
# Towards self–sufficiency in the supply of medical staff – UK perspective

## 11th International Medical Workforce Collaborative Conference
## Edinburgh September 2008

**David Grantham, Head of Programmes, NHS Employers**

## Introduction

Although this paper broadly reflects the issues within the UK, some of the datasets and experiences identified in this paper relate to England only. It should also be noted that, historically, Scotland has been a net exporter of medical staff, where as Wales' and Northern Ireland's imports and exports broadly cancel each other out.

During 2007 and 2008 (and since the last IMWC in Vancouver in March 2007) medical workforce planning has had a high profile within the UK, with a level of stakeholder involvement and political attention that is perhaps unprecedented. The last occasion on which workforce planning achieved anything near such prominence was with publication of the NHS Plan in 2000 with its commitment to significantly increase workforce numbers[1] and the commitment to substantially increase medical undergraduate places.

This renewed attention has come about as the programme for *Modernising Medical Careers* (MMC), first developed by the Chief Medical Officer in 2002, moved on from establishing the Foundation Programme in 2005 (covering the two year's training post medical school) to introducing planned reforms to Specialty Training in 2007 (covering basic and higher specialty training).

The revised arrangements, and particularly the recruitment processes and procedures using a national computerised matching system (the Medical Training Application Service) and introduction of 'run-through' training, were controversial. There were protest marches by doctors in several cities[2] and following two incidents of breaches of security and technical difficulties it was clear MTAS had lost the confidence of doctors. MTAS was abandoned and the Secretary of State was forced to apologise[3]. Local recruitment arrangements were implemented under the supervision of a review group comprising representatives of the profession and Department of Health. Later this was replaced by the MMC Programme Board, created to steer a course through the confusion and chaos in 2007 and into 2008.

The events, and policy shortcomings that caused the crisis, have been chronicled in considerable detail in a number of reports and enquiries. These also reviewed the links between the MMC reform programme and medical workforce planning, and the absence of key linkages in some instances. The principal reports are all readily accessible at the following websites:

[1] The NHS Plan: a plan for investment, a plan for reform http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002960
[2] http://news.bbc.co.uk/1/hi/health/6457901.stm
[3] http://news.bbc.co.uk/1/hi/health/6521095.stm

- Report of the Douglas Review (on the problems that emerged and arrangements for operating the recruitment process in 2007) http://www.mmc.nhs.uk/pdf/23Douglas%20Report.pdf

- Aspiring to Excellence (the final report and recommendations of the independent inquiry into MMC led by Professor Sir John Tooke) http://www.mmcinquiry.org.uk/

- Health Select Committee Report on MMC http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/25/25i.pdf

All this attention has exposed issues concerning the future workforce requirements and the education and training of future doctors to a wide audience, not least current doctors in training and medical undergraduates concerned for their careers.

