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BRIEFING PAPER

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Medical school places in England from September 2018

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The issue

There are concerns that the number of medical school entrants may be insufficient to meet future workforce need. Medical education continues well beyond medical school, and there are also concerns about whether the right numbers of postgraduates are being trained in the right specialties.

The policy response

In October 2016, Health Secretary, Jeremy Hunt committed to an extra 1,500 medical school places, beginning in September 2018. In return for the increased number of places, he said that new doctors would be required to work in the NHS for four years. The Government is due to consult on its plans in 2017.

Bodies representing the medical profession have welcomed the move to increase the number of medical school places, but have also argued this will not address current workforce pressures; the new recruits will take at least 10 years to fully qualify as GPs, and longer to qualify as hospital specialists.

Admission to medical school

Entry to medical school is very competitive and institutions typically require very high 'A' Level (or equivalent) grades, as well as adequate performance on special medical admissions tests. There have been longstanding concerns that medicine, as a subject, remains particularly skewed toward more socio-economically advantaged entrants, and that latent capacity is being left untapped, despite initiatives to diversify student intakes.

This briefing paper relates to England.

1. Background – medical training pathway and how places are commissioned

1.1 What is the training pathway for doctors in England?

The flowchart below provides a simplified overview of the medical school training pathway in England:

Medical degree

4 to 6 years, depending on course, entry type, and other factors

Foundation Years 1 and 2

2 years: In a clinical setting, with rotations in different specialties

Specialty training

Usually between 3 and 8 years, depending on specialty and training pathway

Ongoing continuing professional development

1.2 How are trainee places currently commissioned?

The Higher Education Funding Council for England (HEFCE) website explains:

> The training of doctors, dentists and other healthcare professionals is carried out as a partnership between HEFCE, higher education institutions and the Department of Health (DH). We have a key role to play by allocating funding for education, training and research in health-related subjects.
>
> […]

> **HEFCE's role in funding medical and dental education and training**
>
> Undergraduate medical and dental training […] is jointly funded by HEFCE and the NHS along with the fees that institutions charge. Our funding takes the form of a grant allocated as part of our annual funding allocations to each university.
>
> We calculate these grants according to the number of medical and dental students in each medical and dental school, and are regulated by the target intake.[1]

Whereas grant funding for lower-cost classroom-based courses has largely been replaced by income from tuition fees, high cost subjects such as medicine still attract HEFCE grant funding to supplement their income from fees, as indicated above.

Currently, medical schools have target intakes – i.e., the number of students they can recruit up to. Targets are included as conditions of funding in institutions' funding agreements with HEFCE.[2]

HEFCE explains what can happen if an institution exceeds its intake target:

> Institutions must not exceed their intake targets: we may reduce grant if they do so in two successive years. We also do not count students recruited in excess of the medical or dental intake targets towards our funding of high-cost subjects.[3]

Health Education England (HEE) is responsible for overseeing and planning the education of the healthcare workforce, including undergraduate and postgraduate medical education. Its latest workforce plan is for 2016-17:

> Link to Health Education England's Workforce Plan 2016-17

1.3 Sector concerns about number of trainee doctors

Organisations representing doctors have voiced concern that too few doctors are being trained to meet future workforce needs, with particular concerns being raised about postgraduate medical training from the foundation years onward, i.e. after completion of medical school.

In a report published in September 2016,[4] the Royal College of Physicians argued that:

- The UK did not currently train enough doctors to meet demand.
- There were fewer medical students in 2016 than in 2010, despite there being more patients.

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1 HEFCE policy guide, 'Healthcare, medical and dental education and research', updated 21 August 2015. (All links last accessed 6 March 2017 unless otherwise stated)
2 HEFCE, Guide to funding 2016-17. How HEFCE allocates its funds, May 2016.
3 *Ibid.,* p34
4 Royal College of Physicians, 'Underfunded, under-doctored, overstretched: The NHS in 2016', 21 September 2016.

- The number of medical students pursuing specialty training after core medical training had also decreased.

The report called for medical training across the system and stressed the need for a "coherent plan" to increase the number of medical training places from medical school onward.[5]

How has the number of medical student places changed over time?

