

Memorandum of evidence from the BMA to the Lords Select Committee on Economic Affairs inquiry on Brexit and the Labour Market

April 2018



The British Medical Association (BMA) is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. The BMA is committed to safeguarding the future of the profession and the patients we serve and it is essential we are consulted and involved in consultations to inform negotiations to leave the European Union (EU) which would affect the medical profession and patients.

The NHS has always relied on international doctors to provide a safe and sustainable level of service for patients and to fill gaps in the UK labour market. In 2015, more than 45,000 doctors working in the NHS (almost 30% of the medical workforce) received their primary medical qualification (PMQ) from a country outside the UK¹. These international doctors, alongside those working in research and medical education, are essential members of the UK's medical and academic workforce, and the NHS is reliant upon these highly skilled migrant workers to provide a high quality, reliable and safe service to patients.

There is a risk that following the UK's withdrawal from the EU, the potential imposition of tougher immigration restrictions will not only hinder the safe staffing of health services but also threatens to deter doctors, researchers and medical students from wanting to work and study in the UK at all. This would be to the detriment of the NHS, UK medical schools, universities, research institutes and public health. Medicine thrives on the interchange of experience, knowledge and training across countries and backgrounds. Closing our borders and placing undue restrictions on the UK labour market would be bad for medicine, bad for patient care and bad for medical research.

Executive summary

- In 2014, more than 45,000 doctors working in the NHS (almost 30% of the medical workforce) received their primary medical qualification (PMQ) from a country outside the UK². Data shows 15% of all UK academic staff originated from other EU nations³ with additional staff working in public health. These individuals have enhanced the UK health system over the years, improving the diversity of the profession to reflect a changing population, bringing great skill and expertise to the NHS and filling shortages in specialties which may otherwise have been unable to cope.
- The Secretary of State for Health has outlined proposals to expand the supply of UK trained doctors to reduce the NHS's reliance on doctors from overseas. However, given the length of time taken to train a senior doctor, the NHS will continue to be reliant upon doctors from the EU and overseas in the short to medium term to fill vacant posts.
- The Secretary of State for Health has also confirmed the NHS will need to 'continue to recruit doctors from overseas' to fulfil its commitment to deliver 5,000 extra GPs by 2020/21.
- Further restrictions on the ability of the health and social care sectors to employ overseas workers will only serve to worsen staff shortages seen across the NHS and

¹ GMC (2016) The state of medical education and practice in the UK.

² GMC (2016) The state of medical education and practice in the UK.

³ The Academy of Medical Sciences: Academies publish joint statement on research & innovation after the EU referendum, 19 July 2016

social care sector, which have both been struggling to cope with mounting pressures and significant staff shortages.

- Consequently, any future immigration system must be flexible enough to allow highly skilled doctors, medical academics and researchers from the EU and overseas to be recruited, where the resident workforce cannot produce enough suitable applicants to fill vacant roles and meet needs.

What level of net migration is necessary for the UK labour market to function effectively? How reliant is the UK labour market on high, medium or low skilled migrant labour?

1. The NHS has always relied on international doctors to provide a safe and sustainable level of service for patients and to fill gaps in the medical workforce:

- in 2014, nearly 35,000 doctors working in the NHS (22.3% of the UK medical workforce) received their primary medical qualification (PMQ) from a country outside the European EEA⁴
- a further 10,000 doctors (6.6% of the UK medical workforce) receiving their PMQ in another European Economic Area (EEA) country⁵
- data shows 15% of academic staff employed in the UK come from other EU nations⁶ with additional staff working in public health.

2. Within the UK, data from the GMC on licensed EEA graduates by country reveals that Northern Ireland has a relatively high reliance on EEA graduates (8.8%), which can likely be attributed to the large number of Republic of Ireland graduates working there. England has a higher reliance on EEA doctors (8.2%) than Scotland (6.6%) or Wales (6.4%). The Specialist Register⁷ has a particularly high proportion of European graduates (14.6%) and it is worth noting that surgery and ophthalmology are particularly reliant on EEA graduates, where over a fifth (20% and 24% respectively) were EEA graduates⁸.

