

The International Market For Medical Doctors: Perspectives On The Positioning Of The UK

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PREFACE

This is the report of an 18-month study originally commissioned from the National Primary Care Research & Development Centre (NPCRDC) under the Department of Health (DoH) Human Resources (HR) Research Initiative. Its overall aim was to explore the factors underlying movement of EU/overseas doctors to the UK in the context of the international medical labour market.

Stages 1 and 2 of the study – the analysis of relevant literature and medical workforce datasets provided by the NHS Executive – were carried out as an on-going process informing the project throughout its development. Stage 3 – the in-depth interviews with organisational stakeholders in the UK and at EU level – was undertaken in summer/autumn 2001. Stage 4 – the case studies in five other countries selected on the basis of their apparent position in the international medical labour market relative to the UK – took place between autumn 2001 and spring 2002. The report, which was submitted in draft form to the Department of Health in December 2002, draws together the findings from all four stages, and highlights key issues for future policy on the recruitment and retention of EU/overseas doctors in the NHS. This final version was produced in June 2003 to take account of the comments from Department of Health peer reviewers.

The study was led by Dr Ruth Young, who is now based at the Manchester Centre for Healthcare Management (MCHM), University of Manchester. Prof. Bonnie Sibbbald and Dr Mark Hann at NPCRDC were responsible for the analysis of NHS workforce datasets. The project's full-time Research Associate Jenny Noble, based at NPCRDC, carried out the remainder of the research, together with Ruth Young. Rosalind McNally, Information Officer at NPCRDC provided the technical expertise in the review of existing literature. Dr Aneez Esmail and Dr Jill Lovecy from, respectively, the Department of General Practice and the Department of Government at the University of Manchester also supported the project throughout.

EXECUTIVE SUMMARY

Background to the Project

Addressing the pressures associated with shortfalls in the medical labour market has always been one of the key challenges for workforce planning and development in the NHS. Now, however, this is being set within increasingly ambitious government targets for improvements in service delivery that can only be achieved by a rapid general workforce expansion in the health service. While the key to meeting these challenges clearly rests with education/training and employment structures in the UK itself, the ability to attract (short or longer-term) EU/overseas doctors to the NHS is a vital, complementary component of the overall labour force planning process.

The Key Objectives

It is against this rapidly changing policy context that the current research was commissioned in 2000. The objectives set out were:

- To document the broad geography and structure of supply and demand in the international medical labour market and to outline the UK's present position;
- To provide a clearer understanding of the factors influencing international medical migration to the UK in the light of labour market competition by other countries;
- To highlight the major components of change likely to affect UK supplies; and
- To help inform the UK's recruitment and retention policies for EU/overseas doctors in practical ways.

The work programme was carried out between March 2001 and December 2002.

Research Methods and Conceptual Framework

To meet the objectives, the study brought together information from the following sources:

- A review of existing literature and secondary data on the international medical labour market and physician migration;
- An analysis of large-scale computerised datasets collated by the NHS Executive – namely the GP principal, GP registrar and HCHS Censuses for the period 1991 to 2000;
- Semi-structured interviews with key stakeholders in the UK (e.g. the BMA, GMC, Royal Colleges, Post-graduate Deaneries, Directors of Post-graduate GP Education, STA, British Council etc); and
- Case studies of five countries occupying different positions in the international labour market in relation to the UK – the USA, Australia, Spain, Poland and India.

The conceptual framework for the work had two principal dimensions:

- Flows of doctors in the international labour market are seen through the lens of a migration process with *individual doctors making choices to move* from supplier to demander countries in an attempt to better their economic, social or career situations.
- This migration process is then seen from the viewpoint of an *international marketplace where countries compete to achieve competitive advantage* in terms of attracting doctors

as a valued supply of professional labour. To assist in us in this, we drew on the well-known work of Michael Porter (1998).

The core of the fieldwork element of the research was a questionnaire instrument designed to recover the perceptions and judgements of key organisations acting in the international marketplace. By taking this organisational focus to throw light on an increasingly important issue for the NHS, the intention was to complement the companion project on individual EU/overseas doctors' experiences undertaken by the Open University Centre for Education in Medicine.

Summary of Key Findings

The Overall Picture of UK Demand and Supply

- The clear perception of UK stakeholders was that there is an overall shortage of doctors across the board in the UK medical workforce – i.e. from general practice to many hospital specialties, and from basic training to the fully qualified grades.
- Against this general background of gaps needing to be filled, the demand-side opportunity surface actually presented by the UK to the international marketplace is highly complex. It is configured according to a wide range of factors such as: the supply and demand situation for the particular specialty, the regulatory framework governing different types of training and post-training jobs, and the point on the medical career ladder at which labour market entry is sought.
- From the perspective of a study on international migration this demand can be viewed *de facto* as being represented by those undergraduate education, post-graduate training and post-training positions which migrant doctors can effectively be “slotted” into depending on the constraints they face in a given context.
- In terms of existing supply between 1991-2000, South Asia and the EEA were by far the largest supply sources, followed by Southern Africa. EEA-qualified migrants tended to be younger than, but with similar sex and ethnic distributions to, UK qualified doctors. Those who qualified elsewhere were more likely to be Asian, and were more often male and older compared with UK counterparts. In terms of length of stay in the NHS, UK-qualified doctors stayed longer than EEA doctors, who in turn stayed longer than those from non-EEA countries.
- Within the various global regions, the countries that supplied the greatest numbers of doctors were:
 - Republic of Ireland and Germany in the EEA;
 - Poland in Eastern Europe;
 - Iraq in the Middle East;
 - Egypt in Northern Africa;
 - India in South Asia;
 - Australia in the rest of the world.

The Main Factors Influencing International Doctor Migration

The main push and pull factors underpinning doctor migration were identified as follows:

- At the country-level:
 - Relative economic and social expectations and the prospects for higher financial gain;
 - Wider quality of life issues, including personal safety and the prospects for stability and greater freedom.
- At the medical organisation/professional-level:
 - Relative prospects for obtaining career improving postgraduate training;
 - Home country bottlenecks to career development and progression;
 - Perceptions of enhanced job satisfaction and working conditions.
- At the individual-level:
 - The stage doctors have reached in terms of career development and family formation;
 - Their particular medical field and the health system in which they gained their experience/training;
 - Whether or not individuals and their families are considering migrating for the short or longer-term.

The Factors Influencing Migration to the UK in the Light of Labour Market Competition

Within this complex picture of incentive structures encouraging medical migration between countries, the critical ones that were seen to give the UK competitive weight against its rivals were:

- The established system of UK post-graduate qualifications (especially the reputation and kudos of the Royal Colleges) and training opportunities, and the attraction that holds for potential migrants to enhance their human capital/career prospects;
- The English language, which is relevant both for ease of entry to the UK labour market and as a “passport” to wider opportunity elsewhere;
- The information, recruitment, job-matching, induction/training and follow-up support systems that exist in particular circumstances to ‘handle’ individuals at various stages in the migration and labour market entry process.

The Shape of International Competition

- The study revealed a wide range of ‘demander countries’ looking to source a substantial proportion of their medical labour supply from outside their own health systems. As in the UK, this demand is responding both to national shortages by specialty and/or to particular pressures in deprived/underserved geographical locations.
- In addition to global-level migration between continents to match these demands, there are also more ‘localised’ geographical flows at both regional and country-country levels. Examples of these evolving sub-markets for migrant doctors include: USA/Canada, USA/Central and South America and the Philippines; Australia/New Zealand and the Pacific Rim, UK/EU-EEA, UK/Commonwealth, South Africa and the rest of Africa etc.
- Within this highly competitive global context, the UK appears to operate in a group that primarily includes Commonwealth countries such as Australia, Canada and, to some extent, New Zealand. All are competing across the same three factors identified as providing the UK with the essence of its competitive weight internationally.

- In addition, certain countries within the European sub-market (e.g. Sweden, Norway and Germany) are actively recruiting in, or have existing strong migration links, with countries that are/could be suppliers to the UK (e.g. Spain and Poland).
- The hegemonic position of the USA was perceived as unassailable primarily because of the image it projects of economic/lifestyle opportunity and well-funded health facilities. However, respondents felt there was potential for the UK (but also competitors) to trade on strengths and, at the margin, attract doctors who may otherwise choose the USA.

Ensuring the UK's Future Supplies of EU/overseas Doctors

Two key and to some extent paradoxical responses characterised views on this issue:

- Participants perceived the most significant current UK supplies of overseas doctors (e.g. India, but also Australia, New Zealand, South Africa etc) as relatively secure. They also felt there was some prospect of new supplies (e.g. as Eastern European countries join the EU) coming on stream in which the UK may expect to share in future.
- There was a general perception, however, that the UK may be “resting on its laurels” or “trading on its past reputation”, and “not engaging as actively as it could do” within an international marketplace where standing still can only be associated with a competitive penalty.

It seems clear that, as competition intensifies, the UK needs to take steps to tackle both the perception (and in so far as it exists) the reality involved in the second of these points.

Principal Ways for the UK to Respond to Evolving Market Conditions

Respondents' views can be summarised as follows:

- The need to address the importance of market positioning by taking steps more effectively to focus marketing/recruitment activities on those groups the UK most wants to attract: at what age/career stage; to do what in terms of specialty/geographical location etc. Similarly, there appears to be a need (in terms of image) to be clear about, and indicate, whether or not the UK wants to recruit and retain EU/overseas doctors, or train them primarily to return to source countries.
- The need increasingly to recognise the power of the buyers in the international marketplace – i.e. the individual doctors scanning for opportunity and making their migration choices on the basis of the “the face” presented by a particular demander country to the market. Suggestions in the context of the process of UK labour market entry included:
 - Continue to improve general physical access to the PLAB examination (i.e. in overseas locations);
 - Enable earlier access to PLAB Part 1, during undergraduate medical education, in a similar way to access to the USMLE;
 - Fine-tune screening so that, rather than having automatically to take PLAB, overseas doctors who have already gained higher training and qualifications and/or taken Royal College examinations overseas could be fast-tracked into higher level NHS posts;

- Continue to reduce professional regulatory and wider work permit barriers (i.e. through the Shortage Occupations List and Highly Skilled Migrant category) in a targeted manner for the medical specialities with greatest shortages;
 - Possibly allow work permits to be issued directly to recruitment agencies so that they can employ migrant doctors directly;
 - Tackle the issue of language qualification by judging whether doctors whose first language is English (e.g. Australians) and others (e.g. refugees) who score an average of 7 (rather than a minimum 7 in all sections) might be allowed to access NHS employment without from the outset meeting IELTS requirements.
 - Have more streamlined application processes, and possibly more centralised “brokerage” systems for placing EU/overseas (and indeed UK) doctors in suitable NHS training and post-training employment positions.
- The need, also in the context of seeing doctors as increasingly powerful buyers, to tailor recruitment packages and job-matching across the board more effectively to individual needs. Not only does this imply helping migrant doctors to “get the most” out of their period (long or short) in the NHS workforce, it is also, just as importantly, about ensuring quality in the workplace by socialising them more effectively into UK medical practice.
 - The need for improved information provision on the nature of UK opportunities. Part of that would involve continuing to target specific countries, but also acting systemically to capture the attention of individual EU/overseas doctors. One idea was for a central website covering everything from English language training packages, to professional regulatory and other immigration requirements, broader information on relocating and living in the UK, and links to key bodies like Royal Colleges, BMA, Deaneries etc. Others suggested a one-stop access-point for personal advice in the first instance (either in the UK itself or, for instance, building on existing British Council arrangements in supply countries).
 - The need to ensure that appropriate structures are in place both to signal the shape of UK demand to the international marketplace and to achieve scale efficiencies in terms of information provision and recruitment activities. It was felt, for example, that NHS Workforce Confederations might help present a more coherent picture of the aggregate demand from local education, training and employer bodies. In a country the size of the UK, a further level of central co-ordination was also broadly welcomed to advertise opportunities, provide initial information to potential migrants, and point them to relevant local/professional organisations. The latter ensures that the propensity of regions, in effect, to compete with each other can be kept in tune with national interests.

Conclusion

The main UK stakeholders – e.g. the DH, Royal Colleges and other bodies – are addressing some or all of the actions set out above. It will, however, be important to continue to bring a more *proactive and ‘head up’ approach* to the process of recruiting EU/overseas doctors. This is particularly the case given the ethical considerations of recruiting large numbers of skilled professionals from countries that cannot necessarily afford to lose them long-term. In the final analysis, EU/overseas doctor recruitment needs to be seen in context. It is a significant element in what is required to meet the government’s plans for medical workforce expansion. However, it is also just part of the much wider skill-mix and UK education/training solutions being introduced to meet to the challenges of job-matching for a future NHS.

1 INTRODUCTION

Policy Background: The Importance of EU/Overseas Doctors to the NHS

Human resources (HR) are the most important of all inputs to any health care system (WHO, 2000). Consequently, achieving a balance between workforce needs, and the availability of suitably qualified and experienced people to meet them, is a central challenge at every level – i.e. from local employers trying to fill vacancies to national HR policy attempting to plan long term staffing. The need for staff (demand) and staff availability (supply) varies over time - with changes in working practices and new technologies, from place to place, from health care sector to sector, and from specialty to specialty. Managing those labour market mechanisms that connect demand and supply is a highly complex process, and the existence of short and even long-term mismatches, or imbalances, is normal to the operation of the system. Such imbalances affect all the health professions, but, in the UK in recent years, they have been reported as a particularly consistent feature of the labour market for medical doctors (GMS, 1998; DDRB, 2000; Pickersgill, 2001). Some of the biggest contrasts here are between the different hospital specialties, hospital and general practice, and deprived versus more affluent geographical areas (MPC, 1999; RCGP, 2000; Young and Leese, 1999).

Addressing the pressures associated with maladjustment in the medical labour market is one of the key issues in the current government agenda for the NHS. This is challenging enough to achieve in its own right. At the same time, however, developments are being set within ambitious targets for the rapid general expansion of the medical workforce over the next few years. The specific objectives for increased doctor numbers by 2004 were originally set by the *NHS Plan* (DoH, 2000a) (above the September 1999 baseline) as follows:

- 7,500 more Consultants;
- 1,000 more Specialist Registrars (SpR);
- 2,000 more General Practitioners (GP); and
- 450 more GP Registrars (GPs in training).

The consultation paper *A Health Service for all Talents* (DoH, 2000b) also proposed 400 extra training places for hospital specialties with particular shortages (including: 30 in cardiac surgery; 135 in cancer services; and 230 in mental health). More recently, there was the announcement of an increase of at least 49% in consultant numbers over the 10 years to 2009 (an increase of 12,000 from 24,300 to 36,300) (DH 2001a). The focus on having more

doctors as one of “the key building blocks for growing [NHS delivery] capacity” was then reiterated in *Delivering the NHS Plan: next steps on investment - next steps on reform*. Here, the stated aim by 2008 was “likely ... net increases of at least 15,000 more GPs and consultants ... compared with latest available headcount figures” (DoH, 2001b, Ch.3). Finally, although not directly linked to stated aims in the health sector, the recently published Wanless Report, *Securing Our Future: Taking a Long Term Look*, has identified a “gap in the number of doctors [that] starts to emerge before the end of this decade and is estimated to be around 25,000 after 20 years” (Wanless, 2002, p.90)

An obvious policy response to address the supply side is, of course, the on-going expansion of medical school intakes (by 1,000 more places in addition to a 1,100 increase already planned) in the hope of producing more UK doctors to meet future needs (DoH, 2000a). However, this is not, of itself, sufficient to channel doctors into the shortage areas, nor is it enough fully to support the government’s ambitious plans for overall workforce expansion. With around 13% of doctors estimated to be lost to the NHS five years after qualifying (Denham, 2001), a second clear strategy is, then, to increase participation and tackle wastage within the existing medical workforce. This involves focusing much more on retaining those UK doctors who are already qualified/trained, and encouraging re-entry by the wider pool not currently operating in the NHS labour market. To support this, the *NHS Plan* (DoH, 2000a) also encourages: family-friendly practices such as workplace childcare and part-time training provision; greater flexibility to enable doctors to switch training disciplines more easily; adjustments to hospital consultant contracts; and the continued use of PMS/salaried contracts giving more employment flexibility for GPs. Another key strategy (mentioned in the *NHS Plan* among other white papers) is to shift work from medical to non-medical health care workers. The “Changing Workforce Programme” of the NHS Modernisation Agency (2002) is responsible for a number of pilot schemes in this context.

However, the other obvious way of dealing with supply side shortages is to attempt to attract more doctors from overseas – both from the European Union (EU) and candidate countries, and from the wider international medical labour market. This is by no means a new approach. Indeed, from time to time over the life of the NHS it has been the first-order strategy for tackling deficiencies in the supply of doctors (Smith, 1980). The necessary infrastructure to support a continuing policy of overseas recruitment has fostered a number of well-established routes into UK medical training and/or post-training employment. The main pathways continue to include: sponsorship by relevant Royal Colleges; direct advertising abroad by NHS Trusts; and support for individuals acting to enter on their own initiative on the basis of PLAB and IELTS. The expansionary drive of contemporary policy has, however, given rise to a step jump in the profile

of international recruitment as a means to address shortages in the medical labour market. To support this expansion more centralised processes of application and placement have been brought into play. These are necessary to give greater focus and coherence to recruitment activity at larger scales. Three strategies have recently been employed to attract individuals¹ either directly into medical consultant and GP positions, or into supervised positions with a view to later progression following a period of familiarisation within the NHS (DoH, 2001c):

- **The global recruitment campaign** launched by the DH in August 2001 with advertising in the medical press in North America, Europe, Australia and the Middle East. This has been aimed particularly at shortage medical specialties and specialties where significant expansion will be needed in order to meet targets set out in the *NHS Plan* (DoH, 2000a). It is being administered by the recruitment agency TMP Worldwide, who are assisting those doctors felt to be suitable through the registration and application process;
- **Recruitment campaigns targeted in specific countries** – e.g. Spain, Germany and India - where the UK has gained agreement for such an exercise from the national government and professional bodies concerned. Discussions have also been taking place with relevant bodies in Switzerland, Austria and Poland (DoH, 2002a), with a view possibly to instigating similar recruitment models in those countries; and
- **The International Fellowship Programme** – a special scheme launched in January 2002 to attract experienced specialists from abroad into selected NHS posts for between 1-2 years, and foster international collaboration generally between different healthcare systems. Again this is aimed at shortage specialties and specialties – e.g. cardio-thoracic surgery, histopathology, radiology and psychiatry - that need to grow in the context of the *NHS Plan* (DoH, 2000a). So far applications have been received from doctors in Europe, Australia, Canada, India and the USA, although it appears to be taking longer than might have been expected for doctors to go through the process from initial enquiry to GMC registration and matching with NHS Trusts (Moore, 2002).

¹ In addition to these schemes aimed at increasing the supply of individual doctors, discussions are being held with health care providers (e.g. from France, Germany, Sweden and Switzerland) who may be interested in relocating entire clinical teams from abroad. The intention here is for newly set-up private units in the UK to contribute to the expansion of elective services for NHS patients. A key stipulation in this is that organisations must bring suitably qualified medical staff with them, rather than seeking to recruit existing NHS doctors out of NHS hospitals (DoH, 2002b; Secretary of State, 2002). However, some have expressed unease about the plan on the grounds that it may divert attention from existing NHS modernisation initiatives before they have 'time to bear fruit' (Rosen, 2002).

The drive to increase the flow of EU/overseas doctors does bring with it a number of particular challenges. Some of these relate to comparatively straightforward issues of managing change at a pace that ensures overall quality in the medical labour pool – rather than simply addressing quantity *per se*. In this context, it is essential that the UK continues to act as a quality provider of education, training and work experience to all doctors in contract to the NHS - including those from the EU and elsewhere overseas. More complex issues for receiver countries like the UK are, however, those that encompass what are often euphemistically labelled “quality of care” considerations. At its root this points not only to possible differentials in doctors’ skills and experience but also their suitability culturally to work in the NHS, compared with the domestic labour supply (Moore, 2002). The challenge here is to ensure that such concerns cannot be seen as being addressed in a discriminatory way or as an inappropriate means to restrict access to the UK medical workforce². This may contrast with past experience where overseas and ethnic minority doctors have sometimes been disadvantaged in the UK medical labour market in terms of career progression and geographical location etc (Esmail and Everington, 1993 and 1997; Esmail and Carnall, 1993; Smith, 1980).

For sender, as opposed to receiver countries, the principal concerns about their role relate to their own health system potentially being “stripped” of its expensively trained, skilled medical and other health care professionals. This is particularly the case for less developed countries, in Africa and Asia for example, if international recruitment programmes result in migration on too large or long-term a scale (Bundred and Levitt, 2000; Martinau *et al*, 2002). However, it needs to be remembered that migration is essentially an individual choice; and those that do make such a choice contribute considerable value to the cultures, delivery of services and patient care in the health systems to which they move (Maynard and Walker, 1997). It is also true that doctors working overseas repatriate money thereby boosting inflows of income to their country of origin (Bundred and Levitt, 2000). Hence, a different sort of ethical challenge is also evident. A balance needs to be struck both between sender and receiver countries, and between countries and the individuals who are actually supplying their medical labour and thinking of migrating (Anon, 2000; Findlay, 2002; Van Lerberge *et al*, 2002).

Another dimension of the debate that cannot be overlooked, despite these critical concerns, is that recruitment of health care professionals takes place in the context of an *international marketplace* (Zurn *et al*, 2002). This serves to condition what can and cannot be done to address the supply constraint. The UK is not the only health system seeking to deal with the pressures of medical labour shortages. Imbalances between levels of health care demand and the labour

² Measures to deal with this are already in place through the recommended provision of appropriate induction training and other employment practices to support overseas doctors in the NHS (DoH, 2001d).

supply exist in several developed countries; and although new technologies and medical practices could lessen the pressures in some areas, they will simply re-emerge in others. In less developed countries the problems, though vastly different, are no less acute – with the demand for quality health care vast in relation to the resources needed to meet it. International doctor recruiters (nation states and their agents) are confronted with a global marketplace populated by players of differential power to “purchase” and differential power to “defend” a market share. New entrants arrive from time to time to alter the balance, while the terms of trade (i.e. what skills/people are needed and from where) may also be adjusted in the context of innovation and technical change.

It is in the above context of rapidly changing policy and an on-going learning process that the current research was originally commissioned in 2000 and has subsequently been carried out between March 2001 and December 2002. In this respect there has been a growing recognition that NHS employers, education and training providers, workforce planners and recruitment organisations need to understand the processes behind movement to the UK in order to respond most appropriately. They need more information to be able both to capitalise on a potential source of supply for the UK; and to contribute more effectively to meeting workforce needs in supplier countries by recognising the potential role of return migration of doctors with additional skills (Findlay, 2002).

Study Aims and Main Research Questions

Against this background, the overall aims of the study were:

- To document the broad geography and structure of supply and demand in the international medical labour market, and to outline the UK’s current position in this context;
- To provide a clearer understanding of factors influencing international medical migration to the UK in light of labour market competition from other countries;
- To highlight the major components of change likely to affect UK supplies, so enabling a fuller assessment of the potential contribution of EU/overseas doctors to additional workforce numbers;
- To help inform the UK’s recruitment and retention policies for EU/overseas doctors in highly practical ways.

This required answers to a range of research questions including:

- Which countries are current or potential **suppliers** to the NHS workforce? This might, for example, be because they have doctor surpluses and/or health systems that make NHS training and career experience appropriate for their doctors.
- How **secure** is the supply from such sources likely to be and what factors will bear upon this? This might, for instance, include domestic changes in the numbers of doctors being educated/trained; or perceptions in source countries of the relative attractiveness of the UK compared with other countries.
- What are the **individual** supply side characteristics of EU/overseas doctors currently practising in different parts of the UK medical workforce (e.g. age, gender, nationality, average lengths of stay etc)?
- What are the key **factors that encourage (or discourage)** doctors from different supply countries in their decision to come to the UK? This might, for example, involve exploring the impact on supply of changing economic and societal trends. It also includes looking at: how the NHS is perceived internationally in terms of the education/training/work experience it provides; what influence that might be having on migration choices; and, perhaps most importantly, how the NHS can improve the experience it gives EU/overseas doctors to the mutual benefit of all concerned? A key question in this context was why, despite their being guaranteed free movement through mutual recognition of training and qualifications, EU doctors often migrate only on a short-term basis to gain post-graduate qualifications (Brazier et al, 1992 and 1993; Pitts et al, 1998)?
- What **recruitment and retention strategies** do relevant UK organisations currently use and how can these be improved? This might include, for instance: tailoring packages more effectively to individual doctors' needs, better information provision, and developing additional exchange programmes etc.
- How do changing **regulatory frameworks** – e.g. immigration rules, recognition of qualifications, registration requirements - influence supply patterns and destinations within the NHS workforce? In the past, for example, there was significant overseas (e.g. South

Asian) recruitment of GPs (Taylor and Esmail, 1999), but, post 1985, immigration rules meant that such doctors primarily entered the UK for supervised hospital training (GMSC, 1998). It may be that overseas doctors wanting to work in a primary care setting were simply choosing to migrate to countries with less restrictive immigration rules.

- Which countries are **competing** with the UK for international medical labour? What, if anything, makes those countries more attractive in comparison with the UK? And what can the UK learn from them to improve its own recruitment and retention strategies, immigration requirements, and medical education, training and longer-term working environment – both in hospital specialties and primary care?

Research Design and Methods

In order to answer the above questions, we brought together information from the following sources:

- A review of existing **literature and secondary data** on the international medical workforce, professional migration and labour market approaches to analysis. The main search databases utilised were: MEDLINE, HELMIS, HELECON, BIDS Embase and ISI Web of Science (see Appendix for full details of search strategy). Other published and “grey” literature was obtained using SIGLE, and academic, policy and practitioner contacts both in the UK and major source and competitor countries. At the same time, we also wrote to bodies such as the General Medical Council (GMC), Specialist Training Authority (STA), Post-graduate Deaneries, and Directors of Post-graduate GP Education requesting relevant information on registration, training numbers and participation of EU/overseas doctors in local workforces. Overall, the exercise yielded approximately 300 English language publications that were broadly relevant as background material for the research, as well as data provided through personal communications to the research team. However, it was not our intention to outline the review findings in full in this report (i.e. because that would both duplicate part of the output from the companion project at the Open University Centre for Education in Medicine, and other large-scale briefing reviews recently undertaken, for example by the WHO – see Zurn et al, 2002). Instead, the review exercise has been used to help us, at different stages of the study: to refine research questions; to begin establishing the current UK position in the international medical labour market; to fill out our conceptual framework for competitive analysis of supply and demand; to design the research instruments on the basis of that framework; and to assemble contextual material for EU/overseas fieldwork in particular.

We, therefore, refer to relevant literature as appropriate throughout the remainder of this report and the case study country reports contained in the appendices.

- An analysis of **large-scale computerised datasets** collated by Stats GMS Division and Stats A Division of the NHS Executive (NHSE) – namely the GP principal, GP registrar and Hospital and Community Health Services (HCHS) Censuses. These contain the personal, practice or employment characteristics of all doctors with an NHS contract, and are updated annually. They were made available to us for the period 1991-2000 (GP data) and 1989-2000 (HCHS data). We, therefore, took 1991 as the common baseline from which to collate Census information for the purposes of this analysis. For hospital doctors, country of qualification was obtained directly from the HCHS Census; for GP principals and registrars it was obtained by the NHS Executive linking individuals to their GMC registration. This enabled us to establish: major and minor source countries for EU/other overseas doctors entering the NHS workforce; the most common supply groups (by age, gender, ethnicity etc); the numbers of such doctors in different parts of the NHS (by sector, geographical area etc); their average lengths of stay in post; and any significant changes over time from 1991-2000. The analysis was carried out using MS Access and SPSS Version 10.
- Semi-structured interviews with key stakeholders in the UK (e.g. BMA, GMC, Royal Colleges, Post-graduate Deaneries, Directors of Post-graduate GP Education, STA, British Council etc). These were undertaken in summer/autumn 2001 and covered topics such as: the interviewee's role and the role of their organisation in relation to EU/overseas doctors; the contribution of such doctors to the NHS workforce; perceptions of what makes the UK an "attractive" destination for international medical migrants, and what might need to be improved; which countries are the UK's major supplier countries and which are its major competitors in the international medical labour market; perceptions of the push and pull factors from/to those countries; and what the UK can learn from them in terms of the practicalities of EU/overseas recruitment in the short and long-term (see Appendix for a full list of organisations interviewed). At a similar stage, and using the same research instrument, we also made email contact, and undertook interviews, with a small number of stakeholders at EU level (e.g. Professional Regulation Unit of the European Commission, Standing Committee of European Doctors, Permanent Working Group of European Junior Doctors, European Medical Association etc). Each of the UK and EU interviews was tape recorded, with participants' permission, and transcribed in full. The information gained was analysed by the two main researchers using thematic coding techniques (Dey, 1993; Hammersley and Atkinson, 1995). Notes were kept on possible lines of interpretation and a process of review and reflection employed between the

researchers to check that ideas generated from earlier interviews/analysis remained relevant throughout the fieldwork. Additional interviews were conducted until it was felt that “saturation” had been achieved in terms of the views being expressed. The UK/EU analysis was also used further to refine research questions and instruments for the remaining case study elements of the project.

- Five case studies of supply and competitor countries identified, and agreed with the DH, on the basis of evidence across each of the research stages already outlined. Between them these countries represent a wide cross-section of the international medical labour market in terms of, for instance: political and economic situation; relevant regulatory frameworks; current under or over-supply of doctors; and future medical workforce scenarios. They are:
 - The USA – chosen because it was perceived as by far the strongest competitor to the UK (e.g. for Indian and other overseas, EU and Eastern European doctors);
 - Australia – chosen as both a competitor (e.g. for Indian and other Asian and African doctors) and a supplier of Australian educated/trained doctors to UK;
 - Spain – chosen as a significant supplier, relatively, within the EEA and because together with the UK it is governed by EU mutual recognition of training and qualifications arrangements;
 - Poland – chosen as a minor supplier currently, but with potential to be a larger source of supply on future accession to the EU;
 - India – chosen both as the UK’s current and potential biggest supplier outside the scope of EEA mutual recognition of training and qualifications regulations; and as a major supplier to the UK’s competitors (e.g. the USA and Australia).
- In each of the above countries, fieldwork involved semi-structured interviews and collection of secondary data. Focus groups with individual doctors thinking of migrating were also undertaken in the UK’s main supply country, India. The visits (and telephone interviews in the case of the USA) with key stakeholders (e.g. Ministries of Health, regulatory bodies, professional representative organisations, major training hospitals, medical universities and training providers etc.) were undertaken between autumn 2001 and spring 2002 (translation/interpreter services were also employed, again as appropriate). The topics covered were: the role of the interviewee and their organisation in relation to the medical profession; characteristics of the case study country’s medical labour market (e.g. surpluses and shortages at different career stages and in different specialties); inward and outward migration to/from case study countries; the main pull

and push factors in international medical migration; how the UK and the countries competing with it are perceived in the international medical labour market; and, in particular, what the UK can learn from them to gain “competitive edge” (see Appendix for a full list of organisations interviewed in each country). As with UK and EU interviews, interviews and focus groups in case study countries were undertaken in order to achieve, as far as possible, “saturation” in terms of information gain. They were also tape recorded, transcribed (quality of language comprehension permitting), and analysed thematically by the two main researchers. In the case both of the UK and EU/overseas interviews, we have not reported the interview findings *per se*, but, as with the literature review, have used the material to provide strategic examples throughout the main report and country case studies that follow. Where interviewees’ views are cited, they are individually labelled (UK GP8; UK Anaes 1; EU CPE; Poland Hosp 2 etc) to indicate their country, medical specialty, organisational sector etc.

Once again, it should be emphasised that the project was only ever intended to provide a relatively “broad-brush” guide to the sort of environment that the UK is likely to face in the context of international medical recruitment. It was not, for example, realistic to attempt to provide concrete, quantitative measurements of workforce imbalances in the international medical labour market (see Zurn et al, 2002 for a description of the difficulties involved there). Similarly, we did not set out to explore the experiences of individual EU/overseas doctors in the UK (again, that was the focus of the Open University Centre for Education in Medicine research). Instead our focus was on the perceptions and perspectives of relevant *organisations* in the UK and abroad. Finally, it should be noted that the interviews were never intended to provide a totally “representative” national sample either in the UK or case study countries. Instead, the purpose was threefold:

- To explore participants’ detailed perceptions of the workings of the international medical labour market and the factors influencing the positioning of the UK within it;
- To use this information to understand the complexity of factors and circumstances impacting on doctors as they seek to supply their labour to the market; and
- To explore the ways in which the UK may be able to influence labour market choices across different workforce groups.

Understanding the opportunity-constraint factors in this way is nevertheless important for UK workforce planners, policy makers and NHS recruiters generally as they explore the issue of EU/overseas doctors’ contribution to addressing medical workforce imbalances. Importantly,

although we were restricted in our ability to look at a range of other potentially significant views (e.g. individual practitioners in the UK), the use of multiple sources of information (literature review, UK, EU and case study country interviews, and focus groups) did permit triangulation and hence corroboration of the evidence gained from the many different sources we did access. The study does, therefore, provide an important window on what is an increasingly significant issue both for provider organisations and the UK NHS as a whole.

Remainder of the Report

In Section 2 we outline the overall conceptual framework for the study that was used both to design research instruments, and as the means to organise the wealth of information gathered from the various research stages. Findings from the GP and HCHS Census analysis and interviews with UK stakeholders are reported in Section 3 where the focus is on the current UK position in the international medical labour market in terms of overall picture of demand and supply. Sections 4 and 5 then employ evidence from our UK and EU interviewees, and the supply and competitor country case studies to look at: a) the UK's current position in relation to the process of actually attracting supply and matching it with demand; and b) how the UK compares with its major competitors (which are also identified in Section 5) in the international marketplace on the basis of those same factors. Section 6 then draw together the range of findings on how the UK can maintain its current position, or reposition itself if it needs to do so, within the international medical labour market. The key focus here is on how the UK can gain and sustain competitive edge. Finally, Section 7 summarises overall conclusions and recommendations from recruitment and retention policies for EU/overseas doctors in the UK.

The detailed country reports for the five supplier and competitor case studies – The USA, Australia, Spain, Poland and India – are appended at the back of the main report.

2 FRAMEWORK FOR UNDERSTANDING THE INTERNATIONAL MEDICAL LABOUR MARKET

In this section we briefly outline the conceptual framework used to carry out the research. This also provides the structure through which findings from the GP and HCHS Census analysis, the UK and EU interviews, and the five EU/overseas case studies have been written up in subsequent sections of the report.

Market Forces in an Increasingly Competitive Labour Market for Doctors

Despite the ethical and other concerns raised in the report introduction, it is clear that international processes of EU/overseas doctor movement operate against a background set principally by market forces – even if it is in the context of a strong labour market regulation. While this has always been the case, to a greater or lesser extent, the profile of international recruitment and job seeking seems to have risen in recent years due to a number of factors. First, many of the most developed countries around the world are finding increasing difficulty with medical workforce shortages and are seeking, as is the UK, to solve those problems by recruiting labour internationally from health systems where, notionally, there is an oversupply. Second, international travel and re-location has never been easier for those who have high value in the marketplace for professional skills. Third, the increasing emergence of a ‘common language’ – English – is reducing the cultural and linguistic friction of international migration in medicine as in other sectors. Hence, there is an observable marketplace for medical labour in operation, and, by its very nature as international, it is extremely complex.

Within the marketplace there are purchasers and suppliers of medical labour, and transactions are taking place between them that go some way towards matching country-level demand with supply. There is also competition in which those demander countries wishing to acquire doctors must vie with each other to attract the best quality at the best return in the context of price considerations. From the demand side, there is a changing pattern of countries entering and leaving the marketplace depending on their on-going recruitment needs. From the supply-side, the perceived attractiveness of receiver countries undergoes change in more subtle ways as individuals review their current situation, compare it with the possibilities overseas, and estimate how easy or difficult it might be to re-locate. Finally, there is an evolving differentiation of supply. This involves both the numbers of available doctors from different countries willing and able to consider migration as an option, and the skill bundles

and career stage attributes that they bring to the international marketplace. What it means is that doctors come onto the international labour market from different places at different times, and, at any one time, certain sources will be more readily available to certain demander countries than others.

Exploring National Comparative Advantage: The Porter Model

To assist in us in addressing such a complex market and competitive system from a synoptic perspective, we have drawn on the work of Michael Porter (1998). In a variety of sectoral and labour market contexts, Porter has set out a framework that helps explore *The Comparative Advantage of Nations*. This offers a conceptual model with wide applicability. While not wishing formally to apply all elements of the model here, we have used its salient parameters to structure this study of the comparative advantage of the UK in relation to other countries in the international medical labour market. In essence, a Porter-based analysis is pivoted around what he identifies as the *five forces of competition* (see also technical footnote³):

- The bargaining power of buyers;
- The bargaining power of suppliers;
- The conditions for new entrants;
- The threat of substitute products or services; and
- The structure of rivalry amongst existing competitors.

We shall be using some of Porter's terminology in what follows to emphasise the internationally competitive nature of the marketplace for medical labour at a health system/demander country level. We can also use the framework to examine both *sub-markets* within this overall marketplace (particular specialisms or doctor grades) and the ways in

³ Translated into the context required for this project, Porter's five forces of competition can be described in more detail as:

Power of buyers – This is the relative bargaining power of the demander countries and their health systems in the international marketplace. How far can they dictate rules for engagement, levels of remuneration etc for suppliers (migrant doctors)?

Power of suppliers – This is the relative bargaining power in this marketplace of the individual suppliers of medical skills. How far are doctors themselves able to influence conditions and remuneration levels to the buyers?

Conditions for new entrants – This covers issues such as: How open is the marketplace for doctors with a given set of qualifications and skills? How far can new buyers easily enter the market to alter the competitive balance? Or can numbers of doctors themselves enter at a scale sufficiently large to alter the way the market operates?

Threat of Substitutes – This covers the question of whether conditions in the marketplace are being altered by the exogenous forces of new technologies and practices. Are the 'terms of trade' being altered by entirely new ways of working (e.g. telemedicine, different skill-mixes etc) and will this change the way the marketplace operates?

Structure of Rivalry – This is the way the marketplace regulates itself, or is regulated by governments and other bodies. Are changes taking place that will alter the competitive context and positions of the players within it? In such a highly regulated marketplace as medicine, this is a key variable for the way the market operates.

which these relations find the players (countries and doctors) arrayed in different sets of competitive positions relative to each other. Since we are not attempting to use Porter's logic as a basis for formal competitive analysis, but more as a conceptual framework upon which to configure our more qualitative observations, we have not extended our discussion here (therefore, see Porter, 1998 if more detail is needed).

The Marketplace as a System of International Migration by Individuals

What is, of course, missing from a macro-level economic analysis of the medical labour market (as to differing degrees for any international labour market) is the fact that, at root, any international movement decision is as much about personal utility as it is economic (or is at least made in the context of family). Doctors are not passive goods simply moved around the global (or indeed national) economic system in accordance with the balance of supply, demand and price. Not least, they are themselves *active players* (purchasers of opportunity as well as suppliers of labour) in the marketplace, making key choices (e.g. about what additional education/post-graduate training/post-training employment experience they need to enhance their own career/human capital, or what prospects they want to be able to offer their families/children). From this perspective, the functioning of the international medical labour market can only be fully understood by looking at doctor recruitment, as other skilled worker recruitment, as a process individual *migration* (Rees et al, 1996; Rees and Kupiszewski, 1999; Salt, 1992 and 1994; Salt and Ford, 1993). In other words, the choices made by migrating individuals significantly influence the overall picture of international demand and supply in their own right. Most importantly, the *actual* supply of labour comes from doctors individually bringing their skills and experience to the marketplace – rather than from countries or health systems as a whole.

For the sake of simplicity, we shall still be referring to individual countries as the 'suppliers' or 'receivers/demanders' of medical labour – not least because the aggregate perspective is in itself a useful tool for describing the labour market. From the supply-side, for example, doctors' from some geographical sources may have greater probability than others of bringing specific attributes to the marketplace that have weight from the UK point of view (e.g. speaking English or coming from an education/training system that is more compatible than others with working in the NHS). It may be appropriate, therefore, in terms of scale efficiency, to target recruitment on certain country-level sources rather than others. From the demand-side, it is useful to think of the national picture as a representation of the actions of individual recruiters (e.g. in the UK, Trusts, local GP practices and education/training bodies), each of which finds a way to signal their needs to the marketplace. This aggregate picture of

vacancy rates (e.g. in the UK, of hospital consultant, SHO/SpR grade, or GP vacancies) is refracted through country-level regulatory frameworks and becomes potentially the key basis upon which individual doctors in supplier countries make their migration decisions. It is, therefore, the aggregate actions of individual migrants (and how these are influenced by national and international economic, political, health and regulatory environments etc) that, even from an organisational perspective, we have been most concerned with as the driver behind labour market processes. This is because as the actual supply of labour comes from individuals, it is decision-making at that level which potential employers (e.g. within the NHS) – and demander countries as a whole (e.g. the UK) – increasingly need to influence to ensure EU/overseas doctor supplies in future.

The Elements of the International Competitive Process

In our case then, the power of these suppliers of professional skills relates both to the labour market and personal choices exercised by individual doctors and to the market power exercised by supplier countries as a whole. Nation states could, for example, reduce their own medical school intakes to tackle any domestic oversupply with the outcome that their doctors can find work more easily without having to migrate. The power of the buyer is a function of those factors we considered earlier plus the overall number of buyers competing in the marketplace. In the context of UK health care, the NHS can be viewed as a powerful, almost monopolistic customer for the domestic labour supply (i.e. with private sector employers relatively insignificant in terms of numbers of doctors employed), but it is, nevertheless, competing with other buyers (i.e. other countries' health care systems) in a global market for a limited supply of medical labour trained overseas. The power of those rivals is likely to depend on their relative attractiveness to EU/overseas doctors, for example in terms of pay and conditions and the training and experience they provide, as compared with what the UK has to offer. The threat of substitute products or services is relevant, for instance, because a country's ability to move with technological change and skill-mix in the medical sector may alter its position in terms of the kind of labour it needs to attract and its attractiveness to some elements of the labour supply. Skill-mix changes involving greater responsibility for nurses and other health professionals can mean that countries require fewer doctors to deliver a given range of health care services. Finally, there is always the threat of new entrant competitors. This depends on how easy or difficult it is to join the competitive process at a given level against the built-in advantages of those already in the marketplace.

From this conceptual basis, but also drawing on more focused analyses of labour market dynamics (Gleave et al, 1981; Doeringer and Piore, 1985; European Commission, 1994; Peck,

1996; Wilson and Stilwell, 1992.), we set out to establish the position of the UK NHS within the global medical labour market. Whilst many of these approaches, and Porter's framework in particular, are essentially common sense, they do provide us with a well-known and helpful basis upon which to describe the nature of the doctor migration and the job-filling processes relevant to this research. We will now expand on our analytical framework based on the principles of labour market economics in more detail.

Profiling the Demand Side of the International Marketplace for Doctors Migrating to the UK

If we begin by looking at the demand for doctors within a given health system, it is possible to partition the sorts of opportunities (or 'slots' as we shall subsequently call them) that exert pull in international movement into three groups: a) undergraduate medical education slots; b) post-graduate training slots; and c) post-training employment slots. These present the real opportunities (i.e. vacancies) for doctors from the EU/overseas to enter the medical labour market in the UK. Each slot, has a number of key attributes that will bear upon the individual applicant's willingness to consider moving to occupy it. In the first two cases, the likely considerations would include: the perceived quality of the education/training on offer; the price of that education/training at a given quality; and the opportunities in the post-training labour market open to doctors that have gone through a particular system etc. In the case of direct employment slots, these will also have the normal attributes of job opportunities generally. It will be a question of where they are located, what conditions of employment they offer, what levels of remuneration are available and, again, what quality of life and future employment opportunities they open up to the job occupant.

Clearly, each of these, and all three in combination, will vary considerably from health system to health system, and for those countries seeking to recruit international medical professionals this will underpin their competitive position in the marketplace. In some demander countries, for example, the health system will be one that can confer very considerable benefits in terms of qualifications and experience on the individuals involved, and also significant financial remuneration. In other cases, the quality of education/training on offer may well be high but levels of remuneration low, or vice versa. Seen through the window of the countries involved, the three groups of job and education/training opportunities will represent some form of general statement about an 'opportunity surface' for migrant doctors projected onto the global marketplace. A key feature of this projection will come from the ways in which *information* on the availability of education/training and job opportunities is made known to the wider world, how the available opportunities are promoted, marketed, branded and

generally given “market weight”. Another key dimension here will be the extent to which a given country perceives its need to take international promotion and marketing seriously. Those countries in extreme supply shortage are, for example, more likely to be offering attractive packages, often tailored to individual needs of both training and longer-term employment opportunities. They will be more driven to market these opportunities widely and with enthusiasm in order to attract doctors into their own national labour market. On the other hand, countries with fewer supply problems may simply be offering opportunities less to meet a serious shortage but more as a source of revenue. For instance, both undergraduate education and post-graduate training may themselves be offered as ‘products’ on the international market. So while migrant doctors may be contributing to healthcare provision during the period of their training, this will not be seen as an end in itself.

While these specific features of the education/training or job slots on offer have a role, what international migrants will be seeking is, of course, a better quality of life and future prospects for themselves and their families. Doctors will expect to ‘buy’ a package of relocation opportunity. The availability of children’s education, good housing, and a comfortable cultural environment is a key parameter not of a slot itself, but of the cultural and social setting in which the education/training/job slot is set. The demand side of the international medical labour market, then, presents itself to its potential suppliers as some form of hierarchy in which there are ‘more desirable’ and ‘less desirable’ health systems and demander countries.

Profiling the Supply Side of the International Marketplace for Doctors Migrating to the UK

From the supply side, it is the propensity of individual doctors at different career stages to look for an education/training or job opportunity in other countries that shapes the market. The process here may be considered as one that goes on continuously as individual doctors in one country appraise their current situation against the other potential opportunities available to them if they chose to migrate to another. These conditions will, of course, vary over life and career stages. For example, some will already be well-educated individuals looking for the first stages of their specialty training. Some will be doctors wanting on-going experience on completion of their existing post-graduate training; and others will already be in practice, but looking for further experience (e.g. in a particular specialty or with certain types of medical techniques and equipment etc) and/or better job opportunities elsewhere. In this sense, then, supply is segmented into groups - each of which has attributes to do with doctors

themselves, their current situations, and their personal perspectives on the alternative futures that they may be willing to consider taking up.

Once again, it is possible to generalise supply-side circumstances by aggregating them up into the common characteristics that might apply in a given country. So, for example, doctors from India or Poland might be expected to share a number of common characteristics. Using the country label in this way is simply ‘shorthand’ for a much more complex set of variables in terms of the availability of particular types of labour supply, though national systems of qualification, regulation and medical practice will inject a recognisable commonality in a given country context. Other key features that might significantly distinguish one supplier country from another relate, for example, to the ability to work competently using English as a language, or being able to identify with NHS and UK cultural values.

Another reason for looking at supply through a country level window is that in some cases individual nations will act to facilitate or restrict the supply of doctors that they have educated/trained. Nation states will, for instance, have different attitudes to allowing those on whom they have spent public funds to migrate to supply their labour elsewhere. In other countries where notionally there is a degree of excess supply it may well be that the nation state itself is willing to engage with other countries (e.g. in government to government agreements) to facilitate the process of exchange. It may be that there are also *quid pro quo* arrangements that offer skilled doctors in return for health care support of other kinds. When, therefore, we refer to a given country as a supplier of medical labour the assumption is not that it supplies its doctors to the labour market in any simplistic sense. However, a nation state can take a particular stance - actively facilitating, simply not standing in the way of, or actively discouraging the movement of a particular set of doctors. The root choice is, however, that of the potential migrant doctors.

Matching Supply and Demand: Elements of the Process

In the previous sections we have outlined the concept of a demand-side seen through education/training/job slots and a supply-side as comprising individual suppliers of medical labour to fill them. The action of a labour market is, of course, to combine these two together in some way that satisfies both the needs of demand and the wishes of those on the supply side. The smooth working of any marketplace, and particularly one based on labour services, demands both good information and what might be termed ‘goodness of fit’. What this implies is that in some way the available education/training/job slots are of the right number, of the right set of attributes (e.g. quality, cultural and social setting etc) to attract those who

are willing to supply their labour to fill them. It also implies that this picture of the demand-side is signalled effectively to those doctors that are scanning the marketplace for appropriate international opportunity. From the point of view of this research, it is clear that particular health systems will be more or less able to meet the full spectrum of suppliers' needs and will or will not be identified as offering cachet or market power to those who come to fill the slots. Those health systems that are most able to do this will no doubt be the most successful attractors of medical labour on the international marketplace. What it was, therefore, important to find out from the UK point of view were the sorts of *attributes that characterise the most successful players* in the international marketplace and how the UK stands against them. It is to this topic that we turn in the remainder of the report having first profiled the current shape of demand for, and supply of, EU/overseas doctors in the UK as the basis from which to move forward.

3 THE CURRENT UK POSITION IN THE INTERNATIONAL MARKETPLACE: THE OVERALL PICTURE OF DEMAND AND SUPPLY

In this section, we begin to explore the UK's position in the international medical labour market by looking at the overall picture of demand for EU/overseas doctors versus supply. In doing this we use evidence from the range of sources available to us including UK stakeholder interviews, the analysis of NHSE Census data and other secondary material on medical workforce participation. The topics covered on the demand side are: stakeholders overall views on NHS workforce needs and the role of EU/overseas doctors in meeting them; the actual evidence on workforce needs by specialty, geographical location etc; and the "opportunity surface" presented by the UK to the international marketplace – i.e. the education/training/post-training job slots open as routes to UK labour market entry for doctors from abroad. On the supply side we look at: who the individual doctors are that come to the UK (e.g. in terms of age gender, ethnic origin); where they are in the workforce and how long they stay; where they have come from (i.e. in terms of major and minor supply countries); and any changes in each of these trends over time. Overall, the section aims to illustrate how far, if at all, demand for EU/overseas doctors can be said to match with supply, and to give some idea of the complexity facing such individuals when they look at the opportunities available to them in the UK.

Overall Views of NHS Workforce Needs and EU/Overseas Doctors' Contribution

The clear perception of all the stakeholders interviewed in summer/autumn 2001 was that there is an overall shortage of doctors in the UK medical workforce. No one indicator was used to define that shortage, however it was said to exist across the board – i.e. from general practice to a large number of hospital specialties. Specifically, reference was made: to the numbers of vacancies in certain specialties; to the UK's past inability to educate, train, and retain sufficient doctors to be self-sufficient in supply terms; to unmet need evidenced by long waiting times for appointments; and to the poor quality of applicants, and job slots being filled by less than ideal candidates. The implicit criteria used therefore covered both quantitative and qualitative indicators of shortage. All of the problems were seen as particularly acute in inner city areas, such as inner London, and in certain other geographical regions including the North West, the North East, and the Midlands.

There was also agreement that in the short to medium term, the supply problem is unlikely to be resolved from domestic sources, despite recent increases in medical school intakes, and the

development of new 4-year fast-track graduate medical courses at several universities. However, as these increases in home-grown graduates feed through the system, some thought that they should enable the UK to approach self-sufficiency. The over-riding policy aim implicit in all UK interviews was that the UK ought to be self-reliant. A typical comment was:

“I do think we should still be aiming at self-sufficiency. We may have to have a bridging loan from overseas, but it must be the smallest possible, partly for the other reasons, but partly because it will prevent us moving towards self-sufficiency just because of the way government works.” (UK GP 4)

This viewpoint was supported by many of the ethical and practical arguments already outlined in our report Introduction. The ethical arguments related to the issues surrounding ‘brain drain’ from developing countries, and the inappropriate nature of the training overseas doctors receive in the UK in relation to the health care needs of their home country, to which it is assumed they will ultimately return. The practical arguments related to differences of language and culture, which it was felt could cause difficulties both for trainers, in the training context, and for patients in the context of service delivery. Although all the interviewees acknowledged that overseas doctors make a major and significant contribution to the UK medical workforce, nevertheless, this view was prefaced by comments indicating that, ‘ideally, we would not start from here’.

Perceptions of the likely future demand scenario, and of the role of overseas doctors within it, varied. To some extent demand side pressures could be extrapolated from current legislation, from government policy, and from lifestyle and workforce trends. The latter included: the trends towards shorter working hours; the increasing number of women in the workforce, with a greater percentage working part-time; and the increasing numbers taking early retirement. Another factor pointed to as intensifying workforce pressures in hospitals is the progressive introduction of the European working time Directives, applying to junior doctors. Accordingly, the current maximum of 72 hours will reduce to 58 by 2004, to 56 by 2007, and to 48 by 2009. Moreover, these limits will include hours spent on duty and on-call, or resting in the hospital, whereas currently the limits apply only to ‘actual work’. Other requirements likely to have an impact on the demand for junior hospital doctors are the need for 11 continuous hours rest in a 24 period, and a maximum of 8 hours work in 24 for night workers (Pickersgill, 2001). Finally, the reduction in juniors’ hours, coupled with a government policy commitment to an increasingly consultant-delivered service, (within National Service Frameworks) has implications both for immediate service delivery, and for

training capacity for future supply. All interviewees agreed that given these trends, more doctors would be required, and that in the short to medium term at least, part of the supply must come from outside the UK.

Evidence on Demand-side Shortfalls – The Potential Openings for EU/Overseas Doctors

We have already outlined current government targets for medical workforce growth in the Introduction to this report, where we also noted that those targets are set against existing imbalances between demand and supply. Clearly, it is beyond the scope of this research even to attempt to develop a coherent picture of the NHS medical workforce needs, and within that the percentage requirement for recruits from the EU/overseas. This would be difficult enough given the way in which actual and projected target numbers have been presented, and different timescales for projections promised under separate government announcements for medical workforce increases. It is complicated still further by the enormous social changes (e.g. the increasing numbers choosing to train or practise part-time, or flexibly) which mean that future NHS workforce requirements are as much a function of deployment and retention of existing staff as they are of on-going recruitment. We have nevertheless looked at government sources and published information, as well as data supplied by UK stakeholders, to gauge the major perceived trends, and the quality of information available, in terms of workforce shortfalls. At this stage, we have chosen to focus particularly on the data about vacancy rates as a means of describing the situation in both hospital-based jobs, and general practice. Although a shortcoming of this indicator is that vacancies may be hidden by budget constraints, or because employers have given up the attempt to recruit (Zurn et al 2002), it does provide us with a useful window on the overall picture of opportunity that the UK is able to present to the international medical labour market.

Hospital Specialty Shortages

Information on hospital vacancies tended to be patchy, and was often anecdotal. There is no centrally maintained aggregated database of vacancies for either service positions or for SHO basic specialist training positions, appointments for which individual Trusts are responsible. Deaneries make the appointments to (and part fund) the SpR higher specialist training posts, and keep some records required for returns to the DoH, although our access to the information varied. The 3-monthly DoH Vacancies Survey for March 2001 shows overall vacancies for medical and dental staff at 3 % (Quoted in Zurn et al 2002), but other evidence suggests that this figure masks wide variation. Press reports put the consultant vacancy rate as high as 1 in 8. For example, Scunthorpe and Goole Hospitals have a 13% consultant vacancy rate,

Birmingham Women's Healthcare 12.5%, Oldham 10%, Redbridge Health Care 10%, Calderdale Healthcare 9%, Blackburn, Hyndburn and Ribble Valley Health Care 9%, and North Tees and Hartlepool Trust 8%. The regional distribution of shortages is said to be partly associated with the reluctance among consultants to work in the North of England (DoH, 2002c). Recently, the DoH Team involved in the overseas recruitment campaign also compiled a list of vacancies, with the help of Trusts, in regions known to experience chronic workforce shortages, where the current recruitment campaign is to be rolled out. So far, the North West and the North East regions have been the focus for specific recruitment pilots. Within this overall picture of geographical shortages, the specialties of particular interest to the DoH (already noted in the Introduction to this report) are, amongst others: cardio-thoracic surgery, histopathology, radiology and psychiatry (DoH, 2000b and 2001c). This pattern of national shortage areas is again reinforced by information from individual Trusts on specialties such as histopathology, anaesthesiology and cardiology. Birmingham Women's Healthcare Trust, for example, has the second highest national vacancy rate of 12.5%, but its shortages are particularly acute in histopathology and clinical genetics (DoH, 2002c).

Some information on hospital vacancies was also made available to us by Royal Colleges, although the detail of the workforce data varied. Such data collection was secondary to the main purposes of Colleges (i.e. maintaining standards and quality), and given funding restrictions, clearly would not be a priority in the foreseeable future. However, various reports do point in some degree to an assessment of workforce needs. As just one example, the annual census of the Royal College of Physicians (covering England, Wales and Northern Ireland), estimated that another 2,600 consultant physicians are needed to maintain quality of care (Dobson, 2001). Similarly, according to its recent publication *Clinical Radiology: a Workforce in Crisis 2002*, the Royal College of Radiologists is suffering from a severe workforce shortage. Currently there are 1,600 consultants, but 3,300 are needed just to meet current demands. An estimated 6,000 consultants would be needed to fulfil plans for a 24-hour service, to meet the needs of an ageing population and growing teaching commitments, and to compensate for reduced juniors' hours (RCR, 2000).

Another recent Royal College of Radiologists survey found that there were 200 radiology vacancies across the UK. As 45% of radiology SpRs are women, and 75% of them are considering part-time working, the shortages are likely to continue (Smy, 2002). The situation is made all the more complicated by, for example, National Service Frameworks (e.g. setting time targets for patients to be seen by a specialist) with their implications for staffing levels not only in the clinical areas that they directly cover (e.g. cardiology and cancer care), but also for other groups involved in diagnosis such as radiologists and

histopathologists. Importantly, the problems in radiology are not felt to result from the unpopularity of the discipline itself. Training places are popular and oversubscribed. The problem is that there is not the capacity to further increase training along the current systems. There are alternative suggestions for training methods, including setting up radiology schools, where learning via computer simulation/self-directed inter-active learning, could occur in parallel with hospital-based training for each area/module of the curriculum. It may be, therefore, that in the long-run radiology will have less of a need to recruit EU/overseas doctors than other specialty areas.

In contrast with radiology, shortages in psychiatry were said to result from the discipline's lack of popularity amongst medical trainees in addition to issues of training capacity. There are not enough SHO posts, and not enough candidates to fill the SpR posts. In addition, the 12% consultant vacancy rate is compounded by the fact that many leave the profession, or retire early. The high vacancy rate was said to have a cumulative de-moralising effect on the remaining consultants. Again this is one of the specialties involved in the International Recruitment Campaign coordinated by the DoH. Other areas of perceived shortage include pathology - particularly paediatric pathology, with 1 in 5 consultant posts reportedly vacant in this sub-specialty (Grant, 2002). However, evidence from the International Recruitment Campaign indicates that it is not simply a case of filling vacancies in one specialty without considering the wider impact on other service areas. So, for example, filling vacancies in cardio-thoracic surgery has implications for all other specialty staff involved in the surgery. In this particular case, 4 out of 10 surgical units that originally applied to be part of the International Fellowship Scheme reportedly withdrew because they did not have the resources, including enough cardiac anaesthetists, to support extra operations (Anon 2002a).

As indicated by some of these reports, the UK cannot expand its consultant numbers instantly, given the long lead-time for specialist training. Nor can it dramatically increase training capacity. The expansion in UK-trained consultant numbers needs to be a stepped and synchronised expansion. The implication, therefore, is that there will be a short-term gap, which could be filled by one of two strategies: firstly, by allowing progression from staff grade/associate specialist posts to consultant status, and secondly, by overseas recruitment. The first strategy would help to meet government targets by increasing consultant numbers, but would not increase the overall size of the specialist workforce. However, it might address some of the concerns for professional progression of those who hold such posts, and send positive signals to potential overseas recruits. As far as overseas recruitment is concerned, part of the problem is that the gap, in terms of government targets to reduce consultant level

shortages, is occurring at a level, and in specialties such as histopathology, psychiatry, radiology and cardio-thoracic surgery, in which there is a worldwide shortage.

SHO Grade Shortages

In terms of sheer numbers, the SHO hospital grade is the main area of domestic shortage, and the available pool of overseas labour supply mainly enters the UK at this level, filling about one third of available job slots. However, the numbers are not required to go forward in the same quantity to specialist training and consultant practice. In a pyramidal workforce structure some labour either needs to be shed at this stage, or to remain at a sub-consultant, or career-grade level. Traditionally, more UK graduates have progressed to consultant level, whereas overseas doctors have filled 65% of expanding staff grade posts, and only 17% of consultant positions (and 27% of SpR posts). We look in more detail at overseas entry into the UK workforce in the next section. However, as the increases in UK-trained doctors feed through the system, there is likely to be a supply level too great even for all UK doctors to enter specialty training. Plans to limit the amount of time that can be spent in the SHO grade (Anon, 2002b) will have the effect of forcing some hospital doctors to remain long-term in career grades, or alternatively to undertake further training/retraining in other specialty areas, or for general practice. There are proposals for tailor-made training for overseas doctors, for those changing specialty, and for returners. Such developments will have implications for the structure of the workforce, for the way shortages are defined, and for the demand for overseas doctors. They illustrate, once again, the extent to which this research is set against a backdrop of changing policy, with different stakeholder interests in reducing or increasing supply or demand.

At the present time, however, the reality of the current high level of reliance, of hospitals in particular, on the contribution of overseas doctors, was acknowledged and appreciated, by various stakeholders, such as hospital trusts, Deans, and Royal Colleges. The major reliance in certain hospital specialties is such that without the contribution of overseas doctors, the service would simply not function. This was apparent, for example, in anaesthesiology and psychiatry:

“Some thing like 62% of hospitals, well coming up to two thirds, would not have been able to run a rota without their overseas doctors...If you took the overseas doctors out of the system, they could not, they would shut down this day” (UK Anaes 2).

Directors of GP training, and various Royal College of General Practitioners (RCGP) representatives also felt that there had been, and still was, a considerable reliance on overseas doctors. We look next at some examples of the way in which shortage in general practice was evident to our interviewees.

General Practice Shortages

Stakeholders involved in the provision of general practice vocational training, and in the regulation and registration of GPs, all pointed to the unmet demand for GPs. Estimating the shortages and projected shortages in general practice involves looking at some policy drivers, as well as the evidence from some individual local studies. Government policies driving up demand for GPs include the reaffirmation of the central role of general practitioners, as gatekeepers to access to secondary specialist hospital care, through the power and scope of PCTs. In practical terms, more care has shifted from the secondary to the primary sector, as a result of the increase in day surgery and the earlier patient discharge from hospital. These policy decisions ensure that the demand for GPs will continue to be high. Moreover, despite the potentially countervailing changes (e.g. NHS Direct, the burgeoning e-health industry, and organisational changes in the skill-mix of professionals within the primary setting), it is by no means clear that GPs' workload – and hence demand for GP numbers – will decline accordingly (Sibbald and Young, 2001). Indeed, there may actually be an increase in workload associated, for instance, with the administrative tasks around audit, clinical governance and other recent quality agendas such as more CME and revalidation. Add to this a developing trend towards greater flexibility and part-time working, especially as more women feed through from training into the profession, and the case could actually be made for an even greater increase in workforce numbers. Professional estimates have considered 1.5 wte replacement GPs for every one retiring to be necessary, (RCGP, 2000), but more recent opinion from our stakeholder interviews has revised this upwards to two (UK GPs 6,7,8). The profession is currently not even recruiting one for one.

The potentially diminishing supply of UK trainees to fill GP vacancies is evident from data provided to us by the JCPTGP. In 1990, there were 2,114 new vocational training certificates issued (87% of which were to UK graduates, 4% to EEA graduates, and 9% to other overseas doctors). By 2000, there were only 1,689 new certificates issued, 74% to UK graduates, 14% to EEA, and 12% to other overseas graduates). NHSE data supplied by Deaneries show that the trend continues, with EEA and other overseas doctors each accounting for approximately 8% of doctors on the Vocational Training Scheme (VTS) in 2000, and for 13% and 11% of GPR posts respectively (NHSE personal communication 2000). As with the hospital

specialties, the perceived lack of UK graduates to fill VTS places was more evident in certain geographical areas than others. For example, Yorkshire, Anglia, Wessex, and North Thames (East) had noticeably higher levels of EEA graduates in training posts, and North Thames (East), West Midlands, Anglia, and the North West had higher than average numbers of other overseas doctors.⁴ As another anecdotal example, we were told that Cleveland, in response to its 2001 advertisement for its August intake of GP Registrars, had 50 applicants, and offered places to 20 UK graduates, 6 EEA graduates, and 24 other overseas-qualified doctors (mainly from India, Pakistan, and Egypt – some of whom already had residency rights, and some of whom were self-funding). There were a further 16 vacancies. The situation was said to have improved slightly in the last 5 years. Twenty years ago, there were apparently 10 applicants for every available post.

From the other end of the GP career ladder, the perceived pressures and low morale are felt to be leading to higher levels of early retirement, sufficient to raise serious concerns. In certain geographical regions and inner city areas, (for example, the North West, Birmingham, the Midlands) there are additional problems associated with the fact that many doctors from the Indian sub-continent who entered the NHS as GPs in the 1960s/70s are now approaching retirement (Taylor and Esmail, 1999). This general picture can be fleshed out by more detailed analysis of need versus workforce projections undertaken, for example, by the North West Deanery, (Mathie and McKinlay 1999). They showed that about a third of GP principals were over the age of 50 in 1999, in a region with a relatively high percentage of overseas doctors who entered general practice in the 1960s and 1970s. The study projected the best and worst case retirement scenarios, and concluded that around 1,250 GPs would need to be trained to replace those retiring between 1999 and 2003. Given a current capacity of 124 trainers, expanding training to maximum realistic targets would only produce 487 GPs, leaving a large shortfall.

Other anecdotal evidence of impending workforce shortages was also obtained from our interviews. In the Northampton area, for example, stakeholders reported that there was currently only one vacancy out of 110 GPs. However, of several posts which have become vacant recently, almost all took some time to fill. With 20% of the local workforce due to retire within the next 5 years, the situation could become more serious. Therefore, although

⁴ It is important to note, here, that not all Deaneries were able to provide us with relevant data on VTS doctors. We were also unable to obtain information on the overall numbers of unfilled vacancies, or on the numbers of rejected applications by source country, as no data were kept. Some Deaneries could supply limited information about their current intake of GP Registrars. However, comparative data over time was also unavailable, as a Deanery wide system for making, and recording, appointments, has only recently been implemented. In other words, the picture described here may not wholly reflect all local situations.

the area considers itself to be a “relatively attractive” location, well placed in recruitment terms compared with more Northern areas, “... we genuinely share the view that there is a major crisis” (UK GP4). Once again, however, this example illustrates the lack of truly robust data to assess workforce needs in many areas. As our Northampton interviewee pointed out, “It all tends to get a bit anecdotal when people are planning to retire and all this sort of thing, and if I’m honest (as a Board member of the PCG) we haven’t done the analysis as rigorously as we might have done” (UK GP4). As a further illustration of the difficulty of predicting workforce need, a study commissioned by East Lancashire (University of Lancashire 1998) estimated that only 75 GPs would be needed over the next 5 years for that area within the Deanery, compared with 224 estimated in another local study in 1999 (Mathie and Mckinlay, 1999). In 2001, the authors reassessed the actual rates of retirement, and found them to be running at approximately 70% of their estimates. As a local interviewee commented, “So there isn’t much planning going on!”. However, the same interviewee still argued that, in order to meet overall demand for GPs, “... we need to treble or quadruple training capacity in this Deanery in the next 5 years” (UK GP7).

Routes to Entry and Career Progress in the UK Workforce: Education, Training and Post-training Job Slots for EU/Overseas Doctors

Against this general background of gaps needing to be filled, we can now look at the demand-side opportunity surface actually presented by the UK to the international marketplace. This is configured according to such factors as the supply and demand situation for the particular specialty, and the regulatory framework governing different types of training and post-training jobs (both in general practice or hospital specialties) which have different visa and registration requirements. It is also configured by the point on the medical career ladder at which labour market entry is sought, and can therefore be analysed in terms of opportunities and constraints in undergraduate education, post-graduate training (including basic and higher specialist training, and general practice training) and post-training job slots. In what follows we focus both on the ease of labour market entry for EU/overseas doctors via these different “slots” and the prospects for subsequent career progression between them.

Entry via Undergraduate Medical Education

At undergraduate level, UK medical schools offer places to overseas students to study for their primary medical qualification. At a time of reduced University per capita funding coupled with expansion in numbers, the higher tuition fees paid by overseas students has helped in the funding of course provision. Undergraduate students may enter the UK on a

student visa. Following graduation, they would normally stay in the UK for at least their pre-registration house officer (PRHO) year, (with provisional registration) and possibly subsequently for their SHO jobs (with full registration), eligible under permit-free training. Because of the length of their stay in the UK, they would by this stage be able to apply under immigration law for permanent residence, and so, in combination with their UK training, be in a strong position to access higher specialist training posts. So long as they had UK residency they would also be eligible for GP vocational training. Unfortunately, in terms of data on the career progression for EU/overseas doctors in the NHS (see below for more detail on the supply-side), it is not possible to distinguish these doctors from other UK graduates in the NHS workforce. However, we do know that, on average, overseas students occupy 7% of capacity (with a maximum of 10% occupancy) (Grant et al, 2002) and it seems reasonable to assume that a percentage at least will remain in UK practice.

Entry via Basic Specialist Training (SHO Posts)

SHO posts, for basic specialist training in either medicine or surgery, follow the PRHO year, and are applied for by junior doctors in open competition. Although this is a training grade, it is also the ‘workhorse’ grade delivering the major amount of service. There is a shortage of UK qualified doctors to fill these posts, and so this is the stage at which overseas doctors have traditionally entered the NHS workforce. Currently, overseas doctors occupy over 30% of the hospital SHO posts.

Entry into SHO posts, is the level for which competency (specifically of overseas, as opposed to EU doctors) is assessed through the screening process of the IELTS (International English Language Testing System) and subsequent PLAB examinations. Part 1 of PLAB, the basic clinical sciences section examined through multiple-choice questions (MCQ), may be taken either in the UK or at certain overseas centres. Part 2, the Objective Structured Clinical Examination (OSCE), may only be taken in the UK. Success in PLAB, and obtaining a job, give access to ‘limited registration’ with the GMC (limited to a particular training post). As the SHO post is a training position, immigration regulations allow entry on the basis of ‘permit-free training’ (for up to 3 years, with a possible further extension of one year), so there is no requirement for a work permit for these posts. However, initial entry into the UK to take the clinical part of the PLAB (Part 2, /OSCE), will usually be through a visitor’s visa. An alternative route of entry, which by-passes the PLAB examination, is through sponsorship, either through one of the Royal Colleges’ Overseas Doctors’ Training Scheme (ODTS), or through the British Council. Doctors must have a sponsor both in their country of qualification and in the UK, and must still demonstrate their competency in English through

passing the IELTS examination at level 7 or above. This scheme is currently under review. In contrast with other overseas doctors, those trained in the European Economic Area (EEA) may enter the UK at will to obtain work. They also enjoy the benefits of the mutual recognition of qualifications, and so are automatically granted 'full registration' with the GMC. They do not need to undertake any language assessment.

Importantly, although there are large numbers of demand-side opportunities at the SHO level, there is also enormous competition to fill them. The number of overseas doctors taking the PLAB exams and competing for SHO posts is increasing year on year⁵, and even given that the pass rate is around 60%, the numbers getting through the PLAB now greatly exceed the available job slots. Figures quoted in the OU Interim Report (Grant et al, 2002) for 1997 show 4,430 non-EEA SHO overseas doctors in post, covering 3 or 4 years of training. Available first year slots, unfilled by UK graduates, will therefore be between one quarter and a third of this figure. Qualification through PLAB is, then, no guarantee of employment. There can be as many as 200 applicants for a single SHO post, and there are examples of overseas graduates making more SHO applications than their UK counterparts before they are accepted (Grant et al, 2002). There is therefore a bottleneck for overseas doctors at the point of entry into basic specialist training. Although this bottleneck exists for UK graduates for certain popular specialties, such as surgery, there is currently no UK unemployment at this level. It would seem, therefore, that the greater opportunities for overseas doctors to obtain an SHO post lie in locations and specialties that are under-subscribed by UK graduates – this point was made both by our UK interviewees and by the OU research.

Entry via Higher Specialist Training (SpR Posts)

During the 3+ years of SHO training, Part 1 and 2 of Membership (for example, of the Royal College of Physicians or the Royal College of Surgeons) is taken, leading to the award of MRCP/MRCS. Membership is usually one of the basic entry requirements for posts of higher specialist training undertaken in the Specialist Registrar (SpR) grade (in anaesthetics, for example, passing the Primary RCA examination would be required for entry into higher training). SpR posts are for a period of around 5 years, depending on the specialty, and are

⁵ Total numbers taking PLAB Part 1 amounted to 4,682 in 2001 (2,402 at UK centres, and 2280 overseas), up 3,377 in 1998. There was a small dip in numbers in 2000. Numbers are projected to increase by 56% for the whole of 2002, over 2001 numbers – with 4,483 already examined by August 2002, and a further 2,810 registered/estimated for the rest of the year. Part 2 numbers have also increased dramatically (although less so than for Part 1, partly because of the capacity issue in clinical exams). From 741 examined in 1998 (the year the OSCE was introduced) numbers reached 2,323 by 2001. 2,072 had already taken Part 2 by August 2002, with a further 1,776 estimated for the remainder of the year, a total of 3,848, and an increase of 66%. (GMC Personal Communication, Sept 2002).

limited in number, depending on the planned workforce requirement at consultant level. These posts are known as Type 1 training positions, and carry a National Training Number (NTN). They are applied for in open competition. Successful completion of Type 1 SpR training leads to the award of the Certificate of Completion of Specialist Training (CCST), which in turn allows entry onto the Specialist Register, so enabling appointment to a consultant post. Doctors holding either European Community rights of residence or an overseas nationality can both access a Type 1 post. However, there is an additional entry requirement in that without the right of indefinite residence, or settled status, the post is only classed Visiting SpR (VSpR).

A major bottleneck in progression occurs at the end of SHO grade in terms of the numbers able to access Type 1 SpR training. Some doctors may mark time in SHO posts attempting to gain a training number. The alternatives are to switch to a less popular specialty, or to take up other types of appointment that do not in themselves count as relevant experience for moving up the career ladder, but may nevertheless increase doctors' chances of getting a future SpR post in their preferred specialty⁶. Another alternative for overseas doctors is to obtain a Type 11 SpR training position, (alternatively called a fixed-term training appointment, FTTA, usually lasting between 6 months and 2 years), carrying a Visitor Training Number (VTR). An FTTA delivers the same training as a Type 1 programme, but nevertheless does not lead to the award of a CCST, and cannot lead to entry to the Specialist Register. The intention behind these Type 11 programmes is to enable higher skills training to be gained by overseas doctors intending to return to their country of origin. They can be accessed through an ODTS direct placement, or through competition limited to overseas and non-UK EEA doctors. There are no national workforce pre-set limits on either Type 11, or VSpR posts available to overseas doctors. In practice, however, they are limited by funding constraints (NHSE, 1998). In addition, it is likely that much of the training capacity currently deployed in these posts will be absorbed by the increase in Type 1 programmes to meet expansion. At least one of our UK stakeholders argued that overseas specialty training could effectively be curtailed as a result (UK Org 4).

In terms of the actual proportion of SpR posts occupied by doctors qualifying outside the UK and EEA, the available data (aggregated across the different types of training positions within the SpR grade category) puts the figure as around 35% and 28% respectively. This appears to be a slightly smaller dependence on overseas doctors at SpR level than in the SHO grade (the

⁶ This might include: a) an appointment in a 'staff grade' post, which is purely for service, and has no official training element; b) short-term locum appointments for service (LAS); or c) locum appointments for training (LAT), which may occur, for example, as a result of a period of maternity leave.

latter being made up of 34.5% non-EEA doctors) (DoH, 2000c). In addition, although the limited data that Deaneries were able to make available to us should be treated with considerable caution⁷, it does suggest that non-EEA doctors do not make successful applications for SpR posts as frequently as their UK counterparts⁸. They also appear to be more likely to be in non-accredited training posts (i.e. Type 11 or FTTA posts, with Visiting, rather than an actual National, Training Numbers) that do not lead to a CCST qualification and have implications for subsequent progression to consultant status⁹. Moreover, opinion in some specialties, such as surgery, (which is in general oversubscribed by UK graduates), was that future demand is likely to be more fully met by UK graduates, thereby closing off SpR opportunities even further for doctors from abroad. Again, as with SHO posts, the main opportunities in future were felt to lie in relatively “unpopular specialties”, like psychiatry and anaesthetics, or in “unpopular locations”, which are ‘heavily dependent’ on overseas trainees¹⁰.

Entry via General Practice Training

General Practice has different regulations for access to vocational training from those relating to hospital specialties. Registrar posts for training in general practice may not be accessed by doctors who do not have ‘full’ GMC registration, or who do not have right of residence, which is the criterion for funding. Thus, the majority of non-EEA trained doctors are ineligible for vocational training on the grounds that their GMC registration is ‘limited’, and the largest single group of overseas doctors entering the UK from South Asia, is in effect excluded from these job slots. However, those who have right of residence through marriage

⁷ Data on SpR appointments was not collected by the Deaneries that replied to our enquiries on the basis of country of initial qualification. Although many Colleges and Deaneries intended to start collecting data, which would give a more detailed picture of their specialist trainees in future, most were implementing too many other changes to spare time to do so currently. In other words, they tended only to collect what was required in law for ethnicity monitoring, and even this was not easily comparable across areas. Finally, as only three Deaneries were able to provide us with data, we cannot be certain that the trends reported reflect an overall picture.

⁸ For example, South West Deanery data for 2000/01 (collected information on the basis of ethnic origin) showed that, out of 748 ‘White’ applications, 281 were short-listed, and 110 were appointed. For the ‘Indian’ ethnic group, the next highest number, the figures were 742 applications, 117 short-listed and 23 appointed. Other appointments were totals of 5 Pakistani, (2 of which were VSpR posts), 3 Black African, and 1 Chinese.

⁹ North West Deanery data for 2001 showed, for instance, that: just over a third of SpR trainees were non-EEA doctors (n=345), but they formed only 12% of NTNn (incl. 28 Indians, 14 Pakistanis, 11 Nigerians, 8 Egyptians, 6 Malaysians, 4 Chinese, and 3 each from Singapore and Iraq). This compared with the 59.42% (n=618) from the UK and the 6.44% (n=67) from the EEA that formed 78.46% and 7.85% of NTNn respectively (10 others were of unknown origin). In addition to the NTNn, the Deanery had 179 VTNn predominantly staffed by doctors from India (107), followed by Pakistan (15), and Nigeria (11). Indian doctors also held the majority of FTTA posts (39 out of a total of 67). Only two FTTA posts were occupied by UK holders of CCSTs, and a further five were held by EEA nationals (3 from Spain, and one each from Germany and France) who had taken the positions to gain more experience.

¹⁰ By contrast with the relatively small number of (assumed) overseas doctors in the relatively rural South West Deanery for example, the more urban Sheffield Deanery had a ratio of 54:47 of UK:OD doctors as SpR trainees in the year 2000/1, with the majority of the overseas doctors (26) of Indian nationality. Egypt supplied 3 SpRs, Germany and Nigeria 2 each, with several other countries supplying only one each.

or another criterion may apply, even if their initial qualification is from outside the EEA. The exclusion does not rest on the country of initial qualification. Thus, a doctor who has completed primary medical training in, say India, and has passed PLAB, and has moved from limited to full registration during SHO posts, and who has citizenship or right of residence in the UK, may access vocational training. The medical spouse of a doctor in permit free training, has residency rights, and so, as a doctor, becomes eligible for vocational training. In addition, those who do not have UK residency rights are ineligible for funding for training. Thus, for example, an Australian doctor who is eligible for 'full' registration because his/her PMQ is recognised as equivalent by the GMC, but does not have a right of residence, must obtain a Training and Work Experience Certificate (TWES) (formerly from the Department of Education and Employment, and now from the Work Permits section of the Home Office), to gain access to training, but must also be able to demonstrate that he/she can self-fund the training.

There are two possible routes to achieving certification for general practice training: one is via the three year programme, which consists of 2 years of SHO rotations, relevant to the breadth of the work in general practice, followed by a year's attachment as Registrar in an accredited training practice. At Deanery level, Directors of Postgraduate GP Education allocate the 3-year GP Registrar training positions. The second route is through a self-construct programme of SHO posts, which may then be recognised as suitable for access to the 1-year practice attachment phase of the training. It was estimated by Deaneries that between 50-70% of those ultimately hoping to undertake GP training were following a self-construct SHO route (NHSE personal communication 2001). Until recently, 1-year GPR attachment appointments could be allocated by the training practice itself, without consultation with the Deanery. Now, however, all GP training appointments are made through the Deanery. Because all GP Registrar posts are supernumerary, definitely not service posts, unlike SHO posts, they are 'unpaid' in the normal sense, and therefore the GP Registrar's pay is met entirely from Deanery training funds.

The second option is a more feasible entry route into general practice for non-EEA overseas doctors, as they may be able to apply for and achieve full GMC registration and residency rights, by the time they have reached this phase of their training. However, it is also a more risky option, as they may not manage to obtain the required 'mix' of relevant posts. This second route could provide an opportunity for those overseas doctors who have full registration, but not residency, but who are prepared to self-fund the one-year vocational training place. However, few do, as this is an expensive option. The second route also allows the possibility for doctors to switch out of a hospital specialty into general practice. This

might be the case where there has been an over-production of CCST holders, (for example in obstetrics and gynaecology), or when a doctor has failed to obtain a NTN for specialty training. Some of these doctors have sought registration as GPs, (but would be required to complete an extra 6 month's relevant SHO rotation and the GP vocational training year first).

Although most Deaneries reported that they had experienced difficulty in recent years in filling training slots with UK candidates which means that there are potential opportunities for EU/overseas doctors, there are still constraints in the system. Until last year, for instance, Deaneries could offer whatever number of 3-year vocational training places they had the capacity to deliver, but recent regulatory changes mean that the distribution of training places between Deaneries is now more centrally controlled. As just one example of the impact of this change, Wessex reportedly has a large training capacity, relative to its workforce needs. It has more qualified GP trainers and accredited training practices than it needs to fill its own vacancies. Because of the dearth of UK candidates, it has in the past filled some of its places with EEA doctors. As a relatively "attractive location" that has not experienced GP workforce shortages, it has also been able to afford to 'export' some of those trained GPs to other regions. With the recent regulatory changes such opportunities to accommodate more EU/overseas doctors than are needed in a given locality have been diminished.

Entry into Post-training Job Slots in Hospital and General Practice

Until recently there have been far fewer opportunities for migrant doctors to enter the NHS workforce at the level of post-training employment either in hospital or general practice – both in terms of the overall number of job-slots available and the particular entry requirements in some areas. In general practice, for example, 1985 changes in immigration regulations effectively closed the opportunities for non-EEA doctors because they were unable to stay in the UK for long enough to achieve the required full-registration status to complete vocational training and become GP principals. As we have already described in our introduction, however, recent years have seen more opportunities opened up for EU/overseas doctors to enter the NHS workforce at the post-training consultant or GP principal level. Specifically, the country-based pilot recruitment schemes – initially recruiting doctors from Spain on a regional basis, starting from the North West, and rolling out to the North East region – have identified vacant job slots both for GPs and consultants in various hospital shortage specialties. In addition to the regional pilots for long-term recruitment of doctors, the International Fellowship Scheme has been introduced in order to recruit top-level consultant-level specialists to the UK for a period of 2/3 years. Finally, the government has sought to open up opportunities for EU/overseas consultant-level specialists in the UK by

contracting an independent recruitment company, TMP Worldwide, to manage the recruitment process, resulting from a global advertising campaign.

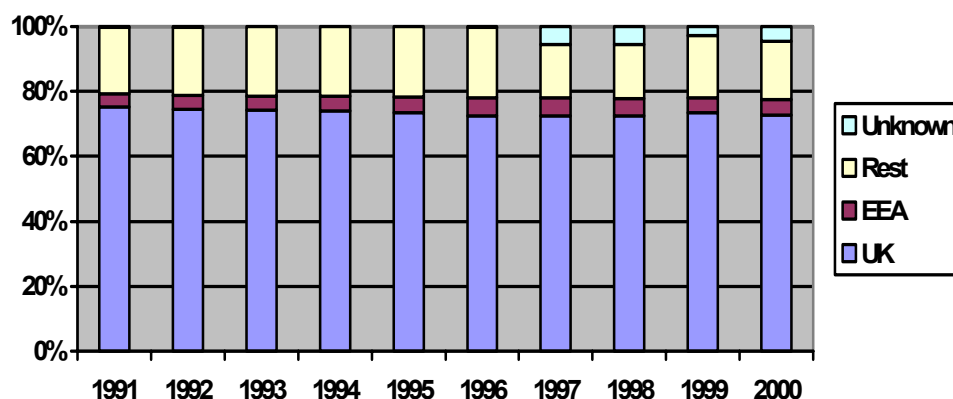
Supplies of EU/Overseas Doctors to the UK: Evidence from GP and HCHS Census Data

We have already mentioned some locally available information about EU/overseas doctor supply at the level of medical training (namely in the SHO and SpR grades) in our above discussion of demand-side education/training/post-training job opportunities. However, for the purposes of this research we needed to build up a much more comprehensive picture of that supply in the NHS workforce as a whole, as far as possible using national level data. This was important in its own right, but was also relevant to the selection of appropriate case study countries for subsequent fieldwork exploring the UK's competitive position abroad. As already outlined, our analysis primarily concentrated on the GP and HCHS Census material (which contains doctors' country of primary medical qualification (PMQ) and other variables) made available to us by the NHS Executive for the period 1991-2000. However, it was also supplemented using secondary data from the GMC on registration by country of primary medical qualification, and from the STA and JCPTGP on specialist and general practice registrations following successful completion of post-graduate training.

Overall Contribution and Characteristics of EU/Overseas Doctors in the NHS Workforce between 1991-2000

As Figure 3.1 shows, the overseas-qualified doctors continued to make an important contribution to the NHS workforce (i.e. as it was recorded on either the GP or HCHS Censuses) throughout the 1990s. More specifically, the average percentage of overseas doctors per year was slightly increased from 25.7% for 1991-1995 and 27.2% for 1996-2000 (See also Table 1 in Appendix 2).

Figure 3.1:
Percentage of overseas qualified doctors in the NHS medical workforce



Within that overall picture, however, there are differences in terms of the characteristics of doctors of different broad supply sources. For instance, Figure 3.2 shows the age distribution of the workforce, aggregated over all years from 1991 to 2000. It is evident that doctors who qualified in the EEA tend to be younger than UK qualified doctors; whereas those who qualified in other countries tend to be older than UK qualified doctors (See also Table 2 in Appendix 2). In addition, Figure 3.3 shows that, from 1991 to 2000, the UK qualified workforce has become more middle-aged with both fewer younger (20-39 yrs) and fewer older doctors (60+ yrs). Doctors who qualified in the EEA show a similar trend. By contrast, those that qualified elsewhere in the world show the opposite trend with a marked decline in the proportion aged 40-49 yrs.

Figure 3.2:
Age group by person years aggregated over 1991-2000

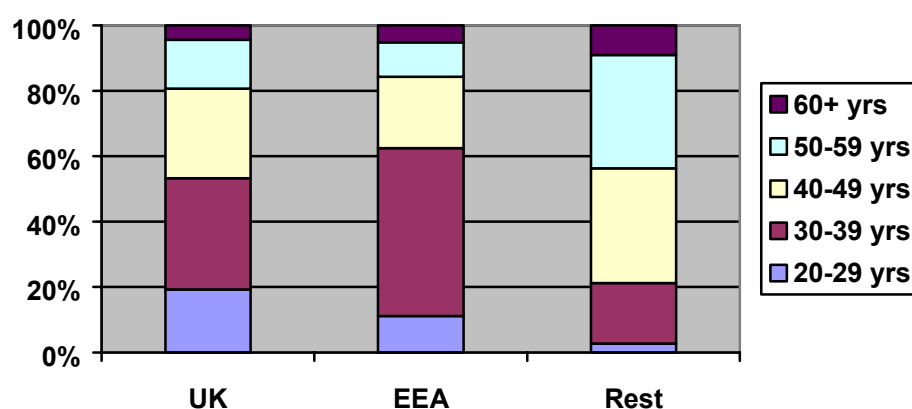
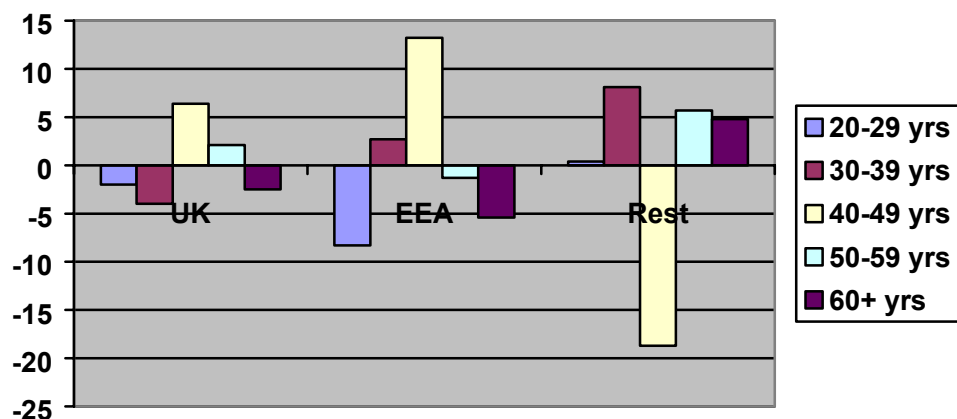
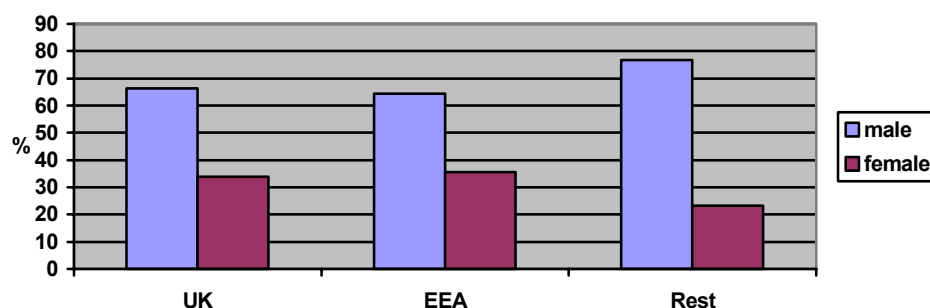


Figure 3.3:
Percentage change in age group from 1991 to 2000



There are similar contrasts between broad supply sources in terms of the gender distribution of the workforce (see Figure 3.4). Aggregated over all years from 1991 to 2000, the figures show that, whereas doctors who qualified in the UK and EEA have a similar sex distribution, those that qualified elsewhere in the world are more likely to be male (See also Table 3 in Appendix 2). Overall, from 1991 to 2000, the percentage of women in the workforce increased by 6.0% among UK qualified doctors, 5.7% among EEA qualified doctors, and 2.4% among doctors who qualified elsewhere in the world.

