Department of Health

Modernising Medical Careers (MMC) England

Recruitment to foundation and specialty training - Proposals for managing applications from medical graduates from outside the European Economic Area

Consultation

Deadline for responses: 10 am on 6th May 2008

Distributed by the Department of Health
6 February 2008

Initial distribution

This document is available from the Consultations section of the MMC website at www.mmc.nhs.uk The document has been sent to the following bodies to request their views:

- Academy of Medical Royal Colleges
- Academy of Medical Sciences
- Bangladeshi High Commission
- British Association of Physicians of Indian Origin
- British Medical Association (BMA)
- BMA Medical Students Committee
- Chief Executives and Directors of Workforce of Strategic Health Authorities
- Committee of General Practice Education Directors (COGPED)
- Commission for Equality and Human Rights (CEHR)
- Conference of Postgraduate Medical Deans in the UK (COPMeD)
- Devolved Administrations for Northern Ireland, Scotland and Wales
- English postgraduate deans
- Fidelio
- General Medical Council
- Hospital Consultants and Specialists Association (HCSA)
- Indian High Commission
- Medical Practitioners Union (MPU)
- Medical Research Council
- Medical Schools Council
- Members of the MMC England Programme Board
- Members of the BMA International Doctors Action Group:
  - All British Pakistani Physicians Association
  - Association of British International Medical Graduates
  - Association of Pakistani Physicians and Surgeons in the UK
  - Bangladeshi Doctors Association
  - British Arab Medical Association
  - British Arab Psychiatric Association
  - British Association of Indian Anaesthetists
  - British Indian Psychiatric Association
  - British International Doctors Association
  - British Pakistani Psychiatrists Association
  - Friends of Bangladesh Doctors
  - Indian Medical Association
  - Iraqi Medical Association
  - Medical Association of Nigerian Specialists & GPs in the British Isles
  - Medical Women's Federation
  - Postgraduate Centre for Refugee Doctors
  - Royal Colleges International Forum
  - Sri Lankan Medical and Dental Association in the UK
  - Zimbabwe Health Training Support
- MMC UK Co-ordinating Group
- National Association of Clinical Tutors (NACT)
- National Association Medical Personnel Specialists (NAMPS)
- National Coordinating Centre for Research Capacity Development (NCCRCD)
- NHS Employers
- Office of Strategic Health Authorities
- High Commission for Pakistan in the United Kingdom
- Postgraduate Medical Education and Training Board (PMETB)
- Remedy UK
- Royal Colleges and Faculties
- Sri Lankan High Commission
- UK Foundation Programme
- UK Anglo-Indian Doctors (UKAID)

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1. Purpose of this document

1.1 The purpose of this document is to set out proposals for managing applications for foundation and specialty training programmes in the National Health Service from medical graduates from outside the European Economic Area [EEA] and seek feedback from stakeholders and their representatives.

1.2 Any decisions made as a result of this consultation will not affect the 2008 recruitment into foundation training, which has already begun. They may affect future recruitment into postgraduate medical training in the NHS at both foundation and specialty level.

The deadline for responses to the proposals in this document is 10.00am on Tuesday 6 May 2008.

2 The Consultation Process and Where to Send Your Views

2.1 The Consultation Process

Criteria for consultation

This consultation follows the 'Cabinet Office Code of Practice'. In particular we aim to:

- consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy;
- be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses;
- ensure that our consultation is clear, concise and widely accessible;
- ensure that we provide feedback regarding the responses received and how the consultation process influenced the policy;
- monitor our effectiveness at consultation including through the use of a designated consultation co-ordinator; and
- ensure our consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full text of the code of practice is on the Cabinet Office website at:
http://bre.berr.gov.uk/regulation/consultation/code/index.asp

2.2 Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
Department of Health
2N16, Quarry House
Leeds
LS2 7UE

e-mail Mb-dh-consultations-coordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

2.3 Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for

disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

2.4 Where to send your views

To respond to the proposals in this document, please send your views using the attached feedback form by email **by 10.00am on Tuesday 6th May 2008** to:

Chief Operating Officer
MMC team
Department of Health
mmc.eligibility@dh.gsi.gov.uk

This document is available from the MMC website at www.mmc.nhs.uk

3 What is the problem under consideration?

3.1 Introduction: self-sufficiency in the medical workforce

3.1.1 For most of its history, the National Health Service has relied upon the contribution of doctors who trained outside Europe. Such migrant doctors play a valuable role in providing services across the UK. The NHS welcomes the exchange of professional skills and ideas across the international healthcare workforce, within a framework of ethical international recruitment that protects the interests of developing countries.

