From asylum seeker to healthcare provider

SUMMARY

Adviescommissie voor Vreemdelingenzaken

Even during the coronavirus crisis, asylum migrants are hardly ever being given the opportunity to work in the healthcare sector

There have been major staff shortages in the healthcare sector for some time now. A shortage of between 56,300 and 73,800 workers is predicted for 2021, which is expected to increase to between 100,000 and 130,000 workers by 2030. Despite this, there are asylum migrants who are unable to find work. Even during the coronavirus crisis, when extra hands are needed in the healthcare sector, asylum migrants are hardly ever being given the opportunity to work as healthcare providers. This is despite the fact that some have already worked in the healthcare sector. The Dutch healthcare sector is also part of a dynamic and extremely diverse society, which means that new types of work are required, such as interpreters or care consultants who can guide people through the Dutch healthcare sector, or who can provide care to ageing migrants. So why is it so difficult for asylum migrants to get a job in a sector that so desperately needs new workers?

In this study, the Dutch Advisory Committee on Migration Affairs (ACVZ: *Adviescommissie voor Vreemdelingenzaken*) investigated what the barriers are for asylum migrants to work in the healthcare sector, how these barriers can be removed, and where the opportunities lie to attract more asylum migrants to work in healthcare. The ACVZ identifies three obstacles in this exploratory study.

Legislation and regulations and their implementation hinder access to employment

First, asylum migrants encounter obstacles thrown up by legislation and regulations when attempting to become healthcare providers. For example, asylum seekers are only allowed to work after six months, and even then all kinds of restrictive conditions apply. Asylum permit holders often receive insufficient guidance when seeking a suitable job and/or education. Based on the Participation Act, municipalities can, for example, decide that an asylum permit holder may not follow additional training while receiving benefits, but must accept unskilled work. Municipalities can also stop assisting an asylum permit holder when their partner finds a job and the family is no longer dependent on social assistance benefit. Obstacles are also related to the implementation of legislation and regulations. Consider, for example, the backlogs at the Immigration and Naturalisation Service (IND), causing eligible asylum migrants to have to wait longer to receive their residence permit, and therefore also delaying their starting civic integration and finding work. Backlogs in registering asylum migrants in the Personal Records Database (BRP) also delay access to work. In addition, language, education and civic integration programmes often insufficiently ensure that asylum migrants are able to acquire the knowledge and skills they need to be able to work in the healthcare sector and to continue working there.

Diplomas and competences acquired abroad are not readily recognised

In the second place, there are obstacles to having diplomas and competences that were acquired abroad recognised and appraised. Despite having worked as doctors or nurses abroad, a complex and expensive procedure in the Netherlands is often first required. For doctors trained outside the European Economic Area (EEA), this takes four years on average. The process involves healthcare providers having to complete nine steps, which range from having their existing course overview assessed to taking a professional expertise test. Accreditation of prior learning (APL) is also complicated in the healthcare sector because of the strong emphasis on formal qualifications and documented references.

Workplace culture is an obstacle

In the third place, there are obstacles related to workplace culture. For example, there may be a difference in opinion about showing initiative and about what is the right way to deal with colleagues and superiors in a pleasant and respectful way. These obstacles may prevent asylum migrants from entering or remaining in the healthcare sector. In addition, asylum migrants and other migrants working in healthcare are regularly faced with conscious and unconscious prejudice, or sometimes even with discriminatory clients, patients and colleagues.

Possible solutions (for explanation see report)

Anyone who wants the healthcare sector to make more use of asylum migrants' potential will have to remove the many obstacles and create opportunities for them. The ACVZ sees the following possible solutions.

Possible solutions to the problem of access to employment:

1) Remove the legal and administrative obstacles to employing asylum migrants and prevent these from reoccurring in future.

The **government** can undo the legal restrictions on asylum seekers working. If the decision is taken not to do so, the Ministry of Health, Welfare and Sport (**VWS**) can assist employers in obtaining work permits for asylum seekers who want to work in the healthcare sector. The Immigration and Naturalisation Service (**IND**) can eliminate the backlogs in processing asylum applications and prevent future backlogs from occurring so that people can start civic integration sooner and begin working earlier. It would therefore help if the **government** invested in the IND's capacity. Furthermore, **municipalities** can eliminate backlogs in the 'BRP track' (*BRP-straat*), the process for registering asylum seekers in the Personal Records Database.

2) Provide as much help as possible to asylum permit holders who want to work in the healthcare sector by identifying them early on, by providing intensive guidance, and by working together closely as municipalities, educational institutions and healthcare organisations.