Figure 3.4:
Sex by person years aggregated over 1991 to 2000



The exact proportions of doctors by ethnic group are unknown as information on ethnicity was missing for approximately 40% of the workforce in all years from 1991 to 2000. However, based on what information is available, the ethnic mix of doctors who qualified in the EEA appears similar to that of doctors who qualified in the UK (see Figure 3.5). Nearly 90% are white. Those who qualified in countries elsewhere in the world are more ethnically diverse with Asians comprising the single largest group (See also Table 4 in Appendix 2). As

Figure 3.6 shows, there were only small changes from 1991 to 2000 in the ethnic distribution of the workforce. In the UK qualified workforce the proportion of white doctors declined while in the EEA qualified workforce it increased. Among doctors who qualified elsewhere in the world the proportion who are black or Asian increased with consequent falls in the proportion that are white or of other ethnic status.

Figure 3.5:
Ethnic group by person years aggregated over 1991-2000

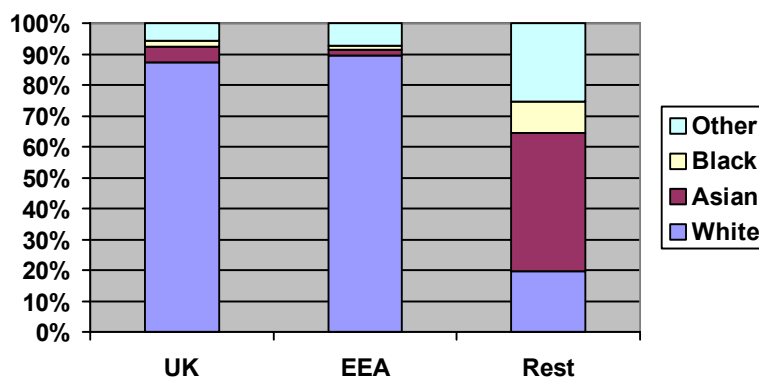
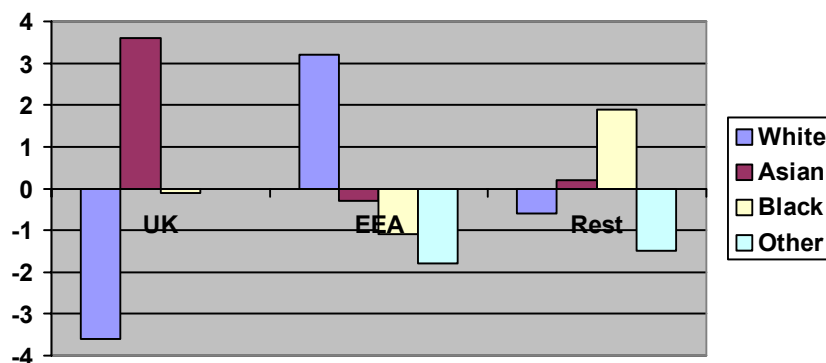


Figure 3.6:
Percentage change in ethnic group from 1991 to 2000

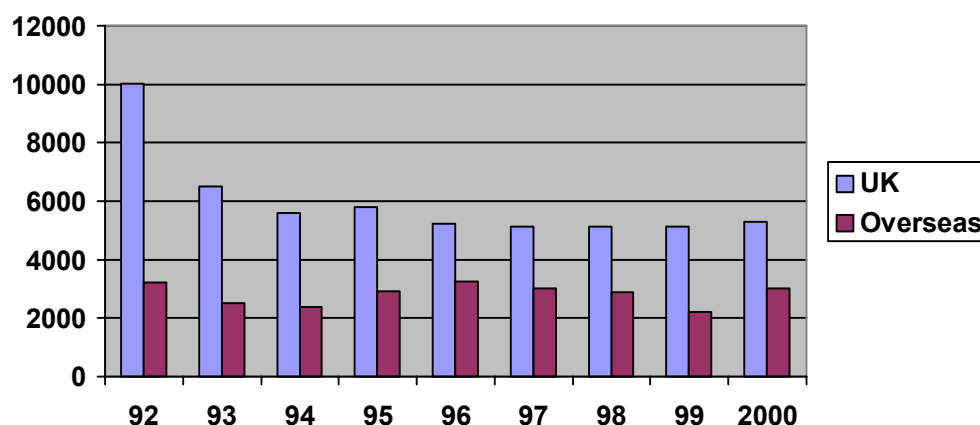


EU/Overseas Doctors as New Entrants to the NHS Workforce – Full Registration

The percentage of overseas-qualified doctors among new workforce entrants with full registration increased from 39.5% in 1992-1995 to 58.3% in 1996-2000 (Figure 3.7). The figures for 1992, however, are atypical in terms of the high numbers of UK qualified doctors entering the workforce. When the figures for 1992 are excluded, the increase in the percentage of overseas doctors is less marked, rising from 43.5% in 1993-1995 to 58.3% in 1996-2000. The change is attributable both to a 17.2% decline in the average number of UK qualified doctors per year (from 5962 in 1993-5 to 4932 in 1996-2000), and to a 10.7% rise in

the average number of overseas qualified doctors per year (from 2598 in 1993-5 to 2877 in 1996-2000) (See also Tables 5-6 in Appendix 2).

Figure 3.7:
Numbers of doctors (with full registration) entering workforce

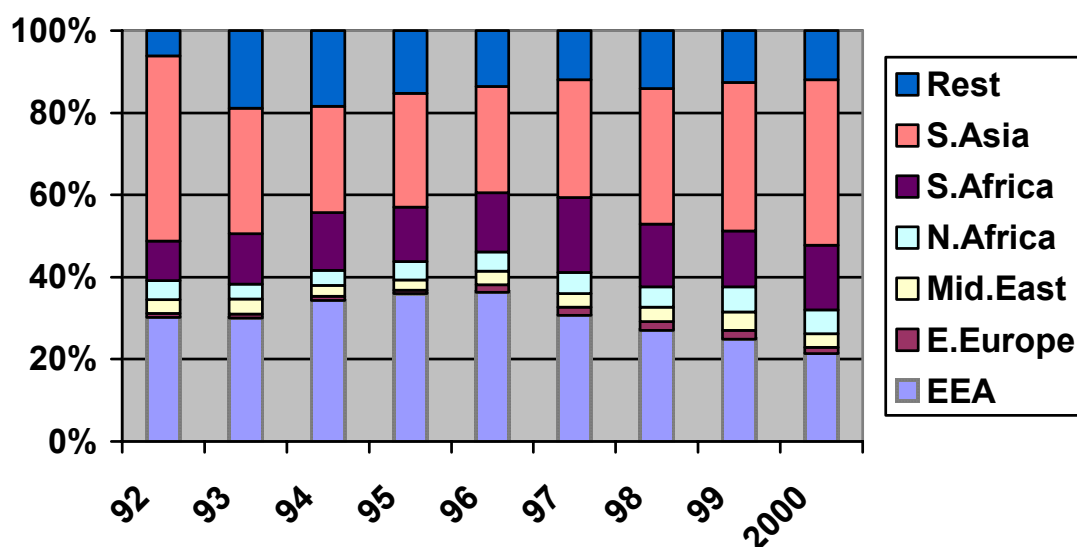


Country-Level Sources of Supply for EU/Overseas Doctors – Full Registration

Overseas-qualified doctors are recruited to the NHS from countries throughout the world. Figure 3.8 shows the major geographical regions of supply for doctors with full registration entering the workforce during the period 1991 to 2000. During this period, South Asia (including India, Pakistan, Sri Lanka and Bangladesh) and the EEA were by far the largest supply sources, with Southern Africa (which includes all countries south of the Sahara) also figuring as important. The proportion of doctors with full registration recruited from South Asia shrank slightly during the mid-1990s and then expanded again. The reverse is true for doctors recruited from the EEA. Other sources of supply show less variation over time. It is also possible, within each geographical region, to highlight the countries that supplied the greatest numbers of doctors with full registration to the UK as follows:

- Republic of Ireland and Germany in the EEA
- Poland in Eastern Europe
- Iraq in the Middle East
- Egypt in Northern Africa
- India in South Asia
- Australia in the rest of the world

Figure 3.8:
Source of overseas doctors (as a percentage of all overseas doctors) by year



Appendix 2 gives a more detailed breakdown of the numbers of doctors with full registration recruited from individual supply countries in the EEA (Appendix 2, Table 7) and other geographic regions (Appendix 2, Table 8) for 1991 to 2000. The 20 leading countries supplying doctors entitled to full registration to the NHS from 1991 to 2000 are also shown in Table 3.1 below. India is the biggest supplier by a wide margin. Germany, South Africa, Australia, the Republic of Ireland and Egypt are also important sources.

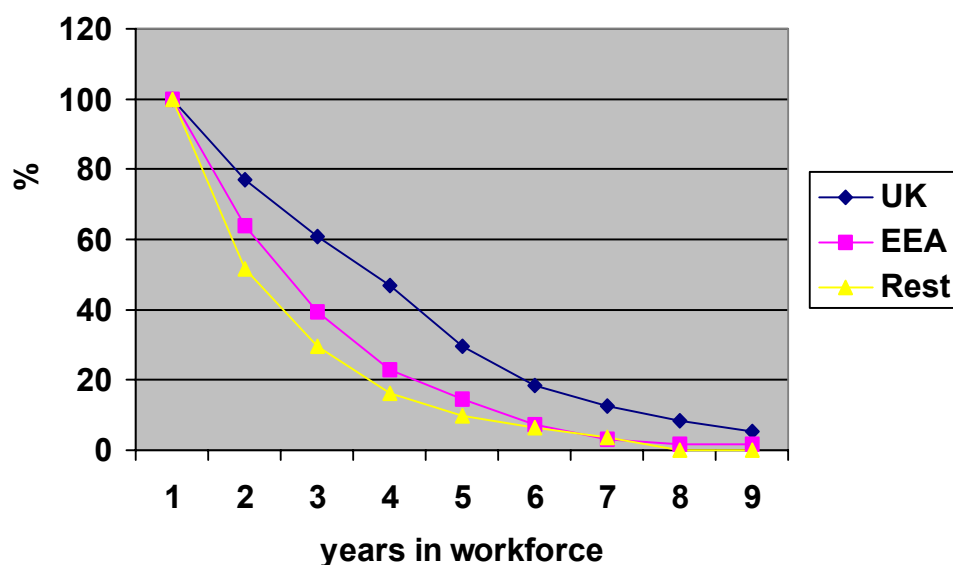
Table 3.1:
Major supply countries to the NHS Workforce – Full Registration

Source country	Average number recruited per year 1991-2000	Source country	Average number recruited per year 1991-2000
India	702	Italy	49
Germany	247	Sri Lanka	49
South Africa	208	New Zealand	46
Australia	193	Jamaica	44
Republic of Ireland	189	Burma	19
Egypt	107	Bangladesh	18
Spain	84	Poland	10
Greece	72	Singapore	8
Pakistan	68	USA	8
Netherlands	60	Malaysia	7

Lengths of Stay for EU/Overseas Doctors in the NHS Workforce – Full Registration

Figure 3.9 shows how long new entrants with full registration remained in the workforce (i.e. how long they continued to be recorded in the GP and/or HCHS Census) before their first departure. The analysis is necessarily confined to those doctors who entered the workforce within the period 1991-2000 because otherwise we do not know when their stay began. The lengths of stay shown in Figure 3.9 therefore underestimate doctors' true length of stay. It is evident that UK-qualified doctors stay longer than EEA qualified doctors who in turn stay longer than doctors who qualified elsewhere in the world. The median duration of stay (i.e. point at which 50% have left) among those who leave is approximately 4 years for UK qualified doctors, 2.5 years for EEA qualified doctors and 2 years for doctors who qualified elsewhere in the world (See also Table 9 in Appendix 2).

Figure 3.9:
Percentage of doctors (with full registration) remaining in workforce by number of years after entry



The length of stay until first exit is influenced by a doctor's sex and age. In the workforce as a whole, men were slightly more likely than females to leave within 5 years of entering, after which women were more likely to leave than men. These differences are most evident among doctors who qualified in the UK or EEA. For doctors who qualified elsewhere in the world, there were no consistent differences between men and women (Table 3.2).

Table 3.2
Percentage of new entrants remaining in workforce by sex – Full Registration

	UK		EEA		Rest of World	
	Male N=11581	Female N=10678	Male N=1455	Female N=1152	Male N=922	Female N=561
% staying to year...						
2	76.1	77.9	63.6	64.3	51.9	50.8
3	60.4	61.4	39.3	39.3	28.7	30.8
4	47.0	46.9	23.2	22.7	17.0	14.7
5	30.2	28.8	14.7	13.2	10.7	8.7
6	19.4	17.2	7.2	7.1	6.1	6.2
7	13.6	11.4	2.2	4.4	1.5	6.2
8	9.4	7.5	0.9	3.3	-	0.0
9	6.1	4.4	-	3.3	-	-

In the workforce as a whole, younger doctors (aged 20-29 yrs at entry) were more likely than older doctors (aged 30-39 yrs at entry) to remain. This difference is most evident for doctors who qualified in the UK or the EEA. The reverse is true among doctors who qualified elsewhere in the world, with older doctors remaining longer than younger doctors (Table 3.3).

Table 3.3
Percentage of new entrants (with full registration) remaining in workforce by age

	UK		EEA		Rest of World	
	20-29 yrs N=21189	30-39 yrs N=1007	20-29 yrs N=1344	30-39 yrs N=1220	20-29 yrs N=1133	30-39 yrs N=342
% staying to year...						
2	77.1	76.7	65.4	62.1	49.1	59.0
3	61.1	57.9	42.3	36.0	28.2	33.2
4	47.2	41.2	25.6	19.9	15.7	15.7
5	29.7	25.7	17.7	9.8	9.2	13.5
6	18.5	15.7	9.0	4.9	6.2	6.7
7	12.6	12.1	3.9	1.9	3.1	6.7
8	8.6	7.7	1.9	1.9	-	0.0
9	5.3	6.3	1.9	-	-	-

Destination of EU/Overseas Doctors within the NHS Workforce – Full Registration

NHS databases provide information on the distribution of new entrants (with full registration) to the NHS workforce across health regions in England. However, boundary changes in health regions between 1991 and 2000 make it difficult to aggregate data in a way that permits changes in the geographic dispersal of new entrants to be followed over time. We chose to group regions into three geographical areas for analysis, as indicated in Table 3.4.

Table 3.4
Categories used to analyse the geographical distribution of new workforce entrants

Area used in analysis	NHS Health Region		
	From April 1999	Pre April 1999	Pre April 1996
North	Northern & Yorkshire North West	Northern & Yorkshire North West	Northern Yorkshire Mersey North West
Midlands	Trent West Midlands	Trent West Midlands	Trent West Midlands
South	Eastern London South East South Western	North Thames South Thames South & West Anglia & Oxford	East Anglia South East Thames South West Thames North East Thames North West Thames Wessex Oxford South Western

Figure 3.10 summarises the destination of new entrants, aggregated over 1992 to 2000¹¹. There is little difference between doctors who qualified in the UK, EEA, or elsewhere in the world in terms of their distribution across England. Over half of all new entrants locate in the south (See also Table 11 in Appendix 2). However, there are differences in the geographical distribution of doctors who qualified outside the UK or EEA (see Figure 3.11). Doctors who qualified in Northern African or South Asia are more likely than UK qualified doctors to locate in the midlands or north of England. Doctors who qualified in Eastern Europe resemble UK qualified doctors in their distribution. Doctors who qualified in the Middle East, Southern Africa, or other areas (not otherwise covered) are more likely than UK qualified doctors to locate in the south (See also Table 12 in Appendix 2).

¹¹ Note that doctors (with full registration) excluded from analysis include: those for whom information was missing on country of qualification or health region of destination; and those whose destination was Wales, a special health authority or a special hospital.

Figure 3.10:
Destination in England of new entrants by area of qualification - person years aggregated over 1992-2000

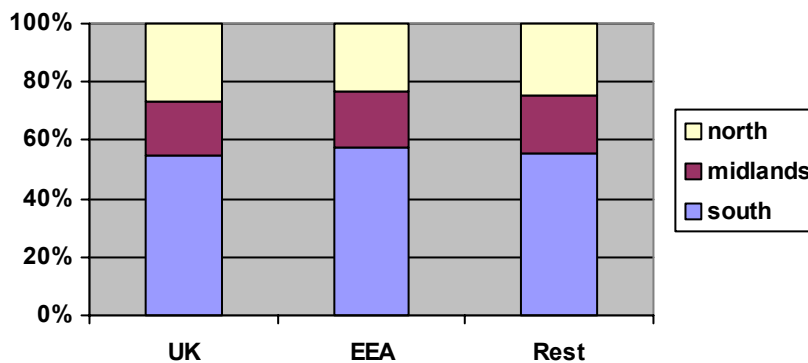
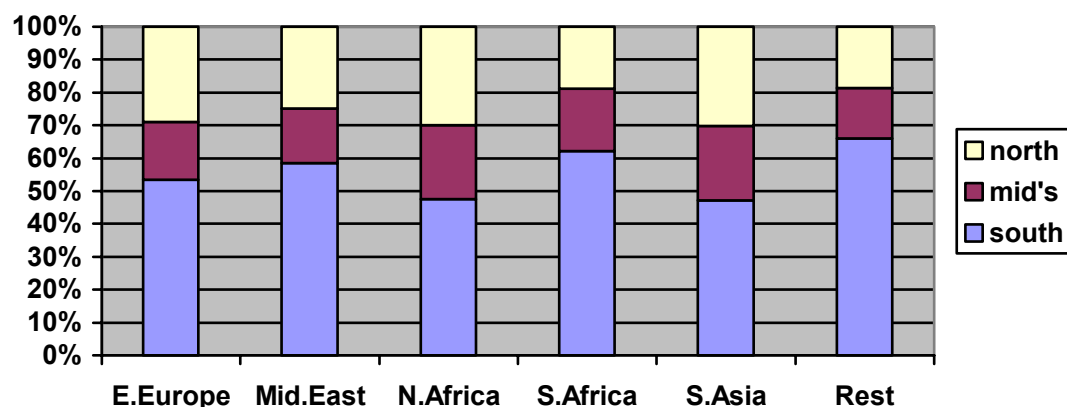


Figure 3.11:
Destination in England (north, midlands, south) of new entrants who qualified outside UK or EEA - person years aggregated over 1992 to 2000



Sources and Characteristics of EU/Overseas Doctors with Limited Registration

Doctors with limited registration comprised 5-6% of the whole NHS workforce recorded on the GP and HCHS Censuses between 1991 to 2000, and approximately 20% of the overseas' qualified workforce in the same period (See Table 13 in Appendix 2). All doctors with limited registration qualified in countries outside the UK and the majority appear to have come from South Asia. However, information is missing on country of qualification for 60% or more of doctors with limited registration from 1997 onwards which means we cannot be precise about their source.

The overall age, sex and ethnic distribution of doctors with limited registration is detailed in Table 14 of Appendix 2. Their characteristics as compared with doctors with full registration are summarised in Figures 3.12-3.14 below. As Figure 3.12 shows, doctors with limited registration tended to be younger than those with full registration. In terms of their gender distribution (see Figure 3.13), doctors with limited registration resembled those with full registration who qualified outside the UK or EEA (i.e. there is a higher proportion that is male in both groups). Finally, in relation to ethnic origin (see Figure 3.14), doctors with limited registration most closely resembled doctors who qualified outside the UK or EEA in terms of the low proportion who are white and the high proportion who are Asian.

Figure 3.12:

Limited vs full registration: age group by person years aggregated over 1991-2000

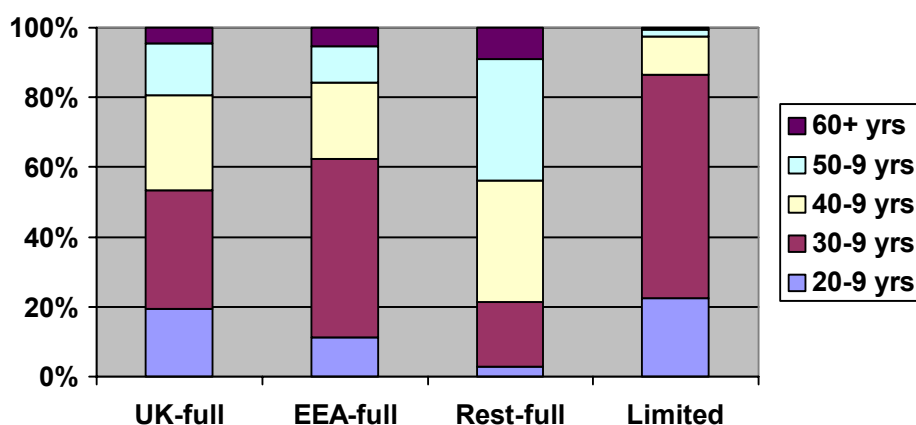


Figure 3.13:

Limited vs full registration: sex by person years aggregated over 1991-2000

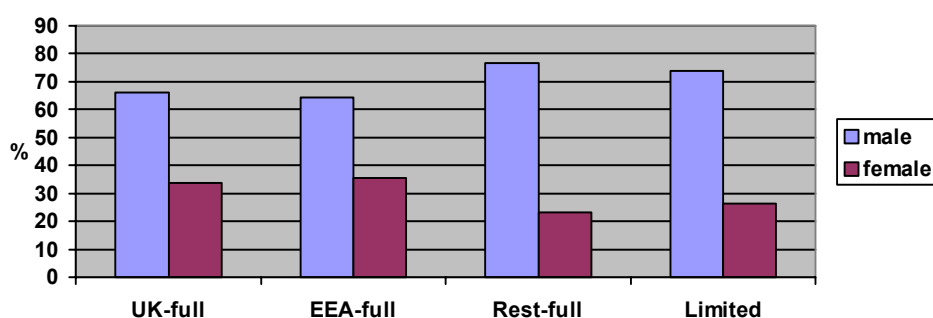
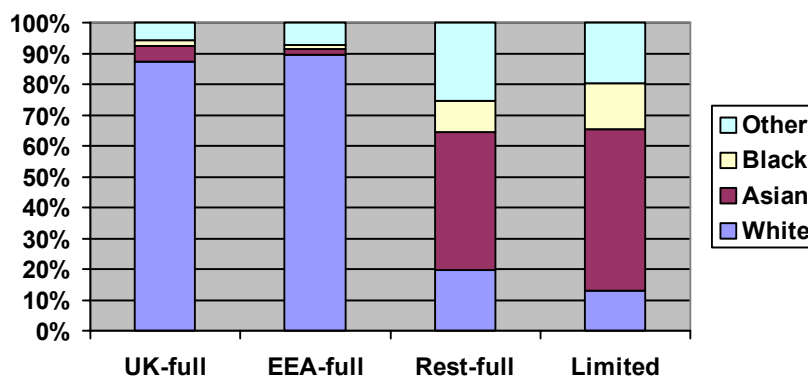


Figure 3.14:
Limited vs full registration: ethnic group by person years aggregated over 1991-2000



Supplies of EU/Overseas Doctors to the UK: Other Evidence on Source Countries

Registration with the General Medical Council

Importantly, other key evidence also supported the breakdown of major and minor sources of supply provided by the GP and HCHS Census analysis. So, for example, GMC data for 1996 and 2000 showed that, despite an overall fall in ‘initial’ grants of registration¹² to EU/overseas-qualified compared with UK-qualified doctors, the proportion of new registrants accounted for by individual source countries remained relatively stable (see Table 3.5). India remained the biggest supplier overall outside the UK, the number of new registrants from that source being 1,227 in 1996 and 883 in 2000. Other suppliers included: in order of magnitude from outside the EEA, South Africa, Australia, Pakistan, Egypt and Nigeria; and, from the EEA, Germany, Ireland, Greece, Italy, the Netherlands, and Belgium. In terms of broad geographical sources, and specifically in relation to grants of full registration, those (Commonwealth) countries whose qualifications are recognised by the GMC accounted for by far the largest number of new registrants - 1,630 in 1995 and 977 in 1999. Overall, over the last few years, *“the average number of new registrants each year is 9,200. Of these, 42% qualify in UK medical schools, 18% qualify within the European Economic Area and 40%*

¹² ‘Initial registrations’ includes all three possible types of GMC registration – namely ‘provisional’, ‘limited’ and ‘full’. ‘Provisional’ registration is granted after UK qualification for the duration of PRHO clinical training, and leads to ‘full’ registration after satisfactory completion of that year. The UK also recognises qualifications from certain other overseas medical schools for the purposes of both provisional and full registration. As an EU member, it also has a legal obligation to recognise the qualifications of EEA member states. In addition, the UK recognises qualifications from Australia, Hong Kong, New Zealand, Singapore, South Africa and the West Indies. (Certain qualifications have been recently de-recognised from Malaysia, Singapore and New Zealand – details are in the GMC guidance literature). ‘Limited’ registration is granted to overseas-qualified doctors from any other WHO recognised medical school, who have successfully passed UK screening. It is granted in the first instance for one year, extendable for up to five years, for the purpose of “*employment in educationally approved training posts*” (GMC 2000).

qualify elsewhere overseas” (GMC, 2001). However, in 2000, the breakdown of new ‘full’ registrations by place of qualification was as follows: UK 50%, EEA 14%, and Overseas 36%.

Table 3.5:
GMC ‘Initial’ Registrations by Doctors’ Country of Qualification in 1996 and 2000

Supply Source	Number of ‘Initial’ Registrations	
	1996	2000
Non-EEA – major suppliers		
India	1,227	883
South Africa	922	454
Australia	511	272
Pakistan	215	156
Egypt	211	103
Nigeria	129	105
Hong Kong	358	30
EEA – major suppliers		
Germany	942	370
Republic of Ireland	307	225
Greece	303	203
Italy	214	200
Spain	231	80
Netherlands	233	57
Belgium	71	52
All EEA/Overseas	7,125	4,246
United Kingdom	3,967	4,457
Total	11,092	8,703

Source: GMC Country Breakdowns for Initial Grants/personal communication

Of course, what the GMC data also illustrate is the extent to which, within the overall patterns described, migration from different countries can, and does, vary over time. There was, for example, a large fall in numbers of new registrants from Hong Kong (from 358 in 1996 to 30 in 2000) that, it seems likely, can be associated with the hand-over of that country to China. By contrast, registrations of doctors from Spain, one of the EEA countries identified as a target for recruitment because of its doctor surpluses, fell from 231 to 80 but with little obvious country-level explanation. Elsewhere, there was a more stable pattern of UK registrations, albeit with smaller overall numbers. New registrations, for instance from Nigeria, fell only slightly from 129 in 1996 to 105 in 2000, despite international pressure on the UK (and on other ‘demand’ countries) not to draw doctors from developing countries with critical doctor shortages. Overall, the falls in new registrations occurred from sources both within the EEA, from the Commonwealth countries with legally recognised qualifications, as well as from elsewhere overseas, so the cause cannot simply be attributed to the entry

requirements applied to those from outside the EEA. It is factors lying behind such country-level variations in migration trends that we begin to explore in the next section.

Entry to the Specialist Register

We were also supplied with STA data for the year April 2001 to March 2002 showing the major and minor source countries of doctors entering the specialist register¹³ (other than from the EEA and the UK). Information was provided by country of both primary medical qualification (PMQ) and country of specialist qualification (CSQ). Out of 243 successful applications¹⁴, by far the largest number overall had come to the UK from South Africa, followed by Australia, the USA, Pakistan, India, New Zealand and Canada. Although this ranking differs from that supplying doctors at the training grades (the latter can be assumed by comparing numbers entering the specialist register with GMC data outlined above), there is still an overlap in terms of the individual countries represented (see Table 3.6). However, not all of these doctors had actually gained both their PMQ and CSQ in the source country concerned. As Table 3.6 shows, if PMQ is considered, then countries as varied as Romania, Zimbabwe, Nepal, Saudi Arabia and the West Indies – as well as, paradoxically, the UK itself – are also represented as “original” sources of UK supply. What these data illustrate, therefore, is that the international medical labour market does not operate on the basis of simple one-off movement decisions. Instead doctors are taking advantage of a wide range of migration opportunities in order to gain specialist qualifications and further their medical careers. Unfortunately, it was not possible to explore such trends in any detail (because the collection of PMQ data, alongside the country of specialist qualification data, had only just begun in 2000/01). Nevertheless, from the data available, we were able to discern that there are broad patterns based, to some extent, on sub-markets such as the Pacific Rim countries of

¹³ This is the register which the GMC is required to publish by the European Specialist Medical Qualifications Order 1995. It enables those whose names are included to take up substantive, honorary or fixed term consultant posts in the NHS. UK-trained specialists, who have gained their Certificate of Completion of Specialist Training (CCST) (since 1996) awarded by the STA of the Medical Royal Colleges, automatically gain entry onto the specialist register. In addition, 36 EEA specialties (out of the 57 recognised UK specialties) are subject to mutual recognition, so that European nationals, who hold both a European PMQ and one of these EU specialty qualifications, are also automatically eligible for inclusion on the UK specialist register. These doctors may make their applications for inclusion directly to the GMC. However, those who have gained their specialist qualification from elsewhere, including those Commonwealth countries whose PMQ is recognised, and those who have a mixed bag of qualifications, must have their applications scrutinised by the STA – i.e. they must have their specialist qualification assessed for ‘equivalence’ to the relevant UK training. In making their judgements, the STA officers are bound by UK regulatory frameworks around consultant appointments, established by statutory instrument.

¹⁴ A further 79 applications (approximately one quarter of the total) were refused by the STA, from a variety of countries, with a mixture of cases of primary and specialty training in one country, or in two separate locations. The main reasons for rejection are that particular training may not match the specialty as it is practised in the UK, or that the specialty qualification did not meet the checking criteria. Applicants, who wish to contest a refusal, may make an appeal to the Secretary of State to have the decision overturned. Approximately 4 judgements a year are overturned on appeal. EEA specialist doctors with one of the 36 recognised specialties would not appear on this list. However, there were several EEA cases requiring scrutiny for one reason or another, including Germany (4) Italy (2), and Spain (1).

China, Hong Kong and Australia/New Zealand. In this context, it is also interesting to note that doctors with a PMQ from India feature in the statistics of several countries supplying the UK with specialists. Indians are gaining specialty training in Australia, the USA, Ireland, and South Africa, before coming to the UK, in addition to those who gain a UK CCST¹⁵. Again, we can only guess at some of the personal stories behind such complex migration histories (and it is not the purpose of this research to explore them in detail). However, some of the general drivers behind migration decisions will be explored further in the next section.

Table 3.6:
Non-EEA Doctors entering the Specialist Register - April 2001 to March 2002

Source Country	No. with PMQ and CSQ from Source Country	No. with PMQ from Source Country but Third Country CSQ (indicated in brackets)
South Africa	71	9 (India, Ireland, Romania, Zimbabwe, and UK)
Australia	29	15 (Incl. 9 UK, 4 New Zealand, 1 India and 1 China)
USA	8	19 (Incl. 4 UK and others from India, Ireland, Pakistan, Nepal, Nigeria, Spain and West Indies)
Pakistan	9	5 (Incl. 3 Ireland and 2 USA)
India	6	10 (Incl. 4 Ireland, 2 USA, 2 South Africa and others from Saudi Arabia, and Australia)
New Zealand	8	3 (All UK)
Canada	2	8 (Incl. 4 UK and others from Egypt, Ireland, South Africa and West Indies)

Source: Specialist Training Authority/personal communication

Certificates of General Practice Vocational Training

Finally, the JCPTGP provided us with data on prescribed and equivalent certificates of vocational training in general practice issued in the UK from 1981 onwards (Table 3.7). This showed that over the last 20 years the annual number of certificates issued by the JCPTGP decreased steadily from a high of 2563 in 1981, to 1787 by 2001. There was a slight increase in the late 1980s, a dip to a low of 1637 in 1998, since when the numbers have begun to increase again slightly. In terms of broad supply sources, certificates issued to overseas doctors are at their highest since the mid-1980s change of immigration rules impacted on flows into general practice from that source. Certificates issued to EEC qualified doctors are at their highest ever. These figures are both in terms of numbers *per se* and as a proportion of

¹⁵ Another source of evidence in this context is the database compiled by TMP Worldwide for information about supply sources (by both country of PMQ or specialist training) of doctors responding the DH's global recruitment campaign. Although we have not been able to analyse the database in any detail, we understand that the level of enquiries following the initial advertisements was particularly high from the USA, and Israel. Here too, there is a suggestion that enquiries may be coming not necessarily from US or Israeli doctors *per se*, but possibly from immigrant doctors in those countries (e.g. from Russia in Israel, or from India in the USA).

the overall total of certificates issued. They are set against the figures for UK graduates, as a percentage of the total number of certificates issued, which have been at an all time low for the last 3 years, at around 75%. Specifically in the last year, there has also been an increase in the level of enquiries and applications from overseas, reportedly in response to the UK government's overseas recruitment campaign. From January to September 2002, enquiries were up 100% (from 453 to 906), and applications were up 95% (from 257 to 501) compared with the year before. Similarly, over the same period there has been a small increase of 21 in the total number of overseas doctors actually awarded a certificate (verbal communication from JCPTGP, Sept 2002). So far this year, overall, there has been an increase of 6% over the same period in 2001, in the total number of certificates issued. Out of 2136 applications, 1626 have been granted certificates. Data are as yet incomplete for the whole of the year. Unfortunately, as the JCPTGP does not keep records of the country of origin/ethnicity of applicants, we are unable to analyse the data on EU/overseas sources of GP supply more precisely.

Table 3.7:
GP Vocational Training – Primary Medical Qualification of Doctors Issued with Certificates from 1981-2001

Year	Overall Total Certificates Issued	Source of Primary Medical Qualification Number (% Total Certificates Issued)		
		UK	EEC	Overseas
1981	2563	1984 (77.4)	86 (3.4)	493 (19.2)
1982	2430	1960 (80.7)	66 (2.7)	404 (16.6)
1983	1714	1407 (82.1)	78 (4.6)	229 (13.4)
1984	1875	1526 (81.4)	78 (4.2)	271 (14.5)
1985	2053	1709 (83.3)	69 (3.4)	275 (13.4)
1986	2199	1876 (85.3)	74 (3.4)	249 (11.3)
1987	2244	1902 (84.7)	92 (4.1)	250 (11.1)
1988	2198	1899 (86.4)	112 (5.1)	187 (8.5)
1989	2186	1898 (86.8)	95 (4.3)	193 (8.8)
1990	2114	1840 (87.0)	94 (4.5)	180 (8.5)
1991	2128	1822 (85.6)	104 (4.9)	202 (9.5)
1992	2115	1794 (84.8)	142 (6.7)	179 (8.5)
1993	1935	1661 (85.8)	129 (6.7)	145 (7.5)
1994	1933	1647 (85.2)	142 (7.4)	144 (7.5)
1995	1866	1584 (84.9)	153 (8.2)	129 (6.9)
1996	2007	1705 (85.0)	175 (8.7)	127 (6.3)
1997	1706	1428 (83.7)	169 (9.9)	109 (6.4)
1998	1637	1333 (81.4)	157 (9.6)	147 (9.0)
1999	1663	1252 (75.3)	211 (12.7)	200 (12.0)
2000	1689	1253 (74.2)	233 (13.8)	203 (12.0)
2001	1787	1361 (76.2)	225 (12.6)	201 (11.3)

Source: JCPTGP/personal communication

Summary

Overall, therefore, what this section illustrates is the complexity of both demand and supply in the NHS workforce as it relates to EU/overseas doctors. From the demand side, it appears that there is, as yet, no completely clear picture for all the different parties involved to present to the international marketplace – i.e. in terms of details of overall numbers of recruits needed on what timescale, or of where the UK wants to recruit in terms of shortage specialties and/or geographical areas. Nor is there any definitive, “quality” information on the EU/overseas doctors that make up the supply side. Finally, what is also clear is just how complicated the UK system must appear to the EU/overseas doctors thinking of coming here – i.e. in terms of the nature of the opportunities that they have to negotiate their way through in order to gain access to the NHS workforce.

4 THE CURRENT UK POSITION IN THE INTERNATIONAL MARKETPLACE: THE PROCESS OF ATTRACTING SUPPLY AND MATCHING WITH DEMAND

So why do EU/overseas doctors come to the UK, and, equally, what discourages them from doing so? How are they made aware of the opportunities available, and how do they actually find appropriate education/training/post-training job slots? What, if anything, does the UK need to do differently, either to become more attractive generally, or to make the demand-supply matching process more effective? In this section we use our UK and EU interviews and the supply country case studies in order to explore the perspectives both of organisations involved in the processes leading to a job or training position being offered and taken, and of the individual candidates for the slots concerned. Of course, in the latter context, the complementary work of the Open University on experiences of overseas doctors in the NHS will provide additional insights. The section focuses specifically on the current UK situation in its own right (including views about changes recently introduced and proposals already “on the table”), before we move in Section 5 to the comparison with competitors.

Push and Pull Factors to the UK: The General Drivers for Migration

First, we examine the broad factors that condition the movement of doctors from one country to another in the international medical labour market. The window through which the process is observed is specifically that for doctors of interest to the UK, though most of the general factors can be regarded as universal. The push factors that encourage doctors to leave supply countries, and the pull factors that draw them to the UK can be analysed on three levels: at country-level, at the medical organisation/professional level, and at the personal/social level¹⁶.

Country Level Factors: Comparative Economic and Political Situations

The interviews for the project revealed, not unexpectedly, that two principal factors were perceived as the strongest country-level drivers of international medical migration. These were:

- Relative economic and social expectations and the prospects for higher financial gain;
- Wider quality of life issues, including personal safety and the prospects for stability and greater freedom.

¹⁶ These will serve to confirm the findings of the literature review both for migration generally and for medical doctors (Findlay, 2002).

The income and lifestyle driver was considered equally relevant for supply countries where doctors are not paid well in comparison with other professions (e.g. Poland and Eastern Europe in general), and where the medical profession is both held in high esteem and relatively well remunerated by local standards (e.g. India). Whatever the situation of doctors in such countries, the comparison with the opportunities for significantly greater wealth in the UK (and indeed other 'Western' countries) was simply inescapable. Permanent migration "to a better life economically" was, for many the long-term goal. However, obtaining overseas qualifications and experience was also seen as the surest strategic route to obtaining the best jobs (especially in private sector hospitals, or private specialty/family medicine practice) if doctors were to return home. Typical comments, for example from our Indian focus groups and Polish interviewees in this context, were as follows: *"I'm planning to go to UK just to earn some quick money"*; *"Six months down the line, if you are working in the UK, you can dream of, you can think of buying a car, which is impossible here if I work for 10 more years."* (India Focus Groups 1 and 2); and *"The first problem is lack of money in the health sector ... but doctors are very committed to come back to Poland with the money the have saved to set up in practice here"* (Poland Hosp 1).

In some countries the relative income driver was combined with fears about political instability, war and persecution, or at the very least, lack of personal freedom. Examples of supply countries for which these sorts of drivers were believed (both by UK stakeholders and EU/case study interviewees) currently to apply, were South Africa, Nigeria, Egypt, Iraq and Afghanistan. Typical views on this expressed from within the UK were: *"It's [the UK] a relatively safe society, and relatively affluent, with a history of being welcoming"* (UK GP 2); and *"Our selling points have got nothing to do with the NHS...I suppose the fact that this is a democratic, free and stable society"* (UK Anaes 2). It was also felt that the UK, despite being far from perfect, gained a degree of competitive edge against other countries that are perceived as having more discriminatory attitudes to ethnic minorities. As one UK interviewee put it, *"We're protected by everyone else's faults"*. These sorts of factors may, however, be cyclical or may change significantly over time through political re-alignment. In the case of Poland, for example, the political and economic situation is perceived to have stabilised since the fall of Communism in 1989. Opportunities for personal and professional achievement are also seen as having increased. According to Polish interviewees, this helped to explain why it was that country's doctors (like other occupational groups) had tended in the past to migrate permanently, whereas now they left only for the short-term. Finally, the cyclical nature of migration drivers was illustrated by evidence from one UK organisation of increasing *"hits on the website from Israel"* (UK Specialist 1). The latter was, for obvious

reasons, one country in which the ‘political instability’ driver was considered particularly strong currently.

Overall, the increasing focus on short-medium term migration perceived in current supply countries such as India and potential supply countries such as Poland has important implications for UK supplies. It will be important to continue to monitor such trends and, as we will describe in more detail below, to respond to them in the UK’s marketing and recruitment strategies.

Organisation/Professional Level Factors: Training and Post-training Job Opportunities

Despite the fact that each of the supply countries is different in many respects as far as training and career structures are concerned, it is possible to point to two prime factors within the organisational and professional sphere that exert the greatest push on outward migration from supply countries. These are:

- Limited prospects for postgraduate training; and
- Bottlenecks to career development and progression.

Among the case study countries explored for this project, for example, both India and Spain were said to over-produce doctors at the PMQ stage leading to competition for progression, and bottlenecks as newly qualified doctors seek to enter hospital specialty training¹⁷. Similarly in Poland, there is a shortage of intern positions for the first year following the PMQ and of specialty training places at the next step on the ladder (this is despite the fact that Poland does not see itself as having an over-supply of doctors completing undergraduate education). In some cases, having progressed through the first set of obstacles, doctors also face a second bottleneck. This comes after the completion of specialist training where there are insufficient numbers of posts to ensure full time or even part-time work for all of those qualified. This was, for example, reported in relation to Spain to the extent apparently that many younger specialists there have had little opportunity to gain practical experience in their chosen field (e.g. in comparison with UK CCST holders). Because of the hierarchical structure of hospital medical teams, even for those already in hospital posts, opportunities for progression to consultant status were reportedly subject to further bottlenecks (this is

¹⁷ Both these countries have similar highly competitive selection procedures for specialty training, using a tough academic medical examination system immediately following the PMQ. The Spanish MIR examination ranks candidates on a national basis, and each may then select the preferred training programme and location, in their turn. Despite functioning more on a regional basis for most State medical schools in India, training places, or seats, in premier nationally renowned medical institutes in India are also allocated on a national basis.

according both to Spanish interviewees and UK stakeholders involved in the North West Region pilot of Spanish doctor recruitment). Finally, in India candidates who are unsuccessful in obtaining specialty training may stay in the system at house officer/intern level and make repeat applications. They may also move into Government service from where they can reapply for a 'reserved' training seat after 3 years with greater chances of success. Such strategies naturally increase the pressure on bottlenecks.

In relation to general practice, problems were reported in both Spain and Poland, also because of insufficient capacity to provide relevant vocational training. This bottleneck applied both for doctors actively wanting to become GPs and for the numbers of GPs needed for the overall health system. In Poland, the situation stems from the fact that family medicine/general practice was only introduced as a specialty in 1993, and it will inevitably take several years for enough GPs to progress through the training system for the workforce to reach capacity. In Spain, problems have been associated with a greater overall demand for formal training since 1996 (i.e. because that was the cut off date - in line with the 93/16/EU Directive - for doctors to be recognised as having acquired rights to practise general/family medicine even though they had had no formal training¹⁸). Spain is, of course, not unique within the EU in having a bottleneck at the stage of entry into postgraduate GP training. Our UK interviewees identified Germany, Belgium and Holland as countries from which doctors had been recruited to UK training (i.e. in locations with an under-supply of UK graduates willing to fill the training capacity) because of home country bottlenecks in training opportunity.

For the case study countries included in this research for their current propensity and/or potential to supply doctors to the UK it was, then, the chance to avoid these sorts of bottlenecks that drew many individuals to consider migration. Looked at from the UK, therefore, one clear window through which to examine the supply-side of the international marketplace is to look for the existence of *home country blockages* in either training progression or post-qualification career development. In doing so, however, it is important to note that, in some cases, such "blockages" are not absolute but relative. In the EEA, for example, while doctors may be able to progress in their own countries, it is the gateway to what they see as *better quality training* or to a higher-level qualification that encourages them

¹⁸ Before 1996, Spain had no requirement for doctors entering general practice/family medicine to undertake a recognised and accredited GP training programme. The 93/16/EU Directive was an attempt to harmonise training arrangements across the EU, imposing a minimum of 2 years, which has recently (2001) been increased to 3 years). As part of the transitional arrangements, EU countries were given the opportunity to recognise the 'acquired rights' of their doctors to practise general/family medicine, even though they had had no formal training. In Spain, the cut off point for this recognition was 1996. Since 1996, therefore, the drivers out to obtain training have been stronger, as the only alternative is unemployment for this group.

to move further a field to develop their careers. For instance, according to UK interviewees with experience of EU migrants coming to the UK to enter general practice, it was the high standard of training generally and the opportunity to participate in a 3-year programme that pulled them to Britain. The availability of spare training capacity at this quality and the opportunity to gain a well-regarded GP qualification (JCPGPT Certificate under Section 30 of Title III of the EU regulations¹⁹) was the stimulus to entry.

Of course, as we shall discuss in more detail In Section 5, the ‘pull’ of the UK in attracting doctors looking to overcome home country blockages in training has to be viewed in comparison with the opportunities available in other demander countries competing for medical labour – many of which are strong players. A point of some significance here is the view expressed in some quarters that the UK may be trading as much on its former standing around quality training/medical employment than on present realities. A range of typical comments was:

“I think the image of medicine in this country is still higher than the true standing justifies. We have become very inactive in promoting our culture, whether that’s because we’ve cut back on investment in the British Council, whether it’s because we’ve lost confidence in our society...but it happens.” (UK GP3).

“I think historically it [the UK] has a reputation for providing excellent training. I don’t think it’s necessarily the best provider in the world now ... as far as I’m aware ... America seems to be leading the way these days ... I think the UK is still trading on it’s reputation, and how long you can actually do that for I’m not sure” (UK Surgeons 1).

“On the one hand ... [we’re saying] ‘Our training’s the best in the world’, but if you were sitting in [for example] Spain and looking at Britain, the record of Britain’s doctors over the last few years, it wouldn’t look like that would it? So I think there are some issues that maybe we’re not as good as we think we are”. (UK Org 5).

Finally, it is important to note the migration in relation to medical training and employment opportunities was also seen as being cyclical in nature. So the point was made anecdotally that, for instance: *“... in America there’s [currently] a problem with cardiologists taking*

¹⁹ Of course, this is not necessarily all positive for the UK. According to UK interviewees, some EU trainees stay in the UK just long enough to meet their own country’s shorter training requirements, so avoiding the summative assessment required by the JCPGPT. Such training enables them then to return (e.g. to Spain or Belgium) where there is no summative assessment following GP training, gain recognition of their competent authority in order to practice both there and, by virtue of mutual recognition of those countries’ qualifications, in the UK (UK GP 7).

some of the operations from cardiac surgeons, and therefore there's insufficient for all the cardiac surgeons to do. So they might be looking to come over here" (UK Specialist 3). Other current examples, amongst others, cited by UK interviewees were that: *"... in Germany they've produced far too many surgeons and we're getting quite a lot of interest from Germany because there aren't too many jobs for them to do"*. (UK Specialist 3); and *"I know that Canada is extremely popular for paediatricians"* at the moment (UK Physicians 1).

Organisation/Professional Level Factors: Perceptions of Job Satisfaction and Working Conditions

The way the UK health system works was, according to some UK stakeholders, another pull factor for doctor migration (particularly for general practice). The attractive features were, for example, seen as continuity of care for patients and a stable patient list for doctors, as well as team working in group practices. Pay and conditions are also perceived as comparatively good for the British GP, particularly when pensions, defence costs and protection are taken into account. As one of our UK interviewees summed up: *"So, the perception is, I think, that general practice is highly regarded, relatively well staffed, not too difficult, and relatively well paid"* (UK GP 4). In addition, participants in some of our supply country case studies reported similar (perhaps "rose tinted") views. These related both to general practice and hospital medicine. So, for example, in Poland the contrast between doctors (in both primary and secondary care) working in dilapidated buildings and taking on several different medical jobs 'just to make ends meet', and conditions in the much better funded and secure UK system makes the latter quite attractive.

Clearly, whatever the underlying realities, the power of these sorts of perceptions can give the UK marketing edge. Again, however, it is important to note that some EU/overseas and UK stakeholders felt the UK's "attractions" were counterbalanced by more negative images that could serve as disincentives to migration. So, for instance, the NHS and UK medical practice generally was felt to suffer in the face of: *"the very centralist, very much managed National Service Frameworks ... [and the pressure to do] only the work which is evidence-based and so forth"*. As the same interviewee also put it: *"I think they [overseas doctors] are saying, where's my professional freedom, where's my possibility to express myself as a doctor?"* (UK GP 8). In addition, some of our European interviewees expressed concern (that was also backed as a perception of EU/overseas' doctors views by UK stakeholders – UK Surgeons 1) about the perceived higher level of US-style litigiousness in limiting the freedoms and increasing the workloads of UK doctors. They also felt there were limitations in a predominantly State based health system on the freedom of doctors to invest their surplus

returns in the sorts of support systems and staff they needed to give the best quality patient care. To a significant degree these sorts of views pivot on entirely different philosophies about the most appropriate – State versus Private – model for health care. These sorts of views are, however, particularly relevant to judgements about migration from those working in comparably well equipped health systems - in the EU for example. There is, therefore, an argument that, as another UK interviewee put it: “ ... *we’re mostly getting doctors from systems which are worse than ours*”. By contrast: “*If the NHS got better, we would then be able to attract doctors from a different market. The French and the more senior Germans would come from decent health services, would come, would travel*” (UK Anaes 2). As another example, there was a view that: “*doctors from the US [are] ... being put off here [i.e. the UK] because of pay [and the] much higher rates of tax etc.*” (UK Specialist 1).

Perhaps the important point here is that the job satisfaction and working conditions issue is contingent to the segment of the professional medical labour market that is being targeted. Were the UK to be sourcing senior professionals from abroad rather than predominantly aiming to attract candidates at the level of post-graduate training, the discourse would shift more toward issues of regulatory freedoms and the scope for flexibility in investment and reward. This is, of course, already the case for certain specialisms (e.g. in the context of the International Fellowship Scheme) within the broader context of an emphasis on the “entry level” grades.

Individual Factors: Lifestyle and Standard of Living Considerations

While those economic and quality of life incentives we discussed previously under Country Factors, and the training/job opportunity and satisfaction discussed under Professional/Organisational Factors are of a general nature, the real drivers for migration are actually much more immediate. In other words, it is important always to remember that they are being looked at through the eyes of the individual doctors considering migration. The balance of push/pull factors and hence the eventual choices of destination in the international marketplace are, therefore, affected by more personal factors. Those emphasised by our EU/overseas interviewees and Indian focus groups in particular were:

- The stage doctors have reached in terms of career development and family formation;
- Their particular medical field and the health system in which they gained their experience/training; and

- Whether or not individuals and their families are considering migrating for the short or longer-run.

This meant that, for example, the chance to increase immediate income and purchasing power was perceived as a more obvious goal for doctors wishing to migrate short-term from supply countries. By contrast, doctors looking to migrate permanently were seen as more likely to be influenced by the types of medicine they will be able to practise first, and by wider lifestyle factors second. While such factors as the money wages and purchasing power at a given time can, therefore, give competitor countries an advantage, it is the wider lifestyle and job satisfaction features for individuals that appear to make the real difference over the longer-term.

Essentially, how these calculations play out in the international marketplace varies substantially by country. Looked at for Australia, for example, the sterling purchasing power value of a re-location package for a British doctor may appear less than competitive because more nominal dollars buy less than nominal pounds. However, the perceived lifestyle gains offer Australia a considerable advantage. From Polish and Indian viewpoints, however, the UK can be considered to be relatively attractive on the basis both of straightforward economic considerations and lifestyle as it applies to education, housing and the general standard of living. In terms of migration to the UK from Australia, the UK also offers particular life-style advantages at certain stages in a doctor's career – i.e. the opportunity to travel (with the added proximity of other travel destinations in Europe). The fact that younger Australian doctors can gain work-related experience and or medical qualifications in the UK was, therefore, seen more of a “bonus” than for other supply countries. Finally, looked at from Spain (and we were told other EU countries with workforce surpluses) the UK's attractions were more about professional and career progression considerations than anything else. See Table 4.1 for more details of major and minor migration drivers as they were perceived for some of the UK key supply sources outlined in Section 3.

Table 4.1:
Migration Drivers from Major and Minor UK Supply Sources: Summary View from
UK and EU/overseas Fieldwork

Drivers for Migration	Supply Source					
	EU/EEA	East Europe	South Asia	Africa	Australia & N. Zealand	USA & Canada
Over-supply/un(der)employment of doctors vs. UK shortages	*		*			
Under-availability of training posts or blockages in career progression vs. UK opportunities	*		*		+	
					(Seen as 'bonus' to travelling)	
Quality of training/job experience in UK vs. own country (resources, work conditions, type of medicine practised etc)		*				
Differences in status/income levels of doctors as a profession generally		*				
Continuing career development at higher level (e.g. short-term to learn certain technique/equipment)		*	*		+	*
UK qualifications highly regarded worldwide (esp. Royal Colleges)		*	*			
Knowledge of English means fewer perceived barriers in UK than elsewhere		+		*		
		(Many also know German)				
Personal motivation to improve standard of living/quality of life etc in UK			+	*		
			(Not as signif. as 1960s/70s)			
Personal motivation to save money for improved living on return to own country		*	*			
Personal desire to travel/'see the world'	+				*	
Existing cultural/Commonwealth links with the UK vs. elsewhere			*	*	*	
Desire to 'leave behind' political or cultural situation in own country				*		
* Major Driver						
+ Minor Driver						

Overall, what this indicates is that the UK needs to play to its strengths, as do all countries looking to recruit in the international medical labour market. Migration is essentially an individual choice – made in the context of personal circumstances such as family – and migrant doctors are also “buyers” of opportunity in the marketplace. Demander countries such as the UK, therefore, have to do as much as they possibly can actively to ensure that doctors are attracted to them rather than to their direct competitors. The key is to design and offer appropriate packages that play up the attractions and seek to adjust negative perceptions. This would not only involve trading more effectively on those positive pull factors already outlined such as the availability of quality training and post-training job opportunities but also

attempting to identify and reduce the barriers/disincentives (perceived and real) that discourage migrants from coming to the UK. It is to these barriers/disincentives that we now turn.

The UK in the International Medical Labour Market: Perceived “Barriers” and Practical Disincentives to the UK as a Destination

In addition to the factors that might be seen as attracting doctors to come to the UK, there is also a range of barriers/disincentives that are equally important to understanding the overall position of the UK in the international medical labour market. As might be expected given the emphasis on medical profession/career progression opportunities as a pull factor to the UK, the barriers too were associated mostly with medical professional structures and the wider organisation of the health system in general. This was the case both for UK interviewees and EU/overseas stakeholders and focus groups.

Professional Registration and Other Workforce Entry Requirements

The first set of “barriers”, or disincentives, surrounding entry into the UK medical market for an overseas doctor relate to professional registration and visa requirements/immigration laws. These regulations differ depending on the type of training/employment entered (hospital or general practice), the level of expertise/qualifications doctors hold, and the supply country/world region where they are based. As far as EU/EEA doctors are concerned, for example, the entry barriers (i.e. into both post-graduate training and the specialist register) are relatively low due to the mutual recognition of primary and 36 ‘equivalent’ specialty qualifications. However, our EU and UK interviewees did perceive some remaining ‘anomalies’ as continuing to hinder free movement. There are, for instance, some European countries that: a) combine their specialties in different ways as compared with the UK; and b) allow certain subspecialties to be achieved without the equivalent of basic training that is required elsewhere. A particular example of the different combinations of medical training compared with the UK taken from our case studies would be anaesthesiology and intensive care, or anaesthesiology with resuscitation in Spain (see Country Report for more details). Another example highlighted this time by UK stakeholders as not getting “*automatic entry*” to the Specialist Register “*because of the way their specialties are defined*” was Italy in relation to surgery (UK Specialist 3). Such differences mean that, whatever the overall policy of mutual recognition of training and qualifications, EU/EEA doctors coming to the UK cannot necessarily “slot” straight into the type of work that is open to them. So, for example,

a period of additional training may actually be required before doctors are granted entry to the UK Specialist Register (or indeed applications may be rejected by the STA).

For other non-EEA/overseas doctors, of course, the regulatory barriers for entry to the UK are perceived as higher still. Only a very few countries (e.g. Australia, New Zealand, Hong Kong, Singapore, South Africa etc) have their PMQ recognised for the purposes of full registration by the GMC. In addition, the relevant competent authorities for specialist and general practice vocational qualifications (respectively the STA and JCPTGP) do not automatically recognise anything other than EEA qualifications as equivalent. Our UK interviewees explained this in terms of equity in the face of limited organisational resources. In other words, because the UK authorities cannot scrutinise and regularly re-accredit the large number of specialist qualifications available world-wide, the preferred approach is to recognise none automatically and to assess each applicant's case separately. As one of our interviewees put it: *"The International Committee carried out a fairly hefty piece of research on this and determined that if we were going to look at reciprocity issues it would have to be global ... [But] we couldn't have a reciprocal agreement with anyone"* (UK GP2). It follows that where as in the past there was some UK recognition of overseas vocational qualifications (e.g. as in the case of the US Board of Family Medicine certificate), even this has now been withdrawn. A further problem reported to us was the situation regarding recognition of additional experience gained within the UK. As one of our UK stakeholders explained:

"... the problem with some of these doctors is that once they're assessed [by the STA] and they don't meet the criteria, there's nothing they can do within the UK to get them onto the Specialist Register. So they can't do say further top-up training in the UK to meet the criteria, they have to go outside the UK to do it [because] The legislation doesn't allow it" (UK Specialist 1).

Overall, these sorts of issues have considerable implications for the migration choices of individual doctors, even those who are fully qualified to practice elsewhere in the international medical labour market.²⁰ It was, therefore, considered: *"fairly crucial now that if the government is to maximise the international recruitment drive that they look at [the sorts of issues just outlined] as a matter of urgency"* (UK Specialist 1).

²⁰ So, for example, we were referred by Australian interviewees to press reports of doctors, including those originally from the UK, who have been practising as GPs in Australia. They would now like to return to the UK, but found that their combination of training and experience is unacceptable to the JCPTGP. Even if they were eligible for GP training in the UK, returning to Registrar status and salary would not be acceptable, as they are seeking to move straight into practice. There are thus mixed messages in Australia about the UK's desire to employ more doctors. They are of the opinion that 'a GP is a GP, is a GP', whereas the JCPTGP was perceived as placing more emphasis on the need for familiarisation with the uniqueness of the UK system.

Finally, for non-EEA/overseas doctors at the junior level there are, in addition to the barriers related to recognition of qualifications, disincentives associated with taking IELTS and PLAB. Specifically, although PLAB and IELTS entry fees are said to cover only the GMC's administrative costs, they are still (according to our Indian focus groups for example) a major investment for individual doctors and their families. Similarly, the requirement to come to the UK to take the Part 2 clinical element of PLAB (and indeed equivalent exams elsewhere such as the USMLE) was a significant expenditure. In this context, doctors (e.g. from India) can only reduce expenditure in those countries where they have informal networks to provide accommodation, financial support etc. The latter is, as we will discuss in more detail later, an important element of the decision-making equation for individual doctors considering migration.

As another example of practical barriers associated this time only with IELTS, there is the straightforward issue of the level of difficulty at which the exam is set. For native English speakers from outside EEA, the requirement to take IELTS was reported as “particularly galling” given the free access regardless of language difficulties granted to EEA doctors. This applied, for example, to Australians, some of whom, according to our interviewees there, do not reach the necessary score of 7 in all parts of the IELTS examination. Similarly, another question raised by one UK interviewee was whether: “... *if you've been trained in medicine [for instance] in India in an English speaking institution, should you be asked to take the IELTS test?*” (UK Org 6). Lastly, UK interviewees saw the IELTS examination as problematic for many refugee doctors already in the UK, who also may achieve an average of 7 across the entire examination but do not do so in all the required elements. This leads us into the underlying causes of such “differential” results across different social groups in the medical workforce. This was often perceived to be as much about social/cultural barriers as “quality” *per se*.

Practical and Cultural “Barriers” to Medical Practice in the UK

In addition to regulatory barriers to entry, there are practical and social/cultural barriers that impact on doctors' abilities to “slot” into the UK labour market. These are not just about passing examinations, but impact too on how easily doctors find it to adapt to what is actually expected of them in the workplace. In this context, UK, EU and case study country interviewees all pointed to unfamiliarity with the health system generally and the norms surrounding professional practice in a new country. One graphic example of how this works in practice was as follows:

“I think the cultural factors and the understanding is just very difficult to pick up ... I was just talking to one of our Indian doctors in terms of exam preparation, and she’d taken a case history from somebody who was an alcoholic. It transpired that this young doctor having come from a teetotal background, Muslim background, actually had never been in a culture where you drank so didn’t even know what lager was ... And this is somebody who’s actually been in psychiatry in this country for a few years now” (UK Psychiatry 1).

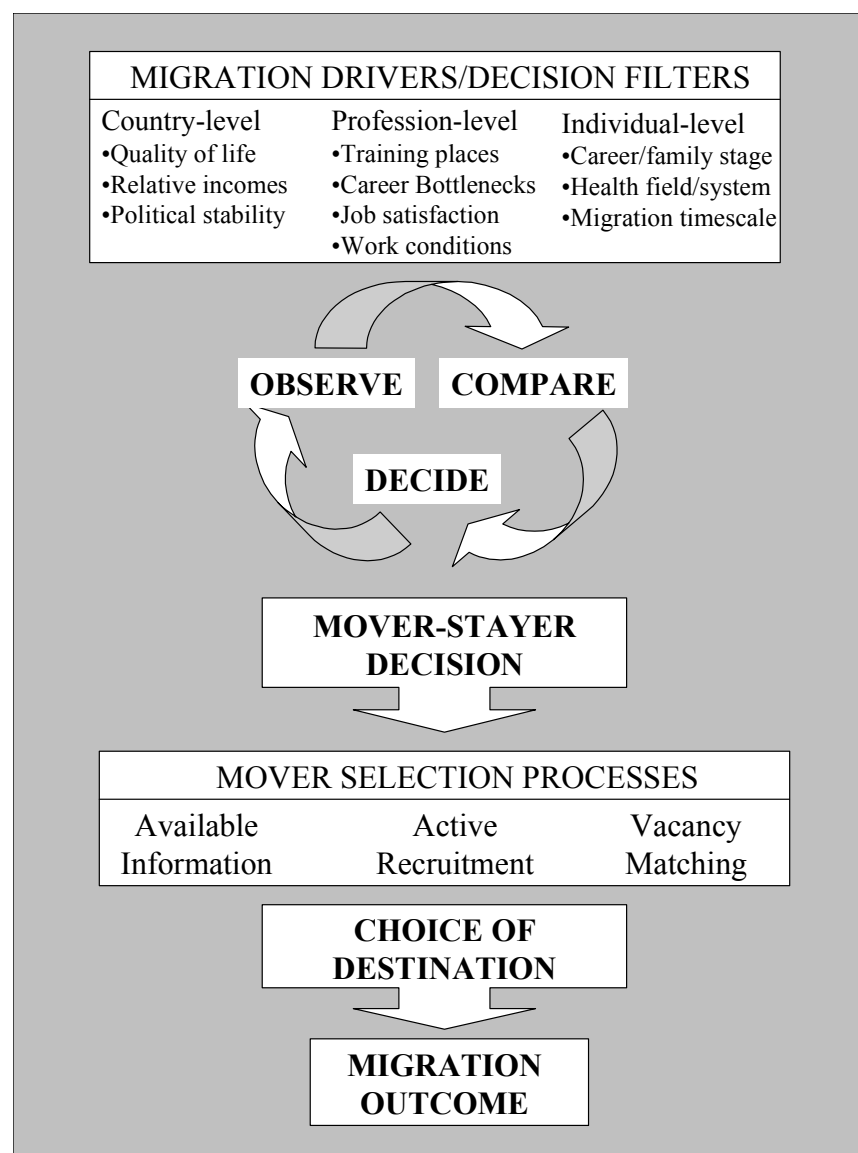
In addition, although it was felt that *“We have one great advantage which is language”* (UK GP 4), there were still said to be difficulties for EU/overseas doctors wanting to work in the NHS. These were associated both with the technical English needed to practice medicine (i.e. related to particular specialties), and the need to communicate colloquially during patient contact (this applied both to SHO and SpR grades in hospital, and particularly to general practice). They were felt, by UK interviewees, to be problematic in relation both to overseas and EU doctors, because the latter are not required, under the Directives for mutual professional recognition and free movement, to take advantage of additional language training. As one of our UK interviewees put it: *“... they get off the plane ... and they can’t believe that the English they learnt at home is the same language, you know”* (UK Psychiatry 1). Importantly, UK stakeholders also pointed to a lack available funding for language-related induction and on-going training despite recent government moves (i.e. the transfer of training funds into the MADEL budget (Medical and Dental Education Levy), now held by Deaneries) to ease the situation.

Balancing Incentives and Disincentives: Factors Shaping the Decision to Migrate

In many respects the push/pull circumstances and labour market entry barrier/disincentives we have just described are those confronted by any international job migrant with professional skills and whose services are in demand (Findlay, 2002). The underlying decision process that individuals open to the option of migration bring to this is also essentially a ‘common sense’ one that is well documented in the literature. This is periodic *observation, comparison and decision* regarding current conditions versus possible imagined futures (see Figure 4.1). The intensity of the process (or frequency with which potential migrants look to their other options) tends to be based on levels of comfort or dissatisfaction with current circumstances but can also be influenced by information that can alter relative satisfaction levels (push and pull factors). This, in turn, is subject to clear lifecycle forces – periods when movement is easier or more difficult in terms of family and work commitments. So for example children’s schooling and partner’s own career needs may be an issue for

some. Others may be less inclined to move if they already have a financial investment in private practice, or are established in the relative security of a permanent public sector job. The weight of the stimulus needed to provoke movement is, therefore, also variable depending on life and career stage. There are, however, some circumstances where, as we have already noted, the decision to move has less voluntarism associated with it. In these cases, the need to relocate may be triggered by external pressures (e.g. country-specific political and social contexts) regardless of life of career stage.

Figure 4.1:
The Mover-Stayer Model for Migration Decision-Making



What we can call the *mover/stayer* decision (see Figure 4.1) is, then, a process that an active targeting and recruitment policy from a demander country such as the UK can seek to influence for those that it wishes to recruit. Given that the target groups themselves will respond to different incentives and have, in the case of those most in demand, a range of choices, this will need to be carefully judged. Information on opportunity is critical, as is the design of packages to assure potential overseas recruits that any barriers or disincentives can be eased for them. What is, however, more specific in promoting the decision to migrate in a highly regulated and qualifications dependent field such as medical practice is the importance of training and opportunities for work experience for further career progression. In this case the channels for possible movement are more limited, highly segmented and can also be subject to particular arrangements (e.g. reciprocal recognition of training and qualifications) between supplier and demander countries. We now turn our attention to those key factors that need to be influenced if the decision to move is made, and if the destination is to be the UK rather than an alternative demander country in the international marketplace. We begin with the issue of quality of information before moving onto the process of recruitment and education/training/job slot matching later in the Section.

Learning about Opportunity: The Quality of Information on UK Opportunities and Entry Requirements

Given the complicated picture of incentives and disincentives just described, what is the UK actually doing to market the opportunities it has available and ease the process of entry and matching for EU/overseas doctors? What, if anything, does it need to improve in relation to each of these activities at the different levels of education/post-graduate training/post-training job slots we have described as being available in the UK and more generally in the international system as a whole? As we will show throughout the discussion, the key message from UK and EU/overseas interviewees was the need for greater streamlining and co-ordination across the board.

Information on Opportunities at the Level of Undergraduate Education

At undergraduate level, entry into the UK for basic medical education appears to be facilitated primarily through university road shows and interviews held in supply countries. We were, for example, made aware of on-going recruitment in countries such as Malaysia. Importantly, because this recruitment is the responsibility of individual universities rather than being nationally co-ordinated, it was not felt to be working as efficiently or effectively as it could be. One UK interviewee told us, for example:

“There’s also been an element of concern about the complete lack of any concerted action, either between government and professional educational groups, and also between centres of higher education, all competing with one another. You know, they’re all fighting, because they’ve got to, you know [they have] their quotas, and they’ve got to get their budgets right. And we should actually be having a far more cooperative approach” (UK GP 5).

In other words, the UK was seen as not making the most of an important mechanism for spreading information – not just about medical education opportunities as a whole, but also about the NHS and subsequent training and post-training employment that might be available to these students generally.

Information on Opportunities at the Level of Post-graduate Training/Post-Training Job Slots

This perceived lack of co-ordination of reliable, up-to-date information was not just apparent in relation to articulating undergraduate opportunities on a national basis. It was also reported around overall opportunities for Basic (SHO) and Higher (SpR) Specialist Training, and post-training job slots for fully qualified doctors. Importantly, in making their migration decisions, potential migrants first and foremost wanted an answer to the straightforward question: ‘Does the UK need doctors at these levels or not, and if so how many and in what specialties?’ However, what emerged, for example from focus groups with PLAB candidates in India, was a much more mixed picture getting through to supply countries. Whereas some had heard (e.g. from their seniors with links in the UK) about the current DH campaign or knew from past dealings with commercial agencies that the UK was keen to recruit, others had heard from contacts already working in the NHS that it might, in reality, be more difficult to obtain a suitable post. In addition, many had no clear picture of the UK systems of basic and higher specialist training, of progression from one level to another, or of the difference between Type 1 and Type 11 Specialist Registrar posts. The lack of understanding may simply arise from the fact that the Indian training system is more straightforward, with no division between basic and higher specialist training. Whatever, the underlying reasons, however, the fact that these doctors had got as far as taking even Part 1 of PLAB, with so little knowledge of the UK system to which they were applying, is an issue. What they felt was needed, therefore, was a much more authoritative access point for information on the types and availability of UK training/post-training job slots. This was said to be important for two main reasons. First, to help potential migrants (for whom the UK is the right choice) get a clear view of why they should come here rather than elsewhere. Second, to reduce the likelihood (revealed as a possibility by PLAB candidates referred to above) that doctors could get so far

as to come to the UK before finding that it is not actually suitable for them. Overall, the need for more accurate information on training opportunities was emphasised most strongly because that is the career stage at which most international migration takes place. In addition, doctors with existing higher specialist qualifications are often required to enter SHO posts if only for induction purposes.

Another very practical way in which the UK might articulate its demand more effectively would be through the information mechanisms it uses to help potential migrants find a suitable training/post training job slot. Doctors in our Indian focus groups reported, for example, that although they could glean general advice on “how to go about it” from the literature and websites of several organisations (e.g. DH, GMC, BMA, Deaneries, Overseas Doctors’ Association and so on), the actual application process was more difficult. In this context, a key issue for our EU/overseas and UK interviewees (including competent authorities, education/training providers etc as well as doctors’ representatives) also, was that there is no central register of post-graduate training/post-training vacancies on a regional let alone a national basis in the UK. Nor is there any centralised application process for Basic (SHO) and Higher (SpR) Specialist Training in hospital specialties or vocational training in general practice. Instead, the most practical advice that many potential migrants reportedly glean from official sources is to look at job advertisements in publications such as the BMJ, The Lancet or Hospital Doctor, or to go to informal/Deanery contacts for assistance. In other words: *“They’re just left on their own to fend for themselves”* and that, at the very least, is *“not very helpful”* (UK Specialist 3). This applies both to overseas doctors looking for a clinical attachment/placement to enhance their chances of passing the OSCE clinical part of PLAB, and to those who are already eligible to practice in SHO posts without taking PLAB. Even those planning to come to the UK on a sponsorship scheme, under the patronage of a Royal College, may only have their first 6 months of training organised for them before having to take their chances in the job market for approved SHO posts or FTTAs. Importantly, centralised arrangements of the type just described would in no way threaten the policy of open competition for posts in line with the law on equal opportunities and employment. It is simply that they would make the “face of the UK” presented to doctors scanning the international marketplace for opportunity much more “user friendly”.

Information on UK Professional Registration, Regulation and Qualifications Requirements

Finally, what emerged as an issue from fieldwork was the wide array of organisations providing information about entry requirements for the UK labour market. These include the British Council, which is also responsible for administering the PLAB examinations abroad,

the GMC, the Department of Health, Deaneries, the STA, the BMA, and the Overseas Doctors' Association etc. In addition, the Royal Colleges may advise those wishing to pursue specialty training and qualifications or to enter the UK via the ODTs. It is probably not surprising, given the length of this list, that once again, the key concern for UK and EU/overseas interviewees and focus groups, was a perceived lack of co-ordination/comprehensiveness in terms of information provision from any one source. There was also said to be a lack of clarity amongst key organisations advising doctors in supply countries about up-to-date UK regulations (e.g. professional registration and visa requirements, length of permit-free status attached to training posts, specialist/GP training regulations etc). Why are the examination systems not standardised across the different Royal Colleges was, for example, a typical question to which our Indian focus groups had not been able to find an answer? As one of our UK interviewees also commented: *"The rules are extremely complex, and people don't seem to know them, people seem to come to us having been given the wrong advice"* (UK GP 7). Once again, therefore, study participants pointed to the need for a one-stop access point from which both individual doctors and organisations involved in medical migration from supply countries can obtain information directly and/or be referred on within the UK system.

Achieving a Balance between Informal and Formal Information Channels

At the moment, according to EU/overseas and UK interviews and focus groups, potential migrants mostly rely on informal networks for up-to-date, practical information on the UK system. Undoubtedly such arrangements do have a vital role in the migration process as played out by individual doctors, but it is important to realise that they are not in place universally. In our case study sample, they were reported to be strongest in relation to India and Australia because of the long histories of family, cultural and medical education/migration links with those countries. In contrast, in Spain and Poland no long-standing medical migration networks exist in relation to the UK. Moreover, even where links between the UK and supply countries as a whole are relatively strong, it does not follow that informal information channels are equally accessible to the full population of doctors potentially able to supply their labour to the international marketplace. It follows that although, for the UK, the transaction costs (i.e. in organisational time, effort and financial resources needed to set up and maintain them) of relying on informal links are relatively low, so too is the efficiency with which they "get the UK message across". This has been clearly illustrated above in relation to a range of relevant topics from knowledge of UK demand side opportunities, to information on UK training structures and specialist qualifications.

Clearly, from the UK perspective it could be tempting to assume that where informal links already exist they will simply continue, and that elsewhere they can be left as in the past to develop (or not) naturally. However, we also know from our fieldwork that there is increasing competition generally in the international medical labour market (see Section 5 for more details). In addition, as more of the medical educators/trainers in the UK's traditional supply countries (e.g. India) have themselves been trained/qualified in, for example, the USA, Australia and Canada then alternative links are building up. There is an argument, therefore, that informal links need to be increasingly supplemented with the sorts of official arrangements to provide quality information and to ease the job-search process we have just described. At the very least this would contribute to maintaining the UK's existing position in its current major supply sources. At best it is likely to provide "value added" to encourage even more doctors to come the UK from those sources.

Given that the UK needs to boost overseas doctor supplies relatively quickly, it is equally appropriate to invest in building links where there may as yet be little tradition, but where the circumstances seem right for returns to be high. Here, the Spanish example provides us with a useful illustration of how extra investment in a formally thought-through and managed UK information strategy can successfully encourage migration in an entirely new context. At one end of the scale, the strategy involved government-to-government agreement and communicating with national stakeholders such as the CESM union and the Spanish equivalent of UK Royal Colleges. At the other, a dedicated DH team held meetings with potential migrants themselves at locations throughout Spain. The latter was important to address barriers to information dissemination that stem from the fragmented Spanish registration system. It was also tied directly into the fact that available job slots had been identified in advance on the UK side. Such arrangements have led to recruitment of several hospital doctors and GPs to North West England (Atherton and Mathie, 2002). According to our Spanish interviewees, they will have 'kick started' the sorts of informal information channels (e.g. between individual doctors and universities/medical training organisations etc) that will continue to drive migration in future.

From Information to Recruitment: Engaging with UK Points of Labour Market Entry

We have already described the formal, centralised approaches to EU/overseas doctor recruitment recently adopted by the DH in our report introduction. They include the country-based pilot schemes (initially in Spain), the International Fellowship Scheme, and agency-based international recruitment using the independent company TMP Worldwide to manage the recruitment process, resulting from a global advertising campaign. There is also a number

of what we have termed more ad hoc recruitment mechanisms currently employed in the UK. These may be informal or formal, but are essentially specialty, locality or organisation specific rather than being system-wide. Examples are: independent agency recruitment of EU/overseas doctors to locum positions in the NHS; the Overseas Doctors Training Scheme (ODTS) and other sponsorship schemes validated through the Royal Colleges; and personal doctor-job slot matching done by Deaneries as well as individual NHS consultants. The rest of this section draws together the lessons from across all of these approaches in terms of enhancing the UK's pull/attraction and reducing its medical labour market barriers/disincentives.

Overcoming UK Professional Entry Barriers: The Need for Streamlined Application and Registration Processes

One of the main aims of the DH's centralised approach to the recruitment of consultant-level specialists using TMP Worldwide has been to reduce the barriers associated with obtaining entry to the UK labour market for these doctors. Specifically, the approach involves initial (though unofficial) screening by medically qualified members of the recruitment team, and TMP staff before suitable applications are passed to the relevant Royal College for its recommendation. From this point on, the procedure is the same as for any potential entrant to the specialist register from overseas in that Colleges make their own recommendations to the STA, and the STA then makes its enquiries before allowing or refusing entry. Importantly, although progress was initially slow, with only 4 new names added to the STA list at consultant level by Spring 2002, by Summer 2002 about 40 applications had been successfully fed through. Moreover, even though in specialties such as pathology and radiology there have been fewer applications than originally hoped, the results in other areas such as psychiatry were said to be "*particularly pleasing*" (STA/Personal communication).

What this exercise illustrates, therefore, is that it is possible to "rationalise" and thereby speed up the process of application and professional registration for EU/overseas doctors wanting to come to the UK. Perhaps more significantly, on the evidence both of the sizeable number of actual applications (reported by TMP Worldwide, from the USA and Israel especially) and our EU/overseas interviews and focus groups, such doctors are also very willing to utilise this kind of centralised application process. Of course, such an approach does require the various professional bodies involved to work closely together to ensure its effectiveness. Information from the STA suggests, for example, that some applications had been allowed to proceed, which did not meet the legal criteria required. STA officials, therefore, had to set aside time to work alongside and train TMP personnel in the relevant regulatory requirements. In

addition, it was shown to be important for Royal Colleges to be represented at meetings between the STA and TMP in order to increase mutual understanding and give clear guidance on screening. Despite these transaction costs, however, most UK stakeholders were broadly supportive of the new arrangements and felt that once they “bedded down” the effort would pay off.

The need for such streamlined application/placement and procedures for professional registration was also illustrated in UK interviewees’ comments about the Overseas Doctors Training Schemes (ODTS) for specialist trainees. Until recently, the Royal Colleges/sponsoring bodies that administer the scheme (although not all do, and not all rely heavily on it for recruitment) had the responsibility for assessing candidates for limited registration, under direct placement, delegated from the GMC. The fact, however, that the GMC is now assessing eligibility for registration on an individual basis is reportedly causing difficulties (e.g. around the degree of College involvement in the procedures per se, and sponsors’ lack of knowledge of when trainees move to full registration and therefore out of sponsorship). In addition, concerns were expressed that Postgraduate Deans, who are responsible for the delivery of training in FTTA posts, are left out of the process of appointments to direct placements. It was felt that the ODTS schemes generally would run more efficiently if they were included in the relevant Royal College/GMC loop. Overall, although some felt that managing the ODTS centrally through a Direct Placement Board (e.g. with Deaneries dedicating some FTTA positions to the scheme) would simply add another layer to the administrative system, most considered that the current proposals to do so were a helpful way forward. Indeed, some such as the Royal College of Obstetrics and Gynaecology told us that they were already testing their own centralised scheme for placements in the absence, as yet, of wider moves to rationalise the ODTS.

To summarise, with the different interests and deep knowledge involved in screening/registration processes the issues are complex to resolve to the satisfaction of all concerned. Clearly, it will be important to continue to monitor new ways of working so that as many lessons as possible can be shared across the range of relevant stakeholders. What is already evident, however, is that coherent application/registration at whatever level of medical training and employment, can be both efficiently and effectively managed by the UK authorities and is more easily understood by potential migrants.

Finding the Right Training/Post-training Job Slot: 1) The Need for Clarity on the Shape of Demand

Another benefit of the recent emphasis on centralised approaches to recruitment by the DH has been the ability to articulate a much clearer picture of the nature and size of the NHS demand side – i.e. the specialties, grades, geographical locations, and employer organisations (both NHS Trusts and GP practices) where there are workforce gaps to be filled. Although not yet working to its fullest potential, the fact that there is a coherent view taken of need at consultant level was generally welcomed as a sensible direction to be moving in for two main reasons associated with efficiency. First, it provided a clear basis for global advertising, aimed specifically at doctors working in medical specialties where new applicants are most needed. Hence, it should follow that there is less redundancy in the system, with a greater proportion of applications likely, from the outset, to fit what is actually “out there” on the demand side. Second, there is the potential at least for an electronic database to be set up by TMP Worldwide on which vacancies available in NHS Trusts could be directly matched with individual EU/overseas doctors. In other words, centralised recruitment could allow a much more streamlined approach not only to consultant-level application procedures as described above, but also to the actual process of demand-supply matching so vital to the workings of any labour market. As another example of such arrangements working in practice, the first task of the DH recruitment team recruiting for the North West Spanish pilot involved identifying vacant GP and hospital consultant job slots. According to our interviewees, it was then possible to focus recruitment efforts precisely where needed in terms of the types and numbers of doctors required (in this case 20 GPs and 20 hospital doctors) right from the outset of first round interviews.

The importance of (as far as is possible) having this sort of clarity on the shape of demand was further illustrated by the situation reported regarding the ODTs. Specifically, as the scheme is currently under review, there is a level of uncertainty about the opportunities being opened up to EU/overseas doctors in Basic and Higher Specialist Training. One recommendation is that sponsored doctors should enter the UK only for higher specialist training in FTTAs. This is because with only 894 Type 11 SpR places available in 1999, and an estimated 250 available annually for new recruits, it is evident that most are currently being placed into SHO posts that do not necessarily meet their training needs. However, concerns were also reported to us about the quantitative impact on recruitment if, as a result of the FTTA emphasis, opportunities for an induction period in an SHO post were lost. In addition, those Royal Colleges (e.g. Anaesthetics and Psychiatry) that rely on overseas recruits at the SHO stage are reportedly worried that they could subsequently find difficulty in

filling these slots. A further recommendation is to extend the ODTS to those overseas doctors whose qualifications are recognised for full registration with the GMC (e.g. Australia, New Zealand etc.). This is as opposed to the current situation that sees doctors who gain full registration moving out of the scheme altogether. Such a move was said to be particularly welcome in shortage specialties, but again the relevant bodies were said to be unable to act because the go ahead had not yet been given. We will return to the issues raised here around placing doctors appropriately to meet their individual training/employment needs in more detail below. For now, however, it is important to note that, without overall policies or approaches, the UK is not sending the clearest possible signals about its available opportunities to the international marketplace.

Finding the Right Training/Post-training Job Slot: 2) The Importance of the “Personal Touch”

One of the key messages we emphasise throughout this report is that migration in the international medical labour market is essentially based on individual decision-making. The doctors concerned are very much “buyers” in the marketplace for medical training and employment experience. They are also in a relatively powerful position in that they have control over a commodity – their own labour – for which there is a strong demand and, hence, a high degree of competition internationally. As both UK and EU/overseas stakeholders pointed out, therefore, these doctors need to be “persuaded” to come to the UK as opposed to other potential destinations. In other words, in addition to simplified, streamlined approaches that enable them simply to understand the UK system more easily, they need to be given the “personal touch”. As just one example, our Indian focus groups said that they would prefer to be able to talk through the process of actually finding a training/job slot in the UK as part of their migration decision-making. By contrast, as one of our UK interviewees explained: *“It’s all done on pretty much of a tick box approach”* in which doctors are left to do their own letter writing (e.g. to Royal Colleges, potential employers etc) before *“call[ing] in those bits of paper ... [so] the GMC will register them”* (UK Anaes 2). In other words, certain aspects of the UK system can seem unfriendly to those who are unfamiliar with it, and if other countries are acting to make their system more accessible that may just “tip the balance in their favour” in terms of migration decision-making.

There are, of course, a number of recruitment methods currently in use in the UK that do provide a more “personal touch”. For instance, matches to post-graduate training slots can take place through NHS consultants visiting medical institutions abroad, interviewing potential recruits and obtaining recommendations there and then from former colleagues, teachers etc. Such specialty and locality/employer specific arrangements were reported

between the UK and, for example, India and Zimbabwe. Known as DESS (double-ended sponsorship schemes), they are currently validated through the Royal Colleges and in future may come within the scope of the ODTs. Similarly, some Deaneries (e.g. Eastern and Wessex, among our interviewees) have established informal and semi-formal links for GP Registrar recruitment, for example, from localities in Belgium, Holland and Germany. This capitalises upon the lack of training capacity in those countries compared with the UK. Importantly, such arrangements not only mean that discussions can be held with individual doctors about their specific induction/training needs and suitable arrangements put in place when they reach the UK, but it also enables robust “quality screening” of individuals from the UK point of view. It follows that as many as 20% of these recruits stay in the UK long-term: “because they’ve developed social links”(UK GP 8); and “they have had a good post-training experience, and feel integrated into the community” (UK GP 6).

By their very continuity such arrangements also enable a clear knowledge base of the “quality” of potential supply sources (i.e. Medical Universities, Post-graduate training bodies etc) to be built up. There was, therefore, a view from supply countries (e.g. India and Poland) that the UK should consider ‘working up’ informal links into more formal recruitment lines. The reasoning behind this view was that greater certainty of demand would enable supplier institutions both to develop appropriate pre-UK-training, and to administer UK qualifications examinations – i.e. in order that doctors could more easily “slot” into the UK system.²¹ However, UK interviewees in particular felt it was important to keep these links informal to avoid the possibility of candidates being put forward on the basis of political or financial influence rather than clinical/academic excellence. Another set of arguments against more formal and enduring recruitment links related to not wanting; “to poach ... particularly from developing countries ... to fill a gap in a developed nation [such as the UK] with money to train its own if it paid mind to” (UK GP 2). Clearly, it would be naïve to think that more formal arrangements would not have implications for supply countries and the institutions within them. At the very least, the promise of an enhanced opportunity to train in the UK should attract more students, thereby providing education/training providers with additional

²¹ Such arrangements were, for example, already in place at the Indian Medical Colleges in Chennai (Madras), and the premier private Apollo Hospital (whose Office Bearers and consultants respectively took part in our Indian fieldwork) – with training and experience provided for UK Royal College of Surgeons Membership examinations taken locally. Moreover, there would certainly be several other institutions in India capable of supplying the UK with accredited and attested doctors. The options would, for example, include: a) using Royal College examinations more generally overseas, supervised as now by UK examiners and moderators, as entry-level qualifications; b) adapting the ODTs sponsorship arrangements, but genuinely structuring induction training in the UK within dedicated posts, so that there can be rapid progression towards SpR training; c) providing, as an alternative to PLAB, an entry-level examination at Membership level, which would enable rapid progression towards SpR training; and d) accrediting aspects of training in some Indian or other overseas institutions, as part of training, which could be undertaken either by UK or Indian postgraduates, so strengthening genuine exchange links.

fee income. On the other hand, such an approach could contribute to a more coherent – potentially mutually beneficial – approach to UK demand-supply matching. This would allow the possibility of fewer transaction costs associated, from the UK side, with: a) locating individual doctors who are suitable for NHS training/employment; and b) slotting them into the available UK opportunities. From the supply country side, it could potentially provide more doctors trained-up to return with valuable skills that are much needed in those health systems (the latter was, for example, applicable to Polish general practice/family medicine).

Finding the Right Training/Post-training Job Slot: 3) Other Opportunities for Streamlining the Job Search Process

Other intermediaries in the job-search process are the many medical recruitment agencies operating on a normal fee basis, both in the UK and globally (including TMP Worldwide and others), whose existing networks and “market presence” might be built upon to achieve “value added”. Such agencies already have considerable experience, for example, in expediting work permit and registration processes, which as we have said above is a barrier for individual doctors considering their migration options. Compared with some of the alternatives, therefore, the agency (i.e. locum) route was seen as a relatively straightforward way into the UK labour market (e.g. by some doctors in our India focus groups). It is also attractive as a means of gaining experience to move to a more “stable” NHS post (e.g. SHO, SpR grade), and is seen as a “high earner” in its own right for doctors wishing to migrate only for short-term monetary gain (e.g. Australians). Despite this apparent high level of potential supply, however, the UK agencies interviewed reported that the demand for doctors to fill hospital job slots via this route is considerably greater than the number of available recruits. It seems, therefore, that some adjustments are needed in order to maximise the agency contribution to demand-supply matching - both in the context of locum placements specifically, and the NHS workforce as a whole. One suggestion from UK interviewees was for a centralised website, that could be accessed by doctors from abroad, with links to a “preferred provider” list of UK recruitment agencies. If the same list was also known to NHS Trusts as the first point of call for filling their vacancies from the EU/overseas (or equally the UK) labour pool, then it was felt that much greater degree of “matching efficiency” could be achieved.

An alternative also suggested by UK stakeholders was to build on arrangements currently being developed within the NHS itself in relation to locum doctor placements. A specific example amongst our UK interviewees was ‘NHS Professionals’ run by a Bradford-based Ambulance Trust, in West Yorkshire. It uses NHS Direct facilities to provide Trusts with a

computerised bank for recruitment of nurse locums and was, at the time of fieldwork, planning to expand to cover doctors as well. As an internal NHS agency, Trusts are apparently obliged to use 'NHS Professionals' as their first point of call before going to the commercial sector. The reported benefits are: a) that locums can be provided with well-established rates of pay, and flexible career opportunities (e.g. for women returners); and b) that employer Trusts pay lower rates of commission than to the "for profit" agencies. There was also said to be potential: a) to set up a database for all locums in England, possibly the UK, which could be used for purposes of accreditation and revalidation, as well as providing selection and screening for Trusts; and b) to recruit overseas doctors into the NHS on a more permanent basis, compared with, "*the perverse incentive of commercial agencies of retaining doctors as locums*" (UK NHS Prof). The latter would enable locums to be provided with an NHS pension, and more attractive development packages, in terms of the range of work offered. So far we have no further information on how the work of NHS Professionals has developed. Nevertheless, the potential of "rationalising" approaches to EU/overseas recruitment in these sorts of ways is clear. Importantly, such arrangements were not just suggested by the agencies themselves (who may be seen as having a vested interest), but were also supported by certain of the UK competent authorities and doctors' representative groups (UK Org 3 and UK Specialist 1).

From Recruitment to Being Comfortable and Successful in the NHS Role

The Importance of Induction, Tailored Training and Work-based Support Structures

Another aspect of reducing barriers/disincentives and increasing the attraction of the UK is to provide more relevant induction, training and work-based support for individual doctors. Such arrangements were supported, both by our UK and EU/overseas interviewees, because they help familiarise doctors with the NHS system and make them aware of precisely what is expected of them. This was important for two main reasons. First, it was said to help ensure the 'quality' of doctors' medical practice. Second, it was thought to improve retention because, from the individual doctor's point of view, it shows that he/she is a valued part of the NHS workforce. In addition, being enabled to 'do a good job' more quickly than might otherwise be the case can only impact positively on job satisfaction.