3.1.2 However, there has been significant investment in training UK medical students so that the UK could become less reliant on global supply. In 1997 it was decided to increase UK medical school places and four new medical training schools have been established. Medical school places in England have increased from 3,749 in 1997 to 6,451 in 2007 in order to achieve greater self-sufficiency. This means more UK medical graduates are entering the NHS every year. In order to progress their careers, these graduates need to complete their foundation training and then compete for entry into a specialty training programme.

3.1.3 The benefits of training for greater medical self-sufficiency are:

- **It ensures a sustainable supply of essential medical skills for the delivery of health and social care services.** The number of doctors who are trained can be planned to ensure that there will be sufficient doctors, GPs and consultants to provide the care and treatment needed.
- **It reduces reliance on global supply that can be uncertain and unpredictable.** The UK is an attractive destination for junior doctors who are seeking to extend their skills and undertake post-graduate training but there are other countries that rely on junior doctors trained outside their borders. For example, countries such as the USA do not train sufficient doctors to meet their demand. An increase in their demand for junior doctors can reduce the numbers willing to migrate to the UK to work in the NHS. It is much more difficult to recruit more senior doctors internationally who have completed their training, such as GPs and consultants. Doctors at this stage in their careers are settled and less willing to move themselves and families to work in a different healthcare system from the one in which they trained.
- **Patients benefit because most UK medical graduates stay and work in the NHS after their training.** The attrition rates for medical graduates from outside the EEA who come to do post-graduate training in the UK is much higher that that of UK medical graduate: over half leave within four years. Patients benefit from a stable workforce where there is less pressure to fill gaps and regularly induct new doctors in NHS healthcare governance, clinical protocols and systems.
- **It is cost-effective.** Because most UK medical graduates stay and work in the NHS after their training, they provide a good return on the investment made in training them. The return on investment from junior doctors who are IMGs is much lower; and because they do not stay, more doctors need to be trained.
- **It supports the World Health Organisation's Millennium Development Goals and the Government's ethical international recruitment policy.**

3.1.4 There is tension between a policy of greater self-sufficiency and allowing open competition for entry into post-graduate and specialty medical training programmes.

Most countries, whether they are pursuing self-sufficiency or not, give priority to their own medical school graduates when appointing to postgraduate and specialty training programmes.

3.1.5 Doctors from the EEA compete in open competition with UK nationals for foundation and specialty training programmes. In practice, very few EEA doctors who have trained in medical schools outside the UK apply for UK foundation and specialty training programmes. Fewer than 4% of applications for specialty training in 2007 were from EEA doctors who had not trained in a UK medical school. This level of competition is manageable.

3.1.6 There is far greater competition from doctors who are not EEA nationals. The UK provides high quality post-graduate, specialty training that is well regarded around the world. Doctors in training in the NHS are paid whilst they train – starting pay for doctors on specialty training programmes is around £28,000 pa. There are no fees for post-graduate and specialty training programmes. This makes the UK a very attractive destination for international medical graduates who want to progress their careers, particularly if their home country has limited opportunities for post-graduate and specialty training.

3.1.7 As the UK produces more UK trained doctors there is a need to reassess the way in which medical migration is managed. The Department of Health invited feedback from stakeholders about proposals for the management of medical migration in October 2007. This consultation sets out proposals for a revised medical migration policy that takes into account the outcome of the earlier exercise and the changes to the Immigration Rules that the Home Office put before Parliament on 6th February 2008.

3.2 What is the problem under consideration? Why is Government intervention necessary?

3.2.1 There are two main problems caused by allowing migrant doctors to participate in open competition for postgraduate training programmes alongside UK trained doctors.

3.2.2 First, competition for postgraduate training places from migrant doctors is likely to result in the displacement of UK trained doctors at an early stage in their training. Because such displaced UK-trained doctors are likely either to leave the UK to practise abroad or leave medicine altogether, the considerable investment of public money in their training up until the point of displacement is likely to have been wasted.

3.2.3 Secondly, migrant doctors have a much higher attrition rate than UK trained doctors (i.e. they tend to leave the NHS much sooner after joining than UK trained doctors). Accordingly, if they are recruited to training prgrammes there is in the future likely to be in gaps in the medical workforce. There are unlikely to be sufficient numbers of UK trained doctors to fill those gaps because most such doctors will already be in positions of their own (and it is unlikely that displaced doctors will be available or suitable to fill the gaps). Accordingly, it is likely that the only way of filling the gaps will be by further recruitment of migrant doctors, thereby perpetuating the cycle.

3.2.4 Government intervention is necessary to prevent the displacement of UK graduates by migrant doctors and ensure the long term sustainablity of the medical workforce.

Other forms of regulation, such as voluntary codes of practice, would not achieve this objective.

