Executive summary

This document provides an impact statement for the Medical Training (Prioritisation) Bill, which introduces a system of prioritisation for allocation of medical foundation training places and medical specialty training places in the UK.

Problem and justification for action

Since the lifting of visa restrictions in 2020, UK-trained doctors have faced growing competition from overseas-trained doctors for training posts. In 2025, 15,723 UK-trained doctors and 25,257 overseas-trained doctors competed for 12,833 round 1 and 2 posts. Presently, for 2026 recruitment we have seen over 47,000 applicants (for round 1 and 2). This recruitment is live and numbers will be finalised in due course. The current system means that we are recruiting doctors from overseas when there is already a substantial pool of appointable doctors who are domestically trained or employed within the NHS. These are doctors that are more likely to work in the NHS for longer and be better equipped to deliver healthcare tailored to the UK population. The taxpayer has also already made a significant investment in them.

While international medical graduates (IMGs) remain a valued part of the NHS workforce, the growing inflow and heavy reliance on them poses risks. Increased unbounded competition threatens career progression, retention and the attractiveness of being a doctor in the UK for UK medical graduates (UKMGs). This is undermining the government's ambition to reduce the NHS's reliance on international recruitment and ensure that our future workforce is sustainable.

Policy objective

The Medical Training (Prioritisation) Bill will introduce and require prioritisation of graduates from medical schools in the UK and certain other persons for places on medical training programmes.

Impact

Applicant numbers

It is expected that we will continue to have a significant group of non-UK-trained medical graduates applying for posts. These applicants might already be working in the UK and NHS or might apply from overseas. The policy will mean we prioritise applicants as set out in the bill and will mean UK medical graduates are more likely to succeed with their applications.

Economic growth

We anticipate that prioritising UK-trained doctors for training posts will have a neutral overall impact on UK economic growth. This policy provides more security in the long term to UK-trained applicants, increasing the reliability and retention of domestic labour supply and improving our workforce planning, potentially improving NHS services as a result. We also anticipate there to be benefits (as set out below) for this improved continuity, which include the improvement of long-term UK based human

capital. These benefits would offset the impact of any reduced immigration of doctors.

Diversity
The NHS is and will remain one of the most diverse employers not only in the UK but across the world. Around 325,000 out of 1.5 million staff (21%) reported a non-British nationality in June 2025[footnote 1]. The General Medical Council (GMC) reported in 2025 that 138,405 licensed doctors who qualified abroad are working in the UK, making up 42% of all licenced doctors[footnote 2]. The medical workforce is diverse compared to the English working-age population, much of this previously driven by international recruitment, however non-White UK-trained doctors represent 37% for resident doctors and 24% of consultants[footnote 3]. Analysis, based on the most recent available data, demonstrates that the policy will likely have an impact in relation to ethnicity, nationality and religion, due to the demographic composition of IMGs compared to UKMGs. The modelling shows that certain ethnic and nationality groups, as well as applicants of particular religions, are more likely to be in the non-prioritised group and therefore may experience a reduction in representation within specialty training cohorts. The bill will not exclude any eligible applicant from applying for postgraduate medical training posts but applications will be prioritised as the bill describes.

Costs
The bill will ensure that the significant sums invested in undergraduate and postgraduate medical training support the delivery of the government's health mission. It will also deliver our commitment to develop the domestic medical workforce, while still recognising the valuable role of international doctors in the NHS, and help ensure that we have a reliable supply of doctors to meet the needs of patients. Additionally, we expect the bill should improve our ability to control costs and mitigate risks for the Foundation Programme in particular. In terms of implementation, we estimate costs of approximately £100,000 relating to Oriel application and recruitment system changes which will be met from existing NHS England budgets.

Inward migration
The policy likely means we will see reduced inward migration of overseas-trained doctors.

Problem and justification for action

Since the lifting of visa restrictions in 2020, UK-trained doctors have faced growing competition from overseas-trained doctors for training posts. In 2025, 15,723 UK-trained doctors and 25,257 overseas-trained doctors competed for 12,833 round 1 and 2 posts (see annex A, table 3). Presently, for 2026 recruitment we have seen over 47,000 applicants (for round 1 and 2). This recruitment is live and numbers will be finalised in due course. If a UK-trained doctor does not secure a training post, typically they will become a locally employed doctor on a local contract, outside of the national training system.