3. Doctors work closely alongside a range of individuals, including nurses, paramedics, allied health professionals, clinical scientists, lab and theatre technicians, porters and cleaners, many of whom are likely to be EU nationals or from overseas⁹. All of these individuals play an integral role in the efficient and safe running of the health service.

4. There are huge challenges with recruiting and retaining social care professionals, with an estimated vacancy rate of 5.4%, which rises to 7.7% in domiciliary care services. High turnover is also an issue, with an overall turnover rate of 25.4% equating to around 300,000 workers

⁴ BMA, 2014 Medical Workforce Briefing, 2015, pg. 11.

⁵ BMA, 2014 Medical Workforce Briefing, 2015, pg. 11.

⁶ The Academy of Medical Sciences: Academies publish joint statement on research & innovation after the EU referendum, 19 July 2016.

⁷ The GMC's Specialist Register is a register of doctors who are eligible for appointment as substantive, fixed term or honorary consultants in the health service in the UK (http://www.gmc-uk.org/doctors/register/search_stats.asp).

⁸ GMC: Our data about doctors with a European primary medical qualification http://www.gmc-uk.org/static/documents/content/GMC_data_on_EEA_doctors_in_the_UK.pdf

⁹ The BMA is a member of the Cavendish Coalition⁹, a coalition of more than 30 health and social care organisations, which is seeking certainty for the current health and social care workforce originating from the European Economic Area (EEA) to remain in the UK.

leaving the profession each year¹⁰. The BMA believes this can be addressed by giving care workers nationally agreed terms and conditions of service, in order to encourage more people into those careers.

5. Migrant workers make up a large proportion of the adult social care workforce. One in five of the adult social care workforce in England were born outside of the UK¹¹ and a number of social care professionals currently working in the UK come from other EU countries. In 2015, 6% of those working in adult social care were from other EU countries, equating to nearly 80,000 jobs¹². The government must take steps to give EU nationals working in the health and social care sector certainty regarding their future status in the UK as quickly as possible to prevent any potential further reduction in the social care workforce.

6. Any future review of UK labour market policy, or potential immigration systems, must take into account the needs of the NHS for both skilled and unskilled labour. It should be based on the needs and demands of the service, ensuring gaps in workforce are filled where they cannot be met by UK nationals in the short to medium term. This will be vital in provide a high quality, reliable and safe service to patients.

What would be the impact of a reduced ability to source foreign workers on British businesses?

7. While the prime minister has pledged to retain the UK's openness to international talent and stated the UK 'will always want immigration, especially high-skilled immigration¹³, she also confirmed that the number of people coming to the UK to work would be capped. We have questions about how the NHS will be able to continue to provide to a high quality, reliable and safe service to patients without access to doctors from the EU and overseas.

8. For example, the government has committed to increasing GP numbers by 5,000 by 2020/21 but we are concerned that recruiting these extra GPs and introducing policies to encourage greater access, such as seven day services, will not be possible based on either the latest GP trainee figures, or as the Secretary of State has confirmed, without medical recruitment from overseas¹⁴. According to figures released by the GP National Recruitment Office, one in five trainee posts in England are currently unfilled and we note that alongside the 611 vacant GP training places, there are also significant regional variations, with almost half of posts in the north east being unfilled.

9. The Secretary of State for Health announced in October 2016 that the NHS would fund the training of up to an additional 1,500 students in medical schools in England from 2018. This announcement outlined the government's intention to achieve self-sufficiency in medical

¹⁰ The Kings Fund, McKenna (2016) Five big issues for health and social care after the Brexit vote.

¹¹ Independent Age, Franklin & Urzi Brancati (2015) Moved to care: the impact of migration on the adult social care workforce.

¹² Skills for Care (2016) Nationality of the adult social care workforce.

¹³ The government's negotiating objectives for exiting the EU: PM speech, January 2017

¹⁴ Rt Hon Jeremy Hunt MP, Secretary of State for Health, evidence to Health Select Committee, Tuesday 24 January 2017: 'We will continue to recruit doctors from overseas as part of the way we deliver on that commitment'.

staffing in the NHS by increasing the supply of UK trained doctors, thereby reducing the NHS's reliance on doctors from overseas¹⁵.

