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Migrant and Refugee Communities Forum

Losing out Twice?

Skill Wastage of Overseas Health Professionals in the UK

The report is based on the evidence produced by MRCF's Overseas Health Professionals Support Project and written by Natasha David and Dr Myriam Cherti for the COMPAS Annual Conference in 2006

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Recruiting Overseas Health Professionals[1] in the UK – an attempt to Redress Imbalances or Create More?

Introduction

The international migration of highly skilled healthcare professionals to the UK has been a long standing tradition within the NHS as part of wider skilled migration. It has been driven by both push and pull factors (e.g. professional development, better pay and conditions etc.) including overt government policies to recruit or restrict access to work. This movement has evolved dramatically over the years. In most cases, employees' expertise is regarded as mobile and transferable, however in the case of health professionals working in the UK their acquired skills and expertise become subject to rigorous testing[2] before being allowed to practice.

The UK government has introduced a number of policies over recent years to address perceived shortages of healthcare professionals in the NHS, including specific international recruitment schemes[3] and opportunities for postgraduate training. These have encouraged health professionals to enter the UK, yet paradoxically have created a bottleneck of postgraduate health professionals who are "job-ready" but unable to secure employment because of severe competition.

This paper will examine the impact of UK employment policies and international recruitment schemes on overseas-qualified migrant and refugee doctors and dentists coming to the UK over the past 5 years. The main focus is on the key barriers facing migrant doctors and dentists seeking work in the UK, and the impact of migration on professional skills and employability. The paper will begin with an analysis of the background policy context for the international movement of healthcare professionals, followed by key research findings and concludes with policy implications and recommendations.

I- Background

The debate on the causal factors and the impact of skilled labour movement from developing to higher income countries is rather well established in policy and academic discussions. As Koser and Salt (1997) argue, the main theoretical initiatives have located the movement of the highly skilled within broader economic processes of global restructuring. These theories propose a pattern of movement determined less by the aspirations of individuals than by changing patterns of demand, and the development of an organisational infrastructure within which mobility takes place (Salt and Findlay, 1989; Findlay, 1990; Salt, 1992). Consequently, the mobility of highly skilled migrants has been accentuated over the last two decades; especially when the developed countries increased incentives attracted a much-needed human resource to meet its labour deficit.

There has been wide criticism in the UK (and elsewhere) of the poaching of overseas-qualified healthcare professionals from developing countries to meet the shortage in the developed world. Consequences of this brain drain include a sharp decrease in the availability and quality of health services in developing countries;

[1] The term health professional includes doctors, dentists, nurses and allied health professionals. For the purposes of this paper the term health professional will refer primarily to doctors and dentists.
[2] (IELTS) International English Language Testing System, (PLAB) Professional and Linguistic Assessment Board, (IQE) International Qualifying Exam.
[3] For example, the recruitment of Indian and Polish dentists in July 2004 (Department of Health, 2004)

increasing inequity; considerable loss of investment in the education and training of health professionals; understaffing of health systems, a burden of greater work loads; added stress to those health professionals left behind; and brain waste – where expatriate specialists are underemployed in developed countries (DfID 2006; Marchal & Kegels 2003; Martineau, Decker, and Bundred 2002; Sriskandarajah 2005; World Health Organisation December 2003).

One issue raised with respect to international recruitment processes is that of ethical recruitment. The Department of Health first published guidance on international recruitment of nurses and midwives in 1999 (Department of Health 1999), provided a progress report in 2000 (Department of Health 2000) and finally a code of practice for NHS employers in 2001 (Department of Health 2001). The guidance is intended to ensure that recruitment is ethical and good practice and value for money are achieved. The Department of Health also produced a list of proscribed countries in 2003 where recruitment is not allowed to take place. Many researchers have criticised the effectiveness of the Code as there are no formal mechanisms in place to check on compliance (Bueno de Mesquita & Gordon 2005; Mulholland 2002a; Sommerville 2006; Willetts & Martineau 2004).

In addition to active recruitment there are three other types of passive recruitment: first, when staff take the initiative to apply as individuals from other countries; second, when workers are resident in the UK, but not yet in employment (e.g. refugees); and third, when health workers move jobs relatively quickly once they have arrived in the UK (Buchan & Dovlo 2004; Mensah, Mackintsoh, Henry 2005).

Since healthcare is a regulated profession in the UK, strict controls are enforced on who can work as a doctor, dentist, nurse or allied health professional[4]. Overseas-qualified healthcare professionals therefore have to register with the relevant registration body for their profession before they can work[5]. Doctors who wish to register with the General Medical Council (GMC) must achieve a satisfactory grade in the only recognised academic English exam, the International English Language Testing System (IELTS). Following IELTS, doctors have to take two medical exams, the Professional and Linguistic Assessment Board (PLAB) 1 and 2[6] or be eligible for PLAB exemption. Alternative routes to registration for overseas-qualified doctors are outlined in (Appendix A). Similarly, for dentists who wish to register with the General Dental Council (GDC) they must achieve a satisfactory grade in the IELTS. Following IELTS, dentists have to take three dental exams, the International Qualifying Exam (IQE).

Under article 11 of regulation 1612/68 EC, doctors and dentists exempted from taking these registration exams include those who originate from the EEA/Switzerland and have qualified in an EEA country/Switzerland. In addition those who have EC rights are exempt – these are individuals who are married to a national of the EEA/Switzerland who is pursuing an activity as an employed or self-employed person in the UK[7].

[4] There are 13 different regulated careers for Allied Health Professionals: art therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers and speech and language therapists.

[5] Doctors must register with the General Medical Council; dentists with the General Dental Council; nurses with the Nursing and Midwifery Council; and allied health professionals with the Health Professionals Council.

[6] PLAB 2 was introduced in April 1998 and PLAB 1 was introduced in July 2000.

[7] If an individual is married to a UK citizen s/he cannot exercise their EC rights – they must take the registration exams. However, if an individual is married to or becomes a UK citizen, then works or

Doctors and dentists passing the registration exams were able to seek work under the permit-free postgraduate training scheme. However, on 7 March 2006 the Immigration and Nationality Department announced a series of changes to the immigration regulations and this was brought into effect from 3 April 2006. The change in rules abolished the permit-free training category and introduced the need for work permits (Department of Health 07.03.06), (see Appendix B).

