



National report: Australia

Final report

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List of abbreviations and acronyms

ABS	Australian Bureau of Statistics
ACCRM	Australian College of Rural and Remote Medicine
AHWI	The Australian Health Workforce Institute
AIHW	Australian Institute of Health and Welfare
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMC	Australian Nursing and Midwifery Council
AHPRA	Australian Health Professionals Regulation Authority
APEC	Asia-Pacific Economic Cooperation
ASEAN	Association of Southeast Asian Nations
ASGC RA	Australian Standard Geographical Classification – Remoteness Areas
COAG	The Council of Australian Governments
COPD	chronic obstructive pulmonary disease
CVD	<i>cardiovascular disease</i>
DALY	Disability Adjusted Life Years
DIAC	Department of Immigration and Citizenship
DEEWR	Department of Education, Employment and Workplace Relations
ENS	Employer Nomination Scheme
ESL	English is a second language
GDP	Gross domestic product
GP	General Practitioner
HECS-HELP Programme	Higher Education Contribution Scheme-Higher Education Loan
HWA	Health Workforce Agency
ILO	International Labour Organisation
IMF	International Monetary Fund
IMGs	international medical graduates

MBA	Medical Board of Australia
MODL	Migration Occupations in Demand List
MoHProf	Mobility of Health Professionals
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
OTDs	overseas trained doctors
PBS	Pharmaceutical Benefits Scheme
PYLL	potential year of life lost
RACGP	Royal Australian College of General Practitioners
RRMA	Rural, Remote and Metropolitan Areas
RSMS	Regional Sponsored Migration Scheme
SLA	Statistical Local Areas
TAFE	Technical and Further Education Institutions
TFR	Total Fertility Rate
TTMRA	Trans-Tasman Mutual Recognition Arrangement
UTS	University of Technology Sydney
VET	Vocational education and training
WHO	World Health Organisation
YLD	Years Lost to Disability
YLL	Years of Life Lost

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Executive summary

Migration is one of the foundations of the modern Australian state. Nearly 30 % of Australia's 22.5 million people were born overseas, and only 2.4 % consider themselves indigenous. The remainder are descended from migrants who arrived in the country some time during the last 250 years. From the forced convict labour used to build the first cities, to the subsidised arrival of English settlers and large influxes of population from other parts of Europe following the first and second World Wars, Australia has a long tradition of looking beyond its own shores to fill essential skills gaps and supplement population growth.

Australia remains a popular destination in the current global environment. Most Australians enjoy a long life-expectancy, and the country ranks well in international rankings of health status, governance, representation and security, and quality of life, although there are significant health issues to be addressed, in particular the stark disparities between the health status and life expectancy of indigenous and non-indigenous Australians. The economy is also strong, with strong commodity prices insulating it from the worst ravages of the recent global economic crisis. As a result, the currency is strong, improving global wage relativities, and the country is not experiencing the kind of wide-ranging public sector cost savings that are being experienced throughout many parts of Europe.

The health sector is also well developed. Principles of the Australian health care system are based on accessibility and equality and have been described by the WHO as '*world-class in both its effectiveness and efficiency*'. In order to create affordable access for all Australians to healthcare, the Medicare and Pharmaceutical Benefits Scheme was implemented to subsidise payments towards medical services and medication. The National Health and Hospitals Reform Commission highlight principles such as equality, innovation, value and the ability to plan for the future as key elements to uphold the nation's healthcare system. Challenges facing the system include a sometimes complex mix of private and public sector players, complex funding and administration including multiple levels of government and a growing burden of chronic diseases which are prevalent in the ageing population, as well as labour shortages in health professions. Nevertheless, working conditions and the practice environment are such that the Australian health system is an attractive option for many health care professionals.

Historical and cultural ties as well as a shared language with the United Kingdom and Ireland colour the migration profile of health professionals, with many health professional immigrants coming from these countries. The 2006 census also noted a shift in migration patterns as 25% of the Asian-born population had arrived after 2001, whereas only 7% of the European born population arrived during the same period. This transition from high migration levels from Anglo Celtic nations or other European nations to Asian nations is also evidenced by Asian-born migrants representing only 24% of longer-standing migrants, despite accounting for 44% of all

recent arrivals. Further, immigrants from New Zealand, China and India increased in numbers during the period of 1996 to 2006. United Kingdom, Greece and Italy-born migrants experienced a significant decline during the same period. This is in sharp contrast to the 1950s-1970s when European-born immigrants were dominant (87%). Given these patterns, European-born migrants to Australia are more likely to be older, whereas migrants from China or India are more likely to be younger.⁽²⁾ This reduction in growth of European settlers was first witnessed in the 1970s where government strategy shifted from the White Australia Policy, opening the possibility of immigration to Australia for many other nationals.⁽⁶⁹⁾⁽⁹⁹⁾

Among migrating health professionals, as with the broader population, the most common country of birth other than Australia was England, though a number of nationalities are over-represented in health sector, compared to the general community according to 2006 Census data. People born in India made up 0.7% of all people, but 5.4% of Generalist medical practitioners and 4.2% of Specialists. Similarly, people born in Malaysia made up 0.5% of all people in Australia, but 5.3% of Dental practitioners.⁽⁶⁵⁾⁽¹¹⁾

Nurses were more likely than the Australian average to have been born in England and New Zealand. People born in England made up 4% of the population but 7% of Nurses; and people born in New Zealand made up 2% of all people and 3% of Nurses. A comparatively large proportion of Nurses were also born in the Philippines: 2.0% of nurses were born in the Philippines compared with 0.6% of the population.^{(65) (11)}

Nurses migrating from other countries are more likely to work in major cities. In the case of doctors, however, newcomers are over-represented in rural and remote areas, where special exemptions can be applied to allow these practitioners entry on condition that they serve where areas of shortage are greatest. Overseas recruitment programs, the availability of various types of incentives, and the development of information portals such as the web-based *DoctorConnect*, are designed to assist, support, and encourage the ongoing migration of health professionals, and help them to navigate the registration requirements that must be met in order for them to practice in the country.

Australia's higher education system is also continuing to develop its role in providing access to fee-paying overseas students, and is increasingly reliant on this income stream to supplement publicly funded education provision. The education and training of health professionals is an important part of this, and this provides an entry path for some students who remain and practice in the country following their studies. It is not known, however, what proportion of students this represents, or whether their stay as working professionals is long or short term.

The Australian health system is currently undergoing a period of significant reform, particularly in respect to the health workforce. The most significant initiative is the introduction of a national system for the registration of the ten most common health professions, which became

operational in 2010. Included are chiropractors; dentists (including dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists. This national body - working with a separate Board for each of the professions replaces the previous system in that, for many professions (including the largest, nursing), workforce mobility was inhibited by requiring them to be registered in each state. Though still in its infancy, the development of the national system should reduce the administrative burden on newly registering professionals and help ensure consistent national practice standards.

In addition, 2010 saw the first year of operation of the new Health Workforce Australia, a cross-jurisdictional body which has been developed to take a nationwide view on health workforce policy and planning. Amongst the HWA's key priorities for its first years of operation is the development and implementation of a more robust and useful set of national workforce data, and work on both a National Health Workforce Dataset and a Workforce Data Consolidation has commenced. However, these projects will need to be fully established before some of the current deficits in information can be met. It is hoped that better tracking of migrating health professionals may in the future allow a better informed assessment of the retention and migrant health professionals and confirm the widely held belief that Australia does not play a significant role as a 'transit' country into Europe.

Factors including a well-developed and well-regarded system for higher education, good standard of living, safety and security, and the relatively strong economy mean that Australia continues to be an attractive destination for health professionals seeking job opportunities and new life experiences. However, stringent requirements in regard to English language testing, the lengthy registration process for many, and a lack of coordination between systems for professional registration and immigration create significant barriers for many health professionals seeking to migrate, and contribute to high reported levels of stress as well as having significant financial implications in terms of both direct costs and earning power.

Some of these barriers and inconsistencies are currently being considered by a major parliamentary inquiry into the entry and support provided by overseas doctors, though at the time of finalising this report the outcomes of that inquiry were as yet unknown. A separate inquiry into student visas, which will consider a range of matters including the number of hours that those on student visas are allowed to work, may also have implications for migrating health professionals, a number of whom first enter the country as students.

Recent government initiatives have included the injection of significant funds to expand clinical training places and move further towards self-sufficiency in training health care workers domestically. However, it is expected that for the foreseeable future, Australia will continue to encourage health professionals, along with other key skilled workers, to enter the country, with skilled migration continuing to form a significant part of entry quotas. Though not without its

challenges, particularly in relation to language and acculturation, this is generally seen as a positive contribution both in respect to the skills gained by the Australian sector, and to the professional development and work opportunities that migrating health professionals enjoy.

Note: This report is based on research conducted across a period of time during which there were significant policy changes occurring in Australia; all findings reported were current at the time of the actual fieldwork, interviews and data reviews, but in some cases may subsequently have been superseded by the impact of new events or policy changes.

Summary of push/pull/stick/stay factors

Australia as country of origin	Australia as destination
Push	Pull
• broaden experience • professional development opportunities (including specialization) • travel and lifestyle • established family/heritage links	• better job opportunities; • better working conditions including technology and support staff; • educational opportunities; • new experiences, cultures and language; • a higher standard of living • strong economy • tradition of inward migration • active recruitment by employers, supported by government • relatively easy recognition of qualification from some countries
Stick	Stay
• family connections • travel and lifestyle • professional status • good job opportunities for some professional areas (e.g. advanced practice nursing)	• good standard of living including domestic safety and security and public infrastructure • job opportunities • strong economy • existing established migrant communities

1. Introduction

1.1 Introduction to MoHProf research

Worldwide mobility of health professionals is a growing phenomenon, impacting the health systems of receiving, transit, and sending countries. EU Member States are increasingly affected by these developments - which might occur simultaneously within the same country. Therefore, the need to develop European policies to adequately address these issues is urgent. At the same time, reliable and differentiated knowledge and findings as a basis for such policy are lacking. MoHProf will contribute to improving this knowledge base and facilitate European policy on human resource planning.⁽¹⁾

This part of the global project examines these within the Australian context. The impact of the different types of migration across the region will be studied in a comparative perspective and research will be conducted into factors impacting migration flows and the evaluation of policies addressing migration and the development of recommendations concerning these policies

Methodological approach

As outlined on the project website, the project's methodological approach was to

“generate more comparable, specified and qualified data gathered by mainly qualitative research. The project looks for quantities of migration flows, as well as detailed qualities like professions, motives, circumstances and the social context, i.e. push and pull factors. Crucial for the approach are key stakeholders, which represent the relevant unities, organisations, and sectors in national health systems. They will enable the collection of existing data and statistics, but, above all, enable the generation of new, qualitative data. In-depth interviews, based on thematic guidelines, with representatives of these key stakeholders will allow a triangulation of the data: their expertise on health professionals' mobility and its impact on structures and processes of health systems will qualify the quantitative findings and explore what mobility means for the health systems and the persons and organisations involved.”⁽¹⁾

Detailed research guidelines⁽²⁾ were prepared and issued to all project teams which guided both the focus of the research and methodological approach.

1.2 MoHProf research objectives

The general objective of the project is to research current trends of mobility of health professionals to, from and within the EU. Research was also to be conducted in non-European sending and receiving countries, but the focus lies on the EU: comparative studies in a selected range of representative states will determine the impact of different types of migration on national health systems. Partners inside and outside the EU cooperated in the project. ⁽¹⁾.

This project will ultimately benefit policy makers and professionals in European Member States and elsewhere. Indirectly, through this research, Australia and the region will also benefit. In particular the benefits will be shown through the development and provision of conceptual frameworks for monitoring systems concerning mobility of health professionals which will provide sustainable data and bases for policy and decision making. Also qualified recommendations can be generated for strengthening human resources policies in Australian health systems and those of developing countries.

The outcome will be to provide conceptual frameworks for monitoring systems concerning the mobility of health professionals and providing recommendations for policy and decision makers

1.3 Research questions/themes

Key research questions and themes were identified by the project group as a result of empirical research to identify factors that may influence health professionals' migration decision. The factors identified were:

- Wages
- Working conditions
- Professional recognition
- Career opportunities
- Workforce planning
- Employment rights and labour representation
- Labour market
- Language
- Historical links
- Policies about migration
- Processes of recruitment
- Data on migration
- Personal security
- Personal factors

A series of hypothesis were then developed, grouped according to these factors, and provided to research teams as part of the initial research guidelines ⁽²⁾. They are reproduced here at Annex 1: Summary of Theoretical Questions.

1.4 Brief overview of methodology

The overall methodological approach of this research will be to combine quantitative and qualitative data gathering. The design is aligned with similar projects being carried out in other countries. The report builds on a framework developed and agreed by the Asian Research Team when it met in June 2009 in Manila to discuss the overall methodology of the MoHProf Project and to consult on the Analytical Framework.

The research was carried out in two phases:

- “Macro” or national level research, conducted from June 2009 to December 2010
- “Micro” level research, involving the collection and analysis of data gained during interviews with research participants from August 2010 to February 2011

The research design was as follows:

1. Collection and analysis of existing quantitative data, statistics and documents from key stakeholder organizations
2. Compilation of a Macro Report, a narrative description of the overall situation of the health care system and migration of health workers in Australia, based on a review of available information. This has been completed; please see the following literature review which briefly summarizes the Macro report.
3. Establish contact with health professional migrants.
4. Design interview themes and questions using WIADs Mobility of Health Professionals guidelines and information gained during the Macro report compilation.
5. Conduct qualitative in-depth interviews or focus groups with migrant health professionals in Australia. Based on migration theories, this included the process of health professional migration

and the impact of health professional migration on careers, quality of life, remittances and economic gain.

7. Produce a country profile which summarizes the Macro and Micro reports.
8. Formulate policy recommendations based on the Macro and Micro reports.
9. Produce a final report synthesising findings of both the Macro and Micro research phases, including policy recommendations.

1.5 Structure of report

This report closely follows the structure recommended in the initial research brief. This introductory section provides a brief overview of the MoHProf research, its objective and process.

Next, there is a detailed section on methodology, which outlines the approach taken on both the qualitative and quantitative aspects of the research, as well as highlighting some of the key issues and limitations encountered and ethical considerations. It should be noted that the discussion contained here focuses on the approach taken for the Australian research effort, rather than the methodology of the overall MoHProf project.

This is followed by three consecutive sections which provide an overview of Australia and its key health priorities, the way that the health system is structured and managed, and an overview of the policy environment as it exists at both national and state levels. Together, these three sections provide key contextual information and describe the policy drivers which influence the nation's approach to health professional migration.

The report goes on to address health professionals' migration more specifically, first of all providing a descriptive profile of the nature of health professional migration and some of the key changes that have occurred in recent years. Drawing on existing data as well as interviews with key stakeholders and health professionals themselves, it goes on to discuss the key themes that have emerged and the factors that have been identified as impacting on health professional migration.

Finally, push/pull/stick/stay factors are analysed, and key research findings and policy recommendations are provided.

A summary of key findings and recommendations can also be found in the Executive Summary provided at the beginning of this report.

2 Methodology

2.1 Quantitative research

2.1.1 *Rationale*

The quantitative data collected and presented in this research project is largely gleaned from existing sources, and primary sources to provide a context for the discussion of health professionals' migration experiences and choices. As the MoHProf project as a whole comprises input from a variety of countries, it is important to include some quantitative information which allows investigators to ascertain inter-country similarities and differences between countries, such as population size, density and profile, health status and key health challenges, and the size and complexity of the existing health care system.

In addition, an initial survey was conducted as part of the "micro" phase of the project, in which participants provided some basic information about their migration history and experience. This small sample allowed researchers to gain a snapshot of key elements (e.g. source country) of a selected sample of health professionals who have migrated or are seeking to migrate

2.1.2 *Sampling*

The method of an integrative review was undertaken to synthesise and interpret data based upon briefing questions. Electronic databases including CINAHL, EMBASE, Medline, Science Direct and the World Wide Web using the Google, Google Scholar and Mednar search Engines were searched using a pre-determined search-strategy of MeSH terms including *migration, health workforce, doctors, nurses, education*.

2.1.3 *Data collection*

Much of the quantitative data included in this report has been obtained following a desk based literature review of electronic data bases and search engines.

In particular data repositories such as the World Bank, World Health Organisation (WHO), Organisation for Economic Co-operation and Development (OECD) Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW) and Department of Immigration and Citizenship (DIAC) were sourced. The Australian Health Workforce Institute is a useful repository of data and analysis.⁽³⁾

Predominately data is based on Australian Bureau of Statistics (ABS) census data released in 2006 and subsequent reports.

2.1.4 Data analysis

Analysis of the data was informed by an extensive review of published literature contained in both peer-reviewed publications as well as “grey” literature including government policy documents and websites, and formal submissions to parliamentary investigations and analysis.

Interviews with key stakeholders were conducted as part of the “macro phase of the project contributed to this analysis, by providing direct qualitative evidence of these expert assessment of the current policy environment and the factors influencing policy development and strategic responses by governments, educational institutions, professional associations and others. This group was a theoretical, rather than a random sample ⁽²⁾.