In 2015-16 HEFCE's target intake for medical students was 6,071. This covers home and overseas students at English institutions.[6] Actual confirmed intake was 5,880; 88% of whom were normally resident in the UK and on home fees. The intake was around 6,200 in 2012-13 and 6,000 in both 2013-14 and 2014-15.[7] The number of Foundation 1 places across the UK filled at the start of the academic year increased from 7,200 in 2009/10 to 7,755 in 2013/14 before falling to 7,554 in 2014/15. Foundation 2 places filled increased across the whole of this period from 7,323 in 2009/10 to 7,817 in 2014/15.[8]

Data from the King's Fund included in The Future is Now report gives a longer term perspective on UK medical school intake. This shows relatively rapid growth in the late 1990s and early part of this century, from below 5,000 per year to more than 7,500, before levelling off in the period to 2010.[9]

5 Royal College of Physicians, 'Underfunded, under-doctored, overstretched: The NHS in 2016', 21 September 2016, p5
6 HEFCE policy guide, 'Healthcare, medical and dental education and research', updated 21 August 2015
7 HEFCE, Medical and dental students (MDS) survey data.
8 NHS Foundation Programme Annual Reports
9 The King's Fund, 'Future Trends: Medical workforce', undated.

2. The policy response

Developments under the Coalition Government

In 2012 HEFCE and the DH commissioned a review to see whether the levels of medical and dental student intakes were in line (as far as was possible) with predicted future workforce requirements. The Review analysed data from workforce modelling which was developed by the Centre for Workforce Intelligence (CfWI). The report of the evaluation – The Health and Education National Strategic Exchange (HENSE), Review of Medical and Dental School Intakes in England was published in December 2012. The Review Group's recommendations included the following:

- Recommendation 4

A rolling cycle of reviews of medical and dental student intakes should be established; to be undertaken every three years (not necessarily concurrently).

- Recommendation 5

There should be a 2% reduction in medical school intakes, to be introduced with the 2013 intake – and this level should be adhered to until further decisions to change.

- Recommendation 6

There should be a further review of medical school intakes in 2014 (for 2015 intakes) – followed by a 3 year rolling programme of further reviews.[10]

Medical school intakes were subsequently reduced in line with these recommendations.

The Medical Schools Council's Annual Review 2012/13 was critical of the basis for the cut in places:

> **Student numbers**
>
> Concern over the number of F1 posts has led to heightened focus on student numbers entering year 1 of the medical degree programme. The Medical Schools Council has worked with HEFCE to clarify the guidance on recording new intakes. Members in England are not convinced that the data, on which the decision to impose a 2% cut for 2012 student intake numbers was taken, were robust. More work needs to be done to model the required future medical workforce and thus the required output from UK medical schools.[11]

In 2015 the Government removed the cap on student numbers from most full-time undergraduate courses, but medicine and dentistry were excluded from this change. This restriction was kept because medical

[10] HEFCE/ DH, The Health and Education National Strategic Exchange (HENSE) Review of Medical and Dental School Intakes in England, 2012, pp6-7
[11] Medical Schools Council, Annual review 2012/13, July 2013, p.8

courses cost much more to deliver than the current receipts from home student tuition fees.[12]

October 2016 – Conservative Government announces up to 1,500 additional medical school places beginning September 2018

In his speech to the Conservative Party annual conference in October 2016, Health Secretary Jeremy Hunt announced that the Government would commission up to 1,500 extra medical school places starting from 2018. He said this would increase the number of available medical student places by a quarter.[13]

In return, the Government would "ask all new doctors to work for the NHS for four years, just as army recruits are asked to after their training." [14]

Mr. Hunt questioned whether it was right to continue to import doctors "from poorer countries that need them, whilst we turn away bright home graduates desperate to study medicine":

> Even if we wanted to carry on importing doctors, the supply is drying up. The World Health Organisation says there's a global shortage of over 2 million doctors - we're not the only country with an ageing population.[15]

By the end of the next Parliament, he said, the NHS would be self-sufficient in doctors.

A PQ of 20 January 2017 asked about financial support for medical students and the plans to increase the number of places. In response, Health Minister Philip Dunne MP confirmed that a consultation would be held in early 2017:

> **Asked by**: Dr Sarah Wollaston
>
> To ask the Secretary of State for Health, with reference to his announcement of 4 October 2016, that up to 1,500 extra medical training places will be made available from September 2018, whether those additional students will be supported by the same (a) undergraduate fee and (b) Higher Education Funding Council for England banding payments as existing medical students.
>
> **Answered by:** Mr Philip Dunne
>
> National Health Service providers will receive clinical placement funding for the minimum number of students that Health Education England forecast are required to meet the longer-term workforce needs of the NHS.
>
> In early 2017, the Department plans to run a public consultation on its proposals to expand domestic undergraduate medical training places by up to 1,500 per year, from the academic year 2018-19.

