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Upscaling the South African Health Sector through the Integration of Skilled Migrants

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Abstract

Considering the skills shortages in the South African health sector, this study explores the possibility of integrating foreign medical doctors into the under-staffed South African health sector. In achieving this aim, semi-structured interviews were conducted amongst 37 medical doctors, alongside three business entities who recruit skilled migrants. More so, textual analysis and review of audited documents in alignment with this papers theme are reviewed. The study emphasises that no assertive policies or stratagem have been enacted or devised by the South African government or non-governmental entities in integrating such foreign doctors. In furtherance to this, no comprehensive documentation of migrants' competence has been considered at the port of entry by the Department of Home Affairs which, on its own, represents a missed opportunity. As an agendum to integrating foreign medical doctors regionally, nationally, or locally, the study advocates a comprehensive compilation of migrants' skills, competence, and qualifications at the port of entries. Such useful data will not only be used for decisive policies but could also be used to integrate, relocate, or mix-match skilled migrants into the under-staffed South African health sector, or integrate them into regions across the globe where their services are needed.

Key words: Skilled migrants, medical doctors, skill shortage, South African health sector

Introduction

South Africa's health facilities are rated amongst the most equipped and sophisticated on the African continent (McQuoid-Mason 2016; Hongoro *et al.* 2015). South Africa runs a two-tiered health system which comprises of an efficient private sector and a less effectual public sector (McQuoid-Mason 2016; Hongoro *et al.* 2015). South Africa spends an estimated nine per cent of its Gross Domestic Product (GDP) on the health sector, which is way higher in comparison to the World Health Organisation's (WHO) recommendation of four per cent for middle-income nations. The South African population is quickly outpacing the available personnel and infrastructural growth within the health sector. This implies that the South African health sector requires a more drastic response to tackle its teaming population (in and out-patients) regarding health care needs.

The issues confronting the South African health system predates 1994s democratic state. The colonial and apartheid era South African policies traversed the conundrum of health issues which include and are not limited to epidemics of communicable and non-communicable diseases (Coovadia *et al.* 2009). Concurrently, South Africa is faced with inequities between the private and public sector (Hongoro *et al.* 2015; Blom *et al.* 2018) such as the under-staffing of medical professionals (Adeniji and Mash 2016); under-resourced public hospitals (McQuoid-Mason 2016); lack of access to health care within rural communities (and peripherals of town); scarcity of medical doctors (Adeniji and Mash 2018); amongst other challenges.

The concern over scarcity of health professionals, more particularly, medical doctors is not a new challenge. However, what is new, is the targeted and large-scale recruitment of health care professionals by advanced nations such as the United Kingdom, New Zealand and Canada. While these countries have recruited medical doctors from less developed countries to reduce the shortages of health professionals within their respective health systems, such recruitment practice has significantly created adverse consequences on health sectors of less developed countries (Darzi and Evans 2016; McQuoid-Mason 2016). The South African health sector also falls victim of such recruitment practice, as medical doctors continuously migrate to countries such as the United Kingdom, United States, Canada and Australia (Darzi and Evans 2016; Mateus, Allen-Ile and Iwe 2014). This 'brain drain' has incessantly confronted the South African health sector for decades (Labonté *et al.* 2015; Elegbe 2016).

The focus of this paper is, however, confined to the feasibility of integrating 'political migrants' (whom are medical doctors) into the under-staffed South African health system. Political migrants in this context refers to individuals residing in South Africa who are non-South Africans whom were displaced from their home country due to concerns, such as war. The healthcare issues affecting South Africa are traceable to the country's colonial and apartheid history, which veered into the post-1994 era (Coovadia *et al*. 2009). In the 1950s, during the wake of apartheid regime, concerned American medical missionaries solicited for the creation of black medical schools leading to the training of (black) medical doctors. Thus, this resulted in the establishment of a non-European section of the University of Natal's medical school in 1951 (Noble 2013).