Data collected as part of the individual surveys was collated and analysed using and Excel™ spreadsheet.

2.2 Qualitative research

2.2.1 Rationale

As discussed in the research guidelines, qualitative data was collected in order to gain new insights into the issue of health professional migration from the Australian perspective. It can also enable “triangulation” of the data , qualifying its findings or putting them in context. It a highly dynamic field such as this, it also has the capacity to provide an (albeit subjective) view of the policy and practice being undertaken at the time of study, providing an early indication of changes that may have occurred since quantitative data or more formal reviews can be completed, verified and published.

Qualitative research can also provide an insight into the limitations reliability, and completeness of the existing data sources, and may bring insight into where and how possible errors or misinterpretations can occur.

Most importantly, though, qualitative data can capture the lived experience of a person in a manner that is rarely is ever possible through quantitative means. In the context of migration, for example, quantitative data can provide indications of the volume of persons migration, but it cannot shed light on the difficulties presented by the migration process, or on the ways in which a migrant or

prospective migrant sought to negotiate or ameliorate those difficulties. This approach is invaluable when seeking to identify intangible factors such as human motivation and intent.

A contemporaneous review of the policy environment focusing on health care reform was also undertaken, focusing particularly on the recommendations of the Hospital and Health Reform Commission and the deliberations of The Council of Australian Governments (COAG). Hand searching of reports and published material were also undertaken.

2.2.2 Sampling

2.2.2.1 Key Stakeholder Interviews

Two different sets of interviews were conducted as part of this project. Firstly, following an exhaustive data review, interviews were conducted with relevant stakeholders (Annex 2: Interviews with key stakeholders: Questions and summary of responses) for an overview of anecdotal evidence and more in-depth knowledge and expertise. The focus of these discussions was particularly on the trends and policy environment, and subjects were identified primarily through a review of key stakeholders and organisations with a role and/or interest in health professionals' migration¹. Secondly, interviews with migrant health professionals were conducted (see 2.2.3.2).

The following organisations were represented in key stakeholder interviews:

- Australian Govt. Dept. of Health and Ageing
- Medical Board of Australia
- Australian Health Practitioner Regulation Agency
- Nursing and Midwifery Board of Australia
- Health Workforce Australia
- Australian Health Workforce Institute
- Human Resources for Health Knowledge Hub, University of New South Wales
- School of Public Health and Community Medicine, University of New South Wales
- School of Public Health, University of Sydney
- Health Information Systems, University of Queensland
- Department of Health, Victoria
- Department of Human Services, Victoria
- New South Wales Department of Health

¹ Names and position titles have not been included here to preserve confidentiality, Further information is available upon request from the research team.

- Department of Health, Western Australia

In each case, one or more individuals were interviewed, with a total of 15 interviews altogether. Stakeholders represented a wide range of professional roles, responsibilities and fields of expertise.

The roles of stakeholders interviewed included

- Chief Nursing Officers from various jurisdictions
- Consultants
- Senior managers, including Chief Executives, Directors and Managers
- Lecturers and professorial incumbents
- Policy analysts
- Workforce advisors
- Registration experts
- Information, data analysis and planning experts.

2.2.2.2 Migrant health professional interviews

Health professional migrants who participated in his research were identified via two State-level Health Departments. These Departments sent out an email notice on behalf of researchers asking for volunteers to be involved. This ensured that the researchers were not aware of any individual's identity prior to that individual agreeing to become involved.

The Departments sent the e-mail query to email addresses held on internal databases. Those databases comprised details of health professionals who had contacted the Department seeking either registration or work. Individuals were free to respond to the email by providing the research team with their contact details or alternatively they could simply ignore the information.

The seventy-nine respondents to this baseline survey had the characteristics listed below. Thirty members of this group went on to be interviewed.

- Male: (32) 41%, Female: (46) 59%
- Age: <25 24%, 25-30 – 41%, 31-40 – 18%, >41 – 17%
- 27 countries of birth were represented: Bangladesh, Brazil, Canada, China, Colombia, Egypt, Fiji, Guatemala, Ghana, Hong Kong, Indonesia, India, Iran, Iraq, Japan, Nepal, Pakistan, Philippines, Russia, Sri Lanka, South Africa, Switzerland, Syria, South Korea, Thailand, United Kingdom, United Arab Emirates.
- 63% respondents had a university degree

- Immigration status: Australian citizen (15%), Australian resident (8%), temporary resident (11%), work visa (15%), student visa (39%), visitor (3%), other (9%)
- Relationship status: Married/defacto (49%), single (50%) this includes 4% separated/divorced. 1% unanswered.

For those individuals who provided their contact details, contact was made through an invitation letter informing participants of the purposes and procedures of the study and including a consent form and general themes of the in-depth interview or focus group. Participation in the study was strictly voluntary, and potential participants were advised that they could opt out at any time.

Respondents are health professional migrants who have chosen to be involved in the study to share their stories and challenges of the health professional migration process.

As all respondents were from non-competent authority pathway countries (see 5.1.3.2.2), a snowball sampling technique was used to incorporate information from migrant health professionals from competent authority pathway countries. Thirty interviewees were contacted through their response to the baseline survey. 5 interviewees were contacted due to being from the United Kingdom to ensure a “competent authority pathway” country was represented. Again, this was a convenience sample but does represent many countries and a variety of ways to immigrate to Australia.

Those interviewed were

- Male: (14) 40%, Female: (21) 60%
- Age: 19 youngest, 56 oldest, $M=32.23$, $SD= 10.99$
- Thirteen countries of birth were represented: Pakistan (5), Bangladesh (3), China (10), Indonesia (3), South Korea (2), UK (5), Guatemala (1), Egypt (1), Nepal (1), Japan (1), Fiji (1), Philippines (1), and Columbia (1).
- Professional status: Registered doctors (5), Registered nurses (14), Doctors not registered in Australia (9), Nurses not registered in Australia (4), Students (3)
- Education: Postgraduate (9), Degree (24), High school (2)

- Immigration status: Australian citizen (26%), Work visa (9%), resident (10%), temporary resident (6%), student (43%), other (6%).
- Relationship status: Married/defacto 43% (15), of these 6 have dependants; Single 57% (20) of these 1 has a dependant and 2 are separated.

2.2.3 Data Collection

2.2.3.1 Key stakeholder interviews

Key stakeholders were approached directly and asked to participate in an interview. Interviews were guided by a series of questions, as outlined by the project team. Interviews were held at several locations throughout Australia, or by phone, usually determined by the individual stakeholders' availability. Interviews were recorded and then transcribed for reference and analysis.

2.2.3.2 Migrant health professional interviews

There were two stages of data collection involved in the interviews with migrant health professionals.

A baseline survey was sent out to a total of 427 health professionals from two Department of Health databases in the two largest states in Australia (NSW & VIC). The survey was sent to a total of 263 international medical graduates (IMGs) from the Victoria database, and to 164 RN1s/RM1s (registered nurse/midwife) from overseas who had been successful in gaining a position in a NSW hospital in 2011.

As part of this survey health professional migrants were also invited to be involved in more in-depth interviews.

It should be noted that the two databases used were of a different nature. The Dept. of Health Victoria database holds details of international medical graduates (IMGs) who had contacted the Department via International Health Professionals Victoria (IHPV) (4) and registered their interest to work as a doctor in Victoria. However, many lived and gained work elsewhere in Australia. They are mainly doctors who are following the standard pathway and have not come through a "competent authority" training programme.

The New South Wales (NSW) Department of Health database included international nurses (RN1s/RM1s) who had been successful in gaining a position in a NSW in 2011.

A total of 79 individuals responded to the baseline survey

<http://www.zoomerang.com/Survey/WEB22BPWEPXG52>

A total of 35 individuals had an in-depth interview

<http://www.zoomerang.com/Survey/WEB22C7FHLEYBK>. Of these of these, 8 filled out the online questionnaire themselves.

2.3 Reliability, validity, and credibility

Responses to both the on-line surveys and the interviews were entered into an Excel TM spreadsheet for analysis, and key issues were identified. The small number of interviews involved allowed each to be individually assessed, and limited the need for complex tools for consolidation and analysis. Analysis of the key stakeholder interviews led to the development of the baseline survey. Then, the themes from this baseline were used to develop questions for the in-depth interviews.

It should be noted that many of the reports from which quantitative data was sourced incorporate data from secondary sources and therefore there is a potential for variations in interpretation.

For the purposes of this report health professionals were defined as persons who are appointed, employed, contracted or otherwise engaged to provide health care services in the, State, Commonwealth and privately funded in the primary, secondary, tertiary, community, aged, rehabilitation and community care settings within a regulated or registered system. There is substantial ambiguity in the terminology for this report around health professionals. This is reflected in a range of language used by regulatory, industrial and professional organisations. It is also important to note that many people will work in managerial roles but still be paid under an industrial award related to a profession such as medicine, nursing and allied health. Some ambiguity is also noted around the term 'nurse' which can range from nurses prepared in baccalaureate programs to those in Vocational and Educational Training Sectors. Vocational education and training (VET) provides skills and knowledge for work through a national training system.

The system consists of a network of eight State and Territory Governments, the Australian Government, along with industry, public and private training providers that work together to provide nationally consistent training across Australia. ⁽⁵⁾ Variations in terminology are also evident with terms such as overseas trained doctors (OTDs) and international medical graduates (IMGs) used interchangeably. Both of these terms are used in this report, dependent on the source.

All ranges of competencies and scope of practice among health professional were considered. It is important to note that there is increasing heterogeneity in the workforce composition and this is likely to increase in the future with alternative models pursued particularly through the VET sector and the introduction of new courses, such as for physician assistants.^(6; 7) This trend towards health workforce diversity can be potentially explained by a range of drivers including workforce shortages leading to substitution; an increased emphasis on interdisciplinary practice; a recognition of the need to tailor roles to the needs of specific groups, such as the elderly and chronically ill and access and the response of educational providers to perceived needs.^(8; 9; 10; 11)

Geographical considerations were interpreted using the Rural, Remote and Metropolitan Areas (RRMA) classification. This classification has seven anchor points - two metropolitan, three rural and two remote. The classification is based on Statistical Local Areas (SLA) and allocates each SLA in Australia to a category based primarily on population numbers and an index of remoteness. The index of remoteness is used to allocate non-metropolitan SLAs to either the rural or remote zone⁽¹²⁾.

2.4 Ethical considerations

The study was approved by the Human Research Ethics Committee, University of Technology, Sydney. Participants in the survey were advised of this, and provided with information to enable them to express or discuss any concerns through the inclusion of the following text in the electronic survey:

“This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.”

It was not anticipated that there would be any significant discomforts or risks to participants. Participants were required to expect the time required to complete the initial survey and, take the time to engage in interviews if they had agreed to participate in the in-depth interviews. All interviewees were be given a consent form and given the opportunity to withdraw from the study at any time.

Ethical concerns would only arise from the procedures of recruitment from data collection which are related to privacy and informed consent, both of which were controlled for. Additionally, ethical issues could arise in an indirect way from conducting research about remittances and developing country settings with regards to resulting recommendations. There is no ethical implication of research results concerning the protection of dignity, autonomy, integrity and privacy of persons.

2.5 Limitations

As discussed in more detail in section 6.2.5, there are currently a number of significant deficits in the availability of data on key factors relating to the migration of health professionals, such as the lack of departure data. In addition, the fact that a number of data elements are held separately, administered by different agencies, and not linked by common identifiers means that the ability to cross-reference various data sources is also limited.

As outlined in the methodology section of this report, the surveys conducted as part of this research were intended to collect subjective and illustrative examples of the migrant experience, rather than necessarily create a representative sample. Neither the sample size or the methodology makes this possible.

In addition, it is important to note that the two State level databases used to identify interview subjects were developed for specific purposes and held details of individuals with particular characteristics, and necessarily excludes others:

- The NSW database contained details of nurses who had gained employment at a NSW hospital in a given period of time. It included no other health professions. The information provided is therefore limited.
- The Victorian database contained details of members of the medical professions who were seeking to have their qualifications recognised through the “standard” pathway. That is, persons who are not eligible to have their application considered under the “Competent Authority” pathway. In this case, therefore, the sample is restricted to those who have been excluded from the simplest entry path.
- The Snowball sample of competent authority pathway migrants sought to fill in some of the information excluded from the two previous samples as the entry pathway was presumably easier for these respondents.

It should also be noted that while both NSW and Victoria have rural, remote and outer suburban areas where shortages of health professionals are experienced, they are two of the most urbanised and most highly populated states. Some other States (e.g. Western Australia (WA) and Northern Territory (NT)) cover a much greater area and contain very remote communities. This can have implications both for service provision and for recruitment and retention. For example, while Victoria and NSW both have sizeable indigenous populations, these communities tend to be based in metropolitan areas or rural cities, while in WA and NT service delivery to indigenous people may sometimes involve travel to communities with limited accessibility, poor basic infrastructure (e.g. housing, fresh water) and may have prospective client groups with closer connections to traditional languages and lifestyles. A migrating health professional investigating work in these areas (and dealing with agencies in these states and territories) may not be represented in the group contacted through this study, and may have different experiences and expectations than those interviewed as part of these studies.

In addition, only nurses and medical practitioners were contacted via the databases used, As a result, other professions were not represented. Any issues about the migration process that may be specific to other professions will not therefore have been identified in this part of the study.

3 Basic country information

Australia is a multicultural and democratic society, a country that has a unique landscape, cultural heritage and enjoys economic, cultural and social growth. ^{(13) (11)}

3.1 Population

3.1.1 Demographic Profile

Recent data from the ABS shows the population of Australia was approximately 22.5 million in 2010. The population is projected to increase to between 30.9 and 42.5 million people by 2056, and to between 33.7 and 62.2 million people by 2101. The annual growth rate for the year ended 30 June 2008 was 1.7% and was higher than that recorded for the five years to 30 June 2007 (1.5%).

Currently, the average age of the population is 37.8 years old, however Australia's ageing population is highlighted by the fact in 2101 the average age is projected to be approximately 50 years of age. Life expectancy at birth is estimated at 78.7 years for men, and 83.5 years for women. Over the past 20 years, life expectancy at birth has improved by 6 years for males and

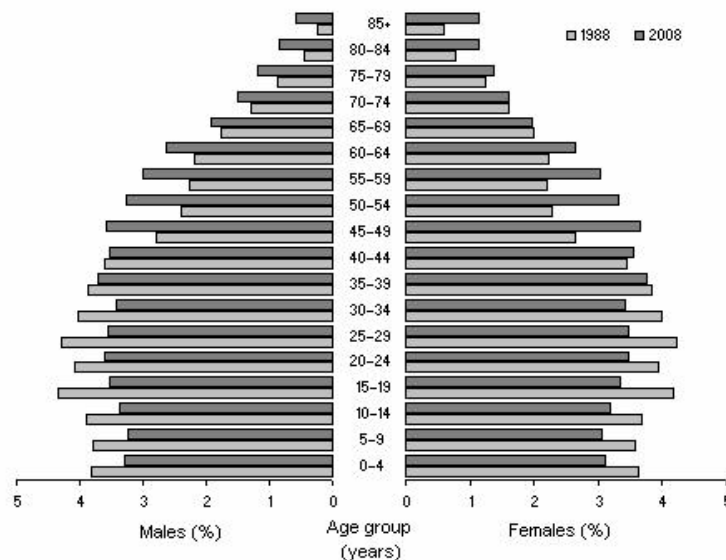


Figure 1: Age of the Australian population, 1998 and 2008

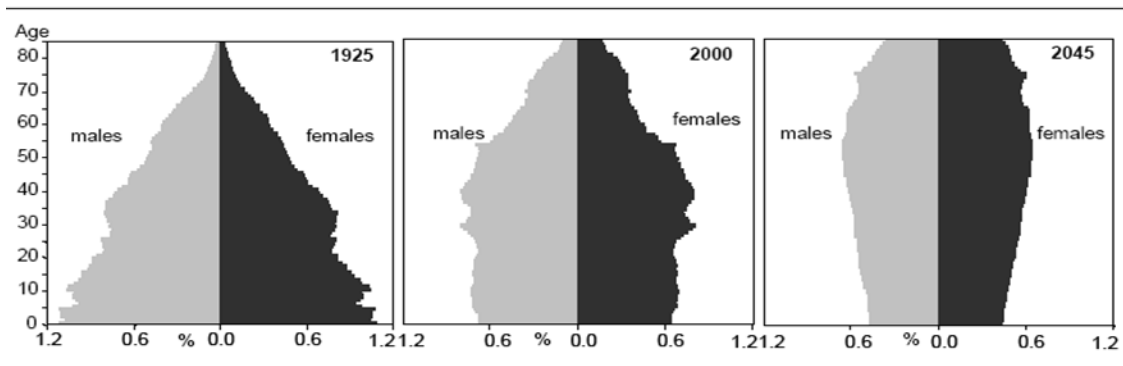


Figure 2: Changing age structure of the Australian population 1925-2045

4 years for females. In 2007, there were also 137,900 deaths registered in Australia, slightly more than in 2006 (133,700). However, the standardized death rate (6 deaths per 1,000 standard populations) has been the same since 2005 and is the lowest on record.