Many overseas-qualified doctors have raised protests against these sudden changes, which were brought in with very little notice. The British Association of Physicians of Indian Origin (BAIPO) organised a peaceful silent demonstration in front of the DH, which took place on 21 April 2006 (Casciani 21.04.06; Ravichandran 2006). Colleges including the Royal College of Surgeons have expressed concerns regarding the new regulations (Bonomi 2006). The British Medical Association's Junior Doctors Committee (JDC) has made representations to the Home Office and the DH concerning these changes. Their requests include: the reduction in the number of PLAB exams; a one-year grace period in the implementation of the rules; transitional arrangements for non-UK/EEA doctors currently working in junior positions; and an annual international application process which would allow overseas doctors to apply for training posts from their home countries (BMA 2006).

Is the UK short of Doctors?

There is a widely held perception, both in the UK and overseas, that the NHS is short of doctors. Although this is correct, it is fully trained doctors i.e. those eligible to be consultants or GP Principals that the NHS is generally short of. The demand for training posts (the first posts entered into by UK graduates and overseas-qualified doctors who have completed the PLAB) is extremely high. Factors contributing to this competition include the 10 new member states that joined the EEA on 01 May 2004[8], an increased number of overseas doctors from India and Pakistan who are coming to the UK to train (Stewart 2005), as well as the medical schools expansion which has started to produce graduates.

Unofficial sources confirmed that from as long ago as 2000 many overseas-qualified doctors who were in the UK taking PLAB were having difficulty finding training posts. Jo Wren, a spokeswoman from the GMC, commented *"We (the GMC) recorded an increase in demand for the PLAB test since late 2000. This appears to have coincided with the first international recruitment advertisements. While it is clear that the advertisements were not targeted at junior doctors, they did nevertheless stimulate interest among this group"* (McGinn & Haivas 2005). There have been calls for warnings to be placed on relevant websites about the competition, to suspend the PLAB test and to only admit overseas-qualified doctors into the UK who have a firm job offer (Sridhar 2000; Trewby 2005; Welsh 2000; MacDonald 2000).

However, as recently as June 2004 Sir Graeme Catto, president of the GMC claimed that *"Most doctors are able to find work in the UK...but I have no doubt looking at the increase in the number of doctors sitting the first and second part of the PLAB that we are going to get a situation very soon where that is not the case…Medical migration is beneficial in raising the standards of medical care to patients in all countries not just the host country that the doctors migrate to"* (MacDonald 2004). In 2005 a number of initiatives were taken to try and warn overseas-qualified doctors of

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studies in either another EEA country or Switzerland and returns to the UK, s/he can exercise their EC rights!

[8] These were Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

the competition in the UK. For example, the Royal College of Physicians has published up to date information on competition for posts in the UK, both on their website and that of the BMA.[9]

Recruiting Doctors

As a remedial strategy for this perceived shortage in doctors, the DH launched the NHS International Fellowships in February 2002 in order to give experienced consultants the opportunity to come and work in the UK for two years. This was in addition to the campaign launched in August 2001 to recruit consultants and GPs to substantive posts (Department of Health, 2002; Mellor 2003). Targets in 2002 included: 7,500 extra consultants and 2,000 extra GPs. This target was then rolled over to deliver 10,000 more doctors (consultants and GPs) and 450 international fellows by 2005.

David Amos, deputy director of human resources at the DH said *"We…need to recognise that international recruitment is something that we are putting a deliberate effort into in order to recruit medics into senior clinical positions because that is where we have the biggest gap that we need to close in the short term to deliver on the NHS plan…The alternative to international recruitment in the short term is not to fill vacancies in the NHS..."* (MacDonald 2003).

Is the UK short of Dentists?

The perception that the UK is short of NHS dentists is accurate and has been widely reported in the media (BBC News 19.02.04). In 2003 it was estimated that the UK needed up to 4,000 more dentists (BBC news 30.07.03). A report by the DH in July 2004 indicated that the current serious shortage of UK dentists was going to get worse and would double by 2011. In 2003 England had 1,850 fewer dentists than it needed. The DH predicted that this shortfall could rise to between 3,400-5,100. This led to the first international recruitment scheme for overseas-qualified dentists (Medical News Today, 25.07.04).

Recruiting Dentists

In July 2004 the DH announced its plans to recruit 1,000 new dentists by 2005 through attracting those who left the NHS; bringing in professionals from abroad; increasing the number of IQE exams; and increasing training places (Department of Health 16.07.04; Medical News Today, 25 July 2004). For the first time overseas-qualified dentists were specifically targeted for recruitment. This mainly involved recruiting from India, Poland and Spain (Department of Health 2004; Department of Health 24.02.05).

In order to facilitate the Indian recruitment, and on an exceptional basis, dentists were able to take IQE A in India. 400 places were available in February 2005, split between New Delhi and Chennai. The DH expressed its commitment to not actively recruit from the states supported by aid from DfID[10]. The DH promised candidates who passed IQE A that they would arrange placements in dental practices in England and wished to take parts B and C. While these dentists, in principle, were not able to register with the GDC and therefore work as dentists, they were however allowed to work as dental nurses and be paid an appropriate salary. The DH also promised to fund the costs of the exam fees (on the first sitting). Once dentists passed part C

[9] http://www.bmjcareers.com/cgi-bin/section.pl?sn=juniorcomp and http://www.rcplondon.ac.uk/International/news02MedicalGraduates.asp (accessed 10.05.06).
[10] Orissa, Bihar, West Bengal and Andhra Pradesh.

and registered with the GDC they would be able to take up a post as a dentist within the same practice.

113 candidates passed IQE A in India in February 2005 and of those 95 expressed an interest in working in England. The DH was only able to place 20 candidates in dental practices[11]. The DH was unable to provide exact figures but confirmed that by December 2005, 53 candidates had taken the IQE B, with some having also cleared IQE C. Dentists were also promised to be reimbursed the cost of IQE B if they were unable to secure a placement in the scheme. On 9 November 2005, the DH announced that the recruitment target had been met, the equivalent of 1,453 more dentists were recruited to the NHS, contributing to a net increase of 1,100 dentists (Department of Health; 9.11.05)[12].

How dependent is the NHS on overseas-qualified healthcare professionals?

The regulatory bodies for medicine, dentistry and nursing keep annual statistics on the number of registrants granted each year. All statistics have shortcomings, which must be noted. The data only records the registrants' country of qualification – this may be different from their country of origin and/or their nationality. In addition, not all those who register with the regulators will be working. With this in mind the statistics illustrate the NHS's increased dependency on overseas-qualified healthcare professionals.

