

Mutually Beneficial Immigration is Key to Global Healthcare Sustainability

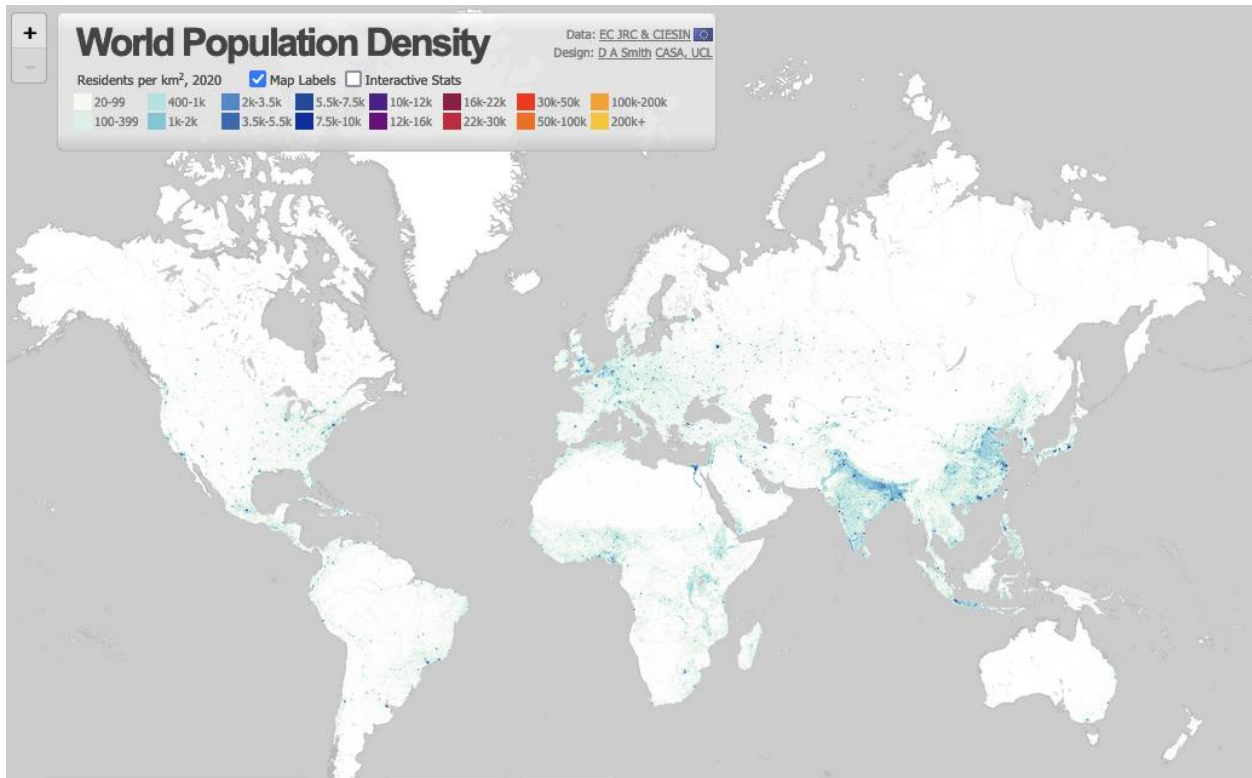
Background

It is estimated that this unequal world we live in, will need 80 million health workers to meet the demands of the global population by the end of the decade, double the number in 2013.^{1,2} The population distribution across the globe is skewed (Fig 1) with high densities in Africa, South Asia and South America which characteristically remains mismatched to their gross domestic product and net wealth, which is enjoyed by nations with the least population densities (Fig 2). Healthcare provision within geo-politically separated nation-states continues to be driven by local social, political and economic factors. Therefore, the adage of 'no size fits all' is applicable. No two countries have the same healthcare system, anywhere in the world, we know today. Yet the desire to achieve 'Health for All' should be universal.³ Implementation of the fundamental principle that health promotion and prevention must be prioritised before the resource intense diagnosis and management of maladies, is believed to be the only way to achieve any form of sustainability in healthcare provision.