## UK self sufficiency in context

### Adoption of the self sufficiency goal

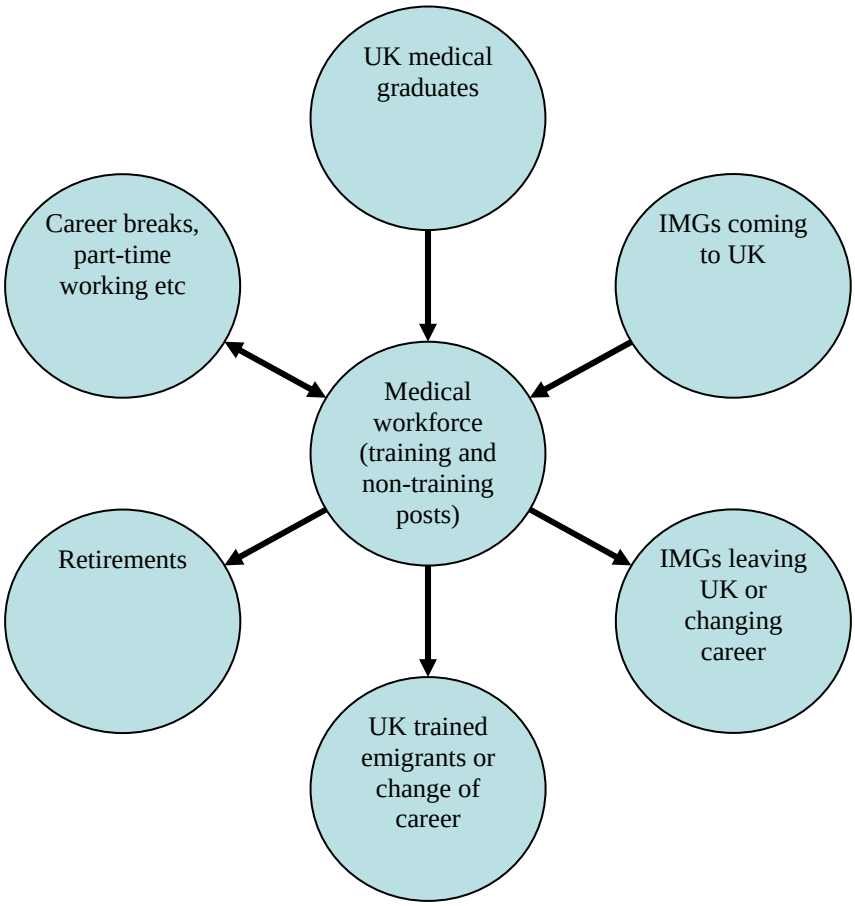
Historically the UK has not trained enough doctors to meet demand. The shortfall has been met by International Medical Graduates (IMGs) – foreign born and foreign trained doctors - coming to work in the UK, particularly from Commonwealth countries.

The UK has pursued the objective of moving to 'self sufficiency' in the supply of doctors since 1997, when the Medical Workforce Standing Advisory Committee (MWSAC) published its third report[4]. It recommended '*self-reliance'* as a long-term goal, which it described as the service relying largely upon UK doctors. It was careful though to explain that it was not aiming for a workforce comprised entirely of UK doctors (ie mobility should be expected but inward and outward flows should be kept broadly in balance).

The main inputs and outputs of the UK medical workforce are illustrated in Figure 1.

[4] Department of Health, Planning the Medical Workforce Medical Workforce Standing Advisory Committee (MWSAC), Third Report, December 1997

**Figure 1: Medical workforce inputs and outputs**




The objective of 'self sufficiency' recommended by MWSAC was accepted by the Government and the principal approach to achieving it has been the expansion of UK medical undergraduate training. However, recognising that ambitious workforce targets outlined in the NHS plan of 2000 could not be achieved through medical school expansion alone, given the lead in time for this to take effect, a number of other initiatives have also been pursued. These have included:

- Overseas recruitment (under an ethical code)
- Returner/retainer schemes
- Flexible working opportunities
- New employment contracts, pension and pay reform
- Refugee schemes
- New role development

At the same time the MMC reforms to Specialty Training have been implemented with one of its policy objectives being to reduce the length of time in training before

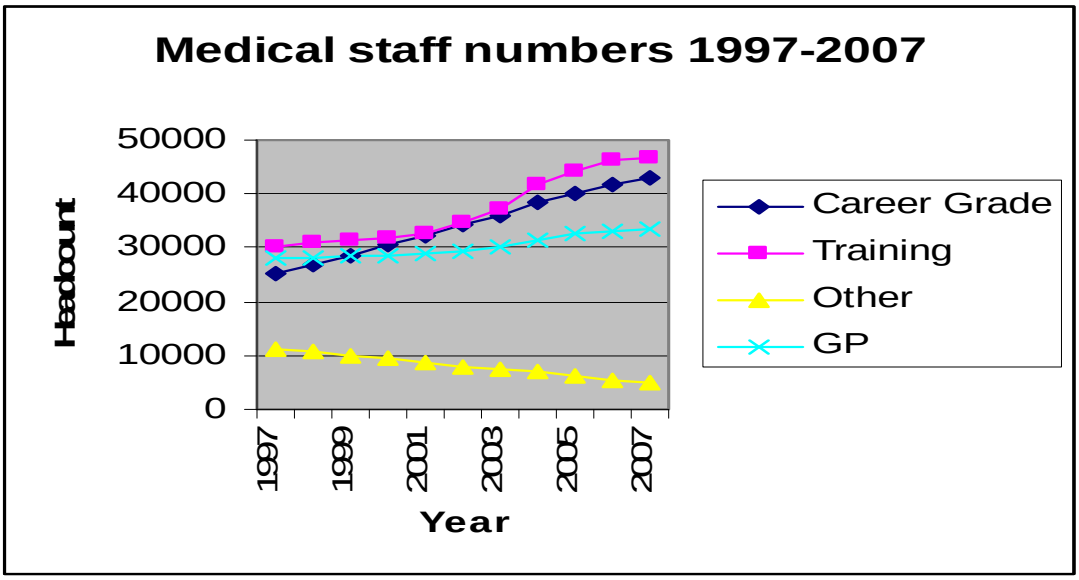
obtaining a Certificate of Completion of Training (CCT), which allows a doctor to work as a general practitioner or hospital consultant. Other factors influencing the supply of doctors include:

- The demographic shift within the workforce as the proportion of female doctors increases
- European Working Time Directive (EWTD) controls on hours
- Immigration rule changes
- Participation rates (part-time working, career breaks etc).

## Workforce growth

The growth in the NHS workforce achieved since 1997 has been considerable, supported to a very large extent by the contribution made by foreign born and foreign trained doctors. Medical staffing numbers in England illustrate this growth:

**Figure 2: Medical staff numbers (England) by grade**




## Contribution of IMGs

The contribution of foreign born or trained doctors within the UK is higher than the average of other OECD countries. It has, until recently, been relatively easy to obtain immigration permission to enter the UK as a doctor. These permissions have also historically given access to UK training opportunities, making the UK an attractive

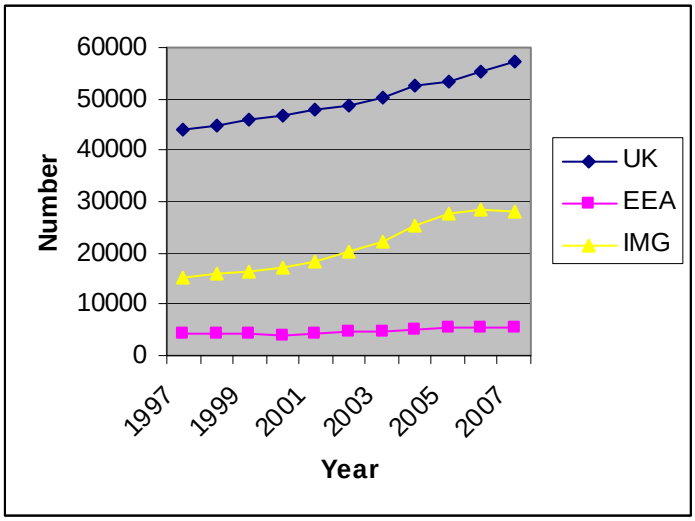
proposition for doctors wishing to pursue training. The UK's salaries for medical staff are also internationally competitive.

In 2000 the average proportion of foreign born doctors employed in OECD countries was 18%, but within the UK the figure was 33%[5], or around 50,000 doctors.

OECD analysis of professional registration data from the GMC suggests the number of foreign trained doctors registered in the UK was 69,813 in 2005, or 33.1% of total registrations. While not all may be registered with the GMC and actually practicing in the UK it can be assumed that the vast majority have registered with that purpose. This is borne out by more recent NHS workforce census data for England for 2007, which also indicate that around one third of the medical workforce qualified overseas.

Within the Hospital and Community Health Service (HCHS) the growth and make up of the workforce (at all grades) between 1997 and 2007, and increased contribution made by IMGs, is illustrated in Figure 3 below[6]:

**Figure: 3 HCHS (England) medical staff by country of qualification**



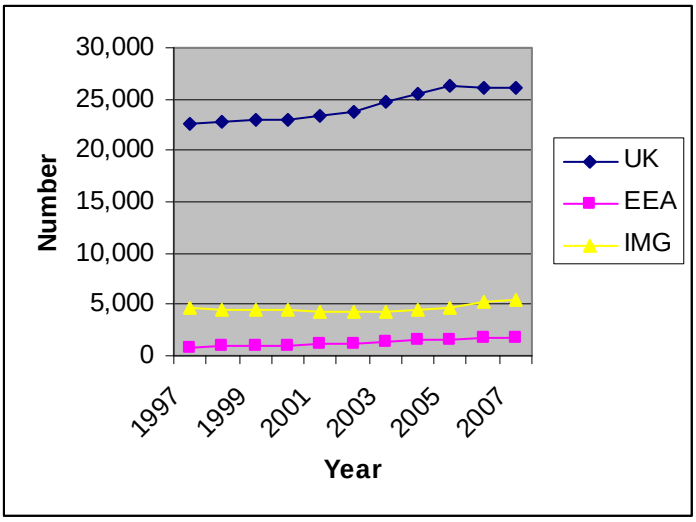

[5] International Migration Outlook: Sopemi 2007 edition OECD www.oecd.org/els/migration/imo
[6] NHS Information Centre 1997-2007 http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1997--2007-overview

The 1997 and 2007 breakdowns of the HCHS (England) workforce are:

| **Hospital medical staff by country of qualification** | **Number** | | **Percentage** | |
|---|---|---|---|---|
| | **1997** | **2007** | **1997** | **2007** |
| UK | 43,839 | 57,116 | 69% | 63% |
| EEA | 4,148 | 5,627 | 7% | 6% |
| Outside EEA | 15,282 | 27,955 | 24% | 31% |
| **Total** | 63,269 | 90,698 | 100% | 100% |

Within primary care the position has been more constant over the same period:

**Figure 4: GP medical staff (England - excluding registrars and retainers) by country of qualification**




| **GPs by country of qualification** | **Number** | | **Percentage** | |
|---|---|---|---|---|
| | **1997** | **2007** | **1997** | **2007** |
| UK | 22,556 | 26,197 | 80.4% | 78.5% |
| EEA | 855 | 1,657 | 3% | 5% |
| Outside EEA | 4,635 | 5,510 | 16.5% | 16.5% |
| **Total** | 28,046 | 33,364 | 100% | 100% |

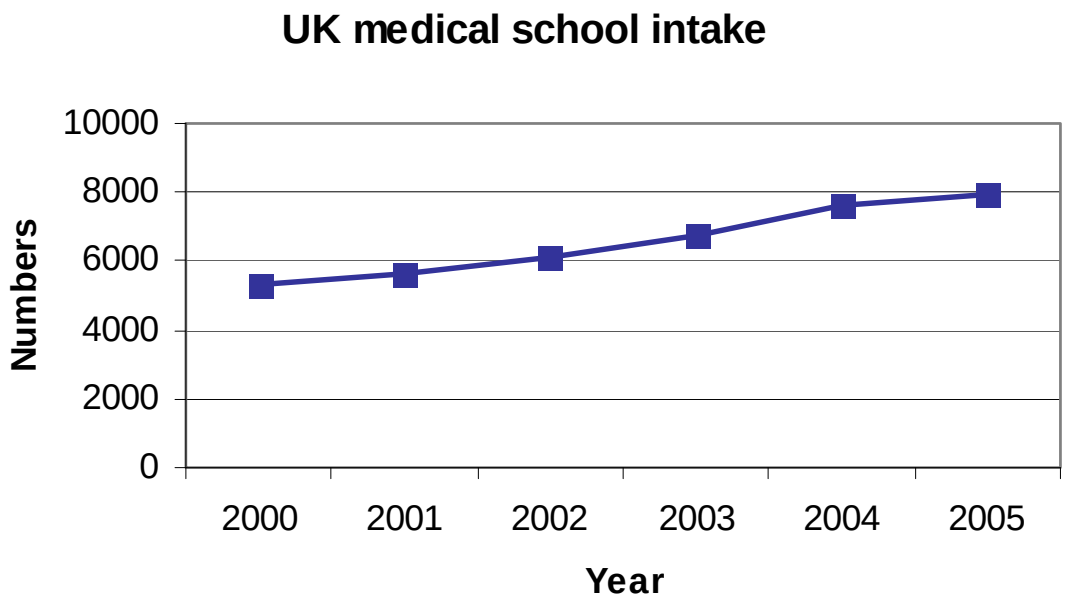
Overall the UK still has a lower number of doctors per head of population than other OECD countries. In 2006 there were 2.5 practicing physicians per 1,000 head of population in the UK, compared to an average across OECD countries of 3.0[7]. This is though an increase from an average of 1.9 per 1,000 in 1997.