This is a growing problem with UK-trained doctors unable to secure formal training posts, which will be exacerbated if overseas inflows continue to add further pressure

to an already challenging situation. This could result in a larger pool of UK-trained doctors who have been unable to secure training posts. As a possible consequence, doctors without a post may seek alternative medical employment abroad or in other fields or industries. This would be a loss to the NHS and the UK population, and would also be a loss of the taxpayer funded training costs,[footnote 4] as domestically trained doctors have been trained in the UK health service to deliver care in that service which is based on UK population healthcare needs.

The current system means that we are recruiting doctors from overseas when there is already a substantial pool of appointable doctors[footnote 5] who are domestically trained or employed within the NHS that the taxpayer has already invested in. The evidence set out in this document suggests that UK-trained doctors are more likely to work in the NHS for longer and be better equipped to deliver healthcare tailored to the UK population, with potential benefits of:

- improved workforce planning and retention of doctors
- better patient outcomes over time
- maximising taxpayers' investment

Additionally, the government has an ambition to reduce the NHS's reliance on international recruitment and ensure that our future workforce is sustainable. Globally, competition for medical staff has never been fiercer. The World Health Organization (WHO)[footnote 6] has estimated "a shortfall of 11 million health workers by 2030" with all countries affected. We need to shore up our workforce and limit our exposure to global pressures. To do this, we need to make sure that our existing workforce, medical graduates and resident doctors are not squeezed out of opportunities for training. Taxpayers invest over £1 billion in undergraduate clinical placements and over £3.3 billion in postgraduate foundation and specialty training each year, and we want to better protect this investment.

Foundation Training

The UK Foundation Programme is a 2-year UK-wide training scheme for medical graduates, bridging the gap between medical school and specialty or general practice training in the NHS. It is a core part of medical education for UKMGs, who must complete Foundation Year 1 to gain full registration with the GMC and work unsupervised in the NHS.

International medical graduates can also apply, though they have alternative routes to registration. The programme is managed by the UK Foundation Programme Office, and historically every eligible applicant has been allocated a post. However, rising numbers of UK and international graduates, driven by increased UK medical school output and immigration rule changes, have led to oversubscription.

This approach has resulted in considerable financial and operational strain. Creating additional posts at short notice creates significant operational pressures which can divert resources from planned priorities. Trusts face challenges in providing high-quality training and pastoral care without extra supervisory capacity, while applicants experience uncertainty due to the placeholder system, which delays confirmation of

hospital placements and complicates living arrangements. These issues will worsen as the number of medical school graduates increases.

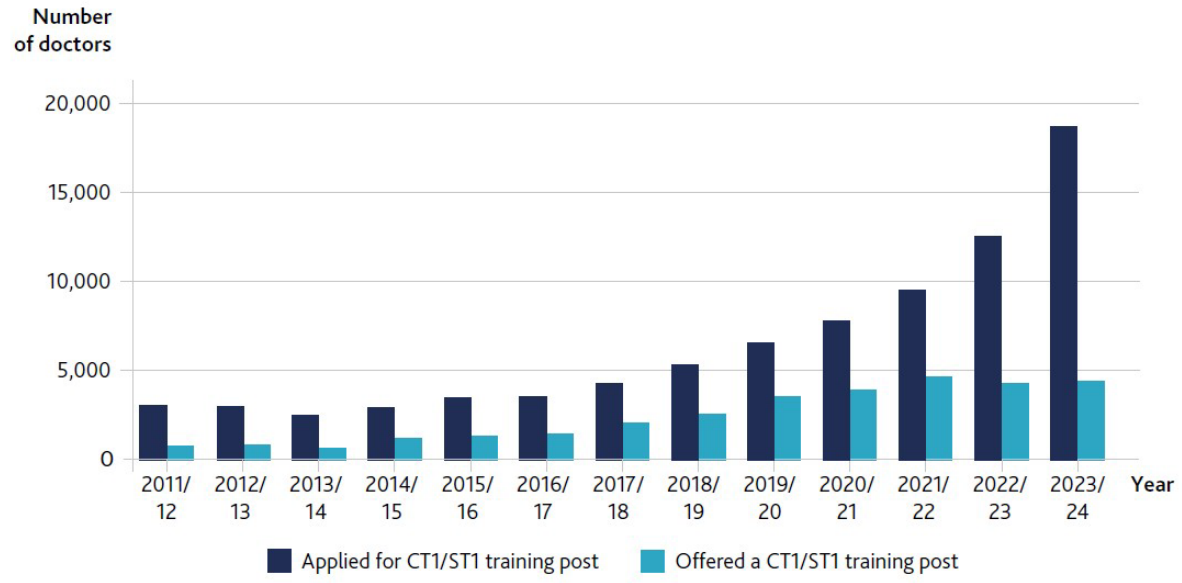
There are particular issues early in training, and especially the foundation years, if domestic trainees are unable to get places. The foundation years, particularly the first year, are essential to a doctor becoming a medical practitioner in the UK. Without completing the first year of foundation training they cannot be registered with the GMC. There is significant inefficiency and many downstream challenges if the medical students and doctors we train cannot secure the next stage of their medical training. If there is a significant chance that a doctor on graduating may not be able to obtain a foundation training place this will make medical careers less attractive and may put off the best people applying to medicine.