Displacement

3.2.5 The problem of displacement is demonstrated by the 2007 specialty recruitment exercise. In that exercise there were nearly 28,000 applicants for around 15,500 training places in England, a ratio of 2:1. Around 45% of applicants had trained outside the EEA. These doctors competed directly with UK graduates for specialty training places. Many of the migrant doctor applicants were working in the NHS to improve their chances of securing a training place.

3.2.6 At the end of the recruitment around 10,000 places were secured by UK medical school graduates. Around 4,800 were secured by doctors who trained outside the UK. Of these around 1,100 had been secured by UK nationals and doctors who had trained elsewhere in the EEA and nearly 3,700 had been secured by doctors who trained outside the EEA. The full results are in Table 1.

Table 1: Place of training and success rates in England, all eligible applicants Specialty recruitment Rounds 1 and 2 – 2007

	Successful		Unsuccessful*		Total	
	Number (*of which FTSTA*)	**%**	**Number**	**%**	**Number**	**%**
All UK graduates	10,060 (*1,480*)	74%	3,560	26%	13,620	100
Of whom:						
UK nationals	9,240 (*1,240*)	77%	2,750	23%	11,990	100
Other EEA nationals	240 (*40*)	63%	150	37%	390	100
HSMP* applicants	240 (*90*)	43%	330	57%	570	100
Other Overseas nationals	330 (*100*)	50%	340	50%	670	100
All International Graduates	4,760 (*1,670*)	33%	9,460	67%	14,220	100
Of whom:						
UK nationals	550 (*150*)	31%	1,260	69%	1,810	100
Other EEA nationals	560 (*150*)	36%	980	64%	1,540	100
HSMP applicants**	2,870 (*1,090*)	34%	5,480	66%	8,350	100
Other Overseas nationals	770 (*280*)	31%	1,750	69%	2,520	100

Note * This should be regarded as an estimate. Identifying exact numbers of unsuccessful applicants is complicated by the flow of applicants between England and the rest of the UK.

- Overseas nationals on the HSMP Highly Skilled Migrant Programme

3.2.7 The high level of competition meant that many appointable doctors would not secure a training post in 2007. To mitigate this problem an additional 1,200 training places were made available after the first round of recruitment.

3.2.8 It is estimated that over 1,300 applicants from UK medical schools were unable to secure a training place in 2007 because of competition from applicants who trained outside the EEA. This takes into account the availability of an extra 1,200 training places. There are other employment opportunities for UK medical graduates who are displaced but many may not be able to progress their careers in a training place if displacement continues.

3.2.9 The forecast for 2008 is that competition is higher than in 2007, with a forecast competition ratio of 3:1. Over half of applicants are likely to have trained outside the EEA. In open competition for places around 1,000 to 1,500 UK doctors are likely to be displaced and unable to secure a training place. There are likely to be similar

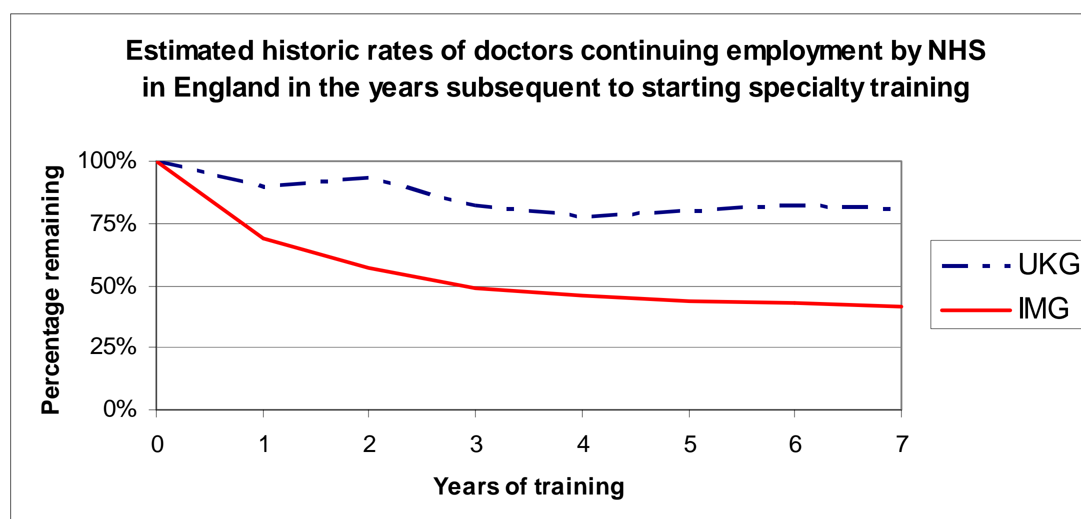
levels of displacement in future years.