As in many developed countries, the ageing of the population is of particular concern, the population pyramid reflecting the change from a pyramid structure to a coffin as shown in **Figure 2**.
(14; 13; 15)

3.1.2 Fertility

In 2007, Australia recorded its highest ever number of births at 285,200 births; 19,300 (7.2%) more than in 2006.

Fertility rates are an important determinant of Australia's future population size, structure and growth. In 1961, at the height of the 'baby boom', Australia's Total Fertility Rate (TFR) peaked at 3.5 babies per woman. Since then fertility has declined, falling sharply during the early 1960s as the oral contraceptive pill became available and liberalization of abortion law has occurred. The TFR reached a low of 1.73 babies per woman in 2001 and has increased since then, to 1.81 babies per woman in 2006.

In recent years, TFRs for Victoria, South Australia and the Australian Capital Territory have been lower than rates for Australia overall. The TFRs for the remaining states and territories, particularly Tasmania and the Northern Territory, have been higher. The TFRs for Australian capital cities are typically lower than those in rural and remote areas.

3.1.3 Rural, remote and urban distribution

Australia has a vast land mass but the vast majority of the population is concentrated around the coastal cities. Seventy per cent of the population live in metropolitan areas, mainly (85%) near the coastline.

3.1.4 Culture and language

The Australian population includes people from approximately 200 countries, as well as those of Aboriginal and Torres Island descent. ^(2, 3) The proportion of those living in Australia and born in Australia has fallen from 74.5 % in 1996 to 70.9 % in 2006.

English is the official language of Australia. In 2006, 83% of the population (aged 5 years and over) spoke only English at home, and less than 1% could not speak English at all. ⁽¹²⁾ The most common non-English language spoken in Australia is Italian, with 311,600 speakers accounting for 1.8% of the Australian population in 2006. Second to the Italian language was Greek ⁽¹²⁾ Mandarin is the fastest growing language, and is expected to become the most popular non-English language spoken over the coming decades.

As a result of its strong history of immigration, Australia is a very multicultural country. Twenty per cent of Australians claim to have at least four areas of ancestry. ⁽¹⁶⁾ In 1947 90% of Australia's population was Anglo Celtic. This had fallen to 70% by 1999 and is projected to have fallen further to 62.25% by 2015. ⁽¹⁶⁾ Over the same period, Australia has experienced a significant increase in migration levels of those from Asian-born nations. ^(12; 17)

Only 2.4% of the population consider themselves to be Indigenous Australians. ^(12; 18) . As discussed in section 4.1 indigenous Australian suffer from poor health and have a lower life-expectancy than non-Indigenous Australians.

Sixty-seven per cent of the 36 health professionals interviewed as part of this research indicated that "new experiences, culture and language" was one of the reasons they had come to Australia.

3.1.5 Education

In 2006, one in four Australians was attending an educational institution. These included school, Technical and Further Education Institutions (TAFE), university, or other tertiary educational institutions. ⁽¹²⁾ Australia's school system consists of both government and non-government schools. In 2006, 65% of school students attended a government school, 21% attended a Catholic School

and the remainder attended other non-government schools. ⁽¹²⁾ ⁽²⁾ The proportion of students attending government schools has been declining since the 1970s. The 2006 census also showed that 84% of 16 year olds were attending school, and that girls were more likely to continue schooling longer than boys.

In addition, the census showed that each generation is becoming better educated than the previous generation and that women are receiving higher qualifications but that their workforce participation, particularly in executive positions, remains lower than for men.

A range of education reforms included in the Bradley and Cutler Reports are geared to achieving greater societal representation in the higher education setting and providing a dynamic and responsive system geared for productivity. An important consideration for workforce planning is the current political agenda of inclusivity and in particular representation of lower socioeconomic groups in the higher education sector. ^(19; 20)

3.1.6 Summary Table

Australia as country of origin	Australia as destination
Push	Pull
Relative isolation of country makes travel to other countries expensive and time consuming. High cost of living compared to some European countries. Many Australian-born health professionals have family ties in Europe.	Shortages on the labour market, including health sector; Changes in age structure – future increase in demand for health and care services; English language means source countries such as Ireland and the UK share language, but language can present a barrier to migrants from non-English speaking countries
Stick	Stay
Family ties Professional status Language and culture	Good quality of life, safety and security. Lifestyle and climate

3.2 Geo-political profile

With a growing population, Australia aims to achieve social order through religious and cultural tolerance, as well as freedom of speech. Australia's bi-cameral political system has developed from the United Kingdom's parliamentary and legal structure. The head of state is Queen Elizabeth II of Britain, represented in Australia by the Governor-General, who is appointed by the Queen on the Prime Minister's recommendation.

The modern Australian political system was formed as a federation of the six states in 1901. The Constitution is only able to be changed through a referendum, in which a proposal is either accepted or rejected by popular vote

The respective roles of the Australian (Commonwealth) and State governments are delineated in the Constitution. Importantly, the constitution specifically places the power to raise revenue through taxation in the hands of the national (Commonwealth) government. However, key responsibility for service delivery lies with the states, which are reliant on transfers of funds from the Commonwealth in order to do so. These arrangements mean that Commonwealth and State authorities must establish funding agreements to deliver services such as transport, education and health. The key body through which these agreements are struck is the Council of Australian Governments (COAG).

Australia also ranks high in relation to quality of life on a global scale. In 2005, Australia was ranked sixth out of 111 countries on the world wide quality of life index, with a score of 7.925 on a scale from 0 to 10.⁽²¹⁾ The United Nations Human Development Report for 2010 ranks Australia second out of all United Nation members in the Human Development Index⁽²²⁾.

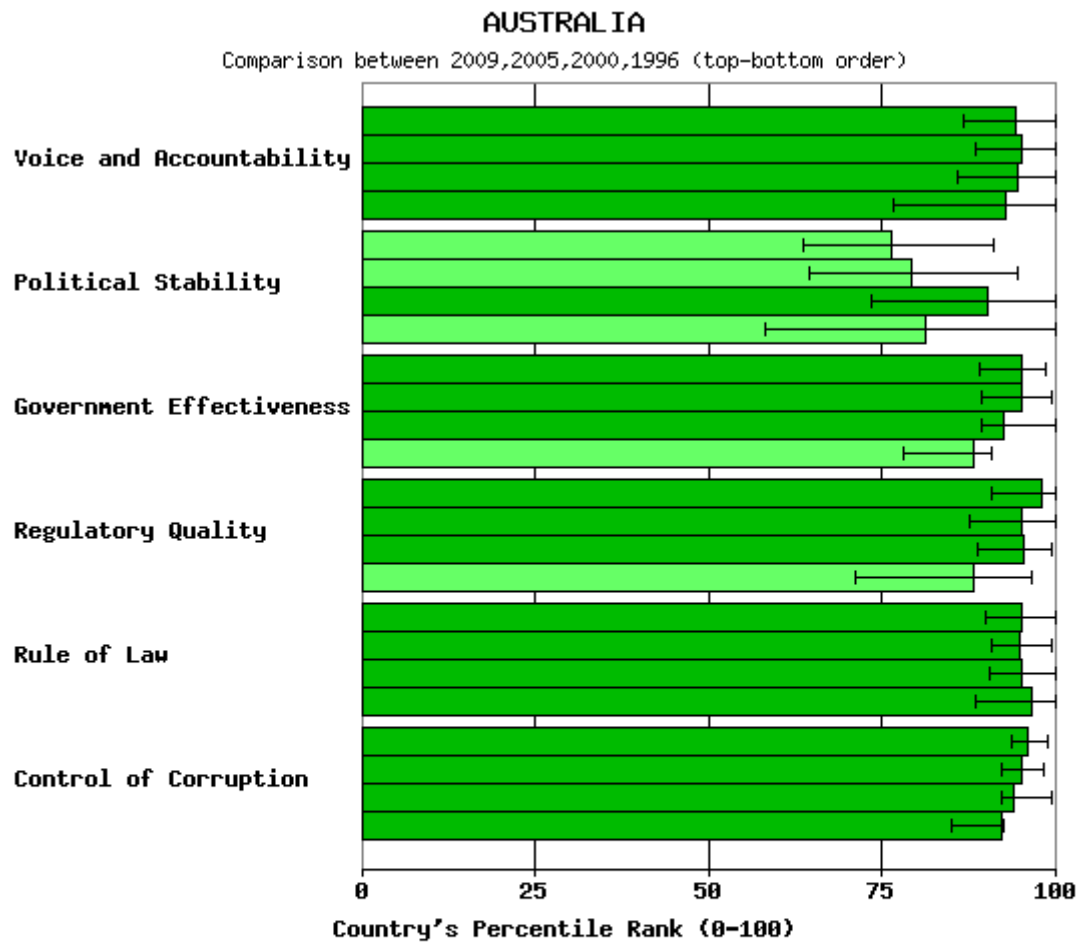
3.2.1 Political stability indicators

Australia is a politically stable parliamentary democracy. The incumbent Labor government was returned in 2010, but relies on the support of a small number of independents and the support of the Australian Greens political party to hold power. However, in an environment where political change occurs peacefully and according to established political and electoral conventions, this level of uncertainty does not generally present a significant barrier to the community or the economy.

The Worldwide Governance Indicators project, sponsored by the World Bank, consistently rates Australia in the 90th - 100th percentile across all key measures, except political stability. In the latter Australia was ranked in the 75th – 90th percentile⁽²³⁾ in 2009, a year in which the incumbent Prime Minister was replaced by his own party, and a closely contested federal election was fought.

The current health reform agenda (including the introduction of national registration (see 3.2) and the establishment of a national health workforce body (see 4.2.5)) have been brokered in an environment when Commonwealth Government and the three most popular States on the eastern seaboard – Victoria, New South Wales and Queensland – have had Labor Governments. However, the Labor Governments in Victoria and New South Wales were overturned in elections in 2010 and 2011 respectively. It is unclear to what extent political changes at state level may impact on the national health reform agenda. However, immigration policy is largely bipartisan in approach.

While political stability was not one of the most common factors cited by interviewees when asked about their motivations for moving to, and staying in, Australia, it was still a significant consideration. Forty-two percent of the 36 people interviewed indicated that the political situation in their country of origin was a factor in their decision to move to Australia, and 11% indicated that there were political obstacles to their return to their country of origin. Quality of life indicators



Source: Kaufmann D., A. Kraay, and M. Mastruzzi (2010), The Worldwide Governance Indicators: Methodology and Analytical Issues

Note: The governance indicators presented here aggregate the views on the quality of governance provided by a large number of enterprise, citizen and expert survey respondents in industrial and developing countries. These data are gathered from a number of survey institutes, think tanks, non-governmental organizations, and international organizations. The WGI do not reflect the official views of the World Bank, its Executive Directors, or the countries they represent. The WGI are not used by the World Bank Group to allocate resources.

Figure 3: Worldwide governance indicators⁽²³⁾

3.2.1.1 *Employment conditions*

It is important to note that in Australia work hours are regulated and monitored ⁽²⁴⁾. Descriptors of common working schedules are listed below:

- Full-time – working a maximum 38-hour week and with all minimum conditions including annual leave, sick leave and parental leave. Generally employers are able to request employees work 'reasonable' overtime, both paid and unpaid. ⁽²⁴⁾
- Part-time – generally working a set amount less than the standard 38 hours, with proportionate minimum conditions such as annual and six leave.
- Casual – employed on a day-to-day basis. There are no other obligations to a casual employee such as holiday and sick pay or even whether the employee works the next shift, although if work extends for 12 months consecutively that status changes.
- Contract – hired for a set period of time.

Many industrial organisations, such as the Australian Nurses Federation, monitor workplace conditions ⁽²⁵⁾. There has been significant vacillation in industrial regulation in Australia over recent years with conservative elements arguing for deregulation. Although Australia does not have compulsory maternity leave the majority of health professionals have these entitlements dependent on the industrial award under which they are paid.

In relation to salary, most health professionals are paid by industrial awards pertaining to specific professions and Medical Benefit Schedule. ⁽²⁶⁾ Many health professionals – general practitioners and dentists, for example – are effectively self-employed working as sole enterprises or in practice partnerships. In these cases, terms and conditions fall largely outside employment law.

More than half of the 36 health professionals interviewed listed working conditions as one of the reasons for wanting to move to Australia, including better working conditions (64%) and higher incomes (56%). These factors were also included as reasons to remain, though better working conditions was included by a slightly smaller proportion of interviewees (58%). Higher incomes was cited by the same proportion (56%). In addition, safety at work was cited by half of the interviewees (50%) as a reason for remaining.

3.2.2 Average Cost of Living

One of the most recognized cost of living indexes is produced by global HR advisory firm Mercer. The Mercer 2010 Cost of Living Survey evaluated 214 cities worldwide across five continents and evaluated a range of goods and services, including housing, transport, food, clothing, household goods and entertainment, as well as measuring currency movements against the US dollar. It uses New York City as a baseline in ranking cities.

The 2010 survey lists Australia's two most populous cities – Melbourne and Sydney among the top 50 most expensive cities. Sydney was ranked at 24 and Melbourne and 33⁽²⁷⁾. The same survey ranked Moscow 4th, Geneva 5th, and London and Paris at joint 17th.²

The qualitative evidence gathered through surveys and interviews suggests that a desire for a better quality of life was one of the most important driving forces for migrants to Australia. Of the 75 survey respondents, more than half listed this as one of the reasons for moving to Australia, second only to education.

Of the smaller group who agreed to be interviewed, higher standards of living (56%), general safety (53%), and the prospects for future generations (53%) were included by more than half of respondents as reasons for coming to Australia. When asked about their reasons for staying, an even higher proportion (72%) indicated the higher standard of living as one of their reasons. Sixty-four percent viewed general safety as a reason for staying, and a slightly smaller proportion (42%) saw the prospects for future generations as a reason for staying.

3.2.3 Summary Table

Australia as country of origin	Australia as destination
Push	Pull
High cost of living in Australia relative to some European countries.	Oversupply of labour, particularly recently trained health professionals. Impacts of Global Financial Crisis on job and career opportunities. Shortages on the labour market, including health sector; Strong economic growth Strong dollar improving relative value of Australian wages Good quality of life, safety and security according to key

² Luanda, Angola was ranked first.

	indications
Stick	Stay
Language and culture	Good quality of life, safety and security. Economic growth and career development prospects. Generally good terms and conditions of employment compared to many countries. Good prospects for future generations

3.3 Economic Indicators

3.3.1 *Growth and GDP*

Rankings produced by The Economist for 2009-2010 show that Australia is ranked in the top ten countries in relation to being the least exposed to the potential of political instability. ^(28; 21) Transparency International produces an annual Corruption Perception Index in which Australia was ranked eighth in 2009 out of 180 nations. ⁽²⁹⁾ Australia's political stability is further shown through the Economic Freedom Index, produced by the Heritage Foundation and the Wall Street Journal, to measure the economic freedom of countries. For 2010, Australia was ranked 3rd out of 170 countries ⁽³⁰⁾⁽²⁷⁾.

According to Australia's department of Foreign Affairs and trade (DFAT), Australia has recorded 17 consecutive years of economic growth since 1992 – averaging 3.3 % a year. It has been one of the most stable and productive periods of Australia's modern history, and places Australia in the top echelon of developed countries in terms of sustained rates of growth ⁽³¹⁾.

The OECD predicts that "The Australian economy, fuelled by the mining boom, should grow robustly in 2011 and 2012 at a rate of between 3½ and 4%. Strong growth, driven by terms of trade gains and dynamic investment, will reduce unemployment." ⁽³²⁾.