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12 See: HEFCE Funding Letter (from the Department for Business, Innovation and Skills [BIS]), 29 January 2015

13 Speech by Secretary of State for Health, Jeremy Hunt, to Conservative Party Conference, 4 October 2016.

14 *Ibid.*

15 *Ibid.*

> For the 2017-18 academic year, undergraduate medical students undertaking the first four years of their courses will qualify for the same tuition fee loan and living costs support package from the Student Loans Company as other full-time undergraduate students. For years five and six of their courses, these students will continue to qualify for NHS bursaries and an additional reduced rate non-means tested loan for living costs from the Student Loans Company.
>
> Teaching grants for medical students will also continue under the Office for Students (which is expected to assume Higher Education Funding Council for England's funding responsibility from April 2018) reflecting the high-cost of the subject.[16]

Giving evidence to the Health Committee on 24 January 2017, Mr. Hunt said that what was needed was a "structured plan, the first step of which is to look at our doctor numbers".[17] He continued:

> It is interesting that Health Education England estimates that we were training about 6,500 a year and we needed to train about 8,000 a year to be self-sufficient. I believe we will always want to welcome the brightest and the best doctors from all over the world, but none the less we should as a country be training the doctors we need. WHO thinks there is a global shortage of about 2 million doctors. Interestingly, even being able to import as many doctors as we want freely from the rest of the EU, as we currently can, we still have doctor shortages. That is why it is important to get our doctor and nurse training right.

He described the increase in the number of medical school places as the "second biggest increase in the number of doctor training places in the history of the NHS".[18] The Government has separately said it will increase the number of doctors working in general practice by 5,000 (full-time equivalent) by 2020.[19]

Reaction to announcement of additional medical school places

The British Medical Association (BMA) said that whilst it had campaigned for more medical school places, it had a number of concerns about the proposals, including that:

- It would take a decade for the increased student numbers to translate into more doctors on the ground. The proposals would do nothing to address current workforce pressures.
- There needed to be a corresponding increase in foundation year training posts, otherwise graduates could be left jobless.
- It would not support a 100% 'home grown' doctor policy, because of the international nature of the profession. Similarly, it did not support any proposal to require medics to work in the NHS post-qualification or face penalties.[20]

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16 PQ 59746 [on Doctors: training], 20 January 2017
17 House of Commons Health Committee, transcript of oral evidence, 24 January 2017, Q 40
18 *Ibid.,* Q 45
19 NHS England, General practice forward view, April 2016.
20 Letter from the British Medical Association (BMA) to Health Secretary Jeremy Hunt, 5 October 2016.

In a BMA press release of 4 October 2016, BMA medical students committee co-chair, Harrison Carter, said:

> 'It is staggering that it has taken the health secretary four years in that position and six years of a Conservative Government to concede that the NHS is not self-sufficient in producing the correct number of doctors.
>
> 'Retaining the workforce has to be the priority. We can have more doctors if we make the NHS attractive for those that currently work in it.
>
> 'Increasing the number of medical student places alone will not be enough to make the NHS self-sufficient in producing the correct number of doctors and raises a number of serious questions for medical students; the Government will need to ensure that the quality of medical education is not compromised by this increase in numbers.
>
> 'This means maintaining staff student ratios and ensuring the participation of senior medical staff in medical education and making sure there are enough clinical placements and jobs for all medical students.'[21]

The General Medical Council (GMC) published a report on medical education in the UK in October 2016:

- Link to GMC report, The state of medical education and practice in the UK, October 2016

In this, they welcomed the proposals to increase the number of medical school places but said there was a need for creative thinking to ensure workforce supply until the increase in medical students worked through the system:

> The GMC […] welcomes the recent government announcement that there will be an expansion by 1,500 of the number of UK medical students. Obviously these will not graduate until 2023 at the earliest and therefore will not be fully trained as GPs until 2028 or hospital specialists until 2033. In the interim, we will all need to think creatively about retaining new graduates, re-integrating those who have had time out, dissuading older doctors from retiring early, and recognising that 35% of doctors currently working in the UK qualified in the EEA or further abroad. The strong contribution of EEA and international medical graduate doctors to UK healthcare should not be underestimated.[22]

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21 BMA press release, 'Medical student plan will take a decade to produce doctors', 4 October 2016

22 GMC, The state of medical education and practice in the UK, October 2016, p. vi

3. Entrants to medicine – student characteristics

In its 2016 *State of the Nation* report, the Social Mobility Commission (SMC) concluded that medicine remained one of the most inaccessible professions. It cited research commissioned by the Medical Schools Council which suggested around 80% of applicants to medical school came from around 20% of schools, and those schools were more likely to be selective or fee-paying (e.g. grammars, independents) or large sixth form colleges. [23]