3.2.10 It costs the NHS around £250,000 to £300,000 to provide a UK graduate with training up to the end of the Foundation Programme. This considerable investment is lost if UK graduates are displaced. If up to 20% of UK graduates are unlikely to be able to progress their careers in future, this may also affect the quality of applicants coming forward for medical training.

Attrition

3.2.11 The problem of attrition is demonstrated by the figures on length of time for which particular categories of doctors continue to be employed in the NHS after they have commenced their specialty training. Historical data indicates that past attrition rates has been significantly higher for doctors who have trained outside the UK than for UK doctors. Chart 1 shows attrition rates derived from the Medical and Dental Workforce Census between 1998 and 2006

Chart 1:



Notes a) Figures based on estimates from Medical Censuses 1998 to 2006.
b) Percentages of doctors can increase year on year as doctors return from periods not in the NHS or outside of England.
c) UK data include non-UK nationals who trained in UK medical schools who have historically higher attrition rates than UK nationals who train in UK medical schools.

3.2.12 Future IMG attrition will be influenced by a number of factors:

- The extent to which migrant doctors favour short term posts, possibly with a view to securing shorter term internationally recognised qualifications such as Royal College memberships.
- The extent to which future medical training regimes provide attractive opportunities and the incentive to stay with the NHS for longer.
- The extent to which ties to the UK are developed over the period of future training opportunities.
- Developments in the global demand for internationally mobile doctors, which may influence decisions on staying in the NHS.

3.2.13 The future structure of medical training is currently under development following the Tooke Review and the NHS Next Stage Reviews. The impact of these reviews on the

attractiveness of UK specialty training to migrant doctors is unclear. On the one hand, it seems likely that the more structured training opportunities are likely to be more attractive than those associated with the historically high rates of attrition. But on the other hand, the possibility of breaking down specialty training into core and higher stages suggests that the career benefits of a short stay in the NHS could increase.

3.2.14 The possibility that attrition rates have been influenced by changes to the immigration routes available to migrant doctors must also be considered. For example, the withdrawal of permit free training (which could not lead to settlement in the UK) in March 2006 and the resulting tendency for migrant doctors to seek leave to enter under other provisions of the Immigration Rules (which may lead to settlement in the UK) could have reduced attrition rates.

3.2.15 However, regardless of the medical training structure and immigration options, some significant differences between attrition rates are likely to remain. A stint in the UK to secure internationally recognised shorter-term qualifications remains a potentially attractive strategy for migrant doctors and the effect of ties to their home countries will always remain.

3.2.16 Furthermore, developments in the global demand for internationally mobile doctors may influence decisions on staying with the NHS;

- Demand for doctors in the home countries of migrant doctors may increase and attract them away from the NHS. For example, there are indications that the demand for doctors in India is set to increase substantially, partly in reflection of its economic growth. As Indian doctors are likely to be a substantial proportion of the migrant doctors in post-graduate training (around half of the IMGs successful in the 2007 recruitment were Indian) and are potentially likely to be attracted by opportunities in India, this represents a potential threat to the NHS's future supply of trained doctors.

- Demand for doctors could increase in countries that compete with the UK in the international market for doctors. For example, the American Medical Association has predicted a shortfall of physicians in upcoming years. This has implications for the likelihood of migrant doctors, who have proven themselves internationally mobile, staying with the NHS. The increased international competition also has unfavourable implications for the cost, quality and quantity of potential international replacements for specialty trainees lost through attrition.

3.2.17 On balance, the consideration of future attrition rates suggests that the very high attrition rates for migrant doctors of the past may not continue, but significant differences between the attrition rates of migrant doctors and UK doctors are likely to remain.

3.2.18 When specialty training places are filled by doctors with high attrition rates, extra costs are incurred because more training places are needed to provide the same number of trained doctors. Providing extra training to allow for high attrition puts pressure on the available training capacity in the NHS.

4. Options for managing medical migration

4.1. The Department considers that there are a range of measures to manage migration more effectively, including the following.

4.1.2 **Departmental guidance**

The Department of Health could issue guidance requiring NHS employers to appoint migrant doctors to post-graduate training places only where there was no suitable UK or EEA doctor.

The advantages of such an approach are that UK displacement would be minimised and migrant doctors would be able to take up training places in shortage specialties and locations.

The disadvantages are that such guidance would reduce the opportunities for migrant doctors to take up post-graduate training places in the NHS, irrespective of whether they may have stayed longer-term in the NHS and irrespective of whether they may have come here with the specific purpose of undertaking training in the NHS (and potentially settling in the UK in the long term). The guidance would not impact on the attrition from training of those migrant doctors who successfully competed for a post-graduate training place.

There are also potential legal obstacles to the implementation of such guidance which are discussed further below.