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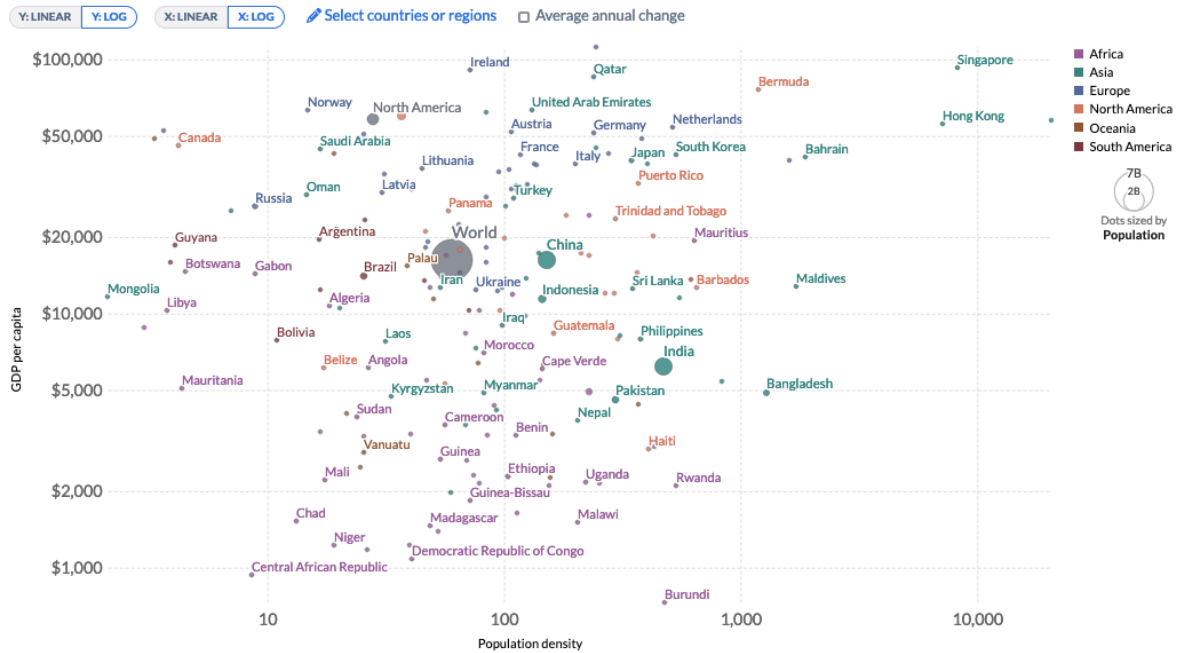
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GDP per capita vs population density, 2020

Population density is the number of people per km² of land area. To allow comparisons between countries and over time, GDP per capita is adjusted for price differences between countries and adjusted for inflation - it is measured in international-\$.
 Our World in Data



Source: Data compiled from multiple sources by World Bank; UN WPP (2022)

OurWorldInData.org/economic-growth • CC BY



In addition to population densities, the fundamental difference in nation states in the 'global south' are the bulging strata of young people compared to the ageing populations of the 'global north'.⁴ What this means in terms of growth of industries, services including healthcare provision is that the manpower that is essential for success and sustenance resides in the global south. Much of the global industrial production or remotely managed services have moved over the last fifty years to countries like China, India, Bangladesh and Brazil, benefiting from the availability of a huge pool of trained manpower. The power that emanates from a steep economic-political gradient has allowed for exploitation of the lower socio-economic norms, poor governance and the easy corruptibility of the political leadership in such countries, to drive up profits. In principle, healthcare is not different to this global phenomenon except for one key fact – that healthcare provision requires a physical proximity between the care giver and their client. This fundamental requirement leads to the challenge of balancing the inevitability of migration and the right-wing rhetoric of 'foreigners taking away jobs'.⁵ This is the geopolitical faultline^{6,7} where organisations that provide advocacy for the rights of immigrant professionals such as Global Association of Physicians of Indian Origin and its constituent member organisations AAPI and BAPIO sit, as well as those that represent nursing professionals and so on.

