

Interestingly, in 2006, 14% of all responding GPs stated that they had changed their planned retirement age because of the recently introduced new GMS (General Medical Services) contract. Of these, 51% planned to retire later and 49% planned to retire earlier.

Results from the Staff and Associate Specialists Survey
Of the 460 respondents (60%), the mean planned retirement age was 60.4 years with the following gender split:

Female	60.0 years
Male	61.6 years

In comparison with the earlier survey, the average planned retirement age had increased slightly, but significantly, from 59.7 years with no significant difference in the degree of certainty about retirement plans coming to fruition.

6.5 Research into Recruitment and Retention of General Practitioners in Wales *(Wales)*

The Wanless Review of Health and Social Care in Wales (2003) highlighted the need for increased primary care workforce capacity within NHS Wales. NHS Wales concluded that the deficit in workforce capacity within primary care must be redressed as a matter of urgency if the benefits of a primary care-led NHS in Wales were to be realised.

Accordingly, a report was commissioned by the Chief Medical Officer and endorsed by the Welsh Assembly Government's Medical and Dental Workforce Expert Advisory Group. The programme of activity included a series of research projects which were

carried out in 2004 and 2005 to explore current problems of GP recruitment and retention.

These included a number of projects covering retirement, including, *'Retirement plans of Senior GPs working in Wales and 'Problems of GP Recruitment and Retention in areas of Wales with the Greatest Shortages'.*

The workstream on retirements involved sending postal questionnaires to all GPs aged over 40 years – total number 1360. 521 responses were received – a rate of c38%. Of these, 62% planned to retire before the age of 60 with the most frequently cited reasons being finance/pension issues, excessive workload from patient care or administration and lack of work-life balance. Leaders in Wales were concerned that if these intentions were to be carried out, it would cause a significant reduction in the GP workforce over the next 5-10 years unless steps were taken to encourage these experienced GPs to continue working.

The recommendations were principally aimed at local health boards (LHBs) and included:

- Encouraging LHBs to 'own' this issue including monitoring and evaluating actual turnover rates of GPs within their areas, analysing age profile, exploring retirement intentions in more detail and performing exit interviews.
- Developing a range of incentives and career opportunities for senior GPs to encourage their retention.
- Development of a comprehensive occupational health scheme
- Improve workforce planning and employment data (a recurrent theme)

The focus on LHBs stemmed from the conclusion that central initiatives had had limited impact on recruitment and retention and that solutions to the challenges would work best if devised locally. Since publication of the report, all LHBs have produced recruitment and retention plans and there is active engagement with them in sharing and extending best practice.

At national level, there was support for the creation of a senior retainer scheme to encourage experienced GPs to continue in practice. However, it has not yet proved possible to secure funding.

Although detailed centrally held data on retirements is limited, LHBs are proactive in maintaining dialogue with local GPs about retirement intentions and planning accordingly.

As discussed elsewhere, it is clear that individual decisions about retirement are influenced by a wide range of factors such as those relating to the GMS contract which are still evolving.

7 Conclusion

As this paper has sought to demonstrate, planners have available to them, and can generate, some rich and diverse data describing retirement rates and intentions (which are not, in any case, always synonymous).

Within England and Wales, the historical dependence on the annual DH Census for reasonably robust data, is gradually declining with the full roll-out of the electronic staff record (ESR). Effectively, this means that 'instant censuses' are routinely available across any defined organisational base to provide up-to-date information on staff and staff movements, including retirements.

However, self evidently, even if data on the past and present is available, there is no guarantee that the future will necessarily be similar in any way.

There exist many highly complex influences and drivers – some of which are contradictory.

A tentative conclusion to be drawn from the material presented in this paper is that in overall terms across the UK, there is no significant evidence of a major problem caused by the 'haemorrhaging' of doctors retiring earlier than expected.

However, perhaps partially because this is such a complex area with different challenges in specific geographical and service areas, the four UK countries are generally encouraging planning authorities at a more local level, to monitor and understand their own local trends and circumstances which may be unique to them.

The corollary is that they should proactively draw up strategies for dealing with any identified 'hot spots'. This in itself will be challenging in a climate of plurality of provision where collaborative solutions may be more difficult to achieve.

At a local level, succession planning is a vital and often overlooked activity – especially as incoming consultants are likely to be less experienced than those they are replacing were at a similar age. Equally, there is immense value in older consultants offering mentoring.

As many commentators have noted, the notion of retirement as a single act on a defined day accompanied by a gold watch at the age of 65 is of decreasing relevance. At a strategic level, such a myriad of individual plans and intentions which are other than 'full retirement' inevitably becomes difficult to track. Necessarily, this increases the uncertainty for workforce planners and organisations with an interest in the medical workforce. This, in turn, reinforces the importance of good intelligence which combines the elements of routine data collections supplemented by regular bespoke surveys.

There is widespread agreement that the level of expertise and resource devoted to workforce planning needs to be increased. In tandem, workforce information systems need to be improved to support better workforce planning.

8 Some final thoughts ....

It is important to recognise that the world of work has changed dramatically in recent years. Professor Linda Duxbury, a Canadian expert on workplace health, describes the characteristics of four distinct groups of (not specifically medical) workers:

- 'Traditionalists': born prior to 1946: totally committed to the company, typified by unquestioning loyalty
- 'Baby boomers': born between 1947 and 1967: 'workaholics', accept stress as part of the job; belief in delayed gratification
- 'Generation X': born between 1968 and 1980: place more importance on career than personal life; experience of many jobs; not committed to a particular company, want immediate gratification
- 'Generation Y': born between 1980 and 1995: want balance of work and personal life; time off for personal life enhancement; do not expect job for life; expect immediate reward.

Workers of each age now occupy the workforce and exhibit some or all of these attitudes and behaviours. It will be increasingly important for employers and colleagues to understand the different motivational drivers for each group.

Commentators are also turning their attention to 'Generation Z', those born since 1995, but we won't worry about them just yet…….

9 Acknowledgements

This paper has benefited considerably from the contributions of:

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