4.1.3 **Increase training places**

Training places could be increased until most appointable UK doctors had secured a place.

The advantages of this option are that migrant doctors would be able to compete directly and fewer UK medical graduates would be displaced.

The disadvantages with this option are that there is a finite capacity for training in the NHS, the costs would be substantial and there could be unemployed doctors after training. A more fundamental problem is that providing extra training could attract more migrant doctors to the UK, increasing the competition for UK doctors. Many of the extra training places are likely to be taken by migrant doctors if they are able to compete directly for them with UK graduates. To ensure that most appointable UK doctors had a training place, the number of extra training places would need to be increased proportionately to the increased supply migrant doctors. This makes increasing training a very expensive option.

It is not considered to be feasible to protect the position of UK medical graduates in a system of open competition, where there is large external supply, by simply increasing training places.

4.1.4 **Reduce the number of UK medical graduates**

Open competition could be allowed to continue and the number of UK medical graduates could be reduced so that the numbers would be low enough for most to be able to progress their careers.

The advantages of this option are that IMGs would be able to compete directly and the best doctors available would be trained.

The disadvantages of this option are that it would take up to 10 years to close medical schools and reduce the number of medical school places significantly. Many thousands of UK medical

graduates would be displaced in the meantime. The costs would be substantial, though offset by lower pre-registration training costs in due course. The impact on the morale of UK medical school students and graduates would be great. It would be difficult to predict the right level of training to maintain a balance between external and internal supply, and taking account of the impact of high IMG attrition rates.

A more fundamental disadvantage is that this option moves the UK away from self-sufficiency, and back to reliance on external supply, with all the risks to future patient care and services that this entails.

4.1.5 Charge for post-graduate training

There are various options to recover the costs of foundation and specialty training from doctors who do not continue to work in the NHS after their training. These include a salary reduction that could be reinstated over the life-time of an NHS career or a fee to be paid if a doctor does not work for a set number of years in the NHS after training.

The advantages of this option are that the return on investment in training is secured and that migrant doctors would be able to compete directly for training places.

The disadvantages are that such an arrangement is likely to require legislation and would take time to implement. It would be difficult to enforce recovery of fees levied after training if the doctor leaves the UK. Fees may not deter migrant doctors and this solution may not solve the problem of displacement unless fees could be set a level sufficient to deter most migrant doctors. This may impact on the quality of applicants.

4.1.6 Changes to Immigration Rules

The Home Office is making changes to the Immigration Rules that will come into effect on 29th February 2008, subject to the parliamentary process. Highly Skilled Migrants, Tier 1 (General) Migrants and their dependants will, in certain circumstances, have a condition imposed on their leave to enter or remain in the UK prohibiting them from taking employment as a doctor in training. “Employment as a Doctor in Training” means employment in a medical post or programme offered by the National Health Service which has been approved by the Postgraduate Medical Education and Training Board as a training programme or post.

The advantage of this solution is that the changes to the immigration rules apply only to new migrants in the categories above. They will have prospective impact and will not disadvantage migrant doctors who are currently able to apply for post-graduate training places in direct competition with UK and EEA graduates. The changes will reduce the potential for the displacement of UK doctors in the long-term but will have limited impact in 2009 and 2010.

The disadvantage of this solution is that it is not a solution to the displacement of UK doctors in the short-term. It is estimated that if no further action is taken in the range of 700 to 1000 UK doctors will be displaced and unable to secure a training place in 2009, 2010 and beyond.

5. The Department's preferred option

Departmental Guidance

5.1 The Department has reviewed the above options and at present the preferred option is to implement guidance that will give priority to UK trained doctors. An impact assessment providing a more detailed options assessment is available on the MMC website at www.mmc.nhs.uk.

5.2 A draft of the guidance that the Department is presently minded to introduce is appended as Annex A. In summary, the impact of the guidance is intended to be as follows:

It will restrict doctors who do not fall into the following categories from taking up post-graduate training posts in the NHS, unless there is no suitable applicant who does fall into the following categories:

- Applicants who have completed a medical degree in the UK and who have been granted leave to enter or remain in the UK which would enable them to start work in the position applied for without a work permit or 'switching' into another category of the Immigration Rules.
- UK Nationals
- Applicants with indefinite leave to remain in or indefinite leave to enter the UK
- Applicants granted leave to enter or remain in the UK under the paragraphs of the Immigration Rules relating to Spouses or Civil Partners of persons settled and present in the UK.
- Applicants with the right of abode in the UK
- EEA and Swiss Nationals
- A family member of an EEA national (residing in the UK) with a valid UK resident document confirming that the individual in question has a right of residence in the UK
- Dependents of non-EEA nationals with indefinite leave to remain or indefinite leave to enter the UK
- Refugees

Post-graduate training is defined as - a medical post or programme, or a group of medical posts or programmes, recruited to as part of an individual recruitment episode offered by the NHS which has been approved by the Postgraduate Medical Education and Training Board as a training programme or post.