Again, there are a number of measures already being developed by the UK authorities in this context, from which it is possible to take some lessons for the future. For example, the recruitment team working on the DH pilot with Spanish doctors in the North West has developed detailed understanding around the provision needed to ease the process of

transition for new recruits from abroad into the NHS (Atherton and Mathie, 2002). Such provision has, for example, involved tailored language induction – including working with Spanish speaking doctors in the same specialty elsewhere in the UK – in order to learn the specifics directly relating to medical practice. It has also proved appropriate to appoint some recruits at the level of Associate Specialist (i.e. working under supervision for an interim period) even though under EU rules they are already eligible for entry onto the UK Specialist Register. Similarly, Deaneries have for the past two years had named sub-Deans with special responsibility for overseas doctors. They also have dedicated funding to offer induction courses to all overseas doctors at the start of their training period in the UK. One UK Deanery interviewed explained the benefits of the individualised approach using the example of a Spanish doctor who they had helped by organising two PRHO jobs prior to GP training. Although the doctor had ‘acquired rights’ in Spain, she had only obtained work in one of the holiday resorts there, but otherwise had no practical experience: “... *as she put it, she knew all about sun burn, dehydration due to food poisoning, and sexually transmitted diseases*” (UK GP 8). Once again, therefore, what such arrangements allow for is the opportunity to discuss individual situations and possibilities for training with all doctors - including those whose circumstances fall outside ‘the norm’.

Overall, an incremental approach to supporting individual doctors at least on initial entry to NHS posts was considered “worth it” for one simple reason. It gives doctors, the majority of whom already have valuable skills that just need drawing out: “*the opportunity to become more conversant and more fluent ... [so] demonstrating themselves to be really quite capable [with] ... the same spectrum, if you like, as we will have here.*” (UK GP 6). By contrast, too many EU/overseas doctors were said to receive “*At the moment ... orientation [that] is about getting to know the system, [but] it doesn’t actually recognise getting to think in the system*” (UK GP 8). Of course, there is a role for simpler measures such as mentoring, overseas doctors clubs and so on. These were said by our UK interviewees to be “*very, very helpful [for example for] ...breaking the institution[s] [such as the Royal Colleges] down into a person, a contact*”. Indeed, without them it was felt that the Royal College system in particular was “... *quite an intimidating concept*” simply because it has “*the power to pass you, fail you etc*” (UK Anaes 1). In general, however, the most important aspect of successful EU/overseas recruitment was felt to be the ability to: “... *offer [at least] six months in a series of proper supported posts.*” (UK GP 6). This was a consistent message across the board both from UK stakeholders and EU/overseas case study countries to stop EU/overseas doctors, as various UK interviewees put it: “... *being marginalized into service jobs [simply] because the service needs to operate*” (UK Specialist 1) or “*filling the posts that nobody else wants*” (UK Surgeons 1).

The Importance of Tailored Support Packages Outside Work

In addition to work-based support structures, UK, EU and overseas stakeholders also emphasised the importance of recruitment packages tailored to individual needs (both practical and psychological) outside work. In doing so, they were recognising that enhancing the social and cultural experience of EU/overseas in the UK can have just as much impact on workforce quality and retention as NHS training and working experience per se. Once again, there is considerable evidence from the Spanish recruitment pilot in the North West region in this context. Specifically, many ‘taken for granted’ items, such as opening a bank account and obtaining a National Insurance number, were found to need attention in addition to more obvious aspects such as finding accommodation, language improvement and cultural acclimatization. There was both more to be done, and for longer, than had initially been anticipated by the DH recruitment team. Importantly, following what were described as the “teething problems” of the first round of recruitment, guidelines have now been issued to employing Trusts to ease this aspect of the induction process for EU/overseas doctors (DoH, 2001c).

Once again, a key consideration for both our UK and EU/overseas interviewees in this context of providing support tailored to “outside-work” needs, is the age and career stage of the doctors being targeted to come and work in the NHS. The point was made, for example, that if the UK wishes to recruit doctors at later stages in the medical career path, then account has to be taken of the fact that they will also be further along in terms of family formation etc. Such doctors will also need to be supported, amongst other things, to find appropriate family housing and education for children. In this context, both UK and EU/overseas stakeholders were highly supportive of the sorts of arrangements being put in place for consultants recruited to the UK under the International Fellowship Scheme.

Why the Particular Importance of Tailored Induction and Recruitment Packages in the UK?

Such an emphasis on quality induction and tailored support packages to meet individualised training/work experience and social/personal needs were particularly important in order to make the most of the types of doctor that were seen as predominantly attracted to the UK. These doctors were either said to be: “*the best and brightest*” (UK Anaes 2), “*normally high flier[s] [who have] ... never failed an exam in their lives*”; or they are “*very poor ... [wanting] the magic answer that they will then pass*” (UK Anaes 1). It goes without saying that the NHS needs to do everything it can to develop, and retain, as many doctors who fall into the former (majority) category as possible. In addition, for the latter (minority) category,

most of the difficulties were not felt necessarily to be because of “quality issues” *per se*. Instead they were attributed to the fact that overseas doctors: “*don’t have familiarity with the sort of structure of exams and so on*” (UK Psychiatry 1) or “*they haven’t had the deep grounding in aspects of our syllabus*” (UK Anaes 1). Once again, it was said to be simply:

“... a combination of language and cultural difficulties, and the nature of the training they had in their home country...It’s been part of their theory [but] they’ve never actually seen or administered the drugs that are available here, so the practical side of it is completely new” (UK Anaes 1).

The second set of characteristics of migrant doctors coming to the UK, that it would appear possible to capitalise upon, relates to their age and career/family position. Australian interviewees, for example, saw medical migration from there to the UK as a ‘stage of life’ process (even if it was strongly facilitated by the recognition of PMQ enabling full registration with the GMC). A typical comment was that: “*There’s an obvious pool of doctors who are mobile, they are generally hospital doctors and the under doctors who are, you know doing their travelling before they settle down...These are the working holiday types of things*” (Aus Int AIHW). Similarly, our Indian focus group participants saw the post-MD stage as ideal to go abroad, before, “*you get married [and] ... miss this time, to study and also ... visit foreign lands and then come back here*”. As they said: *you might not get a second opportunity in your life really*” (India Focus Group 2). A second level of movement was perceived as being at the ‘empty nest’ stage: “*when the kids have gone to Uni, and there’s a chance to do things that maybe you didn’t do when you were younger*”. In addition, this was said to be the time to: “*do it [short-term migration] as a training opportunity, if a particular hospital is strong in a particular area*” (Aus Int AIHW). Importantly, doctors at both these career stages would appear to be what the UK is looking for on the demand side (i.e. to fill both SHO, and to a lesser extent SpR posts, and consultant grades) on both a short and longer-term basis. As one UK stakeholder pointed out, and as we have already argued above: “*We’ve got to be absolutely clear who it is we’re looking to recruit ... and make sure we do what’s needed to attract them. And [not doing so] that’s our primary problem.*” (UK Org 1).

Summary

The main push and pull factors underpinning doctor migration to the UK were identified at three levels:

- At the country-level:
 - Relative economic and social expectations and the prospects for higher financial gain;
 - Wider quality of life issues, including personal safety and the prospects for stability and greater freedom.
- At the medical organisation/professional-level:
 - Relative prospects for obtaining career improving postgraduate training;
 - Home country bottlenecks to career development and progression;
 - Perceptions of enhanced job satisfaction and working conditions.
- At the individual-level:
 - The stage doctors have reached in terms of career development and family formation;
 - Their particular medical field and the health system in which they gained their experience/training;
 - Whether or not individuals and their families are considering migrating for the short or longer-term.

Within this complex picture of incentive structures encouraging migration, the main ones seen as giving the UK competitive weight against its rivals were:

- The established system of UK post-graduate qualifications (especially the reputation and kudos of the Royal Colleges) and training opportunities, and the attraction that holds for potential migrants to enhance their human capital/career prospects;
- The English language, which is relevant both for ease of entry to the UK labour market and as a “passport” to wider opportunity elsewhere;
- The information, recruitment, job-matching, induction/training and follow-up support systems that exist in particular circumstances to ‘handle’ individuals at various stages in the migration and labour market entry process.

However, there were still factors that both UK and EU/overseas interviewees felt could be improved in the way that the UK approaches the international medical labour market. These will be explored in more detail later in the report.

5 THE UK AS A COMPETITOR IN A CHANGING INTERNATIONAL MARKETPLACE: THE KEY EU/OVERSEAS PLAYERS AND THEIR PERSPECTIVES

In previous sections we outlined the UK's current position in terms of the shape of EU/overseas doctor demand and supply, the factors that make it an attractive or less attractive destination internationally, and mechanisms in place for education/training/post-training job slot matching. Although we drew on evidence from EU/overseas stakeholders as well as those in the UK, the focus was on how the UK is seen *per se*, rather than on how it compares with other potential destinations in the international medical labour market. This section, therefore, moves on to look at the UK as a player in an ever-changing and increasingly competitive marketplace for doctors. It explores which countries are the UK's key competitors for EU/overseas doctors, what they are also doing to attract those doctors, and what, if anything, the UK can learn from them to improve its own position in the marketplace?

Key Players and their Activities in the International Medical Labour Market

The Main Demand-side Competitors for the UK

So which countries are the main competitors to the UK – i.e. other major “demander countries” looking to recruit from similar sources of international labour market supply? We explored this question both through our literature review/secondary data analysis, and by asking UK and EU/overseas stakeholders for their views. Overall, the USA (our main competitor case study) was seen as by far the most significant player in the marketplace both in terms of the scale and scope of its impact. It was consistently ranked as the first choice destination internationally by both UK and EU/overseas interviewees, and our focus groups²². Other countries revealed as having a substantial reliance on overseas sourcing (particularly from South Asia and Africa) were: Australia Canada; and to a lesser extent New Zealand (N.B. Australia was also included as a case study for its supply and competitor perspectives). As in the UK, an average 25% of these countries' workforces have a PMQ obtained overseas (between 23% and 30%, fluctuating as a result of policy changes, but within this range for the last 30 years) (Barer 1999; Barnett, 1991; CIHI 2001; Conn et al 2000; Coffman et al 2000).

²² This was backed by a range of literature including: Brotherton and Tang, 1996; Kindig and Libby, 1996; and Mullan et al, 1995; and applied both to developed countries such as Australia and New Zealand (Miller et al, 1998) and developing country sources as varied as India, Pakistan, Egypt, Lebanon, South Africa, South America, and the Phillipines (Baraka, 1994; Goldfarb and Havrylyshyn, 1984; Kale, 1995; Khan and Kamal, 1999; Kronfol et al, 1992; Nakano, 1993; and Rao et al, 1998).

In addition, countries such as Saudi Arabia, South Africa and even Japan have received doctors from abroad in recent years. In the case of Saudi Arabia supplies are from a mixture of EU, Eastern European, and other overseas sources. In Japan they mainly are from its Asian/South Asian neighbours, but also Africa, South America etc; and in South Africa they are mainly from its African neighbours, especially those South of the Sahara. Finally, within Europe, one of the UK's main competitors would appear to be Sweden in terms of active recruitment schemes currently in place, with other countries such as Germany, Austria, Norway, Ireland, and France also drawing or likely to need to draw doctors from similar sources.²³ More specifically, these countries were all reportedly destinations for doctors from elsewhere in the EU, from Eastern Europe, and from non-EEA countries in South Asia, Africa and elsewhere.

Looking at detailed secondary data on doctor migration provided both by our case study countries and by other relevant bodies, it is possible to see a similar, overlapping picture of competition for doctors from the same pool of supply countries being tapped by the UK (as outlined in Section 3). As just one example, Australia, New Zealand, and Canada have all drawn on South Africa (one of the UK's biggest suppliers after India) - particularly to fill specialty vacancies in remote areas. More specifically, Canada received a per annum average of 110 and 85 South African doctors in the early 1990s and 1996/2000 respectively; and 24% of all physicians entering in 2000 were from that source (CIHI, 2001). In 1999/2000, 17% (n=1,880) of those entering Australia on the relevant '442' visa (see Country Report for details) were medical practitioners from South Africa. Australia also admitted a yearly average of 12 South Africans with recognised specialty qualifications between 1995/2000 (DIMA unpublished data). Finally in New Zealand in 1999, South Africans represented one quarter (600) of fully registered doctors qualified overseas (Ncayiyana, 1999). As another example, the same data show that doctors from the UK's biggest overseas supplier, India, made up 11% of '442' visas issued for entry into Australia, and they also represent around 9% (200) of New Zealand's fully registered, overseas qualified workforce. In the USA, approximately 20% of physicians on the American Medical Association (AMA) database also qualified in India, although there it is Pakistan 11.9%, and the Philippines 8.8% that are the next largest supply sources (AMA unpublished data).

²³ It should be noted that our understanding of shortages in Sweden is not based on statistical data, but on the evidence of active recruitment initiatives in the two European case study countries we visited, namely Spain and Poland. Unfortunately, we do not have current information on medical workforce shortages and oversupplies, or migration as they relate to Sweden or other EU and Eastern European countries. Despite several requests, neither the update of the European Junior Doctors country-based workforce study, which was due in 2001, or a survey carried out by the Permanent Committee of European Doctors were made available to us. However, the findings of our interviews in relation to EU countries with potential workforce shortages were, to an extent, backed by other literature (e.g. Aasland et al, 1997; Eknes and Kristiansen, 1993; Gottely and Vilain, 1994; Straubhaar and Wolburg, 1998).

Like the UK, the main reason why countries such as the USA, Australia, Canada and others within the EU are in the market for migrant doctors, is that they have an under-supply of 'home-grown' doctors (see, for example, Kindig and Libby, 1996; Thurber and Busing, 1999). This may be in the medical workforce overall, or in specific slots in the labour market such as in deprived urban, or remote rural, areas, and particular hospital specialties or general practice (COGME 1998, 1999, 2000, AMWAC 1998, 2001). It is also interesting to note that, as in the UK, the emphasis, in most of these countries is on becoming 'self-sufficient' in the domestic production of doctors. As one of our Australian interviewees commented: *"It's a fairly common view...that we don't want to deprive other countries of their medical resources"* (Aust RDA).

However, it appears unlikely that these countries will be reducing their activities in the international marketplace in the near future for a number of reasons. First, given the long lead time for educating a new doctor, and the even longer time scale required to produce a specialist, the issue of self-sufficiency can be expected to take many years to resolve. Second, it was argued, by some, that the relevant professional bodies have an interest in not over-producing doctors (as some would say is also the case in the UK), in order to defend professional power and levels of remuneration etc. Third, it is just as difficult for other countries as it is for the UK to assess the complicated sets of factors involved in modelling and determining demand, and therefore in making appropriate provision for supply.²⁴ In this context, our case study interviewees pointed out that common societal changes are impacting on the physician workforce across the developed world. From the demand-side, there are rising expectations from patients (evidenced by, for example, the long waiting times to obtain an appointment with a GP in Australia). From the supply-side, there is the reduction in doctors' lifetime working hours due to lifestyle changes, earlier retirement patterns, and the changing gender balance of the medical workforce itself. Such forces were seen as giving rise to the need for greater doctor numbers (in absolute terms, as well as Whole Time Equivalents) in countries such as the USA, Australia, New Zealand, to some extent, Canada, as well as the UK.

²⁴ Over the last 10 years and more, the agencies involved in workforce planning in the USA and Australia and Canada, for example, have been forecasting impending or longer-term oversupplies. Such oversupplies are already evident in geographically specific areas, like the affluent suburbs of major coastal cities, such as east Melbourne and north Sydney, or the San Francisco Bay area of California; all be it with pockets of under-supply in rural and remote areas, or in poorer urban districts. Using another indicator, oversupplies are manifest as relatively high overall physician to population ratios compared with OECD countries, and are of concern because of the high proportion of GDP spent on health care. Various policy tools have been employed aimed at balancing workforce demand and supply domestically including: limiting the number of medical school places; and using a combination of incentives, and more recently 'bond' agreements to attract the domestic supply to the hard-to-fill vacancies. However, in the case of the USA, Australia, and Canada, in the last 2 years or so, voices have once again been heard suggesting that pockets of under-supply are about to grow to become an overall shortage.

Geographical Markets and Sub-markets for Doctors

Another feature of the international medical labour market revealed by the literature review/secondary data analysis and the UK and EU/overseas interviews is that it operates at different geographical scales (see Table 5.1). As well as general, ad hoc global migration between continents, there are also consistent, often more ‘localised’ geographical sub-markets in operation at regional and country-country levels.²⁵ Such arrangements are underpinned by a range of factors including: historical links and related migration traditions; the existence of contemporary trading/geopolitical/regulatory blocs, geographical proximity; linguistic commonality, and straightforward market incentives/financial gain (see Table 5.2).

Table 5.1:
Geographical Scales for Sourcing in the International Medical Labour Market:
Summary View from Literature Review and Fieldwork

Geographical Scale	Receiver/Supplier Countries
Global	Individual demander countries (e.g. USA, UK, Australia, Canada, New Zealand) sourcing worldwide from individual suppliers (e.g. India).
Regional blocs	Groups of counties sourcing within their geographical regions: UK: Europe USA: Canada and Central/South America Australia: New Zealand: Pacific Rim Japan: South East Asia South Africa: Sub-Saharan Africa
Country- country	Pairwise arrangements between adjacent countries: UK: Ireland USA: Canada Australia: New Zealand Sweden: Norway Germany: Austria: Poland: Czech Republic Netherlands: Belgium Spain: Portugal

Note: The examples in Table 5.1 are illustrative not an exhaustive list.

²⁵Geographical sub-markets specifically discussed in the literature included: USA/Canada (Barer and Weber, 1999; Buske and Strachan, 2000; CIHI, 2001; Korkok, 1996; Ma et al, 1997; McKendry et al, 1996; Socransky et al, 2000); Australia/New Zealand (Australian interviews e.g. RACP); South Africa and the rest of Africa (Giddy, 1997; Kale, 1995); and also Russia/Israel (Nivel et al, 1993; Shuval, 1995; Shuval and Bernstein, 1995).

Table 5.2:
Structures Underpinning the Operation of the International Medical Labour Market:
Summary View from Literature Review and Fieldwork

Underlying Structural Context	Receiver Countries: Supplier Groupings
Historical links and migration traditions	UK: Australia; Canada; New Zealand UK: South Asia and, to a lesser extent, Africa USA: Philippines; and EU/East European countries
Contemporary trading/geopolitical/regulatory bloc	UK: EEA and East European candidates for EU membership USA: Canada Australia: New Zealand
Geographical proximity	UK: European countries generally USA: Canada and Central/South America Australia: New Zealand: Pacific Rim South Africa: Sub-Saharan Africa
Linguistic commonality	English: Commonwealth countries: North America French: Overseas departments and former colonies German: Austria and Eastern Europe Spanish: South America and other former colonies
Market economics/financial gain	Middle East (e.g. Saudi Arabia, United Arab Emirates etc): Worldwide Africa: Worldwide linked to short-term 'missionary' roles

Note: The examples in Table 5.2 are illustrative not an exhaustive list of country/supplier groupings. In addition, movement may be one-way and/or reciprocal to different degrees depending on the case in question.

In other words, just as the UK has special access to the regional sub-market of the EEA and has a history of migration ties with South Asia, so New Zealand and Australia, for example, have an established inter-exchange system between themselves based on proximity and mutual regulatory recognition. Both are also drawing on supplies from China and other Pacific Rim countries, a regional sub-market, which has developed since the 1970s widening of immigration policies and development of trading links. As well as being the UK's main competitor country for Indian doctors, the USA draws from the sub-markets of Central America, the Caribbean, that are geographically proximate, and the Philippines, because of post-war connections. With mutual recognition of PMQ and GP qualifications, the US is also a net gainer in the cross-border exchanges between the US and Canada. Canada particularly lost significant numbers of GPs in the mid-1990s, as the Clinton policies sought to increase the proportion of generalists in the US workforce. Within Europe, country-country links were also reported between, for example, the Scandinavian countries, between Germany, Austria and Eastern Europe, and between the UK and Ireland. Overall, however, these potentially 'more guaranteed', geographical sources of supply were said to be unlikely to be sufficient to meet long-term needs. The USA, Australia, New Zealand and others will, on the evidence of our case study research, continue to augment their medical workforces from other sources –

and it is likely that those sources will continue to overlap with the ones currently being tapped by the UK.

Countries Simultaneously Sourcing and Supplying Doctors

To some extent, the UK and its main competitors, particularly in the Anglophone world (e.g. USA, Canada, Australia, New Zealand etc), will also be “*robbing Peter to pay Paul*” (Aus AIHW) because they are themselves, preferred sources of supply for each other. This is because transaction costs around the English language and the cultural adjustments needed to work in their respective health systems are perceived as being lower than for doctors from elsewhere. As one Australian interviewee explained:

“The countries that we ... see as our highest priorities [for recruitment] are the UK and Canada, because it’s those two countries’ qualifications that the Australian College of GPs will accept as equivalent ... Probably in the last 10 years the UK is a very high supplier of locums more than permanent workforce... There’s a growing pool from Canada, and a few Americans, New Zealanders... again, English speaking countries” (Aus RDN).

Elsewhere it was reported that the UK and Canada supply a small, but steady, stream of around 12 GPs per year to Australia’s rural and remote areas; and that the UK and Ireland are the biggest suppliers of Temporary Resident Doctors, another key group in the Australian workforce (Aus AIHW). More specifically, the immigration data that we have already referred to in relation to India and South Africa, showed that the UK accounted for 36% (n=1,880) of ‘medical practitioners’ entering Australia on a 442 visa in 1999/2000. A further 5% came from the Irish Republic, with 5% and 4% respectively from the USA and Canada (DIMA unpublished data). As another example, around 200 of the approximate 2,400 total of fully registered doctors qualified overseas in New Zealand are from the UK/Ireland (Ncayiyana, 1999). In terms of ‘robbing Peter to pay Paul’, it should also be remembered that EU/overseas doctors may be ‘shopping around’ for opportunities. Hence the UK, Australia, Canada or any other demander countries are not necessarily their *final destination* in the international marketplace. For example, at the equivalent of SHO and SpR training, Australia draws supplies from India via South Africa and New Zealand – the latter because it is easier to gain residency status in New Zealand, which in turn gives access to the Australian market.

Key Players and Competition by Demand Segment: Education/Training/Post-training Job Slots

We will now look at the specific shape of recruitment opportunities being made available by the UK's main competitors (e.g. the USA, Canada, Australia and, to a lesser extent New Zealand). This will allow us to assess both the overall strength of these countries' demand pull, and how far they are competing for supplies with the same attributes as required in the UK. Again, we distinguish between the different market niches of medical education, post-graduate training and post-training job opportunities, as well as the different hospital specialty/general practice and geographical location slots within each. Overall, the section illustrates that the UK and its main competitors are indeed recruiting EU/overseas doctors into broadly similar positions within their medical workforces.

Competition for the UK in Undergraduate Medical Education

Although, as is also the case in the UK (see Section 3), major competitors such as the USA, Canada and Australia are not seeking nationally to exert market position in relation to undergraduate medical education, it nevertheless represents a significant route for EU/overseas doctors to enter these countries. The data show that in Australia, for example, 13.9% of medical students were from overseas in 1999 (of 7,324 in total, 40 were from New Zealand, 1,016 were other overseas, and 6,568 were Australian citizens/permanent residents) (Conn et al, 2000). In addition, in Canada, out of an approximate total of 6,400 medical students in 1998/99, 233 were 'visa' students recruited from overseas. Such recruitment is attributed to Canadian medical schools making up shortfalls (of finance and capacity) following early 1990s cuts in the domestic medical school intake (Buske 2000). Moreover, a number of Australian and Canadian universities have undertaken direct recruitment in the same countries as UK institutions (e.g. Malaysia). Finally, although in the USA, it appears to be left more to individual doctors to take the initiative and apply to take up student opportunities, it is worth noting the popularity (e.g. with Indian focus group participants) of this particular route into the US labour market. This stems from a reported perception that undergraduate level entry, together with non-medical post-graduate qualifications (e.g. courses in public health) offers a potentially easier route to long-term immigration to the USA than other types of training/job slots.

Undergraduate Entry as a Stepping Stone to the UK's Competitors

Another factor that affords competitors such as the USA and Canada market position almost by default is that undergraduate level opportunities elsewhere in the world are also geared for entry into their medical labour markets. So, for example, in Poland several of the more prestigious universities (e.g. in Warsaw, Krakow, Katowice, Gdansk, Lublin and Poznan) offer 4 and 6-year medical degrees through the medium of English. Such courses are aimed predominantly at US and Canadian students who have not got onto relevant courses there, as well as those who are seeking to enter those countries. They are, therefore, tailored directly to equate with pre-med and/or subsequent levels of study in the US and Canada, and often offer the opportunity to take USMLE examinations whilst in Poland. In addition, students come from countries like Saudi Arabia and from Scandinavia to use these sorts of courses as a stepping stone to medical practice elsewhere. Importantly, it is not that countries like Poland (and we were also told of similar arrangements in Israel) can be seen as being in direct competition with the UK for EU/overseas medical students. Instead, what the example illustrates is that the potential also exists for the UK to draw doctors into the NHS labour market by this route. As one of our EU stakeholders also pointed out, there is similar scope to increase exchange opportunities for medical students within the EU as part of their primary medical education. The benefit of this is that students are socialised into alternative health systems and that may, in future, make them more willing and able to take up the opportunities afforded by free movement and mutual recognition and training. Given that the UK does not yet appear to gain as many doctors as might be expected from its most obvious geographical sub-market – the EU (Brazier et al, 1992 and 1993; GMS, 1996) – this may be something worth considering in more detail. We will, therefore, return to it later in the report.

Competition for the UK in Basic and Higher Specialist Training

As in the UK, demand for physicians in major competitor countries is greatest and on-going at the 'workhorse' stage of basic and, to a lesser extent, higher specialist training (i.e. the equivalent of SHO, and SpR grades respectively). Indeed, it was clear from our UK and EU/overseas interviews that, in most quarters, discussion of the general marketplace internationally could almost be equated with discussion of this post-graduate level demand and supply. Clearly, it would be repetitive to extend the analysis of competition for the UK in any great detail here (see instead later in Section 5 and individual Country Reports). Nevertheless, there are some examples that can usefully be drawn for illustration from countries such as the USA, Australia and Canada.

In the USA, for instance, we were told that the biggest demand for overseas doctors is in Residency training (particularly from the third year onwards when supervision is reduced and doctors can make a more valuable contribution to service provision). In Australia, hospitals experiencing recruitment difficulties are also apparently looking to fill mainly Post-graduate posts from Year 2 onwards (the equivalent of SHO grades), but prefer the greater experience offered by PGY4 plus. The latter would, for example, cover doctors from the UK who have completed their SHO training, and have obtained Membership of the relevant Royal College. Interestingly, Australian interviewees also saw doctors at the post-SHO stage (who are often single and not yet committed to higher specialist or vocational training) as the group most likely to be prepared to trade travel and career break opportunities for work in under-served areas. Clearly, the UK is not operating in exactly the same part of the labour market as its competitors (i.e. USA, Canada and Australia) in terms of the geographical remoteness of the rural locations to which many doctors are being asked to move. However, those countries' priorities do overlap with the UK's needs in terms of recruitment (particularly in general practice, but also in hospital specialty training) in deprived or under-served urban areas (Sibbald and Young, 2001).

To a significant degree, then, Basic and Higher Specialist Training represents the 'business end' of the international marketplace around which in practice the visibility of demander countries of the global and sub-markets described earlier tends to operate. In the main, post-graduate training and equivalent-level but non-accredited training (or service) posts are being opened up to the international marketplace for their own sake. Importantly, however, these opportunities also represent a route in from which some doctors are encouraged (by default or otherwise) to remain afterwards in post-training job slots. Having the most advanced and best-developed training systems is, therefore, one of the key instruments through which demander countries can exert competitive edge.

Competition for the UK in Post-training Job Recruitment

As far as highly trained specialists/consultants, and general practitioners/family doctors are concerned, there appeared to be less international competition in terms of the numbers required in the short/medium term. The USA, Australia and Canada all have relatively strong professional regulatory mechanisms, the purpose of which is to screen for quality control and equivalence in training, but which also have the effect of limiting the numbers able to enter the workforce. Those overseas hospital specialists and general practitioners/family doctors who do gain access directly to qualified job vacancies do so by and large because they are filling openings in rural or remote areas. Australia, in particular (and also Canada) currently

limits the job slots available to overseas-trained foreign nationals to this type of vacancy, although (as we will see later) do offer them comprehensive packages addressing family and social needs, as well as good financial rewards as a specific attraction. As we have already noted (in relation to SHO and SpR grades), therefore, the UK cannot be said to be competing with these countries in terms of the attributes of the geographical locations where most opportunities are on offer. Nor is it necessarily competing for all the same specialties. For example, 2-3 years ago, when the UK had a surplus of CCST qualified obstetricians/gynaecologists compared with consultant vacancies, both Canada and Australia were short of this specialty to serve rural and remote areas. However, there is still a direct overlap with the UK in terms of several other key hospital specialties (e.g. anaesthetics, intensive care, radiology and pathology) in which migrant doctors are required to address shortages, and general practice (Aus Hosp Mel; RDN interviews). See Table 5.3 for a summary view of the UK demand side compared with key competitor countries in the international medical labour market.

Table 5.3:
Types of Demand in the International Marketplace: The Image Presented

Type of Demand	Demander Country				
	USA	UK	Australia	Canada	New Zealand
Shortage specialties – all geographical locations		*			*
		(e.g. cardio-thoracic surgery, histopathology, radiology, psychiatry)			
Shortage specialties - particular geographical locations		* (e.g. GPs)	*		*
			(e.g. anaesthetics, intensive care, radiology and pathology)		
Geographical location shortages – all specialties			*	*	
			(i.e. GPs with additional skills)	(i.e. Family doctors with additional skills)	
All specialties – all geographical locations	*				

Note: Table 5.3 is not an exhaustive picture of different countries' demand side, but instead describes the *predominant* image of a particular demander country in the international labour market. So, for example, although the USA does have under-served areas (e.g. remote and rural) where it attempts to encourage doctors to practice (e.g. with financial incentives), it did not appear to be recruiting on that basis internationally to the same degree as Australia and Canada were perceived as doing.

Positioning for Competitive Advantage: The UK's Attractions Relative to its Main Competitors

So, given that the UK and its competitors are looking to recruit similar sorts of supplies, for the most part through the port of entry of post-graduate training but also in undergraduate medical education and post-training vacancies, how do they also compare in terms of levels of attraction? As we did for the UK (in Section 4), we will now explore the range of push and pull factors driving medical migration at country-level, organisation/professional level and individual-level. In doing so, we can go some way to gauging the opportunities and threats confronting the UK in relation to its competitive position in the international marketplace. Here too we shall retain a synoptic perspective, whilst leaving the detail for individual Country Reports.

Country-level Factors: Comparative Economic and Political Situations

Although the UK was regarded by our interviewees as on a par economically, and in terms of political stability, with most demander countries in the international medical labour market (e.g. Australia, Canada and other European destinations), not surprisingly, one particular competitor “stood out from all the rest” on this criterion. For all of our EU/supply country respondents, the USA was the number one choice of destination, simply because it is “*the land of opportunity*” (UK Physicians 1), offering doctors the greatest opportunities for economic advancement overall. This was considered the case both for the small percentage wishing to migrate on a short-term basis (e.g. in order to earn money to send home immediately or to save to set up in practice on their return) and for permanent migrants. Typical comments illustrating the contrast in perceptions were: “*It’s a free market in the US...it’s totally open, and pay is definitely better when compared to [the] UK.*” (India Focus Group 1); and “*The US is I think the most attractive for people, you know. I think it’s not only for Polish people, I think it’s from the rest of the world, ... they always offer... the best salaries.*” (Poland GP 1).

By comparison, perceptions of the economic and political characteristics of other potential destinations appeared subject to subtle variations that principally came into play if US opportunities were rejected by, or not available to, the individual concerned. From a European point of view for example, it is clear that the position of the UK within the EU/EEA is critical and likely to be more so in future. This is as economic and political convergence continues amongst existing members, and as more countries join from Eastern Europe and elsewhere. In contrast, Australia and Canada as destination countries will continue to offer a

somewhat different form of ‘the good life’ that is as distinct from the UK/Western Europe as it is from the US. Potential migrants from supply countries will also respond differently to demand in the USA, Australia, UK etc on the basis not only of general perceptions, but more importantly on whether or not they have *realistic* opportunities to migrate to those countries. The latter would be influenced by, for example, professional regulatory barriers, wider immigration requirements, and associated incentive structures that are attached to particular job slots, as they apply to the supply countries doctors are coming from. We will return to this issue of individual perceptions and professional/organisational disincentives/incentives, and how the UK can attempt deal with them, in more detail later. For now, however, it is important to note that there are certain givens that the UK can do little about in the international marketplace. What it can do, however, is trade on its own strengths, and offer additional incentives that match competitors such as Australia and Canada, and are also more than the main competitor for every other destination country, the USA, appears likely or willing to provide.

Organisation/Professional Level Factors: Training and Post-training Job Opportunities

We have already noted in our Section 4 discussion, that opportunities for post-graduate training represent a major pull factor for the UK in a marketplace dominated to a significant extent by the search for these sorts of opportunities. The key parameters here are not simply the existence of opportunities but the value potential movers place upon them and the degree of difficulty they confront in accessing them. Together the descriptions for the UK and its key competitors (in Section 4 and later in Section 5 respectively) and the individual demander-country reports, give a flavour of the complicated accreditation, examination and ‘quality control’ systems at this level. What this produces is a marketplace that is exceptionally difficult to “read” for the potential migrants wanting to supply their medical labour internationally. As we have ourselves found in preparing this report, the arrangements are not only highly complex, but those involved from the regulatory side often appeared themselves to understand only their own piece of the whole. It follows that knowledge in such a marketplace is (at least initially) captured as much in symbolic and anecdotal clues as hard information about detail. This may (as we showed in relation to the UK in Section 4) be gleaned either from informal networks or from a variety of sources such as websites, advisory material from relevant professional bodies etc most of which do not give a complete picture. Overall, what was clear from our Indian focus groups in particular, was that, at any one time, these symbols and anecdotes give certain demander countries an advantage over others in terms of general reputation. It is in this context that we have highlighted a view that the UK may currently be perceived as “resting on its laurels” (again see Section 4).

It is not surprising, therefore, that except for a few highly renowned and well-known centres, the UK was not felt to offer substantially better or more prestigious basic or higher specialist training than its competitors (e.g. in Australia and the rest of Europe). Moreover, the USA was again perceived as being “way ahead” of all of the rest – i.e. offering more effective learning opportunities in far more centres of excellence than any other demander country in the international marketplace. A particular attraction for EU/overseas interviewees and focus groups was that, if doctors can get into a suitable post, the US Residency system appears to offer coherent, fully planned programmes of training for each specialty. In comparison, the overseas doctors entering the UK for basic specialist training were said to have no guarantee of a post beyond their first 6 months, even if they are part of the ODTs. Such a view was also confirmed by our UK interviewees who, in the context of quality of training opportunities, commented that the US is seen as “*leading the way these days*” (UK Surgeons 1). As another also put it: “*Medical migration, [e.g.] with India and Pakistan, traditionally came to England because we were the Colonial power ... now a lot of them are bypassing England and going to the United States and Canada*” (UK Org 5).

Interestingly, where the UK was more on a par with the USA was in answering the specific question: “Will I actually be able to get a post in my chosen specialty, the specialty in which I may already have gone well beyond the basics?”. Whereas in the USA, the requirement to undertake a Residency programme meant that past training/existing experience “counted for nothing”, it was at least possible that this prior learning would be considered in the UK (this applied for non-EEA doctors as well as EEA doctors whose experience is already equivalent). However, some reports on the UK were also unfavourable in this respect. Anecdotal evidence, for instance from our Indian focus groups and consultant interviewees, suggested that their compatriots in the UK were not getting on as they had hoped for in a variety of specialties (e.g. anaesthetics, paediatrics, general medicine, general surgery, orthopaedics etc). It was said that, “*they have to stay for quite some time to get a job ... [And] even if they get a job, they don’t get it for a long time. They just get it for three months or so.*” (India Focus Group 1). Clearly, quickly being able to move into higher specialist training would be an added attraction for the UK compared with its main competitors in the international marketplace. Instead, however, there was an impression that migrant doctors were often having to “step back” into SHO posts rather than entering the UK labour market at a more appropriate point (i.e. for their own personal development) on the medical career ladder.

Of course, as we have already noted, it is important to remember that the decision by doctors to move between competing destinations depends on the balance of criteria most important to

them as individuals. So, for example, the STA data for the UK outlined in Section 3 revealed that doctors were “shopping around” between obtaining specialist qualifications and further work experience. Specifically, in this context of post-training job-slots, the UK was again, aside from perhaps 10 or 12 premier teaching hospitals, not perceived to be offering particularly attractive opportunities. Interviewees argued, for instance, that Australian doctors seeking wider experience and short periods of sub-specialty training at a stage when they are already well established in their professional life would rather go to the USA (and even Hong Kong or Singapore). For doctors from India or Poland, who may be interested in learning a specific medical technique (e.g. patient controlled analgesia) in order to be more employable on their return home, it was said to be unimportant where that experience was obtained as long as it was available. Once again, however, relevant training was seen as more likely to be available in the USA. This was particularly so where doctors wanted experience with state-of-the-art specialist equipment, which was seen as being less readily available in the UK. The reason was a perceived lack of investment in the NHS that had served to encourage certain beliefs about the general standard of UK hospital facilities compared with those in the US.

Organisation/Professional Level Factors: Perceptions of Job Satisfaction and Working Conditions

Other factors outlined in Section 4 and in the Country Reports as being important for attracting EU/overseas doctors to migrate internationally relate to comparative perceptions of job satisfaction and working conditions between supplier and demander countries. This was particularly relevant to doctors from countries, such as India and Poland, that are relatively less developed and have relatively lower health system investment than, for example, the UK. Here again, however, it was the power of anecdote and impression that tended to over-ride hard information of circumstances to configure views in supplier countries. It follows that the countries competing with each other to attract EU/overseas doctors tended to be ‘tagged’ by general images of working conditions in the USA, Canada, Australia, the UK etc. This view was, in turn, configured by perceptions of the overall balance of state versus private provision in those countries’ health systems.

In this respect, there was, as we already suggested in Section 4, a note of caution about possible negative aspects of medical practice in the UK. For example, as one of our Polish interviewees commented in relation to primary care in Sweden: “... *their social system, I think, is very comfortable for them ... for every patient there is half an hour reserved for their agenda, and doctors see patients only six hours a day ...*” (Poland GP1). This was compared with average GP consultation times of just a few minutes per patient in the UK. The same

interviewee also stated: “ ... *general opinions about the [NHS as a] system are not very good. Let’s say England is quite often given as an example of the system in which there are long waiting lists.*” (Poland GP1). In addition, EU and Spanish interviewees pointed to differences in a doctor’s earnings potential between the UK and other European countries (e.g. Belgium or Finland) where it is easier to set up in private practice and be directly reimbursed on a fee for service basis by the Social Security system. This was a disadvantage of the UK compared with its EU competitors that simply could not be overcome by mutual recognition of training and qualifications. Finally, the UK was also said to be at a disadvantage compared with the USA, Canada, Australia etc because of the greater opportunities in certain hospital specialties to raise income levels through private practice. For example: “[*In Radiology*] ... *there isn’t the opportunity for big earnings in the UK whereas in the US and Australia there are big earnings because there’s a bigger private market*” (UK Specialist 2); and “*I believe in the NHS, the State monopoly, but that has a down side for earning potential in some disciplines*” (UK Org 5).

Organisation/Professional Level Factors: The Cachet of Royal College Qualifications

Given what we have described as the importance of symbols in reading a complex marketplace, one factor that does give the UK added pull in comparison with its competitors is the cachet of the Royal Colleges. For some, it was simply the case that Royal College qualifications offer: “... *let’s say [the] gold standard*” (Poland GP2); or something that, “... *is really worth [it]...you are recognised world wide.*” (India Focus Group 2). As another Indian interviewee commented: “... *at least half the students who go ... [to the UK] don’t go there for training. Training is OK, you can get it, but otherwise [i.e. even if such experience is not ideal], that is they’re settled with qualification ... it’s a welcome feature.*” (India Uni 1). In addition, doctors taking part in our Indian focus groups said that for some specialties (e.g. surgery), their MD/MS degree would allow them exemption from Royal College Part 1 membership or they would be able to take the appropriate examinations in India. This meant doctors already had “a foot in the door” of the UK labour market that they did not have say in Australia or the USA, and that this offered the UK some degree of competitive edge. Of course, where there is specialty-specific informal recruitment (of the type already described in Section 4 – e.g. through the Overseas Doctors Training Scheme), it was also said to help in terms of progression.²⁶

²⁶ For example, links between the UK and Pondicherry Medical School have apparently seen several of its doctors passing Part 1 FRCA and obtaining Type 1 (or Type 11) training in anaesthetics after just a year’s SHO experience.

Even in this context of Royal College-type qualifications, however, other countries were said to be catching the UK - both in terms of the prestige of their qualifications and the pull of Membership granting doctors exemption from certain wider labour market hurdles. We will return to this particular issue in more detail in Section 6. For now, however, an Australian example is sufficient to illustrate how this form of competitive advantage can be applied to alter the positions of players in many of the same geographical sub-markets and shortage specialties as apply to the UK. In Australia doctors with general practice qualifications from other countries are being encouraged to enter hard-to-fill vacancies in remote rural areas. One incentive is that they will be given the opportunity to enter the wider workforce in a shorter period of time than is usual for immigrant doctors. In order to be eligible doctors have to gain membership of the Australian RCGP, by examination within 2 years. However, this is only awarded *Ad Eundem Gradum* (i.e. only recognised whilst practising in the country) and so effectively restricts doctors from moving on in the international medical labour market. Such moves are important because the countries considered by Australia as the most appropriate sources of these supplies are also some of the UK's major supply countries (e.g. Ireland and South Africa, and to a lesser extent New Zealand and Singapore). In addition, it is here that the implications of countries simultaneously sourcing and supplying doctors internationally are visible. Canadian and UK doctors, who have both membership of their College and their qualifying certificate, are automatically granted Fellowship of the RACGP and so have even lower entry barriers to the Australian medical labour market. Clearly, therefore, the UK needs to be aware that the traditional advantage from the cachet of Royal College membership is subject to competitive moves by others. In areas where there are widely experienced specialty shortages it is to be expected that players will continuously seek to alter their positions to gain competitive edge.

Individual-level Factors: Lifestyle and Standard of Living Considerations

Finally, we argued in Section 4 that one of the biggest drivers to motivate physician migration (e.g. from India and Eastern Europe) is the opportunity to improve personal, or family, living standards and lifestyle. As we have also noted in this context, the USA out-competes all others with the advantage of an image of affluence and an offer of the potential to succeed (e.g. in terms of income level, housing, children's education, leisure opportunities etc) that is inescapable compared with any other country worldwide. Such views were emphasised even more in places like Poland that already have a long history of migration to the USA, because of the likelihood that migrants can use existing family links to 'reduce the downside risks' that might otherwise be associated with moving. As one of our Polish interviewees put it: "*You know we prefer the US.*" (Poland Hosp 1). Where Australian interviewees also felt they

could expect generally to win in competition with the UK is in the perceived attractiveness of their lifestyle. Good food and wine, the café society of the Sydney harbour waterfront, images of healthy outdoor living partly fostered by the Olympic Games, and scuba diving on the Great Barrier Reef, were all seen as appealing images for potential migrants. The advertising and marketing strategies of agencies such as the RDN in New South Wales directly to promote these sorts of images is seen as giving a degree of competitive weight in the marketplace. Importantly, however, as we will describe in detail below, Australia also seeks to compete by providing individualised recruitment packages to attract overseas migrants (with and without the additional advantages of Royal College membership described above). Although this is to fill only 'hard to fill' vacancies in 'less attractive' parts of the labour market, the prospect nevertheless exists that doctors can go on to move elsewhere in the longer term.

None of this is to say that moving to the UK was seen as out of the question, or even all that unattractive, by our EU/overseas interviewees. It simply means that the UK must keep alert to the competitive impact possible imbalances of 'brand image' between itself and its rivals for the same supply segments of doctors. There is, therefore, a need to find mechanisms to sense those 'weak signals' that might be an early indicator of substantial shifts in the competitive context. In addition, incentives such as the individualised recruitment and support packages already described (see Section 4) will continue to be necessary to sustain a market edge over countries such as Australia that already provide similar opportunities and those, such as the USA, that do not. Interestingly, there was one dissenting voice with a negative view of the USA, which only serves to remind us of the extent to that migration decisions are a question of personal perceptions, and that some doctors will be swayed by what the UK has to offer: *"The US, because of the Visa problems, and because of the world scenario regarding peace and this war, and terrorism and all, I'm not much interested in going to US."* (India Focus Group 2).

Positioning for Competitive Advantage: Barriers and Practical Disincentives for the UK's Main Competitors

Again as we did for the UK (in Section 4), we will now explore the major barriers and disincentives for doctor migration to competitor countries such as the USA, Canada and Australia. Here too, the emphasis is on how the UK compares with the situation elsewhere (again see individual case study reports if more detail is required), in relation to those factors that offer competitive (dis)advantages to other rivals.

Professional Registration and Other Workforce Entry Requirements – 1) USA and Canada

Importantly, although the US was ranked more highly in terms of preferred destinations, most of those participating in focus group discussions in India, and in our other current and potential supplier case studies, Spain and Poland, felt that there were significant entry barriers to its medical training and employment. In terms of professional regulation, all overseas doctors are required to sit the USMLE examinations, and must undertake Residency (specialist or family medicine) training in order to gain registration for independent practice. For non-EEA doctors this situation represents, as we have already noted, a relatively 'level playing field' with the UK where most doctors have to repeat at least some of their training at SHO level. However, set against these comparable constraints in terms of professional regulation, the fact that US immigration requirements had recently been tightened in light of the events of 9/11, was seen as an advantage for the UK (i.e. because getting a visa in the UK was easier). In addition, for EEA doctors the barriers are clearly higher in the USA because it is not governed by EU mutual recognition of training and qualifications regulations, and that is an undoubted practical, or pragmatic, consideration for doctors in their individual migration choices. As one of our UK interviewees put it, if measured on the basis of professional considerations only: *"The States used to be a great pull. It was the ultimate goal [but] I get the feeling ... that that is less so, because they won't let people in"* (UK Anaes 2).

Of course, for some with their sights firmly fixed on the States, the UK could still be seen as no more than a steppingstone. Obtaining a UK visa, and applying to the US (e.g. to take the US Clinical Skills Assessment in Philadelphia – having perhaps been refused a US visa in their original country) was thought to be a sensible strategy, for example by our Indian Focus Groups. This was simply because, having already been accepted into a 'Western' country, migrants were more likely to be considered bone fide elsewhere. A further counteracting factor in relation to North America was the suggestion that Canada may be lowering its entry barriers. For example, the national government recently lifted the immigration restrictions on physicians as an occupational group (CIHI, 2000). In addition, a recent decision by the British Columbia Human Rights Tribunal (in relation to the licensing of an IMG) is expected to pressure provincial licensing authorities to find appropriate means to screen/accept foreign qualifications. Hence, it seems more likely that Non-Recruited Landed Immigrant doctors will gain licensure (in place of the existing, near automatic refusal based on country of PMQ). What this means is that, for those wanting a "stepping stone", Canada may be the more attractive option in future because its qualifications are already recognised in the USA. Already, it is generally accepted that the USA is the main destination for the 1-2% of the Canadian workforce lost to emigration, and 30% of those are IMGs (CIHI, 2000). Overall,

however, what should not be forgotten is that once doctors are in the UK (or Canada), whatever their original intentions to move on, if their training/work and personal/social experiences are good then they are much more likely to be persuaded to stay. Therefore, even in relation to the group that sees the UK as a “stepping stone” to the US or elsewhere, there is a potential medium or longer-term, not just a short-term, opportunity to gain for the NHS workforce.

Professional Registration and Other Workforce Entry Requirements – 2) Australia

As a key member of the competitor group for the UK, Australia raises relatively high entry barriers for overseas doctors in terms of professional regulation and immigration requirements. As a doctor, it is, for example, virtually impossible to enter Australia permanently on the basis of profession because the immigration ‘points’ system which gives preference to certain shortage skills (e.g. IT) gives minus 20 to medicine. Although it is possible to gain permanent entry on the basis of refugee status or on a family visa (e.g. accompanying a spouse), according to immigration data, in 1998/9, only 408 doctors entered Australia by this route. In addition, except for New Zealanders, those non-Australian doctors who do gain permanent resident/citizenship rights are required to pass the two-part Australian Medical College (AMC) examination in order to be licensed. This stringent scrutiny is employed on the grounds that, once registration is granted to a permanent resident, it is ‘unconditional’. However, many overseas/refugee doctors find it difficult to pass (simply because, without additional training, they are unfamiliar with the Australian health system²⁷). There is also an apparent bottleneck in terms of numbers actually allowed to sit Part 2 clinical examinations having already passed Part 1. Specifically, according to the Australian Doctors Trained Overseas Association (ADTOA), only about 100 can take the examination in a year, compared with around 600 applying. Finally, permanently resident/citizen specialists may be required to sit even more examinations, and/or undertake periods of unpaid and supervised practice in order to prove their professional competence (and only 59 gained specialist registration by this route in 1999). Although physicians in shortage specialties seem to pass over the latter hurdle more easily (i.e. successfully challenging decisions in the courts on the grounds of discrimination, for example, against a rejection of the RACS) the general view

²⁷ Indeed, the ADTOA has brought considerable pressure to bear, through a hunger strike in 1996/97, to highlight the difficulties and to negotiate training and clinical attachment opportunities for members. For example, a ‘one off’ accelerated undergraduate-equivalent training programme for 100 refugees was provided in Sydney to accelerate access to the AMA examinations. Their claim of unfair discrimination in comparison with the employment opportunities for temporary resident doctors (TRDs), who do not need to pass the regulatory hurdles if they have a PMQ from the UK or New Zealand, has led to some supervised appointments in rural underserved areas (through the RDN) being given to those who have passed Part 1 of the AMA examination, before they take the clinical section.

was that for overseas permanent residents the “*emotional and financial barriers*” of regulatory entry into the Australian market are “*overwhelming*”.

Although since 1998 changes (i.e. enabling assessment for registration based on skills and suitability for a post regardless of country of PMQ) the entry barriers for Temporary Resident Doctors (TRDs) are lower, they are still limited to practice ‘conditionally’ in certain localities only. More specifically, as we have already shown, available job slots are limited to Areas of Need (geographically defined) and positions for which no suitable Australian or New Zealand doctor has been found. Even in the case of GPs, where Australia has an acute shortage in certain rural and remote areas, there has been no relaxation of the restrictions surrounding practice. Moreover, the recently added ‘carrot’, of future opportunities for unrestricted licensing and practice, only comes into play after a minimum 5 years’ service (albeit as opposed to the usual 10 years for overseas doctors).

Overall, therefore, in terms of competition for doctors from other major supply countries is concerned, and to an extent despite the attraction of lifestyle etc, Australia was not seen as particularly accessible. This compared with the situation in the UK where all who have either ‘limited’ or ‘full’ registration may apply in open competition for SHO posts, whatever their geographical location. Progression to ‘full’ registration is relatively easy if there has been training progression, as is gaining residency rights after two years in the country. There are also more opportunities for specialist training available to immigrant doctors in the UK, whereas these are more closed in Australia, with national training numbers more nearly matching domestic graduate numbers. However, as we have already noted, for doctors from other ‘Western’ countries like the UK, Ireland, New Zealand, Canada etc Australia has lowered some of its barriers and that remains a potential threat to the UK’s competitive position.

Practical and Cultural Barriers to ‘Becoming Settled’ in Medical Practice

In addition to regulatory barriers to entry, there are also, as we noted in Section 4, a number of practical barriers to moving in the international medical labour market associated with language and culture. Such disincentives intersect directly with the perceptions of job satisfaction and working conditions that, as we outlined earlier, are so relevant to the individual doctors making their migration choices. Whether or not doctors can already speak a language and handle both technical and more everyday discourses with colleagues and patients was, for example, seen as a key influence on the countries considered as potential destinations. Interestingly, in terms of competition, most interviewees felt that although

doctors would be unfamiliar with the UK health system and professional norms, those difficulties would be just as great elsewhere. It was simply a necessity to get used to a new system or way of working wherever a doctor migrated. Similarly, although the “*one great advantage*” the UK has over other European countries is language, this was not the case in the UK’s main competitor group (e.g. in the USA, Australia, New Zealand, Canada or even South Africa) where English is predominant in all cases. Finally, there are important disincentives associated with doctors support needs outside work (e.g. in relation to accommodation, children’s education, getting to know the local community etc) that are also similar whatever a doctor’s destination internationally.

Once again, therefore, we see the importance of relevant induction, training and inside and outside work support to ease a migrant doctor’s entry into a new medical labour market. Indeed, it may be that, where language, professional and other cultural considerations are more or less equal (as they are between the UK and its major competitors), such support is the key to EU/overseas doctors’ migration choices – i.e. this could be what gains a country its ‘competitive advantage’. As one of our EU stakeholders clearly argued:

“I think the most important thing one can do to import doctors, is to make this kind of infrastructure support available – a life as a kind of package. I mean really offer them, that a wife and children can come too, a place to live and language course and everything ... then it will be possible to start.” (original emphasis) (EU CPE).

These links between doctors’ support needs, both within and outside work, have been a recurring theme throughout the report. We will discuss them again now in the context of what the UK’s main competitors are doing that serve to give them an advantage in relation to the demand-supply matching process.

Positioning for Competitive Advantage: The Activities of the UK’s Main Competitors

This section covers how the UK’s main competitors are positioning themselves to compete – in terms of marketing and information provision, the recruitment techniques they are using, and how they are facilitating the entry of individual doctors into available education/training/post-training job slots etc. Are they doing the same or different compared with the UK; and, once again, what, if anything, can be learned from them to help the UK in sustaining and gaining its own market share?

Learning about Opportunity: Information and Marketing to Potential Migrants

As far as the provision of relevant information to doctors at the all-important comparison/decision-making stage of migration is concerned, there appeared to be a similarly wide variety of organisations (from government departments, to professional representative and regulatory bodies, universities, health service employers, commercial recruitment agencies etc) involved by competitor countries as there was in the UK. Just as the UK also employs different approaches including websites, written literature, general advice giving etc so too do its competitors.²⁸ In addition, information is often available from key contact points in supply countries where the UK is also competing. As just one example, we were made aware during fieldwork that literature (in Spanish) about routes to working in the USA, Sweden, and France was available, together with information from the UK, at the Headquarters of the Unemployed Doctors Group in Madrid.

In a sense it is entirely appropriate that individual doctors should be able to weigh their migration decisions on the basis of as wide a range of information as possible. However, there are certain aspects of competitor country approaches that, in contrast to the reported situation in the UK (see Section 4), at least have the potential to ease doctors' paths to what is most important – i.e. the “big picture” of demand side education/training/job slots, and how to go about applying for them. For example, in Australia organisations such as the RDN and WACCRAM provide a means by which GP shortages in remote rural areas are advertised collectively rather than it being left entirely to individual practices. In addition, in the USA where there are around 24,000 Residency slots a year, numbers are so great that there has to be some system for streamlining application processes and facilitating doctors in locating available openings. This is done through the annual computerised National Residents Matching Program, or the ‘Match’. In this way overseas doctors (both the newly qualified ECFMGs and IMGs from other years still trying to get a preferred match) are able to apply to the approximately 5,000 Residency slots per year that are not filled by USMGs. Another approach this time utilised by Sweden has been to recruit (e.g. from Spain) in conjunction with EURES, the European-wide employment information service. Such an approach is not necessarily easing individual doctors paths to information appropriate to them individually, but it does improve overall coordination. In other words, from a demander country point-of-

²⁸ For example: the USA (e.g. National Medical Association; Education Commission for Foreign Medical Graduates (ECFMG); National Residency Matching Programme (NRMP); Federation of State Medical Boards of the US; Association of American Medical Colleges); Australia (e.g. Australian Medical Association; Australian Medical Council; Specialist/Royal Medical Colleges; National Office of Overseas Skills Recognition; Language Australia and IELTS Australia; RDN; WACCRAM; ADTOA etc), and Canada (e.g. Canadian Medical Association; Medical Council of Canada; Association of Canadian Medical Colleges; Canadian Information Centre for International Credentials) amongst many others.

view it rationalises information provision and reduces the transaction costs to the candidate of working simultaneously across several possible countries.

The overall point here is that in order to be attractive the UK also needs to do things that “get it noticed” and make things as straightforward as possible for individual doctors to find their way into the system. Expanding on recent DH initiatives described in the Introduction to this report and in Section 4 (e.g. the Spanish Recruitment pilot in North West Region and the International Fellowship Scheme) would be one way to do that and get ahead of competitors in this context of *effective* information provision.

From Information to Recruitment: Easing Entry Barriers and Providing the ‘Personal Touch’

Although, according to both US and other EU/overseas interviewees, the USA holds such a hegemonic position internationally that it can rely simply on market dominance to attract enough applicants to fill vacant posts, this was not the case elsewhere in the UK’s main competitor group. For those other countries that we have identified as having to be more active in sourcing recruits internationally there is an increasing focus on direct recruitment and tailored support/mentoring strategies for overseas doctors. So, for instance, Sweden is using commercial agencies, and visits by potential health service employers and government representatives to boost recruitment in both Poland and Spain (see below for a detailed description of these activities). As another example, Australia recruits around 3,000 doctors per year (mainly with a UK PMQ or Membership qualifications) to work as TRDs in hard to fill, mainly hospital vacancies. Typically, after submitting their CV in response to an advertisement, doctors will be called to an informal interview/information-giving meeting at one of several UK hotel locations, during a bi-annual recruitment programme. Importantly, what such arrangements do is to provide a “personal touch” and reduce the perceived entry barriers associated with doctors having to “negotiate” immigration and professional regulation requirements on their own behalf. According to our Australian interviewees from the demand side and our Polish and Spanish interviewees from the supply side, such recruitment methods are increasingly attractive to a growing number of applicants. Clearly, ‘getting the simple things right’ is what, at the margin, can serve to alter market flows away from competitors and towards these countries. In order to compete effectively, therefore, it is important that the UK also identifies active interventions to help counteract real and perceived barriers to recruitment. Here again, it would appear that recent DH recruitment campaigns offer a solid base upon which to move forward.

Finding the Right Training/Post-training Job Slot: Clearly Articulating the Shape of Demand

What direct overseas recruitment (typified by the Australian example just outlined) also enables is the clear signalling of the shape of their demand by employers. Individual hospitals can either act on their own behalf, or a single representative may recruit for a consortium of hospitals from a given locality. Of course, there are a number of examples of UK NHS Trusts and commercial recruitment agencies operating in this way. What Australia has, however, which the UK does not appear to have to such an organised degree, is an ability to signal the kind of demand it wishes to fill on a wider geographical scale. Specifically, Australia has highly organised systems for recruiting to more permanent hard-to-fill vacancies that, although not federally organised, are State based. They include WACCRAM in Western Australia, the Rural Doctors' Network (RDN) in New South Wales, and the Rural Workforce Agency in Victoria. Indeed, to some extent, States, which bear the responsibility for the delivery of health care, compete against each other for recruits, and each has different criteria and processes for registration, making access easier in some locations than others. In addition, the USA has well developed federal as well as state-level schemes (consisting mainly of scholarships to medical school or post-graduate educational loan repayment in return for service in designated areas) for identifying medical shortage areas and recruiting doctors into them. These schemes are not aimed directly at overseas doctors, but do provide further illustration of centralised brokerages that match applicants to sites. It may be that the UK will continue to build on the lessons of the North West pilot of Spanish doctors in relation to collating information on hospital and GP vacancies across an entire region. Significantly, the evidence from competitor countries such as Australia is that there are some key benefits for the system as a whole where employers work together in this more co-ordinated way. Not only is the general process of doctor-job matching more efficient (because there is a single database of a wider number of vacancies to work from), but employers have greater strength to address the international marketplace than if they were acting individually.

Providing the Best Possible Job Slot Match, Tailored Training and Support Packages

As we noted in our UK section, not only are initial application and screening processes important to successful recruitment/retention, it is also vital to spend time getting the right match between individuals and training/job slots. However, this is more involved than simply matching the doctor's medical skills with the needs of a given vacancy (as we described for the National Residents Matching Program in the USA) – though that is undoubtedly an important part of the equation. Instead, (and this particularly applies to older, fully qualified doctors entering practice, rather than training, positions) emphasis also needs to be placed on

the personal/social needs of doctors in the context both of their own families and the communities where they will be living. In the case of Sweden, for instance, general practitioners from Poland are given various opportunities for first hand experience of what to expect if they migrate (see Box 5.1) – both before signing onto a recruitment programme in the first place and at the point of actually moving to their new post. In Australia, matching also involves local communities in the whole process of choosing and supporting a new recruit in a hard-to-fill (i.e. remote and rural) vacancy (see Box 5.2). Enabling the new doctor, and especially his/her spouse and family, to feel part of the community is seen as a responsibility in which all the residents must share if they are to keep a doctor long-term.

BOX 5.1
SWEDEN-POLAND GP RECRUITMENT SCHEME

Sweden’s marketing strategy in relation to recruitment of GPs appears to be based not only on making information available generally in source countries such as Poland, but also on the added attraction of person-job slot matching, tailored induction training and support packages. According to stakeholders interviewed in Poland:

- Potential recruits are first taken on an initial visit to the sorts of locations in Sweden where incoming doctors are likely to be placed. This is to help them to decide if they want to sign up for the scheme in the first place, and is also aimed at improving eventual retention because doctors will have more of an idea what they are “letting themselves in for” when they reach Sweden.
- There then follows a period of induction lasting up to 12 months before the projected date of migration. Swedish language courses are provided in Warsaw, as well as introductory sessions on the workings of the health system and what else the doctors can expect from life in Sweden.
- After completion of this programme, doctors are ‘matched’ to the available positions, with family circumstances being taken into account when considering location.
- Doctors and their families are again taken to Sweden to visit the local communities with GP vacancies in order to help them choose which is the most suitable – both in terms of their medical practice needs, and outside-work circumstances (e.g. housing, education, leisure, social networks etc.).

In this context, Sweden appears to be capitalising upon the GP vocational training in Poland (which was set up in 1993 and modelled on the equivalent UK scheme), to recruit ready trained physicians for this area of workforce need. The whole recruitment process is a government-based initiative, with the protocols of Government-to-Government agreements in place in both Spain and Poland. It appears to be operating with some success (e.g. with reportedly 150 Polish doctors per year moving to Sweden), despite the fact that these two source countries are not ones with a history of cultural ties with Sweden.

BOX 5.2
AUSTRALIA - RECRUITMENT TO REMOTE AND RURAL AREAS

In Australia, organisations such as the Rural Doctors' Network (RDN) in New South Wales advertise tailored recruitment packages to attract doctors to hard-to-fill vacancies in remote and rural areas. Such packages typically include above average pay, retention grants and a house and car. They may also involve salaried employment for those doctors that do not want the relative insecurity of a fee for service payment system, and financial commitment to practice expenses (although, if doctors stay for longer periods, they may be encouraged to move towards the usual Australian payment system). In addition recruitment packages afford opportunities for CME, and socialising/leisure/recreation/learning for a spouse and children as well as the individual doctor. Locum cover is, therefore, also provided to allow doctors time off to undertake these other career-related and personal activities.

Particular emphasis is also given to the type of location where doctors would be most appropriately placed. For example: *"A lot of the towns are quite small, so there may be only one or two doctors in a town, so they have to be very self-sufficient, very strong on accident and emergency and so on."* (Aus RDN). These positions are considered more suitable for highly skilled doctors able to work in unsupervised general practice. Where towns are very isolated, they may also need doctors with anaesthetic or obstetric and surgical skills to undertake procedures, *"so for those towns we often need to look overseas at countries with similar training and standards and similar sort of approach to general and family medicine [e.g. the UK]."* And, *"the scope and nature of rural medicine is a big selling point."* Other larger provincial towns, with vacancies in group practices of 3/4/5 doctors, were seen as more able to provide support and mentoring to an immigrant/refugee doctor, from a non-English speaking background.

However, although the RDA does assess doctors as potentially suitable, they themselves are left to sift job possibilities, from detailed profiles prepared by practices, of the work and resources and supporting services available. When a match seems likely, the RDN will then pay for a site visit, and required Medical Board interview. Previously, the RDN operated in a more directly intermediary role to match individuals to practices, but found that the detailed understanding of what each party required and expected was best left to them to negotiate: *"... they talk to the doctor and get a feel for ...what their needs are. And that works reasonably well."* (Aus RDN)

In addition, Australian and Swedish examples confirm the lessons of recent DH initiatives that appropriate induction (i.e. generally in a new health system and/or language), follow-up training (e.g. in a particular medical specialty of interest), and additional incentives are all key elements of successful recruitment (see Boxes 5.1 and 5.2). Such *tailored packages* would typically combine greater financial rewards than might otherwise be available, and support structures that facilitate both job-related learning and lifestyle opportunities such as those already described. In this context, an important aspect, for example of recruitment to remote areas in Australia, is the provision of locum cover so that a doctor does not have continuously to be on duty. What these schemes also illustrate, however, is that the UK's competitors are attempting to move with, and try to stay ahead of the market. As just one example, the provision of salaried employment (rather than the relative insecurity of fee for service and the financial risk of commitment to practice expenses) was seen as a competitive response by the RDN and WACCRAM specifically to attract UK and Canadian doctors to hard-to-fill rural vacancies. As one of our Australian interviewees put it: *"... the world is changing, people*

are more mobile, and we're trying to reflect that in the way we develop programmes ..." (Aus RDN).

Overall, what both the Australian and Swedish examples illustrate is that, despite the amount of energy and effort involved setting them up, tailored matching, training and support packages along the lines of the UK's North West Spanish pilot can be highly successful in terms of numbers both initially recruited and retained in the workforce longer-term. By having such an emphasis on matching individual doctors and their families with the most all-round appropriate job slot openings, such schemes also help to guarantee the "quality", or suitability, of doctors' practice whilst they are in post. In addition, the positive, word of mouth marketing that such schemes generate – i.e. because they show that demander countries value doctors themselves as important players - can only help to ensure future supplies.

Offering a Ladder of Incentives: Potential to Move into the Wider Medical Workforce as an Added Attraction

Interestingly, an additional attraction for an overseas doctor being recruited to Australia's remote and rural areas (as we have already noted) is the potential for candidates to be able subsequently to move into the wider medical workforce. That possibility, which was only introduced by federal policy in 2001, would not otherwise be on offer given the relatively high entry barriers to the Australian labour market generally. Of course, the hope is that recruits will stay long-term in their original posts, but this has been abandoned as the main marketing/recruitment approach. Instead, doctors are offered incentives to stay for a minimum of 5 years, rather than the normal 10, before there is an option to re-locate to an area of choice, with full and unrestricted access to a Medicare provider Number. The latter then enables them to set up in independent practice, with access to State funded payments. The overall thinking behind this policy is that there are doctors for whom the rural life would be an attraction – but not forever. As described above, the main intention of this scheme was to recruit doctors from countries such as the UK, Canada and New Zealand. However, it has recently been widened to include refugees from other overseas supply countries. Once again, there may be something the UK can take from this experience in terms of the attraction of long-term post-training job, rather than simply training, opportunities to doctors wishing to move internationally.

Summary

On the basis of this research, there did not appear to be any major pressures in the operation of the international medical labour market that are likely to make enough difference significantly to alter either migration drivers or outflows of surplus doctors from current and potential supply country case studies. It also seems unlikely that the balance of pull factors between the UK and its major competitors in the international medical labour market will change substantially enough to work to the detriment of the UK in the near future. Indeed, the UK currently appears to be in a position to improve its stance with respect to its strongest competitor the USA – not particularly because of its own strengths, but because the latter has raised its barriers in the form of visa restrictions. Participants in the research saw these changes as impacting directly on, for example, doctors from South Asia, including India, the UK's biggest single supplier. Significantly, Australia and Canada were not considered as attractive as the UK in our major supply country case study, India. Mainly, this was because they lack the historical links in terms of migration generally, and specifically between medical universities that facilitate entry into the UK labour market. In addition, strong immigration and regulatory barriers exist for these two countries unless doctors are highly qualified and prepared to serve in an area of need. By comparison, the UK has no formal restrictions on practice location. Nevertheless, the situation is not a cause for complacency. There are a number of areas in which the UK could do more, and indeed learn from its competitors (as we have highlighted throughout this section). It is to this topic of what the UK could adjust in order to improve its position still further that we now turn in detail in Section 6.

6 SUSTAINING AND GAINING COMPETITIVE EDGE IN THE UK

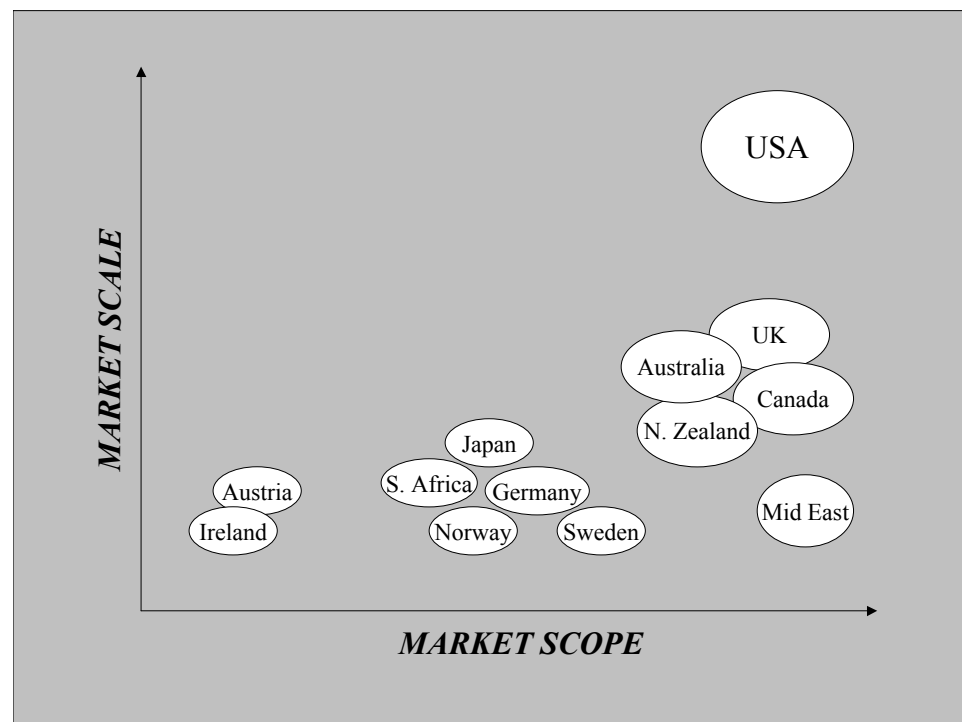
The Context: Mapping the International Medical Labour Market

So far this report has concentrated on a “broad mapping” of the international medical labour market as it currently relates to the UK and its major competitors. This has involved looking at: the changing shape of UK medical labour demand and international supply; the push and pull factors underlying EU/overseas doctor migration to the UK and other countries; the main institutional barriers and disincentives to that migration; and the ways in which different countries are attempting to encourage further migration through improvements in the demand-supply matching process. What emerged from that exercise was not particularly surprising. The major push and pull factors are the obvious country-level ones of comparative economic, political and social circumstances, the organisational/professional ones of education/training and post-training job slot availability and career progression opportunities, and the individual ones of doctors wanting to better themselves in the context of both of the above. The major barriers and disincentives are also relatively predictable being, for example, the barriers associated with immigration and professional regulation requirements, and the language and cultural difficulties of ‘getting to know’ a new system etc. Finally, there is a relatively limited menu of measures that demander countries can put in place to help doctors find an education/training/post training job slot to match their needs. This includes, for example: the provision of quality information on opportunities available; centralised screening of applications against vacancies, tailored induction and other training, and individualised support packages both in and outside work.

We have also attempted, only in the broadest conceptual terms, a general competitive mapping of the global marketplace. As Figure 6.1 shows, at the most general level of scale (i.e. numbers of doctors sourced internationally) and scope (i.e. the range of specialties sought) five broad segments can be identified as relevant to the UK. It is clear that the USA occupies a globally unassailable position on its own. What is of more interest from a specifically UK perspective, however, is the cluster of countries sourcing overseas doctors at the middle scale and operating over wide scope. It is here in the countries of the English-speaking Commonwealth (e.g. Australia, Canada and, to some extent, New Zealand) that, not unnaturally, the UK appears to find its most significant competitor group. Elsewhere (again looked at from a UK window), it is possible to identify clusters of players operating in more specialised niches at smaller scales, and some specific country-to-country players, against which the UK has a market dominance advantage at the present time. The former group

might, for example, include Sweden and Norway recruiting on a regional scale within Europe, or others such as Ireland receiving doctors from the UK, and Austria receiving from the Czech Republic. Finally, although actors such as the Middle East oil states tend to operate at significant scope in terms of range of specialisms, it tends to be on a smaller scale in a strategic market opportunity context.

Figure 6.1:
General 'Competitive Map' of the International Medical Labour Market



Interestingly, those countries that are within the key cluster of interest to the UK do not look that different from each other from the perspective of current and potential major suppliers in the international marketplace (Eastern Europe and South Asia, especially India). They appear as “Western” nations, relatively affluent economically, stable politically and with health systems that are well funded compared with those in the developing countries where migrating doctors are coming from. They are mostly English speaking, all put up barriers in terms of immigration and all have relatively strong professional cultures ready to protect the interests of the domestic labour supply through, for instance, regulation and quality control. Where the UK is out-competed on particular competitive parameters (e.g. by the USA on the economic possibilities offered to its citizens, or by Australia on the image of ‘the good life in the sun’) it tends to be absolute in the sense that no UK direct response is possible. As with most markets, however, it is positions of relative competitive advantage that offer scope for

movement by a country like the UK. It is important that the UK works with those factors that it is possible to have control over and change in order to maximise time and resource investment on those relatively simple activities that are likely to bring greatest return. The task is to adjust the perceptual balance of attractive and unattractive features of the UK because, as we have said before, the international medical labour market may be a highly complex overall system, but, in the end, it rests on the migration choices of *individuals*. For those that are most attractive to demander countries these individuals have a degree of ‘supplier power’ in the market. Their choices can at the margin be influenced by strong marketing, and measures to ease demand-supply matching facilitating entry into one country’s medical labour market above another. Of course, as we have already seen, it is equally possible for other countries wishing to attract international medical labour to put in place more effective matching mechanisms as a means of encouragement to doctors to go there. It is, therefore, important that the UK continues to “raise its game” and compete to the best of its ability on the basis of matching per se, as well as the other factors that may make it attractive to potential migrants.

This penultimate section pulls together the findings both from recent UK experience and international trends outlined in previous sections in order to explore what key things the UK can do to maintain its competitive edge and/or reposition itself to achieve further gains within the international medical labour market. What, for example, can it realistically change in terms of push and pull factors, and barriers/disincentives to migration, and how can it best interact with individual decision-making to make itself more attractive? What, if anything, will give the UK competitive advantage over other major demanders of medical labour in the international marketplace? As a way into answering these questions we again employ Porter’s (1990) insights into the competitive advantage of nations, which recognise that, in all industries (including health) such advantage rests on conscious analysis of “where we are”, “where we want to be”, and “how do we get there”? In other words, it recognises that to be better placed the UK (and the NHS) needs to be an active player, always able to move with an ever-changing international marketplace for EU/overseas doctors.

The Importance of Market Positioning

First and foremost, it is important that the UK position itself as effectively as possible in the international marketplace in order to maximise the potential gains from its marketing and recruitment efforts. This involves first of all acting from a clear understanding of the ‘products’ - that is general or specialist/career stage categories among potential migrants needed to fill demand slots in the UK - that it wants to address. Second, it needs to accentuate

its competitive edge mainly for those target groups of individuals. This, in turn, means clearly articulating the key gaps that, looking at the NHS workforce from the demand side, need to be filled by EU/overseas doctors now and in the foreseeable future. Such gaps may, for example, be for doctors at different career stages (e.g. in undergraduate medical education, post-graduate training, or fully qualified positions post-training). Or they may be for doctors capable of occupying labour market slots, for example particular hospital specialties and/or general practice, and particular urban/rural areas. From this knowledge, it then becomes possible to focus efforts on the groups (say young, GP trainees willing to stay in the UK once they have qualified, or already qualified doctors in the current shortage hospital specialties such as radiology) that the UK needs most to attract. It also becomes possible to gauge the size of market share that the UK needs to win in any given supply category of the international marketplace and to work directly towards that. As a simple example, does the UK need to capture the bulk of the internationally available labour pool of family doctors/general practitioners, in which case it may need to make big adjustments in order to attract them. Alternatively, does it want to occupy a niche part of that same market, for example, offering opportunities mainly to those willing/wanting to work as salaried doctors in deprived urban areas?

In addition, a clear understanding of market positioning would mean deciding which countries it is most necessary for the UK to compete against. A similar question, given the mutually reinforcing gains from becoming known generally to a given labour pool (and the governments/professional bodies that might themselves facilitate physician migration), is whether it worthwhile focusing the UK's efforts on *particular* geographical sub-markets? On the basis of our fieldwork particularly productive sub-markets for the UK appear to be within the EU and Eastern Europe, or within South Asia and India in particular. The advantages of the former (the EU/Eastern Europe) are its obvious geographical proximity (important, for instance, for doctors to stay properly in touch with family and friends), and the existence of regulations (either now or in the relatively near future) governing mutual recognition of training and qualifications. Specifically for encouraging entry into the general practice segment of the UK labour market, there is also a compatibility with several European health systems (e.g. Netherlands, Germany, Scandinavia, Spain, Poland etc) that are organised around a GP gatekeeper model. The advantages of the latter geographical sub-market (South Asia) are its familiarity with UK language and culture, relative to some other parts of the “developing” world, and the existing experience of medical migration (both in hospital and general practice) that stems from the historical links of Commonwealth. There is also, according to our stakeholder interviewees, a willingness in India to see a proportion of the large number of doctors it educates and trains each year move abroad. This compares sharply

with other developing nations (e.g. South Africa and Ghana) that have expressed concern about the impact of migration on their own health systems.

Finally, it is important to decide whether the UK is trying both to attract *and* retain overseas doctors, or not, and to make that clear in terms of the way it addresses the marketplace. As one of our UK interviewees argued, for example:

“The key question is, ‘Are you training these people to practise in the UK, or are you training them to go back to wherever?’ ... If you’re saying we’re going to train them to send them back, probably the training they get here won’t be appropriate ... Those are the sorts of questions that should be asked. ‘What are we doing this for? What are our objectives?’”
(UK GP 5)

What this clarity over “what/how much we need”, “where from” and “for how long” would enable the UK to do is to target its marketing and recruitment on the groups that it *most* wants to attract. This, in turn, would make such exercises more efficient and effective from both sides: a) because less time and energy would be spent at the application stage by, and on, doctors for whom the majority of opportunities the UK has on offer are inappropriate; and b) because the doctors that do then come to the UK would be the ones for whom training/work experience could be more easily tailored to suit their personal development needs. They will also, therefore, be more likely to have a positive experience and want to stay in the UK and/or send good feedback to other potential migrants in the country they came from. Those doctors who are less likely to be successful in finding posts once they are here, or whose training/work experience would be better served by going elsewhere, would have much clearer grounds on which to base their migration choices, and could, quite rightly, chose to go elsewhere. By contrast, current market signals coming from the UK appear *contradictory*, and there can be a gap between the “messages of opportunity” that doctors receive and subsequent reality. This was illustrated by, for instance, the views of Indian medical colleges that candidates there feel encouraged to take PLAB, knowing in general that the UK has workforce shortages, but without being fully aware of the actual limits on labour market entry (i.e. in terms of the availability of SHO positions in given specialties) once they pass. They argued for greater preciseness about the real opportunities the UK has on offer, so that doctors can weigh the evidence and then actively decide if the potential costs, or risks, of migration are worth it. As one of our UK interviewees also put it:

“We’ve got to be absolutely clear that there will be x number of posts around the country, fully funded, available, full educational approval, of an absolutely equivalent standard, ready

and waiting for overseas doctors who we are actively looking to recruit to come and join ... So we don't have the problem of 'post-PLAB no jobs' ... and we could then slot [doctors] into opportunities available." (UK Org 3)

The Need to Recognise Doctors as Buyers in the Marketplace

As we have just suggested, the second fundamental basis for gaining competitive edge is to recognise, and to put at the centre of marketing and recruitment strategy, the fact that those *quality* doctors the UK most wants to recruit are relatively powerful buyers of opportunity in the marketplace. As highly skilled professionals they have considerable power to make their choices and go wherever in the international medical labour market – be it the UK or elsewhere – that their interests are best served. In other words, the market works essentially through an exchange relationship where doctors provide their quality labour in return for some form of perceived utility. We have seen that the main motivators for physician migration are to better their own or their family's economic/social position, and to build human capital to improve their career opportunities in their preferred medical field. Migrating doctors will, therefore, observe and compare the opportunities and make choices based on which country or health system will enable them to gain most in both these respects. As we noted earlier, doctors may also move on between different career stages (e.g. between gaining specialty qualifications and subsequent employment), with no one country necessarily seen as a final destination. There are a number of examples, already described, where competitor countries are attempting to gain competitive edge in the international marketplace by recognising that doctors are relatively powerful and sophisticated buyers. Hence, it is even more the case that the UK must focus its thinking on what will capture the attention and then make things as straightforward as possible for the quality of individuals it is trying to attract. By contrast, as one of our UK interviewees argued in relation to EU/overseas doctors: *"the UK has tended to operate a sort of just in time model ... i.e. we will fund a relatively small number of posts and if there's an excess number of supply well tough"*. What was needed now apparently was *"a change in thinking ... and a change in flexibility"* where *"we recognise that actually we're the ones who are in need at the moment, and we've got to make life easier for the doctors who're going out of their way to come to the UK"* (UK Org 3). In what follows, we demonstrate the sorts of adjustments that might be implemented if it was *"the other way round"* and this *"client centred"* (UK Org 3) focus on how it looks to the individual doctor. This was a clear underlying theme throughout our discussions around the UK recruitment process. What follows is, therefore, structured around the various stages of that process – i.e. from the need to influence initial decision-making on potential destinations

in the UK's favour, to facilitating doctors in actually moving to, and getting the most out of their period in, the NHS workforce.

Playing to the UK's Strengths through Positive Marketing

The Importance of Overall Image

To begin with, it is vital that the UK gets a highly persuasive message of “why you should come here rather than elsewhere” across to its target audience of supply countries and their individual doctors. Part of that simply involves, as we have outlined above:

- a) Articulating a clear picture of the opportunities open to EU/overseas doctors from the UK demand side;
- b) Connecting this view into a specification of required skill bundles and career stage attributes; and
- c) Making both known widely in the geographical sub-markets where a good number of potentially suitable migrants are likely to be situated.

That alone would mean that the doctors who are likely to be attracted by the particular education/post-graduate training/post-training job slots available in the UK would have more useful information available on which to base their initial comparison of migration options. In addition, in terms of the overall image perceived by doctors at the observation/comparison stage of migration, there are some obvious work and lifestyle factors, or stereotypes, needing to be dealt with through more effective marketing. This is important because, no matter what the reality, negative images do weaken the ‘brand image’ of the education/training/job provider, and country of opportunity that is being advertised or sold by the UK to the international medical labour market. Examples would be media reflections of an NHS in which long waiting lists, ‘bed blocking’, low staff morale, and even the scandals over Shipman, Bristol and Alder Hey come across as almost the norm. The counterbalance is to emphasise more of the undoubted positives. That includes, for instance: greater levels of government spending on public services generally (of which EU/overseas doctor recruitment is itself an illustration); recent improvements in job flexibility and incomes for NHS employees; and the investments in NHS infrastructures, and the new equipment/technologies on which migrant doctors often want to gain experience through PFI. There is also the view, that could be promoted, of scandals as essentially one off incidents that, rather than being indicative of hidden problems, are actually leading to further improvements in quality in the health service and the medical profession in the UK.

More prosaically, the image of the UK with, for example, its poor weather and food (mentioned, if only in passing, by many of our interviewees!), and fewer economic/social opportunities compared with say the USA, can also be matched with more positive, if equally stereotypical, marketing emphasising the fact that *“there’s a damn good reason to come ... and when you’re here the UK’s actually quite a nice place to live”* (UK Org 3). This could be focused, for instance, on the UK’s many regenerated urban centres, attractive outer-urban or semi-rural housing developments, and its beautiful countryside (e.g. in the Lake District and North Wales) within easy reach of the areas with NHS workforce shortages likely to have most openings for EU/overseas doctors. It will also be important, in this context of general lifestyle advantages to market the individual economic and social support packages that can be made available as an additional attraction to doctors thinking of entering the UK’s shortage specialties and geographical areas in particular. This is something we return to in more detail later, but raise it here as one part of the equation of playing to the UK’s strengths when attempting to be attractive to EU/overseas doctors at the all important information gathering or observation/comparison stage of their migration decision-making. Again, it is particularly relevant because countries such as Australia, which, as we have said, already have an advantage in terms of the lifestyle image they project, advertise their own tailored packages of community familiarisation and work/outside work support (described in the last Section) to the international marketplace. The same is also true of more geographically proximate destinations such as the Scandinavian countries. They make enormous efforts to attract migrant doctors on the basis of the care they take over the economic and social aspects of tailored recruitment packages and the matching of individuals with appropriate medical job slots. Between them, these countries are competing with the UK in two of its major current and potential sub-markets for migrant doctor supplies – i.e. South Asia and the EU/Eastern Europe. It is, therefore, vital (if only to keep a level playing field) that those markets are as aware of benefits the UK potentially can offer as they are of what is available elsewhere.

Opportunities to Build on Existing Reputation: 1) The Need to Re-emphasise the Quality of UK Training and Specialist Qualifications

Having said all that, however, it was the view of many of our interviewees that, beyond the initial economic/lifestyle comparisons, the biggest reason that medical professionals are willing to migrate internationally is directly to boost their personal careers/human capital. Other potential negatives of the more general kind just described may, therefore, be balanced out in the individual choice equation if, by coming to the UK, doctors are more likely to achieve that direct career advantage than if they went elsewhere. In this context there were

said to be a number of strengths that the UK can play to in terms of its marketing. UK training and specialist qualifications were described as having been, in the past, the Gold Standard worldwide. FRCS, MRCP and MRCGP qualifications, for example, were valuable passports to top jobs, either in the UK, or elsewhere overseas. More recently, however, the UK appears to have begun to ‘rest on its laurels’ and that, in effect, means that it may be surrendering a key aspect of its market advantage that at least did bring doctors into the NHS for the short-medium term. This is because other key destinations in the international medical labour market (e.g. Australia) increasingly give precedence to their own specialist qualifications, and have removed reciprocal recognition of UK equivalents. That, in turn, means that if doctors want to go to those countries as their final destination, they may feel they need to go from the outset rather than migrating via the UK, or taking UK Royal College examinations administered in their own countries.

We have already noted the presence of broad geographical sub-markets in the international medical labour market, and one aspect of this is a specific marketplace for such high standard qualifications. So, for example, Australia appears to be becoming a major focus for the Pacific Rim having nurtured programmes of training and assessment geared to its own qualifications in countries such as Hong Kong, Singapore, and Papua New Guinea. In addition, a number of potential supply countries, such as Pakistan, Hong Kong and Singapore, are apparently putting their own examination systems in place thereby cutting out the need for their doctors to focus on gaining recognition from UK Royal Colleges. For those who are shopping around for relevant experience and qualifications with which to go back to their country of origin or move onto a third country, Australia, Canada, and the USA all offer comparably prestigious opportunities to the UK. Finally, in terms not only of accessing qualifications, but also providing general career and training opportunities, the message was, as one UK interviewee put it, “*definitely out there*” that “*the UK is not as good as it once was*” (UK Org 3). This was principally because of the lack of availability within the NHS of accredited SHO and SpR places as opposed to posts that provide experience but do not count towards accreditation.

Opportunities to Build on Existing Reputation: 2) Promoting the Royal College ‘Brand Image’

The point here is not to say that the UK no longer has a major strength on which actively to market itself and continue to build its reputation as a “gold standard” provider of post-graduate medical training and qualifications. It is more that, because there is now a wider range of players offering similar opportunities in the international medical labour market, the

UK may have to work harder than it used to in order to retain the same market edge. Importantly, the very existence of the “Royal College brand” is a clear strength to be traded on (at all levels from the national or DH, through the Royal Colleges themselves, to local NHS employers) for two main reasons. First, it is a major contributor simply to maintaining a general awareness of opportunities available in the UK in current and potential supply countries. Second, through the association with prestigious qualifications, it is both a positive attraction, and potential facilitative factor for UK labour market entry, to EU/overseas doctors eventually coming to work in the NHS. Many of the Royal Colleges have International Committees, for example, that create an overseas presence by funding doctors from developing countries to attend conferences in the UK, or contributing to the development of overseas teaching and assessment programmes. Some, such as the RCGP, have established an *international* version of Membership that trades on the reputation of the training and assessment regime in the UK, but is not currently recognised as admitting successful candidates to UK practice. Others have mechanisms – e.g. through the presence of their own external examiners at exam sessions overseas – that can effectively reduce the hurdles that migrant doctors must go through to get to the UK. Specifically, such arrangements, as operated by the RC Anaesthetists in Pakistan for instance, provide exemption from UK Primary examinations, and so give a route into higher specialist training in the NHS. As another example, the Part 1 Membership exams of the RC Surgeons taken in Chennai, India are also recognised by the UK authorities as relevant for UK practice. At the simplest level, there is potential through all of these activities to present more accurate information on the shape of the UK demand for particular skill bundles or career stage attributes, and to market a positive view of the UK in general to would-be migrants. In addition, the Royal Colleges will continue to provide a practical channel through which the UK can coordinate mutually reinforcing lines of out- and return migration with supply countries.

Opportunities to Build on Existing Reputation: 3) Promoting Institutional Strengths and Links

Another positive feature to be traded on is the enduring reputation of a number of the UK’s universities and hospitals, and their links (often between individual consultants) with equivalent education and provider institutions elsewhere. As is the case with the Royal Colleges, this can help the UK to maintain awareness generally of the opportunities it has on offer, and can also act as an attraction in its own right, and a facilitative mechanism for migration, to doctors at all stages of the career ladder (i.e. from those who may come to the UK undergraduate medical education and then stay on in the system, to those who come for post-graduate or subsequent work experience). As we noted in Section 4, however, more effort could be made centrally to coordinate the recruitment activities of the UK universities

abroad, and to use those mechanisms as a means to advertise the wider benefits of a UK medical career to younger doctors. This latter point is important because, as one of our UK interviewees explained, if “*you get them earlier on in their training*” then doctors will more likely to be socialised into, and so want to remain in, the UK system than if “*you get them just before consultant stage ... or as consultants [when] that’s much more difficult*” (UK Org 3). In addition, the example of recruiting informally through professional/organisational networks, emphasises how important it is that the UK does not rely on existing arrangements always being there as the means for it to ensure supplies. As another UK stakeholder argued in relation to supply countries, there is a big difference between “*the people in senior positions now, quite a lot of ... [whom] are sympathetic to the UK because they got their training here*” and “*the younger doctors ... who are rising into positions of authority [because] their focus is Canada, the US and Australia.*” (UK GP 5). Not only do new professional links need to be built up, and old ones reinforced (e.g. as we have already suggested through the Royal Colleges), but more systemic marketing is required directly to influence the individuals who might themselves consider migrating and who are faced with more choice than ever before in the international medical labour market.