Doctors

Table 1 shows the registration statistics for the "top 35" source countries (of Primary Medical Qualification) for doctors being admitted to the GMC register[13]. The table also includes UK registrants.

In 1999/2000 the percentage of UK registrants compared to all other registrants was 51 per cent. By 2001/2002 this was 39 per cent, and by 2004/05 this had dropped to 32 per cent. New registrants from the new countries admitted to the EEA in May 2004 for the year 2004/05 total 2,428 – about 15 per cent of all new registrants onto the GMC register. This is a leap from 1,461 in 2003/04 (about 9 per cent of all new registrants) and a steady increase from 65 in 1999/2000 (less than 1 per cent of all new registrants).

Dentists

Table 2 highlights the registration statistics for the "top 25" source countries (of Primary Dental Qualification) for dentists being admitted to the GDC register, which also includes UK registrants. The table however, does not distinguish between dentists registered through Section 16 (2A) of the Dentists Act 1984[14] and those who registered through taking the IQE.

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[11] These were placed in areas like West Midlands, Cheshire and Mersyside, Cumbria and Lancashire, Halton and Norfolk. 5 candidates were placed with Integrated Dental Holdings.

[12] This included 216 dentists recruited from Poland, 297 through other international recruitment and 230 from the IQE.

[13] This includes provisional, limited, full and specialist registration. The blip in the 2003 figures for South Africa, Australia, New Zealand and Hong Kong doctors is as a result of the closure of the old section 19 route to full registration with effect from 1 January 2004.

[14] A person who is an EU/EEA national who qualified outside EU/EEA, or a non EEA national with a non EEA degree who is married to an EEA national, can make an application to the GDC to be accepted for full registration.

In 2002/03 the percentage of UK registrants compared to all other registrants was 56 per cent. By 2004/05 the percentage had dropped to 34 per cent. It is clear from the statistics that Poland had been targeted for international recruitment in 2004/2005, with a leap from 157 to 408 new registrants. Registrants in 2004/05 from the new countries admitted to the EEA in May 2004 total 540 - without targeted recruitment from Poland this number would have been much less.

Nurses

It is worth considering new registrant statistics for nurses here, because nurses have been (and still are) heavily recruited from overseas. Table 3 shows the overseas registration statistics for the "top 25" source countries (of Primary Nursing Qualification) for nurses and midwives being admitted to the NMC register. This table does not include nurses and midwives trained within the UK and EEA.

In 1999/2000 the percentage of UK registrants compared to all other registrants was 90 per cent. By 2004/05 the percentage had dropped to 62 per cent. In 2004/05, and for the first time, India overtook the Philippines as the number one source country for nurses and midwives. Registrants in 2004/05 from the new countries admitted to the EEA in May 2004 total 231. This falls far short of the large numbers predicted from many forecasters.

All these statistics confirm the ever-increasing reliance the UK NHS system places on overseas-qualified healthcare professionals. It is worth noting what some of these statistics mean in relation to the countries the registrants are from. For example, in 2001 there were at least 60,000 Indian doctors working in the UK – that is 12 per cent of the total stock of doctors in India and 30 per cent of registered doctors in the UK (Commander, Kangasniemi, & Winters 2003). On average one in four doctors and one in twenty nurses trained in Africa are working in OECD countries. About 10 per cent of South African healthcare workers lived abroad in 2000 and 17 per cent of practitioners. Each year, Jamaica loses about 8 per cent of its registered nurses and more than 20 per cent of its specialist nurses (Lindsay, Findlay & Stewart 2004; WHO 2006).

II- Research methodology

Since 2001 the Migrant and Refugee Communities Forum[15] has run a support project for overseas-qualified doctors and dentists[16]. It has a database of 1,600 overseas-qualified doctors and dentists; that is 339 doctors and 1,261 dentists. For this study, a questionnaire was designed and emailed to all the 1,600 members of the database. In addition, it was also posted to members on the database who were asylum-seekers or refugees to try and encourage a high response rate among this sub-group; that is 166 doctors and 98 dentists. We wished to encourage a good response from members who were asylum-seekers or refugees because research (Bloch, 2004) has shown that refugees who arrive with professions often do not practice their professions in the UK. Some of the barriers that refugee healthcare professionals face include: difficulty in readjusting to basic level of medical knowledge needed to pass PLAB; their documentation may have been lost or destroyed; difficulties in securing references; and psychological problems as a result of trauma suffered (Berlin, Gill & Eversley 1997; Cowen 2003; Department of Health 2000; Department

[15] MRCF is a migrant and refugee-led community development agency, working with local community organisations in London. MRCF also delivers accredited training, advice and guidance, interpreting and youth work.

[16] The support includes IELTS classes, journal clubs, clinical training, financial support, professional communication and finding work training.

of Health 2003; Esmail & Everington 1997; Refugee Dentists Steering Group 2002; Stewart 2003; Winklemann-Gleed 2006).

The questionnaire was designed with the purpose of collecting primary data from overseas health professionals in order to investigate the following issues: motivational factors behind migration to the UK; the re-qualifying process; obstacles towards employability; and personal reflections upon the whole process.

We have also attempted to arrange interviews with representatives from the DH in order to get further clarifications on the various recruitment schemes of overseas health professionals; however, we did not succeed in this.

III- Research findings

Overseas-Qualified Doctors

39 questionnaires from overseas-qualified doctors were returned, which corresponds to an overall 11.5 per cent response rate. Of those who returned the questionnaires 26 came to the UK as asylum seekers – that is a 15.6 per cent response rate among the targeted sub group. The average age of doctors is 39. 48.7 per cent are female and 51.2 per cent are male. 95 per cent of doctors came to the UK within the last 10 years, with 59 per cent in the last 5 years (see table 4). The main countries of origin are: Iraq, Afghanistan, Iran, Colombia, Kosovo and Sudan (see table 5). The majority of doctors who came to the UK are asylum seekers, which corresponds to 67 per cent of the total number of respondents. 15 per cent entered the UK to join their spouse while only 7 per cent came for postgraduate training (see table 6).