5.3 It is important to note that refugees and migrant doctors who have trained in a medical school in the UK will be exempt from the general restriction. Also that the guidance will not prevent migrant doctors who are not in the categories listed above from working in a service post in the NHS or from filling a training post in a shortage area or specialty.

5.4 **Potential legal constraints**

The Department issued similar guidance in 2006 that had the effect that doctors from outside the EEA, including those on the Highly Skilled Migrant Programme, should be considered for specialty training programmes only if there was no suitable UK or EEA applicant. The guidance was not intended to prevent migrant doctors on the HSMP from applying for service posts in the NHS.

5.5 This guidance was challenged by way of judicial review proceedings. In February 2007 the High Court found the Department of Health guidance to be lawful. The guidance was not implemented in 2007 because the Court's judgement was received after the 2007 specialty recruitment process had started. On appeal, the Court of Appeal decided that the Secretary of State for Health had no power to issue the guidance and that it was unlawful. Copies of the High Court and Court of Appeal's judgments are available free of charge on-line via the BAILII website (http://www2.bailii.org/ew/cases/EWHC/Admin/2007/199.html (High Court) and http://www2.bailii.org/ew/cases/EWCA/Civ/2007/1139.html (Court of Appeal)).

5.6 The Department has appealed against the Court of Appeal ruling. The House of Lords granted leave to appeal and the case will be heard in the House of Lords on 28th February 2008. The Department will carefully consider the decision of the House of Lords when it is given and will abide by the Court's ruling.

5.7 **Previous stakeholder engagement**

Before the Court of Appeal hearing the Department invited feedback on proposals to maximise the opportunities for UK medical graduates to take up foundation and specialty training. The Department proposed to re-implement the policy guidance to give priority to medical graduates who are UK or EEA nationals. The relevant document can be viewed on the MMC website at www.mmc.nhs.uk

5.8 The Department also sought views on potential exemptions to the guidance for:

UK Medical Graduates from outside the EEA – approximately 7.5% of UK medical school graduates are from outside the EEA. The attrition rate for these doctors is generally low.

Refugees – a small number of refugees are medical graduates. The NHS supports refugee doctors to get back into medical practice. Exempting refugees would have very little impact on the displacement of UK doctors.

5.9 The question of **fixed term training appointments** was also raised and whether these should be exempt from the DH guidance. This is less of an issue with the changes to specialty training introduced in 2008.

5.10 Over 750 organisations and individuals offered feedback on the proposals. Most respondents accepted the need to managing medical migration. The Medical Schools Council, Royal Colleges, Deaneries and Strategic Health Authorities recognised the enormous contribution of IMGs to the NHS. However they overwhelmingly supported reintroduction of guidance to protect the investment made in UK medical training and provide UK medical graduates with opportunities to progress their careers.

5.11 NHS Employers found no consensus of views across their constituents. They suggested reducing the number of medical graduates and encouraging doctors to move to unpopular specialties and locations. They supported an increase in training places only where there was a clear service need. The majority of Trusts that responded individually agreed with the DH proposal. Some employers preferred open competition to ensure the best person was appointed.

5.12 The Indian High Commission, BMA, Remedy UK, BAPIO and other organisations representing the interests of migrant doctors did not support the reintroduction of guidance, mainly because of the impact on migrant doctors currently in the UK. The majority of responses were from individuals. Over 80% of individuals were migrant

doctors. Over 80% of individual responses did not support the reintroduction of guidance.

5.13 Concern was raised about the 80% figure then quoted for IMG attrition rates. This figure was based upon an analysis of the actual attrition rates of IMGs working in the NHS up to 2006. Data has now been analysed for the most recent cohort of IMGs in training posts, including doctors on the HSMP. This shows an improved attrition rate of around 60%. The rate is still much higher than the comparable attrition rates for UK medical graduates of around 20%. Further discussion about attrition rates is provided in Part 1.

5.14 Alternative solutions offered were: to stop the PLAB test, stop the HSMP, to increase training places to accommodate all UK and migrant doctors, to charge for training and to improve workforce planning. It was also recognised that there was a need to protect the investment in UK training and that there was a duty to those who had trained in the UK to give them a reasonable opportunity to complete their training. The Department considered that none of the solutions offered a practical way to address the immediate problem of UK doctors being displaced from access to training.

5.15 There was strong support for exempting both refugees and migrant doctors who had trained in medical school in the UK.