Similarly, the challenges to the post-1994 health sector of South Africa are synonymous with those of the apartheid era. Consequently, amidst racialised policies, gender discrimination, poverty, and inequality attributed to the apartheid era, the scarcity of medical doctors is still a prevalent challenge affecting the health sector. Fairly equipped health facilities as indicated at the inception of this section invariably requires health professionals such as medical doctors whose expertise are required to consult with the ever-increasing number of patients (Blom, Laflamme, and Mölsted-Alvesson 2018; Adeniji and Mash 2016). Against this background, the subsequent discourse of this paper will entail (the consequences of) the scarcity of health practitioners in South Africa, approaches used in addressing skills shortages, as well as challenges in addressing skills shortages. These literature sections are followed by an outline of the methodology and a discussion, while recommendations in alignment with the findings are proposed.

Scarcity of Medical Doctors in South Africa

Health professionals are within the occupational categories with severe shortages across the globe (O'Hara 2015). Recent statistics by the World Bank (2019) reveals that over 45 per cent of the World Health Organisation member states report to having less than one physician per 1 000 people. The shortage in health professionals is arguably more severe amongst medical doctors, particularly in under-developed nations. South Africa's health sector is not immune to this challenge as the ratio of medical doctors to patients is estimated at 1: 4 000 in public health sector, while there is a ratio of 1:300 patients within the private health sector (Medical Brief 2016). Further exacerbating this skills shortage is the emigration of South African medical doctors to western countries as well as the middle east (Labonté *et al.* 2015).

Studies by Labonté *et al*. (2015) emphasise the adverse consequences that the scarcity of medical doctors has on the South African health sector; namely, non-attendance to ill patients, poor health system, and elongated waiting times, amongst other adverse consequences. Assertions of widespread skill shortages have been widely recounted amidst stakeholders within the South African health sector. Despite the gravity of such deficiency, limited studies have been conducted on the impact of the scarcity of medical doctors within a South Africa context.

In consonance to the narrative made in this sub-section, the proceeding section provides a discourse on approaches used by the South African health industry in addressing skills shortages.

Approaches Used in Addressing Skill Shortages

Skill shortage is amongst the nine critical challenges identified by the National Planning Commission (National Development Plan, 2011). Having identified skills shortage as a prominent challenge undermining the South African growth trajectory, government entities, such as the Department of Labour as well as the Department of Education, have initiated a number of tailor-made approaches towards skills development. Initiatives such as the National Skills Development Strategy (NSDS), Skills Development Act (SDA), Skills Development Levies Act (SDLA), and National Skills Fund (NSF) were instituted as an agenda towards skills development (Ndedi and Kok 2017; Kraak 2004).

A prominent approach the South African government has used over the years in addressing skill shortages within the healthcare system is through the training of medical students in Cuba. This initiative was devised by Fidel Castro and Nelson Mandela in 1996 to train black African medical students from a disadvantaged background. Hence, since 1996, thousands of students have been sent for training in Cuba (Sui *et al.* 2019; Bateman 2013). Similarly, the Health Professions Council of South Africa (HPCSA) offers internships to medical students. This internship is designed to bridge the gap between theory and practice. Through this, medical students can acquire clinical skills required for their respective Community Service Officer (CSO) year (Bola *et al.* 2015: 535).

More so, the Joint Initiative on Priority Skills Acquisition (JipSA) acknowledged the denial of the acquisition of quality education and skills among the Black population (JipSA 2007: 2). Consequently, the JipSA's assertion resulted in the creation of the Sector Education and Training Authorities (SETA) in 2000. SETA is considered as one of South Africa's most prominent institutes aimed at ameliorating the skills shortage and reducing poverty, while also improving employment opportunities for the citizenry (Akoojee and McGrath 2007; Mail and Guardian 2007). Also, in 2001, the Thabo Mbeki regime set up a Ministerial Task Team on Human Resources. The prime objective of this task team was to provide strategies in reducing the skill shortage amongst health professionals. However, the district level was prioritised, with much attention place on rural communities where health professionals were significantly lacking (Rasool *et al.* 2012: 399). Furthermore, concerted efforts have been made by the South African Nursing Council (SANC) to enhance human resources amongst health practitioners. However, SANC is more particularly focused on educating and training nurses, while less attention is given to other health practitioners (Armstrong and Rispel 2015).