Exams

The first barrier to registration for overseas doctors was the IELTS exam. It takes an average number of 3 sittings and around 21 months for doctors to obtain a passing score. It also takes on average, a startling 21 months, for overseas doctors to pass IELTS exams (see table 7). There have been constant representations made to the British Council and the regulators concerning IELTS. Concerns included lack of transparency, no detailed explanation of scores given, and inconsistent marking. Many respondents also asserted that the exam itself is not a reflection of their mastery of English; it is rather a question of 'luck', as this male Kosovan refugee doctor explains:

> *"It does not always mark correctly. For instance, in my first attempt I got 7 in speaking part, then 6 months later (my speaking had improved a lot but not in the ears of the new examiner)… he marked me with 6…I tried again and got an 8 on that part…IELTS board exam did not review my results on that occasion and the teachers' decision was final".*

About half the doctors claimed that they faced difficulties in getting support through the registration process with the GMC. 74 per cent have attended classes to help them prepare for their exams, which most affirmed they found useful. 48 per cent have received financial support to help them with the cost of exams, which are: £145 for PLAB 1 and £430 for PLAB 2[17]. Besides its high costs, BMA research also found that PLAB was possibly a discriminatory exam and concluded that a high proportion of British doctors would fail PLAB because of its clinical difficulty (BMA 2004a). When

[17] Refugee doctors are eligible for concessions from the GMC

a sample of 50 UK medical graduates took the PLAB exam only two passed (Stewart, 2003).

Many doctors felt that the PLAB exam was a waste of time and effort if, after passing, the competition was too high for jobs. Some regretted taking the PLAB and wasting their time preparing for it, while others expressed a desire for the PLAB to be cancelled unless more jobs were available:

> *"My regret is just wasting my time for taking PLAB test that couldn't secure me any job or improve my life standard. I wish I had never done PLAB…Overseas doctors had jobs, respect and position in their home countries. They come here to have a better life, training and job. If they knew they would be jobless and a Mr or Mrs nobody here, they would have never ruined their position in their country…. If there are no jobs then stop taking PLAB. PLAB and no jobs ruin the life of a young doctor"* (Male Iranian Migrant Doctor).
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> "*I really regret that I have been living in this country since January 1998 and still do not have a proper job. I regret that my knowledge and transferable experiences are ignored and wasted in this country. I wish I was able to use my knowledge and experience in the NHS"* (Male Afghan Refugee Doctor).

Employment

The respondents have on average 81 months of experience prior to coming to the UK. Since coming to the UK the average time of unemployment was 42 months, with the majority of respondents, 70 per cent, currently unemployed (see table 8). This long duration of unemployment is mainly due to the time spent on clearing all the required exams. Although some had taken employment while preparing for their exams, in a variety of fields such as interpreters, health care assistants, phlebotomists, chefs, cleaners, support workers, lecturers and sales assistants. In the case of refugee doctors especially, they are constantly being pressurised by job centres to work in any field to support themselves, "*I thought that this country will help a highly skilled professional person, and I never expect to face such a great problem with the job centre… they push you to do any job…They don't care if you are doctor or not"* (Female Iraqi Refugee Doctor).

It is important to note that even once they have passed all their exams, the majority of overseas doctors face major difficulties in securing jobs. For instance, according to our respondents, only 4 (that is 28.5 per cent) of those who have passed PLAB 2 have secured employment and a startling 9 (64.5 per cent) are unemployed (see table 8). This is partly as a result of the introduction of foundation posts, which have only one intake per year (whereas before there were two intakes per year). In addition, there is no clear guidance on where refugee doctors with many years experience fit into the foundation scheme – at F1 or F2 level.

Aspirations and Regrets

From the detailed accounts provided by the respondent doctors, it is clear that many found life very difficult since they entered the UK. Many had high hopes before coming: "*I thought I would be provided with every sort of support to help me get into my profession very quickly*" (Female Afghan Migrant Doctor); although those who

came seeking asylum generally had no expectations: "*I didn't have any expectations because I came to the UK by a chance. I came here as an asylum seeker*" (Male Iranian Refugee Doctor).

The long and strenuous process of re-qualifying as an overseas doctor in the UK, naturally affects the hopes and aspirations of many qualified health professionals. 37 per cent of doctors expressed regrets at coming to the UK. In their own words they said:

> *"I left the security of a permanent, full time, fairly well paid job in my country of origin, just for the sake of obtaining a postgraduate degree abroad so that I could go back and be better paid. However, the thing that I regret the most is having left my family behind. In these four years abroad, I have lost my father and my closest aunt. I tried really hard to become a better person, someone my family were proud of and they didn't live to see it. I wished I had spent that time there, with them"* (Female Colombian Migrant Doctor).
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> *"I feel like a wasted source of skills. I feel I have lost everything: my identity, my title, my career, my patients, my motivation, my hope for helping people in need. And I wouldn't write about lost family, friends, country etc"* (Female Iranian Asylum-Seeking Doctor).

Research has also shown that refugee healthcare professionals experience the mental effect of being devalued, under-utilised and de-skilled due to the length of time taken to re-enter their profession (Berlin, Gil & Eversley 1997; Cowen 2003; Department of Health 2000; Esmail & Everington 1997; Mian 1994; Refugee Dentists Steering Group 2002; Stewart 2003; Winklemann-Gleed 2006).

Overseas-Qualified Dentists

104 questionnaires from overseas-qualified dentists were returned – an 8 per cent response rate. Of those who returned the questionnaire, 26 have come to the UK as asylum seekers – that is 26.5 per cent response rate among the targeted sub-group. The average age of dentists is 32. 63.5 per cent are female and 36.5 per cent are male. 98 per cent of the dentists came to the UK within the last 10 years, with 76 per cent in the last 5 years (see table 10). The main countries of origin are: India, Iraq, Iran, and Pakistan (see table 11). Although a significant number of overseas dentists who came to the UK were asylum seekers, 25 per cent, the majority came to join their spouse, which corresponds to 53 per cent of the total number of respondents. 11.5 per cent came to seek employment and only 9.5 per cent came for postgraduate training (see table 12).

Exams

As with doctors, the IELTS exam was also described to be a major barrier towards registration. It takes an average number of 2 sittings and around 16 months for dentists to obtain a passing score (see table 13). Since the majority of overseas dentists originate from English speaking countries i.e. India, the relevance of the exam itself remains questionable. Several respondents felt that the exam was, as this Female Nigerian Dentist explains: "*Irrelevant, useless and unfair, since I had all my education in English and my classmate was exempted since he has a British passport. Is that not callous?"*

Although the majority of respondents understood the importance of mastering the English language before being able to register with the GDC, several could not however understand the logic behind imposing this language test on some nationals and not others:

> *"The GDC has to ensure that overseas dentists conform to a minimum standard in the language of this country. However, it's an anomaly that Indian and South African dentists who are usually educated in English and who have a good standard of English are required to take this exam while Eastern European Dentists are not"* (Female Indian Dentist).