[7] OECD Health Data 2008
http://www.irdes.fr/EcoSante/DownLoad/OECDHealthData_FrequentlyRequestedData.xls

## Increase in Medical School places

The principal approach to achieving self sufficiency has been to train more doctors in the UK. Between1997-98 and 2006-07 there has been a 71 per cent increase in medical school places. Intake to English medical schools has increased by 2,449 from 3,749 in 1997-98 to 6,194 in 2006-07. This is projected to increase the number of doctors graduating from medical schools to around 5,800 by 2008-09. This expansion is more than double MWSAC's 1997 recommendation of an increase of 1,000, and is the largest increase in undergraduate medical places since the foundation of the NHS.

**Figure 5: UK medical Graduate growth**




The numbers of medical undergraduates are expected to be sufficient to meet future NHS need, based on the assumptions about future participation rates, flexible working and retirement patterns assumed by MWSAC in 1997. More recent reviews by the Workforce Review Team also suggest that current supply will meet demand. In some quarters there is concern that supply may, in the short term, exceed demand and that there may be some medical unemployment as a result[8].

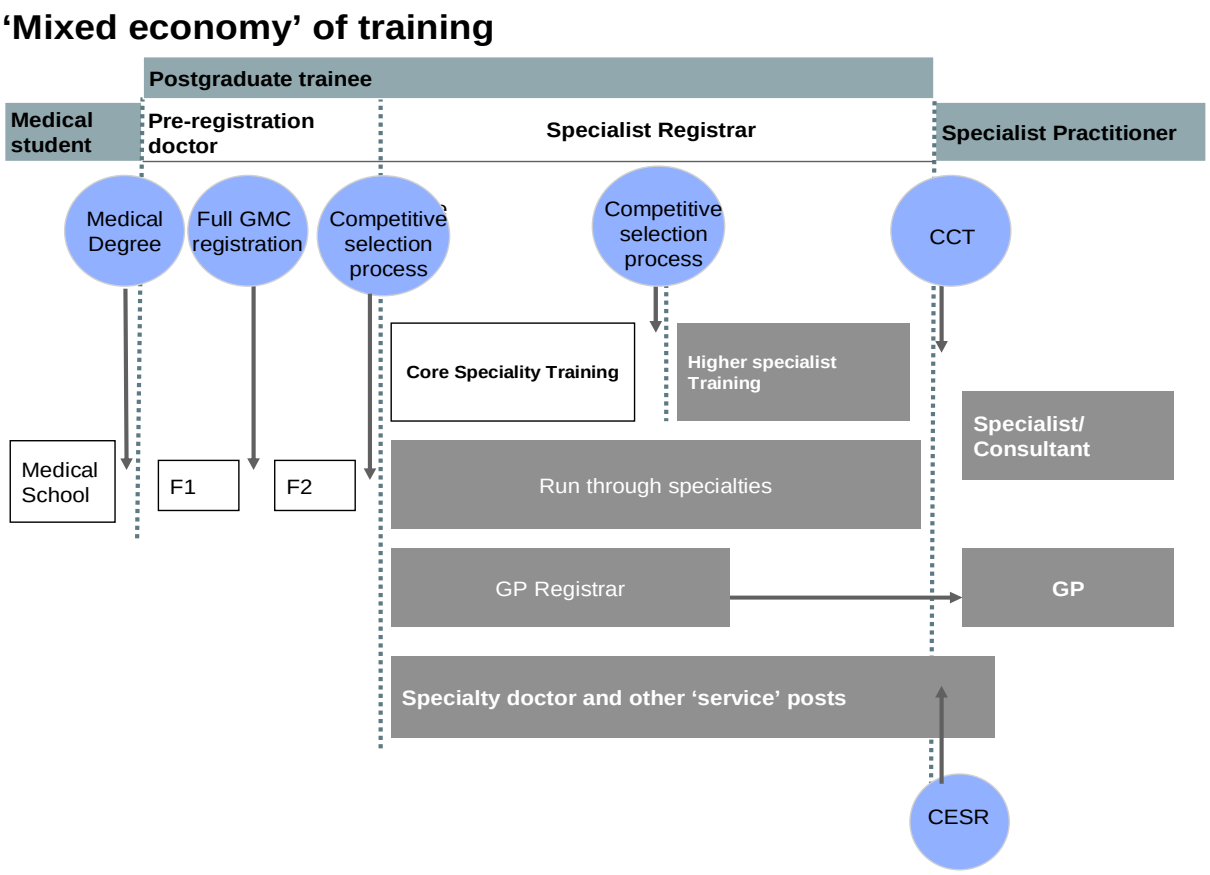
[8] BMA 2006 survey: shortage of SHO posts