Specialty training

Specialty training follows the UK's 2-year Foundation Programme and enables doctors to progress as GPs or consultants in other specialties. Allocation of places is managed by the Postgraduate National Recruitment Programme Board within NHS England on a UK-wide basis. Competition for specialty training posts has intensified, largely due to rising applications from international medical graduates.

GMC analysis of NHS England data (chart 1) shows that increasing numbers of non-UK primary medical qualification (PMQ) doctors are applying to enter formal postgraduate training. For the 2018 to 2019 academic year, 5,326 non-UK PMQ doctors applied for the first years of specialty or core training (ST1 or CT1) but by the 2023 to 2024 academic year, that number had more than tripled to 18,857.

Chart 1: non-UK PMQ doctors applying for - and being offered - CT1 or ST1 training places, each academic year 2011 to 2012 to 2023 to 2024



Source: The state of medical education and practice in the UK: The Workforce Report 2025, GMC (see [footnote 7]).

While IMGs remain a valued part of the NHS workforce, the growing inflow and heavy reliance on them poses risks. Increased unbounded competition threatens UKMG's career progression and retention[footnote 7] with the pool of post-Foundation Year 2 (FY2) doctors likely to grow further, potentially worsening training delays and leaver rates.

Data also shows that domestic graduates have a greater likelihood to stay in the country they trained in than those trained internationally (table 1). This difference undermines workforce sustainability, while emphasising the value of NHS experience over the longer term. This challenge is compounded by increasing global competition for doctors.

The government's 10-Year Health Plan commits funding for 1,000 new specialty training posts over 3 years. The priority is to ensure that the posts available are allocated to candidates who the UK has already invested in as well as best meet the health service's long-term objectives, which the current approach does not achieve.

Table 1: percentage of doctors no longer holding a GMC licence after main training stages

Year of cohort	Origin of doctor	2012	2013	2014	2015	2016	2017	2018
5 years after FY2	UK	8.1%	8.9%	8.6%	8.6%	7.5%	7.8%	7.7%
5 years after FY2	Non-UK	7.8%	9.2%	10.6%	6.8%	10.3%	7.5%	10.0%
4 years after CCT	UK	5.6%	4.9%	4.7%	4.8%	4.4%	4.4%	3.9%
4 years after CCT	Non-UK	14.8%	12.8%	12.8%	10.1%	9.5%	9.2%	8.8%

Source: Department of Health and Social Care (DHSC) analysis of GMC data.

The Certificate of Completion of Training (CCT) confirms a doctor has completed an approved UK training programme and is eligible for entry onto the Specialist Register or GP Register.

Policy objective

The bill will introduce and require prioritisation of graduates from medical schools in the UK and certain other persons for places on medical training programmes.

Prioritisation means UK medical graduates are more likely to succeed in training applications, enabling them to reach higher levels of training earlier in their careers. Higher retention rates following completion of specialty training will help secure a sustainable medical workforce for the future, particularly in the context of increasing global competition for medical professionals.

Doctors trained within the NHS have a strong understanding of UK-specific epidemiology, clinical pathways and healthcare protocols. While IMGs remain a vital part of the NHS workforce, prioritising UK-trained doctors for postgraduate training posts helps ensure familiarity with local systems and practices and reduces reliance on international recruitment.

This approach aligns with the UK government's workforce planning aims, which links the number of undergraduate medical school places to postgraduate training capacity to meet the needs of the UK patient population. By creating a clear pathway from medical school to specialty training, we strengthen domestic talent and improve retention.