Also relevant to this discourse are the Skills Development Act of 1996 as well as the National Industrial Policy Framework of 2007 (Erasmus and Breier 2009). Both were also enacted to alleviate the skills shortage in South Africa. This paper also aims to look at the approaches used by stakeholders within the health fraternity in reducing the scarcity amongst medical doctors. The proceeding section further criticises the approaches used by the South African government.

Challenges in Addressing Skill Shortages

Despite the concerted efforts made by the South African health fraternity in ameliorating the skills shortage amongst health professionals (medical doctors), cynics have identified a number of shortcomings to these efforts (approaches). According to Elegbe (2016), South Africa has a poor skill/talent management/retention culture. This has often resulted in skill-flights of experienced South African health professionals to countries such as Canada, Australia, the United Kingdom, and New Zealand. These advanced countries keep luring health care professionals alongside other high-skilled professionals with incentives and opportunities the less developed countries are unable to match (Elegbe 2016). Besides the

external (international) migration, internal migration has continuously been a challenge as medical doctors continue to migrate from rural communities to work in health care facilities within the urban setting; while some others have moved from public health facilities to the privately managed ones. This has not only fuelled the skill shortages amongst rural or public health facilities but has further widened the inequality within the South African health sector (Mateus, Allen-Ile and Iwe 2014; Segati and Landau 2011; Ndedi and Kok 2017).

More so, Kraak *et al.* (2013) allege that a 'skills development' pace of dynamism and its extent of evolvement quickly outpaces the governmental interventions. In addition, South African health professionals (medical doctors) have equally migrated to more advanced countries due to security and risk concerns in South Africa (Bezuidenhout *et al.* 2009).

Several studies have also criticised South Africa's immigration policies. Most of the blame has been on the Department of Home Affairs for its sluggish procedures in issuing work permits to skilled foreigners (Daniels 2007; Crush 2017). For instance, amongst the 35 200 work permit applications received by the Department of Home Affairs, only 1 010 had been processed in 2011 (Rasool *et al.* 2012: 405). Also obstructing governments efforts in tackling skill shortages are - the inadequacy of funding for education, training and infrastructure; as well as poor monitoring and evaluation of these initiatives (Crush *et al.* 2017).

A further challenge to addressing skill shortage is the lack of capacity amongst stakeholders to effectually implement policies such as the NSDS, SDA, SDLA and NSF (Ndedi and Kok 2017). The South African government has often been the forerunner of capacitation initiatives. These capacitation initiatives may have been more effectual with the active involvement of governmental partners (Mateus *et al.* 2014; Ndedi and Kok 2017). However, the complacency or lackadaisical attitude displayed by government partners such as the private establishments, corporate entities, training establishments and businesses may probably have augmented governments effort should such partners had displayed much advocacy in this campaign. On the part of educational and training establishments, the curriculum is a times outdated or do not fit the needs of public or private sectors (Mateus *et al.* 2014; Bola, Trollip and Parkinson 2015; Sui *et al.* 2019).

Methodology

In exploring the feasibility of integrating migrant medical doctors into the under-staffed South African health sector, the study employed a qualitative methodology with semi-structured interviews conducted amongst 37 medical doctors within the KwaZulu-Natal and Gauteng provinces. The sampling criteria for this study were specific, the researchers were clear about the people to be interviewed, hence snowballing sampling was used where the researcher selects units to be sampled based on their knowledge and professional judgment (Adebayo and Zulu 2019: 113). Participants included medical doctors working in government and private hospitals. These medical doctors were chosen and interviewed based on their experiences, knowledge, and expertise regarding the article's focus. The semi-structured interviews were conducted between March and September of 2019. Prior to the commencement of the interviews, letters of consent explaining the objective of the article were handed out to participants (medical doctors).