The OECD published a major economic survey of Australia in 2010, and found that

"Australia's main economic challenges are medium-term. Australia weathered the world recession well. Managing the exit strategy is less problematic than elsewhere thanks to sound fiscal position and positive economic outlook, although the new upswing starts with a relatively high inflation and little spare capacity. Over the medium term Australia needs to ensure a balanced expansion in the face of a mining boom and potentially volatile terms of trade movements, and strengthen supply to ensure non-inflationary growth. This requires

bolstering weakening productivity, boosting housing supply and further reducing risks associated with a likely widening of the current account to finance mining investments.”⁽³²⁾

Key issues identified by the OECD include

- improving fiscal policy, taking into consideration the distribution of wealth derived from the current mining boom, and to reduce volatility stemming from world commodity prices,
- improvements to the tax system to reduce administrative costs and complexity
- respond effectively to the existing infrastructure deficit, made more important because of the size of the country and remoteness from other markets.⁽³²⁾

Notably, the OECD also called for raising the labour market supply to “ease bottlenecks and help tackle social inclusion, an important aspect of wellbeing in Australia”. It notes that reforms in tax-transfer, education policies and labour market institutions would be key in this regard.”⁽³²⁾

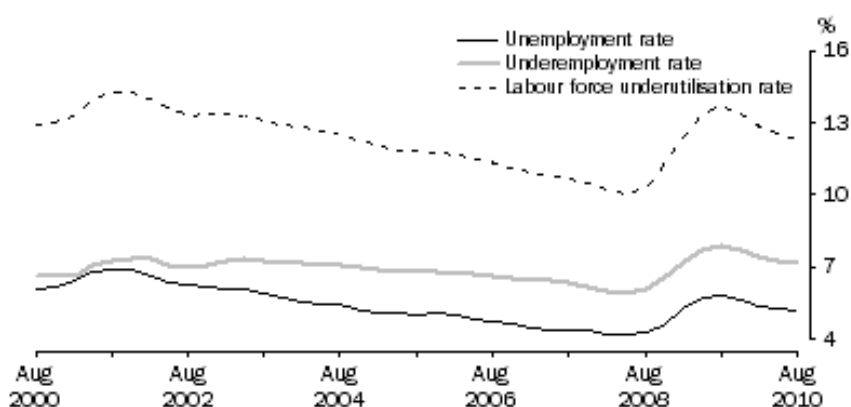
In interviews, key stakeholders have indicated that the strength of the Australian economy, which has weathered the Global Financial Crisis (GFC) well, is having an impact on the migration of health professionals. The strong Australian dollar is making Australian wages more attractive, and the ongoing growth means that employment prospects look favourable in an environment when many countries in Europe are experiencing public sector contraction and less job opportunities. This has meant that the Australian health sector is perceived as an attractive destination, and stakeholders report that enquiries are being fielded from many different types of health professionals, including senior clinicians.

This view was supported by the qualitative information gleaned from migrants themselves in interview. As noted earlier, higher wages was cited by the majority of respondents as being one of the reasons that they had come to Australia and as one of the reasons they would remain (56% in both cases.) In addition, 36% cited the economic situation in their country of origin as one of their reasons for moving to Australia, and 19% indicted that lack of jobs in their country of origin was one of their reasons for staying. Interestingly, however, only 21% of the larger group of 79 people who completed the online survey listed economic gain as one of their reasons for moving to Australia.

3.3.2 Labor Market Indicators

3.3.2.1 Unemployment

The seasonally adjusted unemployment rate in Australia in November 2010 was 5.2%, with male unemployment at 4.9% and female unemployment at 5.6%. In the same month, the participation rate reached a record high of 66.1%. Labour force underutilisation rate was 12.4% (10.5% for men and 14.6% for women).⁽³³⁾



(a) The trend unemployment rate compiled as part of the suite of quarterly labour underutilisation rates may differ from the official monthly unemployment rate as the labour underutilisation rates are subject to a separate seasonal adjustment and trend process.

Note: See the Glossary for further information on the labour underutilisation rates.

Source: Labour Force Survey.

Figure 4: Unemployment, Underemployment and underutilisation, 2000-2010

3.3.2.2 Dependency rate

The dependency ratio shows how many young people (under 16) and older people (over 64) depend on people of working age. The higher the dependency ratio, the fewer the people paying taxes and the more needing an income or financial support through other means, either family, government assistance, or superannuation funds.

Australia's dependency ratio has fallen from 53.5% to 49.1% over the past 20 years. However the dependency ratio is predicted to increase by 2051 to 69.8%.⁽³⁴⁾ This increase will place a higher burden on those that are economically dependent. Australia's aged dependency ratio is forecast to exponentially increase over the next 50 years, from 18.9% to 46.0%.⁽³⁴⁾

In 1995, Australia ranked ninth for the dependency ratio among developed countries.⁽³⁵⁾ In relation to aged dependency, Australia in 1995 ranked 16th among the developed countries, however this ranking is not expected to remain due to Australia's ageing population, which is predicted to increase its aged dependency ratio.^(36; 35) As population growth slows, growth in the potential workforce will also decline.⁽³⁷⁾ These anticipated shortages are stimulating debate and discussion over retirement age.^(38; 39; 13)

3.3.3 *Employment in the health care system*

ABS data shows that in 2006, the health services industry employed 7% of the civilian labour force, accounting for approximately 750,00 people. Over the past 40 years, the health workforce has increased at a much faster rate than the population. From 2001 to 2006, the number of health workers increased by 22.8% compared with a 6.6% increase in the Australian population⁽¹⁵⁾.

3.3.3.1 *Ageing of the health workforce*

The health workforce is ageing more quickly than the non-health workforce thus increasing the workforce shortage.^(15; 40; 41) In 2006, 16% of the health workforce was aged 55 years and over, compared with 12% in 2001.⁽¹⁵⁾ In addition over the last decade there has been a noticeable ageing of the general practitioner (GP) workforce. There has been an increase of 8.3% of the number of practicing GPs over the age of 55 years.^(34; 42) For nurses, the proportion aged 55 years and over doubled over the period of 1999-2005, from 11% to 20% for registered nurses and from 7% to 17% for enrolled nurses.⁽¹⁵⁾ Whilst there will always be a supply of new workers in the health workforce, concerns arise that the rate of new entrants to the workforce will not meet the demands of the increasingly ageing population.⁽¹⁵⁾

3.3.3.2 *Feminisation of the workforce*

There is a feminisation of the workforce with women comprising 74% of the health workforce. Women are dominant in registered midwifery (99%); registered nursing (92%), enrolled nursing (88%) and physiotherapy (67%).⁽¹²⁾ Although nursing has long been recognised as a feminised workforce, currently 36.8 % of the GP workforce is female, an increase of 6.8% since 1998. This is reflective upon the increase in female GP trainees.^(34; 42) The Medical Training Review Panel has noted a steady increase in the number of female trainees across all medical disciplines and believes that this "will continue to increase given that most Australian medical schools now have a female student proportion at, or approaching, 60% of total medical students".⁽⁴²⁾ A female medical doctor works 37.6 hours compared with 46.7 hours per week of her male colleague.^(42; 15; 43) Given

that general practice is becoming increasingly female dominated this may have a significant impact on overall hours worked in general practice.

3.3.3.3 Work life balance and lifestyle choices

The Australian Bureau of Statistics identified an average decline of 8.1% since 1998, in the proportion of GPs working (and providing) more than 10 sessions per week. A session pertains to several hours of aggregated work- generally named ‘morning’ or ‘afternoon’ sessions. This is a decline of 11.7% since 1998 for GPs providing their own after hours cover. The Australian Medical Workforce Advisory Committee AMWAC Medical Careers Survey 2002 identified that 28% of doctors considered that the hours they worked were excessive and expressed a desire to work part-time. The AMWAC 2003 Report on career decision making by doctors in vocational training identified that a large mismatch exists between a GP’s expectations about their personal and professional lives. The report also found that 1.4% of doctors in vocational training intended to drop out of medicine altogether during the following 3 years and approximately 7% said that they would like to leave due to stress/work demands.⁽⁴²⁾ Difficulty in providing sustained and continuous health care services to those in rural and remote areas is likely related to lifestyle choices as Australia has seen a significant shift of populations to coastal areas.^(44; 45; 46)

As shown in the charts provided in Annex 6: Survey results: Summary of reasons for moving to Australia and Annex 7: Interview results: Summary of Push/Pull, Stick/Stay factors, issues relating to lifestyle and quality of life figured prominently in migrant health professionals’ reasons for moving to Australia, and in the reasons they reported intending to stay.

3.3.3.4 Generational change and aspirations

Although data is largely speculative there is a suggestion that Generation Y³ seek rapid career progression, diversity and challenge in their careers. In addition they seek jobs that provide flexibility in order to achieve the work life balance.^(47; 48) These drivers necessitate the overall growing of the health workforce to include more people and also cause areas of health to become more specialised, as greater understanding of disease as well as new technologies demand skill development. Health care settings are currently unable to cope with the increasing numbers of students enrolled in health care courses. In parallel, there is a shortage of adequately prepared people to undertake teaching roles to prepare the health work force. Lack of comparability of

³ Generation Y refers to “the demographic cohort born between 1975 and 1995⁽¹⁴⁵⁾.”

salaries and differing award systems between the academic institutes and industry also contribute to this trend.

Both job and career prospects were viewed very positively by the 36 health professionals interviewed during the “micro” research phase. Fifty-eight per cent saw better job opportunities as a reason for moving to Australia, and 56% saw better career opportunities. In addition, 11% of those interviewed saw the low status of their profession in their country of origin as a factor. Better job opportunities was listed by 72% of interviewees as a reason for staying in Australia, and better career opportunities was listed by two thirds (67%) as a reason for staying.

3.3.4 Summary Table

Australia as country of origin	Australia as destination country
Push	Pull
Less affordable social supports (e.g. childcare) available than are the case in some EU countries. Fewer annual days leave available as a standard employment condition than available in some EU countries. Some limitations in care available through public health system (e.g. dental care private)	Oversupply of labour, particularly recently trained health professionals. Impacts of Global Financial Crisis on job and career opportunities. Shortages on the labour market, including health sector; Comparatively strong economy Strong dollar improving relative value of Australian wages Good quality of life, safety and security according to key indications
Stick	Stay
Costs of relocation – and reduced value of assets outside Australia as a result of strong Australian dollar.	Good quality of life, safety and security. Economic growth and career development prospects.

4 Health Status and Health System⁴

⁴ A comprehensive overview of Australia’s health status and health system is published each year by the Australian Institute of Health and Welfare. A copy of the 2010 report is available at <http://www.aihw.gov.au/publications/index.cfm/title/11374>

4.1 Health Indicators

4.1.1 Mortality

Life expectancy in Australia is among the highest in the world and has been so for quite some time. Life expectancy at birth in 2007 was almost 84 years for females and 79 for males. However, death rates vary a lot across different groups. Those with lowest socio-economic status (SES) experience a death rate about 13% higher than the national rate, while those in the most advantaged quintile have death rates about 17% lower than the national rate. For those living outside capital cities it is around 8% higher. The rate for overseas-born Australians is 6% lower. ⁽¹²⁾

Indigenous people have almost twice the death rate for Australia as a whole. Australians in the lowest quintile of socioeconomic status: Life expectancy at birth (LEB) among indigenous Australians is substantially lower (59.4 for males and 64.8 for females in the period 1996-2001) than that of all Australians (76.6 and 82.0, respectively, for the period 1998-2000)). Between 2001-2005; approximately 71% of Indigenous deaths were in those 65 years and younger. In contrast, over 70% of non-Indigenous deaths were in those 65 years and older. ⁽⁴⁹⁾

Circulatory diseases dominate as the major causes of death in Australia for both sexes, followed by cancers.

Mortality rates for both infants (under one year) and children (age 1-14) have fallen in recent decades and continue to fall. ⁽⁵⁰⁾ Most childhood deaths (68% in 2004) occur in the first year of life, with 15% in those aged 1-4 and the remaining 17% in the 5-14 age range. The mortality rate for neonates was 3.6 per 1000 live births (in the first four weeks of life) and 1.4 per 1,000 in the remainder of the first year. ⁽⁹⁾ However, while Australia ranks in the best third of OECD countries for most health indicators, it ranges in the lowest third for infant mortality. ⁽⁵¹⁾

Table 1: Leading causes of death, Australia, 2006 ⁽¹²⁾

LEADING CAUSES OF DEATH, AUSTRALIA, 2006	
MEN (mortality rate 731.5/100,000)	WOMEN (mortality rate 493.8/100,000)
ischaemic heart disease (17.8% of deaths)	ischaemic heart disease (16.6% of deaths);
Lung cancer (6.8%);	Cerebrovascular disease (10.7%)
Cerebrovascular disease (6.5%);	Other heart diseases (7%);
Other heart diseases (4.5%);	Dementia and related disorders (7%);
Prostate cancer (4.3%);	Lung cancer (4.1%);

LEADING CAUSES OF DEATH, AUSTRALIA, 2006	
Chronic obstructive pulmonary disease (COPD) (3.9%);	Breast cancer (4.0%);
Dementia and related disorders (3.2%);	COPD (3.2%);
Colorectal cancer (3.1%);	Unknown primary site cancers (2.9%);
unknown primary site cancers (2.9%) and	diabetes (2.8%); and
Diabetes with 2.7% of deaths.	Colorectal cancer (2.6%).

Clear evidence of health disparities exist among Australians living distant from metropolitan areas. Common causes of death in these regions are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease.

Clear differences exist in health service usage between areas. There are, for example, lower rates of some hospital surgical procedures, lower rates of GP consultation and generally higher rates of hospital admission in regional and remote areas than in major cities. Compared with metropolitan areas, remote areas have less than half the supply of medical practitioners and dentists (number of 'full-time equivalents' per 100,000 populations).⁽⁴⁹⁾

Table 2: Life expectancy (years) for non-indigenous Australians by remoteness area, 2002-2004

	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Males	79.1	77.9	77.2	78.1	78.3	78.6
Females	83.8	83.1	83.0	83.4	84.2	83.6

Source: AIHW National Mortality Database.

<http://www.aihw.gov.au/ruralhealth/healthstatus/index.cfm>

4.1.2 Morbidity

Three health factors that require the most modification in Australia include smoking, high blood pressure, and overweight/obesity. Smoking levels are continually decreasing, with it documented that 16.8% of people aged 15 years and older smoke daily⁽⁵¹⁾, one of the lowest smoking rates of the OECD countries.

Lack of physical activity is noted as a problem, with between 30-40% of people up to age 75 years old experiencing little to no exercise. ⁽⁴⁹⁾ Approximately 85% of all people, regardless of socioeconomic status, have inadequate vegetable consumption and approximately 50% inadequate fruit consumption. ⁽⁵¹⁾

The total burden of disease and injury in Australia in 2003 was estimated to be more than 2.6 million Disability Adjusted Life Years (DALYs). Cancers were the leading contributor of DALYs with 19%, followed by cardiovascular disease (17%), mental disorders (13%), neurological and sense disorders (12%) and chronic respiratory diseases (7%). Of these infant deaths, 24% were caused by congenital malformations, deformations and chromosomal abnormalities and 47% were caused by conditions originating in the perinatal period. Sudden Infant Death Syndrome comprised 5% of infant deaths in 2004. ^{(52) (58)}

Between 1993 and 2003, the burden of disease in Australia substantially lessened, with a 15% decline in age-standardised DALY rates. Most of this decline was in the fatal component of burden of disease (YLL), particularly for cardiovascular disease, cancer and injury. ⁽¹²⁾ However, the proportion of Australians with a long-term health condition has been increasing. For example, between 1990 and 2005, it increased from 66.6% to 75% for men and from 69.6% to 78.4% for women. The increase in long-term health conditions has been attributed to the ageing population as well as lifestyle conditions such as obesity rates. Almost 75% of all deaths are largely preventable chronic conditions.

The ageing population poses the greatest challenge to the health system in terms of burden of disease and levels of hospitalisation. It was recorded in 2004 that 53% of people in hospital were those aged 65 years or older; presenting the problem that with an ageing population, hospital costs and staff shortages will be exacerbated.

Australian Aboriginal and Torres Strait Islander peoples suffer a disproportionate burden of ill health that is estimated to be 2.5 times that of other Australians. ^(53; 36) Social determinants of health are largely responsible for this high level of burden. ⁽⁵⁴⁾

4.1.3 Summary Table

Australia as country of origin	Australia as destination country
Push	Pull
Poor record of progress on indigenous health.	Relatively high health status of population (with exception of indigenous people).

	Relatively high living and practice standards May be significant personal risk associated in health care delivery in some origin countries. Significant challenges to achieving significant health gains in catchment population for health professionals in some areas.
Stick	Stay
Status of health professionals, particularly in areas of workforce shortage	Relatively high health status of population (with exception of indigenous people). Relatively high living and practice standards

4.2 Health System: General Information

4.2.1 Health Expenditure

4.2.1.1 Total expenditure

In 2007-2008, Australia's health expenditure was \$103,563 million, or 9.1% of gross domestic product (GDP), an increase over the past decade of 1.3%. This compares with 8.45 in the United Kingdom and 16% in the United States. The OECD median in the same period was 8.9% ⁽³¹⁾. Hospitals are the largest consumer of recurrent health expenditure (see **Error! Reference source not found.**).

4.2.1.2 Public sector health funding

Almost 80% of total health expenditure in Australia is funded by government, with the Australian Government contributing two-thirds of this and state, territory and local governments the other third. Additionally, the federal government partly funds public services by way of the provision of money to the state governments, and private hospitals through subsidising private health insurance cover. **Error! Reference source not found.** depicts the financing of healthcare within Australia.

State and territory governments provide funding for community health services, patient transport, as well as public health services and activities. They are primarily responsible for the delivery and management of public health services to the population and are responsible for maintaining direct relationships with health care providers, including the regulation of health professionals. However,

General Practitioners operate as independent providers, with access to services funded through the Australian government's Medicare rebate scheme.