As with overseas doctors, dentists also face major huddles in finding support through the registration process with the GDC. 63 per cent have attended classes to help them prepare for their exams, however only 39 per cent have received financial support to help them with the cost of exams, which are: £600 for IQE A; £650 for IQE B; and £1,550 for IQE C.

This re-qualifying exam process is even more difficult for refugee dentists, who often end up trapped in low skilled jobs as a response to job centre pressures. *"I was expecting help from various institutions, i.e. NHS, DH and the Home Office. The reality there is no help and the process of the exam is very long and unfair"* (Male Iraqi Refugee Dentist).

As with PLAB exams, concerns have also been raised by dentists taking the IQE about its lack of objectivity in part B particularly. Individuals have raised these concerns with the GDC and Channel 4 news also reported on the issue[18]. The non-standardised exams were major issues of debates. "*I am concerned about the different standards in different centres…and the pass rate in different centres are so varied that it puts you off to go to 1 of those ill reputed centres with very poor results"* (Female Indian Dentist).

Employment

The dentists have on average 50 months of experience prior to coming to the UK. The average time of unemployment since coming to the UK was 30 months. While 38 per cent were unemployed for the duration of all their exam sittings, only 23 per cent were able to secure part time or full time employment in dentistry related jobs such as a dental nurse. Some of the literature (UNISON 2006) has pointed out that a number of health professionals enter the low skilled market in order to be able to sustain themselves and their families as well as pay for their exams. This was also confirmed in our research sample (see table 14 below). Some of these jobs include: hotel receptionist, kitchen assistant or even work as a pizza delivery person.

> **"***I came here and had these dreams… I spent a long time of my life learning and studying, suffering from stress and tiredness, so that I end up working in kitchen…the problem is I have a family now, I can't take the decision easily to return back to Egypt"* (Male Egyptian Dentist).

After such a lengthy re-qualification process, the expectations of these overseas dentists of eventually securing a job in their field are naturally high, for some:

[18] Channel 4 news broadcast 12 April 2006. http://www.channel4.com/news/special-reports/special-reports-storypage.jsp?id=2168 (accessed 20.04.06).

"Although I think I was a very good dentist in my country. I believe I am a better one now. I should be! I have done my career twice! But I think that 5 years, which is the time it has taken me to re-register again as a dentist, is too much time. It is a waste of skills, time and money that the UK government and me have lost" (Female Colombian Refugee Dentist).

For a large number of overseas dentists, however, the re-qualification and employment process is so arduous that they just lose hope in being able to regain their professions.

" NHS is supposedly short of dentists, and there are several dentists who are asylum seekers here in the UK, but because of their many and difficult requests by the GDC for re-qualification, anybody after 3-4 years loses hope, especially that they don't see any organised support to get them back to the job market. In the meantime they have to work to survive; I'm shamefully working as a pizza deliveryman…we might end up stuck in these low skilled jobs forever…with small support, we could get back to our professions. Britain is losing out on existing skills in the country, and I'm losing my skills by being stuck in a low skilled job. I feel I'm a worker and not a dentist. By now my personality has changed…I've lost hope in working in my profession…" (Male Iranian Refugee Dentist)

"There are many refugee dentists getting depressed, wasting their skills and living on income support because this process is in many ways incompetent! I think the UK society that has helped these refugees should be able to benefit from all these qualified doctors and dentists instead of wasting their skills on a long tedious process" (Female Colombian Refugee Dentist).

The knowledge and experience that overseas dentists bring with them from their country of origin are made obsolete and 'unrecognisable' in the UK, leading inevitably to a process of devaluation of skills and experiences, as described by the following quote:

"The real difficulty with these exams is that it brought us back to our first years of college…it erased all the knowledge we have and the skills and experience that we had… When I came to the UK, I realised that I am standing in zero point and still I have to go a long hard way to re-establish my dental career… I have 20 years of experience in dentistry but I have been treated as a newly graduate, without taking into consideration my experience and knowledge" (Male Iraqi Refugee Dentist).

Even after clearing all the required pre-registration exams, the transition to the job market is not made easy because of the existing competition. From our research sample, there is 56 per cent unemployment and underemployment among overseas dentists who have completed their registration exams (see table 15).

One could argue that the recent new contract for dentists (introduced in April 2006) is the major cause behind such a high rate of unemployment among overseas dentists, and that maybe they received the wrong signals about the availability of jobs in the UK. However, when one comes across cases of 'recruited' Indian dentists who are currently unemployed, then one starts to wonder whether it is all a misreading of information from the part of overseas dentists, or is it really poor planning?

> *"The NHS came for recruiting dentist to England and gave false promise of giving us jobs till we finish our exam….so I quit my job and started the long tedious process of IQE in Feb 2005. … I had my part B fees reimbursed as a compensation for not giving us the job promised by the NHS. … the NHS went back on their word, now they suddenly increase fees … and now new rules …why were we recruited and brought here??? How can we feel secure here?"* (Female Indian Dentist).

This could be viewed as an exceptional case, but how could one explain that the majority of overseas dentists entered the UK in the last 5 years only, 78 per cent from our research sample. There must have been an overall strong pull factor for this migration trend to take place.

> *"I was under the impression that UK was acutely short of Dentists. I thought if I would have come to the UK I would have got immense amount of opportunities to develop professionally as well as personally. I had hopes to take up postgraduate training from the UK in order to improve my skills. I was ready and committed to work for the NHS…as long as there were provisions for postgraduate training"* (Male Indian Dentist).

The changing regulations that govern the employability of overseas health professionals is another major factor behind the high rate of unemployment. The latest regulation makes it compulsory for dentists to have a work permit to be able to practice, in addition to other requirements, as these two Indian Dentists explain:

> *"Passing the IQE and getting full registration with the GDC is still not a great deal now as the new regulations prevent us from joining NHS practice by the introduction of the Performers List and the mandatory vocational training! It is my personal experience that after securing a Temporary registration with the GDC I am still being prevented from undertaking the duties of an MFDS recognised Dental Attachment Training post like treating patients etc as the authorities have issued me a " Dental Observation Visa" as per the new immigration laws. As I have a Temporary registration with the GDC, I am entitled to practice dentistry under supervision of the Consultant. But there has been no satisfactory explanation in this regard from the Home Office till now"* (Male Indian Dentist).

> *"At the moment there is so much uncertainty of whether overseas dentists will be able to practice or not in this country. It is scary to think that after spending a lot of our time, energy and money to pass the IQE we might not get a job"* (Female Indian Dentist).