While some declined to be interviewed, a few others accepted. Few amongst the participants who accepted to be interviewed also referred the researchers to their colleagues whom accepted to be interviewed. Furthermore, personnel amongst three business entities who recruit skilled foreigners (migrants) were also interviewed. Researchers were compelled to stop interviews after interviewing 37 medical doctors and three business entities, as saturation was attained. The non-probability sampling methods (purposive) were considered while selecting personnel from the business entities. Each of these interviews ranged from 35 minutes to an hour. The line of questioning during the interviews ranged from the consequences and effects of the shortage of medical doctors, potential obstacles to integrating

skilled migrants, and the possible approaches in recruiting skilled medical doctors, amongst a few other questions which popped up during the course of the interviews.

Table 1: Interviewed Participants

s/n	Sample	Sampling technique	Number of participants
1	Medical doctors	Snowball	37
2	Business entities who recruit skilled migrants	Purposive	3
	Total number of participants		**40**

Note: S/n = Serial number

Interestingly, a few medical doctors involved in the semi-structured interviews were foreign nationals (migrants). Hence, they were able to provide emic perspectives into the subject matter. The interviews were analysed through thematic analysis. The textual analysis and review of audited documents in alignment with this paper's themes were also reviewed. Relevant themes are discussed within the following sub-section.

Results and Discussion

The structured interviews were undertaken to obtain insight into participants' views in regard to the feasibility of upscaling the South African health sector through the recruitment of skilled migrants (medical doctors). More so, through textual analysis (of relevant sources), the views of experts and authors were deduced. Though the article focuses primarily on the scarcity of medical doctors within the South African context, the paper reveals that such scarcity is not confined to South Africa or developing countries, but also a reflection of reality amongst developed countries. In consonance, five core themes emanated. These themes are discussed within the next sub-section.

i. Lack of synergy amongst governmental entities

A variety of governmental entities have made concerted efforts in addressing the skill shortages across several sectors. However, there is often a poor linkage between the Department of Labour, Department of Education, Department of Home Affairs, Department of Health, and the Department of Trade and Industry (Daniels 2007; Crush *et al.* 2017), whom are considered as some of the stakeholders (forerunners) in skills developmental concerns. No specific government entity coordinates the activities of these departmental entities, either at a national or regional level (Crush *et al.* 2017; Amit 2015). Furthermore, the Sectoral Education and Training Authorities (SETA) often work in silo, and this has been partly attributed to the underperformance within SETA. Also, government departments have differing views on which professions are in high demand or are perceived as a 'critical skill' sector. Additionally, the complexity and overlapping of institutional planning significantly undermines the efficacy of skills developmental programmes (Crush *et al.* 2017; Amit 2015; Daniels 2007).

ii. Skill flight - emigration of experienced medical doctors

Studies by Mateus *et al.* (2014) allege that since 1996, well above 37 per cent of South African medical doctors have migrated to countries such the United Kingdom, Australia, Finland, Portugal, United States, Germany, and Canada. Bezuidenhout *et al.* (2009) also claim that between 1996 and 2006 the number of South African medical doctors employed in Canadian hospitals has risen above 60 per cent. One of the reasons given for the high recruitment is due to the high standards of medical schools in South Africa. Similarly, amongst a sample of 5 334 medical doctors practising in the United States, 86 per cent originate from South Africa, Ghana, and Nigeria (Mateus *et al.* 2014). Amongst these medical doctors, 1 053 are graduates of the University of the Witwatersrand, 655 from the University of Cape Town, and a further 132 are from the University of Pretoria.