Two national subsidy schemes exist; Medicare and the Pharmaceutical Benefits Scheme (PBS). The Australian government provides most funding for medical services (general practitioners, medical specialists and pharmaceuticals) through Medicare. Medicare was introduced in 1975 and is the Commonwealth-funded universal health insurance provider that provides free or subsidised health care services to the Australian population. ⁽⁵⁵⁾

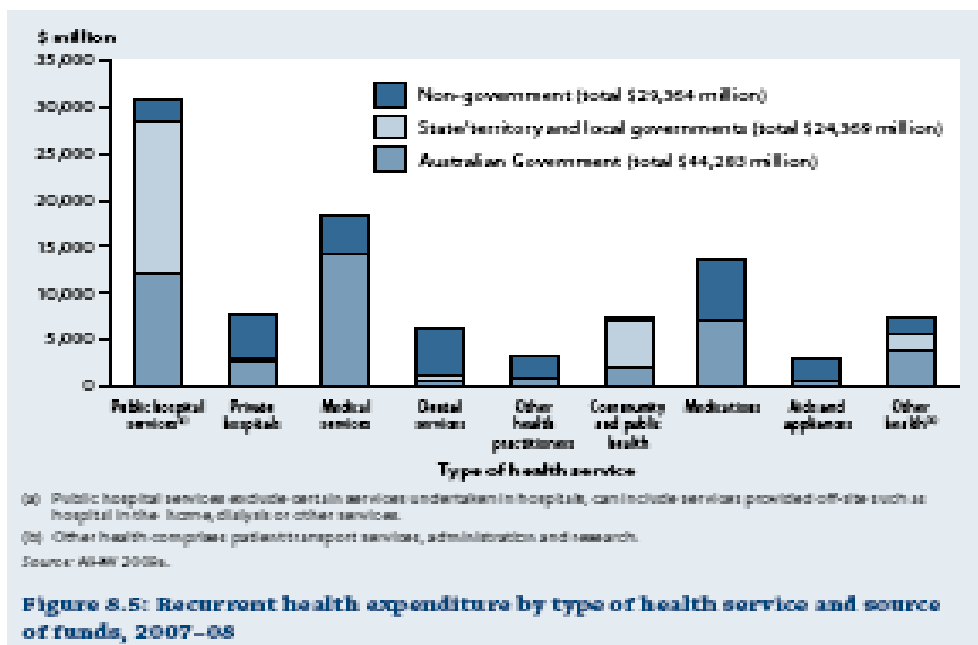


Figure 5: Recurrent health expenditure by type of health service and source of funds, 2007-08. (Source AIHW: permission required)

This relationship between the Australian and State governments is crucial to the development and coordination of coherent health and education policy and workforce planning. Improving State/Commonwealth coordination is seen by many as a key plank in improving the performance and continuity of the health care system. For example, under the current arrangements, General Practitioners are independent service providers, funded through rebates provided by the national Government, though out-of-pocket payments may also be charged. This funding stream is fee-for-service and essentially uncapped. Aged care is primarily funded by the national government, often

with State government supplementation and with a large private sector. Acute care is funded and managed by the state. These differences in funding and administration increase the difficulty of coordination and referral (e.g. effective discharge planning) across different parts of the health sector.

4.2.1.3 Health reform.

A major reform program agenda is now being pursued by Australian governments, following the findings of the recent Hospital and Health Reform Commission. The Commission recommended specific objectives to reduce inefficiencies generated by cost-shifting across health care jurisdictions, poor integration and continuity of care across the health sector, particularly between primary care and hospital services, increase focus on prevention strategies, integrate acute services and aged care services, improve transitions between hospital and aged care, provide health services in rural areas, improve Indigenous health outcomes, and provide a qualified and sustainable health workforce.⁽¹¹⁾

4.2.1.4 Private sector funding

Non-government funding is derived from benefits paid by private health insurance, workers compensation, as well as out of pocket expenses by individuals. In June 2006, 43.5% of Australian people had basic private health insurance.

4.2.2 Health services

In 2007–08, there were 1,314 hospitals in Australia, comprised of 742 public acute hospitals, 20 public psychiatric hospitals, 272 private free-standing day hospital facilities and 280 other private hospitals. The number of public acute hospitals has remained relatively stable since 2003–04. The number of private hospitals increased from 525 facilities in 2003–04 to 552 facilities in 2007–08.

The number of available beds in Australia increased by 5.0% between 1998–99 (80,200 beds) and 2007–08 (84,235 beds), an annual average increase of 0.5%. In 2007–08, the available beds were: 54,137 in public acute hospitals 2,330 in public psychiatric hospitals 2,151 in private free-standing day hospital facilities and 25,617 in other private hospitals.⁽⁵⁶⁾ This calculates to about 397 beds per 100,000 people, down from about 401 beds per 100,000 in 2003–04. The number of available beds ranged from 3.3 per 1,000 in the Northern Territory to 4.7 per 1,000 people in Tasmania in 2007–08. This lack of beds is not surprising given that the population growth is 1.5% and the bed increase is only 0.5% annually.

Public hospitals dealt with more than 7 million presentations to emergency departments in 2007–08, and there was an increase of about 4.9% each year since 2003–04. Australian public hospitals handled about 7.9 million admissions in 2007–08, and there was an increase of about 3.6% each year since 2003–04. Public hospitals provided about 41 million services through outpatient departments in 2007–08, and there was an increase of about 2.4% each year since 2003–04.⁽¹⁵⁾

Assessing projected costs of healthcare highlights the need to minimise chronic disease and increase investment in health research and education. Cardiovascular disease, the leading cause of death in Australia, is estimated to increase by 105% in health expenditure between 2003-2023. Neurological diseases such as dementia, one of the top three causes of death in the ageing population, is said to increase by 280% in the same timeframe.

Australia's healthcare system is fundamentally 'effective and efficient', however when faced with issues of chronic disease, an ageing population, inferior outcomes of people living in regional Australia and the significant health disparity between Indigenous and non-Indigenous Australians. By locating and focussing upon leading causes of death and burden of disease, specifically speaking of cardiovascular and cancer disease, a better approach may be found. In addition to focussing on the most prevalent diseases, the health workforce also needs attention in an attempt to maximise recruitment and productivity.

While 28% of participants interviewed for this study reported that the poorer health system in their country of origin was a factor in their decision to migrate, this was one of the less frequent responses of those available. However, better job prospects and career opportunities, both of which are arguably flow on effects of a robust health system, were seen by 58% and 56% of respondents respectively as factors in their decision to migrate.

Similarly, although lack of jobs in their own country was cited by a relatively small proportion of respondents as a significant factor in their decision to stay (29%), 72% cited better job opportunities as a reason to stay, and 67% cited better career opportunities.

4.2.3 Summary Table

Australia as country of origin	Australia as destination country
Push	Pull
Some limitations in capacity to provide high-level training in some specialty areas. Some limitations on scope of practice meaning fewer	Better tools to diagnose and treat certain diseases than in some other less developed countries (e.g. in cardiac diseases), so good career possibilities for these

opportunities for some professions (e.g. to date, limited role of nurse practitioners or nurse managed practices).	specialists from other countries (mainly less developed); Relatively well funded health system Clear organisation and financing of the system; Relatively high expenditure on health means scope for acceptable conditions of work, access to new technologies and new medicines, efficient information system, access to support staff; Constraints on health sector funding in some EU countries Poorly developed health infrastructure in some countries limits professional development opportunities and job satisfaction
Stick	Stay
Potential for development of particular medical, nursing and allied health professional specialisations. Stronger opportunities for secure public sector employment for some professions (e.g. dental services primarily private sector in Australia, but NHS supported in UK).	High level of health care in Australia Good access to high quality infrastructure, pharmaceuticals and equipment. Strong wage growth

4.3 Supply of Health Professionals

The health professionals working in Australia's health workforce primarily comprises nurses, doctors and allied health professionals, with nurses being the largest health profession. It is estimated that 360,400 individuals (3.5%) of the employed Australian workforce in 2006 were health professionals. This included ⁽³⁹⁾

- 61,085 medical practitioners.
- 96,085 miscellaneous health professionals and
- 203,231 nursing professionals employed in 2006. ⁽³⁸⁾

By 2018, there are forecast to be 409,300 Australians employed in the health care occupations with an average growth of 1.7% per annum. (15; 57) Australia has an above average medical workforce born overseas and below average medical students per 1,000 doctors.

Of people employed part-time in the health workforce, 91% were female, a higher proportion than in the total part-time workforce (71%). Males constituted 9% of those working part-time in the health workforce compared with 29% of those working part-time in the total workforce. Women are dominant in registered midwifery (99%); registered nursing (92%), enrolled nursing (88%) and physiotherapy (67%). In contrast 79% of ambulance officers and paramedics; 69% of specialised medical practitioners and 62% of generalist medical practitioners are women.

Another aspect of the health labour force is that it continues to age – the proportion of those aged 55 years and more was 12% in 2001 but has risen to 16% in 2006. ⁽¹²⁾ In 2004, nearly 29% of the nursing workforce was over 50 years old. Illife forecasts 50% of the health workforce may retire in the next 10 – 20 years. This group will be the health care workers with the most specialist qualifications, knowledge and skills. ⁽⁵⁸⁾

Over a third (37%) of the health workforce was employed on a part-time basis, compared with 28% of all employed people in Australia.

The number of people working in health occupations increased by 22.8% between 2001 and 2006 compared with a 6.6% increase in the population over the same period. Interestingly, complementary therapies had the biggest change in workforce, with a 49.2% increase to 16,354 people. Another big growth in employment was allied health workers, with a 27.9% increase to 65,284 staff in 2006. A similar increase was seen in medical imaging, which increased 28.2% from 8,170 people in 2001 to 10,477 in 2006. ⁽⁵⁹⁾

In common with global trends, the Australian health care system faces significant challenges in the supply of health care professionals. Population ageing, escalating health care costs, and workforce shortages in the health care setting will have an impact on the future health and well-being. ⁽²⁰⁾ In 2006, it was found that there was a shortage throughout all states of mental health nurses as well as registered nurses and midwives. ⁽¹⁵⁾ Other health occupations such as medical image workers, physiotherapists, occupational therapists and dental professionals were also experiencing a shortage throughout both rural and urban communities. ⁽¹⁵⁾ Compared with the major cities, remote areas have less than half the supply of medical practitioners and dentists (full time equivalents per 100,000 populations).

However, stakeholders in interviews conducted as part of this study noted that for some professions, like nursing, there was no consensus on the extent of the workforce shortage. The situation is also variable in different states. For example, one stakeholder noted that their state did

not experience an overall shortage, but needed more highly skilled, specialist nurses and medical workforce.

In 2007 there were 77,193 persons registered as medical practitioners in Australia, of whom 67,208 (87%) reported that they were working in medicine at the time the Australian Institute of Health and Welfare conducted its labour force survey.⁽⁴⁹⁾ In 2007 the majority of employed medical practitioners were clinicians, of whom 38.5% were primary care practitioners, 34.6% were specialists, 14.1% were specialists-in-training, 11.8% were hospital non-specialists and 0.9% were other clinicians.⁽⁶⁰⁾

Between 1997 and 2007 the number of employed medical practitioners increased by 39% .The full time equivalent (FTE) supply of practitioners increased by 11% in the same period, from 275 FTE per 100,000 population in 1997 to 305 in 2007. In 2007, 93% of employed medical practitioners were clinicians. .Of the clinicians, 38% were primary care practitioners, 35% were specialists, and the remainder were specialists-in-training (14%) and non-specialists working in hospitals (12%).⁽⁴⁹⁾

Medical practitioners are not evenly distributed across Australia. In 2007 the supply of medical practitioners in Australia was with 332 FTE per 100,000 population in major cities, compared to rates of 186 and 157 in inner regional and outer regional, areas respectively. The FTE rate of specialists in major cities were 2, 3 and 4 times as high as inner regional, outer regional and remote and very remote areas, respectively. The supply of primary care practitioners was more even: 84 FTE per 100,000 population in outer regional areas compared to 95 in major cities.^{(49) (3)}

In Australia there are 2.8 practicing physicians per 1,000 population. This ranks Australia 21 out of the 30 OECD countries. In addition, Australia is below the OECD average for growth in practicing physicians per capita from 1990- 2007. In 2007, there were 10 medical graduates per 100,000 population in Australia, a similar number to the OECD average. A 10% increase in the number of medical practitioners between 2001 and 2006 is noted (54,791 in 2001 cf. 57,019 in 2006).⁽³⁹⁾ In 2005-06 international medical graduates made up 13.42 % of the total Australian medical workforce.⁽³⁹⁾

4.3.1 Nursing workforce

Nurses are the largest occupational group in the health workforce According to the Australian Institute of Health and Welfare, in 2007 there were 305,834 registered and enrolled nurses. In 2007 registered nurses made up 81% % of the nursing labour force. Between 1997 and 2007 the number of employed nurses (registered and enrolled) increased by 18%. Between 1997 and 2007 there was

a 21% increase in the number of employed registered nurses and a 10% increase in the number of employed enrolled nurses. The supply of nurses increased 13% nationally between 1997 and 2007, rising from 1,054 FTE nurses per 100,000 population in 1997 to 1,189 in 2007. In contrast to medical practitioners, in 2007, the supply of registered and enrolled nurses was highest in remote areas (1,281 FTE nurses per 100,000 population) and lowest in major cities (1,095).⁽⁴⁹⁾

A high proportion of nurses work part time compared to other professions, with 26% working less than 25 hours per week. However, this is a decrease from ten years previously, when 32% of nurses worked less than 25 hours per week. Over the same period a greater proportion of nurses also worked 40 hours or more, increasing from 23% to 36% over the same period. Overall, the number of average hours worked by nurses increased from 31 to 33 hours per week between 1997 and 2007.⁽⁴⁹⁾

4.3.2 Dental workforce

Based on annual data collections conducted by AIHW with the assistance of registration boards, state and territory health departments and professional associations, there was an estimated 10,404 dentists were employed in Australia in 2006, an 8% increase since 2003. There was also an increase in the practicing rate (number per 100,000 population), from 48.7 to 50.3 dentists per 100,000 population. Between 2003 and 2006, there was a significant increase in the number of employed dental allied practitioners of 22%. An increase in the number of these practitioners dual-qualified as both hygienists and therapists is also reported. Between 2003 and 2005, the dental prosthetist labor force remained relatively stable, decreasing marginally by 2%.⁽⁴⁹⁾ The AIHW reports all groups of the dental workforce worked on average between 28 and 43 hours per week^{(49 p. 455).}

4.3.3 Identified skills shortages

The Department of Education, Employment and Workplace Relations produces a list of occupations where skill shortage or recruitment difficulties exist, based on labour market research. The department identified shortages in a broad range of health occupations across all states and territories as at 2007 and 2008). “In all jurisdictions there was a state-wide shortage in registered nurses, registered midwives, medical diagnostic radiographers and sonographers. In 7 of the 8 jurisdictions there was a state-wide shortage in registered mental health nurses, dentists, dental specialists and physiotherapists. Medical practitioners were not included in the research although studies have shown there to be an overall shortage in Australia”. (49 p. 455)

4.3.4 Summary Table

Australia as country of origin	Australia as destination country
Push	Pull
Skills shortages in some areas can result in increased workload for remaining staff, resulting in stress and burnout.	Current shortages for health professionals create good employment opportunities
Stick	Stay
	Projections indicate ongoing areas of shortage for some health professionals, indicating strong employment and career prospects into the future.

4.4 National Health Workforce Reform

In 1998 State and Commonwealth governments agreed on the Partnership Agreement on Hospital and Health Workforce Reform. The Agreement aimed to “improve efficiency and capacity in public hospitals” through

- (a) introducing a nationally consistent Activity Based Funding approach;
- (b) improving health workforce capability and supply;
- (c) enhancing the provision of sub-acute services; and
- (d) taking the pressure off public hospitals. ^(61 p. 3)

This agreement included a series of reforms aimed at alleviating the shortages in Australia’s health workforce and ensuring that the workforce would be able to meet expected increases in the demand for health care resulting from the ageing population, higher levels of chronic disease and rising community expectations. An implementation plan is included as an Appendix to the Agreement, which established key targets as well as outlining both the roles and responsibilities and the respective funding contributions of the Commonwealth and State governments. ⁽⁶¹⁾

4.4.1 National Health Workforce Agency

Central to these reforms was the establishment of the National Health Workforce Agency, established in 2010 as Health Workforce Australia (HWA). HWA is a cross-jurisdictional body operating in government and non-government health sectors, as well as the higher education sector, to address workforce planning, training and reform. Its priorities, as set out in its first annual report, are to work with the Australian Health Minister's Conference (AHMC) on issues including

- Authoritative, evidence-based workforce planning, policy advice and analysis of future supply and demand
- Capacity building and targeted resource in clinical training, achieved through programs of funding development and reform in both the health and higher education sectors
- *“Innovation and reform of Australia's health workforce to encourage an inter-professional approach flexibility in deployment of resources and development of new workforce models”*
(62)

The HWA's annual report states that among its four key priorities for 2010 will be

“to encourage nationally consistent policy and programs to better manage recruitment and retention of international health professionals to work in Australia's health care system. This may include a national platform for recruitment and support for overseas candidates to work in Australia as health professionals. It will also include easier access to all candidates and employers through a national call centre and website, and targeted programs of support for international health professionals working in rural and regional areas.” (62 p. 3)

However, not surprisingly given its recent establishment, interviews with key informants suggest that there is still a significant amount of work to be done to resolve ambiguities about the respective roles of the HWA and pre-existing State and Commonwealth agencies, and well as the newly established Australian Health Practitioner Regulation Agency (AHPRA). Specifications for a new National Statistical resource and National Health Workforce Dataset (NHWDS) are still being developed, and the HWA is working with the Australian Institute of Health and welfare to establish processes for the maintenance of data (62 p. 10)

A new National Health Workforce Planning Tool is also being developed, which aims to compile a macro-level picture of the health workforce, its capacity to train workers and the drivers behind both

supply and demand, by linking data from hospital statistics and “potentially” from the departments of Education, Employment and Workplace Relations, Immigration and Citizenship and other sources. However, no results are expected for some time.