Aspirations and Regrets

A complicated, costly and time consuming re-qualification and registration process combined with changing regulations, would almost certainly affect the hopes of overseas dentists in rejoining their professions. Therefore, it is not surprising that many, over 35 per cent, of the respondents expressed regrets about coming to the UK.

> *"Life is never the same after coming to the UK. I have gone through depression, which I have never experienced in my life before… all these might look silly once I finish the exams. But when we go through this, I should frankly admit that it is not a bed of roses"* (Female Indian Dentist).

The sense of loss of status for refugee dentists is even greater, as they did not choose to come to the UK but were forced instead to flee for their lives, leaving the stability of their jobs, and compelled to put their lives back into pieces again to achieve a sense of 'normality'. The process is never easy or straightforward.

> **"***I came here because I didn't have the choice, I flee from my country because of my political opinion, but I see now apart from all I lost, here I lost my personality, my dignity, my degree, my qualifications etc. I regret that because of my political opinions I lost my life…"* (Male Iranian Refugee Dentist).

IV- Policy implications and recommendations

Refugees and Settled Migrants

There are many overseas-qualified healthcare professionals already settled in the UK working towards the registration exams. Numbers on migrant healthcare professionals are not available but databases of refugee healthcare professionals indicate there are 1,087 asylum-seeking/refugee doctors; 237 nurses; and 98 dentists[19]. These are a resource that should be tapped into (i.e. the efficient use of existing resources). Currently, refugees have to rely primarily on NGOs[20] to support them through the re-qualification process. The UK Government is seriously deficient in its provision of support for refugee healthcare professionals. For example, the Department of Health Steering Group on Refugee Healthcare Professionals funded projects from 2001-2005. The Steering Group has now been wound up and no centralised source of funding is available. The UK Government has a duty to ensure refugee skills are not wasted and that refugees integrate into society.

In addition, the welfare benefit polices push highly qualified professionals into underemployment. These policies are not only detrimental to the NHS, they also affect the aspirations and motivations of the individuals. Many suffer mental health problems due to a drop in status and the inability to work in their professions. As one doctor explained:

> *"Doctors shouldn't be worried about doing another jobs like minicabs, pizza delivery etc. to have their financial support and every opportunity should be given to them to concentrate only on medicine other than anything else"* (Female Afghan Doctor).

Recommendations: The government should prioritise support for refugee healthcare professionals and earmark funds for a strategic programme to assist refugee professionals in passing their registration exams. In addition, the government should ensure that regulators provide concessions for refugee healthcare professionals for the fees of exams.[21] Welfare benefit policies need to be reassessed.

Immigration

The new immigration point system introduced in April 2006 encourages highly skilled migrants to enter the country, and yet paradoxically, health professionals are not able

[19] Data from Refugee Doctors' Database, Refugee Nurses' Database and MRCF database.
[20] For example, Prisoners of Conscience, Council for Assisting Refugee Academics (CARA) and Refugee Assessment and Guidance Unit (RAGU).
[21] The General Medical Council already provides concessions to refugee doctors.

to secure employment, due to work permit requirements. This means the NHS will no longer attract the best and the brightest. Under this system it is likely that health professionals will continue to migrate to the UK but will no longer be able to secure employment or training posts. This potentially provides incentives towards employment in the informal sector. The previous system of permit-free training for postgraduate doctors and dentists was time-bound and allowed overseas health professionals to receive high quality training in the UK and transfer their knowledge back to their countries of origin. Under the new system this will no longer be the case.

The costs of international recruitment programmes are far higher than costs related to supporting overseas-qualified healthcare professionals already in the UK. For example, the costs for recruiting dentists in India in 2004 included administrative costs; trips to India to organise the IQE A; hiring the dental institutes in India for the exams; examiners costs to travel to India; IQE B (£650) and C (£1,550) costs for successful candidates; and dental nurse placements for successful candidates (an average dental nurse salary is between £15,000-£20,000 per annum). The DH refused to provide the same level of financial support to overseas-qualified Indian dentists already in the UK. This is contradictory to the main objective of the recruitment exercise aimed at filling vacancies in the NHS with overseas-qualified dentists. If the DH had offered the same support to dentists already in the UK who had passed IQE A they could have supported more dentists to work in the NHS at a fraction of the cost.

> *"We could have saved £100,000 to the British government, if only they could have taken consideration of cases like mine and spent about £10,000 on every qualified dentist in 1-2 years to help them take exams and start to work for the NHS. It could have benefited both the British government and the existing dentist in the country…"* (Male Iranian Refugee Dentist).

Recommendations: There should be defined time-bound opportunities for postgraduate training for overseas-qualified healthcare professionals. International recruitment should be focused and limited to defined specific shortages in a professional cadre. Where the recruitment is to take place it must be considered carefully and must take into account the limited human resource capacity within low-income country health systems and its impact on the Millennium Development Goals (Bueno de Mesquita & Gordon 2005). There must be a cross-Whitehall approach to issues of migration, poverty reduction and development outcomes (DfID 2006).

Registration Exams

EU and EEA nationals are exempted from both language and qualifying exams, even if they are from a non-English speaking country, while other third country nationals are still required to take both exams. The majority of respondents felt that the current regulation was unfair and unjustifiable.

> *"I have quite often wondered about the irony of the situation…people like me, who have done all or most of our education in English still have to prove our competency in the language by giving IELTS exam before we are allowed to sit for the IQE. And people from the EEA (i.e. a Polish qualified dentist, who may have a serious problem with English) can just walk up to the GDC (no IELTS, no IQE) and get registered! I'm not too happy about the double standards here"* (Male Indian Dentist).

The regulations concerning registering overseas doctors and dentists are so particular that they sometimes become puzzling:

> *" I'm a Dutch national but the GDC doesn't want to register me as a dentist like the other dentists who have EEA nationals because my dental primary degree is from Iraq, although I have 8 years work experience"* (Female, Iraqi Refugee Dentist).

> *"I don't need to take any exams because my husband is a European citizen and as a spouse, I am entitled to be treated as a European, so I am exempt. Even though, I will take IELTS for myself"* (Female Venezuelan Dentist).

It is understandable that some respondents felt that these regulations were discriminatory towards non-EU and EEA nationals.