The bill will ensure that the significant sums invested in undergraduate and postgraduate medical training support the delivery of the government's health mission. It will also deliver our commitment to develop the domestic medical workforce, while still recognising the valuable role of international doctors in the NHS, and help ensure that we have a reliable supply of doctors to meet the needs of patients.

Policy options

As part of developing this proposed policy, a range of options have been explored, including:

- Foundation Programme only, capping and recruiting based on merit (a previous approach that had been discontinued). This option was discounted as medical degrees are ungraded, making assessment of merit difficult. It may leave a higher proportion of UKMGs without posts, decreasing the number of home-grown graduates and potentially increasing IMG entrants. These put at risk 10-Year Health Plan[footnote 8] commitments and the Medical Training Review[footnote 9] objectives such as for curricula reforms. Doctors trained within the NHS have a strong understanding of UK-specific epidemiology, clinical pathways and healthcare protocols. A merit-based system would risk losing those who have undertaken training in the health service in the UK and Ireland, impacting patient care

- introduction of a resident labour market test. This option was discounted primarily because immigration rule changes would not be flexible enough to allow the prioritisation of international medical graduates with significant NHS experience
- for specialty training applications, prioritising doctors who are UKMGs, Foundation Programme completers and those with set levels of experience, which for 2026 legislation includes the criteria of 'significant NHS experience'. This was discounted as it was not operationally feasible to assess all applications for 'significant NHS experience'

Therefore, the remaining viable policy options examined are described below:

- option 1: do nothing - with a strong likelihood of applicant numbers from overseas graduates increasing
- option 2: introduce and enable the prioritisation as described in the bill

Groups who will be impacted by the policy

The following groups will be impacted by the policy:

- applicants to the UK Foundation Programme
- applicants to NHS postgraduate medical specialty training

Impacts of the policy

The bill (option 2) describes the groups that will be prioritised for foundation and specialty training in 2026 and from 2027 onwards. Beyond the inclusion of graduates of UK medical schools, we have also included graduates of Republic of Ireland medical schools because of the special nature of the relationship between the 2 countries. The Republic of Ireland also has similar epidemiology[footnote 10] and health systems which makes their graduates similar to UKMGs.

To reflect international agreements, the priority group also includes individuals with a medical qualification from an institution in a prioritised country (Iceland, Liechtenstein, Norway or Switzerland).

For specialty training posts, for offers made in 2026, it will also include prioritising individuals with certain specified immigration statuses as a proxy to capture applicants who we believe are most likely to have NHS experience. Individuals with these statuses are potentially more likely to have:

- worked within the NHS
- gained knowledge of local epidemiology
- demonstrated a commitment to the NHS

For posts starting from 2027 onwards, the immigration status category will not apply automatically but it will be possible to make regulations to specify additional groups who will be prioritised. This will enable regulations to be made with the intent of

capturing those persons with significant experience working as a doctor in the NHS or the health services in the other UK nations within the group that should be prioritised.

Analysis based on the most recent available data demonstrates that the policy will likely have an impact in relation to ethnicity, nationality and religion, due to the demographic composition of international medical graduates compared to UK medical graduates. The modelling shows that certain ethnic and nationality groups, as well as applicants of particular religions, are more likely to be in the non-prioritised group and therefore may experience a reduction in representation within specialty training cohorts. The bill will not exclude anyone from applying for NHS training but applications will be prioritised as the bill describes. The NHS will remain one of the most diverse employers not only in the UK but across the world.

The policy would, over time, likely change the mix of persons employed as doctors as a result of prioritising UK graduates and others, as foundation and specialty training are comparatively smaller when compared to other staff groups. We anticipate these changes to be broadly neutral for the remainder of NHS employed staff and overall numbers and proportions.

For doctors already working within the NHS we anticipate that the policy would advantage staff in the NHS and UK graduates.

Costs and benefits

It has not been possible to monetise all of the costs and benefits potentially resulting from this policy and as such any conclusion on value for money will need to consider the non-monetised costs and benefits when compared to the ‘do nothing’ scenario.

