Unpacking the Global Health Workforce Shortage and Supporting Migrant Healthcare Workers

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Introduction
In 2015 the World Health Organisation (WHO) estimated that only half of the world’s population had access to appropriate health services.[1] An essential element of achieving the Sustainable Development Goal (SDG) of ‘Universal Health Coverage’ is having appropriate health workforce. This is outlined in SDG 3c which requires financing for ‘the recruitment, development, training and retention of the health workforce’. [2] In Australia the domestically trained health workforce is not sufficient for the growing population, and as such internationally trained graduates are recruited.[3] This movement of health workforce toward higher income countries exacerbates global maldistribution, however policies prohibiting international recruitment pose an ethical dilemma.[4] Additionally, recruitment of migrant health workers from lower income countries may not be effective if not paired with effective professional support, such as that provided in skilled migrant mentoring programs. Supporting healthcare workers to prevent workforce attenuation due those leaving the field is crucial to addressing health workforce shortages, alongside increased local training for reduced international migration and maldistribution.

Global workforce shortage and maldistribution
The world is currently facing both a shortage and a maldistribution of healthcare workers.[5] This maldistribution has resulted in a disproportionate shortage in developing countries, which is in part due to migration of healthcare workers to more affluent countries.[4] It is estimated that 1 billion people don’t have access to a health worker.[6]

Worldwide, 40% of countries had fewer than ten doctors per 10,000 people.[1] This deficiency is more common in developing countries, 90% of which have fewer than ten doctors per 10,000, as opposed to developed countries, only 5% of which are affected (figure 1).

A significant contributor to this disparity is the migration of doctors, often from developing to developed countries.[7] A proposed solution to this phenomenon is to reduce acceptance of healthcare workers from developing countries. However, this presents an ethical dilemma; the rights of the individual contrasting with the needs of the community.[8] It is unethical to prohibit the movement of healthcare workers, particularly those from disadvantaged areas who may be facing
persecution or poor living conditions.[4] In these situations, overly stringent guidelines may result in skilled healthcare workers taking jobs outside of their profession in order to seek opportunities in other countries.[9] This can exacerbate the deficiency of health professionals and waste the resources utilised in training each doctor.

WHO Code of Practice

In response to the global health workforce shortage, the WHO created the WHO Global Code of Practice on the International Recruitment of Health Personnel. The objective is to ‘mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel’. [8] It states that; (1), developed countries should provide technical and financial support to strengthen health systems through development of health personnel; (2), in recruitment, countries should consider the source countries citizen’s rights to the highest attainable standard of health; (3), the code should not limit the freedom of individual personnel; and (4), international recruitment should be transparent, fair, and promote sustainable health systems in developing countries.[6] The impact of this code of practice was evaluated 11 months and 4 years after its adoption, and no difference was found in the recruiting practices of the four largest destination countries; Australia, the UK, the US and Canada.[4]

Australian health workforce

At present, Australia does not have a self-sufficient health workforce; if current training and recruitment trends were to continue, by 2025 there would be an estimated shortfall of 2,500 doctors, rising to 5,000 by 2030.[10] It is considered more economically sustainable to recruit internationally.
trained doctors than to train locally.[3] Australia is therefore an active recruiter of health workers, with 32.2% of Australian health professionals trained overseas.[11] A possible solution to this problem is to increase the number of positions for medical training, but while there may be space to expand the number of medical students in Australian universities, there remains limited positions in postgraduate training programs. The current bottleneck in prevocational, and to a lesser degree vocational, training positions results in disruption to the training pipeline.[10] To address this, clinical placements in medical school and postgraduate training require capacity in terms of infrastructure as well as educators.

The globalisation of healthcare and health workforce is increasing in response to external factors such as economic globalisation and environmental degradation are blurring the lines of borders. To both minimise the impacts of workforce shortage and the inequity of healthcare in developing countries, Australia must both bolster its own training capacity and support lower income countries to do the same.

Supporting migrant healthcare workers in Australia

The experience of doctors migrating to Australia has been reported on in the ABC’s article “Doctors and engineers end up driving taxis’: The uphill battle facing migrants to Australia’. [9] It suggests that one of the most significant barriers faced by migrant workers seeking employment in the Australian healthcare system is the requirement to have local experience in order to gain employment. Without local referees or experience, hospitals are unwilling to hire overseas-trained doctors, even after applicants having jumped through a multitude of hoops to gain Australian registration. This raises the questions of how to integrate skilled workers into local employment positions. A model has been implemented in the business sphere by City East Community College, which utilises mentoring to provide support and foster networks between established professionals and newly arrived skilled migrant workers.[12] The program’s founder and coordinator, Margaret Teed, explains how this project works and how it might be applied to the health system.