Other research cited by the SMC, based on UK medical schools' application data from 2009 to 2012, found that "[o]ver a quarter of successful applicants attended independent schools and four-fifths of successful applicants had parents working in higher managerial or administrative professions." [24]

The GMC's National Training Survey 2013 included additional questions on the socioeconomic status of doctors in postgraduate training (i.e. after medical school) who undertook their secondary education and medical degree in the UK. This found that around two-thirds of respondents had parents who were educated to degree level, 34% went to private school, 25% to a state selective school and 8% received free school meals at some point during their time in school. It is difficult to put these figures in any proper context as they look at those undertaking training after their medical degree and there is no straightforward comparison group.

A further question asked about the postcode of the area they grew up in and the report assigned these to one of five levels of deprivation. This evidence is easier to set in the context of the overall population, if not similar postgraduate training. Were deprivation to have no impact on access to medicine we would expect, over time, rates of around 20% in each band. However 39% of those in medical training grew up in the least deprived fifth of local areas and 6% in the most deprived areas. [25]

The latest data from the Universities and Colleges Admissions Service (UCAS) shows that in 2016 26% of students accepted to pre-clinical medicine in the UK were from independent schools. This rate has fallen somewhat from just over 30% at the end of the last decade. In addition 8% of those accepted to these courses were from grammar schools in 2016, down from 10% in 2010. Both rates were substantially higher than the proportion of students across all subjects from these schools in

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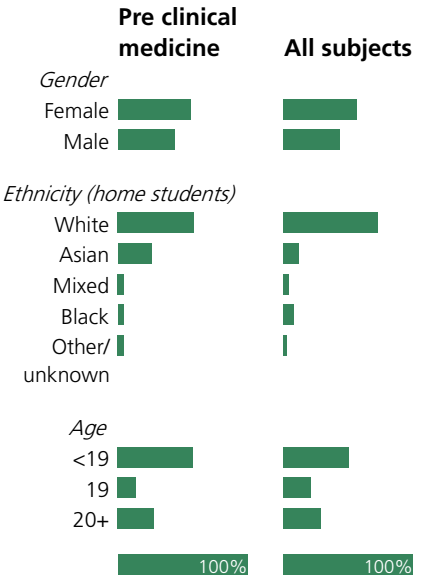
23 Garrud, P., Medical Schools Council – Selecting for Excellence. Help and hindrance in widening participation: Commissioned research report, undated.

24 Steven, K. *et. al.*, 'Fair access to medicine? Retrospective analysis of UK medical schools application data 2009-2012 using three measures of socioeconomic status', Bio Med Central, January 2016, cited in Social Mobility Commission, State of the nation 2016, p. 141

25 GMC, *National training survey 2013: socioeconomic status questions*.

2016 at 9% and 3% for independent and grammar schools respectively.[26]

The chart opposite gives a breakdown of other characteristics of students accepted through UCAS in 2016. Compared to all students those studying medicine were more likely to be from Asian or 'Mixed' ethnic backgrounds and less likely to be from White or Black ethnic grounds. The pre-clinical medicine intake was also more likely to be aged under 19. The gender balance was very similar to the whole student intake.



17.6% of young entrants to medicine, dentistry of veterinary science were from the 'lower' socio-economic groups.[27] This was the lowest of any subject and only just over half the level across all subjects (33.0%). 4.7% were from the areas with the lowest levels of historical participation28 in higher education (sometimes seen as a proxy for disadvantaged areas). Again this was the lowest of any subject group and less than half the overall level (11.4%).[29]

Looking at the changing profile of medical students over a much longer time period BMA published *Equality and diversity in medical schools* in late 2009. This questioned some of the data on socio-economic background of students. It said:

> The socio-economic status of students at medical schools in the UK has changed very little over time. The majority of students still come from professional and managerial backgrounds.
>
> …
>
> Research into medical school admissions between 1956 and 2001 shows 'little systematic change in social class of UK medical students over half a century', with minimal variation in the dominance of those from professional or managerial occupational backgrounds or in the under-representation of those from partly skilled or unskilled backgrounds.[30]

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26 *End of cycle data resources 2016*, UCAS
27 NS-SEC groups 4-7
28 Based on POLAR3 classifications of postcode areas which group these areas into quintiles or 20% bands.
29 Performance Indicators 2014/15: Widening participation, HESA
30 BMA, Equality and diversity in medical schools, 2009, p28 and p12

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