Also among the HWA's deliverables for 2010 are supply and demand projections for the nursing professionals in both the acute and aged care sectors, the anesthetist workforce, the emergency physician specialist workforce, and the intensive care medical specialist workforce.

4.4.2 Australian Health Practitioner Regulation Agency

In 2008 COAG signed an Intergovernmental Agreement on the health workforce, agreeing to create for the first time a single national registration and accreditation system for ten health professions: chiropractors; dentists (including dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists.⁽⁶³⁾

Registration to practice is regarded by key stakeholders as the key hurdle to be overcome for health practitioners seeking to immigrate to Australia. Difficulties in accessing information, understanding and meeting registration requirements, and navigating the various requirements of and interaction between national visa requirements and state registration and regulation requirements have historically been factors cited by immigrants as the most difficult to navigate⁽⁶⁴⁾

The new arrangement is intended to help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce.⁽⁶³⁾ It should also reduce the complexity of seeking registration for overseas trained health professionals seeking to practice in Australia, which has been noted by a number of key informants as a difficult and at times bewildering process. As part of national registration, a national register for each health profession has been established, through the Australian Health Practitioner Regulation Agency (AHPRA), which has responsibility for the National Registration and Accreditation Scheme for the health Professions (NRAS).

AHPRA supports ten separate boards – one for each of the health professions – in implementing the NRAS, which commenced in July 2010, with the state of Western Australia joining the scheme in October 2010. Every practitioner who was registered with a state or territory registration board on 30 June 2010 automatically transferred to the National Scheme, and the process also involves reconciling records so that practitioners with registrations in more than one state will have their

details consolidated into one national registration ⁽⁶³⁾⁵. The different types of registration granted are outlined in the AHPRA Fact Sheet reproduced here in Annex 5: AHPRA fact Sheet: Registration Types and available at the AHPRA website www.ahpra.gov.au.

Interviews with stakeholders highlighted that there is still a degree of uncertainty about APHRA's role in data collection and analysis. While many in the sector are looking to utilize the information available through registration data, APHRA's core business remains managing and coordinating the registration of health professionals. Issues of data collection and analysis are discussed further in section 6.2.5 and 7.3. However, in the long term, the development of a central, national registration system should enable the development of a single set of information on both the size and the characteristics of the health workforce, improve assessments of existing stock and supply and exit from the workforce, and contribute to better workforce planning.

Interviewees expressed a degree of frustration with immigration law and policy, much of which seemed to focus on the role of APHRA and the National Boards and in particular the interface between the clinical exam process and the language requirements. This will be discussed in more detail in section **Error! Reference source not found.**

4.4.3 Summary table

Australia as country of origin	Australia as destination country
Push	Pull
Historically weak policy and planning links between health industry workforce needs and education/training provision.	Identified areas of shortage for most health professions, particularly in rural areas. Projections suggesting ongoing need for health workforce growth due to demand increases and ageing of current workforce. Health workforce planning and development currently area of significant policy development and reform
Stick	Stay
	Move to national registration likely to simplify registration

⁵ Some anomalies are reported to have arisen during the process of consolidating state registrations. In some cases, different states have recognised overseas qualifications differently, leading to different conditions applying to a practitioner's registration in different states. This demonstrates the national inconsistencies that existed under the superseded state-based system..

	process and enhance opportunities for health professional mobility within Australia. Ability to retain registration through extended periods of non-practice.
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4.5 Health Professional Education

For the health professions (such as registered nurses, medical practitioners, dental practitioners, pharmacists and so forth), graduation from a relevant university course is a requirement to practise. Accordingly, an important source of entrants into these occupations is Australian residents completing health-related higher education courses each year.

Between 2002 and 2007, there was an overall increase of 26% in health professionals completing a relevant university course. Increases were recorded for all health fields, with the largest occurring in the fields of nutrition and dietetics (up 94%), and podiatry (64%). The smallest increases were for occupational therapy (8%) and rehabilitation therapies (11%).⁽⁴⁹⁾

Tertiary education is funded by the national government. Significant income is also derived from student contributions. These are administered through the Higher Education Contribution Scheme-Higher Education Loan Programme (HECS-HELP). Students are required to repay loans when they have begun earning income, with the rates varying according to the course. Fees for medicine are approximately \$50,000 for a 6-year course⁽⁶⁵⁾, leading to some concerns about access to such courses for students from lower socio-economic backgrounds. (Australian Medical Students Association cited in⁽⁶⁵⁾). Universities also accept fee paying overseas students, and this revenue source comprises a significant and growing part of many Universities' revenue stream. This provides a financial incentive for Universities to maximise the number of places for overseas students, although competition for funded University places remains strong, particularly for courses such as medicine.

4.5.1 Nursing

Nurses comprise the largest component in the health professions workforce in Australia and their numbers are increasing.⁽³⁹⁾ The number of registered and enrolled nurses employed as nurses in Australia between 2001 and 2005 increased by 7.1% from 228,230 to 244,360. Nurse education and training has experienced a significant change in the last 20 years. In 1985, nursing education was moved into a university setting. Since 1994, all registered nurses in Australia have been

educated to a bachelor degree level at university. Undergraduate nursing programs are offered at 29 universities as well as one college.

To be a registered nurse, an undergraduate university degree will take three years of full time study. In addition to the necessity of a bachelor degree in nursing, graduates must meet the requirements for registration in their state or territory. In order to be registered, nurses must also pass English language tests (see 3.2.2 for further discussion).

A 2004 Australian Nursing Workforce Advisory Committee illustrated that the demand for nurses is not being addressed by increasing the intake of places at nursing schools. The report states that for supply to meet demand, between 10,000 and 12,000 new graduate nurses were required to enter the workforce by 2006 and between 10,712 and 13,483 are required in 2010. However, at the time projections were 5,734 for 2006 and 6,201 for 2010 – both well below the required number and leaving a shortfall of about 40%. Furthermore, because of the ageing population of those currently employed as nurses, it was estimated in 2004 that over 65,000 would retire from nursing over the next 10 years and would need to be replaced, leaving a further shortfall in the demand for nursing staff. ⁽³⁹⁾

Interviews with migrant health professionals indicated that some had utilised the quicker pathway available to migrant nurses in order to migrate. This included some qualified as doctors in their country of origin who had commenced studying nursing in order to gain entry to Australia.

4.5.2 Medicine

Since 2000, there has been a significant increase in the number of Australian medical school places, in response to workforce undersupply. ⁽³⁹⁾ In 2007, 1,586 medical students graduated in Australia but in 2012 this number will be much higher, around the 2,945 mark, an increase of 85.7%. ⁽³⁹⁾ There are currently 19 medical schools in Australia.

A medical program, not including specialisation, will take four years in Australia at a graduate level and six years for undergraduates. Medical practitioners become specialists in specific fields with additional training, which takes place via vocational training and examinations as specified by the relevant colleges. The additional study time will depend upon the area of specialisation.

Many international medical practitioners are unable to register and work as professionals until they fulfil these requirements.

Table 3: Target groups, salaries and educational preparation

Group	Numbers	Shortage	Education and training	Average Salary per year (in AUD)
Primary care physician	22,954 (2006)	Yes	Baccalaureate – 4-5 years dependent on curriculum	\$113,045
Physician specialist	20,254 (2006)	Yes	Physicians become specialists in with additional training, which takes place by way of vocational training and examinations as specified by the relevant colleges. E.g. GPs are required to train for an extra three years with the Royal Australian College of General Practitioners.	\$288,225
Registered Nurses	202,735 (2006)	Yes	Baccalaureate – predominately three years although one organisation has four year course Accelerated programs and masters entry	\$78,200
Enrolled Nurses	19,398 (2006)	Yes	Prepared in VET sector	\$56,995
Dental Workers	10,074 (2005)	Yes	Four years full time study is required for post graduate studies in dental surgery, and 5 years full time study for undergraduates. A Bachelor in Oral Health will involve 3 years full time study. PCI status must be proven before being allowed to undertake dental studies since the applicants will be performing exposure-prone procedures. If dentists wish to specialise, they must complete extra study after having had clinical experience. Registration to practise a dentistry job in Australia requires proof of successful completion of an accredited university dental degree evidence by the relevant Dental Board, once granted this must be renewed annually. Some state and territories may require dentists to participate in continuing professional development for the renewal of their registration.	\$59,202
Pharmacist	15,339 (2006)	Yes	Undergraduate degrees in pharmacy involve 4 years full time study. After completing the degree 12 months of practical training must be completed to be registered as a pharmacist. During this time, the Graduate Training Course run by the relevant state branch of the Pharmaceutical Society of Australia must be completed. In addition, the applicant must satisfy a Pharmacy Board of Review within the particular State.	\$70,075

Group	Numbers	Shortage	Education and training	Average Salary per year (in AUD)
Physiotherapists	12,285 (2006)	Yes	Undergraduate degrees in physiotherapy involve 4 years full time study. Immediate recognition by the relevant state board or the Australian Physiotherapy Council will depend on the accreditation status of the particular course.	\$72,259
Podiatrists	2,097 (2006)	Yes	Undergraduate degrees in podiatry take 4 years full time study. Immediate recognition by the relevant Podiatrists Registration Board will depend on the accreditation status of the particular course.	

Sources: Numbers taken from Australian Institute of Health and Welfare (AIHW).

Education information retrieved from University Admissions Centre (www.uac.edu.au)

*note – some universities may vary the length of their programs; the duration stated is the most common requirement from Universities around Australia.

Salary data for primary care physicians, specialist physicians and nurses taken from OECD, StatExtracts ⁽⁶⁶⁾ and represents estimates for the year 2008. Figure listed for “primary care physician” is figure given on site for “general practitioner”.

All other salary data taken from MyCareer.com.au (average from the jobs posted within the past 90 days – therefore can question the accuracy however provides a general overview).

*note at the time of publication \$1 AUD = \$0.86 USD.

Education emerged as a significant factor for participants in this study. Of the 75 people who responded to the survey, 64% indicated that education was one of the reasons that they came to Australia. This was the most commonly cited response.

Of the smaller group of 36 who agreed to participate in an interview, 58% regarded qualification opportunities as one of their reasons for coming to the country, and 19% indicated that they were gaining qualifications “in order to work better as a health professional in the country of origin”. Sixty-four per cent also cited qualification opportunities as a reason for staying in Australia. It should be noted, however, that a high proportion (42%) of the interviewees indicated they were in Australia on student visas. While this suggests a significant interest in gaining Australian education and qualifications, interviewees also indicated that maintaining their status as a student through re-

Table 4: Completion of selected health-related higher education courses by Australian citizens

Completion of selected health-related higher education courses by Australian citizens and permanent residents (excluding New Zealand citizens), 2002 and 2007					
Field	2002		2007		Percent change in number
	Number	Per cent undergrad	Number	Per cent undergrad	
Medical studies	2,156	54.5	2,541	58.8	17.9%
Nursing	8,553	89.1	10,063	88.9	17.7%
Pharmacy	754	63.7	1,181	65.4	56.6%
Dental studies	336	56.0	520	58.7	54.8%
Optometry	138	60.1	188	55.3	36.2%
Public health	1,704	69.4	2,204	69.1	29.3%
Radiography	609	70.3	781	69.1	28.2%
Physiotherapy	739	65.8	971	68.0	31.4%
Occupational therapy	698	88.0	756	89.0	8.3%
Speech pathology/audiology	436	94.7	543	94.7	24.5%
podiatry	113	62.8	185	68.1	63.7%
Rehabilitation therapies	740	60.8	823	67.2	11.2%
Complementary therapies	333	76.0	482	77.8	44.7%
Nutrition and dietetics	302	91.1	586	91.5	94.0%
Other health	2,004	47.7	2,883	59.3	43.9%
TOTAL	19,529	74.7	24,707	76.2	26.5%

enrolling in courses was also being employed as a strategy to maintain student visa status and remain in the country while they continued to pursue professional registration. Once this had been gained, their intention was to alter their visa status accordingly.

4.5.3 Summary Table

Push	Pull
Australian education and training of health professionals highly regarded internationally. Shortage of, and high level of competition for, some professional education and training pathways (e.g. medicine and specialty places).	Reliance on international recruitment to fill posts in rural/ remote health services Strong tertiary education system with high level of international recognition. Shared/similar curriculum with some Commonwealth countries [e.g. UK] means almost automatic recognition of qualifications; Need to go to e.g. Australia for post basic training (and basic training for physicians) means that international links are established during training [some Asia/ Pacific countries] Scope to establish valuable professional contacts in Australia, allowing for further professional mobility and development; On the whole the education of health care professionals in Australia is highly regulated in both the education and vocational setting. Constraints on health sector funding in some EU countries
Stick	Stay
Potential for development of particular medical, nursing and allied health professional specialisations, accompanied by financial support for practitioners of this specialisation	Clear path of professional career offered, with scope to select speciality, location of work (for most); Potential to earn high salaries;

5 Policy Framework

5.1 National Policies

Prior to February 2010, the Migration Occupations in Demand List (MODL) listed certain occupations and specialisations identified by the Department of Education, Employment and Workplace Relations (DEEWR) that are in short supply.⁽⁶⁷⁾ The MODL at that time included dentists, dermatologists, medical practitioners, pharmacists, and registered nurses. This means that most health professionals were eligible for 'occupation in demand/job offer' points on the General Skilled Migration point's test which assisted in obtaining a visa.

However some restrictions apply to OTDs. As discussed in section 3.2.2, the *Health Insurance Act 1973* places restrictions on OTDs working in private practice through Section 19AB. Section 19AB requires the practitioner to work in an area of workforce shortage for a period of up to ten years and applies to both GPs and specialists.⁽⁶⁸⁾ However, exemptions can be given under this section.

The Department of Immigration and Citizenship outlines the extensive range of visas available to nurses which include the following general categories:

- Employer-sponsored: a nurse can be sponsored by an employer (using either temporary or permanent visas); a particular category exists for those sponsored to work in a rural or regional area
- General Skilled Migration: for those who do not have an employer sponsoring them. A skills assessment must be obtained from AHPRA.
- Working Holiday visa
- Temporary visa program to bridge the skills of those international workers who do not yet have the sufficient qualifications to be registered as a nurse or midwife in an Australian State or Territory.
- Student visas for those enrolled in an Australian registered nursing course

Five to six thousand overseas trained nurses enter Australia annually. In relation to medical professionals, in 2005-06 international medical graduates made up 13.42 % of the total Australian

medical workforce. According to the Department of Immigration and Citizenship, 1,630 GPs were granted visas under the nominated occupations for visa grants in 2006-07, this amount increased to 1,990 in 2007-08, a 22% increase.⁽⁶⁹⁾ However it should be noted that these figures do not account for all medical practitioners entering Australia, as medical practitioners can be granted under another visa category. During this study it was discovered that many health care professionals use the student visa status to gain entry while fulfilling registration requirements.

Visa regulations have been relaxed in order to obtain additional health workers. In addition the Commonwealth has been subsidising the expenses related to recruitment for employers wishing to employ and utilise OTDs.⁽⁷⁰⁾ However, many contend that this is not the most appropriate solution for the workforce shortage. The issue of an increasingly reliance upon OTDs has created ethical debates within Australia.^(71; 42) Iliffe discusses a number of issues arising from this situation reflecting ethical and practical concerns.⁽⁵⁸⁾ One major concern, is relying on other nations to educate the Australian workforce, and thus disadvantaging the source country (often developing nations) by draining their skilled professionals after significant resources have been invested into their training. Practical concerns relate to English language proficiency and the difficulty in ensuring standards of training in the source country are similar to Australia. Other issues relate to the need for nationally consistent approaches for assessing and monitoring OTDs, and the lack of quality supervision and support for OTDs to achieve fellowship status.⁽⁴²⁾

5.1.1 Migration

5.1.1.1 Overview

Migration has had a significant impact on the development of contemporary Australian society.⁽¹⁷⁾ In 2006, about 24 % of the Australian population was born overseas and 45 % were either born overseas or have at least one parent born overseas⁽⁷²⁾. The net overseas migration into Australia in 2005-06 was almost 147,000 persons, which accounts for just over half of the country's net population growth over the 12 months to June 2006.⁽¹⁵⁾ These changing demographics are reflected in a range of industries, including health professions.