Registration-Regulation & Managed Migration

Society's need to regulate healthcare professionals comes from the immense power to do good as well as harm that comes with the territory. Hospitals or places to provide care to people in sickness have existed from antiquity and so have centres of learning for healers or doctors.⁸ In the UK, the College of Physicians in London was one of the first to receive the royal charter in 1518, which allowed to take on the role of setting the standards and certifying doctors, from Bishops who held the

power to license health practitioners from 1411 AD.⁹ This role was taken over by the Registrar of the General Medical Council in 1858.¹⁰ Since then, the UK has professional regulation bodies for nine regulated healthcare professionals. The need to protect the public from 'quacks' has driven the need for registration and the protection from harm by acts of omission or commission by 'errant or rogue' health professionals drive regulation. Therefore, assessing the authenticity of a health professionals' education and training is key to the safety of healthcare provision in any nation-state.

Education and training of health professionals has been conducted from antiquity by personal apprenticeships then by higher education institutions (HEI), aiming to provide a level of standardisation and moving away from the power of knowledge held by individual practitioner - teachers. Even with the move to HEIs, the medical education required several years of theoretical and practical learning and huge resources. In most countries with a state sponsored healthcare system, this is borne by the public purse. Resources are not infinite, hence there is unlikely to be a time when even the wealthiest nation-state can be self-sufficient. Mostly, there is a semblance of workforce planning which attempts to match production to projected demand. However, the long period of training makes it impossible to achieve any degree of accuracy in predicting what demand will look like in 10-20 years' time.¹¹ There are exceptions such as in the West Indies where there appears to be a surplus of doctors to local requirements. Studies of factors that drive migration also demonstrate the influence of push and pull dynamics.¹² In most situations the driver for migration appears to be economic- either poor opportunity in home countries with impoverished healthcare to areas of abundance.

Immigrant Health Professionals

Overall, there will always be a need for migration of health professionals, which is increasing in

volume and growing in its complexity. Immigrant health professionals particularly doctors and nurses are a vital part of global healthcare sustainability. They underpin effective responses to health emergencies and the achievement of Universal Health Coverage. They also bring cultural diversity, additional skills, and knowledge to the health systems they work in. Migrant doctors, also known as international medical graduates (IMGs) or foreign-trained physicians, are medical professionals who have obtained their medical degrees in a country other than the one they are currently practicing or seeking to practice in. Data from over 80 WHO Member States indicate that across countries over a quarter of doctors and over a third of dentists and pharmacists are foreign-trained and/or foreign-born.^{13,14} The WHO Global Code of Practice on the international recruitment of health personnel is a key global governance instrument adopted in 2010, which sets out ethical norms and contributes to sharing of data on migration and fosters international cooperation. The desire is to self-regulate the managed and sustainable migration of HCPs without overwhelming or compromising healthcare workforce in adopter as well as host countries. Many high-income countries are heavily dependent on internationally trained doctors to staff their healthcare workforce. Around one-third of doctors practicing in the UK or USA and up to 41% in Australia or countries in the Middle East, received their primary medical qualification abroad. Simultaneously, an average of around 2% of doctors leave the UK medical workforce annually to go overseas.¹⁵ The migrants' integration experiences depend on their cultural awareness, discrimination, proficiency of language and communication skills, availability of social and professional support networks, social integration and personal attributes.¹⁶

Sustainability

Overall, migrant doctors provide buoyancy by addressing gaps in healthcare provision, meeting dynamic demand, and enriching the diversity and cultural competence of the workforce.^{17,18} They may have received training in different countries,

worked in various healthcare settings, or have experience in specific medical specialties. This diversity can enrich the overall quality of care and contribute to innovation within the healthcare system. Migrant doctors have multi-cultural and multi-linguistic competencies that allow them to effectively communicate with patients from different backgrounds. But there are challenges.

Migration is a fundamental human behaviour driven by anything from curiosity to survival; yet unfortunately such movement of people (whether by volition, compulsion or coercion) across arbitrary boundaries of nation-states often perpetuate injustice and inequality. Migrant doctors face several challenges when practicing in a new country. These challenges may include language barriers, cultural differences, adapting to new healthcare systems, understanding local medical guidelines, and building professional networks. Host nations and their healthcare systems can be a hostile environment for these migrant professionals seeking equality of opportunity, fairness and justice.¹⁹

Alliance for Equality in Healthcare Professions

Bridging the Gap

The British Association of Physicians of Indian Origin (BAPIO) was founded in 1998 with a mission for promoting excellence in healthcare through the pillars of equality, diversity, leadership, innovation, and education. The '*Alliance for Equality in Healthcare Professions*' (AEHP) chaired by the was founded in 2020, in the early days of the arrival of SARS-CoV-2 in the UK, with its primary task to address the differential outcomes for professionals from minority ethnic or multiple deprivation backgrounds. The AEHP brought together over 52 organisations representing the breadth of health and social care professionals in the UK. This work was undertaken by the arm's length body the *BAPIO Institute for Health Research* (BIHR). The seminal report '*Bridging the Gap*' (BTG21)²⁰ set out in 2021, the most comprehensive consensus recommendations covering the full range of

differential attainment (DA) in the entire scope of the medical professional's journey, from before entering the profession to the end.