## Current issues affecting the UK's progress towards self sufficiency

### Future role of doctors, structure of training and the medical workforce

The MTAS crisis of 2007 has reinvigorated debate about the future role of doctors, what the shape of the medical workforce should be and the training paths that should be followed. At present a 'mixed economy' is in operation for training as established by the MMC Programme Board. This consists of 'run through' and 'uncoupled' specialist training opportunities according to specialty. Alongside this training structure there are career/trust grade posts providing service at equivalent levels to training posts (but which are not recognised for training and will usually include a higher service component). The current structure is illustrated below.

**Figure 6: Current training and career structure**




For the future it is expected a consensus on the training structure will be established in time for implementation in 2010, informed by current work on the future role of doctors and the career structures as envisaged by employers and other stakeholders. There is also a commitment to develop arrangements that would allow

better transfer of doctors between specialties and into and out of service posts. This is described as 'modular credentialling'. A key issue will be to establish the right balance between the extent to which doctors undertake broader generic training before career opportunities become more limited as they specialise.

For NHS employers, the expansion of the workforce presents challenges of ensuring that doctors are trained to meet service needs. Achievement of self sufficiency will be dependent upon the training structures not only delivering the numbers of doctors but within the right specialties too.

Employers will also have to adjust to a workforce increasingly made up of qualified doctors with a significant reduction in the ratio of junior to senior positions expected. A fall in the proportion of doctors in training in the workforce from 36% to 18% is projected[9]. Service delivery will, therefore, increasingly be by doctors who have completed training. This will inevitably impact upon the nature of the roles fully qualified specialist doctors will perform as they undertake work previously carried out by the cohort of doctors in training. This raises issues about future medical and multidisciplinary team structures.

## Balance between specialties and doctors' expectations

Although the supply of medical undergraduates may be healthy once they enter postgraduate training there are issues, particularly in surgery and medicine, about the balance of doctors able to progress from basic to higher levels of training. At present there is just one higher surgical training place (ST4 – 6+) for every three doctors currently pursuing basic specialist training (ST/CT 1-3). In medicine the ratio is one higher training post for every two doctors completing basic training. These national ratios mask substantial regional variations with traditional centres of training (the large teaching hospitals) having a larger number of higher specialist training posts. Not all doctors are therefore able to progress the training they have pursued at basic level and must seek an alternative. Conversely there are other specialties where recruitment has been problematic.

From a workforce supply perspective, the number of higher training posts is linked to the anticipated demand for consultants. The fact that there are fewer higher level posts than at basic training level reflects that future demand in many specialities is limited, and catered for. For doctors who have embarked on a career in surgery or medicine however the realisation that progress to CCT and a consultant or specialist post may be difficult presents a problem. Transition to other specialties is not easy. There is little current scope for recognition of previous training between specialties. There are other career grade opportunities, such as the Specialty Doctor grade, but these have not historically offered much by way of progression and eventual

[9] MMC team data quoted in para 4.4.4 of the Tooke Report

achievement of specialist recognition (CCT equivalence). Although possible is not a well established or mapped career path.

There is also a need to expand the GP workforce, in line with the expectation that services will increasingly be provided in primary care. The training for general practice is different to the components of hospital training in surgery and medicine. Adjustment of training to support this shift, and reduce the numbers expecting to progress in surgical or medical careers will be difficult, not least as the current training programmes also deliver a substantial element of service. There are also proposals to lengthen GP specialty training from three to five years, although these have yet to be evaluated.