10. However, given the length of time taken to train a senior doctor, this new intake of medical students will not be practising as, for example, GPs until at least 2028 or as consultants by at least 2032. It is clear this initiative will not meet either the NHS' short-term or medium-term workforce needs so in the interim, the NHS will continue to be reliant upon doctors from the EU and overseas to fill vacant posts and be able to recruit them where necessary.

11. It is clear that a reduced ability to source foreign workers will have an impact on the NHS and on its ability to provide a high quality, reliable and safe service to patients. This is a particular concern given that in the next five years, the general population is expected to rise by 3% while the number of patients aged over 65 are expected to increase by 12% (1.1 million) and those aged over 85 by 18% (300,000)¹⁶. As the medical needs of these patients is likely to grow ever more complex, the demand for highly skilled doctors and health and social care staff is likely to continue for the foreseeable future and will require continuing requirement from overseas given the current labour market.

12. Furthermore, we are concerned that further restrictions on the ability of the health and social care sectors to source foreign workers would only serve to worsen staff shortages seen across the NHS and social care sector in recent weeks, which has been struggling to cope with mounting pressures and significant staff shortages. We are urging the government to ensure that any future UK immigration policy remains flexible enough to recruit health and social care professionals, including doctors, medical academics and researchers from the EU and overseas where the resident workforce is unable to produce enough suitable applicants to fill vacant roles.

Which particular sectors or sub-sectors would be affected by controls on EU migration and further controls on non-EU migration?

13. While the impact of controls on EU migration and further controls on non-EU migration on the existing NHS workforce have been outlined above, it is vital that the impact of controls on the doctors of the future is also considered.

14. Recent reports, and announcements such as the speech made by the Home Secretary at the Conservative Party conference in October 2016¹⁷, suggest there are plans to impose further restrictions on the number of non-EU students who can come to the UK in an attempt to reduce net migration figures. We are also concerned by reports that the government may also seek to potentially remove the exemption to the resident labour market test (RLMT) for students of UK universities who are on visas, thereby breaking the link between study and work.

¹⁵ Jeremy Hunt: Speech to Conservative Party Conference 2016.

¹⁶ <https://www.parliament.uk/business/publications/research/key-issues-parliament-2015/social-change/ageing-population/>.

¹⁷ Amber Rudd MP, Home Secretary, Speech to Conservative Party Conference October 2016.

15. This is a particular concern for the BMA given that EU and non-EU medical students studying at UK medical schools play an integral role in the NHS and are factored into long-term NHS workforce planning. If such changes take effect, non-EU medical students of UK medical schools will have their training pathway through the NHS seriously restricted. This could have a potentially devastating impact not just on the 500 overseas medical graduates of UK medical schools each year, but also on patient safety because of the potential drop in doctor numbers. If the intention is to introduce the RLMT between Tier 4 and Tier 2, then an exemption is required for overseas graduates of UK medical schools to ensure the medical training pathway is not disrupted.

16. It is currently unclear what immigration system will be put in place for EU students once the UK leaves the EU, but it is essential that EU students who are currently studying at UK medical schools are given certainty about their futures in the UK. As with non-EU medical students, medical students from the EU are factored into NHS workforce planning: the ongoing absence of certainty over their future rights to live in the UK and train and work in the NHS may force some EU medical students to leave their prospective careers in the NHS.

What would be the impact on wages, in different sectors, of controls on EU migration and further controls on non-EU migration? What evidence is there of the impact on wages of the level of immigration (from EU and non-EU migration?)

17. Doctors' salaries are subject to centralised pay bargaining and so are unlikely to be affected by controls on EU migration, further controls on non-EU migration, or by levels of immigration.

18. In its most recent report, the Doctors' and Dentists' Review Body (DDRB) on doctors' and dentists' pay in England, Scotland, Wales and Northern Ireland again only felt able to recommend an uplift in line with the public sector pay policy, which is well below comparable wage inflation in the wider economy¹⁸. We have significant concerns that the continuation of this pay policy will further worsen the morale, recruitment and retention of medical staff, thereby exacerbating the existing challenges facing the UK labour market in staffing health services.