Advertising on the Basis of Ability to Deliver: Ensuring Good ‘Customer Feedback’

Finally, of course, attracting recruits to come to the UK by whatever means requires actively marketing, and even more importantly following that up with the delivery of, worthwhile education, training and work experience once doctors are here. We return to the issue of actually providing EU/overseas doctors with training/experience appropriate to their personal needs later in the section. In the meantime, it is simply relevant to note that the UK currently has many good selling points in this context. This includes, amongst other things, proposals for changes to the SHO grade, the possibilities for more structured training and progression from basic to higher specialist programmes, and the Code of Practice published by the DH for NHS employers wishing to recruit internationally (DoH, 2001d). All of these developments would provide useful illustrations for marketing purposes, helping the UK to “*present itself as a country that takes this responsibility [towards EU/overseas doctors across all segments of the NHS workforce] seriously*” (UK Org 3). What such an approach also does is recognise the mutually reinforcing effect of doctors either returning home or informing their social networks elsewhere of the positive experience they had in the UK. This in itself is an additional form of marketing, whereby the NHS is assured of some “chain migration” of EU/overseas doctors. In other words, such doctors will come to the UK because, more so than if they were to go elsewhere, they know that their market choice is likely to have a positive outcome.

The Need to Focus on the Practicalities of Migration and UK Labour Market Entry

What emerged from the Section 4 discussion of the UK's current approach to marketing and facilitating workforce entry and job matching for EU/overseas doctors was a complicated picture of activities by a number of different organisational/professional players in a system that does not appear to be working to its optimal potential. Part of any attempt to improve the UK's marketable image and to maintain (and, where possible, increase) its share of the international medical labour market would, therefore, involve adjustments to this system. Doing just that has been a key objective of DH's recent recruitment drives globally using TMP Worldwide and the International Fellowship Scheme, and with specific country links such as between North West Region and Spain. As we have already outlined, however, there is still scope both for further streamlining and greater flexibility across the different stages of the migration process in order to reduce the barriers/disincentives to migration that undoubtedly are perceived. Once again, this is about repositioning the UK in a context of some *existing advantage* rather than making dramatic changes. Essentially, as we have said several times, it is about putting an explicit focus on individual doctors as the buyers of opportunity at the forefront of recruitment strategies. Such an approach is important both for the UK's continued attractiveness in its own right in terms of migration practicalities, and its attractiveness, at every stage of the migration process, in relation to major competitor countries.

Learning about Opportunity: Information Provided to Potential Migrants by the UK

The Importance of Streamlined Information Provision: Difficulties with the Current Situation

One of the key factors likely to make an impact at the initial stage of migration decision-making, where EU/overseas doctors are weighing the various options open to them, is the quality of information available about different destinations in the international marketplace. By quality we mean both the ease of access to relevant details about a given demander country and the range and nature of the information that is accessible. Is there, for example, a single point of access/referral to information or a number of different organisational knowledge sources that doctors need separately to find out about? How well are those sources of information advertised or made known to key bodies and individual doctors in potential supply countries? Does the information that is provided cover all aspects of knowledge needed to facilitate individual migration? For example, does it encompass simple relocation facts such as finding housing or schooling for children, getting an NI number, and

taking up leisure opportunities in addition to career specific knowledge around immigration and professional registration requirements, learning appropriate medical language, and applying for training/job vacancies etc?

Importantly, what the earlier discussion (see Section 4) suggested about the UK was that such streamlining and comprehensiveness of information provision to the marketplace is lacking. Although there is a general awareness that the UK has shortages in its medical workforce, the real constraints on post-graduate training/post training job slots in certain of the specialties is not as well known. The processes of obtaining registration and finding a suitable post were also felt to be highly complex given that they vary: a) for doctors from different source countries (i.e. EEA and non-EEA); and b) for doctors entering different segments of the NHS workforce (e.g. hospital versus general practice) or stages on the career ladder (e.g. Basic SHO training, Higher Specialist SpR training, or consultant/GP principal level). In addition, the large number and different functions of the various government (e.g. DH), education/training (e.g. British Council, Universities, Deaneries, Post –graduate Directors of GP Education, NHS Trusts), professional regulatory and representative (e.g. GMC, BMA, Royal Colleges, ODA) and commercial organisations (e.g. TMP and other agencies) acting, to different degrees, as both source of information and/or facilitator of labour market entry was a complication. Finally, there was said to be little opportunity, at the initial decision-making stage of migration at least, for potential migrants actually to talk through with a knowledgeable human being the opportunities and difficulties involved in taking up particularly a post-graduate training opportunity in the UK.

The Need for Simplification and Better Overall Coordination of Information

The main messages from our study participants that, if acted upon, might gain the UK competitive edge were, therefore, around the need for simplification and better overall coordination.²⁹ Whereas, in the past, potential migrants have often relied on receiving market signals by word-of-mouth through their own or their seniors' personal networks, there is now a role for increasingly active engagement with individual doctors in the marketplace. This might involve having one or two, authoritative sources for information (that were clearly and consistently advertised as such by everyone involved), for example via the DH in the UK or the British Council as the EU/overseas representative, updated regularly, and available on the

²⁹ Importantly, the relevant supplementary report to *Hospital doctors: Training for the Future* (NHSE, 1995) already recommended that information services for overseas doctors should be more coordinated. It suggested, for example, that Deans and Royal Colleges consider developing and publishing a National Guide to NHS post-graduate training to complement the 'Guide to Postgraduate degrees, Diplomas & courses in Medicine'. This was a 'long term' recommendation, however, it has not yet been acted upon to the knowledge of our interviewees.

web. Not only could such a centralised website include an up-front specification of demand side openings in the UK (i.e. shortage/oversupplied specialties, geographical areas and career positions), it could even provide access to a centralised register of NHS vacancies that was searchable on both nation and regional levels. It could explain the different functions of *all* the key organisations just listed with an education/training or professional/regulatory role in the context of EU/overseas doctor migration, and provide website links/contact details for doctors needing additional assistance. Equally helpful would be a navigational diagram or flow chart of the registration/labour market entry pathways doctors in different situations (e.g. EEA/non-EEA, different specialties and career stages etc) need to take into the UK system. In the context of education/post-graduate training/post-training job slot searches it could give details, for example, of relevant professional journals where jobs are advertised (e.g. BMJ or Lancet) and might even be able to link to a preferred provider list of employment agencies. It goes without saying that such a website, and related published literature, would also need to avoid semi-legal language, and would perhaps benefit from vetting by The Plain English Campaign.

Introducing a ‘Personal Touch’ to Information Provision

Finally, in addition to electronic and paper sources of information, we have noted the importance of the “personal touch” in successful recruitment. So, for example, part of the process of the UK articulating its demand more effectively to the marketplace, and encouraging mainly those who are most likely to thrive in the NHS workforce to consider coming, might be to provide “careers counselling” on the prospects in different areas. As one of our UK interviewees pointed out, it may be more open, honest and productive to say to doctors that:

“These are the manpower figures in certain specialties where it is virtually impossible to get on. If you are re-establishing your career you might want to think about, you know ‘My chances of progressing in obs and gynae are minimal, maybe I need to retrain. And perhaps say general practice where there are huge openings, with obs and gynae interest, would be a better option’. That hasn’t really occurred that degree of career counselling, and I think that definitely has to be a priority.” (UK Org 3).

That study participant was actually referring to refugee doctors already in the UK from overseas, but it is equally possible that doctors still in supply countries, but considering migrating, could benefit from such direct advice. Such an approach is not necessarily appropriate on a worldwide basis, but it could be carried out (along the lines of the model

already tested in Spain) in the small number of countries that are being directly targeting for UK recruitment campaigns. It would undoubtedly involve roadshows or fairs with informed people, preferably medically qualified, to talk face to face with potential recruits. Equally, however, if the British Council were to act (even more than it does already) as a major channel of information, it might be possible to provide similar advice more generally. Of course, the latter may require additional, targeted funding as health is not a British Council priority in every country or world region (e.g. Poland) in which it operates. Finally, it may be worthwhile offering EU/overseas doctors “*a central port of call*” in the UK so that:

“when someone shows an interest and picks up on an advert they then get a full package where it says everything about what they need to know ... to take things forward. They then say ‘My personal interest is in...’ and they have an individual they can then speak to ... [to] provide them with the necessary information to supplement all that [general info that they have already been given]” (UK Org 3).

From Information to Recruitment: Adjusting Labour Market Screening and Other Entry Barriers

Following on from accessing initial information, the next stage of migration decision-making would see doctors coming up against, and comparing, the labour market entry barriers (e.g. professional and language screening, medical regulation and immigration requirements etc) of different countries in the international marketplace. Here too, adjustments can be suggested that might help the UK capture the attention of potential migrants – i.e. by making itself as straightforward a destination as possible compared with its main labour market competitors, particularly the USA. Again, the possibilities centre on the need to rationalise and simplify the screening, regulation and immigration structures that are in place, without of course compromising the UK’s ability to detect (lack of) quality to practice.

Improving Physical Accessibility to the PLAB Examination

In relation to PLAB, for example, our UK and EU/overseas interviewees all endorsed the fact that more local test centres are being provided thereby increasing physical access to the examinations system. It may, however, be useful also to consider electronic computer based examination arrangements to widen access still further. Similarly, it could be worthwhile enabling Part 1 of PLAB (the basic clinical sciences section) to be taken by student doctors at the same time as comparable skills are being tested as part of their medical degree. Both these changes would bring UK screening arrangements for overseas doctors in line with those

in the USA (i.e. around the USMLE), thereby evening out one particular practical contrast between the two countries. The latter would also have the benefit, according to our interviewees, of encouraging candidates early on in their careers to buy into the process of migration generally, and of coming to the UK specifically. This should follow through into: a) migration itself being seen as less of a psychological hurdle because it had always been on doctors' personal agendas; and b) doctors being less inclined to shop around for alternative destinations because they have already part passed UK labour market entry barriers. Importantly, the fact that Part 2 of PLAB (the OSCE) can be taken at a number of regional centres does give the UK some advantage over the USA. Specifically, it gives candidates more opportunity to minimise costs by staying with friends and contacts. In the USA the equivalent clinical test can be taken in Philadelphia only. It may be that if PLAB Part 1 was also made more accessible, then that would combine with existing advantages around the OSCE to give the UK even greater market edge in relation to this particular barrier/disincentive to migration.

'Horses for Courses': Fine Tuning the Examination System

Another set of issues raised in relation to PLAB in addition to its physical accessibility was around perceptions of the appropriateness of the examination system itself. First, in the context of evening out contrasts with competitor countries so that the UK can capitalise fully upon the other practical advantages it offers, it may be appropriate to look at rationalising who takes which exam elements. A reported attraction of the USMLE, for example, was that it appears to offer a more level playing field between US medical graduates and IMGs (overseas doctors). This is because the same qualifying examination is taken by all, and all must subsequently undertake Residency (specialist or family medicine) training in order to gain registration for independent practice. Since the ODTS is under review, perhaps it might also be worthwhile undertaking a wider review of UK qualifications in general as they apply to overseas doctors. Another point is that, given the general nature of skills tested, PLAB is seen as an inappropriate screening process for entry into higher specialist training in the UK. Something that would reposition the UK in the market for doctors at this level, would be the introduction of alternative mechanisms by which candidates who have already undertaken some higher training and qualifications elsewhere could effectively be fast tracked into appropriate posts. Such arrangements might also include recognition of certain overseas qualifications in source countries, with in built quality assurance, such as the Diploma of National Board (DNB) in India (already the subject of scrutiny by the GMC). Alternatively, it ought to be possible to recognise Royal College Part 1 Membership examinations taken abroad that do not currently allow successful candidates access to the UK medical labour

market, and to consider a mixture of training and experience as criteria for equivalence. The latter is particularly relevant given that assessments in general are becoming more competency-based.

Adjusting the Height of Entry Barriers

In relation to perceptions of UK professional regulatory and wider immigration frameworks, there is also potential to even out, and where appropriate reduce, the height of entry barriers compared with major competitors. For example, if current proposals are enacted to quicken the process of obtaining CCST and Specialist registration, the UK would compare more directly with its EEA counterparts in terms of time invested (or used up) at the pre-specialist qualification stage of a hospital career. Such comparisons are relevant to decision-making particularly for doctors migrating around the EEA, but also for those coming to a choice of EEA countries from outside. As another example, removing the requirement to have ‘full’ registration and altering the residency rules around access to GP training would increase the pool of labour (in this case non-EEA doctors) available to another segment of the medical labour market with major shortages. In the long-run, facilitating entry at the level of medical training in both hospital and general practice would provide competitive edge because, as we commented with PLAB, the earlier doctors enter and are socialised into the UK system, the more likely they are to want to stay. Where workforce shortages are particularly acute, however, it also seems appropriate to go further and significantly reduce regulatory/immigration barriers for qualified practitioners compared with alternative destinations. So for example, it will be important to continue, and even extend, work permit arrangements that currently include consultants in various specialty areas on the Shortage Occupations List and GPs under the ‘Highly skilled Migrant’ priority category (the latter if they work in salaried posts, initially for one year). In this context, there was support amongst our UK interviewees for the idea that work permits be issued directly to agencies, thereby introducing more flexibility into the system by allowing them to employ doctors directly. It may also be appropriate to tie the easing of work permit restrictions into structured training (e.g. in deprived urban areas with long-term GP shortages) that would enable migrant doctors to “come up to speed” very quickly in workforce areas where there are likely to be most continuing opportunities.

Tackling the Language Qualification Issue

Another element of labour market screening for overseas doctors is the IELTS English language examination, but language barriers are also a potential disincentive for doctors generally as they attempt to take up medicine in another country. Here too, it appears that greater flexibility (i.e. in terms of the language fluency to be achieved from the outset in IELTS) and wider physical access to appropriate language training could be facilitated without necessarily compromising quality. It is reported, for instance, that many doctors (including refugees with a reasonable command of the language, who are already in the UK), do not currently score the required minimum of 7 in all sections of the examination, but they do achieve a mean of 7. It may be useful to allow such doctors, particularly those with existing specialist experience and qualifications, access to clinical attachments so that they can be exposed to broader medical contexts for language development. Specifically in relation to refugee doctors, there is scope for more programmes giving access to teaching, libraries, and mentoring schemes to enable them to learn quickly. Also in the context of language training, there are clearly more possibilities than are presently being utilised for electronic tools tailored to doctors' needs in different medical settings. Such tools can be geared specifically to the IELTS examination, and made available either as CDs or over the internet for doctors in EU/overseas countries before they come to the UK. If not made directly available via the British Council or DH, they could at least be referred to as part of the streamlined and comprehensive information strategy already outlined above. Overall, it seems particularly worthwhile for the UK to facilitate a reduction in language-related entry barriers to its medical labour market. This is simply because current and potential supply countries (e.g. in South Asia and Eastern Europe) increasingly speak English as their first foreign language. Indeed in countries such as Poland English is now a requirement of the medical degree in the same way as Russian used to be. The UK, therefore, has a head start in terms of attractiveness over other demander countries in Europe (e.g. Scandinavia). If it also made a concerted effort to point doctors in the direction of relevant language top-up training, then that may also gain it competitive edge over other English speaking countries in the international marketplace such as the USA, Canada and Australia.

Importantly, in all of the above, the point is not in any way to compromise medical workforce quality, but to raise issues around the practicalities of the migration process. These currently create additional barriers for individual doctors thinking of migrating that: a) are probably unnecessary in a world of electronic media; and b) the UK cannot afford in the context of globalised medical labour market competition. Consideration is, therefore, needed about what barriers are appropriate and what could be changed to recognise the power of the

individual buyer in the international market where the UK has workforce shortages it needs urgently to fill.

Matching Demand and Supply: Delivering on Tailored Experience and Person-Job Fit

Reducing the Transaction Costs of Direct Training/Job Slot Entry

A final part of the equation in improving the UK's image and putting doctors as buyers at the forefront of recruitment strategies would be to facilitate migrants:

- a) in “getting into the NHS workforce” with as little as possible impact on them in terms of personal transaction costs (e.g. of time and effort, and previous living standards and working conditions foregone; and
- b) in “getting the most” out of their period (long or short) in the NHS workforce.

As we have pointed out throughout the report (both in relation to current UK activities in Section 4 and competitors such as Australia and the USA in Section 5), there are two approaches of importance here. First, there is a need to ensure that individual doctors enter the education/post-graduate training/post training job slots that are most likely to suit them – both in terms of career development and their wider social/personal or family circumstances. This may, for example, involve setting up comprehensive systems (i.e. based upon, but expanding the activities of developments such as the Spanish Recruitment Pilot in North West Region and the International Fellowship Scheme) to “match” EU/overseas doctors both with potentially suitable openings in the NHS workforce and local communities. Second, there is a need to ensure that those doctors who do take up NHS opportunities receive induction, training, in-work mentoring, and equally importantly, out-of-work support packages that are as far as possible tailored to meet their individual needs. Another key element of this is to take account of the language needs of doctors recruited from non-English speaking countries. So, for example, one UK interviewee raised the possibility of Royal Colleges putting together specialty-specific networks of EU/overseas doctors already working in the NHS who would be “*prepared to offer to be a first port of call*” for new recruits in their own language (e.g. German, Italian etc) (UK Psychiatry 1). Importantly, tailored training and support structures both in- and out-of-work are one means by which the UK can keep up with other demander countries such as Australia and Sweden (whose activities in this area were described in Section 5). It is also how:

“We could steal a march on [the UK’s main competitor] North America if we provide that sort of integrated package that they to some degree do, but not fully, so the UK then becomes more attractive” (UK Org 3).

This does not require ‘reinventing the wheel’ for every EU/overseas doctor that comes to the UK, which undoubtedly would be very expensive, but it does mean recognising the importance of catering for different medical career stages. So, for instance, in terms of training it is relevant to note that the Senior Doctor route of entry to the NHS workforce was recently discontinued on the grounds that even senior doctors should enter at SHO level for a period of induction. However, this is not yet part of a dedicated structured programme, followed by a tailored programme of higher training, in which doctors would more easily be able to benefit from utilising prior experience. Importantly, structured training in whatever part of the NHS workforce (i.e. hospital or general practice, post-graduate training or top-up training for doctors that are already qualified overseas) implies the need for an organised programme, rather than, as is presently the case, overseas trainees having themselves to find jobs every few months. What such arrangements would also do is ensure that not as many overseas doctors become ‘stuck’ in career grades having missed the opportunity for top-up training. In addition, in relation to personal/social needs outside work, there is a need to recognise, as one of our UK interviewees put it, that: *“It’s a much more difficult one ... to actively recruit people at your end point level i.e. GP principal or consultant ... [because] people then are more settled, they have families, and are far less likely to uproot”*. To get them to do so, therefore, quite rightly requires a lot of effort on the part of the UK (the existing International Fellowship Scheme again provides an example of what is required). It is almost certainly worth it for small numbers needed to fill relatively short-term workforce gaps – e.g. in given specialty areas or certain geographical locations with acute and on-going problems in general practice recruitment. However, it is important to remember that:

“If you [also] get people relatively earlier and make it attractive for them to stay, they’re more likely to ... [come to] look on Britain as home ... and say ‘Why would I want to go and move and live somewhere else?’” (UK Org 3).

The latter would appear a far more effective strategy to ensure that EU/overseas doctors can fulfil their potential role in meeting medium to longer-term gaps between workforce demand and supply.

The Importance of Having Overall Mechanisms to Articulate Demand and Match with Supply

Facilitating and Integrating Labour Market Strategies across Different Levels

Clearly, the recent DH moves on global recruitment (coordinated by TMP Worldwide), the country-based pilot schemes to recruit doctors, for example from Spain to North West England, and the International Fellowship Scheme are a great move forward in attempting more closely to source supply to fit demand. They illustrate not only how NHS Trusts and GP practices can feed information about specialty and geographical vacancies into a wider knowledge system, but also how that enables the UK as a whole to position itself and articulate an aggregate picture of demand to the world. However, there were still concerns expressed by our UK stakeholders, and illustrated by the gaps in awareness in supply country case studies, that more could be done. It is possible here to take the Australian example of structures based on regional (i.e. State-based) sub-markets and labour market segments (e.g. WACCRAM in Western Australia, the Rural Doctors' Network in New South Wales, and the Rural Workforce Agency in Victoria) as a basis for comparison. As we have already seen, these bodies take a view of their regional/local labour markets, carry out advertising, screen applications and match doctors with potential vacant hospital and general practice posts that they can then explore further. This rationalisation of effort to a 'middle man' means greater efficiency in the demand-supply matching process than would be the case if individual doctors and their potential employers were 'left to find each other'. Going the other way in terms of the relationships between scales of activity, it also means that those bodies that are naturally placed to "know their local demand" are the ones articulating that to the wider world. If that task was left to national agencies dealing with a much broader demand-side picture it may be that certain regions would lose out to other priorities and not get their message across.

In the UK context, there is clearly a potential role for NHS Workforce Confederations coordinating the picture coming from the full range of other organisations acting locally on the demand side – not only NHS Trusts and GP practices for post-training job slots, but also Deaneries and Post-graduate Directors of GP education, and even universities, in relation to medical education and training opportunities? Of course, in a country the size of the UK there is also a role for further coordination above that level so that regions are not, in effect, competing against each other (as UK universities and Deaneries, and, in actual fact, the various Australian States were described to us as currently doing). This is where there is obvious potential to continue to build on recent DH developments, which, in addition to the

above, could bring into the national coordinated picture knowledge of opportunities on offer to overseas doctors through the various Royal College training programmes, and local Deaneries etc. It is, for example, probably entirely appropriate that the majority of EU/overseas advertising comes from a central source, which can provide initial information to interested parties and then point them to more localised structures as appropriate (whether that be for additional advice and support, or to apply for specific education/training/post-training vacancies). As we have already noted, it may also be worthwhile establishing a more concrete version of a ‘central clearing house’ (also building on the arrangements with TMP Worldwide) to facilitate the labour market application and entry process across the NHS system for UK as well as EU/overseas doctors.

Overall, what an integrated strategy does is to recognise that players operating at lower levels of spatial resolution within the UK (e.g. individual education/training and employing organisations) are helped significantly in terms of their own competitiveness if they can tap into scale advantages that help them to ‘punch above their weight’. It also recognises that:

“from a single doctor’s point of view, it’s actually really, really difficult getting to grips firstly with how the whole NHS works and that [for example] the Deaneries are important within that structure ... and then secondly with making contact with [the appropriate local bodies] ... when you don’t actually know which part of the country you’re necessarily going to settle in” (UK Org 3).

Finally, it would enable medical migration trends to be fed into national workforce planning, rather than continuing with what appears to be the current situation in which recruitment and retention of EU/overseas doctors is more a part of crisis management than truly effective forward thinking. What it requires to succeed, however, is continued recognition that by actively working together (as they have done with the TMP Worldwide screening of doctors for entry to the Specialist Register), all the organisations involved from top to bottom (i.e. DoH, STA, GMC, Royal Colleges, Deaneries etc etc) are putting value added into the overall system. They are reducing the transaction costs both of duplicated effort (e.g. in terms of advertising, information and advice provision), and inefficiency in the regulatory and appointment process. As just one example, we already noted in Section 4 the view that the ODTS would run more efficiently if Postgraduate Deans were included in relevant Royal College/GMC loops because they are the ones responsible actually for delivering training in FTTA posts.

Of course, the logic of players operating at lower levels of spatial resolution being helped to tap into scale advantages and ‘punch above their weight’ in the international marketplace can also be followed through the country level. As in the USA where the individual States compete against each other for doctor supplies, the labour sub-market in EU/Europe sees countries with doctor shortages (e.g. UK, Sweden, Norway, Germany etc) competing both for European-trained doctors and those from elsewhere overseas. Such a situation may make sense in a country such as the USA, which, as we have already described, can rely on its overall image to attract migrants in enough numbers to fulfil its needs. However, our EU interviewees in particular felt that system in Europe was inefficient, and that individual countries such as the UK (and indeed others that may not have the UK’s advantage of Commonwealth supply links for example) may be losing out by “leaving the outcome up to the market”. In other words, European countries could, and should, go further than simply addressing mutual recognition of training and qualifications to reduce migration barriers. Instead, they should be working together to develop EU-level structures (e.g. around workforce planning, information provision, recruitment and job placement, and advertising in the global marketplace) to achieve greater efficiency and mutual gain across the European system as a whole. In this context, it should be noted that the USA does, even with its entirely market-based system, have the National Residents Matching Program - the ‘Match’ – providing a centralised element at least to filling training slots. It may be, therefore, that as well as developing national-level structures, the UK should think through more fully its contribution to debates on the possible long-run benefits of greater collaboration (as opposed to competition) at EU-level.

Summary

The following are some of the key policy suggestions that have emerged from the research as relevant to sustaining and gaining competitive edge for the UK in the international medical labour market:

- Improve the relationship of EU/overseas doctor recruitment to NHS workforce planning. This would, for example, involve clearly deciding which groups the UK most wants to attract: at what age/career stage; to do what in terms of specialty/geographical location etc?;
- Clarify decision-making on whether or not the UK wants to recruit and retain EU/overseas doctors, or train them primarily to return to source countries. The latter would, for instance, recognise that doctors returning with good experiences should

generate word of mouth reports to other doctors that would, in turn, encourage continued flows to UK.

- Recognise what are the UK's key attractions and barriers/disincentives as they apply to EU/overseas doctor migration. In this context, it is important to trade on what is already good and what has been/is being improved. It is also important to recognise what can and cannot be improved in terms of facilitating labour market entry etc and make any necessary practical changes.
- Increasingly recognise the power of buyers in the international medical labour market - i.e. individual doctors looking for education/training/job opportunities and making lifestyle choices. This will mean tailoring recruitment packages in terms of: education/training/work experience; personal/family relocation needs; mentoring and support in both work and home life etc.
- Improve marketing/information provision about the UK on the basis of above factors. Part of that would involve continuing to target specific countries and also acting systematically to capture the attention of individual doctors themselves to reduce transaction costs. It would also involve recognising differences between hospital and general practice – e.g. in terms of marketing and responding to the needs of individual doctors taking up posts.

Importantly, most of the above are beginning to be addressed by the main UK stakeholders, in particular the DH, but also some Royal Colleges and other bodies. Overall, it will be important to continue to bring a more centralised element to the process of recruiting EU/overseas doctors in order to reduce the perceived entry barriers and increase the attraction of the UK in the marketplace. It may also be relevant to engage more fully with debates about the benefits of wider collaboration (as opposed to competition) as EU level in order to achieve similar economies of scale at across the board.

7 OVERALL CONCLUSIONS AND RECOMMENDATIONS

Addressing the pressures associated with shortfalls in the medical labour market has always been one of the key challenges for workforce planning and development in the NHS. Now, however, this is being set within increasingly ambitious government targets for improvements in service delivery that can only be achieved by a rapid general workforce expansion in the health service. While the key to meeting these challenges clearly rests with education/training and employment structures in the UK itself, the ability to attract (short or longer-term) EU/overseas doctors to the NHS is a vital, complementary component of the overall labour force planning process. In this context, the present research set out to add more comprehensive information to what seems hitherto to have been a debate based on impression and anecdote, or at best smaller-scale studies (by supply country, by specialty etc), from which general conclusions about the UK situation were inferred. What we have attempted to set out is a perspective based on a two-part conceptual framework. On the one hand, we have stressed that, at root, medical doctor *migration* is just that – a process of individuals (perhaps with their families) choosing to move internationally to better their economic/social/career situation. On the other, we have explored medical doctor migration from the viewpoint of the international marketplace where countries compete to achieve competitive advantage.

From the migration viewpoint, therefore, we were able to make some general observations (based on both UK interviews and EU/overseas case studies) on the drivers that promote international movement for doctors in the UK's current and potential supply countries. These include:

- At the country-level:
 - Relative economic and social expectations and the prospects for higher financial gain;
 - Wider quality of life issues, including personal safety and the prospects for stability and greater freedom.
- At the medical organisation/professional level:
 - Relative prospects for obtaining career improving postgraduate training;
 - Home country bottlenecks to career development and progression;
 - Perceptions of enhanced job satisfaction and working conditions.

We have shown that the balance of such push/pull factors, and hence the decision to stay or move, and, if moving, the eventual choice of destination in the international marketplace, is in turn affected by a number of conditions operating at the individual level. For example:

- The stage doctors have reached in terms of career development and family formation;
- Their particular medical field and the health system in which they gained their experience/training;
- Whether or not individuals and their families are considering migrating for the short or longer-term.

The study also suggested that, within this complex picture of incentive structures encouraging medical migration between countries, the ones that offer the **UK competitive weight against its rivals** in the international marketplace are:

- The established system of UK post-graduate qualifications (especially the reputation and kudos of the Royal Colleges) and training opportunities and the attraction that holds for potential migrants to enhance their human capital/career prospects. The qualifications and experience gained in the UK were felt to endow their holders with much more personal marketability - both generally in the international medical labour market and specifically if they were to return to set up a private practice in their home countries;
- The English language which is relevant for two reasons – ease of entry and as a “passport” to wider opportunity. First, many EU/overseas doctors already know, or were felt to need only relatively brief intensive training in order to gain, enough of the language to be ready for NHS practice. Second, moving to the UK was seen by interviewees as an excellent way to provide children and families with opportunities to learn the “international language of the future”;
- The information, recruitment, job-matching, induction/training and follow-up support systems that exist in particular circumstances (e.g. the Spanish Doctor Recruitment Pilot in North-West Region, the recent campaign administered by TMP Worldwide, the International Fellowship Scheme, the ODTS where it is working well, schemes run by Deaneries and Directors of Post-graduate GP Education etc) to ‘handle’ individuals at various stages in the migration and labour market entry process.

Responding proactively to further enhance these factors (both by trading more effectively on them as existing strengths and making adjustments to achieve further gains) was seen by study participant as having the most potential, *cost-effectively*, to alter the competitive context in favour of the UK.

From the viewpoint of the actions of players in the international marketplace, we were able to offer some views on the positioning of the UK. For example, the study revealed a wide and increasing range of ‘demander countries’ looking to source a substantial proportion of their medical labour supply from outside their own health systems. Hence, the degree of rivalry in the marketplace appears to be intensifying. As in the UK, this demand is responding both to national shortages by specialty and/or to particular pressures in deprived/underserved geographical locations. In addition to global-level migration between continents to match these demands, there are also more ‘localised’ geographical flows at both regional and country-country levels. Examples of these evolving sub-markets for migrant doctors include: USA/Canada, USA/Central and South America and the Philippines; Australia/New Zealand and the Pacific Rim, UK/EU-EEA, UK/Commonwealth, South Africa and the rest of Africa etc. The study suggested that these emerging patterns are underpinned by factors such as:

- Historical links and related migration traditions;
- The existence of contemporary trading/geopolitical/regulatory blocs;
- Geographical proximity;
- Linguistic commonality, and
- Straightforward market incentives/financial gain.

We have suggested that within this increasingly competitive global context, the UK appears to operate in a sub-market that primarily includes the Commonwealth countries of Australia, Canada and, to some extent, New Zealand. Not only are these countries all English-speaking, they are increasingly trading on the basis of their own equivalents of Royal College qualifications and the provision of more appropriate information, recruitment, job-matching, induction/training and follow-up support systems. In other words, all compete across the same three factors we have just identified as providing the UK with the essence of its competitive weight in the international marketplace. It is here that differentiation to sustain market position is at its most critical. In addition, certain countries within the European sub-market (e.g. Sweden and Norway) are actively recruiting in, or (e.g. Germany) have existing strong migration links, with countries that are/could be suppliers to the UK (e.g. Spain,

Poland etc). These too will be seeking to strengthen their market positioning. Overall, the hegemonic position of the USA was perceived both by our UK and EU/overseas interviewees as unassailable internationally. This is dominantly because of the image it projects of economic/lifestyle opportunity and well-funded health facilities. However, respondents indicated that there is still potential for the UK (but also its competitors) to trade on its strengths and, at the margin, attract doctors who may otherwise choose to go the USA – not least because the latter has recently raised its immigration barriers in the light of 9/11.

On the whole, study participants perceived the most significant current UK supplies of overseas doctors (e.g. India, but also Australia, New Zealand, South Africa etc) as relatively secure. They also felt there was some prospect of new supplies (e.g. as Eastern European countries such as Poland join the EU) coming on stream in which the UK may expect to share in future. However, what respondents also set out was a general perception that the UK may be “resting on its laurels”; or not engaging as actively as it could do within an international marketplace where “standing still” can only be associated with a competitive penalty. The UK was, for example, not seen as having the best image internationally in terms of stories about levels of investment in the NHS and working conditions for doctors. There was also a view (from both the UK and from elsewhere) that it may be “trading on past reputation” around post-graduate training provision. Although, as we have already noted, training opportunity was still a key attraction, the UK was not seen as doing the most it could do (or at least advertising the improvements that have been made) to offer EU/overseas doctors what they see themselves as needing to progress their own careers. Instead the system was perceived as being geared principally to providing NHS services, feeding a perception that migrant doctors were primarily seen and “making up the workforce numbers” rather than being valued as highly skilled professionals in their own right.

Bringing these viewpoints together we have been able to offer some suggestions as to measures the UK can take to **respond positively to evolving market conditions**. The principal measures we have highlighted are:

- The importance of **market positioning** – i.e. taking steps more effectively to focus marketing/recruitment activities on those groups the UK most wants to attract: at what age/career stage; to do what in terms of specialty/geographical location etc. Similarly, there appears to be a need (in terms of image) to be clear about, and indicate, whether or not the UK wants to recruit and retain EU/overseas doctors, or train them primarily to return to source countries. A positive competitive gain from the latter would, for instance, acknowledge that doctors returning with good experiences would generate word

of mouth reports to other doctors that would, in turn, encourage continued flows to the UK.

- The need increasingly to recognise (as are competitor countries such as Australia and Sweden) **the power of the buyers** in the international marketplace. In other words, the individual doctors scanning for opportunity and making their migration choices on the basis of the “the face” presented by a particular demander country to the market. This would suggest that it is important for the UK to look more closely, amongst other things, at how the **process of medical labour market entry** (particularly the height of the barriers) might appear for EU/overseas doctors. It might, for example, consider the following:
 - Continue to improve general physical access to the PLAB examination (i.e. in overseas locations);
 - Enable earlier access to PLAB Part 1, during undergraduate medical education, in a similar way to access to the USMLE;
 - Fine-tune screening so that, rather than having automatically to take PLAB, overseas doctors who have already gained higher training and qualifications and/or taken Royal College examinations overseas could be fast-tracked into higher level NHS posts;
 - Continue to reduce professional regulatory and wider work permit barriers (i.e. through the Shortage Occupations List and Highly Skilled Migrant category) in a targeted manner for the medical specialities with greatest shortages;
 - Possibly allow work permits to be issued directly to recruitment agencies so that they can employ migrant doctors directly;
 - Tackle the issue of language qualification by judging whether doctors whose first language is English (e.g. Australians) and others (e.g. refugees) who score an average of 7 (rather than a minimum 7 in all sections) might be allowed to access NHS employment without from the outset meeting IELTS requirements.
 - Have more streamlined application processes, and possibly more centralised “brokerage” systems for placing EU/overseas (and indeed UK) doctors in suitable NHS training and post-training employment positions.
- The need, also in the context of seeing doctors as increasingly powerful buyers, to have active **measures to tailor recruitment packages and job-matching** more effectively to individual needs. This would be in terms of addressing: the appropriateness of education/training/work experience; language, and other training needs, personal/family

relocation requirements; mentoring and support in both work and home life etc. As much as anything this is about fostering a culture shift so that being attractive to EU/overseas doctors (e.g. making them feel valued enough to come to the UK, and providing them with quality experience when they are here) is increasingly seen as central to the entire recruitment process. Not only does this imply helping individual doctors to “get the most” out of their period (long or short) in the NHS workforce, it is also, just as importantly, about ensuring quality in the workplace. By socialising EU/overseas doctors more quickly and effectively into the NHS workforce, they will be better able to deliver the quality services expected by UK national standards.

- The need to take steps to **improve practical information provision** about UK education/post-graduate training/post-training employment opportunities, the nature of regulatory barriers and the job search process. Part of that would involve continuing to target specific countries, but it is also important to act systemically to capture the attention of individual EU/overseas doctors. In this it would be essential to recognise the differences between hospital and general practice and training/post-training employment, and to identify which doctors would be seeking which of these alternative routes to entry. Once again, this involves striking a balance between streamlining activities and providing the “personal touch” to make individual doctors feel valued in the system. In terms of streamlining, both UK and EU/overseas interviewees were, for example, supportive of a central website covering the full range of information needed for doctors to migrate to the UK (i.e. everything from English language training packages, to professional regulatory and other immigration requirements and broader information on relocating and living in the UK), and providing comprehensive links to other key bodies (e.g. Royal Colleges, BMA, Deaneries etc). There were also calls for a one-stop organisational point to access more personal advice at least in the first instance (either in the UK itself or, for example, building on existing British Council arrangements in supplier countries).
- Ensuring that **appropriate structures** are in place both to signal the shape of UK demand to the international marketplace and to achieve scale efficiencies in terms of information provision and recruitment activities. In this context, there is clearly a potential role for NHS Workforce Confederations to co-ordinate and help present a more coherent picture of the aggregate demand coming from the full range of other organisations acting locally – e.g. NHS Trusts and GP practices for post-training job slots, also Deaneries, Post-graduate Directors of GP Education and universities for education and training opportunities. Of course, in a country the size of the UK there is also a role for a further level of co-ordination to ensure that the propensity of regions to, in effect, compete with

each other is kept in tune with demands of the national interest. For example, it seemed to study participants entirely appropriate for much EU/overseas advertising to come from a central source that can then provide initial information to interested parties and point them to more localised structures (whether that be for additional advice and support, or to apply for specific education/training/post-training vacancies).

As we have described, the main UK stakeholders – in particular the DH, but also some Royal Colleges and other bodies – are addressing many of these activities already. Overall, however, it will be important to continue to bring a more proactive and ‘head up’ approach to the process of recruiting EU/overseas doctors. This is particularly the case given the ethical considerations of recruiting large numbers of skilled professionals from countries with developing/transition health systems that cannot necessarily (despite the potential benefits, such as remittance income) afford to lose them long-term. In addition, from the UK point of view, there may be dis-benefits from what some observers perceive as an over-reliance on EU/overseas sources. One view, for example, is that EU/overseas supplies introduce instability to the NHS workforce because they are inherently more difficult to predict and plan for than numbers of UK-trained doctors. Another is that international recruitment may contribute to a problem of doctor oversupply if, and when, the expansion of the UK-trained workforce feeds through to the system as a whole. In the final analysis, EU/overseas doctor recruitment needs to be given its proper place as a small, but nonetheless significant, element in what is required to meet the government’s ambitious plans for NHS workforce expansion. It must continue to sit alongside the much wider set of solutions (described in Section 1) also being introduced to meet the challenges of job-matching for a future NHS, including the expansion of education and training to increase UK doctor numbers, and job-redesign/changes in skill-mix to shift part of the health workload from doctors to other care workers altogether.

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APPENDIX 1: LITERATURE SEARCH STRATEGY

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1. Bibliographic Databases Searched

- **Medline** (Index Medicus)
- **Embase** (Excerpta Medica)
- **HELMIS** (Health Management Information Consortium – comprising the databases of the Kings Fund, the Department of Health (DH Data), and the Nuffield Institute)
- **SIGLE** (The System for Grey Literature in Europe)
- **HELECON** (European Economics & Business Administration database covering LABORDOC the International Labour Office database of work, employment & labour force)
- **Institute for Scientific Information Web of Science Databases** (Science Citation Index, Social Science Citation Index & the Index of Scientific & Technical Proceedings)

2. Search Strategies

2.1 Free-Text

All the databases were searched using the following combinations of free-text terms, and articles were retrieved which contained any of the terms in the record title or abstract.

Overseas Doctor*

Physician* and migrat* (in the same sentence or within 10 words of each other)

Doctor* and migrat* (in the same sentence or within 10 words of each other)

Physician* and immigrat* (in the same sentence or within 10 words of each other)

Doctor and immigrat* (in the same sentence or within 10 words of each other)

In addition, the databases which were health or medicine specific (ie. Medline, Embase & HMIC) were searched for the following broader terms in the abstract or title:

Medical workforce

labo?r market

labo?r supply

labo?r force

workforce near shortage (in the same sentence)

The results were then checked for relevance (ie. mentions of overseas doctors or doctors with medical qualifications obtained abroad).

2.2 Thesaurus Searching

Medline and Embase were searched in addition using the thesaurus subject-headings. Suitable terms were identified using the thesaurus and the following searches carried out.

- **Medline**

(MeSH) Medical Subject Headings used:

Emigration-and-Immigration/all subheadings AND Physicians/all subheadings

- **Embase**

EMTREE thesaurus terms used:

(Immigration OR Migration) AND (General Practitioner OR Hospital Physician OR Medical Personnel OR Health Care Personnel OR Health Care Manpower)

APPENDIX 2: ADDITIONAL TABLES FOR SECTION 3
ANALYSIS OF HCHS AND GP CENSUS

Table 1: Number of doctors (full registration) in the medical workforce by area of qualification

Source		1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
UK	N	66661	68576	69398	69815	71773	72403	70930	72429	59613	70685
	%	75.2	74.6	74.3	73.9	73.4	72.6	72.6	72.5	73.4	72.6
EEA	N	3581	3809	3965	4345	4861	5356	5193	5164	3888	4718
	%	4.0	4.1	4.2	4.6	5.0	5.4	5.3	5.2	4.8	4.8
Rest of world	N	18289	19438	19989	20213	21115	21893	16093	16818	15412	17559
	%	20.6	21.1	21.4	21.4	21.6	21.9	16.5	16.8	19.0	18.0
Unknown	N	161	119	91	75	75	134	5496	5499	2343	4382
	%	0.2	0.1	0.1	0.1	0.1	0.1	5.6	5.5	2.9	4.5
Total	N	88692	91942	93443	94448	97824	99786	97712	99910	81256	97344

Table 2: Age group by area of qualification – all doctors with full registration

Source	1991		1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age																				
UK																				
20-	13774	20.7	14026	20.5	13845	20.0	13317	19.1	14041	19.6	13571	19.1	13748	19.4	14039	19.4	10030	16.8	13251	18.7
30-	23145	34.7	24057	35.1	24480	35.3	24935	35.7	25098	35.0	25208	34.8	24032	33.9	23741	32.8	19239	32.3	21722	30.7
40-	15996	24.0	16897	24.6	17617	25.4	18142	26.0	19266	26.8	20046	27.7	19985	28.2	20818	28.7	18408	30.9	21515	30.4
50-	9851	14.8	9844	14.4	9886	14.2	10062	14.4	10124	14.1	10302	14.2	10533	14.8	11141	15.4	9925	16.6	11942	16.9
60+	3826	5.7	3707	5.4	3521	5.1	3325	4.8	3238	4.5	3089	4.3	2632	3.7	2567	3.5	2011	3.4	2255	3.2
DK	69	0.1	45	0.1	49	0.1	34	0	6	0	7	0	0	0	123	0.2	0	0	0	0
EEA																				
20-	483	14.2	470	13.2	490	13.1	502	12.4	587	12.9	614	12.2	568	11.4	441	8.9	257	7.1	260	5.9
30-	1549	45.6	1719	48.1	1827	48.9	2076	51.5	2430	53.3	2709	53.9	2704	54.4	2674	54.2	1772	49.2	2145	48.3
40-	587	17.3	649	18.2	713	19.1	750	18.6	884	19.4	996	19.8	1051	21.1	1171	23.8	1004	27.9	1354	30.5
50-	444	13.1	417	11.7	388	10.4	409	10.2	425	9.3	455	9.1	464	9.3	475	9.6	420	11.7	523	11.8
60+	301	8.9	283	7.9	283	7.6	249	6.2	230	5.0	214	4.3	186	3.7	158	3.2	151	4.2	155	3.5
DK	30	0.9	34	1.0	39	1.0	48	1.2	0	0	35	0.7	0	0	11	0.2	0	0	0	0
Rest																				
20-	347	2.5	392	2.7	361	2.4	402	2.7	403	2.6	422	2.6	504	3.1	531	3.2	365	2.6	503	2.9
30-	2312	16.3	2364	16.1	2356	15.9	2285	15.4	2483	16.1	2827	17.6	3072	19.1	3527	21.0	3053	21.5	4273	24.4
40-	6365	45.0	6288	42.9	6126	41.3	5751	38.9	5714	37.1	5518	34.3	5036	31.3	4837	28.8	3779	26.6	4613	26.3
50-	4190	29.6	4571	31.2	4828	32.5	5075	34.3	5438	35.3	5748	35.8	5875	36.5	6200	36.9	5382	37.9	6194	35.3
60+	891	6.3	1012	6.9	1133	7.6	1238	8.4	1357	8.8	1540	9.6	1592	9.9	1697	10.1	1614	11.4	1949	11.1
DK	49	0.3	45	0.3	43	0.3	41	0.2	0	0	22	0.1	2	0	17	0.1	0	0	0	0

Note: Doctors whose country of qualification is unknown are excluded from table. DK = age unknown

Table 3: Sex by area of qualification – all doctors with full registration

Source	1991		1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
UK																				
Male	463318	69.5	47200	68.8	47173	68.0	47023	67.4	47672	66.4	47573	65.7	45898	64.7	46314	63.9	38367	64.4	4480	63.5
Female	20343	30.5	21376	31.2	22225	32.0	22792	32.6	24101	33.6	24830	34.3	25032	35.3	26076	36.0	21246	35.6	25805	36.5
DK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
EEA																				
Male	2284	67.3	2397	67.1	2492	66.6	2654	65.8	2946	64.7	3204	63.8	3133	63.0	3081	62.5	2270	63.0	2733	61.6
Female	1110	32.7	1175	32.9	1248	33.4	1380	34.2	1610	35.3	1819	36.2	1840	37.0	1843	37.4	1334	37.0	1704	38.4
DK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	0.1	0	0	0	0
Rest																				
Male	11025	77.9	11380	77.6	11509	77.5	11417	77.2	11868	77.1	12381	77.0	12334	76.7	12806	76.2	10806	76.1	13213	75.4
Female	3129	22.1	3289	22.4	3338	22.5	3527	22.9	3527	22.9	3696	23.0	3747	23.3	3999	23.8	3387	23.9	4319	24.6
DK	0	0	3	0	0	0	6	0	0	0	0	0	0	0	4	0	4	0	0	0

Note: Doctors whose country of qualification is unknown are excluded from table. DK = sex unknown

Table 4: Ethnic group by area of qualification – all doctors with full registration

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
UK																		
White	31023	45.2	34978	50.4	37338	53.5	36361	50.7	37167	51.3	35727	50.4	36533	50.4	30204	50.7	38792	54.9
Black	851	1.3	957	1.4	971	1.4	759	1.0	596	0.8	553	0.8	565	0.7	505	0.9	1067	1.5
Asian	1227	1.8	1524	2.2	1753	2.5	1885	2.7	2157	2.9	2231	3.1	2399	3.3	2273	3.9	3302	4.7
Other	2230	3.3	2447	3.5	2581	3.7	2128	3.7	2181	3.0	2320	3.3	2385	3.3	2102	3.5	2922	4.1
DK	33245	48.4	29492	42.4	27172	38.9	30640	42.6	30302	41.8	30099	42.4	30547	42.1	24529	41.1	24602	34.8
EEA																		
White	1792	50.2	2181	58.3	2537	62.9	2857	62.7	3168	63.1	3138	63.1	3074	62.4	2328	64.6	3005	67.7
Black	77	2.2	81	2.2	90	2.3	52	1.2	53	1.0	61	1.2	65	1.3	43	1.2	91	2.0
Asian	42	1.2	45	1.3	51	1.3	60	1.3	54	1.0	47	1.0	52	1.1	54	1.4	56	1.2
Other	195	5.4	213	5.7	242	6.0	214	4.7	243	4.8	238	4.8	211	4.3	167	4.6	251	5.6
DK	1466	41.0	1220	32.6	1114	27.6	1373	30.2	1505	29.9	1489	29.9	1528	30.9	1012	28.0	1034	23.3
Rest																		
White	1435	9.8	1669	11.2	1852	12.5	1821	11.8	1915	11.9	1899	11.8	2021	12.0	1844	13.0	2365	13.5
Black	674	4.6	787	5.3	876	5.9	871	5.6	980	6.1	1033	6.4	1129	6.7	998	7.1	1396	8.0
Asian	3411	23.2	3849	25.9	4065	27.5	4027	26.2	4262	26.6	4251	26.5	4682	27.8	4191	29.4	5819	33.2
Other	1924	13.1	2186	14.7	2272	15.4	2283	14.8	2524	15.7	2485	15.5	2617	15.6	2261	15.9	3080	17.6
DK	7228	49.2	6356	42.8	5727	38.7	6393	41.5	6396	39.7	6413	39.8	6360	37.8	4899	34.5	4872	27.8

Note: Doctors whose country of qualification is unknown are excluded from table. DK = ethnic group unknown. Ethnic group not recorded in 1992

Table 5: Number of new entrants (full registration) per year by geographical area of qualification

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
UK	10011	75.6	6488	71.9	5598	70.1	5802	66.6	5231	61.7	5115	62.8	5122	63.8	3893	63.6	5299	65.2
EEA	868	26.9	755	8.3	809	10.1	1023	11.7	1144	13.5	894	10.9	722	9.0	517	8.4	604	7.4
Eastern Europe	29	0.2	26	0.2	24	0.3	25	0.2	57	0.6	58	0.7	58	0.7	46	0.7	45	0.5
Middle East	99	0.7	91	1.0	63	0.7	75	0.8	107	1.2	101	1.2	90	1.1	93	1.5	95	1.1
Northern Africa	133	1.0	92	1.0	89	1.1	127	1.4	145	1.7	150	1.8	136	1.6	130	2.1	162	1.9
Southern Africa	283	2.1	308	3.4	331	4.1	399	4.5	455	5.3	536	6.5	408	5.0	282	4.6	449	5.5
South Asia	1296	9.7	766	9.4	612	7.6	792	9.0	812	9.5	837	10.2	881	10.9	746	12.0	1135	13.9
Rest of World	499	3.7	476	5.2	436	5.4	435	4.9	430	5.0	350	4.3	378	4.7	263	4.3	335	4.1
Unknown	11	0.0	13	0.1	18	0.2	28	0.3	86	1.0	93	1.1	221	2.7	17	0.2	192	2.3
Total	13229	100	9015	100	7980	100	8706	100	8467	100	8134	100	8016	100	6112	100	8124	100

Table 6: Number of new entrants (full registration) per year by geographical area of qualification (excluding UK)

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
EEA	868	26.9	755	29.8	809	34.2	1023	35.2	1144	35.3	894	29.6	722	24.9	517	23.2	604	20.0
Eastern Europe	29	0.9	26	1.0	24	1.0	25	0.8	57	1.7	58	1.9	58	2.0	46	2.0	45	1.4
Middle East	99	3.0	91	3.6	63	2.6	75	2.5	107	3.3	101	3.3	90	3.1	93	4.1	95	3.1
Northern Africa	133	4.1	92	3.6	89	3.7	127	4.3	145	4.4	150	4.9	136	4.6	130	5.8	162	5.3
Southern Africa	283	8.7	308	12.1	331	14.0	399	13.7	455	14.0	536	17.7	408	14.0	282	12.7	449	14.8
South Asia	1296	40.2	766	30.2	612	25.8	792	27.2	812	25.0	837	27.7	881	30.4	746	33.6	1135	37.6
Rest of World	499	5.5	476	18.8	436	18.4	435	14.9	430	13.2	350	11.5	378	13.0	263	11.8	335	11.1
Unknown	11	0.3	13	0.5	18	0.7	28	0.9	86	2.6	93	3.0	221	7.6	17	0.7	192	6.3
Total	3218	100	2527	100	2364	100	2904	100	3236	100	3019	100	2894	100	2219	100	3017	100

Table 7: Numbers of new entrants (full registration) per year from major source countries in EEA

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Austria	0	0	2	0.2	0	0	7	0.6	6	0.5	9	1.0	6	0.8	6	1.1	3	0.4
Belgium	37	4.2	39	5.1	33	4.0	46	4.4	53	4.6	46	5.1	29	4.0	26	5.0	28	4.6
France	24	2.7	15	1.9	5	0.6	14	1.3	12	1.0	3	0.3	35	4.8	8	1.5	13	2.1
Germany	162	18.6	155	20.5	229	28.3	353	34.5	419	36.6	325	36.3	244	33.7	165	31.9	174	28.8
Greece	67	7.7	70	9.2	84	10.3	77	7.5	125	10.9	93	10.4	66	9.1	61	11.7	71	11.7
Ireland	326	37.5	218	28.8	195	24.1	202	19.7	183	15.9	175	19.5	142	19.6	113	21.8	152	25.1
Italy	59	6.7	50	6.6	31	3.8	69	6.7	83	7.2	52	5.8	52	7.2	46	8.8	55	9.1
Netherlands	83	9.5	1	0.1	82	10.1	107	10.4	109	9.5	74	8.2	55	7.6	36	6.9	29	4.8
Portugal	2	0.2	2	0.2	6	0.7	5	0.4	3	0.2	3	0.3	1	0.1	3	0.5	3	0.4
Spain	98	11.2	140	18.5	127	15.6	115	11.2	128	11.1	92	10.2	69	9.5	42	8.1	47	7.7
Scandinavia	9	1.0	14	1.8	14	1.7	26	2.5	23	2.0	14	1.5	19	2.6	11	2.1	29	4.8
Total	868	100	755	100	809	100	1023	100	1144	100	894	100	722	100	517	100	604	100

Table 8: Number of new entrants (full registration) per year from leading source countries in each geographical area outside UK or EEA

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
E.Europe																		
Poland	10	34.4	8	30.7	10	41.6	10	40.0	13	22.8	12	20.6	12	20.6	16	34.7	6	13.3
Subtotal	29		26		24		25		57		58		58		46		45	
Mid.East																		
Iraq	78	79.5	71	78.0	45	71.4	66	88.0	78	72.8	78	77.2	70	77.7	58	62.3	55	57.8
Subtotal	99		91		63		75		107		101		90		93		95	
N.Africa																		
Egypt	125	93.9	85	92.3	82	92.1	112	88.1	117	80.6	121	80.6	109	80.1	101	77.6	119	73.4
Subtotal	133		92		89		127		145		150		136		130		162	
S.Africa																		
South.Africa	170	60.0	194	62.9	213	64.3	223	55.8	229	50.3	273	50.9	205	50.2	142	50.3	224	49.8
Subtotal	283		308		331		399		455		536		408		282		449	
S.Asia																		
India	974	75.1	585	76.3	479	78.2	588	74.2	635	78.2	671	80.1	749	85.0	647	86.7	993	87.4
Subtotal	1296		766		612		792		812		837		881		746		1135	
Rest																		
Australia	252	50.5	249	52.3	202	46.3	219	50.3	186	43.2	171	48.8	177	46.8	125	52.9	156	46.5
Subtotal	499		476		436		435		430		350		378		263		335	

Subtotal = total number of doctors recruited from geographical area; % indicates percentage of subtotal for country

Table 9: Percentage of new entrants (full registration) remaining in workforce by number of years after entry

		UK	EEA	Rest of World
		N=22,259	N=2607	N=1483
% staying to year...	2	77.0	63.9	51.5
	3	60.9	39.3	29.5
	4	46.9	23.0	16.1
	5	29.5	14.4	9.9
	6	18.3	7.2	6.4
	7	12.5	3.0	3.6
	8	8.5	1.6	0.0
	9	5.3	1.6	-

Table 10: Percentage of a new entrants (full registration) leaving workforce by number of previous exits

		UK		EEA		Rest of World	
		N	% leaving	N	% leaving	N	% leaving
Number of previous exits	1	22259	25.5	2607	38.3	1483	46.2
	2	12516	43.3	1446	71.7	733	79.8
	3	6526	61.2	818	86.5	435	91.8
	4	3360	77.7	405	93.5	240	97.9
	5	1612	85.6	184	95.7	108	99.0
	6	666	91.9	76	97.4	36	100.0
	7	292	95.6	28	100.0	9	100.0
	8	99	95.9	13	100.0	1	100.0

Table 11: Destination in England (north, midlands, south) of new entrants by area of qualification

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
UK																		
North	1577	25.9	1618	26.9	1377	26.9	1403	26.0	1261	26.1	1292	26.4	1261	25.8	1047	27.2	1424	26.8
Mid	1163	19.1	1029	17.1	918	17.9	981	18.1	885	18.3	914	18.7	920	18.8	740	19.2	1086	20.4
South	3329	54.8	3349	55.8	2823	55.1	3008	55.7	2681	55.5	2656	54.3	2706	55.3	2049	53.4	2788	52.6
Total	6069		5996		5118		5392		4827		4862		4887		3836		5298	
EEA																		
North	128	23.8	177	27.2	204	27.5	210	24.1	242	23.6	139	18.7	191	28.0	130	25.2	158	13.9
Mid	98	18.2	108	16.6	134	18.1	162	18.6	169	16.5	135	18.2	108	15.8	88	17.1	280	24.7
South	310	57.8	364	56.0	402	54.3	497	57.1	611	59.7	467	63.0	382	56.0	296	57.5	515	45.4
Total	536		649		740		869		1022		741		681		514		1132	
Rest																		
North	379	25.3	390	24.7	296	20.9	420	24.8	464	26.1	492	25.2	453	24.6	376	24.1	557	31.9
Mid	271	18.0	298	18.8	258	18.2	330	19.5	311	17.5	394	20.2	409	22.2	364	23.4	453	26.0
South	848	56.6	889	56.3	860	60.8	940	55.6	997	56.2	1059	54.4	974	53.0	814	52.3	1185	68.0
Total	1498		1577		1414		1690		1772		1945		1837		1554		1742	

Note: Doctors with missing country of qualification and/or destination are excluded from table, as are doctors who located in Wales, a special authority or a special hospital
 %=percentage of total for area of qualification

Table 12: Destination in England (north, midlands, south) of new entrants who qualified outside UK and EEA (continued on next page)

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
E.Europe																		
North	34	37.7	3	13.6	2	11.1	7	29.1	14	28.0	19	35.1	14	23.3	11	23.9	14	31.8
Mid	18	20.0	4	18.1	2	11.1	8	33.3	8	16.0	5	9.2	12	20.0	8	17.3	7	15.9
South	38	42.2	15	68.1	14	77.2	9	37.5	28	56.0	30	55.5	34	56.6	27	58.6	23	52.2
Total	90		22		18		24		50		54		60		46		44	
Mid.East																		
North	25	37.8	18	20.9	11	19.6	24	28.5	24	24.4	20	22.7	16	19.0	22	23.9	26	27.6
Mid	12	18.1	15	17.4	13	23.2	10	11.9	12	12.2	12	13.6	16	19.0	19	20.6	16	17.0
South	29	43.9	53	61.6	32	57.1	50	59.5	62	63.2	56	63.6	52	61.9	51	55.4	52	55.3
Total	66		86		56		84		98		88		84		92		94	
N.Africa																		
North	3	21.4	24	29.2	25	32.8	38	32.4	52	42.6	37	27.0	37	29.1	38	29.4	35	21.7
Mid	2	14.2	19	23.1	10	13.1	21	17.9	18	14.7	40	29.1	38	29.9	31	24.0	38	23.6
South	9	64.2	39	47.5	41	53.9	58	49.5	52	42.6	60	43.7	52	40.9	60	46.5	88	54.6
Total	14		82		76		117		122		137		127		129		161	

Note: Doctors with missing country of qualification and/or destination are excluded from table, as are doctors who located in Wales, a special health authority or a special hospital.

%=percentage of total for region of qualification

Table 12: Continued

Source	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
S.Africa																		
North	49	22.3	70	22.3	51	16.5	63	17.1	60	16.0	99	19.3	85	21.2	64	18.4	77	17.5
Mid	38	17.3	55	17.5	61	19.7	95	25.8	64	17.0	104	20.3	78	19.5	67	19.3	64	14.5
South	132	60.2	188	60.0	197	63.7	210	57.0	251	66.9	308	60.2	237	59.2	216	62.2	299	67.9
Total	219		313		309		368		375		511		400		347		440	
S.Asia																		
North	219	25.9	220	31.4	164	28.7	235	32.4	243	33.1	232	29.5	283	34.9	211	28.3	337	29.7
Mid	166	19.6	155	22.1	123	21.5	144	19.8	145	19.7	171	21.8	205	25.3	209	28.1	280	24.7
South	459	54.3	325	46.4	283	49.6	346	17.7	346	47.1	381	48.5	370	45.7	323	43.4	515	45.4
Total	844		700		570		725		734		784		809		743		1132	
Rest																		
North	49	18.4	55	14.7	74	23.9	53	14.2	71	18.0	85	22.9	68	19.0	30	15.2	68	20.9
Mid	35	13.2	50	13.3	60	19.4	52	13.9	64	16.2	62	16.7	60	16.8	30	15.2	48	14.8
South	181	68.3	269	71.9	197	63.7	267	71.7	258	65.6	224	60.3	229	64.1	137	69.5	208	64.1
Total	265		374		309		372		393		371		357		197		324	

Note: Doctors with missing country of qualification and/or destination are excluded from table, as are doctors who located in Wales, a special health authority or a special hospital.

%=percentage of total for region of qualification

Table 13: Number of doctors with limited registration by area of qualification

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
	N	N	N	N	N	N	N	N	N	N
EEA	187	237	225	311	305	333	220	234	284	281
Rest	4135	4766	5142	5421	5720	5812	12	9	1219	27
Unknown	137	91	61	45	32	28	5334	5187	2249	4304
Total	4459	5094	5428	5777	6057	6177	5566	5430	3752	4612
% of whole workforce	5.0	5.5	5.8	6.1	6.2	6.2	5.7	5.4	4.6	4.7
% of overseas workforce	20.2	21.8	22.5	23.4	23.2	22.5	20.7	19.7	17.3	17.2

Table 14: Age, sex and ethnic distribution of doctors with limited registration

	1991		1992		1993		1994		1995		1996		1997		1998		1999		2000	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age																				
20-	981	22.0	1050	20.6	1074	19.8	1099	19.0	1161	19.2	1305	21.1	1326	23.8	1399	25.8	1068	28.5	1324	28.7
30-	2841	63.7	3338	65.5	3644	67.1	3883	67.2	3989	65.9	3940	63.8	3567	64.1	3354	61.8	2256	60.1	27551	59.6
40-	491	11.0	572	11.2	559	10.3	619	10.7	740	12.2	750	12.1	563	10.1	563	10.4	352	9.4	431	9.3
50-	118	2.6	107	2.1	125	2.3	126	2.2	129	2.1	147	2.4	95	1.7	92	1.7	69	1.8	86	1.9
60+	28	0.6	27	0.5	26	0.5	50	0.9	37	0.6	35	0.6	15	0.3	22	0.4	7	0.2	20	0.4
DK	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Sex																				
Male	3454	77.5	3964	77.8	4172	76.9	4370	75.6	4492	74.2	4592	74.3	4099	73.6	3916	72.1	2581	68.8	3017	65.4
Female	1005	22.5	1130	22.2	1256	23.1	1407	24.4	1565	25.8	1585	25.7	1467	26.4	1514	27.9	1171	31.2	1595	34.6
Ethnic																				
White			552	10.8	624	11.5	746	12.9	775	12.8	790	12.8	580	10.4	492	9.1	422	11.2	518	11.2
Black			861	16.9	957	17.5	1013	17.6	867	14.3	695	11.3	565	10.1	529	9.8	386	10.2	458	10.0
Asian			1998	39.2	2261	41.7	2516	43.6	2424	40.0	2733	44.2	2763	49.6	2732	50.4	2218	59.1	2770	60.1
Other			928	18.2	1087	20.0	1144	19.8	1072	17.7	1062	17.2	926	16.6	830	15.3	601	16.0	744	16.1
DK	4459	100	755	14.8	497	9.2	358	6.2	919	15.2	897	14.5	732	13.2	847	15.6	125	3.3	122	2.6
Total	4459		5094		5428		5777		6057		6177		5566		5430		3752		4612	

APPENDIX 3: LIST OF UK AND EU/OVERSEAS INTERVIEWS

UNITED KINGDOM

General Practice Focus

- Dr. David McKinlay, Directors of Postgraduate General Practice Training, NW Region
- Dr Arthur Hibble, Directors of Postgraduate General Practice Training, East Anglia Region
- Dr Frank Smith, Directors of Postgraduate General Practice Training, Wessex Region
- Dr. Philip Evans: WONCA Rep and current President of RCGP; Former Chair RCGP International Committee; Former Chair International Forum (of the Royal Colleges); Former RCGP representative to UEMO, and European Forum
- Dr John Howard: Chair International Committee, RCGP
- Clare Burden: Administrator, RCGP
- Katie Carter: Administrator, JCPTGP
- Dr John Toby: Chair of JCPTGP, lead on Education and Training; former Chair RCGP; also General Practices Committee and BMA

Medical Education and Deanery Hospital Focus

- COPMeD (Conference of Postgraduate Medical Deans), Vice-Chair, and Chair of the Associate Deans Overseas Doctors Group of the Council of Deans: Dr David Graham, Mersey Deanery.
- Joint Committee on Higher Surgical Training: Tara Willmott
- Joint Committee on Higher Medical Training: Nicholas Grant
- Mr. John Lourie: Associate Dean with Responsibility for Overseas Doctors, Oxford Deanery
- Dr. Maeve Kearney: Dean with Responsibility for Overseas Doctors, NW Deanery

Royal Colleges

- RC Psychiatrists: Dr Sally Pidd, Deputy Registrar, and Consultant at Victoria Hospital, Morecombe. Lead Assessor for College.
- RC Physicians: Jonathan Barnwell, Manager International Office
- RC Anaesthetists: Dr Anne Marie Rollin, Consultant and Lead Assessor, and David Bowman, Training and examinations Director.
- RC Pathologists: Dr Hugh Platt (telephone conversation).
- RC Pathologists: Dr. Robbie Bacchus: Overseas Adviser.
- RC Radiologists: Correspondence with President: Professor Peter Armstrong
- RC Surgeons: Tim MacBeth Bower, Administrator

Competent Authorities

- Ian Pocock; Head of Policy Unit, GMC
- Mary Ryan in charge of PLAB.
- Leslie Hawksworth: Chief Executive, STA
- Professor John Temple STA Chair

International Recruitment and NHS Employers

- Dr. Stephen Atherton: Seconded to NHSE full time for recruitment purposes
- Debbie Mellor: Section Head for Recruitment and Retention, NHSE
- Catherine Jenkins for recruitment of OD Consultants, NHSE.
- Jenny Watson: Policy lead on International doctor recruitment, NHSE.
- Lizzie Lowe, HR Division, NHSE
- Lyn McGill: National Sector Head NHS, TMP Worldwide
- Sue Jeffers: Response Management, TMP Worldwide
- Steve Griffin i/c Recruiting Locum Doctors, NHS Professionals Project (Telephone interview).

- NHS Confederation: Chair of HR Committee Mr Nigel Turner, HR Director, Royal Free Hospital, London.

Professional and Other Associations

- Dr. Edwin Borman, British Medical Association
- Frances Presley: Policy Officer, Association of Community Health Councils for England and Wales (Telephone interview)

EUROPEAN UNION

- Dr Robert Pochmarski, Regulated Professions Unit, DG Internal Market, European Commission
- Dr Grethe Aasved, President, Standing Committee of European Doctors (CPME)
- Dr Vincenzo Costigliola, President, European Medical Association (EMA)
- Dr Eduard Marques, Permanent Working Group of European Junior Doctors (Email contact)

UNITED STATES

- Ashish Bajaj, American Medical Association officer with responsibility for IMGs, and issues of national advocacy e.g. being able to move from State to State.
- David Sundwall, formerly Head of Health Resources and Services Administration (1980s), and former Chair of COGME (1997-2001).
- Marilyn Biviano, National Centre for Workforce Analysis
- Steve Tise, Director, Workforce Analysis Branch, Bureau of Health Professionals.
- Stephen Mick, Professor and Chair, Department of Health Administration, Virginia Commonwealth University.
- Lenny Baer, Lecturer in Geography, University of Lancaster (PhD on The Place of IMGs in Rural America (Publication due 2002).
- Oscar Gish, academic in the field of medical migration, Seattle.
- Fitzhugh Mullan, Director of Project Hope, an international medical relief organisation, and Emeritus Professor of Paediatrics.
- Abraham Verghese, IMG Physician and writer.

AUSTRALIA

- Commonwealth Department of Health and Aged Care: Stanford Harrison, (Medical Training Review Panel) and Workforce Distribution Programmes (including OTDs); Ingrid Singh, Workforce Distribution Programmes (including OTDs); Beth Slatyer, Director Workforce Strategies and Planning, with Mary-Ann McQuestin,
- Australian Institute of Health and Welfare, Warwick Conn, Senior Project Officer, and Glenice Taylor, Unit Head of Labour Force and Rural Health
- Department of Immigration and Multi-cultural Affairs (DIMA), Peter Job, Director Business Employment Unit, and Terry Walford, Business Employment Unit, dealing with the permanent entry of doctors
- Academic Unit of General Practice, University of Sydney, Canberra Clinical Centre, Professor Nicholas Glasgow
- NSW Rural Doctors Network, (RDN), Newcastle, NSW, Lisa McFayden

- Deputy Director Medical Services, Gosford, Hospital, NSW, Dr. Marie Kearney, and Dr David Doolan, Area Director for Central Coast Health
- Executive Director of Medical Service Management Team, Canberra Hospital, ACT, Joanna Holt, and Dr Rod Lambert, senior Medical Adviser
- Director of Medical Staffing, Western Hospital, Melbourne (in Manchester at recruitment day), Lilia Abolins
- AMWAC (Australian Medical Workforce Advisory Committee), Senior Planner, Paul Gavel
- Royal Australasian College of Physicians, Acting Director of Health Policy Unit, and Rural Workforce and Training Program, Dr Gary Disher, and Executive Officer, Boards of Censors, Department of Training, Colin Borg
- ADTOA (Association of Doctors Trained Overseas), Manal Kazawi, Secretary, and Dr Milos Balvin, National President
- Australian Medical Association (AMA), Gaye Doolan, Administrative Coordinator, Health Services, by correspondence
- Royal Australasian College of General Practitioners (RACGP) , Sue Phillips, by correspondence
- Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Kerren Clark, Assistant to CEO
- Royal Australian and New Zealand College of Psychiatrists, Liz Sarantos, by correspondence
- Royal Australasian College of General Practitioners, Deputy CEO WSDGP (District), NSW Representative RACGP Council, Di O'Halloran
- John Connell, University Researcher, for WHO (Manila) research on the migration of doctors and nurses in the Pacific region

SPAIN

- Dr Carlos Amaya Pombo, General Secretary CESM, and FEMS representative
- Dr Pedro Alcaida Guindo, Secretary of the Primary Care Sector CESM
- Dr Isabel Lopez, President of CESM, Madrid
- Dr Jose Martinez, Vice Director of the Institute of Health, Barcelona, Autonomous Government of Catalonia, delivering Continuing Medical Education for all Health Professionals
- Consuelo Questo, Consejo General, International Department
- Dr. Lago, Representative of the Unemployed Doctors, Madrid College of Physicians
- Dr. Javier Martinez, Regional Manager in Madrid for HLSP Consulting (Health and Life Sciences), and Institute for Health Sector Development
- Professor Margarita Baron Maldonado, Prof of Physiology, University de Alcala de Henares, Madrid, and President of AMEE
- Professor Josep Antoni Bombi, Professor of Pathology, Dean of the Medical School, University of Barcelona, and President of the National Confederation of Deans of Medical Faculties
- Emilia Sanchez, Ministry of Health (meeting and email contact)

POLAND

- Senator Marek Balicki, Chair of the Social Policy and Health Committee in Senate of Polish Parliament.
- Deputy Director Boguslaw Suski, Department of EU Integration and International Relations of the Ministry of Health and Social Welfare.

- Professor Janusz Wasyluk and Dr Zbigniew Wegrzyn, Head and Deputy Head of Department of Medical Education, Medical Centre for Post-graduate Education, Warsaw.
- Professor Jerzy Leowski, Head of Department Public Health, Medical Centre for Post-graduate Education, Warsaw.
- Professor Jerzy Polanski, Medical University of Warsaw (English Division)
- Professor Hanna Stypulkowska-Misiurewicz, Professor of Medical Microbiology, National Institute of Hygiene, Warsaw; and International Relations Officer, Polish Medical Association
- Professor Adam Windak, Head of Department of Family Medicine, Jagiellonian University, Krakow; and President of The College of Family Physicians in Poland.
- Dr Tomasz Tomasik, Lecturer, Department of Family Medicine, Jagiellonian University, Krakow.
- Professor Andrzej Wiecek, Department of Nephrology and EU Relations Representative, Silesian Medical University, Katowice.
- Dr Radziwill, Chairman and Justyna Chusc, International and EU Integration Department of the Polish National Chamber of Physicians, Surgeons and Dentists
- Dr Jan Maria Cieckiewicz, President and Jerzy Fiediger, Administrator, Regional Chamber of Physicians in Krakow
- Dr Ewa Zydowicz-Mucha, Director (Obstetrics and Gynaecology (Specialist); and Dr Lucyna Mryszczuk, Vice Director of Medical Activities (Gastroenterology Specialist), Bielanski Hospital, Warsaw
- Robin Rickard, Deputy Director and Ewa Puzdrowska, The British Council, Warsaw
- Dr Krzysztof P. Jasiutowicz, Coordinator, Polish Healthcare Website (Email contact).

INDIA

- Department for International Development (DFID), Delhi, Tim Martineau, Senior Health Adviser.
- WHO, Delhi, Sunil Nandraj, National Professional Officer, Evidence and Information for Policy.
- British High Commission (BHC), Peter Holland, First Secretary, Political, (and former health administrator in Lambeth).
- BHC/ Visa Section, Tom Burke, Steve Burns
- Ministry of Health, Department of Medical Education, S.K. Rao
- All India Institute of Medical Science (AIIMS) Professor Kaul/Anaesthetist
- University of Delhi, Faculty of Management Studies, Dr. Venkat Raman, undertaking work on Employment Conditions of Rural Doctors
- Institute of Health Research, Delhi, Dr. Srinath Reddy, Professor/Consultant Cardiologist at AIIMS, and seconded onto a research project for WHO.
- Indian Medical Association (IMA), Delhi, General Manager, Dev Mehra.
- Voluntary Health Association of India (VHAI), (Delhi), Dr. Pramesh Bhatnagar, Director, Community Health.
- Postgraduate Institute of Medical Education and Research, Chandigarh, Professor Pramila Chari, Consultant Anaesthesiologist (1994 President of Indian Society of Anaesthesia).
- Indian Institute of Health Management Research, (IIHMR), (Jaipur, Rajasthan), Director Dr. S.D.Gupta.
- Rajasthan Government Health Department, Directorate of Medical Health and Family Welfare Services, Mahendra Surana
- Registrar of Rajasthan Medical Council, Dr. Rameshwar Sharma
- General Manager/ Operations, Batra Hospital and Medical Research Centre, (private, small, family run), Gulshan Baweja (notes only)

- University Medical Centre, Manipal Deemed University, H.S. Bhat, Management Executive (notes only).
- Dr. Nobbojit Roy, member of the 'Ethical Cell' of doctors, (Mumbai) consultant surgeon, trained UK.
- Tata Memorial Hospital, (Tertiary Cancer Hospital) (Mumbai), Dr. Parul Shukla, Consultant Surgeon, trained in UK.
- Hinduja National Hospital and Medical Research Centre, (Mumbai)(private), Dr Manju Butani, anaesthetist., Dr. R. G. Shirahatti, Director of Professional Services (and former Dean of KES Medical School), informal conversations with doctors (notes only).
- Jaslok Hospital, (private) Dr. Sanjay Nagral, 'Ethical Cell'/ Journal Editor
- CEHAT, Centre for Enquiry into Health and allied Themes, Director Dr. Ravi Duggal,
- St John's Medical School, Bangalore, Dean Dr Mary Ollapally
- M.S.Ramaiah Medical College and Hospital (private), Principal and Dean, Dr. Sandhya Belwadi, Anaesthetist and Registrar of Admissions, Dr. Thota., Dr Philip Raj, neurology.
- Community Health Cell, Bangalore. Dr. Ravi Narayan, and Dr. Francis, Medical Education Curriculum and Commercialisation concerns.
- Mallya Hospital (private), Bangalore Dr.K.C. Janardhan,, Consultant General Internist, UK trained.
- Radjiv Gandhi University, Bangalore Dr. Gawda, Registrar of the overarching Body for Medical Education in the State.
- Apollo Hospital, private flagship hospital, (Chennai), Senior Vice-President/ Medical, Dr. Premkumar.
- Apollo Hospital, private flagship hospital, (Chennai), Dr. Chakravarthy, i/c RCS Edinburgh Examinations and training, Dr. M. Baskaran, Medical Administrator, Emergency Services, Dr. C. P. Dilip Kumar, Dept. of Accident and Emergency.
- Senior Doctors and Medical College Office Bearers, (Chennai) Dr. Balankrishnan Consultant anaesthesiologist, examiner, Dr. B.S. Tiruvadanam, Consultant Surgeon& Gastroenterologist, Sundaravadanan Nursing Home (Endoscopy and Intensive Care), Dr. K. Na. Parimelazhagan, Cardio Thoracic (private), and former Head of Dept at Madras Medical College, Professor T. Gunasagaran, HOD Surgery, Madras Medical College, and Hon secretary of the Association of Surgeons of India.
- JIPMER, (Pondicherry), Dr. Ravishankar, Professor and Head of Anaesthesiology.
- Kanchi Kamakoti Child Trust hospital, (Chennai), Dr. S. Balasubramanian, Consultant Paediatrician, Dr. Shanmughasundharam, neonatologist (notes only)
- Sri Ramachandra Medical College (private), (Chennai), Dean Dr Soma Sundaram
- Kilpauk Government Medical College, (Chennai), Dean Dr. Bennett.
- Tamil Nadu State Indian Medical Association (IMA) Hon. Secretary, Dr M. Balasubramanian, Professor C.M.K.Reddy (formerly of Madras Medical College, and Chair of the Board of Studies), private practice at Halsted Surgical Clinic as a general, laparoscopic and vascular surgeon.
- Dr. Abraham Verghese, Professor of Medicine, Department of Internal Medicine, Texas Tech at El Paso, a graduate of Madras Medical College and autobiographical writer (Telephone Interview).

Focus Groups

- Focus Group 1 Chennai postgraduates, anaesthetists plus other disciplines (n=12)
- Focus Group 2 Chennai postgraduates, anaesthetists plus other disciplines (n=25)
- Focus Group 3 PGI, Chandigarh, postgraduate anaesthetists (n=6)
- Focus Group 4 PGI, Chandigarh, postgraduate anaesthetists (n=6)
- Focus Group 5 JIPMER, Pondicherry, postgraduate anaesthetists (n=65)
- Focus Group 6 JIPMER, Pondicherry, postgraduate anaesthetists (n=6)
- Group discussion with primary care doctors on a management course at IIHMR, Jaipur, from Dhosa rural district, Rajasthan.

APPENDIX 4: GLOSARY OF TERMS FOR UK AND EU//OVERSEAS COUNTRY REPORTS

UNITED KINGDOM

BMA	British Medical Association, the main body representing doctors' professional interests
CCST	Certificate of Completion of Specialist Training, awarded on the successful completion of a Specialist Registrar (SpR) training programme
CME	Continuing Medical Education
CPD	Continuing professional development
EEA	European Economic Area, an area wider than the EU, where member States enjoy some of the benefits of membership, such as the mutual recognition of medical qualifications.
EU	European Union
GMC	General Medical Council, the competent authority for the registration of medical practitioners
GPs	General practitioners
JCPTGP	Joint Committee on Postgraduate Training for General Practice awards a certificate following the successful completion of 3-years vocational training in the UK. EEA citizens, who have a primary medical qualification from within the EEA and have fulfilled member countries' vocational training requirements, have automatic recognition. Other overseas doctors may gain a certificate on the grounds of equivalent training and experience, but are likely to first be asked to complete a period of additional training
MADEL	Medical and Dental Education Levy, dedicated finance used by Deaneries for the funding of postgraduate training programmes
MCQ	Multiple choice questions, the format of the written medical examinations used by all countries to screen overseas trained doctors, and in Part 1 of the UK PLAB examination
MRCP	Membership of the Royal College of Physicians, following success in Parts 1 and 2 of the examinations, usually taken during the SHO training period. The qualification is regarded as a requirement for entry to an SpR training post
MRCS	Membership of the Royal College of Surgeons, following success in Parts 1 and 2 of the examinations, usually taken during the SHO training period. The qualification is regarded as a requirement for entry to an SpR training post. Until recently, the qualification gained at this stage was called the FRCS, or Fellowship of the Royal College of Surgeons. This was highly prized as an 'exit' qualification by overseas doctors training in the UK, gaining access to prestigious jobs on their return home.
NACPME	National Advice Centre for Postgraduate Medical Education, based at the British Council in Manchester
OSCE	Objective structured clinical examination, the second part of the PLAB examination, consisting of 12 'stations' presenting clinical scenarios, which are assessed by an observing doctor
PLAB	Professional and Linguistic Assessment Board, the screening examination set by the GMC for overseas trained doctors wishing to obtain registration to train or practice in the UK. The examination is in 2 parts, the first the MCQ written examination, which may be taken either at centres in the UK, or abroad (where it is administered by the British Council), and the second part, the OSCE, only available at centres in the UK
PRHO	Pre-Registration House Officer, a doctor serving a probationary year following graduation from a UK medical school, before proceeding to full registration. This year is equivalent to the 'Intern' year in the US, and to the PGY1 in Australia.
RITAs	Records of In-service Training Assessments, used as evidence in progression towards a CCST

SHO	Senior House Officer, the junior doctor training grade between PRHO and SpR
SpR	Specialist Registrar. There is limited and competitive entry to this training grade, with National Training Numbers allocated according to workforce planning for future consultant requirements
STA	Specialist Training Authority of the medical Royal Colleges

UNITED STATES

AAMC	Association of American Medical Colleges
ACGME	Accreditation Commission on Graduate Medical Education, decides the overall number and allocation of first year Residency programme slots
AMA	American Medical Association, the main body representing doctors' professional interests
AOA	American Osteopathic Association, the body with oversight of the
BBA	Balanced Budget Act 1997
BBRA	Balanced Budget Refinement Act 1999
BHPr	Bureau of Health Professions, a branch of the Federal Health Resources and Services Administration
CHCs	Community Health Centers (Clinics)
CHMSA	Critical Health Manpower Shortage Area
CME	Continuing medical education, equal to Continuing professional development (CPD) in the UK
COGME	Council on Graduate Medical Education, established in 1983 with a brief to examine graduate medical education issues within the wider health policy context, and report to the legislature and the Secretary for Health and Human Services.
CSA	Clinical Skills Assessment is the practical skills examination component of the entry qualification for International Medical Graduates
DME	Direct costs of medical education
DHHS	Department of Health and Human Services
ECFMG	Educational Commission for Foreign Medical Graduates
FMGs	Foreign Medical Graduates, now more often referred to as International Medical Graduates, although the ECFMG retains its title
FPs	Family physicians
GME	Graduate medical education
GMENAC	Graduate Medical Education National Advisory Commission
HMO	Health maintenance organization
HPSA	Health Professional Shortage Areas
IME	Indirect costs of medical education
IMGs	International medical graduates, previously referred to as FMGs
MD	Primary Medical Qualification for Allopathic medical education
MUA/Ps	Medically Underserved Areas and Populations
NHSC	National Health Service Corps, providing workforce for MUA/Ps through incentive schemes for physicians
NPs	Nurse practitioners, often undertaking roles previously occupied by doctors, especially in MUA/Ps
NRMP	National Resident Matching Program, the annual 'Match' through which Residency training programmes are progressively filled in successive rounds
PAs	Physician assistants, similar to nurse practitioners
TOEFL	Test of English as a Foreign Language
USIA	US Information Agency
USMG	US medical graduate

USMLE	United States Medical Licensing Examination, the 3-part examination, plus CSA, which IMGs must pass before they can be licensed
VA	Veterans Administration

AUSTRALIA

ACCC	Australian Competition and Consumer Commission (the equivalent of the UK Monopolies Commission). The health system has recently been under the scrutiny of the ACCC, following allegations of restrictive practices by various medical bodies
ACT	Australian Capital Territory, with Canberra as its capital, and the seat of Commonwealth Government
ADTOA	Australian Doctors Trained Overseas Association, a lobby group of doctors who have Australian residency rights, or citizenship, but whose primary or specialist medical qualification is from overseas. They face similar difficulties as UK refugee doctors in gaining access to training, registration and work
AIHW	Australian Institute of Health and Welfare, a statutory Commonwealth Government body, with core funding and research independence, collating data and reporting information Australia's health needs and services, and an evaluation of health policies and programmes, every two years. Data are obtained from a number of different sources, which include: data from its own survey or census form, sent out with the annual registration renewal form; State and Territory Medical Registration Boards (see MRB); Australian Medical Publishing (which annually publishes self-provided information on doctors); and immigration data.
AMA	Australian Medical Association, the body representing doctors' professional interests
AMC	Australian Medical Council, the apex body for medical registration (funded by the State and Territory Medical Registration Boards, whose chairs serve on the Council). The body has overall responsibility for the curriculum, quality and standards of primary medical education. Through the AMC examinations, the AMC is also responsible for the examination and assessment of overseas trained doctors who wish to work permanently in the Australian system. The AMC also regulates access to the Specialist Register, on the recommendations of the Royal/Learned specialist Colleges.
AMWAC	Australian Medical Workforce Advisory Committee, a standing committee established in 1996, which advises the Commonwealth Government on both specialist and overall medical workforce planning
AoN	Area of Need, or area of workforce shortage, usually a rural or remote area, where the regulations allow overseas trained doctors to obtain registration to work. See TRDs
CPMC	Committee of Presidents of Medical Colleges
CDHAC	Commonwealth Department of Health and Aged Care, the Australian equivalent of the UK Department of Health, responsible for federal /Commonwealth policy development, and for liaison with the State and Territory Ministries of Health, which bear the authority for the delivery of healthcare
CME	Continuing Medical Education, seen as important, not only in its own right, but as an essential element in the policies to retain GPs and other doctors in rural and remote areas
DIMA	Department of Immigration and Multicultural Affairs, supplying data on the flows of medical migration

HIC	Health Insurance Commission, established in 1984, which operates the Commonwealth Government Health Insurance Scheme, Medicare. It grants a Provider Number to doctors, which enables them to bill for Medicare payments. An unrestricted Provider Number is necessary to be able to choose a practice location. Most OTDs only have access to a restricted Provider Number, limiting its use to a particular time and place. Since 1996, Australian trained doctors must also have a specialist or vocational qualification in order to access an unrestricted provider number
HMO	Hospital Medical Officers include doctors who are not specialists, or in a specialty training position. They may be HMOs, (PGY1, 2, 3) or senior HSMOs (with a total of 5 possible incremental pay points on the scale)
ICU	Intensive Care Unit
MB	Bachelor of Medicine, the Australian primary medical qualification
Medicare	Commonwealth Government Health Insurance Scheme, with patients claiming a Rebate following a fee-for-service consultation, or doctors 'bulk-billing' the HIC on behalf of elderly or vulnerable patients who receive treatment free at the point of service, and this accounts for 80% of Medicare services
MRB	Medical Registration Boards, for each State and Territory
MTRP	Medical Training Review Panel
NSW	New South Wales
NT	Northern Territory
OTD	Overseas Trained Doctor
PGY	Postgraduate year
PGMTB	Postgraduate Medical Training Boards (of the States and Territories) responsible for the provision and funding of postgraduate training places, as centrally advised
PIP	Practice Incentive Program
QLD	Queensland
RACGP	Royal Australian College of General Practitioners, includes members from both Australia and New Zealand
RACP	Royal Australasian College of Physicians, includes members from both Australia and New Zealand
RARA	Rural and Remote Areas classification
RDN	Rural Doctors Network, the New South Wales State recruitment and support organisation, for rural and remote areas of workforce shortage
RRMA	Rural Remote Metropolitan Areas classification
SA	South Australia
TAS	Tasmania
TRDs	Temporary resident doctors. Most overseas doctors working in Australia come into this category, and have a fixed period of Conditional registration, specific to a particular job
VIC	Victoria
WA	Western Australia
WACCRAM	Western Australia Centre for Rural and Remote Medicine, the State body recruiting doctors to remote and rural areas
WONCA	World Organisation of National Colleges and Academics of General Practice (now called the World Organisation of Family Doctors)

SPAIN

AMEE	Association for Medical Education in Europe
CA	Comunidades Autonomas, or the 17 Autonomous Communities /regions, with strong decentralised parliamentary government, and recently increased responsibility for health and social care
CESM	Confederacion Estatal de Sindicatos Medicos, (State Confederation of Medical Unions), the equivalent of the UK BMA
CNDME	Spanish National Association of Deans of Medical Schools
COLEGIOS	The 52 regional Colleges responsible for the local registration of doctors
CONSEJO	The Consejo General de Colegios Medicos de Espana, or the General Council of Medical Colleges, the equivalent of the GMC as the 'Competent Authority' in Spain
EAP	Equipo de Atencion Primaria, or primary care teams working in Primary Health Centres
FEMS	European Federation of Salaried Doctors, (lobbying for German recognition of UK GP training)
INSALUD	Instituto Nacional de la Salud, National Institute of Health, for the administration of public health
LRU	Ley de Reforma Universitaria, guaranteeing University Autonomy in 1983
Mestos	Specialist Doctors without Title, or official qualification
Ministerio de Sanidad y Consumo	Ministry of Health and Consumer Affairs
MIR	Medical Internal Residency examination, the competitive examination for entry into postgraduate training, with a separate exam for primary care and hospital specialties
OMC	Organizacion Medica Colegial, the separate political body of the Consejo General, representing Colleges' interests
PP	Popular Party, a centre right political party which came to power in 1996, re-elected in 2000
PSOE	Partido Socialista Obrero Espanol, the socialist political party, which came to power in 1982
UCD	The Union de Centro Democratico, a centre-right political party, which came to power after Franco
UEMO	European Union of Medical Practitioners
UEMS	European Union of Medical Specialists
SEMFYC	The Spanish Society of Family and Community Medicine, the lobby group of trained GPs
SESPAS	Spanish Society of Public Health and Health Management

POLAND

ASTB	Admission for Specialist Training Board
CMKP	Centrum Medyczne Kształcenia Podyplomowego (Medical Centre of Postgraduate Education)
KLRP	Kolegium Lekarzy Rodzinnych Polska (The College of Family Physicians in Poland)
MZ	Ministerstwo Zdowia (Ministry of Health)
NIL	Naczelna Izba Lekarska (National Chamber of Physicians and Dentists & Supreme Medical Council)
OIL	Okregowa Izba Lekarska (Regional Chambers of Physicians and Dentists)
PTL	Polskie Towarzystwo Lekarski (Polish Medical Association)
Sejm	Upper House of Parliament (which has Social Policy and Health Committee)
Senat	Lower House of Parliament

INDIA

APPs	Alternative Private Practitioners, who may be qualified in alternative systems of medicine, or unqualified 'quacks'
CEHAT	Centre for Enquiry into Health and Allied Themes
CGHS	Central Government Health Scheme, health insurance covering 4.4 million government employees
CHC	Community Health Centres, the next tier up from Primary Health Centres Community Health Cell, an affiliation of doctors promoting the importance of investment in community based medicine, based in Mumbai
ESIS	Employees state insurance scheme, covering 35.4 million low-income industrial workers and their families
GIS	General insurance corporation scheme, covering 1.7 million urban poor
ICRIER	Indian Council for Research on International Economic Relations
IIHMR	Indian Institute for Health Management Research, Jaipur, Rajasthan
IRDA	Insurance Regulatory and Development Authority, established in 1998 to regulate provision and encourage efficiency and quality provision
NGO	Non-government organisations, involved in the delivery of health care and poverty reduction, and operating with their own lines of management and accountability, alongside those of Indian States
NIHFW	National Institute of Health and Family Welfare
NRIs	Non-resident Indians, a term applied to Indians living abroad, but retaining cultural and family links with India, who often contribute financially to those remaining. Inflows of financial and intellectual capital from NRIs have been behind recent economic growth, both in the computer software industry and in the field of advanced medical services
Panchayati Raj	The local district level tier of government. Devolution of control to this level appears to be associated with better health outcomes
PHCs	Primary Health Centres, the first tier of service delivery, mainly involved in family planning and immunization services
TPAs	Third Party Administrators, between insurers and service providers in India, resembling HMOs in America in terms of function
UNDP	United Nations Development Programme
UNHDI	The United Nations Human Development Index, measuring a broad spectrum of indicators, including life expectancy, education, and GDP
VHAI	Voluntary Health Association of India

COUNTRY REPORT 1 – THE USA

Country Report for the USA

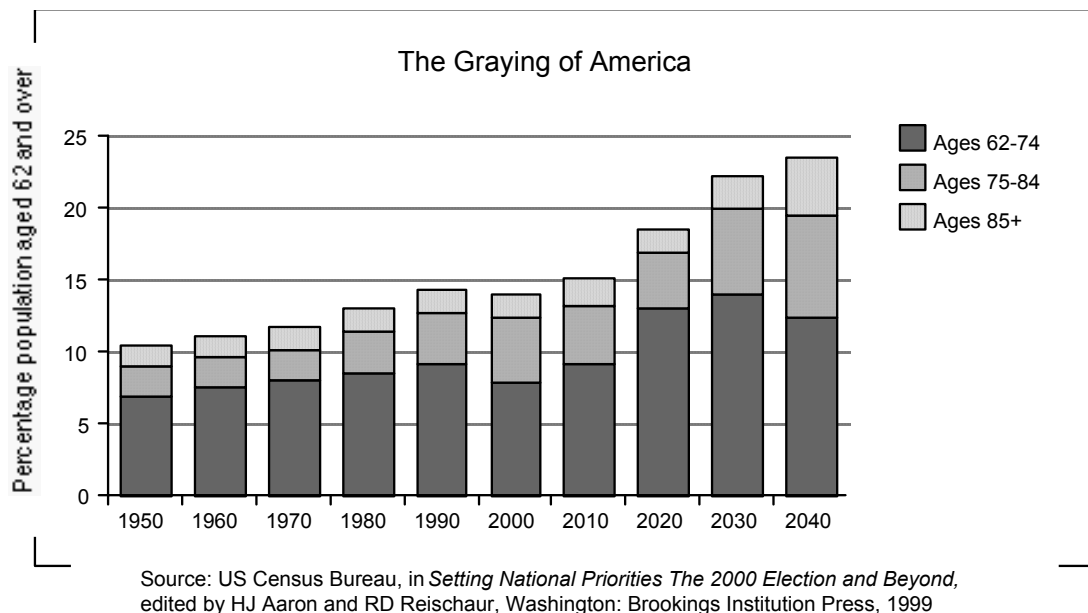
1.General Background

Economy and Population

The U.S. leads the world in terms of its economic stage of development, standard of living as measured by per capita GDP. The wealth of the nation is reflected in expenditure on health care, also the highest in the world, and accounting for 1/7th of the economy. At \$1.25 trillion per annum this equalled 14% of GDP in 1998, and is forecast to grow to between 16-18% by 2010 (COGME IMG 1998). In 1960 health care expenditure was 5% of GDP.