Non-monetised benefits

Benefits of improved training security and retention
The government makes a significant investment of over £4 billion in training doctors in medical school, foundation and specialty training. Therefore, this policy is expected to see more UK medical graduates secure training places, with a fall in the number of successful international applicants in some areas and specialties. This approach aligns with the UK government’s workforce planning aims, which links the number of undergraduate medical school places to postgraduate training capacity to meet the needs of the UK patient population. By creating a clear pathway from medical school to specialty training, we strengthen domestic talent and improve retention.

Improved continuity and a sustainable domestic supply of doctors would be beneficial to those doctors as well to patients and the NHS, as this policy would give our medical graduates training security, recognising the significant investment of time and taxpayer money already made. We would also expect to see some of the previous foundation and specialty training application delays and inefficiencies avoided, as well as reduced risks of displacement or disruption to doctors’ training

progression and advancement, ultimately resulting in better overall workforce planning, stability and improved retention.

We expect more UK medical graduates to secure foundation and specialty training places. That may mean an increase from around 8,500 to up to 14,000 UKMG acceptances annually across all levels of UK specialty training (noting that this is at the upper end of the possible impact, based on presently planned numbers of specialty training posts, rather than a central estimate). That would mean a fall in the number of non-UK training acceptances by up to around 5,000. This would mean a small fall to inward migration. However given IMGs are anticipated to leave the NHS workforce more quickly when compared to UK doctors, we would expect to retain more domestic medical expertise, reducing training inefficiencies or replacement costs.

Epidemiological, medical and cultural advantages

While international graduates bring in fresh ideas and skills, they also have less experience of local epidemiological, medical and cultural settings than domestic graduates. Doctors usually practise best in settings they are trained for[footnote 9] and it is optimal and beneficial that doctors have a familiarity in the areas described below.

The epidemiology of disease[footnote 11] is significantly different in the UK than many of the countries where international graduates train. This is principally seen in a greater preponderance of diseases of ageing, including dementia, frailty, multiple long-term chronic diseases, cancers and so on. All other things being equal, being trained in an environment with a similar epidemiological pattern leads to better medical understanding and potentially better outcomes.

Medical practice varies by country[footnote 12]. This ranges from diagnostic pathways, availability of technical resources, standard medical approaches to problems and usual drugs used, through to communication style between doctors and patients.

Health and understanding of disease in the population is highly socially determined[footnote 13], from risk factors for disease (such as diet and environment) to conceptualisation of disease by patients. This is less relevant for some specialties (such as surgery) but is central to many issues of medical diagnosis and probability of disease.

The government and NHS can influence the direction[footnote 9] of UK medicine through interventions in medical school training to fulfil major long-term policy goals to meet anticipated healthcare need. This can be specific (for example, the steady rise of multimorbidity in England) or generic (a greater emphasis on prevention over treatment). If a substantial part of the workforce misses domestic training this benefit is not realised.

Over a career this difference in experience will become smaller as international graduates become more used to domestic epidemiology and medicine. The aim of the policy is to prioritise established IMGs who have been working in the UK for some time over IMGs who have never worked in the UK.

Ethics and reliance on international recruitment
There are significant ethical concerns[footnote 14] to attracting doctors from countries with very low numbers of doctors per head of population compared to the UK, and in particular low- and low-middle income countries. It is therefore beneficial to other countries as well as the UK that we rely less on international recruitment.

Costs

Adaptation of the Oriel application and recruitment system
There will be implementation costs as a result of needing to adapt the medical recruitment process and systems to accommodate the proposed option. NHS England has estimated these costs to be approximately £100,000[footnote 15] over the proposed implementation timeframe.

Costs to other industries
Without the prioritisation of UK graduates, under the 'do-nothing' option there is likely to be a flow of UK-trained doctors into other industries. We think this is currently small (the majority of UK-trained doctors move into specialty training) but likely to increase if some form of prioritisation is not put in place.

Implementation, monitoring and evaluation

Any costs associated with monitoring and evaluation, including new data collections, have not been quantified at this stage.

As part of implementation and ongoing monitoring and evaluation NHS England will track through the revised recruitment process and Oriel system reporting. After each main recruitment stage, the delivery team will track important data items such as but not exclusive to:

- applicant and application numbers
- prioritisation numbers by stage
- offers
- acceptances
- outcomes
- numbers by equalities and other categories such as immigration status

Government and NHS England will develop more detailed monitoring and evaluation plans if the bill passes. These plans would also seek to address known evidence gaps where possible.