## European Working Time Directive 2009

Another pressure on the MMC reform programme and a challenge to future workforce supply is the EWTD 2009 requirement that no junior doctor should work more than 48 hours per week. Currently just over half of training, and the associated service commitment, is delivered within that limit[10]. The remainder of doctors work up to 56 hours. There is concern that in some specialties the limitations the EWTD places on working hours and therefore the experience junior doctors can gain means that some training programmes will need to be lengthened. There is also some concern that the doctors achieving CCT under the new training regimes and hours restrictions are lacking in experience, which may need to be accounted for in the first specialist post they take up.

## Participation rates and demographic change

Alongside the expansion of the medical workforce there has been a significant demographic shift with women now making up more than half the number of medical students and an increased proportion of the workforce. Attitudes towards work have also changed with increased expectations of greater flexibility in working arrangements. It is widely anticipated that participation rates will fall, but to what extent is not easily quantifiable. Economic circumstances and the sustainability of an acceptable standard of living and lifestyle on a reduced working commitment will play a significant part.

[10] April monitoring results http://www.nhsemployers.org/pay-conditions/pay-conditions-467.cfm

## Role of IMGs and immigration policy

Establishing a consistent position on the long term role of IMGs within the NHS and the immigration rules that should apply given the aim of self sufficiency has been something of a painful journey. The relative ease with which doctors could, under the 'permit free training' and then 'Highly Skilled Migrant Programme (HSMP)' routes, obtain permission to enter and work in the UK was one of the contributory factors leading to MTAS's withdrawal in 2007. Although it was known competition from IMGs had the potential to displace UK medical graduates from securing training posts (the Department of Heath later estimated the potential for displacement of UK graduates as being between 1,000 and 1,500) no effective controls were put into effect because of legal challenge and, arguably, poor planning.

The number of overseas doctors who would apply for the new specialty training posts (which offered the prospect of 'run-through' training to CCT and were therefore very attractive) was therefore significantly more than expected when MTAS was commissioned. Although the 'permit free training' route was closed in 2006 no changes were made to HSMP which remained an alternative route. When the Department of Heath sought to address this by issuing guidance to the service in 2006 not to engage IMGs in UK training posts unless there was no suitable UK/EEA candidate (the 'resident labour market test') this was challenged in the courts and, therefore, that change was not brought into effect over the course of 2007 recruitment.

In the event some 10,000 IMGs applied for posts in 2007, increasing the competition to 32,649 for 23,247 posts and overwhelming the system. Since February 2008 new IMGs applying to the UK are subject to amended immigration controls which do include restriction on the right to take up UK training posts.

The House of Lords later ruled that the retrospective application of the restrictions on access to training posts the Department of Health had sought to impose through its guidance to employers was unlawful, as far as it affected IMGs who had already received their immigration permissions, including HSMP, without such a restriction.

A recent consultation[11] and Department of Health response has established that the restrictions from February 2008 will remain in place for the time being, making it easier for UK graduates to progress by controlling the potential for competition from IMGs. However, IMGs whose immigration status was determined before February 2008 do retain the eligibility to access training posts conferred on them at the time, provided they do not change their immigration status. This has been a complicated situation and one which has no doubt confused IMG doctors about the opportunities available in the UK and served to increase the competition and risk of displacement for graduates of UK medical schools.

[11] http://www.mmc.nhs.uk/default.aspx?page=307

For the future there is no doubt that the flow of doctors into and out of the NHS will continue to allow for and indeed require IMGs, although perhaps not to the levels previously experienced. The UK is also a significant 'exporter' of doctors particularly to Australia, New Zealand and America. In an increasingly globalised healthcare economy there is no reason to expect that migration flows will be reduced. There is the suggestion that some UK trained doctors, unhappy with the MMC reforms and disruption in 2007, have actively pursued overseas opportunities they would not previously have considered. Employers too report that they have vacancies for doctors and attribute some of the shortage of supply (particularly locums) to a decline in the number of IMGs wishing to work in the UK, perhaps put off by the reduced prospects for entering UK training or confused by media reports in 2007 of there being "10,000 unemployed doctors"[12].

The Department of Health and NHS employers are keen to ensure that there remain opportunities for IMGs, either in service posts where there is no UK/EEA worker available or under reciprocal training or development exchanges or short term training posts under the supervision of Royal Colleges. These latter schemes can be operated under Tier 5 of the UK immigration arrangements and provide permission to enter the UK for work for up to two years.