The population is ageing. In 1975, 10.5% of the population was aged 65 years and above, and by 2020 it will be 16.5% (Figure 1).

Figure 1: USA Population Age Projections to 2040



This age profile has implications for expenditure, as average health care costs triple for those 65+, and triple again for those 85+. It also has implications for the ratio of the working: dependent population, and so for funding of health care. For example, in 1965, when Federal funding for Medicare healthcare insurance (for the over 65 year olds) was established, there were 5.5 people of working age to every one 65+ year old. It is estimated that by 2030 there will only be 2.2:1, and that the percentage of the population in the Medicare system will have doubled the current participation level, to 20%. The population profile thus has implications for taxation, the public purse, and health policy, particularly at a time of economic downturn, bordering on recession.

Economic downturn, along with the ageing population, also has a negative effect on employers' ability to fund the insurance health care benefits of their current and retired employees. Rising insurance costs are seen as an uncompetitive burden on private industry, in a global environment where competitors from other countries with social insurance systems do not bear such costs directly.

In the current political climate post 9/11, the national focus in terms of both time and money, is on investment into anti-terrorism, and on tax rebates to stimulate the economy. Making economies in the health care budget is regarded as a priority.

2. The Health Sector

The Nature of the Health System Model

The US health system model is as near a competitive market situation as it gets any where in the world. The sector is subject to Federal Anti-Trust Laws, which operate to combat any potentially monopolistic or anti-competitive practices. The planning, oversight and regulatory functions of the Federal government have been relatively weak up to now. Also, the professional organisation, the American Medical Association (AMA),

“Is very cautious about talking about workforce [because of the Anti-Trust laws] because they don’t want to be accused of controlling the number of physicians because that’s against the law.” (US Int 1).

Federal health policy is mainly in the area of recommendations to States, which bear the responsibility for licensing of physicians, and delivery of care. One major Federal source of recommendations is the Council on Graduate Medical Education (COGME), established in 1983 with a brief to examine graduate medical education issues within the wider health policy context, and report to the legislature and the Secretary for Health and Human Services. This is an important body because graduate medical education (GME), both in terms of the numbers in training, and the mechanisms of funding the training, holds the key to the future workforce. Explicit inter-related COGME goals include: reducing the rate of growth in the supply of doctors; increasing the number of generalists; increasing the diversity of the workforce, in terms of minority participation; promoting a rational system of workforce planning; and preserving safety-net provision (COGME 1998). Other Federal bodies involved in health policy formulation are the Bureau of Health Professions, (BHPr) a branch of the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services. The central overarching approach to workforce planning could be said to be one of providing accurate and up-to-date information, relevant to demand and supply issues, that enables the market in health services to respond effectively. It is acknowledged that there is insufficient accurate data to fulfil this task (Am Int 2,3,4).

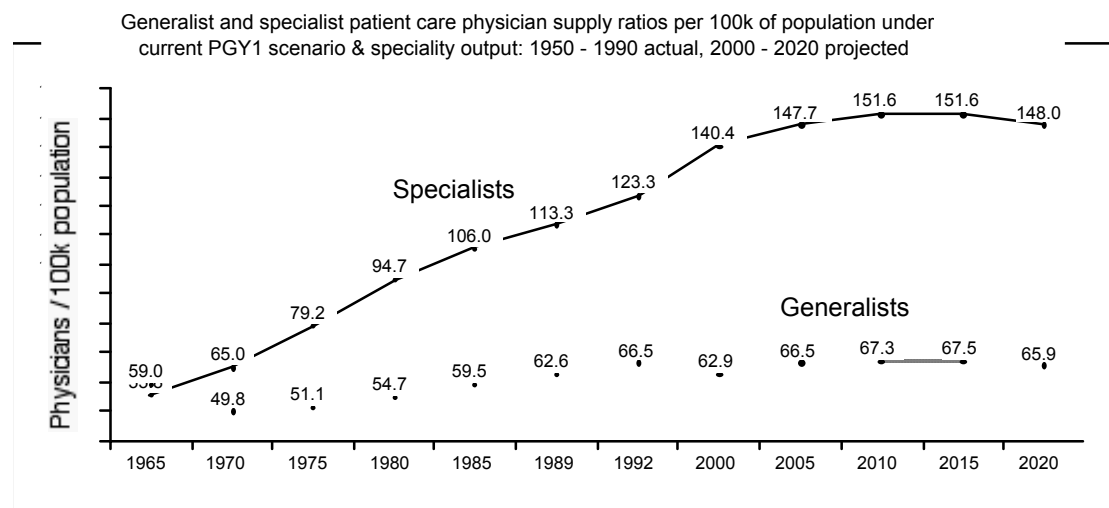
Physicians are mostly private independent practitioners functioning from private offices, mainly as group partnerships rather than as solo practitioners. They contract with third party payers to provide services to patients, and also contract with hospitals, both public and private, to provide services. Payment is through reimbursement from third party payers, such as private for-profit insurance companies (40%), or through public funds (40%) such as Medicare and State Medicaid for the poor. 20% (44million) of the population is uninsured, but does not fall within the Medicaid safety-net provision. Simple fee-for-service payments are increasingly being replaced with managed care plans, run by Health Management Organisations (HMOs). Payment under a managed care plan is by ‘Capitated Care’, whereby the provider is reimbursed at a fixed fee per insured person (per capita) for all their care. This has the effect of moving the risk from the insurer to the provider, and introduces competition over the price of services, thus reducing costs to the payer. By 1998 only 14% of people covered under insurance provided by their employer were still in conventional fee-for-service schemes. The growth of managed care, intense competition and the ‘bottom line’, together with an adequate supply of physicians, have the combined effect of driving down payments to providers. Increases in managed care have also reduced hospital utilisation, shifting more services from in-patient settings to cheaper ambulatory settings.

The Nature of the Delivery Model

Primary/Secondary Care Mix

The long-term trend in the delivery of health care has been for it to become increasingly specialist/secondary care focused since 1965. At that time there were more primary care physicians per 100,000 population (59) than specialists (55.8) (Figure 2). Primary care physicians include general internists and paediatricians as well as general practitioners/family practitioners (GP/FP). The primary care physician: population ratio has more recently (since the 1970s) been between 50-60: per 100,000 but falls short of the COGME recommended range of 60-80 generalists per 100,000. The ratio of GPs/FPs to population is 30:100,000, with an older age profile than other branches of medicine, at 16.2% of active physicians over age 65 years (compared with 10.1% of all active physicians). Meanwhile the specialist: population ratio has tripled. Currently the mix is 70% of care being delivered in specialist settings, and 30% in primary care settings.

Figure 2: The Generalist and Specialist Physician Supply 1965 projected to 2020, based on 1997 data



Source: 1950-1990 data adjusted by BHP from AMA Physician Masterfile and unpublished data. Projections from BHP Physician Supply Model in COGME 1997.

The trend towards increased specialist care has partly been fuelled by increased societal wealth, and advancing technologies. The morbidity profile of an ageing, and increasingly educated population, also makes higher demands in terms of access to specialist treatment.

Concern about this trend has led to several COGME Reports during the 1990s recommending policy moves to shift the balance of delivery towards primary care in an ambulatory setting, with the target of 50:50 primary: specialist physicians. A policy shift towards more primary care in ambulatory settings has also been driven by reductions in inpatient hospital care and shorter length of stay in hospitals, as a result of cost reductions by HMOs. The encouragement of more family practice Residency programmes in the 1990s had the effect of increasing the number graduating annually by 1000-1,500. A comparison for the total FP graduates for 1992 with 1999 showed a 52% increase (COGME 2000b). However, the numbers entering training had begun to drop back by 1998/9, with 230 fewer trainees.

“Interest in family practice appears to be diminishing and hospitals may have less motivation to maintain such residency positions because of reduced Medicare GME funding. (This diminished interest may be evidenced by the results of the national Resident Matching Program (NRMP). Positions filled in family practice by US medical students have declined

from the prior year in each of the three consecutive years from 1998 to 2000". (COGME 2000b, p 5.)

In 2000, approximately one third of allopathic doctors, and half of all osteopathic doctors in training were in primary care disciplines. However, despite the policy drivers towards more primary care delivery, there are dissenting voices. Some suggest that the pressure for more specialist provision is market driven.

"There is less market for primary care physicians than many think. Those going into primary care from the house staff can't find jobs. Medical schools have been sold on a direction which conflicts with the market and the reality of medical practice." (Weisfeldt, M., Prof. Of Medicine and Chair of Dept. of Medicine, Columbia University College of Physicians and surgeons and New York Presbyterian Hospital, quoted in Raymond 1999).

There is an argument, expounded Cooper et al (2002), that the trend towards increasing specialist care is inevitable, and that there is an inexorable link between income growth and specialist physician growth.

"Economic expansion and the growth of health care are inextricably linked. It is unlikely that government or professional regulation of physician output will change that relationship. It just doesn't work to say no." (quoted in Raymond 1999).

Others question whether increasing primary care provision on the grounds of increasing cost-effectiveness and greater efficiency creates the best delivery model for an ageing population. For some age-associated morbidities, such as diabetes, heart, lung, and kidney diseases, specialist care may be better a better delivery model, and a primary care gatekeeper role may be seen as a barrier to access rather than 'tailored access to specialty care' (Raymond 1999). This has been acknowledged in recent moves by managed care plans to include the option of self-referral to specialist-delivered care, and is partly in response to consumer concerns about reduced choice and quality of care when the focus is on cost containment rather than on patient need. On the other hand, research evidence, (quoted by Grumbach 2002), suggests that a greater supply of specialists is not associated with better population health, whereas a greater supply of primary care physicians is associated in general with lower mortality rates. However, the opinion of our interviewees (US Int 2, 4, 8) was that market forces would continue to drive up the demand for specialist care.

"The focus is now on, on that we possibly have enough doctors in the aggregate but that we need to better address the specialty mix, and given the ageing of our population we may need more specialists and less primary care physicians because much of what primary care doctors have done in this country is being done by nurse practitioners and physician assistants."....."as the population ages, and while primary care remains important, people are living longer with chronic illness and the technology to take care of those people is more complicated, feeling, you know, the impression is we're gonna need more specialist care..." (US Int 2).

The practise [of high-tech medicine] always seems to open up new opportunities, and expand forever, it's sort of an overarching factor, the need for new input, new personnel input. ... Then there's the appetite of the American public for more and more care. And you know we have so much advertising in this country...ads that talk about prescriptions that you really must talk to your doctor about, or a new therapy that you are to avail yourself of.... ...That just continues to add to the suction, bringing folks over." (US Int 4)

There thus appears to be a tussle between market forces, driving up demand for specialist care, and policy makers and payers arguing for interventions to further the 'public good' aspects of health care by increasing primary care. Arguments for greater equity, a stronger focus on preventive medicine and public health, and more generalist provision, coincide with the financial requirement to prune spending.

Organisational Form and Reform

The first driver for reform in the health care delivery system is the need, in common with most Western economies, to curtail the spiralling costs of health care. Federal government has an interest in this as the funding source, through taxation, of Medicare payments equal to 20% of total health expenditure. State governments have an interest as the funding source of Medicaid. Private insurers have an interest in their bottom line. The second related issue is the rising number of physicians in the workforce, and the question of whether the increased physician to population ratio is justifiable in terms of cost, efficiency and health outcomes. Related to the physician increase is the issue of the role of international medical graduates (IMGs) in the workforce. As the number of US trained medical graduates (USMGs) has remained more or less stable for the last 10 years or so, the increase in workforce numbers is attributed to increased inflows of IMGs. The role of IMGs in the workforce is therefore central to the wider discussion on policy reform, and has been the subject of several studies, notably COGME Reports (1995, 1997, 1998). We will return to this issue later, particularly as it is central to an evaluation of the international medical labour market.

3. Domestic Supply and Demand Issues

Increase in Overall Physician Supply

The number of physicians in the workforce has risen at a faster rate than the population, although the rate of increase has slowed recently. As we saw above, the increase has been greater for specialists than for primary care physicians. According to HRSA (2000), there were 577,000 practising doctors in 1998, but Cooper quotes a figure of 772,000 active physicians in 2000, or 270 per 100,000 population (Cooper 2002). The American Medical Association (AMA) (personal communication 2002) has 822,600 active and retired physicians on its database.

The question of what numbers are required, whether there is a surplus, a sufficiency, or shortage of doctors in the US health system has been thoroughly debated in the last half century. Depending on the outcome at any one time, corresponding shifts have occurred in the domestic supply of doctors, through the creation and expansion, or contraction, of medical schools, through the general agreement of the key stakeholders. Between 1956 and 1980, the number of medical schools increased from 84 to 127 (2/3rd of them public, and 1/3rd private), and the number of graduates doubled from 8,000 to 16,590. Cutbacks occurred in the 1980s in response to fears of oversupply, but since the 1990s output from domestic medical schools has been more or less stable at around 16,000 allopathic doctors. This stability in the domestic supply of doctors (referred to as United States Medical Graduates, or USMGs) is related to the official stance that there is a sufficiency, if not an oversupply of doctors. There have continued to be calls for further cuts, not only by COGME. The Pew Commission in 1995 recommended restraining supplies through a 20% cut in medical school places, and through restricting IMG numbers. The Institute of Medicine Report 1996 added that domestic cuts would likely lead to a rise in IMGs, unless Residencies/GME was controlled. However, osteopathic medical schools have increased (from 14 to 19 since 1980), and osteopathic graduates from 1059 to 2120 doctors annually in 1998. Half of these osteopathic graduates enter allopathic residencies. Thus the overall totals from domestic supplies entering allopathic Graduate Medical Education (GME) annually is between 17-18,000. Recently, one

new medical school has opened, and concerns are beginning to be raised that the US, in common with other developed countries, may need to increase its supply of doctors, in response to societal trends (US Int 1, 2, 4, 7, 8).

“I guess it’s very controversial. There’s a certain group that feels that we don’t have a large enough US medical school capacity. And that’s depriving some of our own citizens from becoming doctors” (US Int 3).

“We don’t even pretend to claim we can determine the right number...you have plenty of experience now to show that you overshoot or undershoot. It’s not possible given the change in technologies and patient demand” (US Int 2).

The US system of primary medical education is a 4-year programme, following an initial BSc in biological sciences. Demand for medical school places is relatively strong, although the ratio of applicants to places has varied from 2.1 to 2.7 over recent years, and in 1999 stood at 2.2 applicants for every place. The recent lower ratio may be explained by the competitive attraction of business-related careers, and is a phenomenon echoed around the world. The grade-point average of applicants to medical school has risen steadily, indicating that the calibre of applicants is still high. The profession is sufficiently attractive for some of those who are unsuccessful in obtaining a place in the USA to undertake medical training abroad before returning to the US for post-graduate training. Although the numbers of US citizens graduating from foreign medical schools decreased in the 1990s, they have begun to increase again recently. The medical profession still remains, “a very lucrative profession” (US Int 4), and “a respected and well remunerated profession” (Mullan 2000), with an average physician salary of \$200,000. Part of the attraction of the profession is that earnings are in theory unlimited. Once a physician has completed specialist Residency training, then he is not subject to the limitations of a salary, and nor are the number of Specialist posts limited. There are no entry examinations to specialty colleges, which might operate to limit the numbers entering. Anyone who has completed the training and can develop the reputation can function as an independent practitioner (US Int 8). “I think that there’s a lot of advanced medical training opportunities here. And opportunity I think in the longer run to be licensed and practise in more of a market setting” (US Int 3).

A Shortage of Domestic ‘Residents’

Following graduation, and the Intern year (Post-graduate year 1, or PGY1, and equivalent to the UK PRHO year) doctors enter a period of specialist Residency training. The Residency training period may range from 3 to 8 years depending on the specialty. There is no separation of the basic specialist training period (PGY2-4, similar to our SHO period), from the higher specialist training period (our Specialist Registrar SpR training). Entry into a programme implies occupying that training position until completion, although some switches do occur. The number of first year residency slots approved and accredited by ACGME has been relatively stable at around 22,000 since 1993. There are also further sub-specialty programmes. These brought the annual number of new-start residency programmes to 24,571 in 1998, (down slightly from a high of 26,033 in 1993, as a result of cut-backs described later). The excess of supply of residency programmes over domestic availability to fill them is linked to the expansion of public demand for specialist care. It is also a reflection of the bargaining power of major teaching hospitals, and the prestige associated with specialty training and provision.

“If I’m a program director in cardiology and I want to be prestigious, I increase the number of residents. If I increase the number of residents and find a means of financing these slots, I go out in the market so to speak, and find bodies to fill them. And there have almost always been more available residency slots than there have been residents.Then the gap almost closed, and then it started to open up again, and then the AMA stopped publishing data.” (US Int 4).

“In the absence of new legislation or regulation and in spite of calls for reductions, the number of residents has been determined by the staffing needs of hospitals, the availability of trainees, and public funding of graduate medical education...” (Mullan 2000)

“I mean this is absolutely screwy!” [i.e. funding GME through a reimbursement system, especially based on Medicare] *“The large prestigious training hospitals have always been able to beat back major efforts to cut back on the funding of residency slots.”* (US Int 4).

The level of demand means that with a combined total of 17,000- 18,000 allopathic and osteopathic new graduates entering allopathic Residency programmes each year, that there is currently an annual approximate shortfall of 5,000 post-graduate trainees. International medical graduates (IMGs) have flowed into the vacuum.

The Composition of the Workforce

The number of women in the physician workforce has risen from 8% in 1970 and is estimated to reach 30% by 2010, when the current intake of undergraduates begin practising. Whilst this trend echoes that in other case study countries, it is not such a large increase in female participation in the workforce as is seen in, say, the UK and Australia. Nevertheless, assuming their net contribution in terms of working years is likely to be less than their male counterparts, and the fact that they are under-represented in rural and under-served areas, their increased presence is likely to have a moderating influence on overall physician supply.

Ethnic minorities have likewise increased their share of the workforce (from 3% in 1950, to 33% in 1998). However, some minorities are under-represented. Thus, African Americans, Hispanics, and Native Americans form 25% of the population, but only 6% of all practising physicians. There have been recent gains, to 15% of graduates in 1998, partly brought about through positive recruitment policy initiatives on the part of various States. However, successful challenges in the courts that such policies represent discrimination against White Americans seeking entry to medical school, have led to a recent 7% fall in entries of these minority groups. By contrast, Asians are over-represented in the medical profession, forming only 4% of the population, but 18% of recent medical graduates. Asian Americans are reported to currently constitute 50% of undergraduate dental students. Similar trends have been remarked upon in both the UK and Australia.

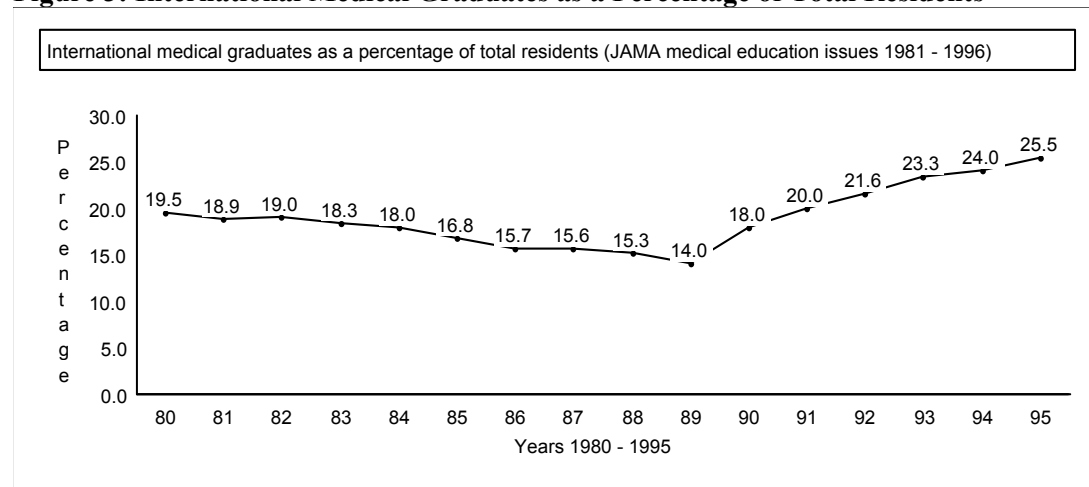
Non-Physician Clinicians (NPCs) have undertaken an increasing role in the delivery of health care during the last decade. They include nurse practitioners (NP), physician assistants (PA), and other substitute non-physicians clinicians such as nurse midwives, optometrists, podiatrists and nurse anaesthetists, as well as ‘alternative’ and ‘complementary’ therapists. Many NPCs operate with an increased degree of practice and prescribing autonomy, under State regulation and law, overlapping and even competing with physicians, and used in preference by HMOs as a first point of contact. It is estimated that by 2005 there will be more nurse practitioners than primary care physicians.

International Medical Graduates currently form more than 25% of the active physician workforce. As we have seen, IMGs enter the workforce through Residency training, filling the vacant slots left by a shortfall of domestic graduates. They have increased in number and proportion of this segment of the workforce between 1988 and 1995, from approximately 12,000 to 25,500 Residents (COGME 1997). The figures for IMG percentages from 1980 to 1995 are shown in Figure 3 below.

During the 1990s Residency slots have sometimes exceeded the domestic supply of new graduates by 6,000 plus. This is expressed as a percentage of United States Medical Graduates (USMGs) (i.e. 18,000 USMGs, but 24,000 ‘slots’ would equal 150%). The actual

percentage has dropped from a high of 150% in 1995 to approximately 129% in 2002 (US Int 2). We will look at the drivers behind this shortly, but meanwhile we can note that there have been fluctuations in physician immigration over the last half century.

Figure 3: International Medical Graduates as a Percentage of Total Residents



Source: quoted in COGME 1997

The phenomenon of the shortfall in domestic supply being filled by inward migration has been a pattern since World War 2, particularly since the mid-1960s, when there was a large influx from South Asia, (12%) but more from Canada and the UK and Europe (50%). It was reported that 80% of graduates from Edinburgh University sat the FLEX, the US entry examination of that period, and as a result of their emigration, many South Asian doctors were staffing the junior hospital doctor positions in Scotland (US Int 2). By 1972 the flows from Canada and Europe had dropped to 19% of the total, and South Asia accounted for 70% of inward physician migration to the States. Other English speaking countries, the UK, Canada, Australia and New Zealand were also drawing on the South Asian source. Today, there are still flows from Canada to the US, which has mutual recognition of qualifications, but this also means that the quantity of migration from Canada is difficult to measure accurately. In the late 1990s the Clinton administration offered inducements to lessen the shortage of GPs/FPs in the US, and there were further outflows from Canada, causing concern about family physician provision for rural Canada.

The main source countries for IMGs now, according to the AMA website, are, in rank order, India (19.5%), Pakistan (11.9%), the Philippines (8.8%), Ex-USSR (3.1%), Egypt (2.6%), Dominican Republic (2.5%), Syria (2.5%), UK (2.4%), Germany (2.3%), and Mexico (1.8%). Numbers from Southern Europe, such as Spain, Italy and Greece are relatively small, even compared to Northern Europe, possibly because the education system has less in common with the US, and *“I don’t think they’re capable of...they’re not prepared to sit our, our entrance exam.”* (US Int 1).

There are some IMGs who are US citizens, who undertake the clinical part of their training abroad, after gaining a US BSc (about 300 p.a.). Options are to go to offshore medical schools in the Caribbean/ Guadalajara/ Mexico, or to Ireland, India, Poland, Israel or Australia, some of which operate a similar type of 4-year post BSc training system to the US. Entry back into the States is eased for some who gain entry to the ‘Fifth Pathway’ programme, which provides a year of specific training at New York Medical College, and then exemption from the ECFMG examinations. However, the rest, even as US citizens, must then fulfil all the entry requirements for IMGs, including the English language test. Offshore

options are financially advantageous, given the dominant strength of the US\$ against other currencies, and are good dollar earners for the host countries.

Imbalance in the Workforce

Despite the increases in the overall workforce, there are **geographical imbalances** in distribution, with underserved communities in rural areas, and in poor inner city areas. To some extent the geographical imbalance coincides with an imbalance between primary care and specialty provision. Family Physicians provide the vast majority of primary care in counties of less than 50,000 population (COGME 2000b). Few specialists and sub-specialists are based in rural communities for obvious reasons that the population is too small to support them and the advanced secondary/tertiary facilities they require. Rural areas will therefore continue to rely on primary care physicians, generalists, and substitute providers such as NPs.

Most States have a range of loan repayment schemes and scholarships aimed at encouraging primary care practice in rural areas. Various programmes under Title V11 of the Public Health Service Act (PHS Act) fund training targeted at undersupplied areas of the workforce. Also at the Federal level, the National Health Service Corps operates in a similar way, and COGME is urging an expansion of this programme in order to meet the rural shortfall. This is particularly urgent as the IMGs who came into the workforce in the 1960s and 1970s serving in needy areas approach retirement age. Other suggested measures to improve distribution include encouraging the entry of students from rural backgrounds into the medical profession (Mullan 2002). Baer (2002) found that State health planners and those responsible for recruitment employed a number of creative options to address the problem of *“how do rural communities make do with less?”*

There are also imbalances in the **specialty workforce**. COGME recently undertook an evaluation of the specialty physician workforce, (COGME 2000c) and looked in particular at the ways in which different specialties determined issues of supply and demand. There was wide variation in approaches to estimating, planning and recommending future supply numbers, and little can be generalised from the study. One source commented that, *“Some of the specialty societies they don’t want more, they, they, they don’t want the competition so they, they kind of overestimate their numbers”* (US Int 2). Nevertheless, some areas of shortage are evident, such as pathology, (which has had declining numbers of Residents over the last 10 years), child and adolescent psychiatry (where provision is high in prosperous urban areas, but low in areas of child poverty), and adult psychiatry. Anaesthesiology has the least amount of unemployment, indicating shortages, currently, but has experienced fluctuations. Demand also exceeds supply for general internal medicine, haematology, oncology and other sub-specialties, and also for nephrology and otolaryngology. Although surpluses had been predicted for radiologists and for radiation oncology during the mid-1990s, there were job vacancies. There are oversupplies in orthopaedic surgery and plastic surgery. According to COGME, both gastroenterology and cardiology have oversupplies, with some of the provision being made by alternative NPCs. However, the up-to-date picture of demand for different specialties obtained from FRIEDA, the website of the AMA, showing vacancies for accredited GME programmes, (July 2002) showed 158 vacancies for cardiology, 67 for gastroenterology, 119 for internal medicine, as well as others.

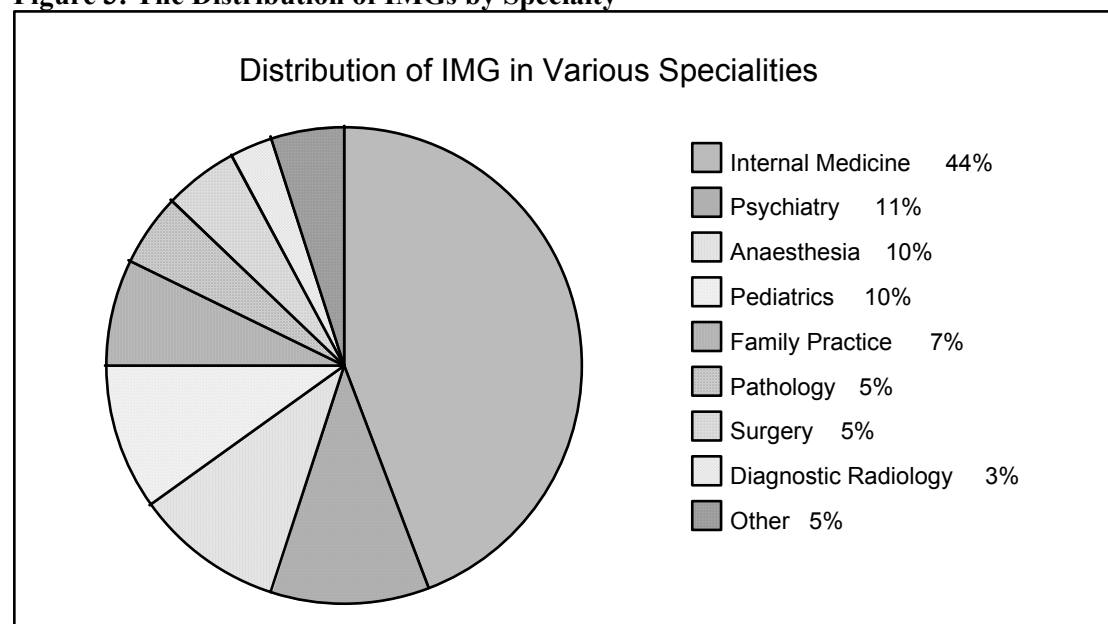
A similar approach to estimating shortage areas is to look at the National Residents Matching Program, (NRMP or ‘The Match’) to see which Residencies are unfilled, and as an indicator of career preferences. The NRMP operates through the Electronic Residents Application Service (ERAS) run by the Association of American Medical Colleges (AAMC). Top student and residency director choices are submitted and paired in successive rounds, (the ‘Match’ and the ‘Scramble’ shortly afterwards. The AAMC (website) data showed that there were 23,459 active applicants in 2001. Around 14,400 of them were USMGs, with a match rate of 94%. The numbers of IMGs in the Match fell from 6,287 in 2000 to 5116 in 2001, although

the percentage 'matched' increased from 38.5% to 44.8%. NRMP reported an overall decrease in interest in family medicine, paediatrics and internal medicine amongst USMGs reflected in the number of applications in 2002. The difference was made up by IMGs. There had been a rise in the number of matches made for anaesthesiology, rehabilitation medicine (physiatry) and diagnostic and therapeutic radiology. These, along with psychiatry and pathology, are also some of the areas which our interviewees thought had higher concentrations of IMGs (US Int 1,4,8). The distribution of IMGs by specialty is shown in Figure 3 below. In 1997, 53% of IMG residents were in the primary care specialties of internal medicine/paediatrics/ family medicine and psychiatry, compared with 24.6% of USMGs. The mode of entry into the labour market is therefore seen as a response to market signals for an increase in primary care provision (US Int 4). IMGs are, however, more likely to undertake sub-specialty training and remain longer in Residency programmes (28% as opposed to 20% of USMGs). These statistics may be partly explained by IMGs switching out of the specialty through which they first gained an entry into a residency programme. They may undertake a second residency programme, or sub-specialise from a more general medical programme.

"They oftentimes go into those disciplines which are typically shunned or less favoured by the USMGs"... "I know that there are some medical residency directors who prefer IMGs, because they tend to ... have more experience, and are willing to do more things." (US Int 3).

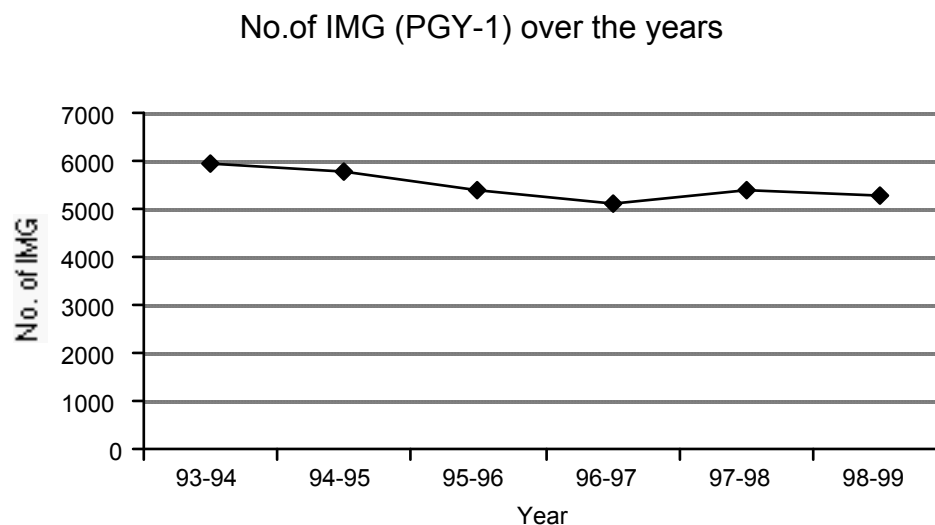
By contrast, USMGs were heavily represented in orthopaedic surgery (especially men), and in dermatology (especially women). The picture is one of IMGs applying to the specialties unpopular with USMGs, and on average making a higher number of applications than USMGs (for example, an average of 37 applications each for internal medicine). AMA advice suggests making up to 25 applications, compared with USMGs 5-10 applications, although submitting more than 15 incurs extra charges. By and large there are advantages to applying to a programme with previous links to their former medical school. As the IMG Department of the AMA points out, this strategy reduces the risk to the GME programme of forged documents, poor quality tuition, or inflated grades. For reasons of timing, it is often in an IMG's interests to also apply to those programmes, which operate outside the Match, and are known to be sympathetic to IMGs (3-4,000 positions are filled this way each year, mainly by IMGs).

Figure 3: The Distribution of IMGs by Specialty



Source: Based on data from USMLE website 1.

Figure 4: The Number of IMGs in First Year Residency Slots 1993-1999



Source: Based on data from USMLE website 1.

IMGs appear to be sensitive and responsive to small fluctuations in market demands and to be making strategic applications to specialties and locations where the opportunities are greatest. However, there are indications that competition is increasing, and the numbers of IMGs actually obtaining a match and entering GME programmes are falling, shown in Figure 4, above.

The attempts to address the imbalances in the workforce can thus be seen to be taking place within a wider policy debate about what the form of the delivery of care should look like in the interests of the quality of care, improved health outcomes, cost containment, and increasing equity of access. Should there be greater Federal and State oversight of public medical schools, and a greater ability to direct funding towards GME in certain specialties and in ambulatory settings, as recommended in COGME 14th Report (COGME 1999)? What should be the skill mix of physicians and other NPCs? Should the primary /specialist care mix be left to the market to determine? Can it or should it be influenced by policy initiatives? For each of these interrelated issues, the role of IMGs in the workforce has been the subject of hot debate. Do they contribute to undesirable workforce trends, as perceived by COGME, by adding to the specialist workforce (COGME 1997, 1998, 1999)? If they do, is it in response to market forces, or do they create the oversupply? Do they fill areas of workforce shortage, either in terms of geographical area or in terms of specialty shortages? An understanding of how IMGs are perceived in the workforce is essential to the purposes of our study, as a base line from which we can evaluate future trends. For this reason, we will now look more closely at the literature and interview data on the role of IMGs.

The Role of International Medical Graduates in the Workforce

Stakeholders and academic experts hold different positions on the issues surrounding the role of IMGs in the workforce. These positions can be categorised as: firstly those who feel that there is a surplus in physician supply, and that the level of IMGs is too great and adds to the oversupply, and therefore serves no public good. (Various COGME reports throughout the 1990s have taken this stance, and we will look at the policy implications resulting from this under the section on graduate medical education (GME below); secondly, those who hold that the market will decide what levels of workforce are supportable, and conclude that given the evidence of past trends towards specialisation that there is an impending workforce shortage, particularly of specialists (Cooper et al 2002); thirdly, those who feel that if demand is set to

continue to exceed supply, then the US should increase its own domestic supplies, *“The capability exists for the US to train and deploy a workforce to take care of its own citizens”* (Kindig 1996).

“Our continued reliance on medical schools in other countries to train physicians for residency programs and practice in the United States draws talent away from these countries, limits opportunities for young Americans, and ultimately results in a medical workforce in the United States that is not well matched to the population in terms of culture and language” (Mullan 2000);

Lastly, there are those who hold that, regardless of overall supply issues, IMGs are helping to fill an undersupply in underserved geographical areas (Mick 1993/1996, Baer, 1999), in undersupplied specialties, or in institutions delivering care to the poor, such as Veterans Association hospitals.

Cooper purports to demonstrate, from the macroeconomic Trend Model he has developed, that the increase in the physician workforce is closely related to the increase in GDP, and that, *“a causal relationship exists between economic expansion and the growth of physician supply”* (Cooper et al 2002). He further argues from OECD data that this is a pattern replicated across most advanced industrial countries. There may be a time lag between increases in GDP and rising demand for health care, and although constraining the regulatory system may lead to short term deviations from the trend, in the longer-term, the pattern persists.

“The striking observation is that the net of these counterbalancing factors yields such stable results, infrequently allowing physician supply to deviate by more than 10% from its long-term relationship with GDP”(Cooper et al 2002)

Others agree that despite various policy initiatives and some short-term blips, there appears to have been *“no impact over the long-term on the staying power of IMGs-it’s always a line that goes up”* (US Int 4). Taking into account other factors influencing supply and demand, (such as population growth, domestic supply, the percentage of IMGs remaining in the US workforce long-term, and the reducing working hours of physicians), Cooper predicts a deficit of 200,000 doctors by 2020, even given the opportunities for substitution, particularly in primary care.

Cooper has stimulated a hot debate about physician supply, which is currently ongoing (Health Affairs articles 2002). The counter argument to Cooper’s is that a trend should not be elevated to the status of ‘natural law’, and should not inhibit policy makers from attempting to ask questions about the sort of health care which is cost-effective and equitably distributed (Grumbach 2002). In essence, Grumbach’s argument is that, just because a situation ‘is’ does not mean that it ‘ought’ to be so. Although Cooper presents his argument as a value-neutral position, allowing the situation to continue unchallenged, in itself constitutes a value judgement.

Attempting to establish whether or not IMGs are filling geographical areas of workforce shortage, a ‘gap-filling’ role, is partly a function of the geographical area used as a unit of analysis. Various comparisons have been undertaken, with somewhat conflicting results. The underlying pattern seems to be that IMGs in general are found in similar locations, in similar proportions, to USMGs. However, IMGs are less likely than USMGs to be in rural counties (at the aggregate level) (9.1% compared to 12%, and this is possibly a reflection of the fact that more USMGs are serving as rural GPs/FPs. There is also an even distribution in metropolitan areas, except that there are more IMGs at the very largest county size of 5 million population (20.6% compared with 10.7%). Overall, these analyses would indicate that IMGs are not particularly undertaking a ‘gap-filling’ role, and their contribution at this

level of analysis is in similar proportion to that of USMGs. Other work indicates that IMGs do form a higher percentage of the total workforce in rural under-served areas, although there is variation by State (Baer 1999), but nevertheless, 25% of all rural Community Health Centres (CHCs) needed IMGs in order to maintain staffing. There is also a heavy concentration of IMGs in the North Eastern States, with the percentage of IMGs of total physicians as follows (US Int 6):

- New York State 41%
- New Jersey 44%,
- Illinois 35%,
- Michigan 30%,
- Ohio 25%

There is also a higher percentage of IMGs in government and Veterans Administration hospitals and mental hospitals. The experience of hospital Medical Directors is that once a hospital develops the reputation for reliance on IMGs, then it no longer attracts USMGs to its residency programmes, so patterns of employing IMGs become self-perpetuating (US Int 4). In one Residency programme in El Paso, all 8 slots for internal medicine were filled by IMGs, from China, India and Pakistan (US Int 8).

An alternative approach to looking at percentages is to look at the 'raw numbers', and to ask the question, if IMGs were removed from the workforce, would more USMGs move into their positions? The likely response is that if IMGs were not in the workforce, *"an appreciable number of persons would have their access to health services reduced"* and, *"A significant minority would face real problems"* (US Int 5). Caution is therefore urged before cutting back on IMGs (US Int 4). An alternative metaphor used by Konrad (and quoted in US Int 5) likens the distribution of physicians to 'sand piles'. In theory, as the piles of sand get higher, they eventually spread out across the flat land and the sand goes everywhere. In practice, a pile of sand can get extraordinarily large before it begins to run down the slopes and spread.

Others take the line that, *"Although IMGs often begin by filling gaps, as they become socialised into US medicine, they become mainstream players. They're following the pattern of any immigrant group."* (US Int 4).

"I think the way we feel about this now, given the recalcitrance of the problems in specialty distribution or physician distribution, they're not going to put, the policy makers are not going to put any restrictions on IMGs in this country...IMGs frequently go to the inner city areas, the public or county hospitals or into rural areas or where our US graduates, given a choice, prefer not to go, for obvious reasons. So that's helped address some of our problems of maldistribution...and they get their visa, permanent visa, they go where the money is just like everybody else."(US Int 2).

Mullan et al (1995) conclude that although IMGs *"are delivering appreciable amounts of hospital-based care. However, [they] then sub-specialize at a disproportionately high rate, reducing their contribution to the generalist pool."* In the light of the policy for more primary based care, these patterns are seen by some as fuelling undesirable workforce trends, both in terms of cost and of specialty mix (Mullan et al 1995). Taking an alternative stance, defining workforce problems in terms of IMGs is seen as, *"an extraordinarily good example of blaming the victim"* (US Int 4). Workforce planners, or the lack of an overall planning system, cannot blame the doctors who flow into the system in response to market demand, and proceed to follow similar distribution patterns to other physicians, just because it is perceived that the system is over or under supplied in some way. Instead, levers need to be applied to encourage movement to underserved areas. These are market issues, and the

question has to be asked whether drawing a line between IMGs and USMGs, is really useful to the discussion?

"If we want these opportunities for our own to go to medical school, and frankly my response to that, - and you can quote me on this, because I've said this many times - if we want more doctors that are American born and trained, that is simply a question of admission policy at the medical schools and virtually nothing to do with IMGs. It is an extraordinarily good example of blaming the victim. It is exceedingly unfair for us to turn around and say, 'You're taking the jobs away from Americans, you're limiting the access to medicine by Americans' It is just rubbish, absolute rubbish. And if you want to have more Americans, or Brits, trained as doctors, well by God, educate them. And if, you know, they don't go where you want them to go, create a national policy... three years of service at a clinic in industrial Manchester." (US Int 4).

Additionally, in an era of globalisation in other economic areas, negative measures applied to the entry of foreign doctors, as opposed to other foreign workers, (such as software engineers who are actively recruited from overseas), could even contravene the Constitution if they were ever formalised into policy.

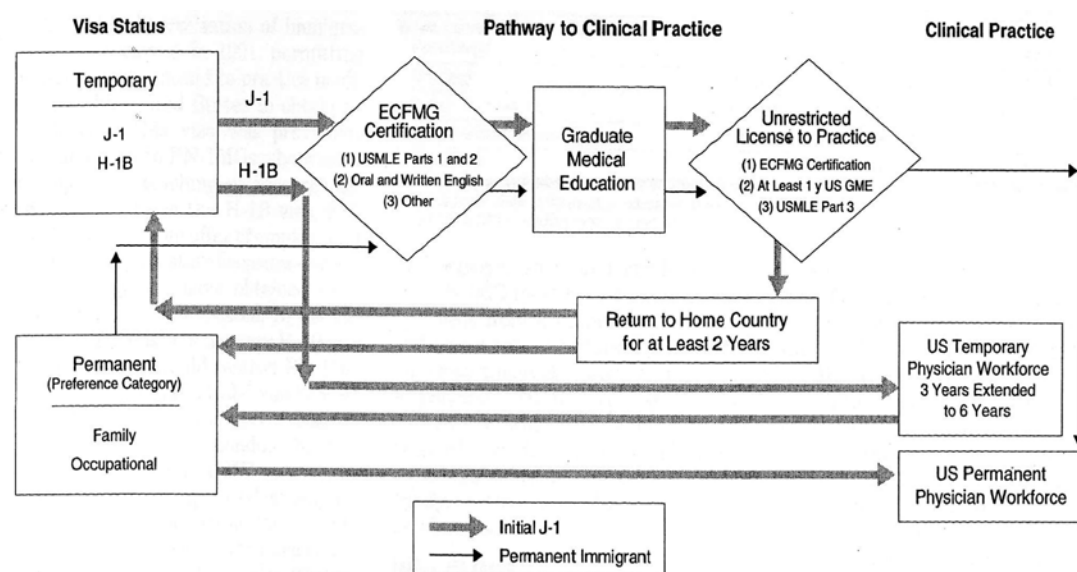
"Fifty years of ineffectual separatist policy in this country...it's unconstitutional in the end to discriminate against a group of potential immigrants because they happen to be physicians... ... A regulatory branch can put restrictions up, but if it ever became a clear law..."(US Int 4).

What policy options are, then, available either to restrict the growth of the physician workforce overall, or to control the supply of foreign-trained physicians in particular?

Mechanisms for Controlling Overseas Inflows to the Physician Workforce

The level of inflows of IMGs into the workforce is a function of the outcome of several processes to do with quality control, immigration control, and the availability of accredited slots for specialist medical training through graduate medical education (GME), as virtually all entrants to the workforce must complete a GME programme. This pathway to clinical practice is shown in Figure 5 below.

Figure 5: The Pathway to Clinical Practice



Source: Mullan et al 1995

If controlling inflows into the workforce is deemed to be necessary, which of these mechanisms, or combinations of these mechanisms, should be employed to do it? How effective have they been, or are they likely to be in the future? These questions are relevant to the focus of our investigation, as the answers have a direct bearing on the stock of available IMGs available to other countries competing on the demand side in the global medical labour market. We will look at each process in turn.

Quality Control

The United States Medical Licensure Examination (USMLE)

All doctors whose initial medical qualification is from outside the USA, Puerto Rico, or Canada (whose medical graduates are automatically accredited by the Liaison Committee on Medical Education) must pass the quality criteria of the Education Committee for Foreign Medical Graduates (ECFMG) for certification. The ECFMG, a private non-profit organisation, was founded in 1956 by the following bodies: the American Medical Association (AMA), the Federation of State Medical Boards, the Association of American Medical Colleges, and the American Hospital Association. Its brief was to fulfil the public responsibility of ensuring the quality of Foreign Medical Graduates (FMGs), now referred to as International Medical Graduates (IMGs).

The first stage of quality assessment is through the United States Medical Licensure Examination (USMLE), which was phased in between 1992-4, (sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners, (NBME), and replacing the former FLEX and National Board exams). The USMLE consists of 3 'Steps' or examinations, and in addition, a Clinical Skills Assessment (CSA) for IMGs, all of which must be completed within a 7 year period. Application to a GME programme may be made after Steps 1 and 2, but the CSA must be passed before the Residency can commence. Step 3 (administered by the Federation of State Medical Boards, and introduced in 1994) is taken after graduation, and enables licensure for independent practice. Steps 1,2 and 3 are the same examinations for US medical students as for IMGs, and so the exam is felt to be a level playing field and a fair test of quality for IMGs. Only the registration entity is different - the ECFMG for IMGs, but the National Board for Medical Education (NBME) for USMGs. However, before IMGs can access Steps 1 and 2 of USMLE, they must first pass an English language test, and also have the validity of their primary medical qualification, or their status as a medical student, and their identity authenticated. The medical school must be recognised by being listed in the WHO World Directory of Medical Schools (and since April 2002 listed in the International Medical Directory produced by the US). These regulations apply equally to US citizens who have undertaken their undergraduate medical studies abroad, apart from the few Fifth Pathway students.

Steps 1 and 2 are the medical sciences and clinical sciences components of the USMLE, and are in multiple choice questions format. They can be taken before graduation, at the same stage as a candidate might be sitting similar examinations for their primary medical qualification, when the content is at its most familiar. This is a considerable advantage compared with other quality screening systems, such as the UK PLAB examinations, which can only be taken after graduation. They also present quite low barriers to entry in terms of their accessibility in test centres worldwide. This accessibility has further increased since 1999 through the use of computerised modular testing, administered by Prometric, Inc. on behalf of ECFMG. Tests can now be taken in over 500 centres worldwide, and scheduled on almost any day. Each Step has 7 or 8 sections, and lasts 8 or 9 hours. Each section lasts for 45 minutes, followed by the option of a short break. Once the time allocation for a section has elapsed, or the candidate has moved on to the next section, it cannot be revisited.

The first-attempt pass rate for IMGs in the USMLE has risen over recent years. In 1995, at the first attempt, approximately 60% of IMG candidates passed the required English language test, approximately 45% passed Step 1, and of them, 45% passed Step 2. Since the introduction of the new format, the pass rate has risen. In 1998, the first time pass rate for IMGs was 62% (compared with 92% of allopathic USMGs and 87% of osteopathic USMGs). The pass rate for IMGs has continued to increase slightly, whilst that of USMGs has dropped slightly. The figures for IMGs are 65% for 1999 (number 6,510) and 2000 (number 8,767), and 66% for 2001 (number 9,800). For allopathic USMGs, the figures are 94% for 1999, 93% for 2000, and 91% for 2001 (number 16,500-16,400). Step 2 results show a similar pattern for IMGs, rising from a 70% first time pass rate in 2000, to 75% in 2001, and a steady 95% for USMGs. The minimum passing scores were raised slightly in each of these years, following standard-setting exercises. Whilst USMGs consistently out-perform IMGs, nevertheless, the data indicate that a substantial percentage of IMGs perform well, even given an increase of one third in the numbers sitting the exam over a 4 year period. IMGs do not perform so well in Step 3 exams, which may be taken before or during Residency training, depending on State licensing procedures. Comparisons show that the first time pass rate improved from 58% to 61% between 2000/2001, whilst the rate for USMGs was 95% and 94% (USMLE website). The bigger differential between IMGs and USMGs between Steps 1 and 3 may indicate that some IMGs require a longer period for cultural and language acclimatisation to reach the standard required for licensure. On the other hand, anecdotally, "I've actually heard a vice-President of the AMA say that probably 20% of the IMGs who are in residency training are superior in their capabilities than the average US graduate" (*US Int 4*).

It was decided in 1996 that IMGs must take a Clinical Skills Assessment (CSA), which was fully phased in by 1998. It is designed in a similar way to the UK OSCE (Objective Structured Clinical Examination), and tests the use of English in clinical skills settings, as well as assessing the clinical skills themselves. Trained actors are used as 'Standardised Patients', and allocate marks against a checklist. Evaluations indicate that candidates have found the testing system fair and effective. In the first 18 months of the CSA, 8,383 candidates were tested, with a pass rate of 96.9%. However, it is thought that these initial candidates were a well-prepared self-selected group, who had also undertaken clinical attachments (CSA website 2). The current first-attempt pass rate is around 80%, with most passing at a repeat attempt, but a small cohort failing repeatedly. The major cause of failure is in the communication and inter-personal skills areas (Whelan 2000), and these are considered to be important skills as poor performance here is a predictor of a raise risk of malpractice and medical errors. A pass in the CSA is valid for 3 years for the purpose of obtaining a GME place. The CSA can only be taken at the USMLE headquarters in Philadelphia. Currently, US graduates do not take the newer CSA, the rationale being that USMGs have been exposed to similar clinical assessment situations during their training. However, a similar test will be introduced by 2004 for USMGs, but with access at several test centres, rather than just the one for IMGs.

In assessing the effect of the quality control measures as they function in terms of entry barriers, we can say that the computerised testing system facilitates access, and presents relatively low barriers to entry at the early stages of testing. There is a speedy system of feedback, with results mailed to candidates within 3 to 4 weeks, and a secure website of results for access by other interested parties (such as Residency program directors). However, advice posted on the web for potential IMGs indicates that a hidden barrier is the need for exceptionally high scores, not just a pass, especially in Step 1, for an IMG to stand any chance of getting through the initial screening process to gain an interview for a place on a Residency programme (<http://www.csa-notes.com>, AMA web site). In terms of cost, the USMLE examinations present relatively high financial barriers for candidates from developing countries such as India. The basic fee is \$645 for each step, and in addition there is a surcharge for taking the exam abroad, which ranges from \$110 (e.g. in India) to \$270 (e.g. in Japan) for Step 1, and \$120 to \$295 for Step 2. Nevertheless, there does not appear to

have been any slackening of demand to take the examinations, with currently nearly 10,000 doctors taking Steps 1 and 2 annually. Neither do the events of 9/11 appear to have acted as a deterrent to moving to the US. During the first two months of 2002, registrations for Step 1 and 2 were up by more than 50% over the corresponding period for 2001, indicating a significant rise in interest (AAMC website 2). The recently introduced CSA presents a heightened barrier to entry, both in terms of the extra examination fee, \$1,200 and travel and living expenses involved in the accessing the location of the test site in Philadelphia (the headquarters of the AMA), and the need to undertake unpaid clinical observerships in order to maximise the chance of success. Logistically and practically there are limits to the numbers feeding through the CSA. Priority is given to first-time applicants, and so there may be time delays for others. Interview perceptions were that the numbers receiving an ECFMG certificate had fallen. A figure of 5,934 ECFMG certificates issued is quoted for 2001, an increase of 15% over the previous year. However, according to the ECFMG website July 2002, approximately 4,500 certificates are currently awarded each year. The drop in numbers is consistent with a drop in the pass rate to 80% from the initial high 96%. It may also indicate that there are barriers to entry to the US to take the CSA, which will be explored further in the section on Immigration Controls. Nevertheless, there is still a pool of unemployed ECFMG certificate holders from pre-1998 to more than fill available Residency slots.

State Licensure

USMLE is thus the first hurdle of quality control, but gaining ECFMG certification is in effect only a permission to seek licensure. Individual States/ Districts (54 in all) are then responsible as the competent authority, and have their own sets of regulations for licensure. Graduates beginning GME are issued with either a temporary license, or a training permit (California), or are covered by the license of the supervising physician (Florida). In most States, least one year in GME is required before taking Step 3 USMLE, to fulfil State licensure requirements for obtaining a full and unrestricted license to practise. However, 34 of the States require more years of GME for IMGs (e.g. 3 years as opposed to 1 year), justified on the grounds that more time is needed to overcome language barriers and to learn new cultural and ethical norms, new techniques and approaches (COGME 1995). Nine States allow Step 3 to be taken before Residency, and therefore enable an accelerated route to licensure.

Regulations to obtain licensure also vary, and may include requirements for detailed descriptions from the Dean of medical school curricula and facilities; photographic identity; written and oral examinations; an interview; an orientation programme. Some States do not recognise the former FLEX exams, or combinations of the old and the new. Licensure in one State does not bring entitlement to licensure in another, although a few do have reciprocal arrangements. A COGME Report to Congress on the issue (COGME 1995) found that process times for IMGs seeking initial licensure tended to be longer than for USMGs. This may be because communication times by mail for the process of verification of certificates and identity tend to be longer. Denial rates were similar for both groups at around 1-2%, but it was probably the result of self-selection, in that IMGs are well versed in which States have more stringent regulations, and avoid them. Endorsement times (when a physician registered in one State seeks registration in another) were similar for both groups overall. However, in its small sample of 9 States, COGME found the denial rate for endorsement was significantly higher for IMGs in 3 States, Louisiana, New Jersey and Ohio.

An attempt was made in 1992 to bring greater uniformity to the licensure system, and to avoid duplication, through the AMA National Physician Credentials Verification Service (AMA/NCVS), but it was abandoned in 1994. The number of States willing to accept the data verified by NCVS was too small to make the system viable. States seem to want to preserve their individual rights to assess the quality of doctors. There are still calls by COGME for further cooperation to avoid duplication and to speed up process times (COGME

1995). Overall, it can be said that the variation between States in the requirements of their licensing system present a variation in the height of entry barriers. Those States, which are heavily dependent on IMGs, have less stringent requirements.

Immigration Control

Immigration controls present the next barrier to entry to the US, both as they apply in general, and as they apply to doctors in particular. Doctors may be successful in passing the USMLE Steps 1 and 2 examinations, but evidence from the fieldwork in India indicates that some are then having difficulty in gaining a visa to enter the US to take the CSA. What are the avenues for entry? Foreign-national IMGs coming to the US with temporary or non-resident status can enter either on a J-1 Exchange Visitor Programme Visa (EVP) for training, an H-1B Visa for specialist/shortage occupations, or on a B category Visa as a visitor (a possibility used by a small percentage to take the CSA exam). Others may enter on the 'family preference basis' with permanent resident status. How have these different options operated over time?

The J-1 Visa, first introduced post-World War 2, is intended to enhance educational and cultural exchange and promote international understanding. The EVP is administered by the US Information Agency (USIA), which authorises the ECFMG as the sole sponsoring organisation for any educational programme involving clinical training. The sponsorship should not exceed 7 years in total, and exchange visitors are required to return to their home country for at least two years before being allowed back into the US. They must sign a document to acknowledge this obligation. However, waivers to this rule may be granted by the Immigration and Naturalization service (INS), following a favourable recommendation by USIA.

The main basis for a waiver is a 'public interest' request. This enables trained physicians, particularly in the primary care specialties, to remain in the US to work in under-served areas. Only Federal Agencies can apply for this to the USIA, and the main ones seeking waivers have been: the Department of Agriculture (USDA), and the Appalachian Regional Committee (both for doctors in rural areas); the Department of Housing and Urban Development (HUB), the Department of Health and Human Resources (DHHR) (both for doctors in urban and other workforce shortage areas); the National Science Foundation and The Department of Defence (both for exceptional research talent). The HUB introduced a moratorium on its waiver programme in 1996, in response to the policy initiatives to reduce the number of IMGs in the workforce. Following the events of 9/11, and the subsequent heightened concerns for 'homeland safety', the Department of Agriculture decided to cancel its waiver programme. This was because of the difficulty of keeping track of the people involved, and possible connections to terrorist organisations.

"That caused an absolute firestorm amongst our State level officials, who have become very reliant on this source of physicians themselves. So there was uproar around the country and much lobbying in Washington..." [US Int 4].

The result has been that the USDA has agreed to continue processing the current applications, whilst not accepting any new ones, pending the outcome of the White House Task Force deliberations.

Since a 1994 Amendment to the legislation, States are now also allowed to directly request 20 waivers (known as the Conrad 20, after the instigator) to enable IMGs who have completed Residency training, to stay and serve in DHHS designated Health Priority Service Areas (HPSA) and other underserved areas. This number was recently extended to 30 per State, on 25.06.02, and is an up-to-the minute indicator of continuing shortages in primary care. Other grounds for seeking a waiver can include hardship to an applicant's US citizen/permanent resident spouse or children; persecution on return home for reasons of race, religion, or

nationality; or simply obtaining a statement of 'no objection' from the government of the home country. Waivers allow either temporary or permanent residence, and confer a 'green card', and are a route eventually to citizenship.

"There are legal and other ways where you can get around the return requirements. We don't enforce that and I tell you...philosophically when you mention that it's very hard in the United States because our country is young and every one of us came here for economic opportunity...my great grandfather...came because it's the land of opportunity...you don't find too much xenophobia here...you don't find policy makers acting like we should throw up the barriers which I understand is happening more and more in Europe"(US Int 2).

Concern has been expressed, especially by the Pew Foundation (1996) and the Institute of Medicine, that the waivers granted are for service, and as such undermine the original intentions of the J-1 Visa. J-1 Visas peaked in 1993/4 and began to decline in 1994/5. It is thought that this may be due in part to an increase in H-1B Visas, rather than solely to a decline in IMGs entering the US.

The H-1B Visa is a specialty occupational visa, applied for by the employer, to fill areas of workforce shortage. Originally it was not intended to include physicians. However, in 1991 the category for doctors engaged in outstanding research and academic teaching, was extended to those undertaking clinical practice, if they had an offer of employment and met requirements for a full, unrestricted State medical license. The visa has an annual cap, which was raised to 200,000 in 2000, and at the same time universities and non-profit hospitals were completely exempted from any cap. Since the collapse of the dot-com market, doctors are taking up more of the general pool of H-1B visas available (US Int 1).

At first sight the regulations for a full and unrestricted license present IMGs with a 'Catch 22' situation. To meet the licensing requirements would normally require some time in GME, in order to take Step 3 of USMLE, and would be accessed through a J-1 visa - and switching between a J-1 and H-1B visa is not allowed. However, 9 States (mainly Eastern seaboard) do not require even 1 year of GME before Step 3 of USMLE is taken, so enabling IMGs to fulfil the criteria to become 'license eligible' before starting a Residency. Knowing the right States, knowing which hospitals are willing to undertake the administrative hassle of sponsorship for H-1B visas, and knowing the timing and costs of the different processes is a subject of independent advice on the web (e.g. <http://www.csa-notes.com/index.html>). The aim is to maximise opportunity, and minimise delays between obtaining a job offer and starting the job, by getting a visa before the cap is reached for that year. This can be greatly assisted by obtaining a Residency position outside/before the Match.

If the visa is for 'temporary' status, then the doctor can only work for the petitioner. However, perversely, if it is a 'permanent' visa, the doctor does not have to work for the petitioner once he has gained entry. There is also evidence that some IMGs may be using the temporary visa to take shortage positions, where the State requirement is for a 2-year commitment to service, (even though the Federal requirement for the visa is for 3 years). They can then leave that position and move into other areas of the workforce, and gain permanent resident immigration status along the way (with the help of an immigration lawyer). The visa is granted for 3 years initially, renewable for a further 3 years, and application can be made during this period for a change of immigrant status to that of permanent resident. This visa does not include the home-return period required of the J-1 visa category. The H-1B visa is, thus, advantageous to the IMG who wishes to remain in the US permanently. Precisely how many Residents are using this access route is unknown.

The Family Preference Visa is another entry route for Foreign National-IMGs seeking permanent entry to the US. The 1965 Immigration and Naturalization Act ended the national origins quota system, and gave preferential immigration to shortage professions, including medicine. This facilitated a large inflow of doctors, so that by 1972, 45% of all initial licenses were for IMGs, and more IMGs entered the US than were graduated by US medical schools. Since the mid 1990s, IMGs account for 20% of initial licenses. The more general picture for legal immigration in the national interest for 1996 was as follows: out of 7/800,000 immigrants, 475,000 were family sponsored, (the 'family preference' basis on which people can be sponsored/ apply for permanent residency includes: 1) spouse, unmarried sons and daughters of US citizens who are under 21 years, and parents of US citizens, 2) children over 21 years, 3) married sons and daughters, 4) brothers and sisters); 100,000 had an employment offer (mainly skilled), 55,000 came on the Diversity Program (a lottery system for all those countries which currently only send small numbers), 125,000 came as refugees/ on humanitarian grounds (which included many doctors). The US is still a country which relies on immigration, and particularly now encourages skilled as opposed to unskilled workers.

A current issue is the estimated annual additional 100,000 new illegal immigrants, half coming via the southern border, and half overstaying their visitor permits. How to best deal with illegal immigration, without damaging other interests, is a difficult issue, partly because international tourism, business and student travel, which can provide an entry route, are worth \$45 million p.a. and is the second largest part of the economy after health. Nevertheless, anecdotal evidence from interviews during this piece of research indicated that immigration control was tightening up, even before 9/11. Process time for Visas had particularly slowed up since then.

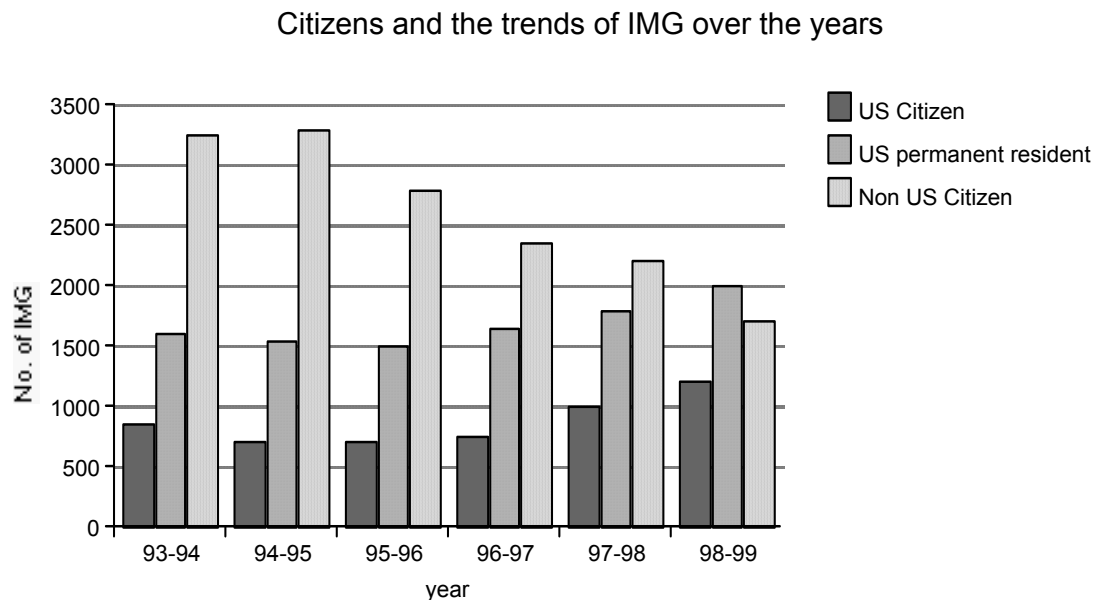
"They're trying to figure out how to tighten up student visas and help track people better...there have been cases where people have come into the country for Residency, and you know this is probably a small number, but a few people have vanished, just never shown up for their Residency Program and nobody really knows what happened to them...we're having trouble figuring out how to do all this whilst keeping enough people coming in to provide work for everyone and you know, not discriminating against people and all that sort of stuff, it's tough." (US Int 1)

The immigrant status of IMGs shifted over the period 1988-1993 to include more doctors with J-1 Visas (up from 16.9% to 35.4%), with permanent residents steady at around 33% and those with naturalized citizenship around 12/14%. The figures for 1993 were: Exchange Visitor 35.4%; Naturalised US citizen 11.8% (those born abroad, but now US citizens); Permanent US Resident 30.7% (those born abroad, but who have obtained permanent visa status, and are in the process of becoming citizens); Immigrant Refugee 4.2%, Native US citizen 10.4% (who have graduated from medical schools overseas); Miscellaneous 5.6% Unknown 1.7%. Interestingly, therefore, approximately 60% of IMGs Residents are either US citizens, or have permanent resident (or Green Card) status. How this situation comes about is not explained in the literature, although there are plans to try to track IMGs and undertake some qualitative case studies. Overall, it is estimated that up to 80% of IMGs who go to the States on temporary visas, either on J-1 exchange student visas, or increasingly over the last few years on H-1B work permit visas, end up staying in the workforce permanently (USMLE website). Mullan et al (1995), put the percentage at 70/75%. Family preference has been the main mode of 'permanent' entry, and the J-1 Visa the predominant 'temporary' mode of entry (Mullan et al 1995). These data are generalised in Figures 6 and 7 below.

As result of policy changes since the mid 1950s to 1990s, *"You might see a blip in the immigration for a short term, ...but when you stand back and look at the graphics, it's had virtually no impact whatsoever upon the staying power of IMGs in the United States."* (US Int 4). COGME therefore came to the conclusion that immigration controls were an ineffective

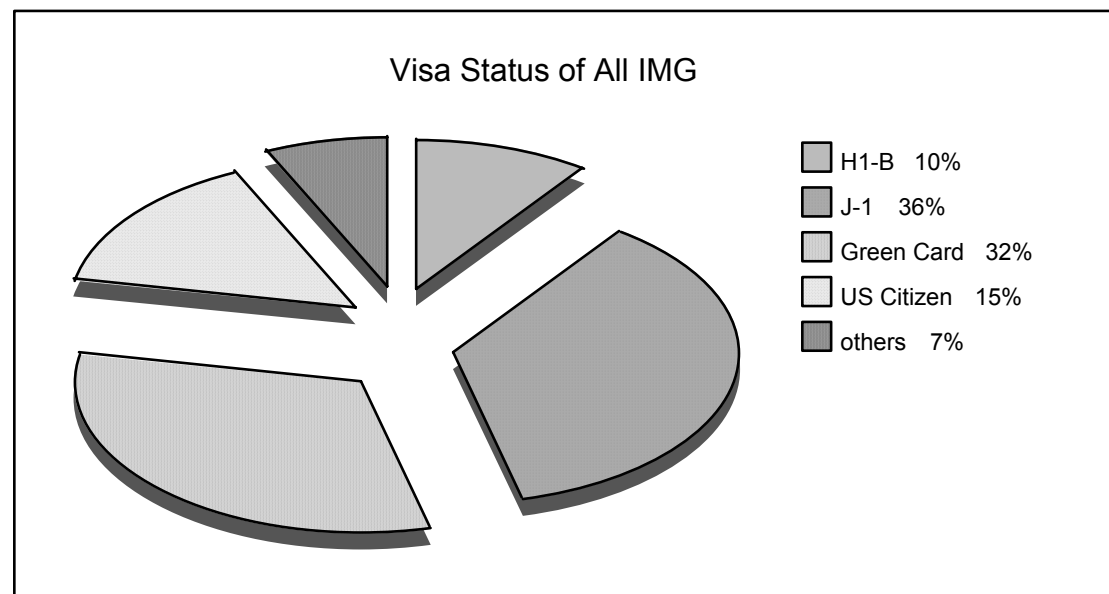
means of controlling inflows of doctors because so many IMGs have a means of achieving permanent residency/citizenship status. If there was a need or desire to control the growth of IMGs, this would be more likely to be achieved through GME policy than immigration policy.

Figure 6: Residency Status of IMGs 1993-1999



Source: USMLE website 2002

Figure 7: Visa Status of All IMGs 1998/9



Source: USMLE website 2002

Graduate Medical Education (GME) Organisation and Funding

Graduate Medical Education is clinical training in approved Residency programmes, for allopathic medicine, osteopathy, dentistry and podiatry. The first year (PGY1) is known as the Intern year, and is followed by 2-4 years of core training. Fellowship sub-specialty training may follow. Residency/Fellowship programmes can therefore vary in length from 3 to 8 years depending on the specialty. There are currently approximately 97,000/98,000 Residents in 7,700 allopathic programmes for 103 specialties/sub-specialties, regulated by the Accreditation Council for Graduate Medical Education (ACGME). The numbers in GME rose steadily from the early to mid-1990s, from 82,902 in 1990/1 to 97,823 in 1994/5 since which time they have remained fairly constant (Table 1). The rises are partly due to the lengthier periods of sub-specialty training, but mainly due to the financial incentive of the per Resident GME payment by Medicare, and other payers, to training provider institutions. As there was no cap on numbers/amounts, there were strong drivers for hospital administrators to increase the number of Residents, especially as the service delivery element of their work (as opposed to the training element) was at a lower cost than alternative sources of labour. Table 2 shows that the major part of the growth in Residency slots has been through IMGs, rising from 12,259 in 1989/90 to 25,880 by 1999/00 (HRSA 2000)

90% of GME programmes are affiliated to a medical school. Some sponsoring organisations, such as the Department of Veterans Affairs, (VA) and the Department of Defence, (DoD) have a particular agenda for training a mix of specialists relevant to their client group (Guterman, 2000). In 1997, the VA trained 32,000 Residents in 130 VA facilities, at a cost of \$400 million, making it the largest single training provider in the country. However, Medicare is the largest provider of GME funding. The second largest source of funding for GME is Medicaid (nearly all State Medicaid agencies voluntarily cover some or all GME expenses associated with the care they purchase). With the growth of Medicaid managed care, this source of revenue has been falling for public teaching hospitals serving low-income patients. Other contributors include the Federal Health Resources and Services Administration, US Departments of Veterans' Affairs and Defence, third party payers, self-pay client payments for services, philanthropic donations, State and local government funds.

The COGME policy push (4th Report 1994 and 8th Report 1996) was for a reduction in the overall number of Residency 'slots' to 110% of the annual number of USMGs, and for a redistribution of specialty training slots to achieve 50% generalist slots, in such areas as family medicine, general internal medicine, and general paediatrics, to serve as primary care physicians (COGME 15th Report 2000). These are known as the 110/50:50 policies. Various mechanisms were suggested to achieve these numbers, including removing 75% of the funding for IMGs in GME, or fully funding only 25% of their slots. The argument was that the US/Medicare should not be responsible for IMG training (particularly as the J-1 Visa programme was intended for trainees planning to return home), and that such slots should be funded out of the overseas aid budget. Limiting the main Medicare source of funding for Residency training programmes, and thereby cutting the number of Residents in training, was seen by COGME to be the most relevant and effective tool for limiting the inflows into the medical labour market and was a policy also endorsed by the major medical associations in a *Consensus Statement on the Physician Workforce 1997* (COGME 15th Report). It also had the benefit of reducing Medicare costs. Several changes have already occurred to funding levels and formulas, but deliberations are still continuing on how to best lever further policy changes. A brief description of the GME funding mechanisms and recent reforms will help to illuminate the intended effects of the policy initiatives on the workforce.

Medicare reimbursements to hospitals for GME programmes

These are in two parts: direct costs (DGME) and indirect costs (IME). The DGME subsidy is paid on a per-Resident basis to the hospital. It is based on the annual number of in-patient

days of Medicare beneficiaries, and the number of Residents, and covers Resident salaries, overheads, indemnity insurance and faculty payments. Indirect costs are those associated with the more expensive delivery of care in GME settings, such as the inefficiencies involved in training alongside service delivery. In addition, academic hospital settings offer a more technically expensive range of procedures, treat a more difficult and acute case mix and treat more indigenous/ minority/ poor/ uninsured populations. IME forms the largest share of the Medicare subsidy, shown in Table 1, below.

Table 1: Medicare Payments to Hospitals for Graduate Medical Education

Medicare Payments to Hospitals for Graduate Medical Education (in Billions of \$)			
	IME Payments	Direct GME Payments	Managed Care Carve Out Payment
1990	2.81	1.7	
1991	3.09	1.82	
1992	3.51	2.26	
1993	3.87	2.41	
1994	4.2	2.44	
1995	4.65	2.5	
1996	4.94	2.55	
1997	4.44	2.09	
1998	4.19	1.76	0.73
Source: Council on Graduate Medical Education, 15th Report: Financing Graduate Medical Education in a Changing Care Environment, 2000. Data from US Congress			

The formula for calculating the amounts paid is based on the estimated costs in 1984/5, with annual additions for inflation. The average Medicare payment per Resident was \$75,000 in 2000. However, there are wide variations in the amounts paid to different institutions because of inconsistencies in the initial way costs were defined and presented. The range was \$60,000 to \$120,000. In effect, the Medicare source of GME subsidy created an open-ended incentive to recruit more Residents, who additionally provided a relatively cheap form of effective hospital labour, particularly by PGY3 and 4. It also encouraged the provision of more specialist training programmes, and longer training in sub-specialties. As the supply of home-produced doctors has been constant over the recent medium term, more IMGs were drawn into the system to fill these vacancies.

It was these unintended consequences of the Medicare GME funding formula, coupled with the increasing costs to Medicare and concern about the solvency of the Medicare Part A trust fund financing GME, which led to the 1997 Balanced Budget Act (BBA). Based on the recommendations of COGME Reports 7 and 8, to downsize the number of Residencies, the Act capped the number of Residents per institution at the 1996 level. It provided strong incentives to downsize programmes by at least 20% over 5 years, in the form of transitional financial assistance, and enforced stiff penalties for failure. There were stricter rules about funding second residencies (either because people simply changed their minds, or because they were attempting to switch from a specialty that was relatively easy to enter initially, to one which they had always preferred). Residency programmes in rural underserved areas were excluded from the cuts. It also reduced the IME component of subsidy. The cuts in DGME were estimated to be \$900 million over the first 5 years, and IME was anticipated to be 29% lower by 2001 than in 1997. The cuts had a major impact on teaching hospital finance, and their ability to operate in an increasingly competitive market place. Revenue

losses amounted to 7.8% for academic health centres, and 5.4% for other teaching hospitals. In total, the amount of loss was \$700 million in DGME, and \$5.1 billion in IME (COGME 15th Report). The impact was such that the Balanced Budget Refinement Act was subsequently passed in 1999, which reduced the cuts, and froze them after 2002. It further softened the cuts by allowing up to 3 FTE Residents per hospital on maternity or other approved leave to count for subsidy. It added further incentives for rural residency programmes, allowing a 30% expansion in this category, and also enabled urban hospitals to operate a rural training track.

The effect of the cuts for New York City and its teaching hospitals was particularly acute. There is a high concentration of medical schools in NY City, 12 in all (public and private). These provide training for 10% of all medical students and 16% of the nation's Residents, and 75% of uncompensated care. Half of all NY City beds are in teaching hospitals, with all the associated higher costs. As a result of the reforms, the bed occupancy rate fell from 85/88% to 75/78%, and downsizing was further exaggerated by the penetration of HMOs, such as Oxford and U.S. Healthcare into the market. In addition, NY City relies heavily on IMG Resident, 49% overall, and even higher concentrations in specific specialties such as geriatrics (88%), nephrology (87%), haematology and oncology (83%), family medicine (68%), internal medicine and paediatrics (67% each). Policies targeted at reducing the numbers of IMG Residents further threatened the operation of these facilities.

The whole issue of GME funding continues to be under scrutiny. Some policy experts, such as the Medicare Payment Advisory Commission (MedPAC), a panel established by the BBA, believe that Medicare funds should be specifically devoted to promoting access to care for its beneficiaries, and less involved with funding GME. Several bodies (Pew Health Professions Commission, Council on GME, COGME) want to see a more stable and equitable 'all-payer' GME fund established, to fairly distribute the cost of training across all payers. COGME also believes that the funding mechanism should be able to lever change in both the numbers and the specialty mix of the physician workforce, by supporting training in non-hospital, community, and underserved settings. At the moment most programmes are delivered by teaching hospitals, or academic health centres, with both in-patient services and ambulatory clinics. Relatively few programmes use community based facilities, such as health centres and clinics, physicians' offices, nursing homes, hospices, community hospitals, managed care organisations. A policy aim (COGME 15th Report 2000) is to increase training in these community settings, which it is thought, will increasingly be the locus of practice for physicians, as care shifts from a hospital-delivered health service. However, although treatment is less expensive in community/ambulatory settings, and therefore preferred by HMOs and other payers, there is research evidence to suggest that delivery of training is more expensive. The problem is how to do this whilst still enabling providers to make GME programmes responsive to changing educational needs, to local conditions, and to population redistribution and expansion. Unanswered questions also remain about who should receive payments directly from the fund. For example, in determining the numbers and specialty mix of Residents, hospitals may have a conflict of interest between their own service needs and wider workforce requirements for more community rotations. Should they therefore be the direct recipients of funds as at present? How should funds be allocated? And how should accountability for their use be established? In resolving these issues, the power of different stakeholders is being played out.

Whilst these questions are being debated, the net result over recent years has been to reduce the number of IMGs entering Residency programmes. As various interviewees explained: *"The increase[in IMGs] has stopped...it's not increasing, it's in part due to changes in how we pay for post-graduate training and I think in part strengthening the testing requirements"* (US Int 2); and

“I don’t know of any physicians who have completed a Residency Program and who are unemployed. Actually I know of people who have been certified by the ECFMG who can’t get into a Residency Program, but once they get through residency I think there’s always a job, they can always find a job”(US Int 1).

4. The US in Relation to UK Requirements

Apart from the trends in 1960s and 1970s for UK doctors to emigrate to the US and other ‘White Commonwealth’ English speaking countries, there has not been a great deal of movement between the two countries. Ireland appears to have more of a tradition of sending graduates. Anecdotally it is said that the UK may operate as a transit lounge for would-be immigrants from South Asia to the US, but this does not show up in the statistics, which are by country of initial qualification. It is thought that the barrier of the ECFMG examination would act as a deterrent for UK qualified doctors. By comparison, entry into Australia and New Zealand is much easier on a temporary basis for UK junior doctors who wish to take a working career/travel break. However, there have been recent signs that UK Specialists entered on the Specialist Register may be eligible to practise in some States without facing the usual hurdles. Two have recently sought STA confirmation of their registration, and asked for details to be supplied to potential employers/ sponsors (STA personal communication 2002).

There has certainly not been a tradition of physicians moving from the US to the UK at any level. All USMGs are virtually guaranteed a post-graduate training position in the States, as supply exceeds domestic demand, as we have seen. Post-Residency opportunities for earnings are far in excess of the UK, as are the opportunities to sub-specialise. There is therefore no obvious UK ‘pull’ for US physicians. However, there is an indication that there may be doctors who would be interested in applying for positions in the UK, but as yet we have no analysis of these doctors by level of qualification, or by country of initial qualification, has been undertaken. The UK recruitment campaign for specialist doctors, begun in 2001, yielded a significant number of initial enquiries from the USA. The same was also true of Israel (TMP personal communication 2001). The surmise must be that the level of enquiries was related to the events surrounding 9/11. It would be fascinating to find out the country of initial qualification of these enquirers. Were they from minority groups who might fear reprisals or closed doors in the US? Were the enquiries from Israel from Israeli-qualified doctors who might want to escape National Military Service? Or were they from doctors qualified abroad? The literature suggests that many doctors emigrating from Russia to Israel in 1990s have found difficulty in practising at their previous level of experience and expertise (Bernstein et al 1995).

These data are held by the recruitment agency employed by the UK Department of Health, TMP Worldwide, and may be valuable contribution to our current understanding of drivers underlying global medical migration. Detailed information is needed to understand whether those enquirers are the kinds of renowned specialists the UK is seeking to recruit for a 3-4 year period, or whether they are at the post-residency phase of their career. One suspects that the former would only be recruited on a one-to-one personal basis, as per the strategy recently begun, employing well-known figures such as Magdi Yacoub. Post-residents would encounter difficulties entering the UK at specialist level, as the ‘fit’ of qualifications and experience is not good. Specialist training begins at the equivalent stage of our SHO basic speciality training, and may be completed after 3 or 4 years, depending on the speciality. Sub-specialty training may then follow. However, even though the number of years of training may be fewer, the hours are much longer, typically 80 hours per week. Some therefore think that the training may equate to UK specialty training (UK Int ?). If the STA proposals to allow entry to the Specialist Register at an earlier stage should be adopted, the ‘fit’ would be much better. It would in fact be more in line with the system in the rest of Europe, where specialist training is completed in a shorter period of time.

5. Competitor Country Analysis

As a competitor, the US is seen as having the edge over all other players in the market in terms of the 'pull' of the financial rewards and the more open nature of the opportunities following residency.

"People feel that opportunities will be better for them in the US or they may feel that they're going to make more money in the US" (US Int 1).

"This is a very lucrative profession. This has got to be a major factor... and freedom to practise and choose your own specialty...we have a more open system for better, for worse."(US Int 4)

It also is the most desirable destination in terms short-term programs for skills enhancement and exposure to new techniques. This was the perception of US interviewees. It was also the perception of interviewees in the UK's major international supply country visited, India, and also in Australia and Spain, and in the potential supply countries of Poland. Australian doctors seeking skills enhancement were also more likely to look to centres of excellence in the States (Miller et al 1998). Particular Universities have developed special relationships, which facilitate such movement. The Johns Hopkins University was frequently mentioned in India.

The US is the main competitor in the market for doctors from South Asia, and leads ahead of the UK, Australia and New Zealand and Canada, all countries facing particular physician workforce shortages. It does not perceive itself as having any real competition from these other demand countries. The pull of other countries was of a different order, and excess supply would not necessarily easily spread to other demand countries.

"I don't think the US does see itself as having a difficult time competing...The hope of practising in the US is very attractive...To some extent these markets are segmented...but if our market has a lot higher incomes for physicians, that's not going to be able to equalise elsewhere" (US Int 3).

However, a counter thought was that there might be some spill over.

"I would think that most foreign national doctors are probably pretty intelligent and they probably have alternative plans. You know they may choose to go to Canada, they may choose the United States or England. And they may have back-up plans. If they can't get into one, they may plan to go somewhere else" (US Int 3).

6. Summary

There are many different stakeholder involved in the sum of decision and policy making which affect the numbers of IMGs entering the US. In a country without a strongly directive Federal policy, actions intended to curb the supply of IMGs into the workforce can be met with counter forces. The strong 'pulls' into the workforce appear to be 'the insatiable appetite' of the US population for ever-increasing levels of health care, the increasing trend towards specialisation, the strong demand from hospital service providers for Residents, and the high financial rewards for practitioners. As there are no workforce limits applied to the numbers able to take up the equivalent of our UK Consultant posts, there is always pressure to increase the numbers of approved Residency slots.

Nevertheless, there are counter pressures, particularly articulated by COGME, and these have been effective over recent years in reducing the numbers of Residency slots, and in shifting the balance (possibly temporarily) towards an increase in provision of primary care physician

training. There is also evidence that immigration is tightening its scrutiny procedures, and it is becoming harder to enter the US from the S. Asia region since 9/11. The lobby group, which recommends reducing dependence on IMGs and increasing opportunities for medical jobs for US citizens, has recently become more vocal. Its arguments are based on ethical considerations, both from the perspectives of other countries, and from the level of unmet demand for medical school places within the US. Whether these ethical considerations, coupled with the policy imperative to restrain public spending on Medicare, will prevail over, what is seen as, the inexorable nature of the expansion of healthcare, must still remain an open question.

However, we can say that factors predisposing towards constraint do not seem to have deterred the numbers seeking to gain accreditation from the ECFMG, the first hurdle to cross in the route to practising in the States. Numbers sitting the USMLE have gone up to around the 10,000 per annum mark. We also know, from both our interviews and focus groups in India, and our USA interviews, that there are many IMGs who are queuing in the States in their attempt to get a Residency. Supply is currently exceeding demand. This may partly account for the fact that the numbers sitting the UK PLAB examination have also increased dramatically in the last year. These doctors, and others who are hoping to follow them, are reading the market signals and considering other destination countries in their search for postgraduate training opportunities. What they do not appear to be doing is redirecting their goals towards staying and working in their own home country. So long as some doctors make it through the barriers, others will live in hope of doing the same. The indications are that the drivers out of major supply countries are still operating as strongly as ever, but more potential migrant doctors are hedging their bets, and attempting different options. Nevertheless, in terms of sheer numbers, the US remains the first choice destination for overseas trained doctors.

The trend of the early 1990s showed a rising trajectory in the percentage of IMGs to USMGs entering Residency training. Although this has fallen back more recently, with the numbers of IMGs still entering US Residency programmes each year at around the 5,000 mark, the sheer volume is a strong market signal going out to supply countries, such as India. Although other demand countries, such as Canada, the UK and Australia, take in smaller numbers, nevertheless, each still has between 20% and 30% of their medical workforce trained overseas. These market signals have already been responded to in India by the rapid increase, during the late 1990s and early part of 21st Century, in the number of private medical colleges offering undergraduate training. Our US data also indicated that the Philippines produce doctors for the export market. Those availing themselves of these training opportunities, often at considerable cost to their families, are not doing so to train for the vacant slots in their domestic markets. Their focus is on more prestigious specialty training. With the long lead-time to produce a doctor, and heavy institutional and personal financial investment in training, as well as personal work investment, this production is not a juggernaut easily stopped.

The particular circumstances of the current time in the US therefore appear to have presented a 'window of opportunity' for other demand countries in the global medical labour market, of which the UK could take advantage. As some of these doctors are already specialty trained in their own countries, and plan to repeat training in the US, they may present a recruitment opportunity to the UK. How the UK can best avail itself of these opportunities is addressed in the main sections of the Report.

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COUNTRY REPORT 2 – AUSTRALIA

Country Report for Australia

1.General Background

Economy and Population

From 1976 to 1996, real annual gross domestic product (GDP) per person increased by 40.4%, creating both government and personal ability to fund medical care expansion. Over the same 20 year period the population over the age of 55 years, the heaviest consumers of medical services, increased by over 50%, whilst overall population growth slowed. Population was 18 million in 1996.

Spending on health was 8.5% of GDP in 2000, about average for OECD countries, increasing steadily from 7.9% in 1990. According to the Australian Institute for Health and Welfare (AIHW), inflation in health services has been more or less in line with general inflation. However, various projections of expenditure on health to the year 2040 forecast an expansion of anything from 9% to 19%. Australia therefore shares the policy concern of health services of all major developed economies of planning for cost containment in the delivery of effective and efficient healthcare services.

2. The Health Sector

Nature of the Health System Model

There is universal access to health care regardless of ability to pay, provided through Medicare, the Government Health Insurance system of reimbursements from the Health Insurance Commission (HIC) for consultations and care, established in 1984. Only certain services are included in the Medical Benefits Schedule, and others (such as dental treatment) are excluded.

Most doctors, apart from those in training or employed in public hospitals as career grade doctors, are self-employed. They are funded through a mixture of private health insurance and Medicare reimbursements. To access Medicare payments, a doctor requires a Provider Number issued by the HIC. Obtaining a Provider Number which is 'Unrestricted' in terms of both time and place, allows a practitioner to locate his practice where he chooses, and to 'bulk-bill' Medicare, on a 'fee for service' basis. Bulk-billing accounted for 80% of services in 1999/2000, and applies especially to the elderly or vulnerable groups, who then need pay nothing at the point of access to services. Other patients pay the practice at the point of use, and then reclaim the Medicare Rebate. If their doctor charges higher rates than the Medicare fee, the patient pays the difference out of pocket. Alternatively, services can be paid for through private insurance schemes. Private practitioners, both GPs and Specialists, are funded in this way.

