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International Medical Graduates - Asset or Liability?

An Australian Perspective

Abstract

One of the gains of globalisation is: its osmotic effect of equalisation motivating all the countries to reach their potential. Human resource specially, medical man- power, determines the health of the nation. Developing countries are becoming increasingly aware, of using their scarce resources to train a doctor, only to lose it to the Western world. The article highlights the exploitation, and possible wastage of highly qualified medical work force who, are accommodated to suit the needs of the host country irrespective of their previous qualifications and experience. The article also makes suggestions to recover and retain the talents of the country.

Keywords

International Medical Graduates, Brain Drain, Developing and Developed countries

Shailja Chaturvedi BSc, MBBS, FRANZCP
Past President Australian Indian Medical Association; EC member, Global Association of Physicians of Indian Origin, Penrith NSW, Australia.

Shail150@hotmail.com

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Background

The trend of developed countries, to attract the valuable health manpower, from less developed countries, is not only depleting the health care resources of the donor country but creating, a two tier system much to the disadvantage, of the emigrating doctor or health professional. Moreover international medical graduates (IMG) proportionately make less difference, to the workforce shortage in the host country, compared to the contribution they would have made, in their homeland. A serious review of Push and Pull factors (1) is required, to balance the workforce in global health care.

Methods

The author has collected information, through personal communication, as well as experience gained from, examining the compatibility of qualifications, as a panel member of Dual Pathway, for the acceptance of overseas post graduate psychiatric qualifications, by the Australian New Zealand College of Psychiatrists.(2) Additionally there is an increasing volume of publications, addressing the dilemma of 'brain drain' and the outcomes of medical migration. (3)

The countries looking after their citizens' health, the wealth of the nation: ought to be commended. Britain's national health services (NHS) have launched, a recruitment drive to attract Australian trained doctors, with cash incentives to fill an alarming shortage of family doctors, across the country. The plan aims to have 2000 foreign doctors in place by 2020/21.(4)(5) Australia in its 2018 budget was pleased to announce, AUS$400 million saving to the health system, by reducing visa for foreign doctors from AUS$2300 to 2100, with plans to reduce AUS$200 each year for the next 4 years. (6) However there remains a massive shortage of manpower in health services in rural and remote Australia. Even with increasing the number of medical graduates from Australian universities, the shortage may not be resolved, due to skewed distribution of doctors geographically across various parts of the country.

Geographic mobility is a recognised fact of professional life, in 21st century across the globe, with its subsequent gains and losses in healthcare and in several industries. Migration of doctors first raised its concern as an issue in 1940s, when it was largely from English speaking, developing countries, to developed countries. (7) It was seen as a covert form of colonialism (8)(9), contributing

towards the wealth of human capital, in the Western world and depletion, in developing nations. Competing for quality manpower, from the best institutions around the world, has increasingly become a norm, which can lead to exploitation. The outflow of health care professionals, is adversely affecting the health care system, in developing world. Healthy nationals are the main resources of the developed world: the probable reason, for enticing the best talents, from the developing world. (10)

Each year a large number of Indian doctors arrive in Australia, where the ratio is 3.5 doctors for the population of 1000 (11) against Indian count of 1.34 per 1000. (12) Australia maintains its highly acclaimed health system by seeking qualified, trained and skilled workforce from around the world. It allows the country to cater for both the urban and rural population, addressing the burden of diseases and meeting the expectations of the consumers as well as, being mindful of the current expectations of work-life balance (13)(14), which many 'supplier' countries do not include, in their health planning.

Despite successful implementation program in Australia for attracting high quality professionals, it has created a two-tier system, between the international and the locally trained doctors. Australia's endeavour, in ensuring high standards and rigour of assessment and registration as a medical practitioner, is perhaps justifiable. It must also be the priority for all countries for maintaining safe and effective health services, to be included in the Competent Authority Countries.(15) The aspiration to become a doctor and the training in accomplishing it naturally inculcates in the person, a deep sense of duty and commitment towards their patients. All doctors wish to maintain the expected high standards of patient care, and to be adopted as a valuable member of the healthcare establishment. It takes approximately 5 to 13 years to train as a fully qualified medical practitioner, which then is considered as 'brain drain' if that doctor leaves their country of qualification.(9) The process of resettlement is complicated with much uncertainty. Most of the emigrating doctors are ill prepared and unaware of the obstacles they may face in the new country. Implicit systemic racism, impenetrable to the protection of higher education or to the health system, is unavoidable. White privilege is omnipresent in medicine. It is more evident amongst the generations born and raised, in their parents' adoptive country, who refuse to live in quiet defiance. They grow up with sense of equality based on their skills and accolade. (16)

