Memorandum of evidence from the BMA to the Home Affairs Committee inquiry on Immigration

January 2017
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 that we are consulted and involved in consultations to inform negotiations to leave the European Union (EU) which would affect the medical profession and patients.

While much of the rhetoric about immigration during the EU referendum campaign and elsewhere has focused on the pressures increased immigration has placed on public services, including the health service, housing and schools, the contribution made by doctors from the EU and overseas to the safe staffing and running of the NHS cannot go unrecognised. 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 UK\(^1\). These international doctors and researchers, including 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.

It is essential therefore, that any proposals introduced by the government to bring down net migration, or change the current immigration system, do not result in jeopardising staffing levels in the NHS or the university and research sectors. Any new immigration system introduced by the government following Brexit needs to remain flexible enough to recruit highly skilled 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. This will be essential to maintain patient safety, to give patients the health service they need, and to maintain the UK’s world leading role in science and research.

Executive summary
- 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 UK\(^2\). Data shows 15% of academic staff contributing to the UK university workforce originated from other EU nations\(^3\) with additional staff working in public health.
- These highly skilled professionals have become essential members of the UK’s medical and academic workforce. They have enhanced the UK’s health, higher education and research systems, improved the diversity of the profession to reflect a changing population, brought expertise to the NHS and higher education, and filled shortages in specialties which may otherwise have been unable to cope.
- EU doctors and medical academic staff currently working in the UK should be granted permanent residence in the UK, regardless of whether they have been resident here for five years or not. This is vital to provide certainty and stability to these individuals, to NHS workforce numbers and, therefore, to patient safety.
- EU students currently studying at UK medical schools need to be given certainty about their futures in the UK. These medical students are factored into NHS workforce planning: in the absence of clarity over their future rights to live, train and work in the UK, some EU medical students will choose to leave the UK, which could pose a risk to future staffing levels in the health service.

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\(^1\) http://www.gmc-uk.org/SoMEP_2016_Chapter_one.pdf_68138039.pdf
\(^2\) http://www.gmc-uk.org/SoMEP_2016_Chapter_one.pdf_68138039.pdf
\(^3\) The Academy of Medical Sciences: Academies publish joint statement on research & innovation after the EU referendum, 19 July 2016
- This ongoing uncertainty is already having an impact: applications from EU nationals and non-EU nationals for places at UK medical schools fell by 9% and 6% respectively in 2017, ending a trend of annual increases over recent years⁴.
- 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.
- The new system must be responsive to need, be flexible and capable of change to take into account changes in workforce requirements, be transparent, affordable and easily understood and managed by employers, sponsors and migrants alike.
- All the above factors must be taken into consideration by the government when examining potential future immigration systems to manage migration both from the EU and elsewhere.

**What approach should the Government take to different kinds of migration – for example skilled, unskilled, family migration, students and refugees?**

**Skilled migration**

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 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)⁵. Given that the medical needs of these patients is likely to grow ever more complex, the demand for highly skilled doctors from overseas to meet the needs of the patient population is likely to continue for the foreseeable future.

2. 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 immigration,’⁶ she also confirmed that the number of people coming to the UK to work would be capped. We are concerned that any further limits on the number of doctors able to work in the UK will only serve to worsen staff shortages seen across the NHS over the past few weeks, which has been struggling to cope with mounting pressures and significant staff shortages.

3. Similarly, the initiative announced by the Secretary of State for Health that NHSE will fund training of up to an additional 1,500 students in medical schools in England from 2018 will not meet either the NHS’ short-term or medium term workforce needs. This announcement outlined the government’s intention to achieve self-sufficiency in medical staffing in the NHS by increasing the supply of UK trained doctors, thereby reducing the NHS’s reliance on doctors from overseas⁷. However, given the length of time taken to train a senior doctor, this new intake of medical students will not be practising as GPs until at least 2028 or as consultants by at least 2032. 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.

4. Following our withdrawal from the EU, it will be essential that any future immigration system continues to be flexible enough to allow EU and international doctors to quickly fill gaps in the

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⁴ Applicant numbers to ‘early deadline’ university courses increase by one per cent, UCAS figures reveal today
⁵ https://www.parliament.uk/business/publications/research/key-issues-parliament-2015/social-change/ageing-population/
⁶ The government’s negotiating objectives for exiting the EU: PM speech, January 2017
health service, university and research sectors and in public health. Currently, the EU's policy of freedom of movement of workers and reciprocal arrangements enables highly skilled migrants, with the appropriate level of training and education to do this, ensuring safe staffing levels and patient safety are maintained. This advantage is likely to be lost if, as expected, the UK no longer accepts freedom of movement of workers and if reciprocal arrangements change once the UK leaves the EU.

**The position of EU nationals currently working in the NHS**

5. The prime minister must deliver on her promise to guarantee the rights of EU nationals in Britain, and Britons living in Europe, as soon as possible.\(^8\)

6. Individuals from the EU who are already working in the NHS and care sector, and EU academic staff need to be given explicit reassurances that they have the right to continue living and working in the UK. To provide certainty and stability to both these individuals and also for the NHS with regard to workforce numbers, EU doctors and medical academic staff currently working in the UK should be granted permanent residence here, regardless of whether they have been resident here for five years or not.