As part of this planning, existing data collections would be reviewed to assess to what extent monitoring and evaluation could be accommodated by current data collections and what additional data would need to be collected. Should the bill be passed, government would ensure adequate baseline data (building on existing data) is captured to facilitate evaluations as part of the future reviews.

Annex A: UK specialty training recruitment data

The table below provides a count of unique applicants to UK specialty training based upon country of qualification (CoQ) and recruitment round. Medical specialty recruitment involves multiple national cycles called ‘rounds’.

Table 2: count of unique applicants to UK specialty training based upon CoQ and recruitment round

Round	Applicant type	2021	2022	2023	2024	2025
1	UKMG	9,710	9,159	9,147	10,635	12,316
1	IMG	6,913	8,404	10,404	14,871	20,807
1	Non-medical graduate	610	761	809	606	762
1	Total	17,226	18,320	20,354	26,102	33,870
2	UKMG	3,246	2,868	3,046	3,161	3,528
2	IMG	2,967	3,273	3,519	3,934	4,953
2	Total	6,213	6,137	6,564	7,095	8,481
1 and 2	UKMG	12,799	11,850	12,038	13,683	15,723
1 and 2	IMG	9,456	11,113	13,368	18,344	25,257

Round	Applicant type	2021	2022	2023	2024	2025
1 and 2	Non-medical graduate	610	761	809	606	762
1 and 2	Total	22,858	23,715	26,208	32,623	41,727
1 and 2	Applicants applying to both round 1 and round 2	581	742	710	574	624
1 and 2	Total excluding non-medical applicants	22,248	22,951	25,399	32,017	40,965

For entries labelled ‘non-medical graduate’, note that public health specialist training is open to both medical and non-medical graduates.

This is administrative data from the Oriel specialist training recruitment system. We continue to work to clean the data and refine the analysis, but there may be discrepancies with previously released statistics. In places the UK, international and non-medical applicants may not sum to the total applicants because of inconsistencies in the recording of applicant details where multiple applications were made. Updates will be made when appropriate and possible.

Most posts are filled in rounds 1 and 2, a relatively small number of unfilled or new posts are filled in round 3, often by applicants from rounds 1 and 2.

Table 3: number of UK specialty training posts by recruitment round

Round	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
1	6,916	8,192	8,545	8,766	8,846	No data	No data	8,785	9,286	9,282	9,265	9,331	9,479

Round	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
2	No data	No data	No data	2,351	2,347	No data	No data	2,994	2,293	2,823	3,415	3,412	3,354
1 and 2	No data	No data	No data	11,117	11,193	12,374	12,175	11,779	11,579	12,105	12,680	12,743	12,833

Source: aggregated UK posts data from published NHS England competition ratios.

1. NHS Digital. NHS workforce statistics June 2025 (viewed on 7 January 2026) ↩
2. GMC. The state of medical education and practice in the UK: workforce report 2025, pages 2 to 3 (viewed on 7 January 2026) ↩
3. Institute for Fiscal Studies. Ethnic diversity of NHS doctors (viewed on 13 January 2026) ↩
4. University of Kent Care and Outcomes Research Centre. Unit Costs 2022-2027 (viewed on 7 January 2026) ↩
5. NHS England. Medical Specialty Recruitment (viewed on 7 January 2026) ↩
6. WHO. Health Workforce (viewed on 7 January 2026) ↩
7. GMC. The state of medical education and practice in the UK: workplace experiences 2025, page 8 (viewed on 7 January 2026) ↩ ↩2
8. DHSC. Fit for the future: 10 Year Health Plan for England, pages 14 to 15 (viewed on 7 January 2026) ↩
9. NHS England. Medical Training Review (viewed on 7 January 2026) ↩ ↩2 ↩3
10. Our World in Data. Global Burden of Disease (viewed on 7 January 2026) ↩
11. Institute for Health Metrics and Evaluation. Global Burden of Disease (viewed on 7 January 2026) ↩
12. Corallo AN and others. A systematic review of medical practice variation in OECD countries Health Policy 2014: volume 114, pages 5 to 14 (viewed on 7 January 2026) ↩

13. WHO. Social Determinants of Health (viewed on 7 January 2026) ↩
14. WHO. Global Code of Practice on the International Recruitment of Health Personnel and Users Guide (viewed on 7 January 2026) ↩
15. NHS England internal estimates of Oriel system adaptations (unpublished) ↩