The representation of IMGs amongst all registered practitioners is well over 40%, and 50% of rural and remote health services are provided by them. Unfortunately the pathway of these international graduates, remain treacherous. As many as make it to registration level, similar numbers are lost in the labyrinth, either unemployed or underemployed. In the quest of fulfilling their dream of becoming a doctor 'again', which may never reach fruition, they work as taxi drivers, fruit pickers, factory workers, carers, wards men and cleaners etc. These doctors are intelligent, diligent, respectful, interested and interesting, as reported by their more empathic mentors. Most of them leave a comfortable life behind for the illusion of greener pastures. (17)

In their host country upon their arrival IMGs face myriads of complex humanitarian challenges, in their personal and professional lives, as they navigate the system, including overt and covert discrimination. Extensive surveys in United States of America overwhelmingly reported, racism and ethnic discrimination in relation to IMGs. In an analysis of 14,314 doctors in USA, non- white professionals were at significantly greater risk, of being disciplined than their white counterparts. (18) Similar findings in the UK highlighted "possible inequalities as unfair" in obtaining training positions, discriminated against minorities. Australian studies reported bias, in clinical skills assessments, as well as work place discrimination. A study of 39,155 doctors registered in Victoria and Western Australia reported that overall IMGs are more likely than Australian trained doctors to attract complaints to the medical boards and adverse disciplinary actions.(19)

The Australian parliamentary inquiry in 2012 concluded, that IMGs have strong common support, but not from institution and agencies. The general perception is that, the IMGs are, needed but not wanted. Australian Competition and Consumer Commission in 2005, recommended fairer methods of assessing and recognising the credentials of an IMG, which is yet to be implemented.(20) Restrictive conditions on IMGs imposed in Australia, unparalleled in the developed world, cause family stress, personal hardship and cultural isolation with significant impact on career and professional development. The IMGs receive little encouragement or collegiality from medical hierarchy. The cost, competition and hurdles often fuel the doubts about their migration.

A suggestion of financial compensation, to the donor countries has not gone any further. However

Canada and UK responded to the South African request, to slow their doctors' emigration. (8) India has recently enforced a certificate of assurance, from the emigrating doctors for their return, and serving the country. Despite these measures and challenges, the adventurous spirit of a young professional cannot be subdued. Exploring unchartered territories has its own, excitement and optimism, which drives the IMGs to set out on the journey, where recognition of their pre emigration expertise may be just a stroke of luck.

The standard pathway outlined by Australian Medical Council (AMEC), seems simple and straightforward. There are only two components: AMC multiple-choice questions, and AMC structured clinical examination. Once successfully completed IMG will be awarded the AMC certificate, enabling the doctor to apply for registration through Medical Board of Australia.(21)(22,23) Unfortunately the factual journey is different. The average time between the 2 components of the examination is about 18 months, when the doctor is not able to work. In case the doctor is unsuccessful in the 1st attempt, which is not uncommon, the wait for the 2nd attempt will be for 2 to 3 years as the priority, in the next examination, is given to the first attempters with 2/3rd of the places reserved for them. In fairness to AMEC there is increasing demand from aspiring IMGs. The AMEC conducts examinations every 2 weeks each year in 3 cities and 3 venues. Nevertheless for the IMG, time marches on as they remain away from the clinical practice and unable to live their lives to the full.

The international credential service which is the first step towards registration, may take from months to years with no assurance of success to qualify for the next step. The IMGs have to submit volumes of detailed documents, sometimes to more than one authority, which if lost, remains the applicant's responsibility to resubmit at enormous costs in time, energy and money. Some of these documents may be time limited and if expired before the completion of all the requirements, need to be repeated. The average cost is as high as AUS$15,000 in addition to travel and the cost of VISAs.

The plight of IMG and their significant role in Australian health system became a growing concern to the Australian government, which initiated a parliamentary enquiry in 2012. The convoluted registration system left the committee perplexed. (24)(25) The extensive report was rightly named 'Lost in the Labyrinth'. The government action was unique, justifiable, fair and commendable. There were 45 recommendations made on humanitarian grounds. (26) The enquiry uncovered many appalling stories, hardships of IMGs and their families.

> A highly skilled specialist, reputed in his/ her country, needed to pass the basic examination in medical science. He/She was the author of one of the recommended study guides. Should he/she feel complimented or humiliated? An accomplished senior specialist, who demonstrated excellent work performance in his hospital based assessments, repeatedly failed the exams due to his age, cultural differences, appearance, presentation, unfamiliarity with Australian idioms and commonly spoken language. This led to the expiry of his/her visa, which was dependent on the employer's sponsorship, giving him/her 28 days to leave the country.

There are many heart wrenching stories presented to the inquiry. The shortage of doctors is also reflected in the paucity of supervisors, and trainers for IMGs. The committee was concerned about the English test, both its currency of 2 years and general applicability to the doctor, who lived and worked in English speaking country for many years. To increase the currency of English test to 4 years was one of the recommendations. Immigration and visa requirement is yet another challenge, due to lack of, inter organisational coordination and communications, between Medical Council, national registration board and department of Immigration. A central depository was proposed by the committee to centralise the documents, and communication between the key organisations.