The system of payment means that obtaining an unrestricted Provider Number is vital to a doctor's ability to set up private practice and maximize income. Unrestricted Provider Numbers are only available to Australian trained doctors who have undertaken a specialist or vocational (GP) training. Other doctors, such as overseas doctors, no matter what their level of training or specialist qualifications, may only access a restricted Provider Number, that is restricted by time and place to an area of workforce shortage. Australian doctors in the hospital grades are likewise limited to a particular location.

The Medicare system is thought to have been one of several factors operating to increase demand for services over the last 25 years. (Between 1976 and 1996 there was a 108% growth in the number of medical practitioners, from 21,150 to 44,000, outstripping the growth in population, from 14 million to 18 million, by 37%). Attempts to limit public spending on health has led to the Commonwealth Government recently encouraging greater take-up of private health insurance, by contributing 30% to the cost of premiums through tax rebates, and through tax penalties for non-cover. The premiums are designed to provide incentives to take out and maintain uninterrupted cover from a young age. This has led to an increase in the percentage of the population with private health insurance from 30% to 45% between 1998 and 2001. (Compare England, where 11.5% of the population has private insurance, with 8% as group policies purchased by the employer and 3.5% by individuals). There are currently 44 registered health benefits organizations in Australia, regulated by the Private Health Insurance Administration Council, but the 3 largest provide for 2/3rd of the market (Int. Aus. LA).

Nature of the Delivery Model

The Health Care system is similar to that of the UK, in that General Practitioners (GPs) are the gatekeepers to secondary care. Referrals to specialists, whether in private clinics or public hospitals, are through GPs. GPs comprise 45.3% of the workforce and specialists form 35.8% of the workforce, 9.7% are specialists in training, and 9.3% are hospital non-specialists (including Interns, Hospital Medical Officers (HMOs/Senior HMOs and career grade doctors) (Conn et al 2000). Most GPs work in group practices, with solo practitioners comprising only 14.5% of the workforce.

Within the last few years, there has been a rapid rise in corporate health provision in the primary care sector, similar to the American Health Management Organisations, with 3 large players in the market. The financial impetus behind this is the opportunity to expand the business vertically, into the provision of pharmacy, radiology, and pathology services provided by the company. An incentive for doctors is that they no longer have responsibility for the purchase, management and administration of a practice. They can more readily dictate the hours they are willing to work, and rely on the organization to arrange out-of-hours and other locum cover.

There is a greater dependence on private provision than in the UK, especially in the hospital sector, where 63% of private work is covered through private insurance. Specialists are mainly self-employed. Medical Specialist Learned Colleges control entry to the specialist market, by regulating professional training and accreditation within Australia, and scrutinising and recommending overseas trained specialists for registration with the relevant State/ Territory Medical Registration Boards. Registration as a specialist (only 2 States have an actual Specialist Register, but more are considering establishing one) confers access to an unrestricted Provider Number for reimbursement for private practice consultations and procedures. It also confers the status needed for recognition by private health insurance companies. Many specialists will also undertake some sessional work in public hospitals, when the hospital then recovers the Medicare fee. Many private hospitals are adjacent to public ones, and there are issues of a two-tier system developing, with public hospitals relatively under-funded. Many private hospitals concentrate their provision on the low risk, high turnover, short-stay cases. There is, for example, hardly any A&E in private hospitals.

States and Territories provide public hospitals (secondary and tertiary care) jointly funded by them and the Commonwealth Government. Treatment in public hospitals, both as an in-patient and as an outpatient, is free, but treatment as a private patient in a public hospital (with a choice of doctor) only attracts a 75% Medicare reimbursement, although the remainder can be claimed through a private insurer, if the doctor has a contract with them. There is a system of co-

payments for the costs of pharmaceuticals, with concessions for vulnerable groups, and higher charges for branded goods.

As GPs, and most specialists, are independent practitioners, with no restrictions on where they can set up practice, unsurprisingly, most have chosen to locate in the major centres of population, especially those attractive to the population in general. (Most of the population lives in State and Territory capital cities. Whilst 28.7% of the population lives in rural or remote areas, they are served by only 15.6% of physicians). The resulting competition among GPs has driven down the price of services to the Medicare floor for more than 80% of patients in metropolitan areas, but is prevented from dropping to an uneconomic level by the system of reimbursement (Wells (2000). Nor has this situation led to doctor unemployment or a reduction in income. Furthermore, as the volume of services can be expanded by both patient and doctor, at zero cost to the patient, so incomes are maintained, there is no doctor unemployment, and there no drivers for doctors to relocate to (what would be a more profitable, under market conditions,) under supplied areas. At the same time, there are no weightings to compensate for the additional social and financial costs of practice in rural areas.

Organisational Form and Reform Changes

Health care policy is a joint responsibility between the Commonwealth (Federal) Government Department of Health and Aged Care, and Ministries of Health of the 8 States and Territories, whose separate powers are constitutionally enshrined. Health care is financed from general taxation, and from a compulsory health tax levy on income, with the Commonwealth contributing 48% of health expenditure in 1999-2000, to the States' (and local governments') 23%. A further 29% of funding comes from private sources (including 16.2% from 'out-of-pocket' expenditure, 7.1% from private insurance, and 5.5% from other sources). In common with other developed health systems, there is concern at rising costs.

"The States complain that the Commonwealth should increase funds in response to the rising demand for hospital treatments; the Commonwealth responds that the States should increase their share of hospital funding" (European Observatory on Health Care Systems 2002).

States and Territories are also responsible for mental health and community health services, as well as for regulating/registering health workers.

The workforce is possibly one of the most highly planned in the world in terms of numerous entry at both the undergraduate level, and for specialty training numbers. The central planning process is assisted by a number of government bodies: the Commonwealth Department of Health and Aged Care is responsible for policy development and implementation; the Australian Institute of Health and Welfare (AIHW), a statutory body with core funding, and research independence, amalgamates and supplies data on workforce numbers obtained from a number of different sources; the Australian Medical Workforce Advisory Committee (AMWAC), established in 1996, is charged with interpreting data and reporting and advising on specialist and overall workforce numbers and training requirements in the light of discernible trends. A recent development is the proposal to establish a National Health Workforce Council (NHWAC) as the strategic think tank, with overarching responsibility for the future structure of the healthcare workforce, to complement AMWAC's work on workforce numbers (Gavel et al 2002). Although there is a high degree of central planning, there is no central power of enforcement, as States/Territories have a high degree of self-direction.

If overall planning happens centrally, a number of stakeholders are involved in the complex process of implementation and delivery. These include; the Colleges, with responsibility for specialist training supervision, and for accreditation in conjunction with the apex regulatory

body, the Australian Medical Council (AMC); the States/Territories Postgraduate Medical Training Boards (PGMTB) for provision of centrally advised postgraduate training numbers. Places may be oversubscribed in metropolitan areas, and go unfilled by Australian-trained doctors in other smaller urban locations. Public hospitals (the equivalent of NHS Trusts) have to manage the budgetary tensions of local responsibility for service provision from central funding, and training needs, funded by the Boards. Responsibility for planning to address the problems of the mal-distribution of GPs, and the distribution of specialists in short supply, is devolved to States/Territories.

The Regulatory System

The Australian Medical Council (AMC) has overall responsibility for the curriculum, quality and standards of medical education, and for the accreditation of permanently resident Overseas Trained Doctors (OTDs), via the AMC examination. This body also regulates access to the Specialist Register, on the recommendations of the Royal/Learned Colleges, following successful completion of Higher Specialist Training. Training requirements and assessment procedures vary between the different specialties, but would typically involve passing Membership examinations during Basic Specialist Training (at the equivalent of the UK SHO stage), followed by a recognized programme of Higher Specialist Training. There may or may not be an exit examination. On-going assessment occurs in a similar way to the UK system, using logbooks etc. Achieving specialist registration for an OTD is a difficult route, unless the specialist is internationally eminent in the field. More often than not, the College will recommend that a further period of training/observer-ship/examination should precede registration.

Registration of doctors is at State level, with their Medical Registration Boards. 'Full' Registration is reserved only for Australian and New Zealand-trained graduates, and for OTDs who have passed the AMC examinations. 'Conditional' Registration is for Temporary Resident Doctors (TRDs), and may be obtained through one of two visa routes. An 'Occupational Training' visa category 442 is for doctors already undertaking a recognized programme of training, and who undertake relevant rotations in Australia, whether or not these will actually count as contributing to their training in their home country. This category is open to, say, UK doctors at the SHO stage, who are taking a career break before proceeding to Higher Specialist Training back home. The other route is via a 422 'area of workforce shortage' visa. An employer must demonstrate that the position has been market tested, and that no Australian has come forward to fill the vacancy, or the position must be in a geographically defined 'Area of Need'.

Medical Education and Training

Undergraduate Education and Training

Applications to medical school were thought, by our interviewees (Aus Int 1,2,4,9) to still be robust, but that the success of the IT sector might have attracted some students who would previously have chosen medicine as a profession. There was also some anecdotal evidence that some may leave the profession early, treating an MB as a degree like any other, a qualification, which could gain entry into the commercial sector. This was perceived as bringing greater economic rewards more rapidly than a medical career. Nevertheless, there are still more good applicants to medical schools than there are places, and the profession looks more attractive in the light of economic turndown.

There has been a recent expansion of medical school places, from the 1,206 citizens / permanent residents who completed training in 1998, to an intake of 1,334 in 1999, and further places added through the establishment of a new medical school. The new capacity is located in underserved areas. Some of the new places are 'bonded' to service in Areas of Need after training. There has been an emphasis on strategies to recruit and retain

students/doctors for rural remote service and training, through raising awareness of career possibilities in rural schools, and through the inclusion of more training in rural locations. There has been less focus on high scores in high school leaver examinations, and greater emphasis on assessment in interviews in the selection process for medical school.

Postgraduate Training

The Intern/PRHO equivalent year precedes full registration, and is known as Post-graduate Year 1 (PGY1), and together with PGY2/3 comprise the Hospital Medical Officer grade. Hospital Senior Medical Officer grade follows, and is equivalent to the UK SHO, or the period of basic specialist training grade. There are five possible annual increments on this HMOs/HSMOs pay scale. These doctors work a 38-hour week, and any on-call, recall and unsocial hours shifts carry payments higher than the basic rates of pay. The Registrar grade is equivalent to our Specialist Registrar grade, and is an accredited training post, demanding a 43- hour week, including 5 hours specifically dedicated to training. Senior Registrar grade incorporates 4 years of accredited training, and a Principal Registrar would be an appointment of someone who had successfully completed all academic requirements for specialist qualification, and required 12 months or less of further practical experience to obtain their Fellowship (Aus. Int. 6,7,8)

Training numbers for appointment to Registrar training positions, and hence eligibility for specialist registration, are centrally regulated. Registration is a requirement for accessing an Unrestricted Provider Number for Medicare payments. The overall number of vocational/specialist training places has remained virtually unchanged between 1997 and 2001, at around 5,680 across all fields and for all years, but there have been some notable decreases and increases, to reflect perceived need. The largest decreases have been in general practice (148) and Paediatrics (38) (Aus Int 9)

Until 1996, access into General Practice was possible once full registration had been gained, and following whatever rotations were considered suitable, rather similar to the previous UK system. Now, however, there are a limited number of GP training positions, restricting the previously open-ended supply of doctors into general practice. Doctors who fail to access a training number would now only have the option of entering a hospital career grade post. In 2001, there were 400 first year GP training numbers. However, an indication that the perception of a GP oversupply may be changing is the increase in GP training numbers to 450 from 2001. This will be further discussed in the next section.

3 Domestic Supply and Demand in Medical Workforce

The Structure of the Workforce

Overall Supply

In 2001 at the time of the Australian fieldwork, the official Government view was that the medical workforce was adequate, if not oversupplied. There was an overall increase in the medical workforce between 1993 and 1998 of 8.9% compared with a population increase of 6.1% over the same period. Primary care practitioners increased by 10.2% and Specialists by 8.2%. This period of rapid growth was followed by temporary cutbacks in training in 1997/8 following estimates of oversupply. However, the Whole Time Equivalent (WTE) workforce was later estimated to be approximately 3.4% lower in 1998 than in 1994 due mainly to increased female participation. Now, given demographic trends, such as the ageing of the population and the physician workforce, the increasing feminisation of the workforce, more flexible and part-time working, and the reduction in junior doctors' hours, there are again concerns about possible shortages. In our interviews, medical professional bodies were most likely to take this view (Aus Int 4, 10). However, government rhetoric (Aus Int 9) also appears to increasingly acknowledge that there may need to be an expansion of the workforce, and this has begun to feed through into medical school recruitment, with attempts to target the

increase towards AoN. Official policy is for Australia to become self-sufficient as quickly as possible.

“It’s a fairly common view...that we would rather see more Australian kids get a chance to do medicine, than sort of bring in doctors as a band aid solution, and not necessarily a morally sound solution...it’s a necessary evil if you like, we don’t want to deprive other countries of their medical resources, particularly countries like South Africa.” (Aus Int 5).

Meanwhile, there is a recognition that the country will continue to rely on OTDs to supplement the workforce on short, medium and longer-term bases for the foreseeable future.

“In general, AMWAC favours adjustment to training intake as the best long-term solution to any anticipated imbalance between supply and estimated requirements. The approach is consistent with Australia’s policy of ‘self-sufficiency’ with respect to the supply of health personnel. However, it should be noted that this approach recognizes that there will always be country to country exchanges of doctors, and that Australia is likely to continue to seek a certain number of overseas doctors, both on a temporary resident basis and a permanent resident basis.” (Gavel et al 2002).

The degree and duration of this reliance are what is in question.

Geographical Imbalance

The overall physician to population ratio was 244.5:100,000 in 1998, up from 238.2:100,000 in 1993. (c.f. the OECD average for 1997 of 253.4). However, these figures mask a wide geographic variation of 306.3:100,000 in capital cities, compared with 143.6:100,000 in rural and remote areas, and down to 66:100,000 in remote areas. Variation in specialists is from 110:100,000 in metropolitan areas compared with 8:100,000 in rural and remote areas. However, these figures do not take account of outreach services and fly-in, fly-out services for treatment in urban centres. For example, Adelaide has the highest physician to population ratio, but also provides services for the Northern Territories. The under-supply of doctors in rural and remote areas can be expressed as 15.6% of all medical practitioners serving 28.7% of the population, of whom 60.2% are in primary care, compared with 39.3% in primary care for the rest of Australia, and an overall primary care workforce of 45.3%. Rural workforce shortages are therefore a major issue.

The Commonwealth government has official definitions of different types of community by population size and growth, and designates those classified as ‘rural and remote’ as Areas of Need (AoN). AoN are undersupplied both in general practice and in the supply of hospital doctors in the public sector, in the training grades and specialties. The Northern Territories and Western Australia are the States with the greatest problem, whilst New South Wales and Victoria and South Australia are relatively well supplied.

Closer analysis reveals pockets of undersupply in general practice not only in AoN, but also in sections of the urban and suburban areas of large cities, especially those of lower socio-economic status. Some of the evidence for this was anecdotal, *“It is impossible to get a GP appointment today, and the average wait is one to one and a half hours”*, (in Canberra) (Aus Int 4). Other evidence was more concrete, in the form of recruitment campaigns in the UK for doctors at SHO-level to staff A&E departments in Western Melbourne (an area of younger/lower socio-economic expansion) and Gosford 90km North of Sydney. Several hospital medical directors spoke about their staffing problems, both for doctors and for nurses (Aus Int 6,7,8). The situation is critical in some of the smaller rural and remote communities, threatening the ability of care facilities to remain open (Aus Int 5). Other particular pockets of undersupply include the Aboriginal Health Services, in all locations.

Across the country there are also shortages in particular hospital specialty areas. These include alcohol and drug-related illness, sexual health, geriatric and rehabilitation medicine, obstetrics, psychiatry, and ENT. The explanations for these shortages vary between the 'unattractive' nature of the work (e.g. geriatric), high indemnity insurance costs (for obstetrics especially), and unsocial hours (anaesthetics and intensive care), and the way doctors are paid (A&E and IC are solely located in public hospitals, and therefore the opportunities for privately paid work are limited). Some of the shortage specialties, such as neurosurgery, are currently in demand worldwide. Shortages are reflected in the expansion of training numbers in surgery (mainly general surgery and urology), emergency medicine, radiodiagnosis, and dermatology. Cobbald (2002) quotes shortages in radiation oncologists, medical physicists and radiation therapists from the Royal Australian and New Zealand College of Radiologists 2001. *"Global competition in these fields is strong, and we have lost some number of practitioners to other countries. The size of our workforce means that loss of a small number of practitioners in a field – especially in highly specialized fields such as radiation oncology – can have a significant impact. Australia has also recruited in these fields from overseas, but to date has not been particularly competitive in the market."*

The most difficult to fill job slots are, however, the general practice vacancies in the rural and remote areas, and: *"...successive Commonwealth budgets have devoted enormous amounts of money to incentive programs to move doctors to – what we affectionately call – the bush"* (Brennan 2000). As noted elsewhere: *"Workforce remains a primary consumer of our time, and it is my personal view that this will only increase over the next few months and years"* (GPDV 1999).

The National Rural Health Strategy was begun in 1994, and is the key national policy framework for programmes and initiatives to deal with rural health problems. Subsumed under the Strategy are financial support for relocation, funding for CME, and the Rural Divisions coordinating units (to facilitate networking of rural doctors), and locum provision. These initiatives address the issues raised by research into the difficulties of both recruitment and retention of GPs (e.g. GPDV 1999, Baillie et al 1997). Each State and Territory now has its own scheme / agency to address workforce shortages, (e.g. Western Australia Center for Rural and Remote Medicine (WACCRAM) and the Rural Doctors Network in New South Wales), sometimes operating in competition with each other. They work closely with their State/Territory Medical Registration Board, and its Board of Censorship, which decides on matters of 'conditional' registration. These regulatory conditions may vary according to need. Thus, it is said that it may be easier to get conditional registration to practice in parts of remote Western Australia than in New South Wales. Doctors without the postgraduate qualifications normally required, or permanently resident/citizen OTDs be able to get a placement in some locations under supervision. For example, in larger provincial towns, group practices of 3, 4, or 5 doctors, were seen as more able to provide support and mentoring to an immigrant/refugee doctor, from a non-English speaking background, who might not yet have completed all the AMC examinations. However,

"A lot of the towns are quite small, so there may be only one or two doctors in a town, so they have to be very self-sufficient, very strong on accident and emergency and so on." (Aus Int 5). These positions are considered more suitable for highly skilled doctors able to work in unsupervised general practice. Where towns are very isolated, they may also need doctors with anaesthetic or obstetric and surgical skills to undertake procedures, "so for those towns we often need to look overseas at countries with similar training and standards and similar sort of approach to general and family medicine [e.g. the UK]." And, "the scope and nature of rural medicine is a big selling point."

During the Australian fieldwork, we looked in detail the New South Wales agency, the Rural Doctors Network, based in the town of Newcastle. The RDN had been through an important learning process, and their experience shows the importance of taking time for planning and

preparation, both in terms of selecting a suitable candidate, and in terms of involving the community in the whole process. The overall support package is important, to doctors and their families when they first arrive, but also throughout their stay. Practical needs, such as housing need to be addressed. Professional support and development needs to be tailored to suit the individual. Locum support is essential to enable release for CME and for holidays, otherwise a doctor might have to be almost continuously on duty in a remote area. Such locum cover underpins and secures the lifestyle aspects of the recruitment package that is particularly important for longer serving doctors. Thought also needs to be given to provide parallel social occasions for spouse and children, say when the doctor is on a CME course. In addition, providing salaried employment, without long-term obligations has been seen as a competitive response to provide what UK and Canadian doctors want. This provides the initial security of a known income, and the lack of financial commitment to practice expenses, rather than the relative insecurity of a fee for service payment system. However, if doctors stay for longer periods, they may be encouraged to move towards the usual Australian payment system.

“We’re trying to promote the idea of what they call a walk in, walk out practice, that’s owned and managed, well not necessarily managed, but owned by the community, whether that be the council or other bodies that could do it. Where preferably the set up for general practice, preferably with reception, clerical, whatever staff, and the basic equipment and so on. So a doctor could walk in, provide the service for as long as they can, want to, or able whatever, and walk out without the investment. It also means medical records remain with the community, at the moment they remain with the doctor, all those other factors. And this is where we’ve got problems in a lot of communities, where people [doctors] are actually trying to sell and recoup or just make a profit, and it’s just not gonna happen...the world is changing, people are more mobile, and we’re trying to reflect that in the way we develop programmes, or encourage communities to develop structures and programmes that will work locally for them.” (Aus Int 5).

Involving the community in the preparation of a job profile, in putting together a package of benefits, and developing a commitment to on-going welcome and support of their doctor and family had been found to be important. The RDN did not itself undertake to make the final job match, however. Their experience was that it was best to leave the responsibility to the doctor and the community to make the final mutual selection. Previously, the RDN had operated in a more directly intermediary role to match individuals to practices, but found that the detailed understanding of what each party required and expected was best left to them to negotiate. Now, typically, a doctor applying would be interviewed and screened by the RDN, and the registration process expedited, but doctors themselves are left to sift job possibilities, from detailed profiles prepared by practices, of the work and resources and supporting services available. When a match seems likely, the RDN will pay for a site visit, and required Medical Board interview. All this is intensive and slow work, but is deemed a necessary investment to attract recruits and expedite job matching.

“We thought the onus needs to be on them, on the doctors themselves to find a position, and we wanted to do it through Divisions [of General Practice]... they’re often responsible for workforce planning at the local level, and they also know the division...they talk to the doctor and get a feel for ...what their needs are. And that works reasonably well. The proactive ones tend to find positions easily, and the ones that are a bit slack about it, it’s up to them whether they pursue opportunities or not.”

Above all, it was found to be important to be honest about what is being offered. Australia certainly seems to have developed a successful brand image. Brochures advertising opportunities to work for the RDN or WACCRAM emphasise the leisure opportunities available, just a short small plane ride away. Australia is seen as ‘the lucky country’ but the reputation would soon evaporate if experience did not live up to expectations (Aus Int 5). The continuing flow of particular nationals to particular regions is testament to the importance of word of mouth reputation in developing a reliable supply chain. Thus, Germans tend to go to the Northern

Territories, there is a steady stream of UK doctors into primary care in the outback (and flying doctor service), and South African doctors tend to locate in Western Australia (Aus Int 2).

In 1999, the Health Ministers' Conference adopted a national framework to further facilitate the recruitment of overseas trained general practitioners who do not need training or supervision whilst undertaking placements in rural and remote areas. The Commonwealth federal government assists by providing streamlined immigration procedures, and by allowing access to an unrestricted Medicare provider number after the completion of 5 years service, provided they have attained Fellowship of the RACGP. Obtaining this essentially then enables the holder to set up in private practice anywhere in Australia. The length of service required is geared to the target supply pool. Five years is about the maximum time a relatively young GP, perhaps with a family, might be prepared to stay in the bush. After that, the family pressures to locate nearer to a range of urban facilities become stronger. Doctors may be prepared to return to the bush once their families have grown up. Other than this targeted policy, such are the disincentives to other doctors to migrate permanently, that there is a 10 year moratorium on overseas trained doctors serving in an AoN before obtaining an unrestricted Medicare provider number. The recently established National Reference Panel (NRP) on OTDs has developed a 5-category classification of international postgraduate general practice qualifications and experience, which are deemed to be equivalent, and provide automatic access, shown at Appendix 1. The incentives are mainly designed to attract and retain doctors from the White Commonwealth countries, which have similar training systems, and where English is the first language. Admission to Fellowship of the RACGP *ad eundem gradum* (only whilst practising in the Australia) is, for example, automatic for UK GPs who hold both the JCPTGP and the MRCGP, and also for GPs from Canada and New Zealand who hold their national qualifications. Other categories may have to gain additional experience, or undertake further exams to gain the Australian Fellowship.

Recruitment to hospital service and trainees posts, undertaken by hospital directors of staffing, also relied to some extent on the existence of an informal supply chain to maintain a steady flow of recruits (Aus Int 6,8). Coupled with the use of websites and e-mail correspondence, hospital administrators were less dependent on annual or bi-annual visits to the UK to gain future recruits. They felt confident that they could now rely on reputation and previous contacts, reinforced by perhaps 5-yearly visit. Nevertheless, recruitment to a newly expanded hospital facility in West Melbourne, including an Emergency Medicine Research Centre, with its new status as a teaching hospital, advertised in the UK (BMJ Classified 3rd March 2001). Recruitment was focused on Hospital senior Medical Officers (PGY4-8) in general surgery, critical care, emergency medicine, and anaesthesia for the ICU. Interviews were held in 4 locations in England and Scotland, and by the end of the visit, staffing was assured, to enable the opening of the new facilities.

The Changing Gender Profile

The gender profile of the workforce is changing rapidly, with a 25.2% increase since 1993 in female participation up to 28.1% of the total in 1998. Females now comprise 52.7% of medical students. In general practice, 33.2% are female, but they comprise 60.3% of GP trainees. As women are more likely to be metropolitan based, these trends may exacerbate the GP shortages in rural areas. 84.4% of specialists are male, 15.6% female, and 53.3% of the latter are concentrated in just 5 disciplines: anaesthesia; emergency medicine (with intensive care); obstetrics and gynaecology; paediatrics; and psychiatry. Public health and radiation oncology also have higher than average numbers of women. These are the less popular specialties, either because of unsocial hours, or fewer opportunities for private practice, or high indemnity insurance. Women are under-represented in surgical specialties. In total, females now comprise 35.1% of specialist trainees. With average female working hours at 39.6 per week compared with 52.7 hours for men, and the ageing male physician population relative to women, there are likely to be further supply repercussions from the changing gender balance. What is not yet apparent is whether women who have had career

breaks and worked shorter hours will make up some of the difference towards the end of their working life.

Inflows into the medical workforce

New Graduates

In 1998 there were 1,206 new Australian citizen/permanent resident graduates. Intakes have since risen, with 1,334 starting courses in 1999, of whom 12.8% were overseas students, and 52.7% were female. A planned expansion over the next two years will bring the numbers of homegrown graduates to 1,400 per annum. 100 of these places are scholarships 'bonded' to service in rural areas for 5 years, with hefty penalties (no access to an unrestricted Medicare Provider Number for 10 years) as well as repayment of the \$20,000 Australian Dollars per annum bursary. Our interviewees reported that there was strong demand for these places in 2001. However, the Australian Constitution specifically forbids the conscription of health workers, so it is unclear whether the bonds will be enforceable in practice. New medical schools have been established in, Townsville in Queensland, and Canberra in ACT, two towns with low population growth (one of the indicators of an Area of Need). This policy move is predicated on the notion that doctors are more likely to remain in locations where they have been educated and trained. Other policies aim to increase the number of medical students from rural areas, by basing entry not simply on school examination grades, on a similar assumption that these students may be more likely to return to rural areas.

Aboriginal and Torres Strait Islanders are still under-represented in the medical student body. Women from South Asian second-generation families are over-represented in statistical terms in the student and young graduate population. They tend to leave the workforce earlier after the Intern year than other women. There is speculation that this may be because there are still strong cultural traditions of earlier marriage and childbearing than the rest of the female medical population. It is too early to say if, or at what stage, these doctors will reappear in the workforce (Aus Int 2,9). AMWAC has acknowledged a dearth of broader evidence on the causes of attrition, and on the career intentions and motivations of junior doctors in general. It plans to undertake cohort studies similar to the UK to develop an understanding of trends that goes beyond the anecdotal.

The 12.5% of additional places allocated for overseas students bring financial benefits to the Universities, and potential educational and developmental benefits for the sending countries, as well as to the individual students. However, not all overseas places are government funded (either by Australia, as part of the Aid budget, or by sending country governments). Australia is considered a good option for privately funded education compared with the costs in say, the UK or USA. For example, applications are received from US graduates for the 4-year graduate entry option recently introduced at the University of Sydney, as this fits well with the system of medical training there. Statistics from DIMA (personal communication 2001) on overseas students show that the total number of overseas students in the category 'Medicine, medical science, pharmacy' had increased from 1330 in 1997 to 1,525 in 1999. These numbers are in addition to the numerous clauses for domestic numbers, and suggest that Universities may be seeking to augment their income from overseas students.

Immigration of Overseas Trained Doctors (OTDs)

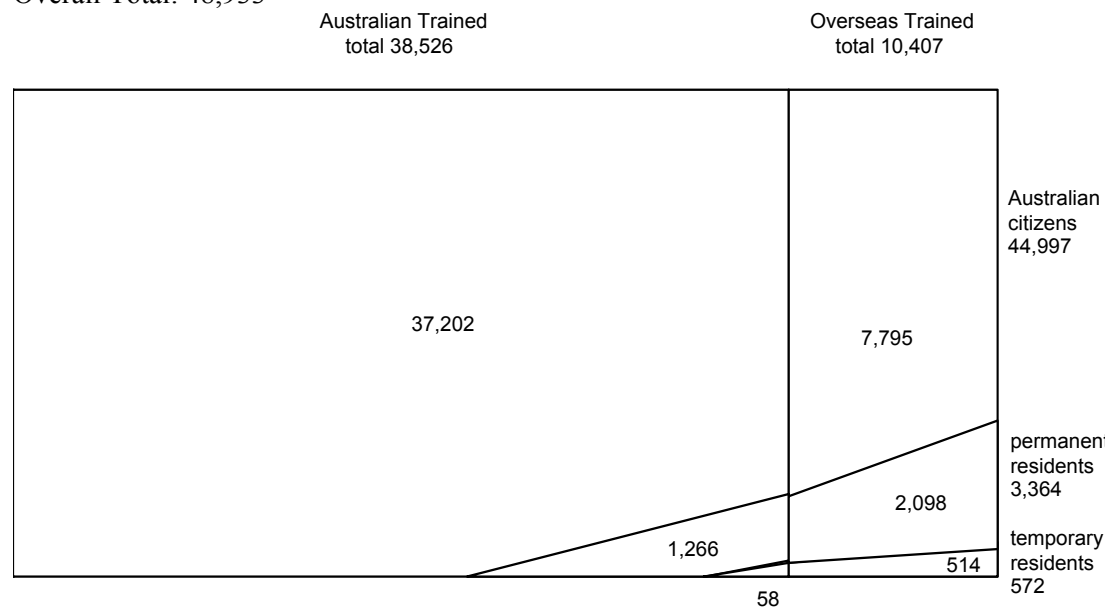
In 1998, counting both permanent and temporary doctors, there were 10,408 OTDs in the workforce, comprising 21.3% of all practicing physicians. However, OTDs formed a higher percentage of GPs (25%), and 30.8% of the workforce of remote areas. Historically, the UK has been the major source for overseas trained doctors, totalling an aggregate of 4,043, or 8.26% of the permanently resident, active workforce in 1998. The UK/Ireland share of all OTDs is 56%, 15.6% are from Asia, 9.6% are from New Zealand, and 18.8% are from a combination of other countries. Nearly all of them (95.7%) have Australian citizenship or permanent residency, a reflection of former times of easier access. The overall percentages of

overseas trained doctors in the workforce also approximates to the overall percentage of Australian citizens born overseas (AIHW personal communication 2001).

Figures 1 and 2 below show the status of the overall Australian physician workforce and the GP workforce, in 1998, both by country of training (Australia / Overseas), and by residency status. The data were supplied by the AIHW, during our interview (personal communication 2001, Warwick Conn). The tables also show that a slightly lower proportion of all medical practitioners in the workforce have Australian citizenship, compared with general practitioners.

Figure 1: All Medical Practitioners 1998, by Country of Training and by Residency Status

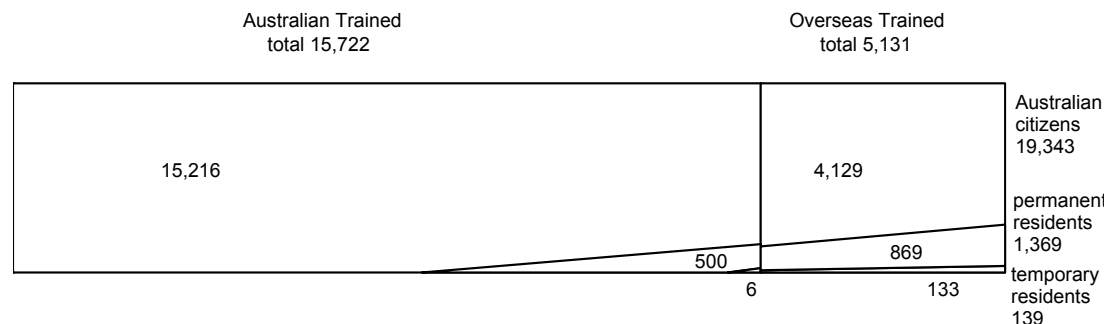
Overall Total: 48,933



AIHW personal communication 2001

Figure 2: Medical Practitioners (GP equivalents) in Australia in 1998, by Country of Training and by Residency Status

Overall Total: 20,853



AIHW personal communication 2001

Over time, waves of migration have occurred in response to particular in-country circumstances. There were particularly large flows from India in the 1970s (possibly coinciding with the tightening of entry restrictions into the UK after the 1960s relatively open access). Several of our interviewees spoke of the recent significant migration of South African specialists, as well as doctors from Zimbabwe, locating especially in Perth and Western Australia. Other recent waves include from Sri Lanka and also Fiji, in response to political circumstances. Most recently of all have been the increased flows from Iran, Iraq, Pakistan and Afghanistan. Changes in migration patterns mirror to some extent what is happening in the rest of the world, and also reflect immigration Government policy (Aus Int 2,3,9). We look in more detail at the current composition of the overseas trained workforce below

Permanently Resident Overseas Trained Doctors (OTDs)

Immigration policies now make permanent migration to Australia almost impossible on an 'occupational' visa, as the occupation 'doctor' is negatively weighted by 20 on the points system for entry. Nevertheless, there are permanent medical immigrants who come in to Australia on 'family' or 'refugee' visas. If they are to practise medicine, as permanent residents, immigrant doctors then face the regulatory requirement of passing the 2-part AMC examination (held twice yearly), something not required of temporary resident doctors (TRDs). The AMC examination takes the form of a Multiple Choice Questions (MCQ) paper, followed by a Clinical Examination, (held 4 times a year) with 12 stations, similar in structure to the UK PLAB test, before they can be registered to practise. All must also pass an English Language test. In 1998/9 408 such doctors entered Australia as permanent residents, including 39.5% from Asia, 14.1% from New Zealand and 16.3% from the UK and Ireland. (These statistics collected by the Department of Immigration and Multicultural Affairs (DIMA), are categorized by last country of residence, not by country of initial qualification. Some of these doctors may have therefore have been in transit from a third country).

The regulatory barrier of the AMC examination has also had limits on the annual number of candidates (200) able to sit it, now removed in principle, as a result of the pressure applied by a group of overseas doctors. A high profile hunger strike by some of their number in 1996/7 led to the formation of their association, the Australian Doctors Trained Overseas Association (ADTOA), which continues to negotiate with the AMC, and the New South Wales Medical Board (where most of these doctors are located) on matters of access. Their claim is that there are structural impediments in the processes involved in gaining recognition, which are discriminatory, and are unrelated to issues of quality control. One result has been the setting up of 'Bridging Courses' particularly focusing on communication and language skills to prepare for the clinical examination. Courses also include orientation to the health service, and clinical practice. Providers include the SW Sydney Area Health Authority, and Victoria Medical Postgraduate Foundation. The courses are oversubscribed, and not accessible by many because of cost. NSW also established a one-off shortened undergraduate medical education course for 100 refugee doctors in 1999. 96 were accepted, and in 2000 88 were still on the course. The reduction was partly due to some of the candidates passing the AMC examination, and therefore leaving to get jobs. OTDs who have passed the MCQ part of the AMC examination, may undertake work in a 'supervised experience' capacity, paid at PGY1 rates of pay, until they pass Part 2, the clinical examination.

"There is no system-wide approach to inducting these doctors, but senior doctors may counsel them. Getting a hospital post is their only possible employment opportunity, as no one would take them on as a GP –they might just get a remote country practice" (Aus Int 8).

In 1999, a total of 220 permanently resident OTDs passed the AMC exam and gained registration, and 59 specialists gained recognition of their qualifications from the AMC on the recommendation of the Specialist/Learned Colleges. There are estimated to be at least a

further 2,000 OTDs in the process of attempting to gain registration (Int. Aus. ADTOA). Two doctors from the ADTOA had spent several years attempting to negotiate the AMC examination system without success. Dr A was from Syria, had studied medicine in Moscow (in Russian), married a Russian citizen, conferring citizenship, and then gained entry to Australia under the 'family' category of the primary applicant (his wife) who herself gained entry under the points system conferred on 'skills' in short supply. He was having difficulty achieving the required scores in the English language test. Dr B was a successful political asylum seeker from Czechoslovakia to Australia pre 1989, and with a wife with dual Austrian/Australian nationality came to Australia as 'family' and then gained Australian citizenship. He has been unable to pass the specialist examination requirements, and has undertaken more junior hospital work in a low-paid capacity. He requests that the assessment process should be open to scrutiny. There has also been prominent legal action, taken for example against the RACS by Dr Asaad Razagni, based on similar arguments.

We looked at the AMC website for statistics of approval of overseas trained specialists. Of 1196 applications received over the period January 1993 to June 2000:

- 336 were approved as eligible for Fellowship
- 293 were accepted for further training or examination (using a modified form of the appropriate Specialist college examination)
- 305 were in the initial stages of processing
- 78 were rejected
- 184 had either withdrawn their applications, or allowed them to lapse

There were some interesting differences between specialties in the percentages approved, and in the percentages referred for further training, or rejected. Surgery had the highest number of applications, the smallest number of approvals, and the highest number referred for further training. The majority of surgery applications were 'pending, withdrawn or lapsed'. Anaesthetics had the highest rate of approval. Do these figures reflect the quality of the qualification and experience, or the levels of workforce supply and demand? Table 1 shows the numbers for selected specialties, but omits the numbers waiting 'in process'.

Table 1: Assessment of Overseas Trained Specialists January 1993 to June 2000

College	Applied	Approved	Further Training /Examinations	Rejected	Initial Processing/ Withdrawn/ Lapsed
Anaesthetists	164	80	36	3	45
Dermatologists	12	0	4	0	8
Emergency Medicine	10	3	2	2	3
General Practitioners	10	10			
Obs and Gynae	138	58	19	21	40
Occupational Medicine	6	1	3	1	1
Ophthalmologists	35	4	10	2	19
Paediatricians	102	16	21	20	45
Pathologists	80	18	25	3	34
Physicians	195	43	52	13	87
Psychiatrists	86	30	29	1	26
Public Health Medicine	14	6	0	0	8
Radiologists	92	35	20	1	36
Rehabilitation Medicine	6	2	2	1	1
Surgeons	246	30	70	10	136

Adapted from AMC website: www.amc.org.au/statspec.asp

“The barriers to registration facing OTDs in Australia have been the subject of criticism, from the OTDs themselves and from parts of the health system undersupplied with doctors. It has been charged that as a standards setting or quality assurance mechanism, the barrier is too high; that the assessment processes, particularly those of the medical colleges, are too slow and not sufficiently transparent; and that the profession, which operates the barrier, does so with protection in mind. Complaints that the system is racially discriminatory have also been made by individual doctors under Australia’s anti-discrimination legislationIt is suggested that the historical acceptance of professional regulation has resulted in a number of anti-competitive practices that are disguised as quality or ethical imperatives” (Cobbald 2001)

Currently, the Health system is under the scrutiny of the Australian Competition and Consumer Council (ACCC), with submissions from various stakeholders with an interest in the outcomes in relation to issues of monopoly, competition, restrictive practices, and the implications for the whole notions of workforce planning and quality provision. This was a high profile issue during the period of fieldwork in Autumn 2001, but we have so far been unable to find any reports on the outcomes, released into the public domain.

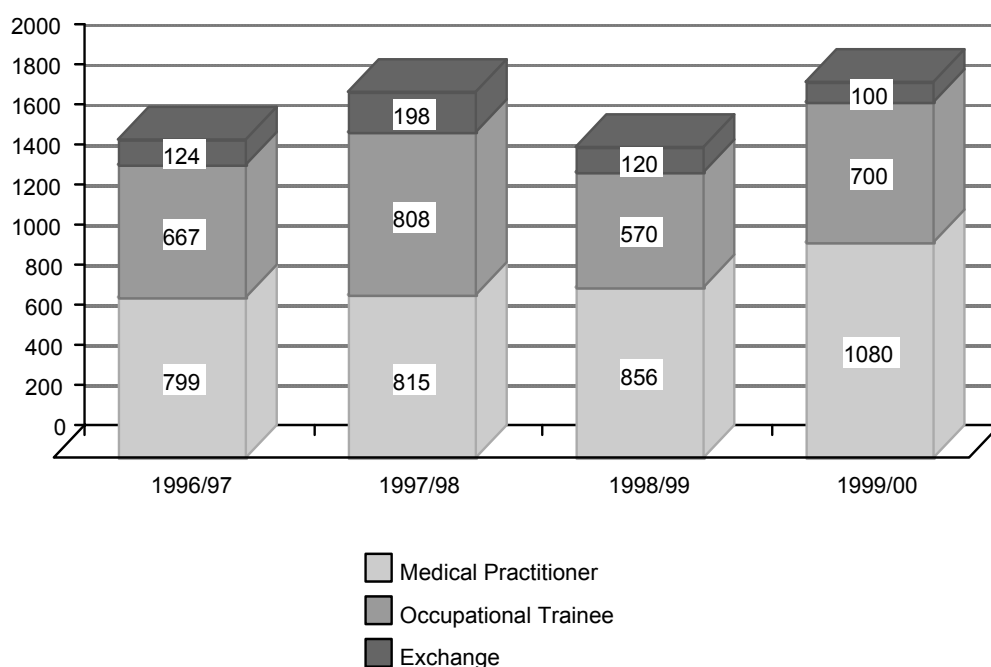
Temporary Resident Doctors (TRDs)

Temporary resident doctors are classified by immigration (DIMA) either as ‘long-term visitors’ (intending to stay for 1 year or more) or as ‘short-term visitors’ (intending to stay for under a year). In practice there may be some miscounting, as actual practice may differ from intentions. However, the average length of intended stay is just under a year. DIMA has recently switched its system to count actual rather than intended length of stay, but has not readjusted past statistics. Note that there are some slight discrepancies in the estimates of TRDs in the workforce between DIMA statistics and those provided by AIWH, which uses multiple data sources to arrive at its figures.

TRDs may enter Australia either on a 422 Medical Practitioner visa, (to serve in an area of workforce shortage, or a geographically defined area of workforce need), or on a 442 Occupational Trainee visa, in theory to occupy a training position. In practice these latter positions are for ‘experience’ rather than counting towards a specialist training qualifications, although they must be shown to be consistent with longer-term career intentions. It was implied by some interviewees that they had been used in some instances as positions mainly for service, attracting lower rates of pay (Aus Int 7). This may be a factor contributing to the reduction in numbers of occupational trainees between 1997/8 and 1998/9. However, it was said, by our hospital-based interviewees, that now TRDs are paid according to national pay scales (Aus Int 6,8). Overall, the numbers in both major visa categories have increased over the last few years, but with ‘medical practitioners’ outpacing ‘occupational trainees’ to stand at a ratio of 3:2 by 1999/2000. A few doctors enter on a 411 Exchange visa (mainly for academic posts). These data are shown in Figure 3 below.

Overall, whilst the permanent resident category of doctor has been decreasing in recent years, the numbers of TRDs of both 422 and 442 categories have been “*increasing dramatically*”, (Aus Int 2). We need to ask the questions: how many doctors are arriving in Australia; where are they coming from; where are they locating, and in what sort of job slots?

Figure 3: Medical Practitioner Arrivals 1996 to 2000 by Type of Visa – 422 (medical practitioner), 442 (occupational trainee), & 411 (exchange) (Primary Applicants only)



(Adapted from DIMA 2001, Table 25)

Where do overseas trained doctors locate?

The destinations of doctors entering Australia, by state, reflect the designated geographical areas of shortage. Because job slots for overseas doctors are restricted to those Australia finds hard to fill from domestic supplies, OTDs arriving over recent years are particularly located in AoN. Queensland has by far the greatest number. Table 2 shows the state of intended residence of medical practitioner 422 visa first arrivals from 1995 to 2000. The numbers relate only to primary applicants (not to secondary applicants i.e. family).

Table 2: 422 Visa First Arrivals by State of Intended Residence

States	1995/6	1996/7	1997/8	1998/9	1999/2000
NSW	28	25	123	139	68
VIC	42	96	114	116	112
QLD	237	427	464	430	660
SA	3	3	7	12	18
WA	90	164	77	133	177
TAS	12	61	19	10	21
NT	11	17	9	12	26
ACT	9	6	2	4	3
Total	432	799	815	856	1085

(Source: DIMA 2001, Table 24)

The numbers locating in Queensland have gone up massively from previous years, to 660 in 1999/2000, and perhaps also reflect the proactive marketing and recruitment programmes mounted by Queensland (I was told they use a recruitment agency, SLADE? in the UK). Western Australia had 177 (with fluctuations in recruitment over previous years), and Victoria the next largest number, with 112. The smaller numbers for other States and

Territories such as Northern Territory and Tasmania are partly a reflection of their smaller populations. The smaller number of 68 for New South Wales, reflects the attractiveness of the State, and Sydney in particular, to home-grown doctors, and therefore the smaller need for OTD despite the large population. To some extent, States, with the responsibility for the delivery of health care, compete against each other for recruits, and each has different criteria and processes for registration, making access easier in some locations than others. These different arrangements partly reflect the degrees of attractiveness of different locations. One hospital 'recruiter' suggested that, for example, Queensland recruited aggressively and successfully on the back of its surfing/scuba diving location. The less desirable outer suburban hospitals in Sydney could always rely on a steady supply of travelling doctors passing through. One hospital in west Melbourne had to work hard at recruitment to staff its expanded facilities, serving a poorer, but growing population, as the city suburbs expanded (in comparison with the ease with which hospitals in the wealthier areas of east Melbourne).

Looking next at the rural/urban split, about half are working in State and Territory capital cities (e.g. Melbourne, Brisbane). Just over a third are in other cities of 100,000 or more (such as Newcastle on the Eastern seaboard, and about 3 hours journey time from Sydney) and large 'rural centres' of 25,000 – 99,000 population (towns such as Gosford, about 2 hours north of Sydney). The rest are in rural or remote areas (partly reflecting the fact that there are smaller populations there) (personal communication DIMA 2001). Nevertheless, TRDs do form a larger percentage of the rural clinical medical workforce, 6.3% in 1998, compared with 3.5% of the total medical workforce (Cobbald 2002). The majority of TRDs (72%) are located in public acute care hospitals, approximately 18% in private rooms, and around 6% in either an Aboriginal health care facility or other non-residential health care facility (DIMA 2001, Table 98, work setting and region of main job 1998). 57.4% were in primary care or hospital non-specialist posts, and 35.9% were in rural or remote areas, (the categories are not mutually exclusive). Further information supplied by DIMA showed the type of practice of TRDs, by country of initial qualification and by region of main job. In 1998, doctors from Asia were over-represented in hospital, non-specialist and specialist-in-training posts, and doctors from the UK/Ireland were over-represented in primary care (DIMA (2001) Table 37).

Where do OTDs come from?

We turn now to look at the source countries of doctors arriving in Australia. Table 3 shows the number of general medical practitioners arriving in Australia, by country of last residence, during the 1990s. It is an amalgamation of permanent and long term visitor arrivals, and is an under-counting of arrivals, as it excludes short-term intended stays, which form the majority of stays. It can be seen that the major supplier for permanent and long-term arrivals has continued to be the traditional one of the UK. The other pattern to note is that there appears to be a sub-market operating of doctor migration from New Zealand and Asia, particularly NE Asia (China and Hong Kong). However, the trend has been for the numbers from NE Asia to decline over the decade, and for numbers from S Asia to increase. Numbers from S and E Africa have increased noticeably over recent years. North America (including Canada) has been a fairly consistent source. Europe, as a whole has been a similar sized source, but within Europe, Western Europe, (Germany and the Netherlands) has been the biggest provider.

Table 4, below, shows the percentages arriving on 422 (medical practitioner) visas, and this time the information is shown by country of citizenship. However, these data omit 442 grants. We also learned from our interview with DIMA that long-term and short-term visa grants to TRDs entering on 422 (medical practitioner) visas had risen steeply over the previous two years. Numbers had gone up from 2,224 in 1998/9 to 2,515 in 1999/2000, and stood at 3,438 per annum as at Sept 2001, despite the official policy of increasing self-sufficiency. Whilst we do not have the statistical breakdown by country of primary qualification, or country of origin, of these latest visa figures, reportedly they are in the same proportions as for earlier data. In other words, the UK remains the major, and an increasing, supplier of doctors to Australia (personal communication DIMA 2001).

Table 3: General Medical Practitioner Arrivals 1991 to 2000, by Country of Last Residence

Permanent & Long Term Arrivals	1991/2	1995/6	1998/9	1999/00
UK	457	595	624	691
Ireland	30	38	54	82
New Zealand	115	133	232	391
Melanesia	18	17	24	12
Micronesia/Polynesia	11	17	15	18
N.E. Asia	299	346	261	242
S. Asia	64	127	112	160
S.E Asia	115	99	151	160
N. Africa	3	16	0	0
C. & W. Africa	3	7	0	5
S. & E. Africa	41	40	102	129
N. America	121	173	156	175
S. America	0	6	4	9
C. America	2	3	0	5
Middle East	35	67	44	44
W. Europe	31	47	59	70
S. Europe	22	24	19	23
E. Europe	9	14	8	17
N. Europe	7	9	18	17
USSR/ Baltic	12	16	10	9
Overall Totals	1,395	1,796	1,915	2,274

Source: DIMA Unpublished Data (personal communication)

Notes:

- Overall Totals' includes other smaller source countries not itemised in the Table, and is therefore more than the sum of arrivals from the countries shown.
- The term 'General Medical Practitioner' is a generic one, excluding specialists. It is important to note that the definitions applying to 'generalist' doctors have changed since 1996. At this time, new regulations were introduced, requiring GPs to gain specialist GP accreditation in order to obtain an unrestricted Medicare Provider Number for General/Family practice. The totals for 1998/9 and 1999/00 include both 'general medical practitioners' and 'medical practitioners'. Confusingly, 'medical practitioners' are the equivalent of UK vocationally trained GPs or family practitioners.
- The UK provided 120 of the 541 GP 'medical practitioners' in 1998/9, and 28 of the 124 arriving in 1999/00 (not shown separately in Table 1, but shown in Table 3)

Table 4: Medical Practitioner (subclass 422) by Country of Citizenship 1999/2000

Country of Citizenship	%
UK	36%
South Africa	17%
India	11%
Irish Republic	5%
USA	5%
Canada	4%
Pakistan	2%
Malaysia	2%
Sri Lanka	2%
Nigeria	2%
Others less than 2%	14%
(e.g. United Arab Emirates, Zimbabwe, Germany, and the Netherlands)	
Total	100%

Source; DIMA 2001 Table 23

Cobbold (2002) quotes AIHW data sources to demonstrate the large contribution made by the UK and Ireland to these overall figures. The figures confirm that they have supplied a significant percentage, and increasing number, of TRDs, both long and short term stays. In 1998/9 the UK/Ireland supplied:

- 58.2% (or 400 out of 687) long-term stay TRDs
- 56.8% (873 out of 1,537) of short-term TRDs.
- Note that permanent migrations are excluded from these data

Over the period 1992/3 to 1998/9 the numbers from the UK increased significantly:

- from 148 to 400 (long-term)
- from 334 to 873 (short-term)

Not only is the UK the major supplier, but also the other significant supply countries are all English speaking apart from India, and even here the language of education is English. It is in fact overt policy to recruit from 'former Empire/Commonwealth' countries where the medical education systems are similar to Australia, and the common language makes for easier adaptation. Active recruitment occurs openly in the UK and Ireland, and Canada.

"But the countries that we obviously would see as our highest priorities [for recruitment] are the UK and Canada, because it's those two countries that qualifications that the Australian College of GPs will accept as equivalent...and New Zealand of course ... Probably in the last 10 years the UK is a very high supplier of locums more than permanent workforce...There's a growing pool from Canada, and a few Americans, New Zealanders... again, English speaking countries" (Aus Int 5).

Although Australia is party to the WONCA agreement (1999 in Durban) not to recruit from South Africa, nevertheless Australia has not sought to prevent entry to those doctors seeking to leave South Africa, and in recent years, South Africa has become a major supplier (Aus Int 2). Whilst the longer-term security of the South African supply was in doubt, nevertheless the applications 'on hand' at 30/06/01 still showed 79 being processed. And there seemed to be 'no worries' about the supply from the UK and Ireland, with current visa applications as at 30/06/01 'on hand' at 189 and 29 respectively (DIMA personal communication).

Overall, respondents felt that overseas trained doctors OTDs made a 'considerable/very important' or 'vital contribution' to the Australian medical workforce, varying according to location, sector (public/private) and specialty. Most felt that Australia 'ought' to be self-sufficient in doctors in the long run, but also acknowledged that this was impossible in the short-term.

Doctors from the UK In the Australian workforce

We wanted to look more closely at the data relating to migrations between the UK and Australia. We were supplied by DIMA with raw data for permanent and long-term arrivals and departures to and from Australia, by country of last /future residence /stay. Note that the tables do not include information about short-term stays. We know, however, that the average length of stay in Australia is just under one year, the definition of a short-term stay, and that therefore the tables significantly undercount the actual amount of migration. Nevertheless, the tables serve to demonstrate some trends in medical migration.

We derived information about the age and gender profile of general medical practitioners arriving in Australia from the UK, shown in Table 5 below. The male to female ratio of doctors arriving in Australia from the UK has shifted over the last decade. In 1991/2 60% of permanent and long-term arrivals were males. The rate of increase for females has been

greater than for males, with notable increases between 1991/2 and 1995/6 and 1998/8. Males comprised only 52% of the total by 1999/2000. Over the decade there has been a consistent pattern for the largest group of both males and females to be under 29 years of age, although the numbers arriving between 30-39 years of age have also increased. Females under the age of 29 have exceeded males since 1995/6. The numbers aged over 40 are small for both males and females.

Table 5: Permanent and Long-term General Medical Practitioner Arrivals in Australia from the UK by Gender and Age, 1991-2000.

Gender/Age	1991/2	1995/6	1998/9	1999/2000
m. 0-29	54	82	113	118
m. 30-39	54	68	107	97
m. 40+	14	18	23	18
Total male	122	168	243	233
f. 0-29	50	95	136	138
f. 30-39	25	50	46	71
f. 40+	4	6	4	4
Total female	79	151	186	213
Totals	201	319	429	446

DIMA Unpublished data (personal communication Sept 2001)

Table 6 shows arrivals from the UK in Australia, and subdivides the data on permanent and long-term arrivals over the last decade. Figures for 1998/9 onwards show GP and other general medical practitioners separately. GPs are the first, smaller numbers in the columns, and confirm what we were told by several interviewees, that there has been a “steady trickle” of UK doctors attracted to general practice in the outback, and other rural and remote areas. However, the number of GPs from the UK staying long-term was zero in 1999/2000. This phenomenon has possibly provided the motivation to introduce the incentives for GPs from certain countries to locate in underserved areas, outlined on p.6. The numbers and the policy response tell the story of the distribution problems in Australia, with a perceived surplus of GPs in urban areas, and an acute shortage in rural and remote areas. The numbers of other doctors arriving for a stay of more than one year have risen significantly. Permanent arrivals dropped significantly, and reflect the heightened barriers to medical migration to anything but an underserved area. Australian doctors returning to Australia from the UK after a long-term stay have remained fairly steady. The numbers echo the perception of our interviewees that many Australian doctors choose to undertake a period of work abroad, in a similar way to UK doctors. Such exchange was seen as beneficial for all concerned (Aus Int 1,2,9). However, the number of GPs returning after a long-term stay in the UK perhaps represents a missed opportunity to recruit and retain these doctors.

Table 7 shows Departures from Australia to the UK, both of UK long-term visitors, and of Australian residents, going to the UK either permanently, or for a stay of more than a year. The first thing to notice is that there are many more Australian permanent departures (78) to the UK than the UK equivalent in arrivals in Australia (11) in Table 4. This represents a recruitment opportunity for the UK. However, the number of Australian long-term departures to the UK (270) is significantly lower than the UK equivalent to Australia (435, Table 4) and shows that the UK loses out in a major way, with around a third fewer long-term arrivals.

Table 6: Permanent and Long-term Arrivals in Australia from the UK 1991 – 2000

Arrivals from UK	1991/2	1995/6	1998/9	1999/2000
UK Permanent Arrivals	112	55	2+ 20 = 22	0 + 11 = 11
UK Long-term Arrivals	89	264	34+ 373 = 407	8+ 427 = 435
Total UK	201	319	36+ 393 = 429	8+ 438 = 446
Australian Long-term Returns	256	276	84+ 111 = 195	20+ 225 = 245
Overall Totals	457	595	120+504 = 624	28+663 = 691

DIMA Unpublished data (personal communication Sept 2001)

NB Numbers for 1998/9 and 1999/2000 are split into GPs (medical practitioners) and other doctors (general medical practitioners). GPs form the smallest group.

Table 7: Permanent and Long-term Departures to the UK from Australia 1991 – 2000

Departures to UK	1991/2	1995/6	1998/9	1999/2000
Australian Permanent Departs	26	23	21+ 35 = 56	4+ 74 = 78
Australian Long-term Departs	248	244	97+ 153 = 250	22+ 248 = 270
Total Australian	274	267	118+ 188 = 306	26 + 322 = 348
UK Long-term Visitors	130	203	43+ 104 = 147	8+ 225 = 233
Totals	404	470	161 + 292 = 453	34+ 547 = 581

DIMA Unpublished data (personal communication Sept 2001)

NB Numbers for 1998/9 and 1999/2000 are split into GPs (medical practitioners) and other doctors (general medical practitioners). GPs form the smallest group.

Table 8 simply puts together the Arrivals and departures to/from the UK, and shows that in any given year, the number of UK visitors arriving in Australia is much greater than UK visitors departing. Moreover, the percentage difference has become greater over the period. It must represent a steady loss to the UK workforce.

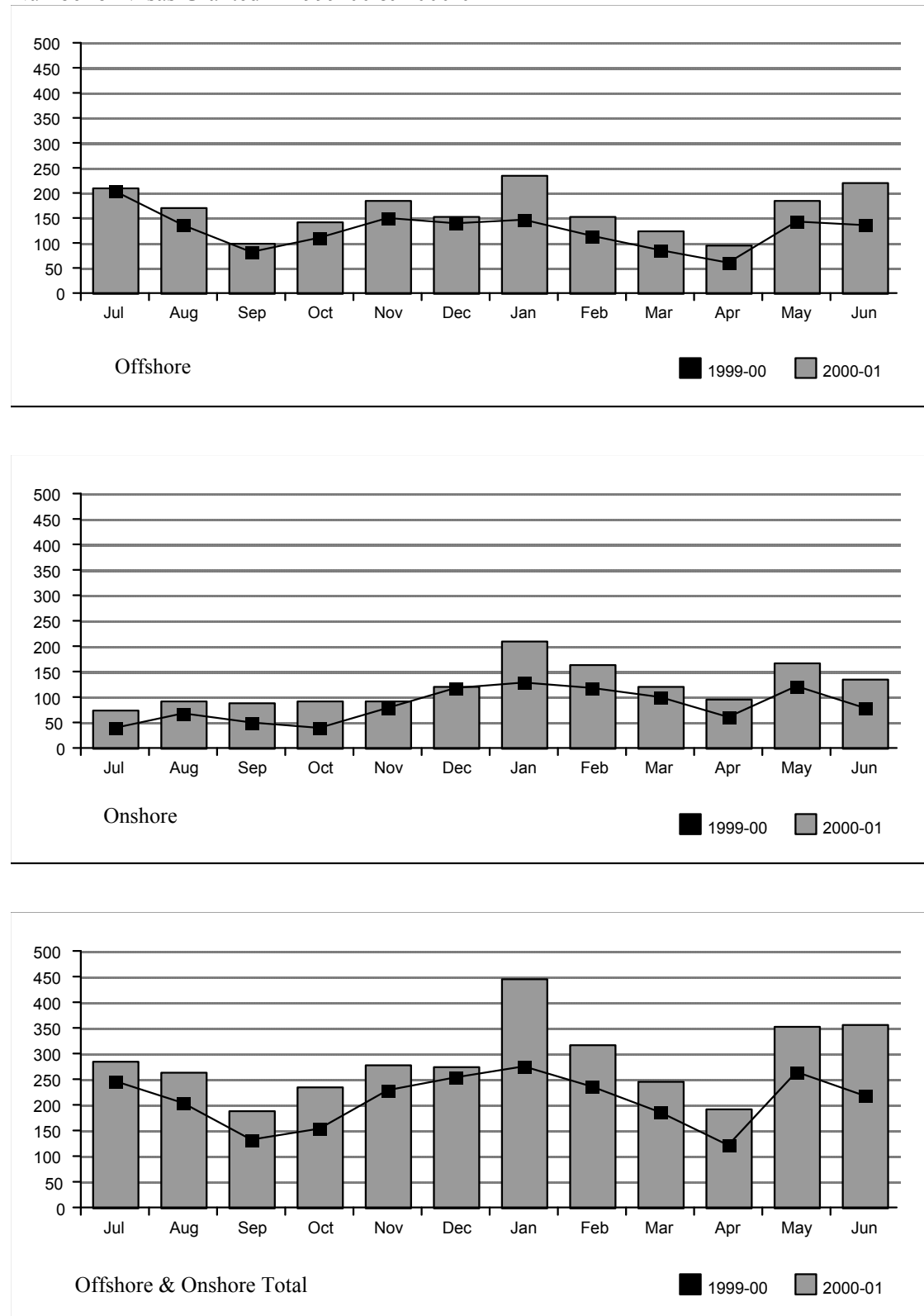
Table 8: Permanent and Long-term Arrivals and Departures to/from the UK, to/from Australia 1991 – 2000

UK Arrivals & Departures	1991/2	1995/6	1998/9	1999/00
UK Arrivals	201	319	429	446
UK Departures	130	203	147	233

The hypothesis that there is a steady loss of UK doctors to Australia is supported by the data relating to the place of application for a visa. We know that the number of doctors seeking to extend the length of their working stay in Australia is increasing, from the evidence of onshore applications to remain. The 422 general medical practitioner visa grants data, distinguished by the place of visa application, i.e. off-shore (applied for from abroad) or on-shore, are shown below in Table 7 below, for 1999/2000 and 2000/2001. The first thing of note is the large increase during 2000/2001 of the total number of visas granted, up from 2,515 to 3,438 in the space of a year, with the increase being more or less evenly divided between offshore applicants (for which read “first-time applicants”) at 1,509 and onshore applicants (for which read OTDs already in Australia looking to extend their working time

there) at 1,980. The qualitative data from our interviews indicated that the onshore applications were similar to offshore applications in terms of the percentages from various supply countries. The UK therefore accounts for more than a third of applications to extend a stay.

Figure 4: 422 Medical Practitioner Visa Applications, by Offshore/Onshore Location - Number of Visas Granted in 1999-00 & 2000-01



More detailed data for 422 offshore visa grants for 1998/9 and 1999/2000, also supplied by DIMA, and shown by the location of the 'granting post', also reveal some interesting insights, shown in Table 9 (DIMA personal communication Sept 2001). London and Manchester combined had the largest number of grants, with 449 primary applicants (and 160 secondary/dependent applicants, a total of 609), slightly down from 657 total from the previous year, due to a decline in the Manchester applications. This evidence may tie in with the concern of some hospital recruiters, relying on UK doctors, that some were now reluctant to come to Australia, because in some cases they were not able to defer a training position in the UK for a year, whilst they took a working holiday (Aus Int 10). Pretoria had the second largest number of visa grants, with 108 primary, and 168 secondary applications, an increase of over 40% on the previous year. Despite this increase, it was thought by some interviewees that those, mainly white, South Africans who were going to leave had by and large already done so, and that the supply would soon dry up (Aus Int 5,9). However, as we saw earlier, DIMA still had a substantial number of applications from Pretoria on hand.

The data also show different migration patterns in terms of the family profile of applicants from different countries. In this table, secondary application numbers are shown (i.e. applications from the family/dependants of the primary applicant) in addition to primary applications for 1999/2000. For South Africa (Pretoria) 159 primary applicants had 316, or double, the number of related secondary applicants, indicating that many of the doctors migrating were at an age and stage to have family accompanying them. By comparison, the figures for London have less than half the number of secondary applicants, which may indicate that these migrants are younger/at an earlier stage in their career. Whilst this supposition cannot be read directly from the data, the qualitative interviews support that hypothesis (Aus Int 1,2). Doctors from the UK are typically seeking 422 or 442 visas at Senior House Officer (SHO) stage, often at the end of basic specialist training, and having achieved Membership examinations, before taking up a Specialist Registrar (SpR) or vocational training position back home. Working for 6-12 months in an "occupational trainee" position in an undersupplied public hospital, with rotations relevant to their intended specialty, provides a paid opportunity to travel at the point of a natural career break. These rotations cannot, however, be credited as part of their future specialty training in the UK (Aus Int 8).

Of interest are the small number of applications from India (new Delhi and Mumbai), with 35 primary and 51 secondary applications. This represents around 4% of the total number (863) of primary offshore visa grants, and is partly a reflection of the fact that these posts have only recently been opened. It by no means accounts for the 11% of 422 visa grants made to general medical practitioners with citizenship (and an assumed primary medical qualification from India (see Table 2). This is additional evidence, therefore, to support the anecdotal evidence that doctors from India may move between more than one country overseas in search of specialist experience and training.

Table 9: 422 Visa Grants by Post Offshore 1999/2000 YTD & Feb 1998/99 Comparison

422 Offshore Granting Post	1999/2000 Primary	1999/2000 Secondary	1999/2000 Total	1998/99 Total	%Variance
London	369	137	506	462	9.5
Pretoria	108	168	276	196	40.8
Dublin	74	38	112	86	30.2
Manchester	80	23	103	195	- 47.2
Los Angeles	41	39	80	85	-4.7
Ottawa	31	42	73	73	0.0
New Delhi	27	44	71	33	115.2
Dubai	21	31	52	5	940.0
Auckland	27	23	50	30	66.0
Islamabad	8	15	23	4	475.0
Washington	9	12	21	24	-12.5
Singapore	8	7	15	6	150.0
Mumbai	8	7	15	0	New Post
Kuala Lumpur	7	7	14	8	75.0
Bonn/Berlin	5	7	12	15	-20.0
Brussels	7	3	10	1	900.0
Harare	6	4	10	1	900.0
The Hague	4	6	10	3	233.3
Colombo	3	7	10	7	42.6
Lagos	2	7	9	0	0.0
Brunei	4	3	7	6	16.6
Others	14	16	30	39	-22.9
Total	863	646	1509	1280	17.9

Specialist medical migration to and from the Australian medical market

We look next at specialist medical migration to and from the Australian medical market from data supplied by DIMA related to permanent and long-term migrations.

Table 10: Permanent and Long-Term Medical Specialist Migration to/from Australia

<i>Specialist Medical Migration</i>	1991/2 from/to UK	1991/2 from/to Other	1995/6 from/to UK	1995/6 from/to Other	1998/9 from/to UK	1998/9 from/to Other	1999/00 from/to UK	1999/00 from/to Other
Permanent Arrivals	33	148	29	176	15	95	12	93
Long-term Arrivals	55	99	32	120	24	119	35	125
Total non-Australian Arrivals	88	247	61	296	39	214	47	218
Australian Residents Returns	52	74	31	48	7	30	13	33
Total Arrivals	140	321	92	344	46	244	60	251
Permanent Departures	2	11	6	23	2	7	4	13
Australian Long-term Departures	16	35	20	40	11	28	16	19
Total Australian Departures	18	46	26	63	13	35	20	32
Visitor Long-term Departures	18	34	34	49	18	47	32	55
Total Departures	36	80	60	112	31	82	52	87

Source: DIMA unpublished data (personal communication 2001)

The information about specialist migration in Table 10 has been divided into that relating to the UK and that relating to 'Other' countries. It is important to remember that 'Permanent' specialist arrivals (such as those arriving on a family visa, or with refugee status) may or may not have their specialist status recognised by the Australian Royal and Learned Colleges. They may not necessarily gain registration and employment. Those who intend to settle permanently, for example, specialists from South Africa, may nevertheless practise as specialists, (with their employment restricted to their specialty, and with notional supervision, by means of the restricted Provider Number) to a particular location of workforce shortage.

Overall, permanent specialist immigration from the UK has fallen over the decade from 88 arrivals in 1991/2, to 47 in 1999/2000. The UK share of the permanent migration of specialists has fallen from 35.6% to 21.6%, although the overall numbers from other countries has also fallen. The fall off is probably related to tighter immigration controls over permanent medical migration since 1996. As mentioned earlier, the barriers to achieving recognition of overseas specialist qualifications is perceived to be high by OTDs (Aus Int 11). The variation over the decade in source countries of specialist permanent migration to Australia, shown in Table 11, probably reflects international migration patterns due to political and economic circumstance.

Analysis of the data indicates that NE Asia (China and Hong Kong) have been consistently strong sources, especially in 1995/6, with the rise probably related to the events of Tianamen Square, a hypothesis suggested by several interviewees (Aus Int 2,9). Larger numbers from USSR/Baltic countries in the early 1990s occurred at the break-up of the Soviet Union.

Table 11: Specialist Permanent Arrivals to Australia by Country of Origin 1991 - 2000

Permanent Arrivals	1991/2	1995/6	1998/9	1999/00
NE Asia (Hong Kong/China)	28	63	25	19
New Zealand	16	8	7	12
UK	33	29	15	12
S. & E Africa	5	10	13	12
North America (US/Canada)	11	16	7	9
S. Asia	9	24	1	9
Middle East	6	5	3	9
S.E. Asia	19	4	10	8
USSR/Baltic	22	17	3	4
N. Africa	14	9	3	3
N. Europe	0	0	0	2
S. Europe	2	7	5	2
W. Europe	5	5	6	1
S. America	0	3	4	1
Ireland	2	0	2	0
Totals	181	205	110	105

Source: DIMA unpublished data (personal communication 2001)

New Zealand has been a steady source, a reflection of the special ties between the medical professions with their shared Specialist Colleges, and mutual preferential immigration arrangements. As already noted, the UK contribution has been declining. South and East Africa (mainly South Africa) has increased as a supply source, probably as a direct result of the recent political situation. Many (mainly white) South African doctors are choosing to emigrate, and some are choosing Australia, (although Canada and the UK are also drawing on

this source of doctors). South Africa is one of a handful of English speaking countries from which doctors are actively welcomed in Australia, because of the language and training system similarities. Specialists applying for recognition by the Specialist and Learned Colleges may therefore be more readily accepted than some specialists from other sources. This would enable access to an unrestricted Provider Number, in turn allowing doctors who have been recruited to an Area of Need to practise privately, something which “*is very necessary*” in rural areas. (Aus Int 10). The speculation of interviewees was that these doctors are used to living in vast open spaces, are willing to settle in, say, Western Australia as specialists in AoN, and make the adaptation to the Australian outback relatively easily (Aus Int 2,10). South East Asia (especially Singapore and Malaysia), and South Asia (including India, Sri Lanka, and Pakistan), as well as the Middle East, have also been suppliers, although the numbers overall are small, and have fallen.

Outflows from the Australian Medical Market

Which countries are favoured as destinations by Australian specialists, who choose to spend some time abroad, either for a long-term stay to widen their skills and experience, or to settle permanently? We looked at data on permanent and long-term departure of Australian residents/specialists by country of destination in Table12. Although there have been some fluctuations over the decade, the trend has been for a significant reduction in the overall numbers of specialists who are Australian residents/citizens, leaving Australia. The UK continues to be the preferred destination for long-term stays, and may have gained some ground in relation to permanent migrations, in comparison with the US in the last few years. This may be a reflection of the increasing difficulty in gaining a visa to enter the US on a long-term basis rather than the increased attractiveness of the UK. NE Asia (Hong Kong and China) continues to operate as a sub-market with Australia, with some small numbers going both permanently and for a long-term stay. However, there is still a discrepancy between the numbers who go there, and the numbers who leave, with Australia making the gain. New Zealand also loses more specialists than it gains in the sub-market with Australia.

Again, we do not know more about which specialist doctors are migrating, and whether they are overseas trained, or Australian trained. At this career stage for existing specialists, the speculation must be that a long-term stay abroad is to gain wider experience and to augment skills. Alternatively, some of the migration may be by residents/citizens who find it difficult to access a post in the location of their choice. It may be worth further investigation to discover more about the motivations and career intentions of these qualified specialists who migrate, as they may present a recruitment opportunity.

Table 12: Permanent/Long-Term departure of Australian Specialists, by Country of Destination

Destination	1991/2 perm.	1991/2 l/term	1995/6 perm.	1995/6 l/term	1998/9 perm.	1998/9 l/term	1999/00 perm.	1999/00 l/term
UK	2	16	6	20	2	11	4	16
USA	7	9	6	10	2	11	1	5
Canada	3	3	1	6	1	3	0	3
NE Asia	8	0	5	5	3	2	3	4
S Asia	1	0	0	3	0	2	0	0
SE Asia	6	6	1	2	0	3	0	0
New Zealand	3	0	6	4	1	0	7	1
Middle East	5	0	0	2	0	2	0	3
S&W Europe	2	0	1	5	0	2	1	0
Ireland	1	0	2	0	0	0	0	0
S&E Africa	0	0	1	2	0	0	0	1
Others	0	1	0	1	0	3	1	2
Totals	13	51	29	60	9	39	17	35

Source: DIMA unpublished data (personal communication 2001)

We looked at data on Australian Residents/specialists returning to Australia, by country of last stay in Table 13. (These data summarized also appear in Table 8, row 4, Australian Residents Returns). We can see from Tables 12 and 13 that the UK remains a leader in this segment of the global labour market, although the overall numbers coming to the UK have declined noticeably over the decade, and the UK has lost ground relative to the US. It may not simply be that the UK and the US are competing with each other to attract specialists, but that Australia itself is increasingly filling its own demand for sub-specialty training. Some of our interviewees suggested that this might be the case.

Table 13: Returns to Australia of Australian Specialists, after a long-term stay abroad

Australian specialist returns	1991/2	1995/6	1998/9	1999/2000
UK	52	31	7	13
USA	28	17	5	8
Hong Kong	9	5	4	5
Canada	7	6	4	1
Malaysia	4	2	0	1
Italy	3	0	0	0
New Zealand	3	1	2	1
Singapore	2	2	0	1
South Africa	1	1	0	4
China	0	0	2	4
Others	17	14	13	8
Totals	126	79	37	46

Source: DIMA unpublished data (personal communication 2001)

How does the pattern of specialist emigration from Australia compare with that of other non-specialist doctors? The most important overseas destinations for Australian general medical practitioners were thought by our interviewees to be, in order of importance, the UK, followed by the USA, and Canada. These are traditional migration patterns, largely undertaken at an early career stage, to gain further experience or sub-specialty training. A typical stay for, say, an orthopaedic specialist might be 2-3 years, enough time to get a FRCS. *“About a third of our orthopaedic surgeons, as soon as they finish their training here in Australia, mostly go to the UK...”* (Aus Int 2). Younger doctors might spend 1 to 2 years based in the UK, perhaps doing some locum work, and earning enough to travel in Europe. The flows out are mainly temporary, are built into the planning process, and are not seen as a major problem, as Australia is a net importer in both GPs and the more popular surgical and physician specialties (Aus Int 1,2). There are also more recent flows to Singapore and to Hong Kong, which reflect supervised training ties with those countries. There have also always been some who will travel in a voluntary/missionary capacity to developing countries.

Our data from the UK Census analysis gives us more detail about the specialty areas entered by non-specialist Australian doctors who migrated during the 1990s, shown in Table 14. This shows all newcomers from Australia, by their specialty area. In the early years the figures closely mirror the numbers of long-term departures of Australians to the UK as a destination, shown in Table 7. However, in later years, the numbers departing for the UK are higher than the corresponding arrivals into the UK workforce. We do not have an explanation for this, but might speculate that more are either spending more time travelling, or working as locums through agencies. The shortage specialty of anaesthetics is drawing in the most Australian doctors.

Table 14: Australian Overseas Doctors Entering the UK Workforce 1992-1999

Specialty	1992	1993	1994	1995	1996	1997	1998	1999	Total
Anaes	52	55	34	38	35	24	24	17	279
Obs & Gynae	26	23	15	14	21	14	15	15	143
Paediatrics	25	17	13	19	11	20	8	11	124
General Surgery	18	18	22	22	11	13	26	13	143
Trauma & Orthopaedic Surgery	14	11	14	11	11	8	11	9	89
Geriatrics	10	0	0	0	0	0	0	0	10
Unknown (poss. GP)	0	17	0	0	0	11	11	0	39
General Medicine	0	13	11	0	0	11	0	0	35
Gen. Psychiatry	0	11	0	0	0	0	0	10	21
Ophthalmology	0	0	0	0	12	11	0	11	34
All Newcomers	245	243	189	200	173	167	173	137	1,527

We asked our interviewees their opinion on whether any new destinations were likely to come on line for emigrating doctors, in the foreseeable future? There were not thought to be major new destinations coming on line, and the overall picture of destinations was unlikely to change, unless there is a change in receiving country entry rules. Although, for example, Malaysia, Korea, and Thailand were recently thought to be potential new entrants to the demand market, this threat had receded since the economic downturn in the Pacific Rim countries. They now could not afford to invest in the necessary technological infrastructure for further hospital facilities. Nor could they afford to compete in a consultant-delivered service. In the short-term they were simply unable to match the money available in developed countries. The trend was more for the wealthy in developing countries to travel abroad to obtain their specialist treatment. Thus, residents of Bangladesh would travel to Singapore, which acts as a hub for services in the region, and Saudi Arabians go to private clinics in the UK or the States. On the whole, the needs of developing countries were for generalist doctors, which was a different skills market from the main medical market. They were not therefore seen as potential new entrants to the global market.

Nevertheless, there were questions raised concerning the trend towards globalisation, and the portability of a medical qualification, and the implications for outflows. There are unaccounted for losses from the junior medical workforce and a concern is that they may have gone elsewhere to train. The reasoning behind this speculation is the link between specialist training and qualifications in Australia, and access to an unrestricted Provider Number for Medicare Insurance Rebates. Obtaining a provider number was automatic for Australian trained and qualified doctors until 1996, when the requirement to also have a specialist/vocational qualification also became a criterion. As well as enabling quality control of training, this measure also limited numbers of newly qualified doctors entering a training programme, thereby restricting to a degree the previous fairly open-ended supply of doctors entering general practice. Rather than remain as hospital medical officers, some may have chosen to migrate in search of postgraduate training opportunities. A related concern is that some may have exited the medical workforce in favour of more lucrative business opportunities. Other possibilities are that they may be employed by drug companies, or working in medically related fields.

How did our interviewees perceive the ‘push’ and ‘pull’ factors of medical migration to and from Australia?

4. Perceptions of Push Factors in Physician Migration

Push factors out of major SE Asian supply countries, such as India, were seen as basically economic, the chance for a better income and lifestyle, and more opportunities for training

and career development. It was said that doctors for this region would often go opportunistically to New Zealand, willing to take any job, and then attempt to get into Australia from there. Push factors operating in smaller supply countries related to political situations, with increases linked to major events. So, for example, the annual permanent medical migration from mainland China increased from 42 to 186 between 1992/3 and 1995/6, following the events of Tianamen Square, but then fell back in subsequent years.

The regulatory mechanisms of the profession might influence outflows from Australia, because of the restrictions on training numbers. Professional links between the UK and Australia could also act as push factors. Opportunities for recognised training in dermatology and ophthalmology in the UK were cited, offering more opportunity than available at home. Dermatology only has 8/9 training positions a year in Australia, and ophthalmology 12. Those who fail to get places can either queue in the hospital system or go elsewhere. However, currently very little is known about junior doctors career intentions and destinations, and cohort studies are planned by AMWAC to address this lack of information.

Permanent resident, overseas-trained doctors, such as our interviewees from the ADTOA, who had experienced difficulties in achieving their registration goals, both at junior and specialist levels, might be expected to consider out-migration. Perhaps these difficulties would act as push factors? In some highly publicised cases, some specialists have taken their skills elsewhere, but some have appealed against their exclusion from specialist registration, won, and stayed. Other options had been considered, weighed and rejected. The impression was that it was better to stay within the Australian system, and attempt to work through it. An older specialist did not want to face another upheaval, and, in any case, *"it's too snowy half the year in Canada"*. The pull of Australia outweighed the push.

On an individual level, there didn't necessarily appear to be any common distinguishing features of doctors more likely to migrate, as against those who didn't, other than that in general doctors were "a bright lot" from the top 4% of the population academically. They were likely to have the initiative to organise a time abroad, and have an interest in going. Personal push factors to medical out-migration in Australia were mainly related to the desire to travel and see the rest of the world, an impossibility from a base in Australia! Although the main country level circumstance driving this is its location, there are economic bonuses to be gained, because of the strength of the £. Working for a time in the UK could pay off some student debts, and enable some European travel. Sometimes personal ties made at this stage would lead to permanent migrations. There was no hard evidence on personal qualities, which might influence medical migration to Australia. However, anecdotally, OTDs came from the more educated and wealthy segments of societies, who could afford to pay for training and accommodation during the periods when no money was being earned, for example whilst getting through the AMC exams. The New Zealand graduates who emigrated were said to be resourceful. These inward and outward migrants contrasted with the doctors of the ADTOA, who experienced severe difficulties in achieving their professional goals, often associated with language problems and lack of access to training and education facilities, similar to those reported for refugee doctors in the UK.

5. Competitor Country Analysis

Overall Positioning of Australia

In the competitive market for doctors, we need to differentiate between the types of physician in demand, whether specialists or generalists or general/family practitioners. Australia faces shortages in particular specialties, which echo shortages in other Western health systems, and also faces shortages of general practitioners in particular rural and remote locations. The overall view was that all English-speaking countries were facing the same problems, competing 'head to head' and a lot of *"robbing Peter to pay Paul"* (Aus Int 10) was going on. For example, New Zealand faces critical shortages, as many of its doctors migrate to

Australia. The two markets are closely linked, with rural New Zealand suffering most at the end of 'the feeding chain' as far as supply is concerned. New Zealand is looking at ways both to stem the outflows and to attract new entrants, particularly from the UK. Canada has also recruited extensively in the UK and in South Africa. For example, anecdotal evidence from interviewees suggests that many South African doctors have relocated to Canada, with some attractive packages to work in areas of undersupply, both location and specialty. [Anecdotal evidence also suggests that some of the vacuum left by their departure was being filled by doctors migrating from both Zimbabwe and from India). At the same time, Canada was reported to be "a growing pool" for doctors working through the Rural Doctors' Network in Australia. Australia and Canada appear to face similar shortages in general/family practitioners working in rural and remote areas, and are competing for doctors from South Africa and the UK. The well-advertised UK recruitment campaign was seen as a potential major threat to Australia. If successful in attracting Australian doctors more long-term, it could upset the workforce planning strategies. Others felt that Australia was not greatly threatened by competition, and felt confident that as "*nice place to live and work*" it could continue to attract doctors. Nevertheless, the feeling was that "*This is all going to hot up isn't it? The ageing population, the ageing medical workforce everywhere, they're all going to be competing.*" (Aus Int 5).

There also seems to be a competitive market for other doctors from supply countries outside the white Commonwealth countries. For example, visa grants by post by region in 1998/9 showed 27 primary applications from Auckland, New Zealand. These could not be New Zealand citizens, who have automatic rights of registration and entry into Australia and would not therefore need a 422 visa. More likely they would be from India/the Indian subcontinent and the Pacific Rim in general, as until recently New Zealand was considered an easier entry route, used as a launching pad for entry into Australia. (Now, although OTDs with New Zealand residency/citizenship may enter Australia, they are no longer able to sponsor family for entry, which acts as a deterrent for some). It would also be interesting to know how many of the UK applications for 422 visas to Australia as UK citizens/residents held UK primary medical qualifications. Are some of the applicants say, Indian medical school graduates, who have passed the UK PLAB and undertaken basic/higher specialist training, before going to Australia? These examples highlight the fact that the existing data leave many questions about the international migration of doctors unanswered.

The USA was undoubtedly seen as the main competitor. In terms of sheer numbers, the US draws in the most doctors from, say South Asia. It also has the wealth to suck people into the system, especially into research. The USA therefore attracts doctors from the main competitor countries to this niche market. Doctors who are particularly career-focused could maximise their opportunities to do research and to specialise or sub-specialise. (These perceptions are supported by research in the US, which demonstrates that doctors from Australia and New Zealand in the US workforce, are concentrated in academic departments, and tend to be at a later professional stage) (**MICK Ref**) The USA also had a financial market advantage in attracting doctors in training from major supply sources, such as India, and it was thought that this latter demand might soon rise, as retirements from the large influx of Indian doctors in the late 1960s come on stream both in the UK and in the States. Others felt that the USA and Canada were not such major threats, in terms of drawing Australian doctors, as the need to pass the entry exams was seen as quite a high barrier to entry. However, Canada had been successful in drawing radiation therapists and non-medical physicists from Australia recently, and was competing successfully for medical specialists from South Africa. Although the UK was felt to compare favourably with the USA, Canada and Australia in terms of the quality of training it offered, as Australia itself had improved its training considerably, there was less pull than 20 years ago for Australians to spend time in the UK. Nevertheless, there was still prestige attached to spending time in Oxbridge, major London hospitals, Edinburgh or Aberdeen. However, there were also major US centres of excellence, which rivalled the UK, and many more of them (Aus Int 1, 2, 8, 9, 10).

Lifestyle factors were also in Australia's favour, with less work pressure than in the States, and a great climate and outdoor lifestyle. The fun-loving, party, sports image appealed especially to the younger age group of doctors. Whilst many of these younger doctors were in Australia on a short-term basis, it was hoped that qualified GPs from the UK and Canada would also be attracted for longer. Australia was felt to be ahead of its competitors as a permanent location, given the attractions of the package offered by the State/Territory rural schemes, and the new 5-year moratorium on accessing a provider number (Aus Int 5).

Australia compared less favourably with its competitors, however, in terms of financial incentives: the exchange rate against the US dollar had gone from 65 to 50 cents in the previous 18 months, and the currency was in a relatively poor position against Sterling. This meant a strong pull to the USA and the UK, where indebted Australian and New Zealand medical graduates could earn well in lucrative locum jobs to pay off debts more quickly. However, these migrations were not thought to affect Australia's position in the long-term, with typically, Australian doctors only staying away for a year or two, before returning. The position of the Australian dollar had a positive pull effect, however, when it came to attracting medical students. US students could complete a 4-year postgraduate medical degree at a greatly reduced cost compared with the States. Students from Malaysia, Hong Kong, China were also attracted to Australia, partly for financial reasons, as well as location (Aus Int 2, 4).

6. Key Issues

Before undertaking the data collection in Australia, it was assumed that the UK and Australia were mutual beneficiaries from the processes of temporary exchange of doctors, typically at the close of the SHO phase of training. Gaining experience abroad in well-respected training hospitals, under eminent professionals has always been accepted good practice and is thought to be mutually beneficial overall to both sender and receiver countries. Unlike the UK, with regard to medical migration from Australia, Australia raises comparatively high barriers through both immigration policies and through registration arrangements to prevent permanent medical migration. However, it has specific policies and incentives to target recruitment and retention to those job slots, which are difficult to fill from the domestic supply. The data suggest, however, that the UK is the loser in this transaction, and that the loss is increasing, and could well be on a more long-term or permanent basis than had been supposed. The loss may be of doctors with a UK primary medical qualification, or of other overseas trained doctors who have undertaken further training in the UK, or both. The situation should be further monitored.

However, there are potential recruitment opportunities for the UK, particularly for recruiting Australian trained doctors to general practice training in the UK. The UK's excess training capacity in general practice, and the willingness of some Deaneries to be involved in pilot training of Australian graduates, could constitute an attractive 'pull' to those junior doctors who are unable to access a vocational training at home. It could be particularly attractive, as the qualifications are recognized as equivalent to Fellowship of the RACGP. A doctor, who wanted to have a portable qualification with the option to return home after some years, would therefore find the training attractive. As an Australian citizen, s/he would not be subject to the restrictions of UK doctors to work in area of workforce shortage, but could use the mix of Australian graduate and UK postgraduate qualifications, combined with Australian citizenship, to locate at will. Whilst these conditions would act as a 'pull' to the UK, other factors would need to operate to retain them. A pilot scheme might incorporate some of the lessons learned about recruitment and retention, both from rural Australia itself, and from our own pilot programmes with Spanish doctors. We also know from our UK interviews that some 20% of EEA doctors who come to the UK for general practice training remain long-term, and that personal, social and community ties are the main reason for staying. There may be opportunities to build on this experience.

Australia has the luxury of an excess general practice workforce in general. For some GPs, who may obtain only the Medicare floor price for services, or may be under-employed in over-supplied areas, this may constitute a real or potential 'push' factor. There is evidence from the UK press that some Australian GPs, perhaps UK trained originally, have sought to return to the UK, but found difficulty in obtaining recognition from the JCPTGP, even though they have full GMC registration. There may be issues of status and pay involved in these doctors gaining sufficient UK experience and CME to satisfy professional requirements, it may be worthwhile making an investment in such doctors, to facilitate transition. Each success story sends a message back to the source country.

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COUNTRY REPORT 3 – SPAIN

Country Report for Spain

1. General Background

Population and Economy

The population of Spain is approximately 40 million, with one of the lowest population densities of the EU at of 77.9 per km², falling as low as 20 per km² in central areas. In common with the rest of Europe, the country has an ageing population. There has been a particularly strong fall in the birth rate, from 2.9 average births per woman in 1970, to 1.15 in 1998. From having the second highest birth rate, it now has the lowest rate of all the EU member States. Infant mortality has fallen from 18.9 per 1000 live births in 1975, to 5.5 in 1999. Life expectancy is comparatively high, the third highest in the EU, at 74.4 years for males, and 81.7 years for females in 1997. It is calculated that the country will loose 25% of its population in 50 years time, and the population over the age of 65 will double to 37%, the highest in the world (European Commission 2000).

Economic Stage of Development

Employment is relatively low, with 61.2% of adults between the ages of 15 and 64 in work in 1998. (Compare the UK with 74.9%). Spain also had the highest reported unemployment rate in the EU, at 18.8% of the working population, (compare the UK at 6.3%), with rates for women and young people under 25 years being particularly high, (26.6% and 35.4% respectively). The young people's rate is the highest in Europe (followed by Greece and Italy).

There is still a relatively high rate of employment in the agricultural sector at 7.9% (c.f. UK 1.7%). However, the sector has shrunk considerably since the 1950s when Spain was politically and economically isolated, and 50% of the population were living in peasant agricultural poverty. The 1960s saw a rural exodus and rapid economic growth as Spain transformed itself into a market economy, following huge American loans in exchange for nuclear bases, joining the IMF, the International Bank for Reconstruction, and OECD. The economic boom was fuelled by rising tourism and by remittances from Spanish workers abroad, (in France, Germany and Switzerland) and the illegality of strikes and industrial action at home. The economic downturn in late 1980s created pressures in Spain's welfare system, with declining contributions to insurance and tax receipts, and increasing payments in unemployment benefits and in old age pensions. For every beneficiary there were only 2.3 contributors, compared with 5 in the rest of Europe. International tourism is still a strong sector, with revenue around 25million ECRU, and very small expenditure, around 3 million. Now the industrial and service sectors account for 30.4% and 61.7% respectively (c.f. UK 26.7% and 71.6%) (European Commission 2000).