> *"The GDC should respect equal opportunity and don't discriminate between European dentists and overseas dentists. The current system is very difficult and unfair for overseas dentists. I studied about 6 years to get my doctorate in dentistry. While, European dentists or even the British dentists study 5 years for getting BDS…. from my point of view, this is discrimination"* (Male Iranian Refugee Dentist).

Recommendations: Regulators should undertake a review of the re-qualification exams (Stewart, 2003) and standardise the exam settings. In particular the GDC should urgently review the different standards of exam centres for IQE B:

> *"There should be a transparent system of assessing candidates for their proficiency, since the candidates performance on that particular day is what counts; nothing in his/her past qualifications is considered"* (Female Indian Dentist).

Regulators should also consider limiting the number of places available for the registration exams if no jobs are available[22]. Although the regulators argue that they only administer the exam and that exam places are not linked to job opportunities, it is clear that overseas-qualified healthcare professionals believe that if there are exam opportunities then there must be available jobs. Linked to this point there should be clear and up-to-date information on relevant websites regarding employment opportunities in the UK and statistics on the experiences and employment of PLAB and IQE candidates (McGinn & Haivas 2005).

[22] From 10 April 2006 the GDC has stopped taking applications from new registrants applying for the IQE. They argue this is because there are not enough examining centres to meet the increased demands for the IQE. They will review this policy after 6 months. This policy is not linked to job opportunities.

PMQ Country	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005
Jordan	11	18	24	24	22	39
Malta	12	13	19	18	34	40
Nigeria	31	50	41	41	39	40
Ukraine	2	15	25	11	51	46
Bulgaria	14	11	11	10	35	47
Switzerland		3	25	34	42	49
Australia	269	276	328	2,099	13	65
Latvia	1	3	3	3	26	65
Denmark	24	30	42	39	54	66
Iraq	51	47	68	38	52	67
Syria	34	51	56	36	52	69
Romania	24	27	34	37	68	72
Sudan	25	35	46	60	85	74
Bangladesh	10	33	37	38	54	77
Austria	50	50	84	76	108	87
Belgium	57	57	71	117	132	87
Slovakia	1	5	2	4	54	105
Egypt	64	73	81	95	74	106
Iran	30	32	45	46	79	107
Russia	23	32	46	42	91	109
Sweden	81	85	92	100	240	138
Sri Lanka	51	84	158	138	185	150
Republic of Ireland	259	207	188	195	186	152
Spain	85	92	140	154	136	171
France	65	81	143	157	242	191
Lithuania		3		2	64	209
Italy	220	216	213	288	386	349
Czech Republic	16	30	27	31	272	377
Greece	239	228	266	375	531	447
Hungary	18	18	21	41	255	508
Pakistan	144	276	484	663	957	907
Poland	17	18	21	19	736	1,084
Germany	489	352	422	494	1,071	1,230
India	868	1,215	1,940	3,203	3,650	2,940
United Kingdom	4,443	4,044	4,350	4,708	4,709	5,078
TOTAL	**7,728**	**7,810**	**9,553**	**13,436**	**14,785**	**15,348**

Table 1: Initial (overseas and UK) admissions to the GMC register by country for top 35 countries
Source: General Medical Council, 2006

PDQ Country	2002/03	2003/04	2004/05
Netherlands	4	1	5
New Zealand	13	12	5
Norway	4	6	5
France	9	6	7
Malta		11	8
South Africa	55	37	9
Belgium	6	5	10
Denmark	14	15	10
Latvia		3	11
Czech Republic		8	19
Slovakia		11	19
Australia	42	18	24
Italy	13	22	25
Hungary		34	28
Lithuania	1	22	42
Dentists Act	21	35	51
Ireland	51	50	53
Portugal	14	48	56
Sweden	80	68	78
Spain	54	61	109
Greece	54	79	114
Germany	56	73	125
IQE	87	172	252
Poland		157	408
United Kingdom	757	772	777
TOTAL	**1,335**	**1,726**	**2,250**

Table 2: Initial (overseas and UK) admissions to the GDC register by Primary Dental Qualification country for top 25 countries
Source: General Dental Council, 2006

PNQ Country	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05
Sierra Leone						24
Singapore						28
Japan				20	37	34
Lesotho					50	43
Sri Lanka				23	36	47
Malawi	15	45	75	57	64	52
China						60
Swaziland					81	69
Nepal				71	43	73
Canada	130	89	79	52	89	88
Botswana	-	87	100	39	90	91
Kenya	29	50	155	152	146	99
Mauritius	15	41	62	59	95	102
USA	168	147	122	88	141	105
Zambia	40	88	183	133	169	162
Pakistan	13	44	207	172	140	205
Ghana	74	140	195	251	354	272
New Zealand	461	393	443	282	348	289
Zimbabwe	221	382	473	485	391	311
West Indies	425	261	248	208	397	352
Nigeria	208	347	432	509	511	466
South Africa	1,460	1,086	2,114	1,368	1,689	933
Australia	1,209	1,046	1,342	920	1,326	981
Philippines	1,052	3,396	7,235	5,593	4,338	2,521
India	96	289	994	1,830	3,073	3,690
Others	329	472	605	418	514	380
TOTAL ALL OVERSEAS	**5,945**	**8,403**	**15,064**	**12,730**	**14,122**	**11,477**

Table 3: Initial (overseas) admissions to the NMC register by Primary Nursing Qualification country for top 25 countries
Source: Nursing & Midwifery Council, 2005

Length of residence in the UK	No of doctors	% of total
More than 16 years	1	2.5
11-15 years	1	2.5
5-10 years	14	36
Less than 5 years	23	59

Table 4: Doctors' length of residence in the UK

Country of Origin	No of doctors	% of total
Iraq	6	16
Afghanistan	5	13
Iran	5	13
Colombia	4	10
Kosovo	4	10
Sudan	4	10
Algeria	3	8
Ukraine	2	5
Yemen	2	5
Azerbaijan	1	2.5
Cuba	1	2.5
Pakistan	1	2.5
Romania	1	2.5

Table 5: Doctors' countries of origin

Reason for coming to UK	No of doctors	% of total
Asylum seeker	26	67
Join spouse	6	15
Postgraduate training	3	7
Seek employment	2	5.5
Others	2	5.5

Table 6: Doctors' reason for coming to the UK

Exam	No passed	% of total	Average time in months to prepare	Average number of sittings to pass exam
IELTS	34	87.1	21	3
PLAB 1	21	53.8	8	1
PLAB 2	14	35.8	5	1

