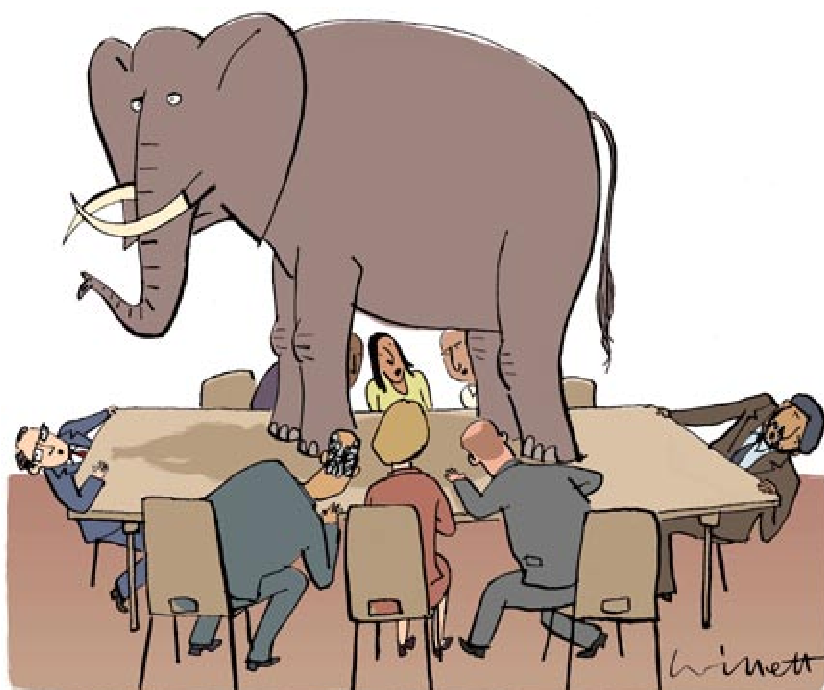
Medical immigration: the elephant in the room

The threat of unemployment among UK graduates is being blamed on the computerised recruitment system. But, argues **Graham Winyard**, the real problem is government policy on medical immigration

The effects of the collapse of the United Kingdom's electronic recruitment and selection system for junior doctors, the Medical Training Applications Service (MTAS), have shaken British medicine.[1] Anxiety has been raised about the careers of thousands of young doctors along with questions about the fitness for purpose of some of medicine's key institutions.[2] The government has ordered an independent review not only of the recruitment system but of the whole of the new pattern of postgraduate education, Modernising Medical Careers,[3] and it is understandable that the system is being blamed for all current difficulties.

The reality, in respect of medical unemployment, is more complicated and more worrying. Even if MTAS had worked perfectly, we would have still faced major problems with medical unemployment because of the government's muddled approach to managing medical immigration. This has created a large surplus of applicants over available training places, making disappointment for thousands inevitable. The policy confusion has compounded a longstanding failure to address the implications of the major expansion in UK medical school output for postgraduate education and career structures. These are vitally important issues for the future of medicine in this country. But because immigration is such a sensitive matter, they remain little discussed—the "elephant in the room."



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Accepted: 4 September 2007

Table 1 | Medical staff in training posts in 2006 by country of qualification[5]

	All	UK (%)	Rest of EEA* (%)	Elsewhere (%)
Specialist registrar	18 449	10 529 (57)	1204 (7)	6716 (36)
Senior house officer†	18 376	9 722 (53)	930 (5)	7724 (42)

*European Economic Area.
†Excluding doctors in foundation year 2.

Implications of medical school expansion

In the late 1990s UK medical schools produced nearly 5000 graduates each year, considerably fewer than the NHS needed. This had two important consequences:

- The NHS recruited large numbers of doctors from overseas, with more than one third of training posts occupied by international medical graduates
- UK graduates, provided they were willing to be flexible about their career choice, were reasonably assured of full specialist training and a post as a consultant or general practice principal.

In 1997 the Medical Workforce Standing Advisory Committee advocated a long term policy aim of being able to "rely largely on UK doctors though not aiming for a workforce composed entirely of UK doctors."[4] The committee recommended immediate expansion of medical school places by 1000, and the government added a further 1000 places as part of the NHS plan published in 2000, an overall increase of 40%. We are now halfway through this expansion, with the number of graduate doctors set to rise from 5576 in 2006 to 7000 in 2010.

The committee's initial recommendation was based on some fairly conservative assumptions so the scale of the overall increase still seems reasonable. However, its implications for postgraduate training capacity have never been considered, not least because until recently the more pressing concern was filling the large surplus of senior house officer and specialist registrar posts needed to run the service.

Given the NHS's position as a near monopoly employer, and the fact that foundation programme graduates need at least two further years of specialty training before they can be employed in career posts, it seems logical to ensure that these extra graduates are able to access such training. However, the advisory committee explicitly excluded such medium term planning from its remit, while shorter term planning of training numbers has always been based on assessments of NHS demand for consultants and general practitioners rather than trainee demand for specialist training. The only exception

Table 2 | MTAS round one applicants analysed by country of qualification and immigration status, together with appointment rates on 26 June 2007 (unpublished data, Department of Health)

Country of qualification	Immigration status					No (%) appointed
	UK	Other EEA	HSMP	Other overseas	All	
UK	14 650	605	663	752	16 670	11 471 (69)
Non-UK	1 998	1803	9 351	2827	15 979	4643 (29)
All	16 648	2408	10 014	3579	32 649	16 114 (49)
No (%) appointed	11 043 (66)	937 (39)	3090 (31)	1044 (29)	16 114 (49)	

EEA= European Economic Area, HSMP= Highly skilled migrants programme.

to this has been the Department of Health's commitment to expand the number of foundation year 1 posts to match output from medical schools, while the extra investment in year 2 posts for general practice and other priority areas has resulted in sufficient full foundation programmes to match graduate growth to date (although this is by no means certain for the future).