Standard of Living as measured by GDP per head (and in terms of purchasing power standards) at US \$ 16,400 was the third lowest of all the EU countries in 1999, with only Greece and Portugal lower. (Compare the UK with GDP US \$20,348 per head in the mid-range). Spain's minimum wage is the lowest in the EU at less than EUR 2 per hour (c.f. EU average is EUR 5.65 per hour) (Eiroline 2002), and affects 500,000 Spanish workers. Despite pressure for it to be raised, increases are only in line with forecast inflation, 2.0% for 2002. There are marked regional disparities in economic prosperity, with the South and North Western Spain being economically the poorest (at a similar level to Southern Italy, Eastern Germany, Greece, and parts of the Republic of Ireland). Nevertheless, there has been an increase in consumer spending similar to the average for the EU as a whole, over the period

1985 – 1997. The wealthier, more industrialised areas, such as Madrid, Barcelona (Catalonia), and Bilbao (Basque Country) raise the average.

The EU Commission's Assessment of Updated Stability Programme for Spain 28.02.2001 states that:

“Real GDP and employment have grown more briskly than expected”...But rising core inflation is of concern, and fiscal policy should be ready to tighten further to counteract any additional overheating pressures...especially in view of the future effects of population ageing, to which Spain is particularly exposed...Attention should be given to the long-term sustainability of finances”.

Growth rates of 3.2% in GDP are forecast for 2002-2004. Spain has given a commitment to allocate any social security surpluses to increase the social security reserve fund created in 2000. Social Security spending, (including health expenditure) as a% of GDP in 1996 was 22.4%, one of the lowest spending countries (along with Portugal, Greece and Italy and Republic of Ireland). (Sweden had the highest at 34.8%) (European Commission 2000).

In summary, the current economic climate is one of constraint in public expenditure, reflected in the 2002 Budget.

Pressing Development Issues

Transport

Improving the transport infrastructure, namely the motorways and railways networks is seen as a priority to bring economic growth to the poorer, more remote regions. As measured by km per 1000 km² Spain's transport systems are relatively poor, so that Spain has the highest share of the EU regional aid budget for infrastructure improvements.

Health Issues

- AIDS is a major issue, with the highest standardised mortality rate caused by AIDS in the EU, especially related to drug use, although the annual incidence of new cases is declining. There is a National Anti-Drug Campaign coordinating the efforts of different government and voluntary agencies to address this.
- Lung cancer incidence increased 11% between 1985 –95 and cardio-vascular diseases have also increased. Spain has the highest rates of tobacco and alcohol consumption in the EU (although these are falling), and there are issues of a high % of obesity and weight problems/lack of exercise, adding to risk factors.
- There is a high incidence of traffic and work related accidents, although these are being addressed by health promotion and improved prevention practices.
- Compared with the rest of the EU, there are higher than average rates of mortality due to infectious diseases.
- However, the numbers who have chronic conditions because they are long-lived have increased in relation to the numbers who suffer from infectious diseases and those who undergo major surgery.
- Growing health inequalities are manifest in the standardised mortality rate, which was 30% higher for manual workers compared with professional and managerial classes in 1980, and was 70% higher in the early 1990s. These increases are most marked in the poorer regions, and are mirrored in other indices such as chronic illness, diabetes, physical disability, self-assessed health status and lifestyle.

These trends call for changes in the treatment facilities and the way the healthcare delivery system is organised, with an increased emphasis on public health. Health care costs per head in Spain are amongst the lowest in the EU, with only Portugal and Greece being lower.

Education

There was a pressing need to expand the numbers entering secondary education in the 1960s/70s as a means of fuelling economic development. Opening up access to the university system led to a dramatic expansion in 1970s and 1980s, although quality was thought to suffer through the large numbers enrolling, particularly in 'facultas' for traditional professions, such as medicine, to the detriment of 'escuelos' for other sectors such as teaching and nursing. Now there are complaints that there are too many traditional professionals, and not enough people being trained in crafts and trades. In more recent time, numbers completing at least a secondary level of education have increased from 39.3% in 1990 to 51.7% in 1997. Spain has one of the highest take-up rates of post-secondary education in the EU. There are approximately three times the number of applicants to medical schools as are awarded places, and this ratio has remained fairly constant, although there has been a 10% absolute reduction over the last 3 years, due, it was said, to the pattern of demography. Applicants do not appear to be deterred because doctors have difficulty finding work, as there are also employment problems in other areas of professional work (interview 9). However, others thought that there was stronger demand now for IT and management training, and that the quality of medical school applicants had declined (Interviews 1,2,3).

Political Context

There have been major political changes in Spain following the death in 1975 of the right wing dictator, Franco, who had ruled since the end of the Civil War in 1939. The Union de Centro Democratico (UDC), a centre-right party, presided over a transitional government from 1976-78, until the introduction of the 1978 Constitution, and the first democratic elections. They remained in power until the 1982 elections, when the Partido Socialista Obrero Espanol (PSOE) gained control not only of the central government, but of 2/3rd of the Regions as well. The socialist party then enjoyed a continuous period of power, under the same Prime Minister, until 1996. The 1996 elections brought the Popular Party (PP), a centre-right party to power in a minority government, sustained with the support of the Catalan and Basque centre-right parties (in two strongly independent regions). The PP was re-elected in 2000 with an overall majority.

Spain is now a Parliamentary Monarchy, with a 2-Chamber Parliament, Congress and Senate, for the Central State. However, Spain is characterised by major political decentralisation, with 17 Comunidades Autonomas (CAs), or Autonomous Regions, varying in population size from Andalucia (7.2 million) to La Rioja (264,000). Each CA region has its own parliamentary government, with smaller provinces (50 in total) and municipalities (8,000 in total). The CAs' powers are guaranteed under a Statute of Autonomy. This details the central government responsibilities, the CA responsibilities, and any shared responsibilities, and the protocols for settling any conflicts between them through the Constitutional Court. Health and Social Care have been a joint responsibility, with some exceptions, but the situation has recently changed. This will be detailed under the section on the Health Sector below.

2. The Health Sector

The Health System Model

The public health care system has developed by degrees from an insurance-based, means-tested, system covering just 20% of the population in 1942, to a gradually expanding social insurance system (30% in 1950s, 45% in 1963 to 53% in 1966, 81.7%, by 1978) covering the bulk of salaried workers and their families. The introduction of the 1967 Basic Social Security Act expanded coverage to include self-employed professionals and civil servants. Now 98.8% of the population has the right to free health services, but there are still anomalies. The system still does not provide 100% coverage, as certain wealthy self-

employed categories are excluded, as are immigrants. 60% of prescription drug charges are covered, but dental treatment is not covered.

Following the election of the socialist party in 1982, there has been a gradual transition from a social security system based on insurance, to a National Health Service model, with universal access to mainly public provision, and tax-based financing (since 1989) to meet extended provision: from a Bismarck to a Beveridge model (Rodriquez et al 2000). There are also three publicly funded mutual funds exclusively for civil servants, who have a choice between public or private provision. In theory they may not move between the two systems, but in practice there is evidence that many switch to use public provision for high technology interventions.

Although in 1963, 45% of the population was covered by public health insurance, only 10% of hospital beds were covered. By 1967 this had risen to 23%. A programme of new hospital building and expansion of existing ones, coupled with greater government employment of doctors meant that by 1975 approximately 70% of hospital beds, 70-80% of hospital doctors, and 75-85% of the total health care budget were publicly funded. Now the hospital system is mainly public, but 90% of hospital doctors might undertake some private work, and there are regional variations. Some 15-20% of hospital provision is contracted out to private not-for-profit providers, and an even greater % in Catalonia, where there is a strong tradition of not-for profit private provision, accounting for 2/3rds of the sector.

In addition to the government provision, overall, about 10% of the population is also covered by private voluntary schemes. There is wide variation in the use of the private system, with 20% of Catalans having some form of private insurance. The sector is encouraged to expand through encouraging employers to provide cover for accidents and illness at work (including sick pay), with tax relief for employer-purchased private insurance. However, when this tax relief measure was introduced in 1998/9, the personal 15% tax break for individually privately purchased insurance was removed. Its possible reintroduction, or an alternative social insurance rebate, to encourage an expansion of the sector, is a current issue. In common with other countries, a method is sought of lightening the overall rising public expenditure on health care. There is some evidence that out-of-pocket payment, as well as insurance, may be used to speed access to initial specialist consultation, although this route cannot be used to quicker access to procedures in the public system.

Opinion on whether the private sector is set to expand was uncertain. The policy emphasis has been on providing equity through a public system, free at the point of access, similar to the NHS, and there is resistance to losing these gains. However, there are drivers within the system which might lead to an increasing private market share, namely long waiting times for non-urgent surgery, and a large number of un/under-employed doctors, some of whom are turning to putting their energies into private practice. One such doctor, with 5 years specialty surgical training, and working alongside an already established private practitioner, was earning in 5 days a month an income equivalent to the full-time salary of a public sector employee at the same stage (approximately 2,000 – 2,500 Euros per month). Incentives to purchase private insurance may fuel growth in the sector.

Organisational Form and Reform Changes

Administration

There have been major reforms since the transition to democracy in both the organisational form and the content of health care provision. At the close of the Franco era in 1975, there were a variety of health care networks, inadequately organised and poorly coordinated. Primary health care and preventive care were particularly underdeveloped. In 1977 the Ministry of Health and Social Security was established (becoming a separate Ministry of Health in 1981), and currently as the Ministerio de Sanidad y Consumo, is also responsible

for consumer affairs. The executive National Institute of Health, (Instituto Nacional de la Salud, or INSALUD) was formed to administer public health care, organisation and policy in 1978. University hospitals and undergraduate education came under the Ministry of Education.

The 1986 General Health Care Act consolidated the reforms established by means of various directives since the PSOE came to power. The task of reconciling different provider and interest groups, the State and Autonomous Communities, to build a National Service was given to the Interterritorial Council of the National Public Health System in 1987 to act as a consultative body. Basically, responsibility is shared between the State central administration concerned with legislation, information, planning and coordination; The Autonomous Communities, responsible for their health care services, for public health, community care, mental health, and some social services; and local governments, in charge of environmental health control. Until 2002, INSALUD had a greater role in the administration of health care in 10 of the 17 Autonomous Communities, but all regions were ceded devolved powers recently. Overall, the move is towards greater decentralisation.

“Generally speaking, therefore, major health planning and legislative initiatives are based on the need for fundamental consensus among the different political powers”. (CESM1999)

Health System Reforms

The reforms of the 1970s and 1980s gave greater prominence to primary care.

Given the near universal coverage of the health system, increasing expectations and the incorporation of new technologies, there have been huge increases in health spending. Public sector health care expenditure (as a % of GDP) rose from 3.9% in 1982 to 5.17% in 1992. (INSALUD). Overall, the reforms of 1990s have had a similar focus to other health systems worldwide, aimed at cost-containment, increasing efficiency and effectiveness, and rationalizing organization and management, and the process is still ongoing. There are debates about purchaser / provider splits, and in 1999 steps were taken to move public hospitals towards the status of independent agencies. Greater power and responsibility has been devolved from the centre to all of the Autonomous Communities in the field of health care.

User Groups in the form of participatory committees exist in theory at all levels and structures of provision, but in practice the participants are mainly local government or professional representatives, and there is limited development of user associations.

Professional Organisations

The Consejo General de Colegios de Medicos (General Council of Medical Colleges), the equivalent of the GMC as the ‘Competent Authority’, is made up of 52 provincial Medical Colleges, each with responsibility for registration of doctors working in its area. The separate political body representing Colleges’ interests is the Organizacion Medica Colegial (OMC), (Organisation of Medical Colleges) located in Madrid. Other organisations are affiliated, such as the Working Group of Unemployed Doctors, and the National Council of Medical Specialties, (consisting of one society per specialty, and involved in self-regulation, recruitment, and professional training issues).

However, the organisation does not have a major role in health care reform, operating with a high level of authoritarianism and fragmentation.

The trade union equivalent to the BMA is the Confederacion Estatal de Sindicatos Medicos, (CESM) (State Confederation of Medical Unions) and has been instrumental in organising strike action and in negotiating wage settlements, notably in 1988. Two other unions are increasingly influential: the SESPAS, Spanish Society of Public Health and Health Management; and SEMFYC, the Spanish Society of Family and Community Medicine, representing GPs who have had a specialist training, introduced following the EU Directive 93/16, and implemented since 1995. This is a lobby group for reform to include an increasingly influential role for primary health care.

Position of Doctors in Society

Doctors' Status and Pay

Doctors are paid as salaried civil servants, and GPs are paid a salary comparable to other hospital specialists, with different components as incentives. For those practising as GPs, but without a vocational qualification, the pay is lower. There is little opportunity for GPs to increase their income, as there is little access to private work, as there are no incentives for patients to pay for primary care. Overall, pay in the public sector is low for those below consultant grade. Comment by interviewees suggested that the level of pay was lower for doctors than for plumbers and plasterers, trades in short supply, and was certainly well below levels of pay in other European countries, such as the UK. Increasing numbers of unemployed doctors, coupled with the feminisation of the workforce are thought to be factors in reducing the social and economic status of the medical profession. Between 75% and 78% of first year medical students are now women (Bombi 2002). In 1988 doctors took part in the public sector strikes over the levels of pay, which led to a general strike.

Primary Care

Historically, primary care has been a lower priority in terms of budget, infrastructure and human resources than secondary specialist care. Until recently, the general picture, especially in rural areas, has been one of small clinics, or 'consultorios' staffed by a solo general practitioner, the part-time employee of the local council, working perhaps 2-3 hours per day. Larger 'polyclinics' or 'ambulatorios' in larger centres of population might offer some outpatient specialties, but with few diagnostic or administrative support services. The network of rural services was under the centralized social security administration, with the doctors having the status of part-time social security employees.

A series of surveys in 1979 (reported in Euroline) highlighted widespread dissatisfaction with primary care services, with 85% of doctors and 66% of the general public expressing concern. This compared with 15% of doctors and 40% of the public finding public hospital care unsatisfactory. A focus on primary care reform has since the early 1990s has led to more local primary care clinics, with Primary Care Teams (Equipo de Atencion Primaria, EAP) of general/family practitioners, paediatricians and a range of allied health care professionals, delivering services. These services are completely publicly owned, with staff paid on a salaried basis. Overall, 73% of primary health care doctors work within the reformed structures, and although there are regional variations, increasingly fewer doctors work as single-handed GPs, except in rural areas. Since 1993 consumers have had freedom of choice in consulting GPs and Paediatricians. They do not have to be registered on a particular doctor's list, although in practice most people do go to their local clinic. In 1997, health care centres were given self-governing status. However, the relatively low status of general practice is reflected in the high numbers of patients who choose to go to the A&E departments of hospitals for their first consultation, rather than going through their GP. 50% of A&E department admissions are related to patients' perceptions of problems with accessibility to primary care (Rico et al 2000). The situation is a cause for concern, mentioned by several interviewees.

Part of the reform in primary care has been to formalise training in Family and Community Medicine, established by Royal Decree 3303/78 in 1978. Access to the 3-year training is via the competitive MIR examination. Half the training is in hospital residency, and half takes place in health care centres, similar to the UK. Primary care specialty training is now absorbing the major share of graduates, but the sector is nearing saturation point, as the average age of GP doctors is relatively low.

Following the introduction of formal training, transitional arrangements were made to enable those already practising to gain accreditation. A number of criteria had to be met to gain 'acquired rights' including 5 years' practice, and undertaking some further vocational training. The arrangements were not implemented until 1989, following EU Directive 86/457/EC, by which time some 8,500 doctors had fulfilled the criteria, with another 2,100 still to complete the vocational training by the cut off point. Still other doctors fell short of the 5 years of practice. The 1986 Directive was replaced by Directive 93/16/EC requiring a minimum 2 year post-graduate training for Family Medicine, but guaranteeing pre-1995 graduates the right to practise general medicine even without a specialist training. Nevertheless, in 1998 the Spanish Ministry of Health brought out a new Royal Decree 1753/98 requiring the pre-1995 doctors working in the public health system to comply with new requirements, which now include 5 years experience in the public system, vocational training and a new requirement to take an objective test and evaluation. UEMO sees these new measures as disproportionate (Garzon2002). The measures probably reflect the power of the lobby group SEMFYC, protecting the interests of trained GPs. There are reckoned to be about 10,000 'unqualified' practising general practitioners, and the numbers have who have not been able to access any specialty training have been increasing by 600 per year since 1995.

Overall, across both public and private practice, primary care now accounts for approximately 50% of provision.

Secondary Care

Within the public system access to specialist consultation is by referral from the GP, although since 1996 patients have freedom of choice as to which consultant they would like to see. Most hospitals are publicly owned, and the majority of staff is salaried employees. Privately funded patients may access specialist care direct, and doctors are allowed to advertise.

Problems for hospital doctors reported by a FEMS survey showed that hospital doctors have to work to short-term temporary contracts, with job insecurity and with little opportunity for progression. Heads of Department have no fixed term of office, and so may hold their position until retirement. There may be political influence in senior appointments.

Geographical Distribution of Doctors

There is an irregular distribution of doctors by region. The average number per 10,000 inhabitants is 33.07, (with 16.56 per 10,000 being in Family/General practice) but is as high as 61.85 in Aragon, and as low as 16.18 in Castille-La Mancha. The rate of doctor unemployment is correspondingly lower in low ratio areas, (2.5 per 10,000 in Castille-La Mancha) and higher in high ratio areas (13.61 in Aragon). The regional imbalances in workforce distribution mirror the differences in employment levels and the standard of living, so Estramadura, a very poor region, has particularly low physician numbers. Aragon, Navarre, and Castile-Leon have lost population to urban areas, and have an ageing physician workforce. Madrid and Barcelona have a large oversupply. However, within the major cities there are also pockets of severe undersupply in poorer areas.

The oversupply in some areas is partly a reflection of the regional distribution of medical school training places, with particularly large schools in Madrid and Barcelona. (Just 3 centres supplied 25% of the current qualified doctors). There are also imbalances in the distribution of MIR specialty training places. As historically there is little movement between regions, there is little transference of surplus to areas of undersupply. Most University students study in their nearest university town, unless they are at a private university, such as Navarre in Pamplona (which has an excellent reputation for medicine). There is some movement of doctors after the MIR selection examination in the allocation of training places, but the migration tends not to be long term. This is because the market is not seen as an open one, with equal opportunities, despite official bureaucratic systems meant to promote fair play. Instead, there is perception of a system of patronage and preference, operating to the advantage of those who have undertaken all their training and qualifications in the same hospital area as any specialist job being advertised.

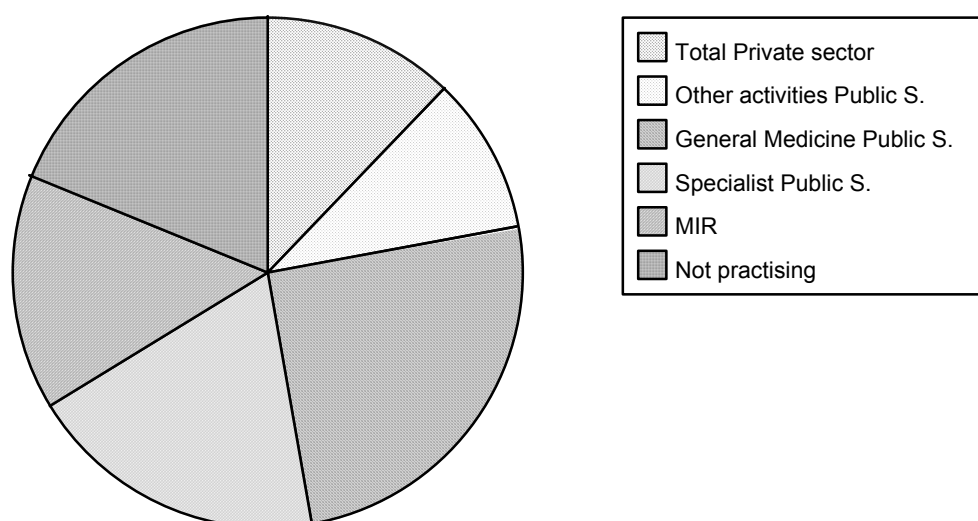
Workforce Characteristics

Different sources give the number of doctors in Spain differently. FEMS quotes a figure of 120,000, with a population: doctor ratio of 333: 1 (c.f. the UK 531: 1, Austria 254:1, and Italy 177:1).

Workforce Distribution by Sector

The following medical workforce analysis is based on a major study undertaken by CESM, using 1998 data, and published in 1999. Table 1 shows the distribution of the qualified physician workforce by sector. The data show that 25% are in public primary care services, 19% in specialist public services, and 15% are training in an MIR post-graduate programme. 19 % are unemployed. 10% work in public sector medically related fields such as hospital administration, and a further 12% work entirely in the private sector, which includes work in pharmaceutical companies, in the field of health systems development, and working in developing countries.

Table 1 1998 Medical Work Force by Sector

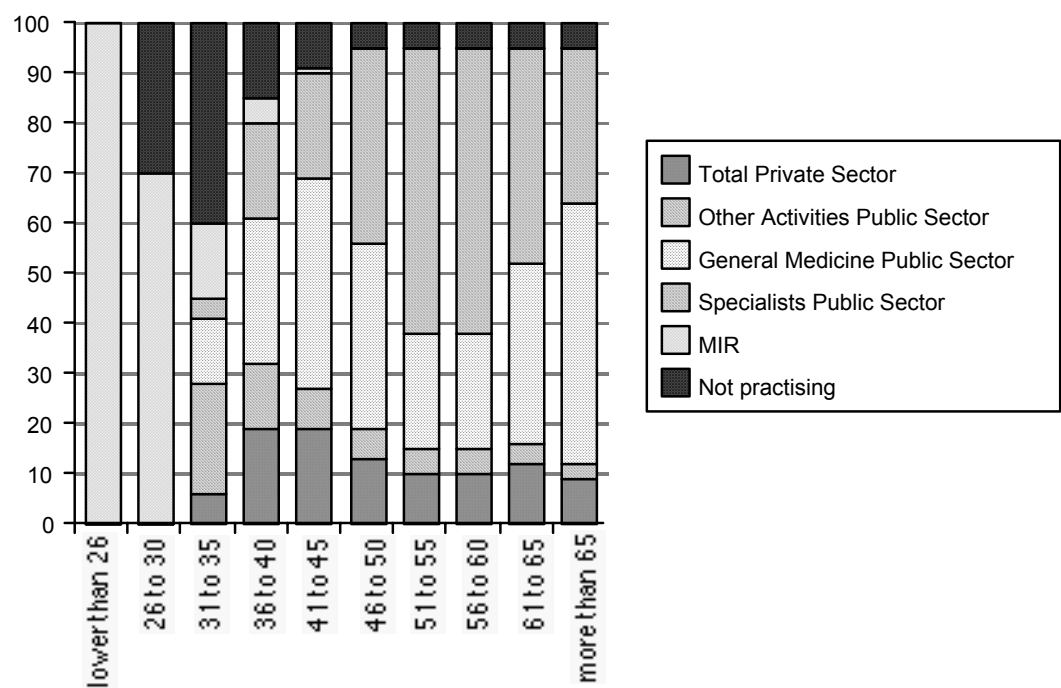


Workforce Sector Distribution by Age

Table 2 shows that primary care physicians have a younger age profile than secondary care specialists, with the biggest numbers in the 41-50 age group compared with 51-60 age group for secondary care. Because of the skew to the older age groups in secondary specialties,

there is concern that the current oversupply of doctors could lead to an undersupply of experienced doctors by 2020, as these doctors move into retirement. This will affect some specialties more than others. The under 35s have the largest % of unemployment, and have diversified most into other related activities in the public sector. The majority of MIR trainees are under 30, although there are some older trainees from the ‘pool’ of older doctors.

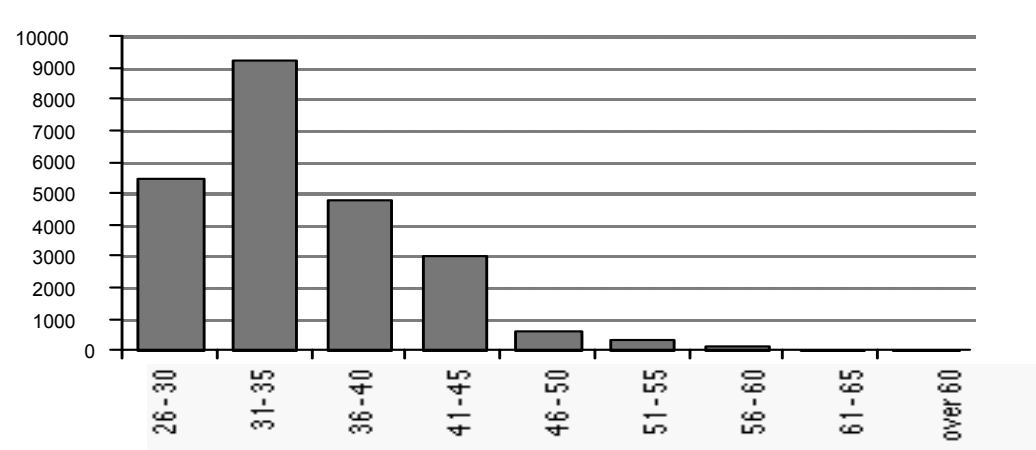
Table 2 Sector Employment by Age Group



The Structure of Doctor Unemployment

There are estimated to be 24,096 unemployed doctors, 70% of them under the age of 40 years. Unemployment is greatest amongst the ‘historical pool’ of graduates from the time when there was no numerus clausus i.e. 1970 to the early 1980s. The existence of this oversupply is still having a knock-on effect on the workforce. There is greatest unemployment amongst the 36 - 40 age group at 60%, 40% amongst the 31 – 35 age group, and 30% in the 26 – 30 age group. Overall, unemployment is more than 50% of doctors under the age of 35 years. Table 3 shows the unemployment age distribution.

Table 3 Age Distribution of Unemployed Doctors

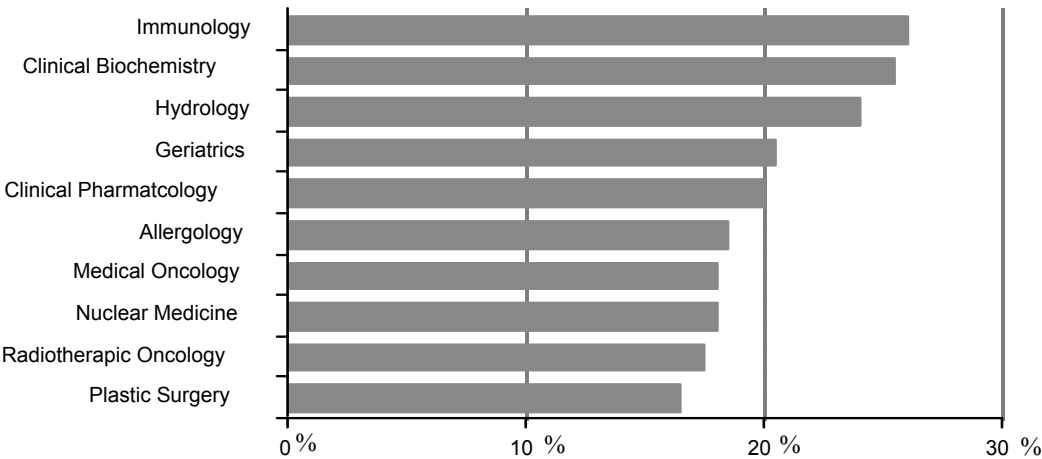


65% of unemployed doctors are female, compared with 46% of the practising workforce. The percentage of women entering the workforce has risen over recent years, so that they form more than 50% of the workforce below the age of 40 and 62% of those below 30.

Unemployment by Specialty

The highest rates of unemployment by specialty, shown in Table 4, are as follows: Immunology 25.9%, Clinical Biochemistry (25.6%), Hydrology (23.8%), Geriatrics (20.6%), Clinical Pharmacology (19.9%), Allergology (18.3%), Medical Oncology (17.7%), Nuclear Medicine 17.7%), Oncological Radiotherapy 17.5%), and Plastic Surgery (16.5%). Younger doctors tend to locate in the specialties with some of the greatest oversupply. Table 4 shows unemployment by specialty.

Table 4 Percentage Unemployment by Specialty



However, all the specialties recognised in Spain have a degree of unemployment. And the extent of this is shown in Table 5.

Table 5:
Unemployed doctors by Specialities.

SPECIALITY	Unemployed	Total	Percentage
Allergology	72	393	18.3%
Clinical Analyses	108	791	13.7%
Pathology	115	790	14.6%
Anesthesiology & Reanimation	231	2,555	9.0%
Angiology & Vascular Surgery	22	181	12.2%
Digestive System	114	921	12.4%
Clinical Biochemistry	51	199	25.6%
Cardiology	115	972	11.8%
Cardiovascular Surgery	13	125	10.4%
General Surgery & Digestive System	205	1,915	10.7%
Oral & Maxillofacial Surgery	26	171	15.2%
Paediatric Surgery	19	163	11.7%
Thoracic Surgery	7	67	10.4%
Plastic & Reparative Surgery	51	310	16.5%
Dermatology	68	580	11.7%
Endocrinology & Nutrition	50	466	10.7%
Clinical Pharmacology	31	156	19.9%
Geriatrics	44	214	20.6%
Hematology & Hemotherapy	105	861	12.2%
Immunology	30	116	25.9%
Intensive Care Medicine	112	841	13.3%
Internal Medicine	309	3,395	9.1%
Nuclear Medicine	44	249	17.7%
Preventive Medicine & Public Health	55	421	13.1%
Microbiology & Parasitology	88	555	15.9%
Nephrology	51	480	10.6%
Pneumology	104	794	13.1%
Neurosurgery	18	161	11.2%
Clinical Neurophysiology	43	272	15.8%
Neurology	100	675	14.8%
Obstetrics & Gynecology	216	2,110	10.2%
Ophthalmology	127	1,267	10.0%
Medical Oncology	61	344	17.7%
ENT	108	954	11.3%
Paediatric & specific Areas	360	3,854	9.3%
Psychiatry	199	1,498	13.3%
Radiology	146	1,485	9.8%
Oncologic radiotherapy	51	292	17.5%
Rehabilitation	96	731	13.1%
Reumatology	68	516	13.2%
Traumatology & Orthopaedic Surgery	166	1,677	9.9%
Urology	78	655	11.9%
Stomatology	95	2,836	3.3%
Hydrology	43	181	23.8%
Physical Education Medicine	88	643	13.7%
Legal & Forensic Medicine	36	231	15.6%
Occupational Medicine	159	1,831	8.7%
Others	49	667	7.3%
Family & Community Medicine/MG	1,817	65,206	2.8%

Workforce Surplus Projections

For their 1999 Report, CESM used a modified database of 133,420 doctors derived from GP and specialist census data to project short and medium term levels of employment. Assuming that the numbers in MIR training remain stable at the 1997 level, and based on a retirement age of 65 and 70 years (in 2 separate models) the medium term projection to 2018 is that the oversupply of doctors will continue to increase, causing unemployment especially amongst young doctors. Because the profession is dominated by the 36-50 age group, the percentage currently in the 51-65 age group expected to exit the workforce on retirement by 2018 is only either 8.1% or 8.7% of the total workforce. The surplus is expected to increase to 70,092, an increase of 35.58%, or to 76,614 (37.7%), depending on the retirement age used in the model.

Specialties projected to have major surpluses by 2018 are those where the percentage of doctors under 35 years is greater than the percentage approaching retirement. 32 of 49 specialties will increase by over 50% by 2018, including the following with the biggest increases: medical oncology 96.2%; oral and maxillofacial surgery 89.4%; geriatric medicine 98.3%; and clinical neurophysiology 90.1%. Specialties currently in balance, but with a deficit in coming years as 50% of the workforce approaches retirement include: cardiovascular surgery; neurosurgery; cardiology; and paediatric surgery. Particularly in the specialty of cardiovascular surgery there is said to be evidence of professional entry controls arising from "*volume controls to enhance private practice earnings*" (Maynard in CESM 1999, p74)

3. Domestic Supply and Demand Issues

Spain's Oversupply of Doctors

There is a large historical pool of un/underemployed doctors in Spain, estimated in the major study by CESM in 1999 to be in the order of 24,000 in 1995, and including 2,000 MIR trained specialists. By 1999, the number of unemployed specialists had reached 6,602, and the number trained in Family and Community Medicine since 1995, and unemployed was 5,600. The rest of the unemployed doctors had had no specialty training, and were unlikely to have had any work experience. Modelling future oversupply, based on the number of post-graduate training places (MIR) remaining at the 1997 level, (entries to the workforce), and exits from the workforce based on retirements, it is forecast that 37,609 specialists will be unemployed by 2008, and that there will be an additional 70,000-76,000 doctors by 2018. The age structure of the working medical population means that there is very little difference in the forecast whether the age of retirement is taken as 65 or 70 years, as only 8.1% - 8.7% of doctors fall within the retirement band either way (CESM1999).

Systemic Causes of Oversupply

The oversupply was begun in the 1970s, when the General Law on Education meant that all students with the necessary qualification, the bachillerato, could enter university. Policy emphasis was placed on open access to educational opportunity, and there was a need to absorb high numbers of potentially unemployed youth into post-secondary education. Although the government reintroduced an entrance examination to slow the explosive growth of the system by 1986/7, Spain still had the 2nd highest ratio of students to population in Europe. Spending per student was, however, only one third the Western European average. Undergraduate medical school intake began to rise steadily from 1970, and then increased rapidly during the post-Franco era of political, social and economic reform, with no numerous clauses operating in medicine. The prestige and earning power of a still largely private medical professional were strong attractions to training for the profession.

The strongly decentralised system of government, coupled with the fierce regional pride of different Autonomous Communities in having their own educational provision, mean that

there is no central planning and control of medical workforce or of numbers in training. There are 27 medical schools (one of which is private, Navarre), one opened as recently as 1998 in Castille-La Mancha. There are still strong institutional pressures operating to maintain an oversupply. For government, as general unemployment is still relatively high, there are political cost implications to reducing access to higher education. The argument from government appears to be that the cut off point in terms of numbers should not necessarily be at undergraduate level. Members of other professions may have to adapt to practising in other fields, and “society absorbs them”. The view of specialist Journals in the Health Sector expressed through the interviews reported in the CESM report, was also that a free market should regulate the demand for undergraduate education in medicine.

University autonomy, granted under the Ley de Reforma Universitaria (LRU) in 1983, also fuelled expansion. Autonomy was considered to be an important dimension of democratic freedom, but also enabled new medical Faculties to be established. The funding mechanism for Universities, related to numbers in place, is also an incentive for Rectors to enrol maximum numbers, and there is resistance amongst teachers to seeing their power reduced through a reduction in student numbers. Nevertheless, there has been an agreement since 1981 between Deans of Medical Schools within the University Council that a numerus clausus would be applied within each Faculty. The way it seems to be applied is through raising the grade requirements, rather than through a variety of selection methods or an absolute ceiling on numbers. However, there has been a large reduction in medical school intake, from a high of 22,554 undergraduate entrants in 1977 down to 3,600 annually by 1995 (CESM 1999). More recent figures show that the numbers have crept up again, with 4193 entrants in 1996/7, rising gradually to 4471 in 2000/1, an overprovision in that year of 88 beyond the official intake targets (Bombi 2002). The peak of new medical graduates of 10,346 in 1983 reduced to 4,600 by 1993. These figures also demonstrate the high attrition rate, estimated to be as high as 40% between 1970 and 1998, and also reflect the long length of time taken to complete undergraduate medical studies, in average 8 years (with men taking longer than women, and the time taken also varying between different faculties) (CESM1999).

Those who succeeded in graduating from medical school during the early years of formalised post-graduate training then faced a further difficulty of access, with only 39.9% on average attaining a regulated Specialist qualification. In recent years, since 1993, the number of training positions has more nearly matched the number of graduates, but with a backlog of older graduates still attempting the MIR qualifying examination, there is still a bottleneck at this stage. Different interest groups have different perceptions of the situation. As the ultimate funders of post-graduate medical education, the Ministry of Health has an interest in the entry and exit from specialist training converging with employment opportunity. However, health service providers are afforded a choice within this situation of oversupply, particularly as alternative opportunities within private health care are currently limited. In summary, *“The funders, providers and University are currently locked in a model with benefits they will not give up for something they perceive as uncertain.”* (CESM 1999).

Given the large pool of doctors from the 1970s/80s it is unsurprising that only 36.9% had the opportunity for specialist training. It is estimated that 5,192 others, known as ‘mestos’, (Specialist Doctors without Title), practise as specialists. Since 1994, however, and the implementation of Directive 86/57, there has been greater convergence in the matching the number of MIR training places to graduates, at least initially. The problem is that there is now a growing pool of specialist-trained doctors who are un/underemployed. They may have only ever worked in locum positions, covering maternity and holiday leave. In addition, there are those who have trained in another EU country either by undergoing a formal training programme, or by gradually accumulating sufficient amounts to enable specialist registration in Spain. Such amounts of training would not necessarily lead to registration in the country where it was obtained, but might meet Spanish requirements. For example, Spanish doctors

are thought to come to the UK for short bursts of training for 3-6 months at a time in LAT posts, and a total of 3 or 4 years' accumulation of such training would lead to registration in Spain, whereas the time of training to obtain the CCST in the UK might be 5 years. Because of mutual recognition, they would then be eligible to apply for posts elsewhere in the EU, including in the UK. There are also doctors resident in Spain who have trained elsewhere abroad, other than the EEA. Interviewees mentioned the large numbers who are applying from Argentina, attracted by the pull of the old country. In this case, their qualification has to be validated by the Ministry of Education. The criteria include 5 years or more of equivalent training, the recommendation of a peer, possibly an examination, and possibly some top-up training. There is an issue about transference of recognition of the qualification elsewhere in Europe, demonstrated in the case of an Argentine doctor. The arguments in law hinge on the difference between recognition of qualifications, and the right to entry onto the specialist register of another country.

4. The Position in Respect of UK Requirements

Cultural and professional links with the UK

There is very little evidence of historical ties with the UK in terms of professional exchange in the medical field, other than through some participation in Hippocrates, when GP trainees might spend 2-4 weeks in another European country. Spain has obviously stronger, former colonial links with South America, with Argentina in particular. There are also links with Morocco, and other Arab countries, and there is a 5% quota for foreign students coming to Spain to study. Apparently, according to one University Professor, there was quite an influx of students from the US to Spain at the time of the Vietnam draft in the 1960/70s, but this flow stopped after the war. Nevertheless, it was felt that there was a closer cultural affinity with the US than with the UK, *"I lived in the Utah State University for 2 years, and they were friendly with foreigners, and I was at home culturally"* (Interview 8). However, there were close ties also with the French, sharing a love of good food and wine, sun, music and theatre with Spaniards. In contrast, the English were seen as very 'peculiar', and isolated within the continent, evidenced by 'tea-time'! Small details added up to big issues.

In the more recent past, there is evidence of Spanish doctors coming to the UK for short periods of training or locum work. The interview data suggested that this was for expediency to gain training and experience to enhance an individual's position in the Spanish labour market. Some doctors, depending on their personal circumstances, might be prepared to come to the UK for 6 months to a year, but would not be contemplating long-term residency. Those doctors who migrated were not the best doctors, who would gain entry into specialty training. They were more likely to be the medium level doctors. However, there were not thought to be any really poor quality doctors, because the strong selection filters to gain entry to medical school, and to remain in the system (with approximately a 2% attrition rate). With English increasingly becoming the international language, coming to the UK with a family so that the children had an opportunity to go to school here and learn English was seen as a possible bonus. However, other circumstances might make such a move difficult, if the other parent (often a doctor or other professional) was in employment. An example was the unemployed 35-year old surgeon working 1 day a week in the private sector, whose wife was working as a paediatrician based in a community health centre, and whose children were at school locally. Working abroad would have added the problem of finding a location with work for both adults, plus the complication that paediatrics is not practised at the primary care level in the same way in the UK. Add to the scenario the existing extended family support to the nuclear family, and the push out of Spain because of un/underemployment was much less than the strong ties to remain.

What are the barriers, then, from the Spanish point of view, to medical migration to the UK? Culturally the UK is seen as different, and worse, than Spain. Several interviewees mentioned that a major issue was the food, and the inability to eat out casually, but well, in the UK. In

Spain it is possible to have good bar snacks without eating 'cardboard' food, and to have a drink without being restricted by licensing hours. In general, the feeling was that, "we live well in Spain", despite the un/underemployment. Another negative factor is the weather in England. Perhaps work might be considered in the South of England where the weather is less cloudy and rainy, and which is also nearer to home, but the Northern climate was felt to be too bad to contemplate. "*Character is related to the Sun*" (Interview 9)... "*What can the UK do to attract doctors?*" - "*Change the weather!*" (Interview 7).

Language is seen as the biggest impediment to practising in the UK. The interview with the Unemployed Doctors' representative was undertaken in French, the only common language. The first foreign language taught in schools is French, with Portuguese taught in those near the border. Therefore, it was seen as easier to seek work in those countries. Increasingly English is now being taught as the first foreign language, so that in the future opportunities in the UK may be more accessible. There are strong motivations for medical students to develop competency in English, as all major publications are in English.

Language difficulties were anticipated during the recent major UK recruitment campaign for doctors and nurses, and language training offered and provided for those taking up positions, during a 3-month period of induction. Language training cannot be made a condition of a job offer under EU law. However, it can be offered, and appears to have been gratefully received. Anecdotal evidence suggests that some of the language problems will require longer-term interventions, and may be linked in some instances to variations in terminology and classifications within particular specialties.

This brings us to issues of the skills and qualifications 'fit' between the UK and Spain. Undergraduate medical education is in general more subject/discipline based than in the UK, with less problem-based and integrated, thematic teaching and learning. There is also less undergraduate exposure to primary medical care in Spain, with very few schools having compulsory placements at this level. Access to specialty training is through the MIR examination, a competitive, knowledge based examination in MCQ format (one examination for access to Specialty training, and another for family medicine). To date there has been no assessment of clinical competence in the MIR, but this is currently being reformed to include some 'clinical vignettes' similar to the UK OSCEs. Candidates are listed in rank order, and choose their place by region, specialty, and hospital. Residency training is generally shorter in Spain than in the UK. Coupled with the greater doctor to patient ratios, this is thought to have implications for the quality of training, and for the depth of knowledge obtained. The concerns of UK stakeholders about standards were echoed within Spain in relation to the variation in the quality of both undergraduate and postgraduate training. During the period of rapid expansion teaching quality was bound to fall, and the academic failure rate was high. More recently there have been new broader and updated curricula agreed and introduced, but there has been resistance amongst some University teaching groups, "*There has been very little improvement in the coordination and integration of different disciplines, and teaching methodology has hardly varied with regard to previous curricula*" (Bombi 2002). Also, there is felt to be a need for greater standardisation for quality assurance (CESM 1999). There are also concerns about variation in the quality of training at the post-graduate level. CESM expressed concern that not all post-graduate programmes conform to the current curricula and that the Ministry of Education is still issuing Specialist degrees for these courses. Although there are efforts by the AMEF to bring a greater degree of harmonisation across Europe to undergraduate and post-graduate curricula, as well as to Continuing Medical Education, this does not yet appear to have had an impact substantial enough to address concerns about equivalence.

Taking the question of appropriate fit for one UK shortage specialty for which recruitment in Spain is underway, histopathology currently has a 4 -year MIR training in Spain. There are calls within Spain for this period to be extended, and for an exit exam to be put in place to test standards. There is no Spanish equivalent to the Royal College of Pathology qualification, (and

the European histopathology qualification is a relatively basic one). In Spain, a period of supervised practice would be expected after qualifying before undertaking fully independent work, whereas in the UK CCST holders could expect to go straight into a consultant post. Histopathology is one of the shortage UK specialties with targeted recruitment in Spain. Recruits to the North West have had to spend time working under the supervision of a Spanish-speaking consultant in Oxford, in order to develop the required levels of competency, in addition to their planned induction and mentoring. (STA personal communication 2002). Dr Stuart Coghill, Chair of the Federation of Histopathologists, (incorporated by the Hospital Consultants and Specialists Association), expressed the following concerns,

“The use of some diagnostic terms and even disease classification differs between countries. So the use of language has to be highly precise when writing histopathology reports, as subtle differences can greatly alter the clinical significance of the report”. (Hospital Doctor 2 May 2002)

There is concern within the UK specialty that standards may be allowed to drop for political expediency. Despite the mutual recognition of specialist qualifications under EU law, there seems to be a widespread acceptance by all concerned that new Spanish recruits will not be able to immediately step into unsupervised consultant positions. Most of the job offers under the current recruitment campaign are being made at the Associate Specialist level, offering experience, which may later lead to a consultant post.

There are no political or legislative constraints to be overcome in seeking to recruit doctors from Spain. There is a Government-to-Government Memorandum of Understanding, and active encouragement at the Spanish central government level for the UK to help to reduce the pool of un/underemployed doctors. Practical constraints encountered by the recruitment team have been a concomitant of the federal system of administration, and the high level of decentralisation for doctor registration. Dissemination of information and recruitment interviews have also both had to devolve to a more local level, i.e. to the 52 Colegios, and has become more time consuming in the process.

5. Competitor Country Analysis

There is currently no strong culture of migration of professional groups from Spain for economic reasons. During the 1950s and 1960s, when there was severe poverty in some of the more remote regions of Spain, many unskilled workers took short and longer-term jobs in more economically prosperous countries experiencing labour shortages (such as Germany). Very few stayed, but most returned to Spain with the opening up of the tourist market and development of other economic opportunities. There is not even much internal migration, with cultural and language barriers operating, as well as strong regional ties of loyalty and independence. The reluctance to move away from family and community is reflected in the low internal migration of doctors between regions. Even if there is movement as a result of the MIR placements, most doctors try to return to their home base. Most doctors practise, or remain unemployed, near their place of initial qualification.

There are no firm data available on the numbers of doctors migrating. Interviewees thought that the most likely destinations for doctors in recent years have been firstly Portugal, and secondly France, but even these migrations might take the form of cross-border working. Thus, doctors residing near the border with Portugal might commute daily, as Portugal has experienced some doctor shortages. (However, it was thought that this demand was likely to diminish, as Portugal created 2 new medical schools recently). Doctors in the Basque region might work in France. In former colonial times, there was migration to South America, particularly to undertake specialty training in fields such as tropical medicine and public health which were formerly unavailable in Spain, but such migration is now rare. It was thought that migrants seeking permanent work abroad would be likely to be attracted to the

USA, as the country offering the greatest financial rewards. It was thought that there had been more migration to the US in 1970s and 1980s, when it was easier to specialise and then stay. Checking this out with information sources in the USA did not reveal any significant amount of migration from Spain, although some movement to Spanish speaking areas of the States, such as California, might have been anticipated. Entry barriers to the USA are seen to be high, especially compared to free movement between EU countries. However, the US was seen as the prime destination for post-doctoral research for clinical scientists because of the quality of the provision, but also because of *“the less formal approach to life”* (interview 8). The US was also seen as a good location for training in management of health systems, and public health, areas into which unemployed doctors might diversify.

There is evidence that other European countries, besides the UK, experiencing a shortage of doctors are currently recruiting in Spain, in particular, Sweden. Both countries have Government-to-Government Agreements to facilitate international recruitment. The shortage in Sweden appears to be for Family medicine/ General Practice, with a pilot project 3 years ago for 40 doctors to serve in rural areas, but no firm evidence was available about the details of the recruitment procedure, or the longer-term retention rates. CESM interviewees estimated that about 450 Spanish doctors were working in Sweden, mainly as GPs or as ophthalmologists. However, the opinion was offered that, *“it’s crazy! How long will they stay with low temperatures?”* (Interview 5). Sweden was considered more unattractive than the UK as a destination, because of the cold and the weather (Interviews 1, 6). The Office of the Unemployed Doctors Group within the OMC has information packs available, with explanatory notes in Spanish, on the processes involved in gaining access to medical employment in the UK, and the USA, Portugal and France, and short pieces of information about Norway, Iceland, and Liechtenstein. Should France experience a shortage, which is rumoured as a possibility because of the reduction in doctors’ working hours, Spain would be an obvious source country, particularly for those regions in close proximity (Interview 1). The OMC Unemployed Doctors’ Office has had recent visits from both UK and French private recruitment firms (Affinity Recruitment and COSEM). However, one interviewee expressed the view that this would not pose a serious threat to the UK, as Spain and the UK shared a common enemy in France! (Interview 7). Ireland was also thought to be a destination for Spanish doctors, with around 100 estimated to be there. CESM thought that around 200 Spanish GPs and 400 hospital doctors were working in the UK. Negative feedback from doctors who have been in the UK gave the impression that the NHS was not in good shape, that the health system had declined, and that there was not a favourable climate for research. Returning doctors had complained of ‘meffiance’ towards Spanish doctors, with restrictions on what they are allowed to do, with surgeons complaining of unwarranted supervision (Interview 6). However, on the positive side, the UK was considered to be fair, where things were done ethically, and people felt welcomed (Interview 7).

The UK’s competitive position in seeking to recruit doctors from Spain does not appear to be strongly threatened by international competition, vis a vis Sweden, in terms of the relative attractiveness of the two countries. However, we do not have detailed information on the numbers who have been successfully recruited and retained in Sweden. In the light of the large numbers of unemployed doctors across the board, the success of the UK recruitment enterprise would seem to depend more on its own strategies for the development and nurturing of effective information and support systems. This would seem to be especially important in the area of intensive language training and cultural familiarisation, which could begin to take place within Spain.

6. Summary View

Policy Requirements

The EU policy framework already means that Spanish doctors have mutual recognition of undergraduate and postgraduate qualifications and therefore automatic access to training programmes, and to entry onto the Specialist register of the STA. As far as general practice is concerned, those doctors with the Spanish post-1986 training and qualification will automatically be issued with a UK certificate of the JCPGTGP. Right of residence, which is an additional UK requirement for general practice for non-EU citizens, over and above the qualification issues, are also automatically fulfilled under EU law. Paradoxically, the very EU laws facilitating movement across national borders, also operated as a barrier until recently to a particular group of EU doctors practising as GPs in the UK: namely, those doctors who were practising as GPs before the Directive came into force who have 'acquired rights' to practise in their own and other EU countries. Although they could not be required to undertake further training in order to take up employment, nevertheless, the language and cultural barriers described earlier were a deterrent to movement. An under/unemployed Spanish GP was not eligible to take up a GP Registrar position in the UK, even though that might be seen as an attractive route to training and employment. Applications to GP Directors of training by EU doctors in these circumstances have been refused on the grounds of an existing 'acquired rights' eligibility to practise. Some Deaneries may have operated this policy because it was deemed a legal necessity to refuse further training, which cannot be legally required. However, the inability to require language training, for example, has not prevented it being offered and received on a voluntary basis to recent Spanish recruits to the NHS. (During the course of this research, the budget arrangements for training within Deaneries have changed, allowing Deans to deploy funds for voluntary additional training. There was evidence from some Deaneries of positive and creative ways to provide GP training opportunities to doctors trained elsewhere in the EEA, mentioned in the main body of the Report). On the other hand, a refusal could be because of an unwillingness to fund a doctor who is likely to return home once training is complete (as such doctors tend to be older, having already unsuccessfully explored the opportunities at home, and are therefore more likely to have family reasons for returning). It was reported, for example, that around three quarters of German and Belgian doctors who have gained their GP training and qualifications in the UK have subsequently returned home.

Part of the pull to the UK for un/underemployed doctors, particularly those seeking training, must be the additional flexibility, which postgraduate training and qualifications afford the individual doctor. They have the choice of either remaining in the UK, or of attempting to re-enter their home workforce at a higher level than before. However, there are still some issues around the transferability of qualifications obtained in one EU country being accepted in another. UEMO reports that German doctors gaining the UK JCPTGP certificate are being refused registration for General Practice back in Germany. UEMO also calls for doctors obtaining a qualification in another EU country not to be disadvantaged in the labour market on returning home. This would indicate that such temporary migrants are disadvantaged, and this in itself would be a disincentive to others to follow. Consideration therefore needs to be given to the feedback, both positive and negative, of doctors who have either been to the UK to look at jobs, or who have already been working here for some time. The following issues were raised in interviews. Doctors were not thought to have been given enough responsibility soon enough. Although it was recognised that a period of supervision was necessary, they were kept in these positions for too long, and therefore did not see any progression. Too much emphasis was being placed on the differences in training, which exist for example in Anaesthetics (linked to Resuscitation in Spain, and to Intensive Care in the UK). The trade union (CESM) view was that vested interests of particular specialties prevented the deployment of available skills in the EU market, despite shortages. They also complained

that there had been insufficient open communication and dialogue about what was required by the UK, and that some of the things promised to migrating doctors has not been delivered.

Whilst the legal and policy framework encourages movement, other measures at the local level are needed to attract recruits from Spain and to facilitate their entry into the UK medical labour market. Such measures relate mainly to facilitating means of cultural and linguistic familiarisation. Whilst the induction programme in the UK includes these things, there may also be scope for introducing training in English to potential migrants within Spain. This could include medical language skills as well as cultural familiarisation. An audit of various clinical situations could be transposed into inter-active training videos, backed up by group teaching.

In addition, one medical school professor thought that the UK needed to put more effort into developing general academic and research links with Spanish medical schools, such as his own in Barcelona, which have both developed a good reputation and which still have a surplus MIR trained doctors. Interviewees thought that other pull factors to trade on might include a temporary move to the UK to gain experience at a reputable centre e.g. ophthalmology experience at a London centre was much sought after a few years ago. The UK has the advantage of being relatively close in terms of flying time, and with cheap flights, migrants need not feel too cut off from family. However, counter indications include the discontinuity mid-career, the problems of accommodating a partner's work and career, and providing suitable schooling for the children. Nevertheless, for some, the opportunity for their children to become bi-lingual, especially in English, could be an attraction.

Attracting doctors already at the pinnacle of their careers was not thought to be a likely proposition, partly because of the language difficulties, particularly for an older person to become sufficiently fluent. Any package would have to be financially very, very attractive to compensate for the negative factors involved in cultural separation. However, it is worth noting that senior medical specialists are able to take long term unpaid leave of absence, with their position kept open for their return. This might facilitate short/medium term migration for the right person. It is also, of course, a driver out for younger specialists unable to obtain a permanent position.

Some of these issues surrounding recruitment and retention of doctors of EEA doctors will inevitably emerge from the recent and on-going UK recruitment effort in Spain, aimed at sourcing both doctors in shortage hospital specialties, and GPs, geographical areas of undersupply, such as the North West and North East. It will be important to monitor the campaign, to describe the profile of the doctors recruited, and analyse the data on retention, as well to evaluate features of the induction process over the medium and longer term.

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COUNTRY REPORT 4 – POLAND

Country Report for Poland

1. General Background

Population

Poland is the largest country in Eastern Europe both in terms of population (38.6 millions in 1997) and geographical area (312,685 square kilometres). It is bordered by Belarus and Ukraine to the East, by Slovakia and the Czech Republic to the South, by Germany to the West, and to the North by the Kaliningrad enclave of the Russian Federation and Lithuania. Warsaw, the capital, has a population of 1.8 million, and almost two-thirds of the rest (62% or a total of 23.93 millions) also live in the major urban centres such as Lodz, Krakow, Wroclaw, Poznan, Gdansk, Szczecin, Lublin and Katowice. Ethnic Poles make up 97.5% of the population, with Byelorussian, German, Lithuanian and Ukrainian minorities accounting for the remainder. Just over half (51% or 19.87 million) of the population are women (compared with 18.79 million men). In 1998, 20.9% of the total population were children aged 0-14, 25.7% were aged 0-17 (i.e. pre-working), 59.9% were aged 18-59/64 (i.e. working ages for women and men respectively), 14.4% were over 60/65 and working, and 11.8% were over 60/65 and retired. Overall, a total of 23 million Poles are aged under-40 making Poland's workforce one of the youngest in Europe (Domagala et al, 1999; US Department of Commerce, 1999).

Economy

The Polish economy is based primarily on manufacturing industry and agriculture. In 1996, those sectors accounted respectively for 3.3 million and 4 million of the total working population of 21.1 million. A further 3.6 million people were employed in transport, communications, trade, education, or financial, social and health services (Turner, 2000). Looked at another way, in 1997 the public sector employed approximately 31% of Poland's total workforce, with 6.7% employed in health services and social work alone (Domagala et al, 1999).

During the late 1980s/90s, the country suffered severe economic problems that peaked with an annual registered unemployment rate (an underestimate of true unemployment levels) of 16.4% in 1993. The stabilisation programme (i.e. the reform package designed to change the centrally planned pre-1989 system into a free market economy) implemented in 1990 also entailed unexpectedly high social costs including rising poverty levels. This meant that the tax base was shrinking at precisely the time when demands for welfare benefits and investment in social provision were increasing. It placed enormous pressure on the state budget and led to additional cuts in all major areas of public spending, including health (Millard, 1995) (see below for details).

Since the mid-1990s, there have been signs of stronger economic growth. By 1996/7, for instance, unemployment had fallen to 13.6%, inflation had declined to 14.8%, and GDP was growing at an annual rate of 6.9% (Karski, Koronkiewicz and Healy, 1999). Poland is one of the candidate countries from Eastern Europe in the next wave of entry to the EU, and will undoubtedly benefit economically from accession.

Pressing Development Issues

Despite recent growth Poland still faces considerable challenges in the context of its economy: unemployment remains high; the country's GDP is only 37% of the EU average; and both industry and agriculture – i.e. major employing sectors – are in need of continued

restructuring and modernisation. Even with its relatively large workforce, agriculture, for example, accounts for only 6% of GNP compared with 57% from services and 37% from industry (Central Statistical Office, 2000; UN Economic Commission for Europe, 1999).

Other major challenges nationally include (Domagala et al, 1999; European Communities and World Health Organisation, 2001; Suski, 2002):

- Economic and social infrastructure development (e.g. transport networks, housing, education systems, new technologies);
- Environmental issues (e.g. industrial, water and air pollution); and
- The need to improve occupational (e.g. safety and hygiene at work) and public health (e.g. by tackling communicable diseases such as Tuberculosis and HIV/AIDS, and encouraging healthy lifestyles).

The fact that inequalities in the distribution of earnings and levels of poverty are on the increase (with an estimated 14.4% of households living on an income below the official social minimum in 1999) (Central Statistical Office, 2000; UN Economic Commission for Europe, 1999) is also important because of their association with levels of illness and unhealthy lifestyles.

Major urban-rural and regional disparities also exist in terms of economic and social development. In the predominantly agricultural areas of the North East near the Belarus and Ukraine borders, for example, unemployment is more than three times the national average and there is little chance of rapid economic growth (Domagala et al, 1999). Finally, it is important to note that any economic recovery is slow to be reflected in government revenues, hence public investment - including in the health sector - remains tightly controlled (Millard, 1995).

Political Context

The relative state of flux has also been reflected in the political situation in Poland since the 1989 re-establishment of democratic government. Reforms have continued throughout the 1990s culminating in the adoption of a new constitution in 1997. This established a situation in which Parliament has upper and lower houses (Sejm and Senat), elected by proportional representation every four years. The head of state is a directly elected President, while the Prime Minister comes from the majority or coalition parties. Post-1999, the country has been administratively divided into 16 regions (voivodships) – each with limited autonomy. Within each voivodship are smaller units or powiats (308 districts and 65 towns have this status) that are further sub-divided into 2,489 wards (gminas). Local government is carried out by councils, which are elected every four years at every level using either a first-past-the-post system or a proportional party-list system.

Although not aimed at the health sector specifically, such changes have had a considerable impact on it. This is because the above system is also the basis for the administration of facilities and financing in the health sector (see below). Overall, the new political system has been characterised by political volatility with nine changes in national government between 1989 and the most recent elections in November 2001. This has major implications for the stability of health system reform that will be outlined in more detail below.

2. The Health Sector

Health System Model and On-going Reforms

The health care system that Poland inherited from the pre-1989 period offered universal coverage with a comprehensive programme of health care benefits distributed through

facilities owned and run primarily by the state. It was an over-centralised, over-specialised, and inefficient system both in terms of financial costs and the use of human resources. Hence, governments have instigated a number of major structural re-organisations of the health sector in recent years (Girouard and Yukataka, 2000; Karski, Koronkiewicz and Healy, 1999; Lenain, 2000; Millard, 1995; Sobczak, 2002). These changes are outlined below as they stand to date. However, there is a proviso, which is that the new government elected in November 2001 has been planning further reforms. These seemed likely to re-centralise, but there was still (at the time of fieldwork in April/May 2002) a great deal of uncertainty in the system about what the new structures (e.g. funding) will look like in practice.

The first step of the post-1989 reforms was to move away from the centralised model with the 1991 transfer of responsibility for *administration* of different aspects of health services from the national Ministry of Health and Social Welfare to the various levels of local government outlined above. The second step, from 1993 onwards, was to devolve *ownership* of most public sector health facilities (hospitals, polyclinics, outpatient facilities and primary care services) to the same decentralised levels - i.e. the regions/provinces (voivodships), the local authorities (gminas) and, from 1998 the re-established districts (powiats). The types of services provided at the different administrative levels are as follows:

- At the level of the gmina, primary care services (which in Poland includes family practice, general practice and paediatric care);
- At the powiat level, ambulatory care, which generally covers a wider range of specialisations, and hospitals offering services at a level of basic specialisation (surgery, paediatrics, internal medicine, gynaecology etc).
- At the level of the voivodship, more specialised tertiary services or narrower specialisations are provided (Domagala et al, 1999).

New Emphasis on Primary Care

At the same time as introducing the above changes in ownership/administration, the Polish government began to emphasise the role of new models of primary care in future health system development. The main change was a shift to the family doctor (i.e. general practitioners along UK lines) as the critical mechanism of the primary care system. Hence, a system of vocational training for new qualifiers and provision for re-training of existing specialists in family medicine was introduced in 1993 (see below for more details) (Wasyluk et al, 1999). Overall, the aim was to encourage the provision of treatment at the first point of access to the health care system rather than primary care acting simply as a “referral agency” to more highly specialised doctors in the secondary sector. This is likely to have considerable impacts on doctors in terms of the career paths and employment opportunities available to them. However, there is little data available to quantify the changes so far in detail, and the overall balance of provision is still weighed towards the hospital sector (see below).

Funding/Insurance System

The third major set of structural changes has centred on the method of financing health care. From January 1999, the taxation-based health care system was replaced with one financed through autonomous health insurance bodies (sickness funds). There are 16 regional funds (based on the voivodships) and a separate fund for uniformed public employees such as the army and railway workers. The key element of the post-1999 financing system was that it split purchaser and provider functions, the overall intention being twofold: that government funding could be scaled back as insurance cover expanded; and that government administration could also be phased out as insurance funds contract directly with service providers.

Importantly funding is one of the key aspects of the health system to which the current government (elected six months prior to fieldwork) wishes to bring further change. Specifically, the Ministry of Health wants to introduce a National Health Fund (with 16 regional branches) to replace the independent regional health funds by the year 2003. The hope is that unification of all contracting procedures will both equalise contracting rates and access to healthcare across Poland, and enable cross subsidisation across the regions. Some aspects of decentralisation are to be retained, with regions compiling a local health plan that can then form the basis for consolidation into a national health plan. The new law on the National Health Fund is currently following its legislation path (Meicover 2002).

In terms of actual spending on health services, Table 1 summarises recent changes at the overall level (i.e. per capita and % of GDP), as well as changes in the percentage of that spend coming from the public purse. In addition, Table 2 details the fixed percentage of Sickness Fund budgets allocated to different groups of services, illustrating that there is still a major emphasis on hospital services as opposed to primary care. Overall, in 1999, it was estimated that the expected total collection of the Sickness Funds would be 18 billion PLN (approximately USD 4.7 billion) (US Department of Commerce, 1999).

Table 1: Expenditure on Healthcare 1990-1999

	Percentage expenditure by Year		
	1990	1998	1999
Total expenditure on health – per capita USD	258	543	558
Health spending as percent of GDP	5.3	6.4	6.2
Public expenditure on health as percent of total expenditure on health	91.7	65.4	71.1
	Health spending		GDP
Real per capita growth rates 1990-99 (in %)	4.8		3.5

Source: OECD Health Data (2002)

Table 2: Regional Sickness Funds: Budget Percentage allocated in 1999 according to Service Groupings

Service Grouping	Budget %
Basic medical services (family doctor, outpatient clinic)	16.2
Specialists	7.7
Hospitalisation (including surgeries)	48.3
Special care facilities	1.0
Dentistry	1.9
Drugs authorised for reimbursement	18.0
Health spas, palliative care	6.9

Source: US Department of Commerce (1999)

Ownership and Privatisation

The above changes in the Polish health sector were underpinned by the 1991 Health Care Institutions Act that allowed for different types of ownership of health care organisations. Hence providers cover the range of autonomous health facilities publicly owned by the voivodships, gminas etc., as well as the voluntary (non-government, non-profit sector) and private (for profit) sector. The latter, in turn, might include large companies as well as groups or individuals (e.g. independent family physicians) contracting separately with the sickness fund. This reflects the general political view that the private sector should be freed from the restrictions of the pre-1989 period and become “equal” in status to the public sector. Since 1994, therefore, there has been almost no form of health care (except complex transplants and intensive care) that is not available from individuals working in the private sector. However, there are differences within the sector in that private medical practices, maternity clinics etc are widespread, but there are relatively few non-public hospitals. The latter are also run mainly by voluntary rather than ‘for-profit’ organisations (European Communities and World Health Organisation, 2001).

Overall, there was a view expressed by our interviewees that private practice for individuals and small groups (particularly for specialists and family doctors delivering primary care) was now a “*crowded marketplace*” (Poland Int 9). Given that a significant amount of investment is needed to start up a new practice and get recognition from insurance funds, a period of experience or qualifications gained overseas was seen as a distinct advantage for two reasons. First, it gives doctors the opportunity to save enough funds to invest in premises and equipment etc. on their return to Poland. Second, it was perceived as giving them ‘market edge’ in terms of status and reputation with Polish patients thereby raising the income potential of the practice they set up.

Position and Status of Physicians

Polish health care has been persistently beset with difficulties arising from under-funding and under-investment. Much of the infrastructure inherited from the pre-1989 system (e.g. buildings and equipment) was of a low standard or obsolete – particularly in primary care, and even more so in rural areas compared with Warsaw and other cities. In addition, the proportion of health expenditure accounted for by physician’s salaries was relatively low. All of this has meant poor working conditions, low levels of pay compared with other sectors of the economy, and associated problems of poor morale and stress amongst health sector personnel (Domagala et al, 1999). This is particularly the case given the view that the majority of doctors in Poland are in the profession because they have a strong vocation. Not having the facilities and resources to treat their patients as they would ideally like can, therefore, only serve to add to perceived pressures (Poland Int 10).

Such problems of morale have been further exacerbated in recent years by the uncertainty created by government budgetary cuts. Around 5% of hospitals closed outright in the three years to 2001 (ILO, 2001), and there have also been significant job losses (particularly in the hospital sector) as employers have sought to reduce costs by reducing staff numbers. In addition, as we have already noted, the health sector has faced numerous reforms throughout the 1990s. The 1999 funding reforms, in particular, were felt by the medical profession to be ill thought through and threatening to their position. Now as those reforms have begun to bed down, the profession is facing further uncertainty as a result of the November 2001 election of an old-style government wishing to re-centralise health care structures. Such issues were of key importance at the time of fieldwork for interviewees from doctors’ representative organisations such as: The Polish National Chamber of Physicians, Surgeons and Dentists, and the Polish Medical Association.

Overall, the view of a number of our interviewees was that in Poland *“doctors [still] have a very attractive social position in society”*. However, as we will see below, this was *“not because of the money”* (Poland Int 6). Instead it was being measured more on the basis of general reputation, professional standing and the respect that doctors receive from patients. More objectively, the general status of health care personnel does appear to be lower in Poland than in the West. This is also the case in other East European countries, such as the Czech Republic, Hungary etc. that could potentially be seen as sources of physician migration (Healy and McKee, 1997).

Physician Employment/Payment System

In terms of payment systems, the current situation in Poland is that most health care personnel are still salaried employees in the public sector. For these workers, there are standards laid down covering both working hours (a 40 hour week or 7 hours 35 minutes/day for medical personnel) and minimum, maximum and bonus levels of pay. Hospital doctors, for example are paid a standard salary that is also “topped up” through bonus payments, overtime and on-call duty payments that effectively doubles their base payment level. Primary care family doctors have generally been paid on a capitation basis for their registered patients, but some receive weighted payments for infants, those age-65+, and those with chronic illnesses. Depending on the nature of their contract family doctors can also be remunerated on fee-for-service, fee-per-case or an otherwise mixed basis (Domagala et al, 1999). It was hoped that doctors’ incomes would rise with the advent of insurance funds and to some extent this has been the case. In addition, there are other ways in which physicians can increase their earnings – i.e. by providing “non-standard services” in the public sector that require what are termed co-payments from patients; or by providing private sector services that are also paid for directly by the patient. Finally, although they are illegal, substantial informal gratuities or out-of-pocket payments to doctors and other health care professionals have been common since the 1970s (European Communities and World Health Organisation, 2001; Karski, Koronkiewicz and Healy, 1999; Shahriari and Lewis, 2001).

Since the 1989 transition, there have been strong pressures for better health sector salaries leading to strikes - most notably of anaesthetists (Dyaczynska-Herman and Karpel, 1998; Tyler, 1999), members of the All-Poland Physicians Trade Union (OZZL) working in approximately 650 hospitals and 1000 clinics (Szarlik, 1997), and nurses (Czerwinska, 2000). Despite this, however, a doctor’s official base pay is still (at \$US 250 per month) only about 80% of the national average (Newman, 1997). Pay levels in the public sector remain particularly low, and many doctors take on multiple jobs in order to boost their incomes. Indeed, the ILO People’s Security Survey (ILO, 2001) estimates that 50% of doctors’ income in Poland comes from secondary sources. It is not uncommon, for example, for different doctors working in the same public institution to have several different employers including the voivodship and gmina. The number of professionals working privately, many in addition to their public sector jobs, is estimated at about 16,000 dentists (90% of all dentists) and 60,000 doctors (66% of all doctors) (Karski, Koronkiewicz and Healy, 1999). The overall view of interviewees was that opportunities to earn better incomes in medicine were increasing – particularly in the private sector – but that other alternative careers such as IT and private business ventures may still be more attractive in future. Based on the straightforward comparison of physicians’ economic position, therefore, the contrast between Poland and most Western countries (including the UK) was simply inescapable.

All of the above were perceived by our interviewees as strong “push factors” for physician out-migration from Poland – both for the short and long-term.

3. Physician Supply and Demand

Unfortunately, there was very little concrete data that could, at the time of fieldwork, be made available to the research team (the Polish National Chamber of Physicians, Surgeons and Dentists, for example, was still in the process of assembling relevant information from Regional Chambers). This makes detailed descriptions of physician surpluses/shortages, employment/unemployment and immigration/emigration by specialty, age groups, gender, country of origin/destination etc. very difficult compared with our other country case studies. As one of our interviewees put it:

“I’m sure that we still don’t know exactly how many doctors we need in Poland ... Even ... more than 10 years after we changed our system, I’m not sure if all doctors are correctly defined. It means there is no list of doctors who are working in different areas, and so it’s difficult to say how many doctors we have” (Poland Int 6).

We have, nevertheless, put together as accurate a picture as possible from our Polish interviews and secondary sources.

Overall Picture of Surplus versus Shortage

The number of physicians (2.1/1,000 population in 1990; 2.3/1,000 in 1998; and 2.2/1,000 in 2000) is lower in Poland than in Eastern Europe in general and the EU (the latter had almost 3.5 physicians/1,000 population in 1998). Overall, therefore, Polish interviewees did not consider the country to have a surplus of doctors, and felt it was unlikely to do so in future either. This is especially the case since, the surplus that was perceived in the mid-late 1990s, has been tackled by reducing medical student intakes from approximately 4,000 per year to the current 2,400 (Poland Int 1). Similarly, reductions already described in the employment of fully qualified doctors (particularly in the hospital sector) are continuing to feed into the system (see Table 3). Finally, the fact that the above totals reportedly include ‘retired’ doctors working part-time was said to be relevant to judgements about workforce surpluses. More specifically, it illustrates the importance of looking at the workforce in terms of Whole Time Equivalents as well as overall numbers (Poland Int 4).

Table 3: Change in Physician Employment in Poland 1980-2000

% Change in Employment by years (increase or decrease)				
1980-90	1990-95	1995-96	1996-97	1999-2000
28.4	9.5	1.6	0.3	-8.26

Source: Polish Ministry of Health and Social Welfare cited in Domagala et al, 1999, p.217.

Equally, Poland does not appear, at the moment, to perceive a problem in terms of overall physician shortages. Even during the early 1990s when the state health service lost a total of 60,000 employees (not in a planned manner, but as an ad hoc response to budgetary crisis), the *“medical profession proved adept at protecting its employment and the number of doctors actually increased”* (Millard, 1995, p.182). Such trends continue to influence perception despite the evidence of a slight reduction in employment since then (see Table 3). Moreover, it was the view amongst our interviewees that medicine is still, despite its problems, a relatively “attractive” profession. Medical school applications may well have fallen in recent years (e.g. with alternative careers available in IT, service sector etc), but overall numbers

remain adequate to fill available places with good quality students (European Communities and World Health Organisation, 2001).

Several interviewees, did report that there are approximately 500 “unemployed” doctors starting out in their career, but this primarily related to the lack of government funded internship places (the year following undergraduate qualification) and later specialist training. Doctors are more under-employed waiting for such places to become available than unemployed *per se*. In addition, it was felt that any recent tendency towards surplus would (as elsewhere) be counteracted in future by the inevitable demands of an ageing population and new technologies/changing lifestyles raising life expectancy. Such developments would, it was felt, increase once again the need for health sector employees.

Mal-distribution between Specialties and Geographical Areas

Instead of problems around overall numbers, the key perceived difficulties in the Polish medical workforce relate to the uneven distribution of human resources inherited from the pre-1989 situation. Dealing with these mal-distribution problems remains one of the key challenges for Polish health care.

In terms of mal-distribution between medical fields, for example, only 17% of doctors in 1989 were working in primary care as opposed to the more prestigious hospital sector. This meant that turnover was also higher in primary care as doctors aimed to get into, and keep, hospital posts. More recent figures continue to indicate that there are “*too many specialists, with more than three specialists for every primary care doctor*” (Karski, Koronkiewicz and Healy, 1999, p.35). However, there are certain specialties (e.g. Psychiatry) that interviewees did report as having (as in the UK) greater difficulty recruiting doctors than others (Poland Int 1). Because the emphasis has been on curative services, there is also a serious shortage of staff with public health skills (Healy and McKee, 1997 and Poland Int 3).

In terms of geographical mal-distribution, the overall doctor:patient ratio was pre-1989, and still is, far less favourable in rural areas (especially the Eastern regions) compared with Warsaw and other urban conurbations (Millard, 1995). Such trends are being exacerbated further by the fact that the increasing opportunities for private practice and associated raised incomes are greater for physicians in the capital and main cities. There are also differences between geographical areas in doctors’ specialty (see Table 4 for the example of the primary care sector) and gender distributions (see Table 5).

Table 4: Physicians Employed in Primary Care by Specialisation and Type of Geographical Area

Specialisation	Urban Areas		Rural Areas		Total	
	No.	%	No.	%	No.	%
Family medicine	609	3.8	405	6.8	1014	4.6
General medicine	511	3.2	601	10.1	1112	5.0
Internal medicine	3860	24.0	1243	21.0	5103	23.2
Paediatrics	4525	28.2	1262	21.3	5787	26.3
Gynaecology	2073	12.9	753	12.7	2826	12.8
Other	1751	10.9	881	14.8	2632	12.0
Without specialisation	3034	18.9	1099	18.5	4133	18.8

Source: Polish Ministry of Health and Social Welfare cited in Domagala et al, 1999, p.234.

Table 5 Physicians Employed by Gender and Type of Geographical Area

Gender	Urban Areas		Rural Areas		Total	
	No.	%	No.	%	No.	%
Men	5271	32.8	3324	56.1	8595	39.1
Women	10781	67.2	2606	43.9	13387	60.9
Total	16052	100.0	5930	100.0	21982	100.0

Source: Polish Ministry of Health and Social Welfare cited in Domagala et al, 1999, p.234.

Mechanisms to Achieve Workforce Adjustment

Importantly, however, no one central health body has full power over planning, regulation and administration of health care in order to make the necessary adjustments. Whereas, the Ministry of Health and Social Welfare had undertaken the previous “command and control role” in relation to the health sector, in the transition to a new political system the aim was to dismantle much of the legacy of “bureaucratic socialism”. Hence, there is a lack of comprehensive workforce planning, and no really strong mechanisms to re-distribute physicians either between different specialties, or particularly between over- and under-served geographical areas. The Ministry has also found it difficult during the 1990s to steer though and implement policy proposals given the frequent changes in government and political emphasis of the on-going structural reforms in the health sector.

The main mechanism that does appear to be available to the government to attempt to manage entry into the different specialties is its funding of the internship year following the undergraduate medical degree. According to our interviewees, there have been moves to reduce places in over-supplied specialties and increase them elsewhere. However, because the general shortage in overall numbers of internship places means a long wait for training anyway, many doctors simply wait for their chosen specialty to become available. This is instead of taking up opportunities that might be available to train immediately in an alternative medical field.

A key area where numbers of training places have been increased significantly in recent years is family medicine/general practice. Not only has vocational training been put in place for newly qualified doctors, re-training has been provided for existing specialists to move into family medicine (i.e. to redistribute doctors between the hospital sector and general practice). Overall numbers remain relatively small compared with need however. As one interviewee explained, Poland has so far (i.e. since the 1993 introduction of vocational training in family medicine) trained approximately 6,000 family doctors/general practitioners. This compares with the estimated 20,000 needed to re-organise health care provision successfully around the gatekeeper role of the general practitioner. A key issue here is lack of training facilities and infrastructure to support the necessary throughput (Poland Int 9).

Migration Numbers and Destinations

Overall, the picture of population migration in Poland remains a negative one – although the net losses have decreased from 19,000 in 1994 to 14,000 in 1999. The main reported destinations for emigration have been Germany, the USA and Canada, Austria, Sweden and France. The largest numbers of immigrants into Poland are from Germany, the USA, Ukraine and the other newly independent states in Asia (Council of Europe 1997 and 1999). As much as anything such patterns are linked to return migration following previous emigration waves to those countries. They are also, in the case of (former East) Germany, linked to the Post-World War II drawing of political boundaries which saw different ethnic populations spread between the two countries.

This was a pattern confirmed by the interviewees in relation to perceptions of physician migration to and from Poland. The countries consistently ranked as major destinations for both short and longer-term/permanent migration were, within Europe: Germany, France, Scandinavian countries such as Sweden and Norway, and the Netherlands. Outside Europe, the main destinations – both for doctors and nurses - were said to be the USA, Canada and Australia, as well as countries such as South Africa (following on from a history of short-term migration pre-1980s), and those in the Middle East (e.g. United Arab Emirates) and Asia. The latter, in particular, were said to allow doctors to make *“quite good money compared with Polish salaries”* (Poland Int 8). The UK was seen as a much less significant destination for long-term migration, but was felt to have potential for gaining short-term experience that might increase doctors’ employment/earnings potential on their return to Poland. The relatively small number of physician immigrants were again said to be ethnic Poles returning primarily from the post-World War II diasporas in Ukraine, Lithuania and Central Asian states such as Kazakhstan.

4. Position in Respect of UK Needs

History of General Cultural/Professional Ties

The main reasons cited for the above pattern of physician migration were relatively unsurprising. Particularly for Poles from the west of the country, there are strong linguistic and family links with Germany. Similarly, the long-standing tradition of emigration to the USA means that there too migrants are building on existing family and cultural links. The sheer scale of previous emigration links to the USA was also considered important by interviewees. Compared with the one million Poles living in Chicago alone, numbers that moved to the UK (e.g. after World War II) were seen as relatively insignificant. Another view expressed was that migrants may be ‘more welcome’ in countries such as the USA, Canada and Australia that were founded on emigration rather than in what were perceived as ‘more traditional, closed societies’ such as the UK. As one of our Polish interviewees put it: *“I think that in the UK you are not so much open to foreigners”* (Poland Int 9). Importantly, the historical links (particularly with the USA) are now being reinforced by return migration and inward investment by ethnic Poles who previously left (Poland Int 4).

In terms of professional links with the UK, interviewees mainly mentioned Polish doctors visiting for short-term ‘vacation’ experience. There have also been exchanges of specific technical assistance, for example, to facilitate the development of education in family medicine under the auspices of the European Union’s PHARE programme. The latter involved universities from the UK, Denmark, France, Ireland, Spain and the Netherlands in a European Consortium for Primary Care (ECPC) co-ordinated by the British Council (ECPC, 1995).

However, the major links continue to be with other EU countries particularly Germany, also with Scandinavia and the USA. For example, foreign undergraduates in the various Polish Medical Universities that teach medicine in English, are mainly US citizens (and Canadian) beginning their medical education more cheaply than at home (see below for more details). In addition, there are professional links boosted, for instance, through exchange schemes sponsored by Universities, pharmaceutical companies and public bodies in the US and elsewhere abroad. Finally, private companies and charitable foundations from the US and Scandinavia (and indeed other countries like Switzerland in one example shown to the research team) are also heavily involved in modernisation developments in hospitals. This includes both hospital out-sourcing (e.g. laboratory facilities, outpatient diagnostic facilities etc) and other in-house activities (e.g. provision of intensive care beds etc).

Provision of Undergraduate Medical Education in English

One specific example of the professional and education/training links between Poland and other countries is provided by the provision of undergraduate medical education in English. Such courses have now been established in several of the more prestigious medical universities (e.g. in Warsaw, Krakow, Katowice, Gdansk, Lublin and Poznan). They are aimed predominantly at students from the USA and Canada, and are tailored directly to equate with pre-med and/or subsequent levels of study in those countries. They also often offer the opportunity to take USMLE examinations whilst in Poland. In addition, students come from countries like Saudi Arabia and from Scandinavia as a “stepping stone” to medical practice elsewhere.

Nature of Education/Training for Polish Doctors

Poland has 11 Medical Schools. Undergraduate medical training lasts six years, followed by a one-year internship (which is compulsory under the 1950 Act controlling medical professions) (Wiktor-Jedrzejczak and Madej, 1998). Training in a specialty takes another two or three years and secondary level specialisation a further three to seven years. Licence to practice is granted after qualifying although doctors are also obliged to register with the Chamber of Physicians (at regional rather than national level) before they are able to practice. Post-graduate education is organised by the Medical Centre for Post-graduate Education in its own hospitals and clinics, in Medical Academy hospitals and in other authorised hospitals. There are plans to replace the present two level training of medical specialists with a single level followed by an optional period for the acquisition of additional skills. The family medicine training programme developed by the Ministry of Health is also offered through the regional offices of the Medical Centre for Post-graduate Education. Specialist training in family medicine takes two years, with a shorter conversion course for physicians who are already internal medicine specialists. See Table 6a-6c, which is appended at the end of this country report, for a detailed outline of the requirements both for specialties and family medicine/general practice.

Skills/Qualifications Goodness of Fit

The general view amongst interviewees was that medical education and training in Poland was of a high standard and easily comparable to UK. More specifically, the quality of undergraduate education was said to be illustrated by its growing popularity with overseas students (e.g. from the USA, Canada and Scandinavia) of the medical degrees taught in English (described above). The main issues mentioned by interviewees in relation to hospital doctors at later career stages were simply around lack of experience with particular pieces of equipment and diagnostic techniques. However, it was felt that this knowledge could be relatively easily picked up through induction and appropriate training in particular specialist areas in the UK. In relation to general practice, the comparability and transferability of the training programme for family doctors in Poland has been clearly documented (Wasylyuk et al, 2001). Both training and educational objectives and expected competencies for family doctors in Poland compares favourably with the standards set in other EU countries including the UK. The only big area of difference perceived by our interviewees is that Polish training for general practice lacks some interactive methods. However, there are moves also to address that in future (reported by interviewees at the Medical Centre for Post-graduate Education).

Objectively, of course, there are issues that might make it difficult for a Polish doctor simply to “slot” into the opportunities available in the UK medical workforce. These stem, amongst other things, from the fact that the Polish system of medicine has been shaped on the Russian model with its strong emphasis on specialisation. Doctors, therefore, train in different combinations of specialties and sub-specialties as compared with those generally accepted in

the UK. Again, see Tables 6a-6c for a detailed outline of the Polish system in this context. However, a particular example cited by a number of interviewees related to the overlaps between medicine and dentistry, which reportedly has been an issue in negotiations with the EU on mutual recognition of training and qualifications. More specifically, the role of a dentist has a wider scope in Poland than in Western European countries such as the UK. The perceptions are further complicated by the fact that, in the first two years of the undergraduate degree doctors and dentists study the same courses before then splitting into their separate education streams (Poland Ints 2 and 6). As another example, public health has not been considered a discipline in itself in Poland (the nearest subject areas being sanitary inspection and occupational health), until certain of the medical academies (e.g. Krakow) established dedicated schools. However, this has only been in the last 2-5 years and the view was that the curricula are not yet well developed due to a lack of real understanding of the needs (Poland Int 2).

In addition, there were said to be cultural differences illustrated by family medicine/general practice. So, for example, although it has been the intention of the Polish health reforms to develop GPs as gatekeepers (i.e. on the UK model), it was the view of one hospital-sector interviewee that they do not yet perform that role in the way intended. This was because of pressures to maintain personal income levels and the perception amongst family physicians (particularly those that retrained rather than entering through solely the family medicine route) that they too have specialty specific knowledge. What was apparently happening was that doctors: *“try to keep patients as long as possible ... they try to be the main doctor not [the] gatekeeper”* rather than recognising that *“they cannot know everything [of] what is important in particular specialties”* (Poland Int 6).

Overall, it was felt that the cultural difficulties would probably be greater in general practice than in hospital medicine because GPs would need more system-specific training in order to work essentially ‘on their own’. Such training might, for example, include: where it was appropriate to refer patients onto for specialist treatment; recommended drugs and other treatments; how to communicate with patients in everyday language etc. By contrast, in hospital specialties Polish interviewees felt there would be more opportunities to work alongside doctors already familiar with the UK system in order to glean the necessary knowledge and new skills to practice effectively.

Key Regulatory Constraints to be Overcome

The issue of mutual recognition of training and qualifications on Poland’s entry to the EU, and how far the UK can recognise Polish medical qualifications and training in the meantime, were considered by interviewees to be key to the potential for physician migration from Poland. A typical comment in this context was:

“The big barrier for Poles entering the UK is the need for ‘nostrification’ or acceptance of their qualifications. It’s [seen as] very difficult to get that and so it is difficult to get permission to practice in the UK” (Poland Int 11).

Importantly, this was not just perceived as an issue for Poland, but also for countries such as the Czech Republic, Hungary and Slovenia. Moreover:

“There are [even] different systems [between Eastern European countries themselves, for example] to be a specialist of internal medicine ... Big differences in what you have to do, how long you have to be in training, the exam and what kind of exams, of courses, different things” (Poland Int 6).

Overall, there was a real keenness amongst interviewees to build on what has already been achieved (e.g. in relation to general practice/family medicine) to overcome the sorts of

difficulties described. As one of our interviewees argued in relation to the combinations and content of post-graduate training/examination systems in relation to particular specialties:

“It will be 2003 [before Poland joins the EU] so it will still be a bit of time to improve the post-graduate educational system before [Eastern European] countries admit to full membership” (Poland Int 6).

In this context, interviewees argued that Poland would welcome possibilities for exchanges and technical assistance to develop training and improve standards – both across the board and in key areas such as public health.

Competitor Country Analysis

Although there are several established migration destinations for Polish doctors (see above), the key competitors for the UK in terms of popularity and sheer numbers were said to be, outside Europe, the USA, and, within Europe, Germany. This applied to doctors moving of their own individual accord (rather than through organised recruitment drives instigated by overseas countries) and was for all the reasons underpinning migration decisions already described. However, the main advantage of these countries compared with the UK was felt to be the *“existing base of family and relatives”* (Poland Int 8) – for Germany because of historical cross-border links and for the USA because of previous large-scale population movement. This has the effect of reducing the risks (e.g. financial) of international migration for the individuals concerned, and effectively provides destinations with “additional word-of-mouth advertising”. It was, for example, both generally well known that in the USA *“life is better”*, but *“former migrants who come back to Poland and tell their stories are usually the ones that have been successful, not the failures”* (Poland Int 10). Another key attraction of the USA was said to be the quality of its post-graduate medical training and specialist qualifications. This is important because training and qualifications are also factors for the UK to trade on in the international medical labour market. As one of our Polish interviewees explained: *“in the old times, years ago, the UK had the best reputation, [but] nowadays the US takes first place”* (Poland Int 3).

In terms of on-going active physician recruitment in Poland, the key players appeared to be Scandinavian countries such as Norway and Sweden. In 2001, Norway signed a government-to-government agreement with the Ministry of Labour and Social Policy that allows Polish doctors and nurses to be employed there (Szymczak, 2001). Most recently, Sweden has (according to our interviewees) also signed a government-to-government agreement and has been recruiting up to 150 family doctors per year (and additional specialists) between 2000/02. The latter scheme, which is administered by a Warsaw-based recruitment company called Medina, provides Swedish language training whilst doctors are still in Poland, job matching with potential employer organisations, and relocation packages for doctors and their families to smooth the transition into living and practising in Sweden. More specifically, according to interviewees in Poland:

- Potential recruits are first taken on an initial visit to the sorts of locations in Sweden where incoming doctors are likely to be placed. This is to help them to decide if they want to sign up for the scheme in the first place, and is also aimed at improving eventual retention because doctors will have more of an idea what they are “letting themselves in for” when they reach Sweden.
- There then follows a period of induction lasting up to 12 months before the projected date of migration. Swedish language courses are provided in Warsaw,

as well as introductory sessions on the workings of the health system and what else the doctors can expect from life in Sweden.

- After completion of this programme, doctors are matched to the available positions, with family circumstances being taken into account when considering location.
- Doctors and their families are again taken to Sweden to visit the local communities with vacancies in order to help them choose which is the most suitable – both in terms of their medical practice needs, and outside-work circumstances (e.g. housing, education, leisure, social networks etc.).

In this context, Sweden appears to be capitalising upon the GP vocational training in Poland (which, as we have already described, was set up in 1993 and modelled on the equivalent UK scheme), to recruit ready-trained physicians (i.e. with 3 years experience). In the context of other specialties, the recruits usually have 5 years post-graduate experience. One of the main attractions of the scheme is said to be the stability of a 3-year contract in Sweden compared with the instability of having multiple jobs to earn sufficient income in Poland (Poland Int 9). Overall, the recruitment scheme appears to be operating with some success despite the fact that Poland's history of cultural ties with Sweden are not as strong as with elsewhere.