Australia's migration policies have developed over time, reflecting changes in the political climate. The "White Australia Policy" aimed at ensuring Australia maintained its composition of a predominantly Anglo Celtic population was progressively dismantled after World War Two, being finally formally abolished in 1973.⁽⁷²⁾ Policies aimed at advancing the manufacturing industry, family reunions, providing a safe haven for those seeking asylum or displaced after World War II, and more recently, skilled migration.⁽⁷³⁾ Australia's net gain from the international movement of

skilled persons has nearly doubled since the end of the 20th Century; the most rapid growth was seen amongst professionals. ^(74; 75) The migration of health workers strongly influenced by the regulatory policies of State and Commonwealth government that determine a health professional's ability to practice. In addition, professions where a skill shortage has been identified can gain preferential entry, and the health professions are consistently recognised in this list.

In general, membership by Australia in organisations such as World Health Organisation, World Trade Organisation, Asia-Pacific Economic Cooperation (APEC), and its involvement with the Association of Southeast Asian Nations (ASEAN) shows that Australia is formally committed to enhanced movement and flexibility of workers across borders. It should be noted, however, that Australia has yet to sign or ratify The United Nations Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (1990) which protects the economic, political, cultural and social rights of working non-nationals. No Western migrant receiving nation has ratified the treaty.

Key stakeholders see the Australian economy as being a significant “pull factor” for health professionals in the current environment, with the strong Australian currency combined with reduced job and career prospects in the traditional source countries of United Kingdom and Ireland resulting in people “clamouring” to come to Australia. A number of stakeholders mentioned that this has included senior professionals with well-established careers, which have previously been more difficult to attract.

Stakeholders interviewed for the study generally shared a very positive view of migration of health professionals to Australia, seeing it as holding benefits both for the migrating individuals and for the Australian health sector, particularly in filling vacancies in rural areas.

5.1.1.2 Australia's Migration Program

Australia's Migration Program is designed to contribute to Australia's economic, demographic and social wellbeing by facilitating the permanent and temporary entry or stay of people. The Migration Program has three streams with the Skill and Family Streams being the highest:

- Skill Stream that targets skills which contribute to Australia's economy and remains at 70% of the Migration Program
- Family Stream which recognises the value and importance of family migration to Australia's social and economic goals.

- Special Eligibility Stream includes groups such as former Australian residents who have maintained ties with Australia and certain groups of people subject to resolution of status.

For 2010-2011, the Australian government announced that the Migration Program would be set at 168,700 places under the Migration Program, plus an additional 13,750 humanitarian places (including refugees) ⁽⁷⁶⁾ The 2008-09 Migration Program comprised:

- 54,550 places for family migrants who are sponsored by family members already in Australia
- 113,850 places for skilled migrants who gain entry essentially because of their work or business skills
- 300 places for special eligibility migrants and people who applied under the Resolution of Status category and have lived in Australia for 10 years.

The balance between the skilled and family streams is 67.5 % and 32.3 % respectively. ⁽¹⁰⁾

In general, visa requirements are imposed by the Department of Immigration and Citizenship (DIAC) or bodies with a delegated duty, while the registration of medical practitioners and nurses in sits with AHPRA and the individual professions' Boards. Therefore, before obtaining a visa in Australia, all international health professionals must first obtain registration from the relevant agency, then apply to DIAC for a visa. This has been identified as a source of administrative delay, and in a recent submission to a parliamentary Inquiry, DIAC argued that these delays could be reduced in DIAC officers were able to access the data held by registration agencies ⁽⁷⁷⁾.

Interviews with migrant health professionals highlighted the stress and inconvenience resulting from these inconsistencies, and reported that various strategies were used to try and overcome them. For example, some reported that it was easier to pursue registration if they had already gained residency through other means. In addition, residency could help with access to student loans which could assist in meeting the expense of bridging courses required for professional registration, which, interviewees reported, could incur an expense of up to \$10,000.

Table 5: Recent arrivals of selected health occupations by selected country of birth (2006) ⁽⁷⁸⁾

	1986	1996	2006
Generalist medical practitioners (no.)	639	1,429	3,586
Proportion recently arrived from (%):			
England	22.1	20.9	9.8
New Zealand	16.0	12.2	3.2
India	8.3	9.8	19.2
South Africa	8.0	4.3	6.8
Ireland	2.3	4.0	1.5
Philippines	0.8	0.7	3.7
Other	42.6	48.1	55.9
Specialists (no.)	317	819	1,566
Proportion recently arrived from (%):			
England	24.3	21.0	14.8
New Zealand	17.4	14.4	7.7
India	3.8	15.1	23.3
South Africa	6.9	7.7	11.0
Ireland	3.8	2.4	2.1
Philippines	0.9	1.2	2.4
Other	42.9	38.1	38.6
Nurses (no.)	6,397	4,037	10,995
Proportion recently arrived from (%):			
England	24.0	25.3	24.9
New Zealand	24.0	16.5	11.7
India	1.2	1.8	5.9
South Africa	1.8	1.6	7.1
Ireland	4.9	6.9	2.6
Philippines	4.6	5.4	7.6
Other	39.5	42.5	40.3
(a) Arrived in Australia in the five years preceding the 2006 Census.			
Source: ABS 2006 Census of Population and Housing.			

5.1.1.3 Skilled Migration Policy

Australia's recent shift to skilled migration policies has significantly changed the composition and dynamic of Australia's migration patterns. ^(79; 80; 81) From 2004 to 2005, [record numbers](#) of skilled migrants were granted visas, accounting for approximately 60% of the entire migration program. ⁽⁷³⁾ The Skilled Migration policy commenced on 1 July 1997 ⁽⁸²⁾ and operates in the following ways:

- Applicants must pass a points test on skills, age and English ability and receive additional points for sponsorship by relatives in Australia. Formerly, applicants with qualifications relevant to the Migration Occupations in Demand List (MODL), that contains occupations and specialisations identified by the Department of Education, Employment and Workplace Relations (DEEWR) that are in short supply, receive extra points. In 2001 to 2002, 4,586 visas of this nature were granted. This program also includes a Regional Linked for those sponsored by relatives in regional areas (not points tested). However, as of 1 July 2011, the points system has been amended so that "points will no longer be awarded for specific occupations, although all applicants must still nominate an occupation on the Skilled Occupation List (SPOL) and have their skills assessed in their nominated occupation" ⁽⁸³⁾. Further information on the change from DIAC is included here in
- Business Skills migration encourages and facilitates the immigration of successful business people to settle permanently in Australia, in the hope that they will develop new business opportunities. In 2001 to 2002, 6,409 business skills visas were granted
- Employers may also sponsor overseas workers through the Employer Nomination Scheme (ENS), Regional Sponsored Migration Scheme (RSMS), and Labour Agreements. These visas enable Australian employers to fill skilled permanent openings with overseas workers if they are unable to find appropriate domestic workers. In 2001 to 2002, 1,817 visas within this category were granted
- Distinguished talent visas reflect overseas personnel with special or unique talents of benefit to Australia, for example athletes, scientists or musicians. In 2001- 02, 72 visas of this kind were granted

A number of state-specific plans and regional initiatives also exist to attract skilled migrant workers. Under State Specific Migration Mechanisms, employers, state/territory governments or relatives can sponsor prospective skilled migrants. ⁽⁸²⁾

5.1.1.4 Political environment

There is a strong level of bipartisan support on broad principles of many significant issues, including immigration policy. Differences between the two most popular political parties are evident in the degree of immigration and the severity of measures implemented to prevent illegal immigration, rather than on the broad approach of immigration policy. While some anti-immigration voices are prominent in the media, they receive marginal support.

5.1.2 Summary table

Australia as country of origin	Australia as destination country
Push	Pull
EU provisions may result in greater/more diverse work opportunities for health professionals once approved to practice in Europe. Most professions able to spend extended periods of time in Europe while maintaining registration to practice in Australia. European Working Time Directive, if observed, may mean less demanding working conditions for some health professionals.	Established migrant networks and connections in Australia: Long tradition of immigration from European countries (and more recently from Asia-Pacific) ; specific tradition of migration links with Commonwealth countries (e.g. UK) Policies in place at State and Federal level to actively recruit health professionals from other countries Some health professionals are “fast tracked” for immigration- given priority in allocation of qualification points for entry. Limited professional development opportunities for recently qualified clinical staff in current environment in Some European countries Impact of global economic crises means that funding for health sector is constrained in some EU countries
Stick	Stay
Ability to gain residency and/or citizenship in some European countries may depend on continuous long-term stays. EU arrangements create opportunities for ease of travel and access throughout Europe if European passport can be obtained.	Availability of incentives and settlement support for highly sought-after occupational groups.

5.1.3 Qualifications and professional recognition

5.1.3.1 National Registration and Accreditation Scheme

The National Registration and Accreditation Scheme (NRAS) commenced in 2010 in all Australian jurisdictions⁶. It is a single national registration and accreditation system for ten health professions, namely medicine, nursing and midwifery, [pharmacy, physiotherapy, psychology, osteopathy, chiropractic, optometry, dental and podiatry. ⁽⁸⁴⁾ Under the scheme, previous state and territory registration boards have been replaced by a single national board for each profession, which are responsible for all matters relating to the registration of practitioners and for setting professional standards.

Mandatory standards are established for all ten professions which include those relating to

- Professional indemnity insurance
- Criminal history checks
- Continuing professional development
- English language skills (see below), and
- Recency of practice

Boards are also able to develop profession-specific registration standards, codes and guidelines. The Board conducts an assessment process, which may include examinations, and then makes a decision regarding registration. Dissatisfied applicants may appeal to a Tribunal for review.

The National Boards are supported by the Australian Health Practitioner Regulation Agency (APRA), which is responsible for providing administrative support including managing registration processes and publishing national registers ⁽⁸⁴⁾. The process is overseen by a Ministerial Committee, which ratifies the Board's decisions.

⁶ NRAS commenced on 1 July 2010 in all states except Western Australia, which commenced on 18 October.

It is hoped that the new system will improve both the quality consistency and administration of the registration process, including the registration of overseas trained practitioners, and “help health practitioners move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce”⁽⁸⁴⁾.

5.1.3.1.1 English language skills registration standard

In March 2010 the Australian Health Workforce Ministerial Council approved a new English language registration standard for health practitioners. All applicants must be able to demonstrate English language skills and International English Language Testing System (IELTS) academic level 7 (7.5 for pharmacy) or the equivalent.⁽⁸⁵⁾

Internationally qualified applicants must be able to demonstrate a score of 7 in each of the four components: listening, reading, writing and speaking, as well as an overall pass in the occupational English Test (OET) achieving an A or B in each of the four components. Results must be obtained in the one sitting and within 2 years of applying for registration⁽⁸⁵⁾ and the registration process must have been started within 12 months of passing the IELTS test.

This is a more stringent requirement than has previously applied, and is regarded as a significant barrier to many applicants. In addition, there is not a nationally consistent approach taken across the country about the level of English language requirement or training received during nursing training. As a result, it is possible for a candidate to complete a three year degree course, and yet be barred from registration on the grounds of insufficient English language skills. According to press reports, more than 100 nursing students were caught in the transition to the new requirement having enrolled prior to the requirements introduction, and were not able to meet the new standards⁽⁸⁶⁾.

This raises the question of whether the test would be more appropriately applied at the point at which overseas students entered university. However, as one stakeholder pointed out during an interview “if they are going to return home to practice, why bother?”

Although there has been some debate about the introduction of the new standards, including whether these tests are the most appropriate ones to use, stakeholders have generally indicated support for the new standards, on the grounds that effective communication with patients is essential to safe and high quality care. However, it was noted that it had “created problems” for some recruiting agencies.

However, interviewees expressed a high level of frustration at the language provisions, though in many cases the respondents expressed more frustration with the lack of occupational focus and the English language elements of the assessment process,. For doctors experiences such as spending significant time and effort and cost to pass the clinical requirements and only then finding they are unable to meet language requirements. Frustration with the requirement to pass all four components at once was also noted. Often interviewees would reach level 7 on one component only to fail it the next time around, having to sit the test more than ten times before gaining a level 7 in all four components simultaneously. This, combined with the fact that the English test expires after two years, was stressful for applicants.

A number of interviewees also noted that “constant” changes to rules and requirements as making to process lengthy and stressful. However, researchers have also noted that health professional’s perceptions of the process did vary. One hypothesis is that their perception of the adequacy and requirements, and the efficiency of the bureaucratic and administrative processes surrounding them, was influenced by their previous experience⁷. Also, different cultures dealt with the processes in a different way.

5.1.3.2 Medical Practitioners

In order to practice in Australia, doctors must be registered with the Medical Board of Australia (MBA). To gain registration ,they must demonstrate they have the necessary skills, qualifications and experience to provide safe care. The MBA determines these requirements, including requirements for supervision, develops and approves standards, including overseeing the assessment of knowledge and clinical skills of overseas trained doctors (OTDs).⁽⁸⁴⁾

The Australian Medical Council (AMC) also plays an important role in assessing the training and assessment standards of specialist colleges and assessing authorities in other countries who conduct examinations for registration, in order to decide whether those who have completed a course of study elsewhere have the knowledge, skills and experience regarded as necessary to practice in Australia.

⁷ Under this hypothesis, if a person is accustomed to a high level of administrative/bureaucratic intervention, then they become less frustrated by the process, and perhaps more adept at managing it, than a person who is accustomed to low administrative requirements. However, further investigation of this hypothesis is beyond the scope of this study.

There are debates surrounding the legitimacy of these examinations and as Birrell notes the difficulty of these test and examinations.⁽⁷⁰⁾ The medical knowledge test is a multiple-choice test that requires speed reading in technically complex English, Birrell explains that this format and difficulty would challenge any doctor years out of medical school, let alone those not fluent in English (see section **Error! Reference source not found.**)⁽⁷⁰⁾.

5.1.3.2.1 Categories of registration

There are several categories of registration for practice:

- Provisional registration, available to Australian and New Zealand graduates who are applying to undertake an approved intern position. OTDs who have obtained their AMC certificate are also eligible, and must undertake 12 months of supervised practice before they can apply for general registration.
- General registration, available to medical practitioners who have completed an approved qualification in Australia or New Zealand, plus an approved internship. OTDs are required to obtain a certificate from the AMC and undertake a period of supervised training. The AMC will grant a certificate via 1) examination, or 2) the Competent Authority Pathway.
- Specialist registration, available to those assessed by the AMC-accredited specialist colleges as being eligible for Fellowship. These specialist colleges are responsible for specialist training and examinations including the assessment of OTDs.
- Limited registration, available to those who have obtained their qualifications outside Australia or New Zealand. There are different categories of limited registration, each with specific conditions set by the MBA. Limited registration is granted for 12 months and may be renewed up to 3 times. These categories comprise
 - Post-graduate training or supervised practice for those training or undertaking an internship,
 - Area of Need, for those working in areas of designated workforce shortage and who have been assessed as being qualified to practice safely
 - Public interest, which are short term, limited scope registrations employed in circumstances such as natural disasters, and

- Teaching or research, where limited clinical practice is required related to the work.

The MBA issued a communiqué in October 2010 noting its expectation that OTDs with limited registration who intend to stay long term progress to general or specialist registration⁽⁸⁴⁾.

- Non-practicing registration, available to retirees, those working overseas, or temporarily not practicing in Australia for other reasons (including maternity leave).

5.1.3.2.2 “Pathways to registration”

Assessing the suitability of OTDs for practice occurs through three main pathways:

- The Competent Authority Pathway. Doctors who have been previously registered in countries with similar training and assessment requirements as Australia.

As of February 2011, the sole provider for this pathway was the Australian College of Rural and Remote Medicine, though the AMC is expected to approve further providers in the future.⁽⁸⁷⁾

As of May 2011, eligibility for the Competent Authority Pathway included was outlined on the AMC website in the table included here as **Error! Reference source not found...** further detail is available at . <http://www.amc.org.au/index.php/img/ca>.

- Specialist pathway. The AMC recognises specialists trained overseas if their qualifications are recognised by Australian/Australasian specialist colleges. Application can be made for registration if these qualifications are assessed as “substantially comparable”.
- AMC Standard Pathway for OTDs, which is the path available for all medical practitioners who do not gain registration under the specialist or competent authority pathways. Applicants can be assessed through a workplace-based assessment (currently being piloted) or examination comprising both multiple choice and clinical examinations⁽⁸⁴⁾.