Thank you so much Margaret for taking the time to meet with me today and discuss your program.

Can you tell me a bit about what it involves and why you started it?
The City East Mentor Program is based on the former NSW Government funded ‘Skilled Migrant Mentor Program (SMMP). In 2016, City East Community College saw a need amongst people, professionally skilled migrants, refugees and asylum seekers with functional English and full work rights, who have spent at least 6 months looking for work. There is a ‘brain waste’ of skilled and qualified people washing dishes, driving Ubers and painting houses. The program aims to support people to work to their full potential and contribute to Australian society.

So how does the City East Mentor Program actually work?
I’ll walk you through one of our success stories. Ali was a statistician in Pakistan with over 10 years work experience, and his last job was with the state bank. He came to Australia under the skilled migrant visa program, which is how the majority of our clients arrive. This needs to be applied for from the home country and prior to application he had to upskill in English language and have his qualifications assessed, a long and costly process. Once successful, Ali was able to move to Australia with his family with permanent residency and full work rights. Ali had been in Australia over 12 months and submitted well over 100 job applications with little or no response. He ended up getting night work as a security guard and was told by everyone in his community ‘forget about finding professional work, you’ll only ever be a security guard’. Ali undertook a ‘Skillsmax’ 5-week course for migrant professionals focussing on Australian workplace skills and culture. I do presentations at these courses and personally interview everyone who applies. Then I match them with appropriate mentors.

I matched Ali with Janet, a HR and finance professional who has worked at the big four [accounting firms] but is now semi-retired. They worked hard together over 7 months. The program process is for mentors and mentees to have contact at least once every two weeks, by skype, email or in-person, to support people in their job strategies. They work on resumes, cover letters, LinkedIn profiles, interview skills, and how to ‘sell yourself’ to prospective employers. The interview process in other countries can be very different to Australia, for example, we have more behavioural style questions. Mentors also assist in broadening the professional network. Ali’s success story is that he is now working as an analyst for a
What components did you need to set up the program?
The first thing was creating processes, how it would all come together, and criteria for both the mentees and mentors. Then it was a matter of sourcing both. Job seekers were fairly easy to find, through TAFE and other organisations, we created partnerships with the Asylum Seekers Centre and multicultural centres. The mentor base was more difficult, I sent emails to 100 mentors in the database from the previous SMMP program, we got 20 back and 10 of them converted to mentors. Beyond that I advertised on seek, but it was very much word of mouth. We’ve since established links with companies through personal connections who now support us by encouraging staff to volunteer.

What barriers are experienced by your program?
Funding is the biggest problem. For the first two years of the program we had no funding and I was working alone one day a week, which then had to increase to two days. We did get NSW Government funding for 12 months, but despite exceeding all of the goals for the program, the funding ceased June 2019. Currently we’re operating on one grant from a philanthropic organisation, a little support from our partner companies, and small grants from councils to run networking events. We’re operating at a funding shortfall, and City East Community College accounts for this.

What are the main outcomes of this professional mentoring program?
Mainly employment outcomes, 58% of our jobseekers get work within 5 months of being matched with a mentor, and we’ve paired over 320 job seekers with mentors. In addition, there are social impact outcomes of connecting community and supporting migrants in their transition into life and work in Australia.

Do you think this could be successful in the healthcare sector? What are some barriers you could foresee to implementation?
We’ve had very few healthcare workers through the program. It’s mainly because I don’t actively seek jobseekers; they find me. Most of our applicants participate in Skillsmax courses and the majority of applicants have engineering, IT and finance backgrounds. The few we’ve had – one was a doctor from Iran who we matched with a mentor in a hospital in Sydney. She had to seek people she could shadow for Australian experience. We’ve also had a pharmacist who was able to get a pharmacy internship position here, and a dentist from Iraq who was very highly qualified and matched with a dentist here, he was able to undertake dental assistant work while going through the process. We’ve also got a healthcare worker from Myanmar who’s currently trying to get JMO work and going through that long, involved process.

Support of migrant healthcare professionals who enter Australia continues to be an issue, leading to trained doctors and other healthcare workers seeking employment in roles outside of their field. The ‘City East Mentor Program’ is a model which may be useful in the healthcare industry to match doctors going through the process of AMC and MBA accreditation with established professionals to organise opportunities for shadowing and growing professional networks. Greater support for migrant healthcare workers will reduce ‘brain waste’ in the professional space and prevent exacerbation of global health workforce shortages.

About the Author
Dayna is a fifth year UNSW medical student in the BMed/MD program at the Albury/Wodonga campus. She holds volunteer committee positions with AMSA and UNSWMS where she explores her passions for medical education, rural health and student advocacy.

Conflicts of Interest
N/A

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Images
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