Invariably, less developed countries bear the cost of educating their citizens, while countries such as Canada, the United Kingdom, and Australia benefit from their expertise. Such medical doctors who migrate overseas are offered conducive work environments and better earnings compared to their counterparts in South Africa. Consequently, such migration is detrimental to the South African health system. Such assertion is buttressed by the high number of vacancies in hospitals across South African public health institutions (Breier and Erasmus 2009; Darzi and Evans 2016). Going by the afore-narrative, it is evident that a skills shortage exists amongst medical doctors in South Africa. Furthermore, South Africa has a poor retention strategy for not only medical doctors, but for other highly skilled professions as well (Elegbe 2016).

iii. Doctor - patient ratio

The Doctor-patient ratio amongst South African public hospitals is estimated at 1: 4 000. This has an adverse impact on the quality of services such patients may receive from a medical doctor. A majority of medical doctors who participated in this study allude to the claim that an estimated 45 minutes to one hour was required to conduct a standard 'examination, review, counsel, and to advise a patient', however, due to the large numbers of patients they consult with, such medical doctors are often compelled to limit their consultations to 15-20 minutes per patient. Besides, the doctor-patient ratio is inter-related to the elongated waiting time amongst public health facilities.

The hospitals often estimate patients' waiting times to be three hours before consulting with a doctor. However, many of the patients wait longer than four hours for their appointments. Such elongated waiting times are often a norm at district health facilities. Some participants (medical doctors) also made mention that district hospitals often had the largest crowds of patients, as patients were often referred by clinics and other hospitals. Further to this, participants also claimed regional hospitals had more resources, and less patients in comparison to district hospitals, with higher volumes of patients and less resources. Hence, this suggests that medical doctors assigned to district hospitals were often overwhelmed and were also most affected by the shortage of medical doctors and other health professionals. The doctor-patient ratio is forecasted to worsen over the passage of time due to the growing population, poor recruitment plan, and limited budget within the Department of Health (Crush and Chikanda 2015; Labonté *et al*. 2015).

iv. Governmental initiatives and interventions

Having identified concerns such as the inadequacy of funding for education, training, and infrastructure, poor skill/talent management/retention culture, immigration policies, and the poor monitoring and evaluation of initiatives, as impediments to governmental initiatives and interventions (NSDS, SDA, SDLA, and NSF). Participants further criticised some interventions that directly dealt with skill development amongst medical doctors in South Africa. These included the licensing examination for foreign medical doctors (by the HPCSA) and the registrar training initiative.

The first critique to this is that foreign medical doctors had to travel to South Africa before examinations could be written, which is often burdensome, in comparison to the United Kingdom, Canada, and elsewhere, wherein foreigners are allowed to write the 'licensing examination' in their native countries. Secondly, the South African government serves as a host to foreign medical students who travel to South Africa to complete their medical qualification and training (registrar training). After the completion of the registrar training, newly qualified medical doctors are sent back to their native countries. To some critics, this is a lost opportunity, and as such new medical doctors may have been integrated into the South African health system to reduce the shortage of medical doctors.

v. Obstacles to integration of skill migrants

Contrary to the friendly immigration policies adopted in Canada, New Zealand, and Australia (Segati and Landau 2011; Segati and Landau 2008), the immigration policy in South Africa is adjudged complex and incomprehensible (Tove van Lennep 2019**)**. Firstly, the South African immigration policy contains some restrictive measures which make it difficult for health facilities or other business entities to recruit foreign nationals. Such restrictive measures were partly made to protect the South African labour force (Tove van Lennep 2019**)**.

A further hindrance to foreigners' permits are the evaluation of foreigners' qualification by the South African Qualifications Authority (SAQA), which is a lengthy process; application backlogs at the Department of Home Affairs due to shortage of personnel; as well as a quota for work permits (Pokray 2006: 2; Rasool *et al.* 2012: 402). Rasool *et al.* (2012: 402) further raises the difficulty in obtaining the required documents for a work permit. For instance, while foreign nationals are submitting their applications for a work permit, they are required to present a police clearance certificate from every country they had lived in for more than a year. Obtaining such documents often takes several months, which frustrates foreign nationals while applying for a work permit.