The 10-year moratorium seen as a form of conscription, by many was considered by the committee and was approved, in the interest of remote and rural health services. During this period the doctor had temporary limited registration, pays taxes and levies though, has no entitlement to government funded public services, like children's education and health care. (27) The committee acknowledged that inefficiency and complexity of registration, can take an IMG over 2 years, to get the temporary registration. Pre-employment structured interview is a condition for permanent registration, even if the doctor has worked for many years on temporary registration, and even if seeking the same position. (28) Prolonged delays, between registration and employment, have widespread effect on human resources, IMGs and their families. The appeal against seemingly untoward outcome is complex and costly both in money and time. It needs to be

completed within the currency of registration, which most IMGs fear for worse consequences.

Recommendations

There is no higher authority above the regulating body and specialist Colleges, like ombudsman in all other fields, for fair deal. The assessment and screening system must be robust and seamless, for any country, to allow doctors to take responsibility for other people's health. However the agonising journey of an IMG's resettlement, steals away their vigour, enthusiasm, motivation and joy of being a doctor.

The reasons for emigration may be varied both for the individual and the country, though financial incentives may be a common and significant consideration. The 2nd largest source of foreign revenue in Bangladesh, of nearly US$ 3billion from the expatriates can hardly be ignored. Equally attractive is the testimony of US$ 70 billion remitted to India by its 15.6 million expatriates. Nevertheless it may be lucrative in the short term, but it is in exchange of the human capital, vital for country's future.

The developing countries must improve their technological and innovative capabilities along with the infrastructure and education to retain and recover the human capital. Technology has made global sharing of knowledge and experience, a reality between developed and developing countries. International scientists from developing countries who are involved in research, have been shown to produce 4.5 more publications and 10 times more patents than their counterparts at home. The expatriate scientists and healthcare professionals should be given opportunities in their homeland for developing collaborative training programs, research and teaching.

Health care services are a growing section of world economy. Networks like super course (www.pitt.edu/supercourse) which has connected 20,000 scientists, health care professionals and researchers through Internet technology, has delivered 2000 free lectures to the global audience. Availability of high quality education and opportunities in research, are key to empowerment, and attract regional talents and retain them. China's scientific leadership in the human genome projects has attracted, international collaboration in joint ventures with gifted scientists from China and abroad.

The IMGs in their host countries are certainly a recoverable asset for their home countries. Both World Bank and W H O have been supportive of honing the home- grown product. The USA, UK, Canada and Australia are preferred choice countries for IMGs as they are perceived to have political stability, better remuneration, lifestyle, professional satisfaction, better postgraduate opportunities and most of all safety for family which are strong factors in attracting foreign doctors

There is increasing consensus about achieving health care, as a universal human need. Doctor's training is a heavily subsidised education, using country's scarce economic resources. Should it be for the benefit of wealthier countries to reap the benefit? It raises the moral question of developed country's reliance on developing countries. (29) Nevertheless responsibility must be shared by the developing countries, for causing the push factor, by developing policies and health infrastructure, to replicate the pull factor of the West. India must take the lead in reversing the brain drain by seriously considering the trend towards producing masses of doctors only to serve other countries.

There are more Indian psychiatrists outside India than within the country. A large psychiatric hospital in a major city of India is struggling to find a psychiatrist, whilst the bulk of Indian psychiatrists around the world are mostly filling up the vacancies rejected by the local medicos. Australia has 12 psychiatrists against India at 0.3 per 100,000 of population. In India alongside 4 major non-communicable diseases, mental illness will cost an additional US $ 6.2 trillion between 2013-2030, according to National Bureau of Economic Research.

India has highly accomplished medical workforce, which has created the world- class market for medical tourism. There is no dearth of philanthropy in the medical community with many free medical services to serve the remote and rural areas. Unfortunately despite the projected growth, India ranks far below the countries, which attract human talent. India's healthcare infrastructure is 2nd worst in the index countries and the government is rated to have low political will to push through reform.

Conclusion

Medical migration is a serious issue, both for the emigrating doctors and their countries. The IMGs who excel in their adopted countries are few and far between. Most of the IMGs float around in middle-range jobs, or disappear in the masses, not to resurface again as a doctor. There is an urgent

need to reverse the brain drain, by providing opportunities in developing countries to excel.

Despite oversupply of IMGs, improved patient/doctor ratio and substantial savings in training costs to the developed world, the brain gain has not significantly benefitted these countries. There is cry for shortage of medical manpower. Australia is facing a crisis in mental health, where Indian psychiatrists are becoming almost the face of Australian psychiatry at the expense of creating big holes in their home country. So if adequate manpower does not provide an equitable and efficient health care system in the West, there is urgent need to expand on the factors, which will make the difference.
Reliance on the meagre resources of developing countries and taking away their prime investment in preparing a doctor for the future of their country with its deleterious impact on their own health care system should no longer be an option without bilateral/collaborative flow of knowledge, skills, research and technology.

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