Does the Government have adequate data on the number and characteristics of immigrant workers on which future assumptions and policy can be based?

If there are deficiencies in the data what changes are required to improve it?

19. There is a very clear need for consistent and accurate data collection on the NHS workforce across all four UK nations. As discussed earlier, the government has expressed its intention to achieve self-sufficiency in medical staffing in the NHS by increasing the supply of UK trained doctors. However, without accurate workforce data, which precedes robust workforce planning, it will be difficult to establish exactly what the NHS needs in the short, medium or longer-term.

¹⁸ Review Body on Doctors' and Dentists Remuneration Forty Fourth Report 2016.

20. Accurate data will be even more vital if, following the UK's withdrawal from the EU, the government imposes tougher immigration rules which restricts the NHS's ability to recruit staff from overseas.

21. With regards to primary care, we note that while significant improvements have been made in data collection across England since the adoption of the workforce minimum dataset (wMDS) in 2015, these figures are not yet completely accurate: it is likely to be a few years until a reliable picture is available of primary care workforce numbers in England. We also note that Wales is looking into adopting the wMDS.

22. The organisation best placed to both collect and analyse primary care workforce data from all four UK nations is NHS Digital (previously known as the Health and Social Care Information Centre, HSCIC). This level of data collection, which would require all four UK Health Departments to commission NHS Digital to carry out this work, should be considered as a matter of urgency.

Is there a case for a regional variation in immigration policy?

23. Many areas of the UK have difficulty attracting and retaining sufficient numbers of trainees and doctors of all branches of practice. Whereas this used to be mainly confined to rural and coastal areas, we are aware that this has now also started to affect urban areas with higher population density. For example, in London, where recruitment has traditionally been easier, 27% of GP practices were unable to fill vacancies over the past 12 months¹⁹. The highest figure was 35% in the west midlands and east of England. In secondary care, there were over 10,000 medical and dental vacancies advertised in September 2016, spread throughout England²⁰.

24. Regional visas have been suggested as a possible way to address recruitment concerns in underdoctored areas, giving regions a greater degree of control over regional immigration policy to meet local need. Whilst this might increase workforce numbers in the short-term, we do not believe this option provides a long-term solution. Evidence from Canada, where elements of regional autonomy over immigration are in place, shows that where immigrants improved their earnings, they decided not to settle in the area that had granted their visa. As soon as their visa allowed, these immigrants moved to a different area; other considerations, such as family connections or established immigrant communities may play a stronger role in influencing the decision to stay in the region permanently. We are also aware that different immigration systems would be difficult to implement and enforce without establishing onerous internal checks to ensure that immigrants remained in the region which granted their visa.

How successful have policies to control the level of migration from non-EU countries been? Are any changes required if these controls are extended to migrants from EU countries?

25. We note that the introduction of much stricter restrictions for non-EU workers entering the UK since 2010 has had a detrimental impact on NHS recruitment and workforce numbers. Shortages in the nursing workforce became so acute that nurses were added to the shortage

¹⁹ BMA survey of GPs in England, Oct- Nov 2016.

²⁰ NHS Digital – NHS Vacancy Statistics England Feb 2015 – Sept 2016 Provisional Experimental Statistics.

occupation list to allow hospitals to recruit from outside the EU with no cap on numbers for example.

26. If the government were to introduce a cap on EU workers following the UK's decision to leave the EU, it would be crucial to ensure that sufficient provision was made for healthcare workers through flexibility in the UK immigration rules. Currently, immigration rules rely on salary levels, rather than taking account of need, as a filter to determine who is granted a visa. The shortage occupation lists go some way towards trying to meet gaps in demand, but these are not comprehensive or responsive enough to adequately measure need or take account of future changes in workforce. Merely using salary levels is a crude measure and any new immigration system ought to take account of demand and need to ensure that gaps in workforce are filled, where they cannot be met by UK nationals in the short to medium term.