5.16 A more detailed summary of responses is available on the MMC website at www.mmc.nhs.uk

Final decision

5.17 The eventual decision as to whether or not to implement guidance and, if so, in what form, will be taken in the light of the outcome of this consultation exercise, an equalities impact assessment and the decision of the House of Lords.

5.18 The Department will continue to investigate alternative solutions for the future as well as seeking ways to improve workforce planning.

5.19 The Department will also continue to work with the medical Royal Colleges, the Home Office, the Department for International Development and the health service, to extend opportunities for doctors from sub-Saharan Africa and elsewhere, to access essential specialty training that is unavailable in their own countries. This will build on the opportunities already available through the Medical Training Initiative.

6. Equalities Impact Assessment

6.1 The Department will use evidence collected through this consultation to inform an Equalities Impact Assessment. Statistical information on the nationality, gender and ethnicity of UK medical students and applicants to the 2007 specialty recruitment will also be considered. The outcome of the Equalities Impact Assessment will be published.

6.2 Accordingly, the Department wishes to hear the extent to which people consider whether;

- The differential effect of the guidance is justifiable in seeking to achieve the aims specified
- There could be adverse effects on equality that may not be justifiable
- There are options for mitigating the effects on different population groups
- There are opportunities for promoting equality in some way
- The exemptions for refugees and migrant doctors who have trained in a medical school in the UK are justifiable.

6.3 In providing comments on potential differential (positive or negative) effects on equality, the Department is also seeking views on;

- which group or groups may be affected the most,
- whether it is believed that the effects will be
  - widespread or confined to a small number of people
  - substantial/ severe, moderate or minor,
- how likely are the effects to actually happen, and
- If you have particular evidence that you wish to cite to support your view.

6.4 The Department of Health is committed to fulfilling its obligations on equality in relation to:

- Age
- Disability
- Gender
- Race[1]
- Religion and belief
- Sexual orientation

[1] The Race Relations (Amendment) Act 2000 defines “race” as covering race, colour, nationality, and ethnic or national origins.

7. Providing Feedback - Your views

Proposals for managing applications from medical graduates from outside the European Economic Area – Feedback Questionnaire

Name

Organisation (if responding as an individual please indicate):

Address

Occupation:

If doctor where are you doing/did you do your undergraduate training? (delete as applicable)

UK EEA other Non EEA

7.1 You are asked to provide your views on the following questions.

		Yes	**No**
1	Do you agree that the problems identified in this document exist?		
2	Do you agree that the problems identified in this document are of the scale identified?		
3	Do you agree that the problems identified in this document require intervention?		
4	Are there any other relevant problems that have not been identified in this document? **Please specify**		

5	Assuming that there are problems requiring intervention, has the Department correctly identified the options for resolving those problems, or are there other potential options? **Please specify**		
6	Has the Department correctly identified the advantages and disadvantages of the options?		
7	Is there any further information that the Department should take into account when assessing the scale of the advantages and disadvantages of the options? **Please specify**		
8	Do you agree that issuing Departmental guidance giving priority to UK and EEA applicants for postgraduate training programmes (and to other identified categories of applicant) would resolve the problems identified in this document?		
9	Do you agree that issuing Departmental guidance giving priority to UK and EEA applicants for postgraduate training programmes (and to other identified categories of applicant) is the best way of resolving the problems identified in this document?		
10	Do you agree that the categories of applicant identified in the draft Departmental guidance set out in Annex A should be accorded priority for postgraduate training programmes?		
11	What do you consider the likely impact of such Departmental guidance would be? **Please specify:**		
12	Do you consider that any changes should be made to the draft Departmental guidance? **Please specify:**		

7.2 In addition, if you have views on issues arising out of this consultation document that are not addressed by the questions referred to above, we would like you to provide them too. Please add your comments below:

7.3 Please send your views by completing this feedback questionnaire and the following monitoring questions.

Please return by email **by 10.00am on Tuesday 6th May 2007** to:

Chief Operating Officer
MMC team
Department of Health
mmc.eligibility@dh.gsi.gov.uk

7.4 Monitoring Questions

This consultation will inform the EIA we are undertaking on the development of the policy for managing applications from medical graduates from outside the European Economic Area. Completion of this form will support the Department to assess the impact of the proposals.

Completion of this form will not affect the way in which your responses to the consultation are considered.

You do not have to answer any of the questions if you do not wish to. Your responses will still be considered.