The Central Agency for the Reception of Asylum Seekers (**COA**) can contribute to this and increase the opportunities for asylum migrants by identifying individuals who worked as healthcare providers in their country of origin and sparking their interest, so that they can continue to do such work in the Dutch healthcare sector. The COA can further increase their chances by placing them in municipalities or regions where work or training in the healthcare sector is a viable option.

Municipalities can offer the possibility of training for a job in the healthcare sector while retaining benefit. It would also help if they appointed a dedicated case manager who focuses specifically on asylum permit holders. Municipalities should preferably also continue to pay extra attention to supporting female asylum permit holders and later arrivals due to family reunification, even after the family is no longer dependent on benefit because one of the partners has found a job.

In cooperation with **educational institutions and healthcare organisations**, municipalities can also invest in combining work experience with training, allowing asylum permit holders to receive tailor-made training for a job in the healthcare sector. This could take the shape of modular education in which the language education also focuses on asylum migrants' future work, while the social skills required for working in healthcare also receive a lot of attention. There are good examples that can be followed, such as the *In de zorg - uit de zorgen* (Problems solved working in healthcare) and *Statushouders in de zorg* (Asylum permit holders working in healthcare) projects (see case descriptions in report). In order to retain asylum migrants in the healthcare sector, it would help if **healthcare organisations** made a sustained commitment to their language education and development throughout their careers.

Possible solutions regarding diplomas obtained abroad and prior learning:

3) Speed up and simplify the process of recognising the foreign diplomas of asylum permit holders, support the latter in this process, and offer more opportunities for a practice-based approach to the training and related assessment of asylum migrants.

VWS can expand the possibilities for asylum migrants by concentrating more strongly on speeding up and simplifying the procedure for foreign diploma recognition, and by supporting and supervising asylum permit holders with a foreign healthcare diploma in all steps of the recognition procedure (including

financially). The starting point must be that asylum migrants are able to quickly start to work in practice, perhaps under supervision, and ultimately are able to function at the same level as in their country of origin.

Healthcare organisations can further offer opportunities by facilitating that asylum migrants trained as healthcare providers in their country of origin (perhaps after passing a general skills test) are allowed to work and/or do a work placement under supervision, so that they can gain experience in the Dutch healthcare system. Healthcare organisations can also make more use of the accreditation of prior learning (APL) system (EVC: *erkenning van eerder verworven competenties*). The APL system has existed since 2012 and is based on a covenant between central government and the social partners. Although there are recognised APL providers, in the healthcare sector too, employers seldom use them currently.

4) Respond to the dynamic and very diverse society in which the healthcare sector operates by focusing more on tasks instead of jobs, and by creating new professions found in a 'migration society' (i.e. with a strong migration component).

In the healthcare sector, the focus could be more on duties (e.g. in a supporting role) instead of on jobs with qualification requirements. **Health insurance companies** and **healthcare organisations** can play an active role in this. There are also new opportunities related to the ageing of migrants already in the Netherlands and the arrival of new migrants, since new professions will be needed that will have to be assessed (i.e. regarding accreditation and so on). There could be more room for recognising competences and skills related to multilingualism and connecting different worlds.

Possible solutions regarding workplace culture:

5) Consider the diversity of Dutch society as a starting point for the organisation of healthcare.

Healthcare organisations should consider bringing their staff recruitment and selection, their range of training programmes and courses, and their healthcare provision more in line with the social reality of today's migration society. Addressing and accommodating the great diversity of Dutch society (and therefore of clients, patients and colleagues) as a standard component in the training and education of management, administrators and staff, would yield opportunities.

The Ministry of Health, Welfare and Sport, health insurers and healthcare organisations could ensure that the healthcare sector workload is reduced and that training and coaching new and existing colleagues with an asylum background is a standard scheduled task and not something that an already overburdened employee has to do as well. Healthcare organisations can also offer asylum

migrants the opportunity to fulfil the role of cultural mediator within the organisation, which can enrich the organisation.

6) Provide a safe working environment for all employees and spread the message that a diverse workforce is normal and not exceptional.

In order to create a safe working environment for everyone, it would help if **healthcare organisations** discussed discrimination and racism in the workplace, and acted on it when it occurs. They can also send out an unambiguous message – including to clients and patients – that the organisation is diverse and inclusive, and explicitly state the standards this involves for dealing with one another. They could use training programmes from the Netherlands Institute for Human Rights, for example, in order to increase the awareness of supervisory boards, managers and employees regarding discriminatory behaviour and its effects on employees. Finally, healthcare organisations can train managers and HR staff to recognise unconscious bias in recruitment and selection.