7. Reports suggest there has been a significant increase in the number of EU nationals in the UK applying for permanent residence as a means of guaranteeing their rights after Brexit.\(^9\) However, we are aware of concerns from our members that the current process to claim permanent residence, especially where the online form cannot be used, is unwieldy and time-consuming for the individuals involved. We welcome work being done in government to make the application process simpler and faster.

**Medical students from outside the EU studying at UK medical schools**

8. Recent reports, and announcements such as the speech made by the Home Secretary at the Conservative Party conference in October 2016\(^10\), 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.

9. If such changes take effect, non-EU medical students of UK medical schools, who form part of NHS workforce numbers, 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 NHS workforce 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.

10. We are concerned that following recent developments in the UK, international students will choose to study in countries which are more conducive and supportive of international students and an international workforce, rather than in the UK. This is a particular concern following the

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8. The government’s negotiating objectives for exiting the EU: PM speech, January 2017
10. Amber Rudd MP, Home Secretary, Speech to Conservative Party Conference October 2016
rise in xenophobic attacks and sentiment following the UK’s vote to leave the EU, and policies which appear to devalue or undermine the contribution made by medical students and doctors from overseas.

11. Already the message is being sent out to potential students from the rest of the world that the UK no longer welcomes them\(^\text{11}\) and the threat of ever more stringent immigration policies risks deterring international students from seeking to study in the UK at all. UCAS figures for 2017 undergraduate entry show that applicant numbers for non-EU nationals for places at UK medical schools has fallen from 3,240 in 2016 to 3,040 in 2017, a decrease of 6%. This ends a general trend of annual increases\(^\text{12}\).

12. This is deeply worrying, with potentially disastrous consequences for the UK’s ability to attract talented medical students and to build potentially fruitful relationships with future leaders in healthcare from across the world.

**Medical students from the EU studying at UK medical schools**

13. The ongoing lack of certainty and clarity following the decision to leave the EU and the implications this will have for the medical profession, is already having an impact on EU students coming to the UK, and is most recently demonstrated by the fall in the number of EU students applying to study medicine in the UK for the coming year. Figures from UCAS for 2017 undergraduate entry show that applicants from the EU to the October deadline for medicine degrees have fallen by 9% (620) to 6,240 ending a trend of annual increases over recent years\(^\text{13}\).

14. It is vital that EU students who are currently studying at UK medical schools are given certainty about their futures in the UK. Medical students are factored into NHS workforce planning and there is a risk that in the absence of certainty over their future rights to live in the UK and train and work in the NHS, some EU medical students may choose to leave their prospective careers in the NHS. Medical students play an integral role in the NHS workforce and so any fall in numbers could pose a risk to staffing levels and patient safety in the longer term.

15. Furthermore, EU students at UK medical schools should not be penalised if they have chosen to study and work in the UK, to then find the rules change during the course of their studies, which prevents them from continuing to progress through their training pathway in the NHS. Neither should UK taxpayers find they have paid for partial training of EU medical students who are then not allowed to stay and work in the NHS. These factors must be taken into account by the government.

16. The falls in application numbers from EU and international students are worrying and while there may be a number of reasons for this drop in applications, anecdotal evidence from our members suggests those who are not UK nationals feel unwelcome in the UK since the UK’s vote to leave the EU. It is vital that the UK remains culturally attractive to medical students from overseas. This will require a flexible and efficient immigration system which is able to meet the changing needs of the NHS, a culture that values diversity and tackles discrimination.

\(^{11}\)Hindustan Times *The message from Britain is clear: Indians are not welcome anymore*

\(^{12}\) Applicant numbers to ‘early deadline’ university courses increase by one per cent, UCAS figures reveal today

\(^{13}\) Applicant numbers to ‘early deadline’ university courses increase by one per cent, UCAS figures reveal today
Skilled and unskilled migration in the NHS workforce

17. Doctors work closely alongside a range of individuals, including as 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 overseas. All of these individuals play an integral role in the efficient and safe running of the health service. Any future immigration system must take into account the needs of the NHS for both skilled and unskilled labour and should be based on needs and demands to ensure that gaps in workforce are filled where they cannot be met by UK nationals in the short to medium term.

18. The BMA is a member of the Cavendish Coalition\textsuperscript{14}, 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.

What are the benefits and problems with different kinds and levels of migration, for the economy and society?

19. Much of the rhetoric about immigration during the EU referendum campaign focused on the pressures increased immigration has placed on public services including the health service, housing and schools. Studies looking at migrants arriving in the UK since 2000 show they have made a positive contribution to public finances, paying more in taxes than the value of public services they have used.\textsuperscript{15}

20. It is important to acknowledge the contribution made by migrants, including doctors, in delivering and sustaining public services, such as the NHS, care services, and our universities. For example, 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 Economic Area (EEA) with a further 10,000 doctors (6.6\% of the UK medical workforce) receiving their PMQ in another European Economic Area (EEA) country\textsuperscript{16}. Data shows 15\% of academic staff contributing to the UK university workforce originated from other EU nations\textsuperscript{17} with additional staff working in public health.