Dignity at Work Standards²¹

There is a high level of incivility prevalent in healthcare organisations, although these organisations should theoretically be places with empathic, caring, high achieving, highly trained staff working in scientific and technologically advanced - complex systems. Most healthcare environments are high stakes, high risk, emotionally challenging workplaces. This highly charged environment, when combined with high workload and the imbalance between resources and demand, creates a toxic soup, where incivility prevails. Predictors of incivility also include challenges in communication or coordination, safety concerns, lack of support, and ineffective leadership. This incivility disproportionately affects the migrant doctors. BAPIO in collaboration with the AEHP partners developed standards to raise awareness of uncivil behaviour and establish effective methods to eradicate it. Working with its academic partners in the Universities of Glasgow and East Anglia, the project will deliver a toolkit fit for supporting a diverse workforce and improve organisational environment and ultimately better outcomes for patients.

Locally employed doctors (LED) Charter

In the UK National Health Service (NHS), LED are a group of doctors who are hired Locally employed doctors by trusts to provide services. They are non-training, non-Staff and Associate Specialist (SAS), and non-consultant groups. According to the General Medical Council there are over 100,000 of these doctors working in the NHS and most of them are International medical graduates (IMG). Even though they are vulnerable and at high risk of making mistakes that jeopardise patient safety, they receive less help and education. There is no defined support system for this group of doctors. The Health Education England (HEE) schools are not responsible for these doctors. They do not have

access to Professional Support and Wellbeing (PSW) or other possibilities for development. BAPIO, in collaboration with the AEHP, looked at the challenges confronting this group of doctors and proposed solutions to improve the quality of their experience and patient safety.²²⁻²⁴

Way Forward

The migration of doctors from low-income or resource-limited countries to more affluent nations can contribute to a phenomenon known as 'brain drain'.^{25,26} This highlights the loss of highly skilled professionals from their home countries, which can further exacerbate healthcare disparities in those regions. Efforts are being made globally to address this issue and encourage doctors to return or contribute to their home countries in meaningful ways. It is crucial to address ethical considerations when recruiting migrant doctors. This includes fair and transparent recruitment practices, respect for labour rights, and providing adequate support systems for migrant doctors to ensure their well-being and prevent exploitation.²⁷ Investing in the training and professional development of migrant doctors can contribute to long-term workforce sustainability. Offering opportunities for skill enhancement, mentorship programs, and career advancement can help retain migrant doctors in the healthcare system, maximizing their potential contributions. Retaining doctors in the healthcare workforce is crucial to addressing the shortage. Factors such as challenging working conditions, inadequate compensation, limited career advancement opportunities, and lack of support systems can contribute to doctor attrition. Efforts to improve working conditions and provide professional development opportunities can enhance workforce retention.²⁸

Conclusion

The events of 2019-2020 from #Blacklivesmatter²⁹ movement to the #COVID-19 pandemic³⁰ have exposed the cracks in civilisation and changed the

mindset of a critical mass of people around the world. It is no longer acceptable to continue to propagate inequalities and injustice for different people. The world needs and demands change. Fortunately, we are seeing some green shoots globally. Examples from the UK are: the NHS equality, diversity, and inclusion (EDI) improvement plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.³¹ The GMC published the latest report on its progress – as a regulator and as an employer – in combatting inequality.³²

Addressing the global shortage of doctors requires a multi-pronged approach, including expanding medical education programs, promoting equitable distribution of healthcare professionals, improving working conditions and incentives, and leveraging technology to enhance healthcare access. Collaborative efforts between governments, healthcare institutions, and international organizations are necessary to tackle this complex issue and ensure that communities worldwide have access to adequate healthcare services.

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