Superficially, there should not be a problem. Much of the training capacity necessary to match the expansion of UK medical schools is in place, as table 1 shows. Whether these posts can actually be accessed by UK graduates depends on the competition that exists for them from doctors trained elsewhere. The advisory committee explicitly assumed that UK qualified doctors would replace those from overseas, stating: "We believe that, given the opportunity, trusts would prefer to fill these posts with domestic graduates rather than overseas doctors."[4] But it is of course illegal for trusts and deaneries to discriminate on the basis of country of qualification, however much sense this might be thought to make in terms of workforce planning.

Thus even before this summer's problems we faced a situation in which UK graduates might find it increasingly difficult to obtain a place on a traditional training programme. UK trained doctors began to voice concerns about possible unemployment in 2005 in free text returns to cohort studies run by the UK Medical Careers Research Group (Michael Goldacre, personal communication).

Competition through MTAS

These concerns were dramatically realised this summer, when a centralised system to select doctors for four levels of training post (specialty training years 1, 2, 3, and, in a few specialties, 4) was introduced for the whole of the UK. A total of 19 172 posts were initially available through MTAS for round one applications, rising to 19 797 by June as extra posts were created; 32 649 eligible applicants competed for these posts, an average competition ratio of 1.65 applicants for each post.

Table 2 shows applicants and their success rates in round one by immigration status and country of training. Although the data on immigration status and country of training are derived from self volunteered non-verifiable information from the MTAS applications and so must be treated with caution, the overall picture is clear. In a system designed for the further training of UK medical graduates almost half the applicants were overseas trained doctors. There were broadly sufficient posts to accommodate UK applicants, together with those from the rest of the European Economic Area (who have clear legal rights to compete for posts on equal terms under European law), and this was the basis of Lord Warner's assurance in December 2006 that "doctors in training in England should consequently be pretty confident about securing a training post."[6]

At that time it was not intended that international medical graduates would be able to compete in the initial application rounds. The Department of Health had announced earlier in 2006 that it was introducing a resident labour market test, requiring that international graduates be recruited only when no appointable doctor was available from within Europe.[7] As a first step to achieving this it abolished permit-free training, but it was subsequently unable or unwilling to secure effective action to restrict entry through the highly skilled migrants programme. This is a scheme allowing highly skilled people (as judged by a scoring system based on age, educational achievement, and previous earnings) to migrate to the UK to seek work without a specific job offer.[8] It is not occupation specific and, as table 2 shows, large numbers of doctors from outside Europe meet its criteria. The inclusion of thousands of overseas doctors has transformed the prospects for all applicants and has made widespread failure to secure a proper training post inevitable.

Some of the problems may be mitigated by the creation of special posts to tide eligible applicants over until next year's competition round. However, competition ratios then are likely to be worse than this year unless more radical action is taken.

Ways forward

The UK urgently needs policy coherence on immigration and medical training. It currently has the worst of all worlds. Investing heavily in expanding our medical schools makes little sense if we cannot enable the extra graduates to pursue a career in medicine and contribute to the NHS. The implications of making medicine a career in which, after seven years of training and thousands of pounds of debt, graduates face a serious risk of permanent exclusion are enormous. Not only is this economic nonsense, it represents a betrayal of the legitimate expectations of those who entered UK medical training in recent years. It is also an abuse of doctors lured from overseas to compete for non-existent jobs.

It is correspondingly difficult to understand the ambiguity on this issue of those organisations fighting to rebuild their credibility with trainees. The BMA is determined that the "MTAS fiasco must never be repeated" but remains a fierce critic of the necessary changes to immigration policy.[9 10] The review led by the medical royal colleges was "deeply concerned," calling for better workforce planning and "clear policy on the recruitment of overseas doctors" but saw the large number of non-UK doctors who applied as one of the successes of the system.[11]

The direct connection between policy on medical immigration and the likelihood of unemployment for UK medical graduates is inescapable. Although there are compelling reasons for the UK to provide postgraduate education tailored to the needs of other countries, this is not what the highly skilled migrant programme facilitates, and the damage to other health systems caused by wealthy countries recruiting doctors in this way has been graphically described.[12 13] The most obvious action would be to suspend the skilled migrant programme as it applies to doctors and establish a two stage recruitment process similar to that used in other countries,[14] whereby overseas applications are considered after those of domestic graduates (which in our case would have to include Europe).[15]

The rights of overseas doctors already in the system must be safeguarded, but if decisive action is not taken the situation will be worse next year. Not only does the UK remain an attractive place to train but if, as seems likely, "traditional" recruitment processes are used, foundation programme graduates could find it hard to compete for run-through training with overseas doctors with substantial specialty experience. This muddle is in no one's best interests and needs open and honest discussion and clear leadership, however difficult that may be.

SUMMARY POINTS

The UK had far more applicants than specialty training places this year

Government immigration policies not MTAS have created this imbalance

Expanding medical schools makes little sense if extra graduates cannot pursue a career in medicine

Immigration policies need to be changed to reflect this

Competing interests: GW was chair of the Conference of Postgraduate Medical Deans (COPMeD) from 2004-2006.

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- Up to three tables, boxes, or illustrations (clinical photographs, imaging, line drawings, or figures—we welcome colour). We may be able to publish some additional boxes or figures on bmj.com only
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