In terms of the efforts the UK has made to ensure that its use of IMGs is not to the detriment of those countries from which IMGs are recruited agreements on recruitment have been entered into with ), India (2002) ,South Africa (2003) and China (2005). Since 2001 there has been a code of practice on ethical international recruitment in the NHS[13], including a list of 151 countries from which the NHS has agreed it will not recruit.

## Workforce planning

The upheaval of 2007 and detailed reviews of MMC have informed the Government's recent review of the NHS – the Next Stage Review. One of the key changes for the future is to re-establish a national advisory mechanism on medical workforce education and training issues, Medical Education England (MEE). Scotland already has an equivalent body. MEE will be supported by a 'centre of excellence' for workforce planning, the detail of which is yet to be determined. MEE's role will be to scrutinise and advise on the quality of workforce planning at national level and on the education and training pathways delivering the workforce supply.

---

[12] http://www.bma.org.uk/pressrel.nsf/wlu/PGAY-6ZWDMJ?OpenDocument&vw=wfmms http://www.bma.org.uk/pressrel.nsf/wlu/STRE-73GJDN?OpenDocument&vw=wfmms http://news.bbc.co.uk/1/hi/health/6584403.stm

[13] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097730

MEE will be expected to wrestle with the issues of:

- Establishing consensus on the future postgraduate training structure
- Examining and advising on workforce plans (at national level)
- Scrutinising the education and training commissioning (undertaken at regional level by Strategic Health Authorities)
- Advising on the development of curricula (integrating both professional and service perspectives)

There is also a clear intent that employers should have a greater role and say in workforce planning, reflecting their devolved responsibilities in other areas such as accountability for financial and service performance. 'A High Quality Workforce' states[14]:

"In a devolved NHS, to be successful, workforce planning must be devolved locally and assured nationally."

"Employers as providers of the services that people need will then be responsible for determining plans to develop the right workforce to provide safe, high quality patient services in the future. Most workforce planning will therefore be carried out at a local provider level".

## Finance

Expenditure on the NHS rose by an average real term growth of 7.4% between 2000 and 2006. Health expenditure as a percentage of GDP increased from 5.6% in 2000/01 to 7.3% in 2006/07. This period of substantial growth is now at an end. In 2007 the Comprehensive Spending Review (CSR) promised continued investment but at a lower rate of growth of 4% per annum. The expansion of the medical workforce will inevitably be limited by the finance available to NHS organisations.

The Tooke report identified that on the basis of replicating current trends and participation rates by 2050 medical labour costs would increase by 127% as the number of consultants was increased from 31,500 to 91,000 and GPs from 32, 700 to 83,000[15]. This is likely to be an unsustainable position financially leading many to question whether the number of doctors anticipated to qualify as specialists can be accommodated in the consultant and GP grades (assuming current levels of remuneration continue). In the absence of sufficient funding the alternatives are reform of the medical grades and/or introduction of new roles and remuneration structures, or curtailment of the growth anticipated.

[14] 30 June 2008, Department of Health (paras 101 and 104)
[15] Para 4.4.4 and Figure 4.26, Aspiring to Excellence

## Summary

Overall, despite the difficulties of MMC implementation, the UK remains on course to achieve self sufficiency according to most projections until around 2030. There is then some debate about whether further growth will be necessary depending upon varying projections of demand, supply and affordability.

The key points are:

- Growth in UK undergraduate numbers appears sufficient to deliver NHS 'self sufficiency' in overall numbers, at least until around 2030
- Clarity of the roles trained doctors will perform and the postgraduate training structures that will support training in the future is still to be determined
- There is a need to provide greater flexibility to transfer between different specialties and to 'rebalance' specialty training opportunities to reflect future service needs
- Funding growth will slow, encouraging the development of new specialist roles outside the current consultant and GP grades
- There will be less reliance upon IMGs (but IMGs will continue to make up part of the flow of into and out of the stock of UK doctors)
- Uncertainty over participation rates may impact upon future supply
- Achieving specialist accreditation will not guarantee employment at that level.

**David Grantham**
**Head of Programmes**
**NHS Employers**