21. 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 be attributed to the large number of Republic of Ireland graduates working there. The mobility of healthcare staff between the Republic of Ireland and Northern Ireland, as well as the provision of cross-border healthcare, are issue which need to be extensively considered by the government during the Brexit negotiations\textsuperscript{18}. England has a higher reliance on EEA doctors (8.2\%) than Scotland (6.6\%) or Wales (6.4\%). The Specialist Register\textsuperscript{19} had 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 graduates\textsuperscript{20}.

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\textsuperscript{14} The Cavendish Coalition
\textsuperscript{16} BMA, 2014 Medical Workforce Briefing, 2015, pg. 11.
\textsuperscript{17} The Academy of Medical Sciences: Academies publish joint statement on research & innovation after the EU referendum, 19 July 2016
\textsuperscript{18} EU Select Committee: UK-Irish relations
\textsuperscript{19} 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)
\textsuperscript{20} GMC: Our data about doctors with a European primary medical qualification http://www.gmc-uk.org/static/documents/content/GMC_data_on_EEADoctors_in_the_UK.pdf
22. These doctors from the EU and overseas have become essential members of the UK’s medical and academic workforce and the NHS is dependent on them to provide a high quality, reliable and safe service to patients. These highly skilled professionals have enhanced the UK health, higher education and research systems over the years, improving the diversity of the profession to reflect a changing population, bringing expertise to the NHS and higher education, and filling shortages in specialties which may otherwise have been unable to cope. We unreservedly condemn the xenophobic attacks by individuals who have taken the referendum result as a green light to attack the NHS staff who care for them.

23. With regards to international students, this group of migrants makes a significant economic and cultural contribution to the UK bringing income, influence and generating employment in the UK. They contribute £7 billion to the UK economy and to public services through tax receipts\(^21\) alone.

24. The higher education sector is a major UK success story, contributing £73 billion in output to the UK economy, £39.9 billion to UK GDP in 2011/12,\(^22\) and spreading UK influence and services across the globe. In 2014/15, almost half of all university income in the UK was derived from tuition fees and education contracts (£15.6 billion). Non-EU students contributed over a quarter of tuition fee income paying fees of £4.226 billion\(^23\) while home and EU domiciled student course fees accounted for £10.481 billion of the overall income of UK HE providers. The presence of students from across the world and from the rest of the EU helps financially underpin universities and UK medical schools.

**What approach should be taken to EU migration as part of the Brexit negotiations – for example, points-based systems, or work permits; and geographical variations?**

25. There are a number of issues the government needs to consider when looking at future immigration systems to manage migration from the EU. 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.

26. Furthermore, the government will also need to consider whether or not to expand the current immigration system for overseas workers to incorporate EU citizens, or introduce a new system to manage European migration. Consideration needs to be given to whether or not the government wants to administer multiple immigration systems in which EU citizens continue to be given preferential access for jobs in the UK, or putting in place one immigration system which treats EU and EEA citizens the same as migrants from any other nation.

27. Multiple immigration systems could be incredibly complex and unwieldy for both the government and employers to administer, and for individuals to navigate. To avoid this, the government may

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\(^{21}\) *The Telegraph* (October 2016) Ben Howlett MP Theresa May should be smart over immigration and take students out of the official figures

\(^{22}\) Universities UK: Higher education in numbers

\(^{23}\) House of Lords library note (October 2016) *Leaving the European Union: funding for universities and scientific research*
choose to implement a single immigration system for all migrants into the UK, which treats EU and EEA citizens the same as migrants from any other nation.

28. With regards to geographical variations, we are aware of suggestions that regional immigration policies could be implemented to help meet the employment needs of local areas. However, we note that a regional system would be difficult to enforce and would require a system of checks to ensure immigrants remained in the area which initially granted them their visa.

**How should trade-offs between immigration policy and economic policy be handled?**

29. There is a danger that the imposition of ever tougher immigration restrictions will deter doctors, researchers and medical students from wanting to work and study in the UK at all – this would be to the financial, economic and cultural detriment of UK medical schools, UK universities, research institutes and wider society. Medicine thrives on the interchange of experience, knowledge and training across countries and backgrounds: closing our borders would be bad for medicine, bad for patient care and bad for medical research.

30. We believe that further restrictions on international medical students coming to the UK through changes in immigration policy will inevitably lead to a consequent decrease in opportunities for UK medical students to study overseas and so limiting opportunities to collaborate and share experience, knowledge and training. We believe this will be detrimental for medicine, patient care and medical research.

31. Any cuts in the number of non-EU students to UK medical schools would have serious consequences for medical school funding, as non-EU students pay, in England, fees of between £25,000 and £35,000 per year. If they were replaced by UK medical students, this would create an increased burden on both the UK tax payer and individual universities.