Table 7: Doctors' exam passes

Employment status whilst preparing for exams	No of doctors	% of total
Unemployed	29	69
Phlebotomist	3	7
Health Care Assistant	2	5
Interpreter	2	5
Chef	1	2
Cleaner	1	2
Lecturer	1	2
Sales Assistant	1	2
Support worker	1	2
Waiter	1	2

Table 8: Doctors employment status whilst preparing for exams

Current employment status	No of doctors	% of total
Health Care Assistant	1	7
Pre-Registration House Officer	1	7
Senior House Officer	3	21.5
Unemployed	9	64.5

Table 9: Employment in the UK for doctors who have passed PLAB 2

Length of residence in the UK	No of dentists	% of total
More than 10 years	2	2
5- 10 years	23	22
Less than 5 years	78	76

Table 10: Dentists' length of residence in the UK

Country of Origin	No of dentists	% of total
India	38	37
Iraq	17	16
Iran	8	8
Pakistan	7	6.5
Brazil	5	4.5
Nigeria	5	4.5
Colombia	4	3.5
Kosovo	3	3
Sri Lanka	2	2
Syria	2	2
Venezuela	2	2
Afghanistan	1	1
Bangladesh	1	1
Egypt	1	1
Jordan	1	1
Kenya	1	1
Kuwait	1	1
Moldova	1	1
Palestine	1	1
Romania	1	1
South Africa	1	1

Table 11: Dentists' countries of origin

Reason for coming to UK	No of dentists	% of total
Asylum seeker	26	25
Join spouse	55	53
Postgraduate training	10	9.5
NHS recruitment in India	1	1
Seek employment	12	11.5

Table 12: Dentists' reason for coming to the UK

Exam	No passed	% of total	Average time in months to prepare	Average number of sittings to pass exam
IELTS	90	86.5	16	2
IQE A	72	69.2	8	1
IQE B	38	36.5	8	1
IQE C	16	15.3	4	1

Table 13: Dentists' exam passes

Current employment status	No of dentists	% of total
Unemployed	63	60
Dental Nurse	18	17
Dental Assistant	4	4
Dentist (in own country)	4	4
Clinical Teacher	2	2
Hotel Receptionist	2	2
Senior House Officer	2	2
Dry-clean driver	1	1
Health Records Clerk	1	1
Internet café	1	1
Interpreter	1	1
Kitchen Assistant	1	1
Notes summariser	1	1
Pizza Delivery	1	1
Receptionist	1	1
Royal Mail	1	1
Secretary	1	1

Table 14: Dentists' employment status whilst preparing for exams

Current employment status	No of dentists	% of total
Senior House Officer	1	6.5
Student	1	6.5
Other non-related dentistry jobs	1	6.5
Dentist	6	37.5
Unemployed	7	44

Table 15: Employment in the UK for dentists who have passed IQE C

Glossary

AHP	Allied Health Professional
BAIPO	British Association of Physicians of Indian Origin
BDS	Bachelor in Dental Surgery
BMA	British Medical Association
DfID	Department for International Development
DH	Department of Health
EEA	European Economic Area
GDC	General Dental Council
GMC	General Medical Council
IELTS	International English Language Testing System
IQE	International Qualifying Exam
JDC	Junior Doctors Committee
MFDS	Membership of the Faculty of Dental Surgeons
MRCF	Migrant and Refugee Communities Forum
NMC	Nursing and Midwifery Council
NHS	National Health Service
PDQ	Primary Dental Qualification
PLAB	Professional Linguistic Assessment Board
PMQ	Primary Medical Qualification
PNQ	Primary Nursing Qualification

Appendix A: Alternative Routes to Registration for Doctors

The overseas doctors training scheme (ODTS): Established in 1984, the scheme is run by the royal colleges, with support from the education department of the NHS Executive. The scheme is a dual sponsorship programme administered by the medical royal colleges. ODTS graduates are expected to return to their own country on completion of the agreed period of training. The dual sponsorship scheme allowed a senior colleague (first sponsor) from overseas to arrange a training post with a consultant in Britain. The UK consultant becomes the second sponsor. With this recommendation the trainee doctor gets registration (without taking PLAB) and a first training post in Britain. Competition for places on the ODTS is very high.

Appointment to a type 1 specialist registrar post: Type 1 posts are educationally approved higher specialist training posts. Registration is restricted to the speciality concerned.

Eligible for specialist registration: Doctors who are recommended by the Specialist Training Authority of the Medical Royal Colleges (STA) for entry to the specialist register on the basis of overseas training may obtain limited registration. Registration is restricted to the speciality concerned.

Completion of basic specialist training: Doctors who in addition to their primary overseas medical qualification and twelve months' postgraduate internship, can provide evidence that they have completed basic specialist training to the satisfaction of the appropriate UK postgraduate training body can be granted limited registration to cover supervised appointments in the speciality in which basic training has been completed.

International Fellowship Programme: This scheme is designed to recruit consultants who are abroad to selected posts for one to two years only. Trusts carry out their own recruitment.

Appendix B: Immigration Rules for overseas-qualified doctors and dentists

Prior to the change in rules in which came into effect on 3 April 2006 the immigration rules were as follows for overseas doctors/dentists:

Type of work/training	Immigration Requirement
To sit PLAB test	PLAB or visitors visa.
To train in hospital or community health post	Permit free status 4 years maximum for basic specialist training. 3 years initially for higher specialist training then extensions of up to 3 years at a time if postgraduate dean supports and HO agrees.
To work in hospital career grade (non-training) – as consultants or as salaried or locum GPs	Employer must obtain a work permit.
To train in general practice	Permit free postgraduate training status.
To work as GP principal	Highly skilled migrant programme.
To work solely in private practice	Self employment rules apply.

Immigration requirements for overseas doctors prior to 3 April 2006
Source: BMA 2004b

Following the change in immigration rules which came into effect on 3 April 2006 the immigration rules for overseas doctors/dentists are as follows:

Type of work/training	Immigration Requirement
To sit PLAB test	PLAB or visitors visa
To train in hospital or community health post	Work permit - must prove that there are no UK or EEA qualified doctors who meet the requirements of the post.
To work in hospital career grade (non-training) – as consultants or as salaried or locum GPs	Employer must obtain a work permit.
To train in general practice	It is currently unclear whether doctors will be allowed to apply for GP jobs.
To work as GP principal	It is currently unclear whether doctors will be allowed to apply for GP jobs.
To work solely in private practice	Self employment rules apply.

Immigration requirements for overseas doctors from 3 April 2006
Source: Raghuram 2006

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