Gender (delete as applicable)

Male Female Transgender Transsexual

Do not wish to declare ☐

Nationality (delete as applicable)

UK Other EEA Non-EEA

Do not wish to declare ☐

Ethnic Group

Choose ONE section from A to E, then indicate your cultural background

A. White ☐

British ☐

Irish ☐

Any other white Background please state ☐

____

B. Mixed ☐

White and Black Caribbean ☐

White and Black African ☐

White and Asian ☐

Any other Mixed background, please state ☐

☐

C. Asian or Asian British ☐

Indian ☐

Pakistani ☐

Bangladeshi ☐

Any other Asian background, please state ☐

☐

D Black or Black British ☐

Caribbean ☐

African ☐

Any other Black background, please state ☐

☐

E Chinese or other ethnic group ☐

Chinese ☐

Any other, please state ☐

☐

Do not wish to declare ☐

Survey of Disabilities

Do you consider yourself to have a disability? (delete as applicable)

Yes No Do not wish to declare

Please indicate which option(s) below best describe your disability

Visual impairment ☐

Hearing impairment ☐

Speech impairment ☐

Walking impairment ☐

Physical co-ordination impairment ☐

Reduced physical capacity ☐

Severe disfigurement ☐

Learning difficulties ☐

Mental Illness ☐

Progressive Conditions ☐

Neurological Conditions ☐

Other ☐
please describe

Religion or Belief

Atheism ☐

Buddhism ☐

Christianity ☐

Hinduism ☐

Islam ☐

Jainism ☐

Judaism ☐

Sikhism ☐

Other ☐

please describe

[ ]

Do not wish to declare ☐

Annex A

Draft Guidance

Separation of applications

1. Once the final date on which applications could be made for a training position included in the individual recruitment episode has passed**,** recruiters should separate all applications received on or before that date into two separate categories:

Category 1

2. Category 1 will consist of applicants who fall into one or more of the following categories:

    A) Applicants who have completed a medical degree in the UK and who have been granted leave to enter or remain in the UK which would enable them to start work in the position applied for without a work permit or 'switching' into another category of the Immigration Rules.
    B) UK Nationals
    C) Applicants with indefinite leave to remain in or indefinite leave to enter the UK
    D) Applicants granted leave to enter or remain in the UK under the paragraphs of the Immigration Rules relating to Spouses or Civil Partners of persons settled and present in the UK.
    E) Applicants with the right of abode in the UK
    F) EEA and Swiss Nationals
    G) A family member of an EEA national (residing in the UK) with a valid UK resident document confirming that the individual in question has a right of residence in the UK
    H) Dependents of non-EEA nationals with indefinite leave to remain or indefinite leave to enter the UK
    I) Refugees

Category 2

5. Category 2 will consist of all applicants who do not fall into one or more of the categories listed under Category 1.

Consideration of Applications

6. Recruiters should first consider only candidates in Category 1 for appointment to the relevant training position. Candidates in Category 2 should only be considered for appointment to a training position if unfilled training positions remain after all suitable Category 1 candidates have either accepted or rejected an offer of a training position.

Assessment of applications

7. A separate assessment should be made for each individual recruitment episode for a training position.

8. The separation of applications into Categories 1 and 2 should be based on an assessment of each applicant**'**s status on the final date on which applications could be made to a training position included in an individual recruitment episode. Assessment should be based on an applicant's valid leave to enter or remain in the UK on that date. An

applicant's valid leave to remain or enter in the UK should usually be demonstrated through a passport or other valid travel document and a letter from the Home Office confirming that leave has been granted.

Definitions

9. Individual recruitment episode - The single process beginning with the advertisement of a training position and concluding when all offers made to applicants who applied in response to that advertisement have been either accepted or rejected.

10. Training position - a medical post or programme, or a group of medical posts or programmes, recruited to as part of an individual recruitment episode offered by the NHS which has been approved by the Postgraduate Medical Education and Training Board as a training programme or post.

11. Indefinite leave to remain – leave granted under the Immigration Act 1971 which allows recipients to enter and remain in the country without any time limit on their stay and to take up employment or study, without restriction

12. Spouses or civil partners

13. Right of abode – leave granted to certain Commonwealth subjects under the Immigration Act 1971.

14. Refugee – An asylum seeker recognised by the UK Government as meeting the terms set out under the 1951 UN Convention on the Status of Refugees

15. Work permit – A permit granted under paragraphs 128 – 135 of the Immigration Rules which allows the holder to work in the UK as directed by the Secretary of State.

16. Suitable applicant – An applicant who has been assessed as meeting the person specification and eligibility criteria for a training position.

17. Applicant who has completed a medical degree in the UK - An applicant who has successfully completed and obtained a recognised UK degree in medicine or dentistry from a UK publicly funded institution of further or higher education.

18. Immigration Rules – The rules laid down by the Secretary of State as to the practice to be followed in the administration of the Immigration Acts for regulating entry into and the stay of persons in the United Kingdom

19. Switching – The process by which an applicant changes the category of the Immigration Rules under which they are granted leave to enter or remain in the UK.