Potential for Migration to the UK

The general view amongst interviewees was that although the UK in general may be a good place to live and bring family, the NHS itself is not as attractive to work in as other health systems. More specifically, the UK was seen as having a *“good”* health care system, but it is *“not the best in Europe”* and certainly *“not as attractive”* as the US (Poland Int 5). Compared with other countries, the NHS was perceived to be under-funded and possibly unable to offer the best salaries and employment conditions to potential migrant doctors. Such views were particularly associated with media coverage, for example, of long waiting lists and low staff morale in the NHS (Poland Int 11). In addition, there was a perception that the UK system may lack stability because of the number of reforms in recent years (particularly in primary care, but also in the hospital sector) (Poland Int 5). However, compared with Poland the situation in the UK is clearly favourable. If the UK were to market itself effectively, therefore, and offer the kinds of packages available elsewhere (e.g. in Sweden) then the view was that Polish doctors would be prepared to move here.

The biggest “pull factors” in the UK's favour compared with other EU countries in particular were felt to be:

- a) The English language – which is relevant for two reasons. First, many doctors already know, or only need brief intensive training in order to gain, enough of the language to be ready to practice. English was perceived a much easier language to learn compared with, for example, Swedish. It is also a requirement for Polish medical students in the same way that Russian used to be – although, as our British Council interviewees pointed out, it may not be that high a priority for medical students given their generally very full curriculum. Second, moving to the UK was seen by some interviewees as an excellent way to provide families with opportunities to learn the “language of the future”. That is particularly important in the context of Poland's planned entry into the EU (Poland Int 5); and
- b) The fact that UK post-graduate training and qualifications (e.g. RCGP membership) are still highly regarded. Some interviewees felt that individuals with qualifications and experience gained abroad are much more marketable - both generally in the international medical labour market and specifically if they were to return to set up a private practice in

Poland. Any additional regard for, and reputation gained by having, UK qualifications could only be a further advantage for such doctors.

Once again, however, the UK was not seen as marketing itself well. There was said to be little real understanding in Poland either of the UK health system generally (where, as described above, knowledge tended to rely on media anecdote rather than hard facts), and post-graduate training and other workforce opportunities in the NHS. Such marketing, as well as active recruitment, were felt to be important because there were provisos even with the factors in the UK's favour just outlined. For example, countries such as the USA, Canada and Australia also have similar advantages in terms of providing an environment of English usage. As we have already noted, in much of Western Poland doctors are as likely to speak German as may prefer to go there if the opportunities on offer there seem equal to those in the UK. Finally, the language was perceived as a higher barrier for those older doctors who learnt Russian as their first foreign language. Compared with younger doctors they were seen as potentially needing more English language training and induction to settle into the UK system.

5. Summary View

- There did not appear to be great concern amongst official bodies including the government and Ministry of Health and Social Welfare about doctor out-migration and its possible impact on the Polish health care system. Such views were partly associated with having much more urgent problems to deal with than medical workforce planning – for example, in the economy generally, in relation to health sectors infrastructures, or the current “big push” towards EU entry. In addition, the comments in relation to emigration were that “*that’s the reality*” (Poland Int 8) if Poland cannot offer its doctors a good salary and working conditions. In other words, migration was simply seen as an understandable personal response to economic circumstances, although it was hoped that in future as the Polish economy improved people would be encouraged to return.
- In terms of general migration prospects, there was a general summed up by one interviewee that: “*The UK is not the place where I would like to stay permanent*” (Poland Int 4). This was coupled with the observation that Poles appear increasingly to prefer short/medium-term migration opportunities, for example for around 2-3 years. This would be in order to make a financial gain that can then be invested in setting up in private practice on their return home, or for vocational training in specialties such as general practice in which there is a shortage of places in Poland. Other short-term migration opportunities, say for 3-4 months were also felt to be appropriate for doctors to learn new equipment or particular techniques in “*fields [that are] further advanced elsewhere*” (Poland Int 12). There is clearly, therefore, a need to balance the needs of individual Polish doctors with those of the UK that may be to retain overseas doctors on a slightly longer-term basis.
- In this context, there was said to be clear potential for the UK to recruit both hospital specialists and general practitioners in Poland along the lines of the existing Swedish model described earlier (and indeed the pilot of Spanish doctor recruitment in North West Region). Such methods – i.e. involving tailored language and other types of top-up/on-going training, mentoring/support, and person-job matching – were seen as more likely to ensure successful entry by the recruits into the labour market of any destination country. This was because of doctors’ better familiarisation with the new system in which they are working and the fact that they are more likely to feel valued and so want to stay. It was also relevant because of the issue of compatibility of Polish specialisms/combinations of specialisms compared with those in the UK. In this context, the general view (including

of the British Council in Warsaw) was that Polish medical education and training was of a relatively high standard. With a relatively small amount of investment by the UK in appropriate induction and support, Polish doctors could, therefore, make a strong and useful contribution to the UK medical workforce.

- Recruitment packages were also felt to be important necessities because even doctors at a relatively early career stage have to give up a considerable amount in their own country in order to migrate. In the Polish context specifically, interviewees emphasised the length of time doctors have to invest in their education and training, the fact that many already have families by the time they are fully qualified, and that they may not want to give up the stability of an existing position in the Polish system. For those already established in a specialism (in the hospital sector in particular) it was felt to be important to “*protect your position because you may not be able to get back*” into the system later on (Poland Int 4). However, there was anecdotal evidence that some of those who had already migrated, initially on a temporary basis (e.g. to Sweden), were “*changing their mind and deciding to stay*” once they had the positive experience of working overseas. The kind of language/on-going training and support on offer and careful matching of doctors own employment/family needs with the opportunities available was felt to be vital in this success.
- The overall message was, therefore, that all doctors, even from relatively underdeveloped countries such as Poland, are in a strong position in the labour market by virtue of having “in demand” professional skills. Polish doctors are, according to our interviewees, both increasingly likely to see the benefit of remaining in Poland and at the same time increasingly aware of the global nature of the marketplace for their skills. Countries like the UK, therefore, need to do a considerable amount in order to attract them when there are also good opportunities elsewhere – not least in key competitor countries such as the USA, Germany or Sweden which already have strong cultural/historical ties with Poland and/or existing recruitment programmes.
- Overall, there are a number of ethical issues in relation to recruiting from a country such as Poland. As already noted, Poland is a relatively poor country with a health system still in need of considerable development. Hence, there are questions about how far the UK should be thinking in terms of its own immediate medical workforce needs, or the need to provide additional training/tailored job experience to assist the long-term development of the Polish system. Examples might be to help fill current gaps in general practice or public health. Importantly, such a strategy is likely to be relatively productive for the UK because it would contribute to the kind of word-of-mouth marketing by returning Polish doctors that other countries already benefit from by virtue of existing migration/historical ties. We have emphasised elsewhere in the report the key role – in addition to formal marketing and recruitment by the UK authorities – of such informal information networks in maintaining and boosting medical migration flows.

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TABLE 6a: SPECIALIST GENERAL MEDICAL PRACTICE (Source: Dr Zbigniew Wegrzyn, Medical Centre for Post-graduate Education, Warsaw)	
1) Organisation <ul style="list-style-type: none"> • Qualifications given • (Rules and Regulations) 	<p>The specialty of Family Medicine was first introduced in Poland in 1992. It is the equivalent of the specialty known as General Practice in the European Union countries. Physicians who have completed their internship (pre-registration year of general clinical training) and are qualified to practice medicine (have been admitted to the Register) are eligible for specialist training for Family Medicine.</p> <p>Procedure of Admission for Specialist Training</p> <p>Prospective candidates are evaluated by the Admission for Specialist Training Board, whose members include the Regional Consultant (in a given chief unit of local administration), a representative of a relevant medical society and a representative of the Regional Medical Council of Physicians and Dentists.</p> <p>When the specialist training is to be undertaken in the form of Residency Programme or the number of prospective candidates exceeds the number of training positions, the candidates take an examination (Multiple Choice Questions, or MCQ, prepared by the Centre for Examinations in Medicine) and attend an interview. Candidates for specialist training are then selected by the Board on the basis of their MCQ examination and interview results.</p> <p>Specialist Training</p> <p>The regional centre refers a trainee physician to a health care establishment which he/she has selected. The trainees are offered either a residency position or another kind of full time-employment. The regional centre issues the trainee physicians with a special document known as the specialist training record, a list of medical and surgical procedures they are required to perform and the prescribed training programme. The regional centre keeps a register of physicians training to be specialists within the territory of a given unit of local administration. A physician undergoes a specialist training, having a fixed-term contract of employment with the health care establishment responsible for training. The contract covers the period of specialist and vocational training (Residency Programme). During the entire period of training, the trainee physician is obliged to work the same number of hours as other physicians employed full-time by the health care establishment. The regional centre notifies the trainee physician's regional medical chamber about the commencement of the training.</p> <p><i>Qualifications Given</i></p> <p>Specialist Diploma in Family Medicine. Membership of the Polish College of Family Physicians.</p> <p><i>Rules and Regulations</i></p> <p>Minister of Health Act of 6 August 2001.</p>
2) Structure <ul style="list-style-type: none"> • Theoretical and practical training courses? • <u>General Medical Practice</u> • Qualifications • Average length of training 	<p>Theoretical training courses</p> <p>The specialist training includes theoretical training divided into 12 courses.</p> <p>Topics of the courses:</p> <ol style="list-style-type: none"> 1. Concepts of family medicine (general practice/primary care) in Poland and abroad. 2. Foundations of epidemiology. 3. The doctor — patient relationship. 4. Family practice — organisation and management. 5. Quality of care.

	<ol style="list-style-type: none"> 6. Management of selected clinical conditions. 7. Medical certification and occupational medicine. 8. Development of practical skills. 9. Disease prevention and health education. 10. Accessory investigations in general practice. 11. Family - structure and function. 12. Terminal care. <p>Practical training</p> <ol style="list-style-type: none"> 1. Internal Medicine Hospital Department and Out-patient Clinic 6 months. 2. Paediatric Hospital Department and Out-patient Clinic — 6 months. 3. Maternity Hospital Unit and Antenatal Clinic — 3 months. 4. Surgery Hospital Department and Out-patient Clinic — 1 month. 5. Psychiatry Hospital Department — 1 month. 6. Dermatology Hospital Department and Out-patient Clinic — 3 weeks. 7. ENT Hospital Department and Out-patient Clinic — 3 weeks. 8. Neurology Department and Out-patient Clinic — 3 weeks. 9. Ophthalmology Hospital Department and Out-patient Clinic 3 weeks. <p>Specialist and vocational training for General Practice (family medicine) is divided into 3 stages.</p> <p>The induction period lasts from one to two months and the trainee is attached to a general practice. The aim is to get acquainted with the family doctor's job and specific aspects of primary care. The trainee learns about the duties and responsibilities of particular members of the primary health care team, the principles of their co-operation and managing medical records.</p> <p>The second stage, which lasts 20 months, focuses on training in hospital departments and specialist clinics.</p> <p>When rotating through various specialties, the trainee physician assumes responsibilities of a junior assistant supervised by his/her trainers, who are departmental Heads or other senior members of the medical staff. The aim of training in hospital departments and out-patient clinics is to acquaint the trainees with specialist services provided by these facilities, including diagnostic methods and treatment, and help them acquire practical clinical skills.</p> <p>In the third stage of training the trainee is attached to a family practice. The centre for primary care training refers the trainee (resident) to a family practice (general practitioner surgery) recognised by the centre. The trainee is attached to the general practice for 22 months, being supervised by the general practitioner. The trainees prepare for assuming sole responsibility for patient care as licensed family physicians. One trainee attached to a general practice is tutored and supervised by one licensed family physician.</p> <p>After completing a theoretical course and a period of practical training in hospital setting (clinical attachment), the trainee is given a certificate, which is entered in his/her specialist training record.</p> <p>The training programme for Family Medicine lasts 4 years.</p>
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<p>3) Trainee Posts</p> <ul style="list-style-type: none"> • Overseen by whose rules? • Qualitative criteria • Supervised by whom? 	<p>The trainee physician has a fixed-term contract of employment (trainee/resident position) with a health care establishment providing the specialist and vocational training. The contract expires when the training has been completed. The trainee physician works 7 hours a day and has to work 20 night shifts, or to be on call, either at a general practitioner clinic or a local accident and emergency department. When attached to a health care establishment, the trainee sees patients at the surgery and during home calls, with appropriate supervision and support of the trainer. Twice a week, the trainer and the trainee meet to discuss the management of currently admitted patients. They also discuss the issues related to training and plan its further course. After a period of training (attachment), the trainer and the trainee submit their independent reports/evaluations to the training centre. When all requirements are satisfied, the training is evaluated as successfully completed and the trainee may proceed to another stage of training.</p> <p>Health care establishments providing specialist and vocational training for family medicine (residency programmes) set up special supervisory boards which evaluate the quality of training provided, with special focus on postgraduate medical education, efficacy of treatment, analyses of the causes of deaths and of hospital-acquired infections.</p> <p>The trainee undergoes specialist training supervised by a physician he/she has selected from among the medical staff of a given health care establishment. The choice is subject to approval by the Regional Consultant in a given specialty. The specialty training is supervised by a physician who is licensed to practice a given specialty. The trainer, or supervisor, is responsible for detailed planning of the training to ensure its successful completion, including the selection of setting where subspecialist training is to take place. The trainer's duties and responsibilities include the following:</p> <p>1) selection of patients for whose management the trainee assumes responsibility, advising on the suitability of and evaluation of the suggested investigations and the interpretation of the findings, diagnosis, treatment, prognosis and advice to patients; 2) direct supervision of diagnostic procedures, treatment and rehabilitation performed by the trainee within the scope of the specialist and vocational training until the trainee is able to assume sole responsibility for patient care; 3) participation in more complex surgical, medical or diagnostic procedures, creating additional risk to the patient, performed by the trainee, until the latter has attained the necessary skills to carry out the procedures/treatment unaided; 4) evaluation of the trainee's clinical skills; 5) evaluation of the trainee's theoretical knowledge; 6) confirmation that the trainee has participated in and performed the required number of prescribed medical and surgical procedures.</p>
<p>4/5) How and where is:</p> <ul style="list-style-type: none"> • Theoretical training – number and type of establishment • Practical training being given - criteria for recognition of establishments 	<p>Specialist theoretical and practical training is provided by the establishments accredited by the Medical Centre of Postgraduate Education and listed by the Minister of Health.</p> <p>1. Accredited family practices (general practitioner surgeries). The trainee is attached to a family practice (general practitioner surgery) recognised by the training centre.</p> <p>2. Accredited hospital departments and out-patient clinics. The residency programme in hospital departments and out-patient clinics includes 44 days of theoretical instruction. The instruction should be evenly spaced (one day a week) and provided as lectures and seminars with active participation of the trainees. The lectures and seminars are held in the morning hours and the teaching groups do not consist of more than 12 trainees.</p> <p>The accreditation criteria for establishments providing specialist and vocational training for Family Medicine state that such establishment</p> <p>1) provides services in a given specialty and comprise in its structure a (regional) training centre for Family Medicine</p> <p>2) provides an adequate training programme in a given specialty to a defined number of trainees</p>

	<ol style="list-style-type: none"> 3) has set up special boards to supervise the quality of teaching and treatment provided, especially within the scope of post-graduate medical education. 4) employs sufficient number of licensed family physicians — individual general practitioners, family physician employed in general practitioner surgeries or health centers — who may act as trainers supervising the specialist and vocational training for family medicine 5) employs sufficient number of licensed specialists working in out-patient clinics or practicing individually, who are able to provide specialist and vocational training 6) is sufficiently equipped for training purposes. 7) provides health care services, appropriate in their type, scope and number, for training purposes. 8) provides adequate educational and training facilities. 9) has been approved as a training establishment by the regional consultant in a given specialty.
6) Status of Teachers	<ol style="list-style-type: none"> 1. Physicians licensed to practice the specialty of family medicine, attending patients in their general practice or in a health centre (group practice). 2. Physicians employed in state health care establishments in general practitioner clinics or other facilities providing a similar range of medical services. 3. Physicians licensed to practice other specialties, providing specialist and vocational training within the residency programme and employed in public hospitals and out-patient clinics. 4. Physicians licensed to practice other specialties, providing specialist and vocational training, attending patients in their own specialist surgeries.
7) Constitution of supervisory grades in the context of theoretical and practical training	<p>During the entire period of specialist training, the trainer (supervisors) evaluates the trainee by means of tests and examinations. These include appraisal of</p> <ol style="list-style-type: none"> 1) theoretical knowledge of clinical issues in family practice, organisation and management of a family practice, quality of medical care, medical certification, legal aspects of health care, health education and disease prevention 2) actual performance and skills required for minor surgery, obstetrics and gynaecology, and interpretation of accessory investigation findings. <p>After completing his/her specialist and vocational training, the candidate has to take a state examination, consisting of evaluation of clinical skills, a Multiple Choice Question (MCQ) examination and an oral examination. This comprehensive examination is developed by the Centre of Medical Examinations in collaboration with the National Consultant and a relevant professional association.</p> <p>The State Examination is conducted by the specially appointed Examination Board. Its members are proposed by the National Council for Examinations in Medicine in consultation with the National Consultant, a relevant professional association and the Supreme Medical Council of Physicians and Dentists. Members of the Examination Board include a representative of the National Consultant, two representatives of a relevant professional association, a representative of the Supreme Medical Council of Physicians and Dentists or a Regional Medical Council of Physicians and Dentists and a representative of the National Council for Examinations in Medicine.</p>

TABLE 6b: SPECIALIST MEDICAL TRAINING (Source: Dr Zbigniew Wegrzyn, Medical Centre for Post-graduate Education, Warsaw)	
<p>1) Organisation</p> <ul style="list-style-type: none"> • Qualifications given • (Rules and Regulations) 	<p><u>Physicians who have completed their internship (pre-registration year of general clinical training) and are qualified to practice medicine (have been admitted to the Register) are eligible for specialist training in a given specialty.</u></p> <p>Procedure of Admission for Specialist Training Prospective candidates are evaluated by the Admission for Specialist Training Board, whose members include Regional Consultant (in a given chief unit of local administration), a representative of a relevant medical society and a representative of the Regional Medical Council.</p> <p>When the specialist training is to be undertaken in the form of Residency Programme or the number of prospective candidates exceeds the number of training positions, the candidates take an examination (Multiple Choice Questions, or MCQ, prepared by the Centre for Examinations in medicine) and attend an interview. Candidates for specialist training are then selected by the Board on the basis of their MCQ examination and interview results, which allows them to start their specialist training.</p> <p>Specialist Training The regional centre refers a trainee physician to a health care establishment providing services in a given medical specialty which he/she has selected. The regional centre issues the trainee physicians with a special document known as the specialist training record, a list of medical and surgical procedures they are required to perform and the prescribed training programme. The regional centre keeps a register of physicians training to be specialists within the territory of a given unit of local administration. The trainees are offered either a residency position or another kind of full time-employment. A physician undergoes a specialist training, having a fixed-term contract of employment with the health care establishment providing training. The contract covers the period of specialist and vocational training (Residency Programme). Also, the trainee may be granted a leave of absence from the establishment where he/she is originally employed to complete the training. During the entire period of training, the trainee physician works the same number of hours as other physicians employed full-time by the health care establishment. The regional centre notifies the trainee physician's regional medical chamber about the commencement of the training.</p> <p>Qualifications Given After completing the specialist training and passing of the stipulated state examination, the physician is licensed to practise a given specialty, which is confirmed by a specialist diploma. A licensed medical specialist is eligible to take managerial positions in the health care sector (Head of a hospital department, specialist clinic, etc.</p> <p>Rules and Regulations All issues related to specialty training and licensing of physicians and dentists are governed by the regulations of the Profession of a Physician and a Dentist Act of Dec. 5, 1996 and the Minister of Health Regulation of 6 August 2001 (amended 18 December 2001).</p>

<p>2) Structure</p> <ul style="list-style-type: none"> • Theoretical and practical training courses • Qualifications • Average length of training – Minimum periods for each specialisation 	<p>Theoretical course</p> <p>In the course of their specialist training, the trainees attend prescribed courses included in the curriculum.</p> <ol style="list-style-type: none"> 1. Induction course in the first year of training, covering foundations of good medical practice. Based - theoretical and practical training courses on current, reliable publications (evidence based medicine), foundations of pharmacoeconomics, formal and legal aspects of continuing medical education, and introduction to clinical subjects with the scope of the specialty training. 2. Professional development courses whose number and scope is determined by the curriculum, including health promotion and oncology as related to a given specialty. <p>Practical training</p> <ol style="list-style-type: none"> 1. Actual performance and participation in the performance of a prescribed number of medical and surgical procedures included in the curriculum <ul style="list-style-type: none"> - performed by the trainee himself/herself - performed by the trainee either assisted or supervised by the trainer. 2. Clinical attachments which require mastering of particular clinical skills. 3. Acting as a doctor on call at least 3 times a month. <p>Qualifications</p> <p>After completing a theoretical course and a period of practical training in hospital setting (clinical attachment), the trainee is given a certificate, which is entered in his/her specialist training record.</p> <p>Average length of training — Minimum periods for each specialization</p> <table border="0"> <thead> <tr> <th>Specialty</th><th>Subspecialty</th></tr> </thead> <tbody> <tr> <td>1. Anaesthetics and intensive care - 5 years</td><td>1. Allergology - 3 years</td></tr> <tr> <td>2. Paediatric surgery - 6 years</td><td>2. Angiology - 3 years</td></tr> <tr> <td>3. Thoracic surgery - 6 years</td><td>3. Audiological medicine and phoniatics - 3 years.</td></tr> <tr> <td>4. General surgery - 6 years</td><td>4. Balneotherapy - 2 years</td></tr> <tr> <td>5. Maxillo-facial surgery - 6 years</td><td>5. Vascular surgery - 2 years</td></tr> <tr> <td>6. Internal medicine - 5 years</td><td>6. Surgical oncology - 2 years</td></tr> <tr> <td>7. Communicable diseases - 5 years</td><td>7. Plastic surgery - 2 years</td></tr> <tr> <td>8. Dermatology and venereology - 5 years</td><td>8. Respiratory medicine - 2 years</td></tr> <tr> <td>9. Laboratory medicine - 5 years</td><td>9. Diabetes mellitus - 2 years</td></tr> <tr> <td>10. Clinical genetics - 5 years</td><td>10. Endocrinology - 3 years</td></tr> <tr> <td>11. Cardiac surgery - 6 years</td><td>11. Epidemiology - 2 years</td></tr> <tr> <td>12. Nuclear medicine - 5 years</td><td>12. Clinical pharmacology - 3 years</td></tr> <tr> <td>13. Occupational medicine - 5 years</td><td>13. Gastroenterology - 2 years</td></tr> <tr> <td>14. Accident and emergency medicine - 5 years</td><td>14. Geriatrics - 2 years</td></tr> <tr> <td>15. Family medicine - 4 years</td><td>15. Haematology - 3 years</td></tr> <tr> <td>16. Forensic medicine - 5 years</td><td>16. Clinical immunology - 2 years</td></tr> </tbody> </table>	Specialty	Subspecialty	1. Anaesthetics and intensive care - 5 years	1. Allergology - 3 years	2. Paediatric surgery - 6 years	2. Angiology - 3 years	3. Thoracic surgery - 6 years	3. Audiological medicine and phoniatics - 3 years.	4. General surgery - 6 years	4. Balneotherapy - 2 years	5. Maxillo-facial surgery - 6 years	5. Vascular surgery - 2 years	6. Internal medicine - 5 years	6. Surgical oncology - 2 years	7. Communicable diseases - 5 years	7. Plastic surgery - 2 years	8. Dermatology and venereology - 5 years	8. Respiratory medicine - 2 years	9. Laboratory medicine - 5 years	9. Diabetes mellitus - 2 years	10. Clinical genetics - 5 years	10. Endocrinology - 3 years	11. Cardiac surgery - 6 years	11. Epidemiology - 2 years	12. Nuclear medicine - 5 years	12. Clinical pharmacology - 3 years	13. Occupational medicine - 5 years	13. Gastroenterology - 2 years	14. Accident and emergency medicine - 5 years	14. Geriatrics - 2 years	15. Family medicine - 4 years	15. Haematology - 3 years	16. Forensic medicine - 5 years	16. Clinical immunology - 2 years
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3) Trainee Posts <ul style="list-style-type: none"> Overseen by whose rules? Qualitative criteria Supervised by whom? 	<p>The trainees are offered either a residency position or another kind of full time-employment. A physician undergoes a specialist training, having a fixed-term contract of employment with the health care establishment providing training. The contract covers the period of specialist and vocational training (Residency Programme). Also, the trainee may be granted a leave of absence from the establishment where he/she is originally employed to complete the training.</p> <p>During the entire period of training, the trainee physician works the same number of hours as other physicians employed full-time by the health care establishment. (Health Care Establishments Act of August 30, 1991).</p> <p>Health care establishments providing specialist and vocational training set up special supervisory boards which evaluate the quality of training provided, with special focus on postgraduate medical education, efficacy of treatment, analyses of the causes of deaths and of hospital-acquired infections.</p> <p>The trainee undergoes specialist training supervised by a physician he/she has selected from among the medical staff of a given health care establishment. The choice is subject to approval by the Regional Consultant in a given specialty. The specialty training is supervised by a physician who is licensed to practice a given specialty. The trainer, or supervisor, is responsible for detailed planning of the training to ensure its successful completion. including the selection of setting where sub specialist training is to take place. The trainer's duties and responsibilities include the following:</p> <p>1) selection of patients for whose management the trainee assumes responsibility, advising on the suitability of and evaluation of the suggested investigations and the interpretation of the findings, diagnosis, treatment, prognosis and advice to patients; 2) direct supervision of diagnostic procedures, treatment and rehabilitation performed by the trainee within the scope of the specialist and vocational training until the trainee is able to assume sole responsibility for patient care; 3) participation in more complex surgical, medical or diagnostic procedures, creating additional risk to the patient, performed by the trainee, until the latter has attained the necessary skills to carry out the procedures/treatment unaided; 4) evaluation of the trainee's clinical skills; 5) evaluation of the trainee's theoretical knowledge; 6) confirmation that the trainee has participated in and performed the required number of prescribed medical and surgical procedures.</p>	

<p>4/5) How and where is:</p> <ul style="list-style-type: none"> • Theoretical training establishment • Type – university centre/ teaching hospital/ health establishment • Practical training being given – criteria for recognition 	<p>Specialist theoretical and practical training is provided by the establishments accredited by the Medical Centre of Postgraduate Education and listed by the Minister of Health. Practical training is carried out at the accredited family practitioner surgeries, hospital departments and out-patient clinics. The accreditation criteria for establishments providing specialist and vocational training in a given specialty state that such establishment</p> <ol style="list-style-type: none"> 1) provides services in a given specialty and comprise in its structure a hospital departments and outpatient clinics 2) is a teaching (clinical) hospital, 3) provides an adequate training programme in a given specialty to a defined number of trainees 4) has set up special boards to supervise the quality of teaching and treatment provided, especially within the scope of post-graduate medical education 5) <i>employs sufficient number of licensed specialists (consultants) — who may act as trainers supervising the specialist and vocational training in a given specialty</i> employs sufficient number of licensed specialists working in out-patient clinics or practicing individually, who are able to provide specialist and vocational training 7) sufficiently equipped for training purposes 8) provides health care services, appropriate in their type, scope and number, for training purposes 9) provides adequate educational and training facilities 10) has been approved as a training establishment by the regional consultant in a given specialty.
<p>6) Status of Teachers</p>	<ol style="list-style-type: none"> 1. A trainee physician undergoes the specialist and vocational training under the supervision of a physician he/she has selected from the medical staff employed in a given health care establishment, subject to the approval of the Regional Consultant in a given specialty. The Trainer, or supervisor of the specialist training is a physician licensed to practice a given specialty and employed full-time. 2. A trainee physician undergoes practical training (clinical attachment) under the supervision of a physician licensed to practice a given specialty, employed full-time and selected by the Head of the health care establishment providing training, subject to the approval of the regional consultant.
<p>7) Constitution of supervisory grades in the context of theoretical and practical training</p>	<p>After completing his/her specialist and vocational training, the candidate has to take a consisting of evaluation of clinical skills, a Multiple Choice Question examination (MCQ) and an oral examination. This comprehensive examination is developed by the Centre of Medical collaboration with the National Consultant and a relevant professional association.</p> <p>The State Examination is conducted by the specially appointed Examination Board. Its members are appointed by the National Council for Examinations in Medicine in consultation with the National Consultant, a relevant professional association and the Supreme Medical Council of Physicians and Dentists. Members of the Examination Board include a representative of the National Consultant, two representatives of a relevant professional association, a representative of the Supreme Medical Council of Physicians and Dentists or a Regional Medical Council and a representative of the National Council for Examinations in Medicine.</p>

TABLE 6c: CONTINUING EDUCATION (Source: Dr Zbigniew Wegrzyn, Medical Centre for Post-graduate Education, Warsaw)	
1) Arrangement <ul style="list-style-type: none"> • Organisation, structures, location and financing 	<p>In Poland, continuing medical education (CME) is not compulsory, although the Code of Medical Ethics (Art. S6) obligates physicians to continuously update and improve their theoretical knowledge and clinical skills. Most physicians engage in continuing professional education. In an attempt at formal recognition of this, the Supreme Medical Council of Physicians and Dentists in its Resolution no. 013/97/00/III (of April 15, 2000 concerning determining the manner of fulfilling the obligation to improve qualifications by a physician or a dentist) stated that physician may fulfill their obligation of continuing education by means of self-education and participation in various forms of post-graduate education. A physician may keep a track record of his/her continuing education with a set number of educational points awarded for different form of continuing education (confirmation of collection of given number of credit points).</p> <ol style="list-style-type: none"> 1. Professorship - 500 points, from the day of the award of the title. 2. Academic degrees <ol style="list-style-type: none"> a) a post-doctoral degree - 300 points b) a doctor's degree - 200 points 3. Specialty in a given area of medicine - 250 points, from the date of passing the specialty board examinations. 4. Subspecialty in a given area of medicine - 150 points, from the date of passing the specialty board examinations. 5. Participation in post-graduate training, organised by a recognised establishment - 1 point for 1 hour of training (no more than 80 points), from the day of completion confirmed by a certificate. 6. Publications: <ol style="list-style-type: none"> a scientific book - 300 points, from the date of its acceptance for publication; an original scientific article - 150 points, from the date of its acceptance for publication in a scientific journal; a review article - 100 points, from the date of its acceptance for publication in a scientific journal; a review of a book - 50 points, from the date of its acceptance for publication in a scientific journal; a research communication - 50 points, from the date of its acceptance for publication in a scientific journal; a voice in a scientific debate - 10 points, from the date of its acceptance for publication in a scientific journal. 7. Publications: <ol style="list-style-type: none"> a popular-scientific book - 200 points; a popular-scientific article - 15 points, from the date of its acceptance for publication; translation of publications listed in points 1 and 2 - 40% of the score awarded for publications in the Polish language. 8. Re-edition of a book - 50% of the score awarded for its first edition. 9. Participation in a scientific conference, a congress and a symposium: <ol style="list-style-type: none"> a. delivering a paper on a given topic - 50 points, from the date of its presentation; b. delivering a paper as a guest-speaker - 70 points, from the date of its presentation; c. preparing a poster (communication), presenting research findings - 50 points, from the date of its presentation; d. attendance at a scientific conference, a congress or a symposium - 20 points, from the date of confirmed attendance. 10. No additional points are awarded for the actual publication of a paper delivered at a scientific conference, a congress or a symposium. 11. Delivering a paper during an in-house training session, 30 points from the date of its presentation. 12. Attendance at an in-house training session, 10 points from the date of confirmed participation.
2) Qualification awarded	
3) Benefit attached to qualification (financial, tax relief, honorary etc.)	

	<p>13. No additional points are awarded for additional presentations of the same paper at several in-house training sessions.</p> <p>14. The score awarded for active participation and attendance at in-house training sessions cannot exceed 70% of the score required in any reported period.</p> <p>15. Taking-out a yearly subscription to a professional journal - 5 points per title (no more than 5 titles).</p> <p>16. Buying a professional textbook (monograph) - 5 points per title (no more than 5 titles).</p> <p>17. Using a medical library and the Internet - 5 points.</p> <p>18. Supervising a specialist training of one physician - 50 points for any reported period.</p> <p>19. Supervising pre-registration training (internship) -20 points for any reported period.</p> <p>20. Membership of the specialty examination boards - 20 points.</p> <p>21. Topic-oriented clinical attachment (in Poland):</p> <ul style="list-style-type: none"> a. one day - 6 points; b. two days - 14 points; c. three days - 24 points; d. any day over 3 days - 1 point, though no more than a total of 35 points, from the day of confirmed completion of the clinical attachment. <p>22. Clinical attachment abroad:</p> <ul style="list-style-type: none"> a. one day - 10 points; b. two days - 20 points; c. three days - 30 points; d. any day over 3 days - 2 points, though no more than a total of 50 points, from the day of confirmed completion of the clinical attachment. <p>23. When the book, article, paper, review, poster, communication, voice in a scientific debate, etc. have been written (presented) in a foreign language, the number of points awarded is doubled.</p> <p>24. When the book, article, paper, review, poster, communication have been authored by more than one person, the number of points awarded is divided between the authors proportionally to their share of work.</p> <p>A physician who has accumulated 150 educational points over a period of 24 months may apply to the Regional Medical Chamber of Physicians and Dentists, whose member he/she is, to record this score in his medical licence or a separate certificate.</p> <p>A physician applying for a managerial position in a public health care establishment may present the above as an additional document confirming his qualifications.</p> <p>The Regional Medical Council of Physicians and Dentists may award special bonuses (money awards) to those physicians, who have been engaged in various forms of continuing education, especially when they have accumulated over 150 educational points over 24 months.</p>
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COUNTRY REPORT 5 – INDIA

Country Report for India

1.General Background

Population

India's population passed the 1 billion mark in 2000, and is estimated to have since added a further 20 – 25 million people, some comparing the increase to adding the equivalent of the population of Australia to the population of India each year – the estimate in 2000 was 16 million per year (WHO 2001). Grasping the enormity of the population problem is the key to understanding India's health issues and the difficulty of resolving problems.

Despite India being a large country, the overall population density is comparatively high, at 273 persons per km². 74% live in rural areas, 26% in urban areas. The sex ratio is 927:1000 females to males (a reversal of the normal distribution, and an indication of female infanticide). The age profile is the opposite of the ageing populations of Western Europe, with 36% under the age of 15 years, and only 3.9% above 65 years. However, the death rate, and the infant mortality and fertility rates have all fallen, mainly progressively. In 1995 the crude death rate was 9.0, (falling from 27.4 in 1945, through 19.0 in 1965, to 11.8 in 1985). The Infant Mortality Rate (IMR) fell from 161 (per 1000 live births) to 74 over the same 50-year period. The crude birth rate was 28.3 in 1995, (falling from 39.9 in 1945, 41.2 in 1965, 32.9 in 1985); and the total fertility rate (per woman) was 3.5. (WHO 2001, Deodhar 2001). Expectation of life at birth has increased from around 32 years of age (at Independence in 1947) to over 60 generally, and is as high as 74 for women in the State of Kerala.

Stage of Development

The country is in a transitional stage of development, and recently (1997 data) moved into the 'medium human development' category of the Human Development Index (HDI), ranking 132 out of 174 countries. (ICRIER 1999b). The HDI includes a broad spectrum of indicators, including life expectancy, educational enrolment and attainment, adult literacy, as well as per capital Gross Domestic Product (GDP). However, on the WHO World Development Indicators 2000, India ranks as a low-income country with per capita Gross National Product (GNP) US\$ 440 in 1999 (compared with an average for low-income countries, including Nigeria, Bangladesh, Pakistan and Indonesia, of GNP \$US 410). Figures for 1998 indicate that 44.2% of the population has an income of less than \$UD 1 per day, the official 'poverty line' benchmark, although current 'guesstimates' by interviewees quote a figure of one third of the population in poverty. Overall, India accounts for an estimated 40% of the World's poor.

"Malnutrition remains a silent emergency in India" (World Bank 2001a) with 53% of children malnourished, compared with an average of 36% for the group of low-income countries. Women are significantly more malnourished than men, and 60% are anaemic. Maternal mortality rates are high, especially in rural areas, ranging from 440 – 580 deaths per 100,000 live births. Estimates of illiteracy vary from the Government's 38% (based on rounds of the National Sample Survey), to 46.5% estimated by UNESCO. Female illiteracy is high at 57% (compared with the average of 49% for this group of low-income countries) (World Bank 2001).

There are wide variations in development between States measured on various indicators. Life expectancy ranges from 55 to 67 years, neonatal mortality (per 1,000 births) from 14 to 44, IMR from 16 to 98, and total fertility rate from 1.8 to 4.8. Kerala consistently emerges as a State performing well on all the development indicators, and in terms of health status compares with

upper-middle income countries such as Argentina. Kerala and Tamil Nadu (capital Chennai/Madras), accounting for 9.1% of India's population, are classified in development terms as States in middle to late transition, with moderate to high capacity. Maharashtra (capital Mumbai/Bombay) and Karnataka (capital Bangalore), Punjab, West Bengal, Andhra Pradesh, Gujarat, and Haryana (with 39.1% of the population) are in early to middle transition, with low to moderate capacity. Orissa, Rajasthan, Madhya Pradesh, Chatisgarh, and Uttar Pradesh (33.1% of the population) are in very early transition, with very low, to low capacity, and Assam, Bihar and Jharkhand (13.3% of the population) are characterised by instability, civil conflict and /or poor governance, with high to very high mortality (World Bank 2001, Shariff 1999, Parikh 1999).

As well as variations between States, there are also wide variations in health status within States. Rural areas and the poor have worse facilities and worse health outcomes than the urban population and the rich.

“There are also large disparities across India, which places the bulk of the burden of these conditions on the poor, women, and scheduled castes and tribes. The poorest 20% of Indians have more than double the mortality rates, malnutrition, and fertility of the richest quintile” (World Bank 2001).

Pressing Development Issues

Health

Although major advances have been made in completely eradicating some diseases, such as plague, guinea worm, and smallpox, the ‘unfinished agenda’ of eradicating communicable diseases prevalent at Independence remains. Tuberculosis and malaria are still endemic, and malnutrition is widespread. There continue to be epidemics of dengue fever, cholera, gastro-enteritis, viral encephalitis, Kala Azar, infectious hepatitis, typhoid fever and food poisoning. HIV/AIDS is of growing concern, with an estimated 4 to 5 million people infected, doubling every 14 months, and the disease now spreading beyond the most vulnerable groups. There are major National Programmes of Control and Eradication for Malaria (absorbing an astonishing half of the total health budget), for Tuberculosis, and for HIV/AIDS. Two thirds of deaths of under 5-year olds are from diarrhoea and acute respiratory infections leading to pneumonia, illnesses preventable with access to clean water, safe sanitation and waste disposal, and penicillin. Although in theory 98% of the population has access to safe water, and 49% to excreta disposal (1997 figures), in practice water is often polluted or unsafe.

The unfinished agenda is an issue for public health measures, and for general social, economic and education enhancement, given the recognition of the inter-relationship of poverty, education, and health. Some pressure groups in India, for example VHAI, Community Health Cell, and CEHAT, perceive that public health and epidemiological issues have taken a back seat to curative medicine and a growing concentration on the control of non-communicable diseases. Lifestyle diseases such as coronary heart disease, high blood pressure and hypertension, diabetes and cancer now also have National Programmes to address them, as a result of decisions by ‘affluent and power holding groups of people and politicians’ (Deodar 2001). However, much of rural India still lacks an effective public health infrastructure, and access to good primary health care, and political will has proved slow to strengthen services.

“India’s health transition is characterized by shifting demographics, altered health behaviours, and changes in disease patterns, with more degenerative and man-made diseases and more polarization of health conditions. A high proportion of the population continues to suffer and die from preventable infections, pregnancy and childbirth-related complications and under-nutrition - the ‘unfinished agenda’ of the health transition.” (World Bank 2001)

There is much debate currently concerning ways to raise the profile of equity and social justice issues in relation to health care. There seems to be general agreement from this lobby that strengthening women's education and empowerment generally will be significant factors in generating greater community involvement and control over programmes, thereby creating more effective delivery of care. Part of the problem seems to be that because development issues are multi-dimensional, many different agencies may be working on different aspects of local problems. Each project is vertically managed, with its own agenda and chain of accountability. Achieving targets in one programme may actually prove to be counter-productive for another. So the 'Pulse Polio' immunization programme, operating independently, has actually reduced the overall immunization rate for other childhood illnesses. It is therefore seen as important for the many different non-Government Organisations (NGOs), as well as government agencies to begin to work together across sectors, and with the community, in a more integrated way at the local level. Where power and control has been successfully devolved to the Panchayati Raj Institutional (local district) level, the outcomes by a range of health indicators are better than for States where planning and budgets are more centrally controlled. (World Bank 2001/ Deodar 2001). The National Population Policy 2000, with a mix of socio-demographic and health goals, endorsed the notions of decentralization of planning and delivery, and greater inter-sectoral working, within the overall policy aim of bringing the Total Fertility Rate (TFR) to replacement level by 2010. It also recommended a doubling of the Family Welfare Budget to achieve the goals.

Another aspect to the under-resourced public health system is the inadequate reporting and notification of cases of epidemic diseases, the lack of trained staff, and therefore the slow response to any real or potential outbreak. There are insufficient facilities to carry out epidemiological investigations, and if they are begun they are often not completed. Control measures are often ad hoc rather than planned responses. The plans of the National Health Policy 1983 to establish a chain of effective epidemiological stations have not materialised. All in all, the financial inputs to the health system are seen by the public health lobby to be focused on areas dictated either by International Agencies, (such as HIV/AIDs programmes) or dictated by the wealthy, rather than on the areas likely to have the most significant impact on health status.

The most recent National Health Plan (2001) explicitly places more emphasis on the role of the private sector in helping to meet various health targets. An increased role has implications for training of doctors, for health financing and insurance, as well as for the framework of delivery of care. These implications will be discussed below.

Infrastructure

Although the focus of the National Health Plan (2001) is the pressing need to tackle the unfinished health agenda, tackling other aspects of development are also important, and are given prominence in various seminar and development reports (ICRIER 1999a,b). The importance of the link between economic development and poverty, the need for infrastructure development of education, power, water, transport and telecommunications are all mentioned. In particular, the importance of the role e-commerce has played recently in India gaining market share in industries such as call centres and legal and medical transcription services is highlighted. The trend towards globalisation, explicit now in development policies, is central to the way in which the economy develops. Although we do not explore this further here, it is important to note that the culture surrounding globalisation generally also has an impact on the culture of health care delivery. Globalisation is "driven by market expansion, trade, capital, information" and, without effective governance, may adversely affect equity and human rights issues.

"It is clear that policy choices are involved at every step –in the economy: how and when to liberalise, deregulate, and privatise and what limits to set; in culture; in governance; and in technology: how far to make communications accessible to people, and how to protect indigenous people." (ICRIER 1999b).

These choices can equally well be applied to the health care market, both for the provision of services, and the training of doctors.

Economy

India has a quarter of the world's population, and ranks 10th in terms of industrial output. India's economy grew considerably during the early 1990s, as a result of liberalisation policies coupled with globalisation, which opened India to flows of foreign capital investment, both financial and intellectual. The broader implications of globalisation are as yet unclear:

"The first message is that with shrinking time and space and disappearing borders, expansion of global markets is far outpacing measures to govern them or to cope with the repercussions on people". (ICRIER 1999b)

Nevertheless, globalisation policies (in in-flow of foreign investment), liberalisation (in-flows of private finance) have occurred in response to World Bank pressure for reform, and tied to loans and development aid (India is one of the highest annual borrowers). 1993-6 saw an export boom, with annual export growth of 20%, and overall economic growth in excess of 7%. An outstanding success story has been the growth in the software industry in, for example, Bangalore and Pune, driven by inflows of intellectual and financial capital from the Non-Resident Indians (NRIs) of Silicon Valley. Software exports rose from US\$734 million to US\$2,650 million by 1998/9. However, inflation at a similar rate to growth was a problem until 1996/7 when there was a deceleration in the rate of industrial growth and exports. Nevertheless, India managed to escape the worst of the Asian economic crisis of the late 1990s, until sanctions were applied as a result of nuclear testing, undertaken by the new right wing BJP Government in May 1998. Sanctions applied by the USA especially, coupled with a moratorium on loans from the World Bank and the Asian Development Bank, and from other bi-lateral donors, led to a slow down. Net foreign portfolio investment and private capital flows fell. A high of US\$5.4 billion total investment in 1997/8, fell to US\$2.4 billion by 1998/9 (Acharya 2001).

Currently the central government has a fiscal deficit of around 10% of GDP, (placing India as one of the top 3 fiscal deficit countries worldwide). There have also been increases in State fiscal deficits, rising from 2.6% of GDP in 1980/1 to 4% of GDP in 2000/1. (Handbook of Statistics on the Indian Economy 2000 p 25 quoted in ICRIER 1999a). The situation is of serious concern, given that more than half of government borrowing is used to pay debt interest. Government policy now emphasises economic consolidation and aims for a reduction in fiscal deficit to 2% of GDP by 2006.

The implications for public spending are clear, and were evident by the lack of attention in the 2002 March Budget. So, for example, although the National Health Plan 2001 acknowledged that State governments needed increased resources from the centre to finance health care, none was forthcoming. Spending, especially in poorer States, on essential services such as health and education, roads and irrigation, has been hampered.

2. The Health Sector

Nature of the Health System

Structure

At Independence, the intention was for the health system to be progressively built on the recommendations of the Bhore Committee 1946, modelled on the UK National Health system, admired in terms of its ethos. The recommendations envisaged 15% of government expenditure going on health care, with delivery structured through a hierarchy of provision, based on population norms, with a referral system from primary through secondary to tertiary care. The structure includes sub-centres at village level (5,000 population); Primary Health Centres,

(PHCs, per 30,000-50,000 population); Community Health Centres (100,000-120,000 population) providing some obstetric and gynaecology and paediatric specialist services; District Hospitals (1-2 million population) providing the full range of secondary care; and Zones of 5-7 districts (5 million population) with tertiary provision. At the apex is the State Directorate of Medical and Health Services, which has two distinct branches, one administering public health measures through the primary health care system, and the other delivering hospital-based care. Special emphasis was to be placed on preventive methods and on eradicating communicable diseases. Access was not to be dependent on ability to pay. Whilst several different Committees have since emphasised different norms (for example, the ratio of hospital beds: population, the ratio of doctors and medical schools: population), and have recommended strengthening different strategies for delivering effective care, norm-based planning has remained.

Finance

Whilst the aim of a universal, comprehensive public allopathic health care service remains in theory, especially at primary care level, there has been progressively greater encouragement of private practitioners, in order to reduce the burden of government expenditure. The progression from the ideal of a system based on the much-admired NHS, to a system largely privately financed, is mirrored in the expenditure figures. Health spending by the government (central government contributing 25% and States 75%) amounts to around 1% of GDP, actually falling from 1.1% in 1985/6 to 0.78% in 1996/7, and reaching 0.9% in 2000. However, the time trends for the last 11 years show a steady increase in the actual amount spent (World Bank 2001). Nevertheless, overall, government expenditure is comparatively low (c.f. 2.8% GDP average government health spending for low and middle-income countries). Government funding comes from a mixture of tax revenues and cost recovery through fees. The richest 40% of the population pays 80% of user fees, but although the rich pay more, they also have a higher usage even of public services. The rich, the city dwellers, and the non-scheduled tribes and castes all benefit disproportionately to the poor, the rural population and the scheduled tribes and castes. There are wide variations in spending between States, with the poorest States (Bihar, Madhya Pradesh and Uttar Pradesh) spending half that of the wealthier States (Kerala and Punjab), although the central government input has some equalising influence. The variations in spending are reflected in the health indicators mentioned earlier, and threaten to expand the gaps in outcomes.

Overall spending on health, public and private, was about 4.5% of GDP in 1996, or about US\$18 per capita, (still below the average of 5.6% of GDP for low and middle-income countries). With approximately 82% of health spending being private, India has one of the highest proportions of private health financing anywhere in the world. It is estimated that 82% of outpatient visits, 56% of hospitalisations, 46% of institutional deliveries, 40% of pre-natal visits, and 10% of immunizations occur within the private sector. (World bank 2001). Most of this expenditure is out-of-pocket.

Health Insurance

Only about 10% of the population has some form of health insurance. There are mandatory schemes mainly in the government or formal employment sectors. These schemes are based on contributions from both employers and employees with some State or central government input. For example: the Central Government Health Scheme (CGHS) covered about 4.4 million employees in 1996, covering all outpatient and inpatient care in government hospitals and on referral to approved private hospitals, mainly financed by central government, with salary-based contributions; the Employees State Insurance Scheme (ESIS) covered 35.4 million low-income industrial workers and their families (less than Rs. 6,500 per month) in 1998. This scheme gives some cash benefits, but is mainly used for physician salaries in referral hospitals, and for global hospital budgets financed by ESIS through State governments; the voluntary private General Insurance Corporation Scheme (GIS) MEDICLAIM covered 1.7 million, mainly urban poor, with the patient reimbursed according to the sum insured. At the level of the rural and urban poor there have been some

community-based, small-scale risk-pooling insurance schemes, covering approximately 30 million people. They are financed by a combination of patient collection, government grants and NGO donations, and cover mainly preventive care, with some ambulatory and inpatient care. They provide a small degree of security in the vicious cycle of ill-health and inability to work. However, for many in the rural informal employment sector, hospitalisation frequently results in financial catastrophe. Extra costs may include travel to a specialist centre, food and accommodation, and informal payments to doctors. It is estimated that 40%, variable by State, have to sell assets, such as home and land, or borrow at high interest, or both, so that on average 25% then fall into poverty, (World Bank 2001).

Private Insurance

The issue of private health insurance is currently high on the political agenda. India has recently opened its doors to the corporate insurance market through the liberalising Insurance Regulatory and Development Authority (IRDA) Act 1998. The Act sees Health Insurance as a basic human right, and the benefits of private provision include quality control and cost containment through the activity of Health Management Organisations (HMOs). Sri Srinivasan, former Union Health Secretary, sees the role of private provision as: *“to supplement, compete or set a standard with public provisions for inducing efficiency and quality of public services.”* (Seminar Report on Health Insurance, 2000).

Many large multi-national players are beginning to test the waters including Sun Alliance, Prudential, Standard Life, and Allianz, and it is estimated that the market will grow at 20 – 25% pa over the next 5 years. Investment in the field is said to be 29% foreign and 71% Indian. The law introduced to regulate this market in India, under the Insurance Regulatory Development Authority, (IRDA), does not allow Insurance Companies to operate their own hospitals. There has to be separate service providers and insurers, with third party administrators (TPAs). In this respect, TPAs in India resemble HMOs in America in terms of function.

However, there are some major issues still being debated. Obstacles to entering the market include a requirement to deposit capital of Rs100 crores (1crore=10 million), and the policy to give priority to insurance companies offering health insurance as an exclusive operation. Although the intention was stated as enabling the business on a large scale, in practice these are disincentives. There is a major problem of assessing risk accurately, as there is a dearth of statistical information on the health status of groups/populations. There is also a lack of opportunity to spread risk through other insurance business. Inevitably the market looks geared towards the safer wealthier segments of society. One third of the population are said to be wealthy middle to upper middle class, and certainly able to afford private care/insurance. Another third, the lower middle class, may struggle a little, but are likely to make private health expenditure a priority, and one third will be too poor to afford treatment or insurance unless there is some local village level pooling and coverage. Whatever the short-term difficulties, the private insurance market looks set to develop, and major advertising for insurance is evident everywhere. Advertising is geared towards the middle class through credit card avenues, and offers easy monthly payments. A substantial business would exist simply by channelling the 4.5% of GDP spent on private health care, mainly out of pocket, into insurance premiums. Private insurance goes hand in hand with the expanding private hospital sector. To quote Sri Srinivasan again: *“In the climate of liberalization, corporate hospitals are becoming attractive propositions for good investments.”* (NIHFW 2000). The possibility of a two-tier health system, with public provision, particularly of hospital care, for the poor, and private insurance-funded provision for the wealthier, seems nearer.

The Delivery of Health Care

Doctors

At the time of the Bhore Committee, and at Independence, it was estimated that 73% of doctors were in public service, and 27% in private practice. More recent figures show 78% to 80% to now be in private practice (Duggal 2000).

The Medical Council of India (MCI) Register shows that India has a relatively high doctor/patient ratio, with currently an average of 1:1,800. This shows an improvement over the estimate of 1:2,460 for 1993 (Stern 2000). Estimates vary because of the unreliability of the registration systems. Registration with the national Medical Council of India is a once only process on qualifying. Registration to practise happens at a State level, and is renewable every 5 years. These data are then collated every 5 years by the MCI. However, not only do many fail to register, many also remain on the register once they have ceased to practise, or emigrated. However, the consensus of opinion is that overall the number of doctors is adequate, but there is a major problem of mal-distribution. There are wide variations between wealthy and poor States. For example, Karnataka has a 1:1,602 doctor /patient ratio, and Uttar Pradesh has 1:16,560 (Whitefield Statement Excerpts, 2001). Another source, (Community Health Cell, 1999) estimates that Karnataka had a total of 23,727 doctors in 1997/8, a ratio of 1:2,110 doctors, but that the cumulative stock would be 33,393, with a ratio of 1:1,682 by 2006/7. This would give an estimated surplus of 8,700 by 2006/7. These data are used by the Community Health Cell lobby group to argue that no more resources should be directed into medical education, as there is no evidence that expanding the number of medical school 'seats' or the number of schools will address the geographical mal-distribution.

In addition to allopathic trained doctors, there are also alternative private practitioners (APPs). The first group of APPs are doctors trained in traditional systems of Indian medicine, and include systems of Ayurvedic, Homeopathy, Siddha, Yoga, Unani, and Tibetan medicine. Each of these systems has training programmes and a registration board. This group of qualified APPs is thought to constitute about a quarter of doctors in India. Small-scale studies have also shown that many of these alternative doctors cross-practise a mixture of systems, including allopathy, and many receive kickbacks from pharmaceutical companies. Their average earnings are around Rs.8,000 per month. (Pharmaceutical company representatives are thought to have a far better picture on the ground of numbers of primary care practitioners than official medical bodies). There are also a large number of 'quacks' (estimated at 1.25 million), practising allopathic medicine and dispensing drugs, but who have no training or qualifications. They mainly serve the rural poor, and earn around Rs.5,000 per month. (These figures are based on the World Bank (2001) findings from studies in Andhra Pradesh and Uttar Pradesh). All groups of private providers are often consulted in preference to the public doctors, with patients paying a fee for service, or possibly a payment in kind, although this latter was found to be less prevalent than once supposed. About 15-30% of patients may receive a combination of free care, fee reduction, or free samples of medicine.

Primary Care

80% of medical consultation occurs at the primary care level, and the majority is delivered through the private sector. Family practitioners mainly work in single-handed practice, and conditions vary considerably from the squalid to the plush.

The effect of low government expenditure in the public primary care sector has been to spread the delivery of services too thinly to be effective. Sub-centres and PHCs are in a poor state of repair, lacking equipment and drugs, so that in many rural areas the theoretical primary care provision is in practice defunct. PHCs are largely viewed as family planning clinics and immunization centres, with only about 8% of curative care delivered through them. Doctors who opt for, and are selected for, government positions such as these would typically be first generation doctors, often from quite poor backgrounds, who have opted for the security of a

government post and a guaranteed retirement pension. Such a position would also bring kudos to the extended family. Staff housing is so poor, that typically a doctor or other health worker might only occasionally visit their centre, rather than being there on a daily basis. Many are absent totally during the hottest season, returning to their home village. Evidence from a focus group meeting with primary care doctors from the Dhosa district of Rajasthan (held whilst they were taking part in a Management Training course at the Indian Institute for Health Management Research, IIHMR) confirmed that they disliked being located at a distance from their extended family. However, being assigned to duties at a distance from the operation of familial or political patronage appears to be official policy on the grounds of equity. In addition to being undermanned, many PHCs, CHCs and District Hospitals have unfilled positions. For example, Maharashtra has 25% of rural positions vacant, and Uttar Pradesh 40%. Overall, only 33% of doctors serve the 76%-80% of population in rural India (World Bank 2001).

Various policy initiatives have been tried to redress the imbalance of health care. There are some incentives (in the form of easier access to specialist training) for doctors to serve in rural areas for a period of 3 years, and some bonded undergraduate schemes. However, the cost of redeeming the bond is so low that few are honoured. An alternative strategy has been to deploy a different skill mix of health workers. There has been increased emphasis on the role of both male and female health workers, and on the training of community-based volunteer assistants, (paid an honorarium and known as anganwadi workers), (Gill 1998). Acknowledging the important role of indigenous Indian health systems of medicine by working more closely with APPs, and looking at possible partnership arrangements to increase participation in national programmes, giving them greater support and resources, are seen as some possible approaches to improving access to health care. This policy stance was strengthened by the creation of the Indian Systems of Medicine and Homeopathy (ISM&H) within the Ministry of Health and Family Welfare in 1995. Attempting to revitalise public ambulatory services across the board would require massive resources and is not considered a feasible proposition by some, (World bank 2001), particularly in the current climate of privatisation. Nevertheless, there is a vocal alliance in favour of attempting to redirect medical education and training in the public sector towards primary health care needs, and requiring a compulsory period of rural-based training and service to ensure delivery of the service (CHC 1999, Deodar 2001, Narayan 2001).

Hospitals

Government hospitals provide approximately 30% of secondary care, with free provision of treatment, medicines and wards. Within them there are also special wards, which attract a fee both for the accommodation and drugs. The non-government hospital sector has a strong presence, with 70-75% of hospital care delivered through private hospitals, with 20% of this via mission hospitals. The Christian Medical Association of India has 300 member mission hospitals, often serving populations in remote areas, and offering training for post-graduate family practice, as well as operating as centres of excellence in major specialties. Two outstanding examples are Christian Medical College (CMC) Vellore, and St. John's Roman Catholic Medical College, Bangalore. However, overall, there is a lack of people committed to working in the rural sector, attributed to a shift in medical ethics towards the commercialisation of health care.

"The group was aware of the changing scene in India, where in many cases the practice of medicine has become commercial, unethical, unjust, dishonest and unbecoming of a profession that has been traditionally interested in serving others" (Whitefield Statement Excerpts, 2001).

Other private hospitals, some with a medical school attached, may in theory have charitable or trust status, through having some of their income directed towards 'research'. Facilities in the best private corporate hospitals in major cities rival and in some cases exceed what is available in the West. The Apollo group, the market leader, and the first corporate for-profit health organisation in India, is an example where diagnostic facilities and intensive care beds and telemedicine conferencing facilities are second to none. Recent government and Supreme Court

rulings dictate that some capacity in private hospitals has to be allocated to patients receiving free or lower fee-for-service treatment, and allows universal rights of access to private accident and emergency departments in cases of trauma and accident, but there is no evidence of the latter being implemented as yet. However, the basic market position of these hospitals is as 'for profit' organisations. The sector is heavily segmented in favour of curative care for the rich, and has been expanding rapidly over the last decade. In-patient care for the poor is in public sector hospitals, where the conditions are over-crowded and under-resourced. Reportedly, there is public dissatisfaction and loss of confidence in public sector health services.

There are few constraints to entering the private market especially on a small ambulatory clinic basis, as there are no regulations related to numbers/population, and few infrastructure requirements for a clinic. Small hospitals, or Nursing Homes as they are often called, have been growing since the 1980's, and continue to expand. Running costs are relatively low and are met out of revenue, mainly fees. Both quality assurance and price controls are low. One interviewee described his family Nursing Home business:

A 100-bed hospital was opened as a family concern on the outskirts of Delhi. The father had been a GP in the UK (a locum possibly, as he worked in several different areas from Manchester to Norfolk), but now he is a 'cardiologist'. The mother works in obstetrics and gynaecology. The son has a first degree from Sheffield, and a diploma from the IIMR in hospital administration. The family saved and came back to India 10 years ago, and then bought what was still relatively cheap land on the outskirts of Delhi, but which has since soared in value as a result of the city's expansion. The lower middle classes, who have benefited financially from selling off some of their land, are the hospital's clients. They are willing to pay for health care. The area also has some drug and alcohol problems, partly the result of the population having large amounts of money from the property sell-offs. The staff members are mainly MBBS qualified with no specialty training, and are private practitioners who contract with the hospital for sessions e.g. 9-2pm etc. Some senior Residents are always on call, and 2 consultant cardio-vascular surgeons undertake contract work. The family is hoping to expand the business, and is looking to work towards an international quality standard of ISO 9000, which may bring business from areas of shortage abroad, and from the UK in particular.

Access to private sources of finance appears to be relatively easy with businesses financed either through personal savings or through private loans. Larger enterprises may benefit from tax breaks and duty exemptions, and even free land for hospital development, depending on the State. Some of the larger medical enterprises, hospital and medical school developments, are financed through diversification from cement and liquor empires.

Despite some attempts to bring greater equity to the private hospital sector through the fee structure, in general, there has been little government regulation of the private health market. There is general recognition that government needs to increase its oversight function in relation to quality assurance and regulation, but without creating an 'inspectorate raj' culture (World Bank 2001). The medical profession favours Quality Assurance through continuing medical education (CME), and professional associations are increasingly involved in delivering further training. There is a small but vocal alliance of 'ethical' groups of doctors and private individuals who seek to publicise cases of mal-practice and negligence in an attempt to raise the profile of accountability within the medical profession.

Medical Education

Undergraduate Medical Education

Officially, the number of medical colleges and the number of medical seats (places) are based on the population norm of 1:100: 5,000,000. In 1947 there were an estimated 25 Medical Colleges, with 1,983 students. By 1991 there were 146 Colleges with 16,200 students per annum. In 1996 the number of colleges was 162, and it is now estimated to be 184. The MCI estimate that

currently approximately 18,000 doctors graduate with MBBS each year (personal communication 2001), although this number must be set to grow, given the recent expansion in the number of medical colleges.

The actual number of medical colleges exceed the norms, partly because of the way power and decision making is shared between central government and the States and Universities. A State government may permit a new medical college or University course, or give leave to apply for permission to open a college by granting an 'essentiality' certificate. The basis of 'essentiality' might be provision for religious and linguistic minorities. In Karnataka a RC Christian, a Muslim, and a Tamil language based college were three recently successful applications. The application is considered by the MCI, which then makes a recommendation the Ministry of Health on the basis of an inspection. The criteria for approval are based on quality norms, and not on any notion of workforce planning. The criteria include: a minimum amount of land, (25 acres for a 50 seat college, and 50-60 acres for 100-150 seats); an attached teaching hospital with minimum of 5 beds per MBBS student entry, so a 500-bed hospital for 100 seats; and a specified number and type of Faculty members and workforce. A large bond has to be deposited with the Government, returnable after the first graduates finish their course, and the College has therefore successfully delivered on its promises. An MCI inspection then makes a recommendation to the Ministry of Health, which then moves the College from 'approved' to 'recognised' status. Students enrolling at the 'approved' stage may be risking their qualification not being recognised, if the college fails to make the transition, as is sometimes the case.

According to two central government Reports (Shrivastave 1975 and Bajaj 1994) the need was to concentrate on quality improvements, and the Annual Report of the Ministry of Health and Family Welfare 1993/4 showed that 26 of the 146 colleges were not recognised by the MCI because of a shortfall in quality standards. In 1996 the MCI position was that no more colleges were needed, except perhaps in States without any, and this has been reiterated in various press articles. Nevertheless, there is unchecked growth in the number of Colleges. Up until 1974 expansion was mainly in government provision, but there have been no new government colleges since then. There followed a plateau in terms of expansion until 1985. Since then, expansion has been in the private sector, mushrooming particularly since 1993 in the new climate of liberalisation. In 1947, only 5% of Colleges were in the private sector. By 1994 this had risen to 30% of colleges, and now the figure is 39%. According to 1993 data, the States with the largest number of Colleges were Maharashtra, with 30 (an excess of 14 over entitlement, Tamil Nadu and Pondicherry, with 15 (an excess of 4 over entitlement), and Karnataka, with 19 (an excess of 10 over entitlement). Karnataka had the highest percentage of private Colleges, 78.9%, as well as the largest admission ratios. More recent data for Karnataka show that there are now 21 medical colleges. Moreover, recently in 1999, 20 out of 60 applications to the State to open new colleges were given 'essentiality certificates' (Community Health Cell, 1999). Recently, in an attempt to bring common standards to the many medical colleges in Karnataka, a core curriculum has been developed under Rajiv Gandhi University, Bangalore the overarching Body for Medical Education in the State.

There seems to be no shortage of applicants either. All the colleges are selective, mostly on the basis of performance in their own entrance examination. These mechanisms have allowed an expansion of medical education in response to high demand from potential students and their parents.

All government medical schools must have a percentage of seats reserved for 'scheduled castes', 'scheduled tribes' and 'other backward' groups, with positive discrimination for them in terms of the marks required for success in the highly competitive entrance examination.

Postgraduate Medical Education

There is intense competition for postgraduate training seats, in virtually all disciplines, given the severe bottleneck in terms of their availability in relation to the number of MBBS qualified candidates. The numbers of seats for Master of Surgery (MS) or Doctor of Medicine

(MD) places are allocated to each teaching hospital, and it is estimated that only 12-15% of graduates can progress to higher training for the MS/MD qualification, or for the alternative Diploma of the National Board. Places are also limited for local 2-year Diploma courses, with a lower level of training. This should not be confused with the new National Board Diploma, which is of a high standard, with a guaranteed quality across India as a result of rigorous quality controls and monitoring. The number of institutions able to offer the NBD is limited, as are the number of trainees recruited. However, trainees who have received their MS/MD might also opt to take the National Diploma, particularly if their qualification is not from one of the renowned premier medical schools. The purpose behind the establishment of the Board is to enable an assurance of the standard across India, in contrast with the variation in the quality of other medical school qualifications. It is hoped that the consistent quality will also send out a message to the international medical world of an assurance of quality.

Allocation of places for the 3-year MS/MD training programmes, is through competitive examination, within each institution, with candidates ranked according to their scores. In rank order they may then choose their preferred specialty, at an open meeting of faculty and students, known as 'counselling'. I observed one such session at Pondicherry. All available training slots are displayed on a chart, and candidates come to the front as their name is called, and select their preference. In some cases, if this is no longer an available option, candidates may choose to be wait-listed, in the hope that someone ahead of them might be selected, and choose in preference, training at another institution. Alternatively, they may choose another specialty. Certain seats are reserved for scheduled tribes and castes, and for those who have worked in an underserved rural area for 3 years, so candidates from these categories may be able to access postgraduate training with lower grades.

Achieving an MS/MD/DNB qualification is essential for specialist work in an Indian hospital, but requires a further 3 years of supervised practice to progress to a medical school teaching position.

3.Domestic Supply and Demand

In the private hospital sector, the biggest demand is in cardio-thoracic work, and therefore for cardiologists and cardiac surgeons. There are 'state of the art' private hospitals dedicated to this specialty, as well as dedicated wards and intensive care units (ICUs) with impressive facilities in multi-specialty hospitals. Even smaller nursing homes are working in this area. In the boxed example on page 9, the management is planning to expand the cardio-thoracic surgeon workforce from 2 to 4. Our hospital interviewees indicated that there is also demand for sub-specialties where there are few highly trained specialists. For example, there is a lack of expertise and available facilities in transplant surgery, but these are set to grow. Demand is increasing for radiologists, as cancer becomes an increasing cause of morbidity. Histopathologists are similarly starting to be in greater demand, as cancer treatment becomes a new focus. The field of oncology has not been a well-developed stream until recently, but is now growing. The effect of the Consumer Protection Act (1990's) was mentioned in this context, as patients become more litigation-aware, so diagnosis and treatment systems need to be state-of-the-art. Anaesthetists are especially in short supply as this specialty also takes care of ICUs, and is present in theatre across all specialty operations.

In the primary care sector, there is a shortage of doctors to work in the public sector in rural areas, as detailed earlier. In contrast, the private primary care market is saturated with small single-handed practices functioning in competition with alternative practitioners and quacks. Opportunities for doctors without any specialist training are limited and poorly paid in both private and public hospitals. Doctors might mark time in these positions whilst trying to obtain a post-graduate seat. These are the only domestic markets open to doctors holding only the basic MBBS qualification.

Given the limited opportunities for postgraduate training, there are therefore strong drivers to emigration to gain qualifications and experience. We asked our focus group members about their preferred destinations. The destination regarded as the most attractive, number one choice of destination for doctors from India, is definitely the US. The reasons for this were a mixture of lifestyle choices and professional opportunities.

Opportunities for high earnings featured strongly, for example: *"It's a free market in the US...it's totally open, and pay is definitely better when compared to UK."* However, money was also a factor in migration to the UK, for instance: *"I'm planning to go to UK just to earn some quick money."* *"Six months down the line, if you are working in the UK, you can dream of, you can think of buying a car, which is impossible here if I work for 10 more years."* High earnings also enable money either to be sent back home, or savings to be made to return home at some stage. Those hoping to migrate to the US tended to see their move as a permanent intention to migrate, rather than a shorter-term training opportunity.

"Well, basically in India there's a craze for all things foreign. Since any person who goes abroad and comes back, it will be a very attractive thing on his CV. That's one reason. In India, since we are not allowed to emigrate to the UK, we can only work for a limited period, for 5 or 6 years. The visa is time bound and you cannot extend it. So that's one thing. People who go to the US are generally those who intend to stay there. I agree it may be a very miniscule percentage comes back and returns to India. That's one factor, whether you're interested in settling abroad, or whether you want to come back. So that's one thing UK says to us, I mean as far as I read it. Apart from that, I think opportunities, I mean experience –wise and exposure-wise, will be the same. And as for workload, after having worked in PGI, I think you can handle the workload in any other place. That's, we do have quite good experience working here."

There was a dissenting voice with a negative view of the US: *"The US, because of the Visa problems, and because of the world scenario regarding peace and this war, and terrorism and all, I'm not much interested in going to US."*

Although the US was ranked more highly than the UK, most of those participating in discussions intended to move to the UK, either as a strategic stepping stone to the US, or as a more realistic alternative to achieving their training/professional goals. The main reason for choosing the UK was the relative ease of entry, particularly obtaining a visa. Several doctors had taken Parts 1 and 2 of USMLE, and then applied for a visa to the States to take the Clinical exam in Philadelphia, only to be refused. Obtaining a UK visa, and applying for a US visa from the UK was thought to be more feasible. An alternative strategy was to apply to the US as a student. I met three doctors who were applying to Universities to undertake PhD studies, two in public health (seen as a growing field), and one in physiology (the reason given that a deeper understanding was relevant to anaesthesiology). If they were accepted, their programme could be undertaken on a student visa, which was easier to obtain.

Most of the junior doctors had decided to try to go to the UK, perhaps as second choice, but nevertheless as a positive option. Typical comments were: *"It's been my dream."*; and *"I'll be better accepted than what I am today here, and getting the FRCA exam is really worth...you are recognised world wide."* An added pull for the UK was that for some specialties, their MD/MS degree allowed them exemption from Part 1 of membership examinations, or they may have been able to take Part 1 in India. In fact, the FRCA Primary has to be taken in the UK, and only after several months of training. Whilst some doctors seemed to know the detail of the relevant Royal College examination systems, others were puzzled that different colleges had different rules. Why weren't they standardised?

The focus groups in India were held with doctors who had already obtained a post-graduate qualification (mainly in anaesthesiology, but there were also other specialties represented).

Their goal was to study for FRCA, which they thought would take 3 to 4 years. They had already completed 3 years leading to MD (as a Junior registrar), and many had also completed, or were part way through, 3 further years of intensive postgraduate training and experience as a senior registrar, with a great deal of independent management of their case load. One of the issues for these doctors was that leaving for the UK (or the US) at this stage might compromise their chances of an academic post back in India in the future. (The MD, + 3 years' postgraduate experience, are pre-requisites for consultant or professorial work). Being able to move quickly to higher specialist training, or sub-specialty training would make moving to the UK worthwhile, but spending a long time as an SHO would not.

"One question is there, which is probably limiting me going to UK is one thing. Because I am completing my senior residency over here, it's kind of three years intensive training post MD... So if I go to UK now, I'll be joining there as SHO, so it would seem out of place for my experience, and the research work I've put in."

Concern was expressed that they might have to move out of their preferred area of specialisation (such as cardiac anaesthesia) into, say, pain relief. A related concern was that their experience would not be taken into consideration. However, it was more likely to be considered in the UK than in the US, where having to go right back to undertaking a Residency programme, definitely meant that your experience counted for nothing

Feedback from friends in the UK confirmed that they were not getting the experience they had hoped for. For example:

"Actually, most of my friends share the same thoughts, almost all of them want to return. One or two of them are in anaesthesia, they are finished from this place, and from all I've heard from them, the caseload probably is much more here...some of them do feel a bit disappointed that they've gone there and they're not getting an active hand in managing patients. And also because the caseload is pretty low there."

On the other hand, strong links between the UK and JIPMER in Pondicherry meant that there had been a good number of doctors going to the UK for the past few years, and many had obtained a Type 1 (or Type 11) training after a year as an SHO, during which time they had taken Part 1 FRCA. In this way, they had benefited from the ODTS scheme. Other friends who had gone to the UK to do paediatrics, general medicine, general surgery, or orthopaedics, *"they have to stay for quite some time to get a job. Even if they get a job, they don't get it for a long time. They just get it for three months or so."* The experience of consultants was that their trainees, particularly in surgical specialties, had a difficult time accessing training in the UK, *"So in fact some of them have returned because they couldn't get a placement."*

Although most wanted to return to India, one paediatrician, with several years' post-MD experience as a senior registrar, felt that the lure of better facilities would make it unlikely he would return: *"If I were to go to UK, I will never come back. That's one thing I'm very, very sure about. Because whatever I learn, I cannot practise in India because of the basic lack of facilities."*

Most doctors in India do not have access to the best facilities of the good corporate or private hospitals. There is as yet little insurance for health care, and the government only funds emergency surgery, not elective surgery. All this means that the pull back to India, for professional reasons, is weak. Others disagreed, and felt that corporate hospitals would follow the lead of the latest that was available in the West, when they had doctors trained in the techniques. There was a demand for advanced techniques, such as patient controlled analgesia, which one anaesthetist wanted to study in the UK. Consultants in Chennai agreed that, with the growth over the last 15 years of corporate hospitals, *"if you've been trained abroad, most of the centres take you straightaway as a consultant."*

Going abroad post-MD was seen as the best time, before, *“you get married sometime. So if you miss this time to study and also at the same time visit abroad, visit foreign lands and then come back here. You might not get a second opportunity in your life really...I would go as a bachelor and come back, and by then I should have acquired all the extra skills, learning about different people, getting to know their culture and then getting to know their work there...how they conduct anaesthesia. And in addition to that you get your degree and money also. So I find it very productive if I can go at this stage and come back here.”*

Pull factors back to India were mainly seen as family ties. For instance:

“My parents and I’ve got a proper, like we’ve got a complete house and the whole works in my home town. And so I am more comfortable here. I’d only be going there for the purpose of obtaining the degree.”

The desire to bring children up in the Indian culture, once they reached teenage years especially, is a strong pull back:

“Most of them will get adjusted to the Western culture. But they don’t want their children to be Westernised. They will not accept that. That is the sole reason why most of them will come back after say 10 years, when the children are getting a little older...in that situation they don’t want their children to back answer them, because that is not our culture. They feel that our children should be like what we had been to our parents.”

Most of the doctors hoping to access training in the UK were content to accept the framework of rules, through which they had to operate. After all, there were rules and regulations operated by the different States in India. For example, Tamil Nadu had requirements that you were a Tamil speaker, and a resident, before you could access postgraduate training. Nevertheless, some raised questions related to perceived unfairness in the UK entry and training systems included the following items:

- The perceived unfairness of having to take IELTS, when EEA doctors who didn’t speak English, were exempt;
- The lack of recognition of MD/MS training.

On the other hand the opportunity to take Part 1 Membership (of the RCS) was welcomed by consultants:

“That’s a big relief, because at least half the students who go there, they go there only for qualification. They don’t go there for training. Training is OK, you can get it. But otherwise, that is they’re settled with qualification. They can get it here. The ordeal of going there and finding a placement and sustaining yourself...so it’s a welcome feature.”

Many of the candidates for the UK PLAB examination are at this post-MBBS stage. There was evidence from focus groups of junior doctors and from informal conversations with PLAB candidates as they exited the exam in Chennai, that this was a high stakes examination for them, both in terms of the effort and the finance involved, as it represented their only realistic opportunity to obtain the postgraduate training they desired. Some, with anxious parents waiting as they finished, carried the aspirations of their family on their shoulders. One candidate had specifically chosen the PLAB route as the best opportunity to access surgical training. This was unrealistic within India, because his scores were not high enough to gain a postgraduate seat. The UK was viewed as an easier option than the States, partly because family medical connections could virtually guarantee a clinical attachment following success in PLAB. Candidates at this post MBBS stage, who have not obtained a post-graduate training place in India, are not the most able of the candidates, but the over-production of

doctors does not necessarily mean that they are not competent. However, other candidates have completed an MD/MS or diploma course, and are seeking entry through the PLAB route because they have been advised that the ODTS/sponsorship route is a difficult and lengthy process. They enter the UK with the equivalent training, experience and qualifications to an SHO who has obtained parts 1 & 2 of Membership examinations. Their immediate goal is to undertake SHO rotations (maximum time allowed is 4 years) and pass Membership, which will be viewed as an exit qualification by reputation in India. FRCS has a high standing, but whether the new replacement with MRCS will command the same respect is unknown. Some may stay to take higher specialist training, but the numbers of Overseas Trained Doctors (ODTs) obtaining Type 1 training numbers is relatively small. Opportunities for Type 2 training positions are set to reduce, as the training capacity will increasingly be used for the larger numbers of UK graduates. Most of the junior doctors, who participated in focus group discussions in India, do not have a longer-term strategy in mind at the stage of taking PLAB, but have a range of possible options open. Gaining MS/MD first in India is an insurance policy, as it is the only post-graduate qualification officially recognised in India, (since the government de-recognised overseas qualifications, such as UK ones in retaliation for the UK adopting the same measures). Not only is MD/MS required for practise in any public hospital, it would also be required for private hospital work, otherwise, in a litigation case, the court could find against a doctor who had not been 'properly trained'.

Numbers taking PLAB have grown dramatically over the last 2 years, almost doubling from Indian centres from 1044 in 1999 to 1851 in 2001. This may be because of increasing numbers of graduates from the growing number of private medical schools, or partly because of higher barriers to entry into the USA. The United States Medical Licensing Examination (USMLE) has become more accessible in the first two parts, which can now be taken on-line at several centres in India at virtually any pre-arranged time. Until recently candidates had to fly to Singapore to sit the papers. However, the 3rd part, the Clinical Skills Assessment (CSA) is new, and can only be taken at the Philadelphia headquarters, with significant cost implications. There are also stories of candidates who have passed the first two parts being refused entry visas to take the third. Once past the entry barriers, however, obtaining a Residency position through the 'Match' is possible, especially in hospitals in poorer urban areas or in certain rural geographical areas, and in less popular specialties. Some Residency Directors are said to prefer Foreign Medical Graduates (FMGs), as they are better qualified and willing to undertake more tasks. (US Int 3), and it is reported that a former AMA President considered 20% of FMGs to be superior to US graduates (US Int 4). Certain specialty areas are undersupplied, such as psychiatry, radiology, pathology, anaesthesiology, and accident and emergency (A&E). Some FMGs change from their first preference in order to stay in the States. Others may start with a Residency in a shortage, less desirable specialty, such as immunology or rheumatology, which includes more general training, and use it as a basis to later move into general internal medicine. Completion of a 4 year Residency programme confers specialist status, and is therefore seen as a better and shorter, if more intensive, option than the UK regime. Although some FMGs experience difficulty in accessing a Residency program, there is no reported unemployment of post-Residency FMGs. Currently about 4,000-5,000 Residency slots a year are filled by FMGs (and about 6,000 apply per year). This represents around a fifth of all available positions. The largest supply country is India, followed by the Philippines and Pakistan.

There did not appear to be any pressures within India, which would be likely to alter the 'push' out factors in the near to medium term. It is unlikely that the balance of pull factors, between the US and the UK will alter to the detriment of the UK. The visa restrictions are unlikely to be lifted in the US in the near future. The UK appears therefore to be in a relatively strong position in relation to the US, by default – not particularly because of its own strengths, but because the US has raised its barriers. Australia and Canada and other possible destinations are not considered as attractive as the UK, mainly because there are not the same links. There are still strong links between consultants in the UK and India, and

patterns of facilitating entry into the UK, through the presence of friends who have gone before. Nevertheless, the situation is not a cause for complacency. As more Indians settle in other competitor countries, the possibilities of chain migration increase.

4. Position in Respect of UK Requirements

The UK has the advantage of strong historical ties with India in the market for attracting doctors. The ties include a tradition since 1960s of doctor migration to the UK, so that many current students and junior doctors have role models with positive impressions of the UK. The medical training system and curriculum are strongly based on the UK system and are taught in English. New developments, such as the introduction of the OSCE and reforms to specialist training and assessment mirror UK developments. Strong links exist with some of the Royal Colleges, with the Royal College of Surgeons of Edinburgh having Chapters in India. This is particularly true of the regions around Chennai (Madras) and Calcutta. (The joke told to me was that the British left India and left behind the Bengalis!) It is now possible for specialist doctors in training to sit both part 1&2 of the MRCS (Edin) in various centres, including Chennai, and examiners go out from the UK to supervise/moderate examinations, and also to deliver training. These examinations are viewed as a Gold Standard and there is a strong market for them.

Many of the doctors I met had been steeped in British culture before they went to the UK, from Enid Blyton books to tea and scones, they were Anglophiles, and longed to witness it first-hand. Inevitably they faced cultural adjustments on arrival, which were eased financially and socially by the support of friends or relatives who had gone ahead of them - chain migration. Many had experiences of racial intolerance or prejudice from patients or colleagues. These ranged from innocent remarks from a 3 year old, 'Mummy, why do all doctors come brown?' (from a child in Barnsley), to resentment from a UK graduate at the promotion of an Indian to a Senior Registrar position (in Belfast). One had failed Part 1 of MRCP, and thought that the difficult viva was down to prejudicial treatment. He later changed his mind after reflection and discussion with a senior colleague, and decided that deeper probing of his knowledge was justified, given that the examiner had no knowledge of his background training. All of these doctors, from different hospitals and quite independently said that these events 'were only natural'. They could similarly be expected if a foreign doctor came to work in India. These cultural difficulties were minimised and rationalised by doctors who had successfully made the transition back to India into senior specialist positions. One said of his experiences in England, *"the grass is greener, but you've got to put up with the rain!"* (Ind Int 17)

All the doctors I met had some very positive experiences of aspects of their training in the UK. These included discernment in diagnostic skills (being taught to focus on the most likely causes of illness, rather than knowing the whole textbook range); and practice in clinical skills (the one best way rather than a range of possible ways). One doctor said he '*learnt wisdom*'. He arrived with a great deal of textbook knowledge, even including sub-specialty level, necessary to pass MD in India. He had also had a great deal of clinical experience and was initially dissatisfied at having to do the things he had already been doing back home. But he learned and re-learned, and became more 'clear-thinking'. He also learned new skills: in dealing with patients (in contrast to the deference and ignorance of patients in India) and in contrast to the deference/reverence to seniors which had been expected of him during his time in medical school in India.

What these experiences show is that in general terms of culture and education, India provides a relatively good fit for UK workforce requirements, although some adjustments are necessary when doctors arrive in the UK. Qualifications, which appear very similar, also have some important differences of emphasis. Language is also an issue. All doctors now entering the UK must first have passed the International English Language Testing System

(IELTS) at level 7 or above. Although all the junior doctors I spoke to had already passed this test, I noticed a difference between those doctors who were hoping to go for the first time, and those who had already been to England, in terms of fluency and intonation. Sometimes the music of the language was difficult to understand, especially when spoken quickly. My ear attuned after a while, but tape transcribers back in England found difficulty in understanding some taped interviews. There are indications of the importance of induction programmes for all OTDs coming to the UK for the first time to training positions. Sub-Deans, with responsibility for OTDs, are now providing such courses (for the last couple of years). The length and content could be evaluated for appropriateness and effectiveness in facilitating adaptation.

The virtual demise of the Overseas Doctors Training Scheme, a scheme avoiding PLAB and allowing faster access to higher specialist training posts, will curtail entry into shortage specialty areas at that level. Taking the case of anaesthetics, I met several MD (Anaesthetics)-qualified doctors, some with virtually the 3 full years of post-MD supervised experience necessary to apply for consultant posts, who wanted to come to the UK. Notwithstanding the need for induction, there is a wealth of experience of specialists from India's premier post-graduate institutes, who want to come to the UK, which is not being tapped. To go right back to early SHO posts, other than for a short period of induction, is not the best use of human resources. I was given to understand, by Office Bearers of State and National specialty Colleges, that negotiations are taking place between the RC Surgeons of Edinburgh (and possibly other Royal Colleges) to move towards mutual recognition of some post-graduate qualifications. Could this provide a means of entry at a higher level? These consultants are certainly in the market for training doctors to provide for UK requirements.

At the same time there are current debates within the UK about the possibility of lowering the requirements for entry onto the Specialist Register, to bring the UK more in line with the rest of the EU/EEA. Many EU specialist qualifications are obtained after 4 or 5 years training post-House Officer/Intern year, when in the UK it might be 4/5/6 years post SHO basic training. Such a change would also be more comparable to the US Residency training period. Higher specialist (sub-specialty) training could then follow. The move would in effect create different levels of specialists/consultant, generalists and sub-specialists. There would be more training numbers for the former than the latter. The Specialist Training Authority is in favour of the move, as are several of the Royal Colleges (with the notable exception of the Royal College of Surgeons of London), but the BMA is opposed to the change. Proposed reforms to the SHO grade, which will involve more structured training programmes rather than rotations, could be made to dovetail into the change. It is also likely that time in the SHO grade will be limited, to stop people remaining there in the hope of obtaining their chosen higher specialty training. They would either have to move into a career grade at that level, or into another specialty, with credit given for relevant prior learning/experience.

In the short-term, these reforms would enable the deployment of well-qualified OTDs, from India and elsewhere, to move more easily towards positions appropriate to their training, experience and qualifications. However, there would still be barriers to employment in the most senior/ sub-specialty consultant posts through the limitation of training numbers. In the longer term, it is anticipated that the availability of current-style Type 2 specialist training will diminish or disappear, as the training capacity is absorbed by the larger numbers of Type 1 positions required for a consultant delivered service. The larger number of UK graduates now feeding through the system is anticipated to fill the SHO and specialist training capacity.

One other anticipated change to the legislation will allow easier access to the Specialist Register. Currently, an OTD's post-graduate qualifications are assessed for equivalence with UK qualifications. Where they fall short in some specific area, only experience gained abroad can be counted towards filling the gap. In other words, qualifications and experience have to be all UK based, or all overseas based, but not a mixture. Addressing this anomaly

will enable some OTDs who have accumulated training (but not experience) in training positions in the UK to qualify for the Specialist Register. The opportunity to enter the Specialist Register in this way might attract some doctors back to the UK who have returned to India to senior positions.

5. Competitor Country Analysis

Competitor countries can be viewed either as ‘buyers’ of doctors, or as ‘sellers’ of qualifications and job opportunities. The main buyers in the market for doctors who already have specialist training and qualifications, have been the Middle East countries, which lacked the infrastructure for medical training but had the economic resources to build hospitals from their oil exports. Doctors with specialist qualifications can earn high incomes, and that is the main motivation for going. Senior doctors in public sector hospitals and teaching hospitals, who may not be allowed to undertake work in the private sector, (variable by State), are allowed to take leave of absence, and they go to Kuwait, or Saudi Arabia to augment their relatively poor income, sometimes for several years, and sometimes for a short period annually. In addition, Kuwait has a Government-to-Government agreement with India, which includes the recruitment of doctors and nurses.

Competitor countries as sellers of qualifications are rated by what those qualifications themselves will buy. Within India, qualifications from abroad are still considered better than just an MD/MS from India, and are an attraction to clients and private hospitals, and therefore to doctors. From an employer’s perspective, the MRCP/FRCS still has a good reputation. Experience gained in well-known UK centres of excellence is highly regarded, but experience in some district general hospitals was rated no more highly than Indian experience. The best UK training is on a par with US training and qualifications, although Residents in the US are considered to have more ‘hands-on exposure’ to clinical cases, partly because of the typical 80 hour working week. This preference for US training may increase with the introduction of the EU Working Time Directive, which will reduce the amount of hours spent in training each week in the UK. The US system in general is looked on more favourably than the UK’s mainly because of the bad press that the UK NHS has in India. From an individual doctor’s perspective, the US system of training presents more opportunities to stay in the country long-term with more open access to senior posts and more opportunities for private practice. The USA is therefore the preferred destination, followed by the UK. More recently Australia and New Zealand have become destinations, possibly following some UK training.

Could India itself become a competitor on the international playing field for specialist level doctors? There are increasing signs that Indian doctors trained in the UK to a high level are deciding to return to India, mainly to enter the private hospital sector. These include CCST holders and consultants already on the Specialist Register who have held substantial posts, and not just doctors who have been unable to progress beyond staff grade posts. The decision to return is usually based around a number of factors, such as the desire for children to be brought up in the context of their traditional culture, near to relatives, as well as life-style and status issues. Doctors have high status and respect, and are mostly still able to practise medicine without fear of litigation. They are also able to afford a life-style with servants unheard of in the UK. Doctors at this level had turned down offers of posts in regions of the UK with recruitment difficulties, such as South Wales and the North East. Although some had been worried about re-entry into Indian society after a long absence, (being away for more than 4/5 years was thought to present difficulties) they had all found the transition easier than they had anticipated. Doctors returning to the public sector are more rare, but I did meet a highly qualified consultant who had returned specifically to a top post at the Tata Memorial hospital in Mumbai, the premier tertiary cancer hospital in India. This post held research opportunities internationally, which were, however, likely to be pursued in the USA, despite his existing links with the UK. Other doctors from the missionary hospital sector also had specific training requirements to fulfil in the UK before returning home. The doctors (anaesthetists and surgeons) I met in the Hinduja private hospital in Mumbai had nearly all spent at least some time in the UK, either longer-term (the

longest was for 13 years, and had been a general internist consultant surgeon), or short-term for sub-specialty skills/techniques training. Some returned to the UK annually, typically for a month, for lucrative locum work via recruitment agencies. Their own private work with private patients could be structured around this regime.

Could India enter a substitute international market offering packages for hospital in-patient treatment? With reports of long waiting lists and low capacity in the UK, the talk is that people might be flown out to India's best private hospitals for operations, with India becoming an International Hub for health care, (in the way that Singapore has been for e.g. Diplomats/Wealthy in Bangladesh in the past). It is claimed that India is already a hub for S.E. Asia, and is becoming so for the Middle East, as people have general confidence in the private healthcare market.

6. Summary View

In the foreseeable future, the UK will have no difficulty in recruiting doctors with their basic MBBS qualification to SHO training positions. Demand for these posts from ODTs already exceeds supply, especially for popular specialties like surgery. Supply from the UK is also set to increase as the impact of the higher number of medical school places is felt. Currently the UK in effect retrain many doctors with MD/MS post-graduate qualifications, sometimes unnecessarily. The experience of one consultant who recruits from India into anaesthetics is that a short period of acclimatisation in an SHO post is all that is required before moving a well-qualified and experienced doctor into a Specialist Registrar post. The key to success is through personal contacts and links with premier institutes and medical colleges. In specialties with a shortfall in trainees, this is a possible route for recruitment.

The expanding private hospital sector in India has created opportunities for specialist consultants, many having undertaken training in the UK. Some of them continue to work for periods abroad, both in the UK and the Middle East. Establishing contacts through research and skills training could be an important way to develop mutually beneficial links.

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