More so, the initial South African immigration policy (Act No. 13 of 2002) was widely criticised for its lack of depth. This was largely due to the lack of consultation prior to the enactment of this policy. Hence, governmental and non-governmental entities were consulted prior to drafting the more recent immigrant policies. Thus, the Immigration Amendment Act No 19 of 2004 and that of the Immigration Regulations of June 2005 were developed and passed (Willand 2005: 3). Despite these amendments, several critics still judge South African immigration policies as rigid, restrictive, and non-conventional (Centre for Development and Enterprise 2005: 3; Crush *et al.* 2017). From the above discourse, it is evident that the South African immigration policies are problematic (Rasool *et al.* 2012: 403). The above discussions are arguably impediments for skilled migrants to obtain work permits.

In furtherance to the above argument, some South African citizens are resentful of foreigners. This is evidenced in the 2008, 2015, 2018, and 2019 wave of xenophobic attacks in Johannesburg, Durban, and some other communities within South Africa (Ngcamu and Mantzaris 2019). Uncertainty of immigration policies and laws have also been quite controversial. This assertion is based on the memorandum sent out by the Department of Health on the 4th of September 2019 which suspended the recruitment and employment of foreign health professionals. According to some foreign medical doctors who partook in this study, such a memorandum dissuaded and exasperated some foreign medical doctors. The content of this memorandum was, however, reversed after a few weeks. Going by the afore-narrative, foreign medical doctors may likely explore employment opportunities in countries such as Canada and Australia which have more friendly immigration policies compared to those of South Africa.

In line with the above discourse, the article further suggests pathways towards the actualisation of the study's advocacy in the next sub-section.

Charting the Way Forward

As an agenda to upscaling the South African health sector through the integration of skilled migrants, the following recommendations are advocated in this paper:

1. Firstly, the Department of Home Affairs alongside the United Nations High Commissioner for Refugees (UNHCR) should work towards a comprehensive compilation of migrants' (refugee's) skills, competence, and qualifications. Such useful data should not only be used for decisive policies but could also be used to integrate, relocate, or mix-match foreign medical doctors into the under-staffed South African

health sector, or integrate them in to regions across the globe where their services are needed;
2. Secondly, a review and amendment of the South African immigration policies are imperative. Such amendments should be in line with the friendly immigration policies and models used by Canada, Australia, and New Zealand in attracting foreign medical doctors;
3. Thirdly, the Department of Home Affairs should adopt a pervasive, competitive, and flexible skills immigration policy in attracting foreign medical doctors;
4. Fourthly, the transfer of skills from experienced foreign medical doctors to novice South African medical doctors should be undertaken; and
5. Fifthly, the adoption of plausible retention strategies for experienced medical doctors to reduce skill-flight should be considered.

Conclusion

The skills shortage within the health sector is not confined to South Africa but is a global issue. Solutions to this challenge cannot be attained overnight as it requires proactive measures by stakeholders. Invariably, this paper draws attention to the scarcity of medical doctors within the South African health sector. The issue of the skills shortage amongst health professional is not novel within the South African context, as it has been identified and discussed amongst earlier authors. However, due to the severity of the scarcity amongst health professionals, this requires occasional and continuous attention. Thus, upscaling the South African health system through the integration of skilled migrants (medical doctors) no doubt requires proactive measures by stakeholders within the health fraternity while working with other governmental parastatals such as the Department of Labour, Department of Education, Department of Home Affairs, Department of Trade and Industry, as well the Department of Science and Technology. As advocated in this paper, South Africa could adopt immigration strategies, interventions, and policies used in New Zealand, Australia, and Canada in reducing the skill deficit within the health sector. This arguably may not be the ultimate solution, but a step in the right direction.

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