Table 6: Categories eligible for the Competent Authority Pathway Source: AMC (87)

Category A	UNITED KINGDOM General Medical Council (GMC)
	I have successfully completed the Professional and Linguistic Assessments Board (PLAB) test since 1975, AND THEN: • Have successfully completed the Foundation Year 1or 12 months supervised training (Internship equivalent) approved by the GMC in the United Kingdom or another AMC designated Competent Authority country.
Category B	UNITED KINGDOM General Medical Council (GMC)
	I am a graduate of a medical course conducted by a medical school in the United Kingdom accredited by the General Medical Council, AND HAVE THEN: •Successfully completed the Foundation Year 1or 12 months supervised training (Internship equivalent) approved by the GMC in the United Kingdom or another AMC designated Competent Authority country.
Category C	CANADA Medical Council of Canada
	I have successfully completed the licentiate examinations of the Medical Council of Canada (LMCC) since 1992
Category D	UNITED STATES Education Commission for Foreign Medical Graduates
	I have successfully completed the United States Medical Licensing Examination Step 1, Step 2 and Step 3 since 1992 AND I have successfully completed a minimum of two years of graduate medical education within a residency program accredited by the Accreditation Council of Graduate Medical Education.
Category E	NEW ZEALAND Medical Council of New Zealand (MCNZ)
	I have successfully completed the New Zealand Registration Examination AND I have successfully completed the required rotating internship (four runs accredited by the MCNZ).
Category F	IRELAND Medical Council of Ireland
	I am a Graduate of a Medical School in Ireland accredited by the Medical Council of Ireland AND I have successfully completed an internship in Ireland (certificate of experience) or in another

5.1.3.2.3 10-year “moratorium” for doctors

The Commonwealth Government also recognises the need for migration policies to attract health workers and under its Strengthening Medicare program introduced in 2004, the Commonwealth government has actively recruited OTDs.⁽⁷⁰⁾

Section 19AB of the Health Insurance Act 1973 (commonly known as the Ten-Year Moratorium) applies to any Overseas Trained Doctor for a period of ten years from the date of first medical registration in Australia. Section 19AB of the Act restricts access to Medicare benefits and generally requires overseas trained doctors to work in a district of workforce shortage for a minimum period of ten years in order to access the Medicare benefits arrangements⁽⁸⁸⁾.

From 1 July 2010, the Moratorium reduction scheme offers more incentives to work as a rural GP. Reduction of the 10-Year Moratorium may be available if a General Practitioner wishes to work at a District of Workforce Shortage (DWS), as designated by the Australian Government Department of Health and Ageing (DoHA)⁽⁸⁹⁾.

This effectively prevents general practitioners migrating to Australia from developing a viable practice unless they establish it in one of the areas of shortage. While sector stakeholders acknowledge that this was a stringent requirement, and represented a significant or even “draconian” barrier for doctors, it was also acknowledged that the policy was an effective way to get medical services in to areas of shortage where others choose not to work.

However, stakeholders acknowledged that this creates significant challenges for new arrivals, including access to preferred schools and other services and amenities, and reduced social and work opportunities both for the practitioner and members of their families.

As part of the Governments *Rural Health Workforce Strategy*, medical practitioners can reduce the period of restriction, which is “discounted” for those practising in the most remote locations, as defined in the Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA) system. Services are assessed by Medicare Australia on a monthly benefit and the scale applied accordingly, with the moratorium reduced to 5 years for those practising in the “very remote” areas. According to the Department of Health and Ageing, in November 2010 1,988 OTDs had received a scaling benefit⁽⁸⁴⁾.

In addition, the *Five Year OTD Scheme* also aims to provide incentives for suitably qualified OTDs to practice in those rural areas to which it is most difficult to recruit medical practitioners. Service

obligations can be reduced to as little as three years under this scheme, provided criteria are met including that the doctor provides at least 7 sessions per week and intends to seek or currently holds permanent residency or Australian citizenship ⁽⁸⁴⁾.

Key stakeholders interviewed for this study believed that the role played by migrant doctors in rural communities was an important one, and that they were, in the words of one respondent, “filling holes in places Australian doctors didn’t want to go”. However, some concerns were expressed about whether these practitioners were receiving sufficient support when posted to “the bush”, both in terms of professional mentoring and support and also social supports including assistance for families.

5.1.3.2.4 Inquiry into Registration Processes and Support for Overseas Trained Doctors

The process and support of gaining registration to practice and a visa to enter the country is currently the subject of an parliamentary Inquiry being conducted by the Standing Committee on Health and Ageing of the (national) House of Representatives. The *Inquiry into Registration Processes and Support for Overseas Trained Doctors* is accepting written submissions as well as holding public hearings.

It was launched in 2010 with the following Terms of Reference

Recognising the vital role of colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs), the Committee will:

- 1) Explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges’ assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions;
- 2) Report on the support programs available through the Commonwealth and State and Territory governments, professional organisations and colleges to assist OTDs to meet registration requirements, and provide suggestions for the enhancement and integration of these programs; and
- 3) Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies ⁽⁹⁰⁾

Submissions to the Inquiry (that are publicly available on the website⁸⁾ ⁽⁹⁰⁾ have been made by a number of key stakeholders, as well as a number of individual OTDs who have experienced the registration process. The submissions suggest that the complex and length process is often a source of frustration and inconvenience, as well as being a financial burden.

This view was strongly echoed in the discussions held with participants in this research, most of whom were still seeking registration through the standard, rather than the Competent Authority pathway

5.1.3.3 Nurses

For nurses to work in Australia, they need to be registered with the Nursing and Midwifery Board of Australia (NMBA). Due to the high demand for nurses in Australia, there are a number of visa options available which are granted by DIAC. According to DIAC, most visa applications for nurses receive priority processing due to the nursing shortage. ⁽⁹¹⁾

If applying under the 'General Skilled Migration' category, prior to 2010 nurses were required obtain a Migration Skills Assessment from the Australian Nursing and Midwifery Council (ANMC), including proof of English proficiency (see below). The Australian Nursing and Midwifery Council (ANMC) was a national body whose membership consists of the eight states and territory nursing and midwifery regulatory authorities in Australia. This role has been incorporated into AHPRA which is the administrative arm overseeing all 10 health professions, and the gazetted accreditation authority for nurses is known as the Australian Nursing and Midwifery Accreditation Council (ANMAC). AHPRA is authorised by the Minister for Immigration and Citizenship to assess the qualifications and skill of internationally educated nurses and midwives for migration to Australia, and uses the framework endorsed by the Nursing and Midwifery Board of Australia (NMBA) ⁽⁹²⁾. In addition to practice and language requirements to work in a hospital or other health care area, nurses need to pass a health examination which includes a chest x-ray. ⁽⁹³⁾

5.1.4 International recruitment

5.1.4.1 International Recruitment Strategy

The International Recruitment Strategy provides funding, administered by Rural Health Workforce Australia, for distribution to Rural Workforce Agencies (RWAs) after the successful recruitment of an

⁸ See www.aph.gov.au/house/committee/haa/overseasdoctors/subs.htm

OTD into an eligible location. RWAs are paid \$15,000⁹ per placement. RWAs coordinate and assist prospective OTDs through providing assistance and advice on a range of matters including registration, legislation and visa enquiries’⁽⁸⁴⁾.

5.1.4.2 Specialist training Program (STP) – Specialist International Medical Graduate (SIMG) element

Financial support is provided for the upskilling of SIMGs through this program, which aims to

- Provide training for SIMGs seeking to become Fellows of a specialist college, and
- Support the permanent entry and retention of SIMGs in Australia, in areas of need.

SIMGs must have been assessed by the relevant college as being partially or substantially comparable to and Australian-trained specialist and require a further 12 or 24 months training. Permanent residents are given priority, though others who express a “desire to remain” are considered. SIMGs in STP funded positions must be given appropriate supervised training for the duration for their time.

Funding of AU \$3.5 million¹⁰ per annum is provided, up to a maximum AU\$10,000 per SIMG.

5.1.4.3 DoctorConnect

DoctorConnect has been produced by the Department of Health and Ageing to provide a starting point for both overseas trained doctors (OTDs) who may be considering work in Australia and employers seeking to recruit them.⁽⁷⁶⁾

5.1.4.4 Additional Assistance Scheme

This Scheme is administered by the Rural Health Workforce Australia through Rural Workforce Agencies and aims to assist participants by addressing any medical knowledge or clinical deficits in order to work towards Fellowship. Participants receive tailored education and training support which may include mentoring and oversight of training and exam preparation, on-line training, participation in video conferences, pre-exam workshops and skills programs.

⁹ Equivalent to 11,295 Euro at 22 May 2011

¹⁰ Approximately 26 million Euro at 30 June 2011

Australian citizens and permanent residents participating in the Rural Locum relief Program or the Five Year OTD Scheme may be eligible. Up to 200 participants will be offered support under the scheme in 2010-11

5.1.4.5 Other

A research report commissioned by the Victorian Department of Human Services in 2008 details the range of strategies and incentives available to overseas trained medical practitioners to practice in Australia ⁽⁶²⁾. Examples include:

- Marketing overseas and interstate, through campaigns, expos and journals, websites and use of recruitment agencies
- Coordinated assessment, orientation and training, including state-wide recruitment and retention programs for rural agencies, individual case management and orientation and placement services. ⁽⁶²⁾ Recruitment support packages as lump sum “sign-on” fees (AU\$5000) to meet relocation costs, registration costs, or as incentive for moving to areas designation as high need (AU\$10,000), as well as various other income and cost subsidies ⁽⁶²⁾. In some states, individual hospitals may also offer incentives. ⁽⁶²⁾
- Programmatic responses such as Rural Recruitment Scheme, including reducing the amount of time that overseas trained medical graduates are required to practice to gain a Medicare number (necessary for private practice – see 5.1.3.2.3). ⁽⁶²⁾
- Training including orientation, Australian Medical Council exam preparation, and English language training

Although there are a range of programs encouraging foreign workers to the Australian health profession, a number of obstacles for those migrating to Australia remain. These include visa regulations, registration and recognition with relevant boards, and meeting English requirements. Implementation of these policies is enforced by state and federal bodies.

Anecdotally, the sector anticipates that proactive efforts to recruit overseas have reduced in the current environment, primarily as a result of the global financial crisis. Key informants in the macro interviews all noted that the buoyant Australian economy, combined with large scale public sector cuts across areas of Europe will make Australia a much more attractive destination for health professionals seeking job and income security in the short term, and therefore there is less need for active recruitment.

5.1.5 State policies

States are recruiting overseas health professionals via their Health Department websites. Websites of all states and territories, with the exception of Tasmania and the Australian Capital Territory, are passively recruiting overseas trained professionals and provide a variety of programs and information to facilitate the immigration process. For example, Queensland Health has also created the Doctors for the Bush Program. Doctors for the Bush is a 5 year program that offers practice opportunities (public or private) to suitably qualified and experienced IMGs seeking permanent residency in Australia ⁽⁹⁴⁾. Presently, the New South Wales (NSW) Department of Health is actively recruiting for overseas trained nursing and midwifery positions in all areas and overseas trained doctors to fill positions in rural areas ⁽⁹⁵⁾. The State Government of Victoria is also actively seeking medical professionals. The Victorian Department of Health has provided further incentive by offering Scholarships for International Nurse Graduates ⁽⁹⁶⁾.

Most states and territories have a webpage to encourage international professional migrants for e.g. Victoria has International Health Professionals Victoria. Most of the stakeholders spoken to suggested that due to the global financial crisis many individuals are using these websites to approach the Department of Health for registration and job opportunities. Many of the Departments of Health have now started to collect these international health professionals on relevant databases.

5.1.6 Summary table

Australia as country of origin	Australia as destination country
Push	Pull
EU provisions may result in greater/more diverse work opportunities for health professionals once approved to practice in Europe. Many professions able to spend extended periods of time in Europe while maintaining registration to practice in Australia.	Some health professionals are “fast tracked” for immigration- given priority in allocation of qualification points for entry. Limited professional development opportunities for recently qualified clinical staff, Impact of global economic crises means that funding for health sector is constrained in some EU countries
Stick	Stay
Tightening of entry criteria and job opportunities in some European countries may have effect of reducing the mobility of those who have secure employment.	Limitations on access to Medicare for newly arrived doctors means that longer stay may be required to achieve full earning potential.

5.2 EU policies

5.2.1 *Other International Policies or Agreements*

The Commonwealth of countries, of which Australia is a member, is a voluntary association of 53 [member states](#) most of whom were part of the [British Empire](#). This voluntary association is one of the leading promoters for improved arrangements for health workers recruitment internationally; it has identified critical shortages in 17 Commonwealth countries and estimates that there are 300,000 preventable maternal deaths per year.⁽⁹⁷⁾ In response to the ethical issues that arise from these global shortages, preventable deaths and diseases and increased migration levels the Commonwealth Code of Practice for the International Recruitment of Health Workers was adopted by the countries of the Commonwealth at a meeting in Geneva in May 2003. The purpose of the Code is to prevent excessive and destructive recruitment of health workers from developing countries.⁽⁹⁸⁾ However the Code is not legally binding therefore there are limitations on its application, within the Australian context certain groups believe that Australia's active recruiting policies breach this code of which it is a signatory.⁽⁹⁹⁾ In response to this the Department of Health and Ageing maintains that it supports the Code and does not actively target developing countries.⁽⁷⁹⁾ Australia has committed itself to other international arrangements; although not specific to the health profession, agreements such as the Australia-United States Free Trade Agreement and memberships to regional trading blocs have worked to enhance the flexibility of workers between nations. However, the language criteria and relevant board admission are still enforced for those workers to whom the agreement applies.

The 'Recognition of Nurses/Midwives from Member States of the European Union' Policy is enforced by the Australian Nursing and Midwifery Accreditation Council (ANMAC) (refer 5.1.3.3).⁽¹⁰⁰⁾ The rationale of this policy is to assist the ANMAC in determining recognition of qualifications as part of a skills assessment for migration purposes. As stated by its predecessor body, the ANMC: "The ANMC recognises the education and training of EU member states as similar in theory and practical content to Australian standards if they meet the EU Directive 2005/36/EC."⁽¹⁰¹⁾ This policy waives many of the requirements for those that received education or training in a European Union member state.

Another arrangement is the Trans-Tasman Mutual Recognition Arrangement (TTMRA) which came into effect on 1 May 1998, it is a non-treaty arrangement between Australia and New Zealand. It was then codified into Australian law through the [Trans-Tasman Mutual Recognition Act 1997 \(Commonwealth\)](#). This arrangement permits movement between Australia and New Zealand, although the ANMC maintains the right to request registration to local Nursing authorities. Medical

practitioners are exempt from the TTMRA. However, in the case of doctors where qualifications were obtained in New Zealand and Australia, mutual recognition-type arrangements already exist. The Organisation for Economic Development contends that effectiveness of these codes and intergovernmental agreements will depend on the content, the coverage and the compliance.⁽¹⁰²⁾ While most key stakeholders interviewed as part of this study were aware of the existence and principles of both Commonwealth and WHO Codes of Conduct in relation to the migration of health professions, most did not see the Codes as playing a significant role in modifying or influencing decision-making in a direct way. However, all parties noted the need to ensure ethical behaviour on the recruiting process, and informants indicated that the Commonwealth Department had established a list of 'preferred' recruiters as a measure to ensure appropriate practice. Most parties interviewed were aware of the possible impact on source countries through the loss of local health professionals, but were equally cognisant of the significant role played by remittances in some countries and some families, particularly in respect of Pacific island nations. In addition, some stakeholders cited instances where the Codes had been successfully utilised to address inappropriate or unethical recruitment practices.

5.2.2 Summary Table

Australia as country of origin	Australia as destination country
Push	Pull
Codes of Practice of recruitment likely to have little impact on European nations' willingness to recruit from a highly developed nation such as Australia.	Policies in place at State and Federal level to actively recruit and support health professionals from other countries. Arrangements in place to recognise professional qualifications for some European countries. Limited professional development opportunities for recently qualified clinical staff, Impact of global economic crises means that funding for health sector is constrained in some EU countries
Stick	Stay
	Availability of incentives and settlement support for highly sought-after occupational groups.

6 Migration Flows

A search for greater economic and social security are driving forces for migration ^(103; 104). Other reasons include increased accessibility to international travel, tax regimes, professional development, training and potential for upward mobility, cultural diversity or experience, improved working environment, lack of equipment and drugs, political stability. Historical factors such as ties between Commonwealth countries (particularly those which have developed from British colonies and are English speaking) and an increases in international trade and other agreements also play a part. Developments such a communication technologies also play a part, creating cheaper, and more efficient modes of communication that allow migrants to continue and develop their home-based relationships and interests transnationally. ⁽¹⁰⁵⁾

6.1 General Migratory Profile

The 2006 census also noted a shift in migration patterns as 25% of the Asian-born population had arrived after 2001, whereas only 7% of the European born population arrived during the same period. This transition from high migration levels from Anglo Celtic nations or other European nations to Asian nations is also evidenced by Asian-born migrants representing only 24% of longer-standing migrants, despite accounting for 44% of all recent arrivals. Further, immigrants from New Zealand, China and India increased in numbers during the period of 1996 to 2006. United Kingdom, Greece and Italy-born migrants experienced a significant decline during the same period. This is in sharp contrast to the 1950s-1970s when European-born immigrants were dominant (87%). Given these patterns, European-born migrants to Australia are more likely to be older, whereas migrants from China or India are more likely to be younger. ⁽¹²⁾ This reduction in growth of European settlers was first witnessed in the 1970s where government strategy shifted from the White Australia Policy, opening the possibility of immigration to Australia for many other nationals.

⁽⁸²⁾ Figure 6: Increasing diversity of migrants shows the increasing cultural diversity of immigrants.

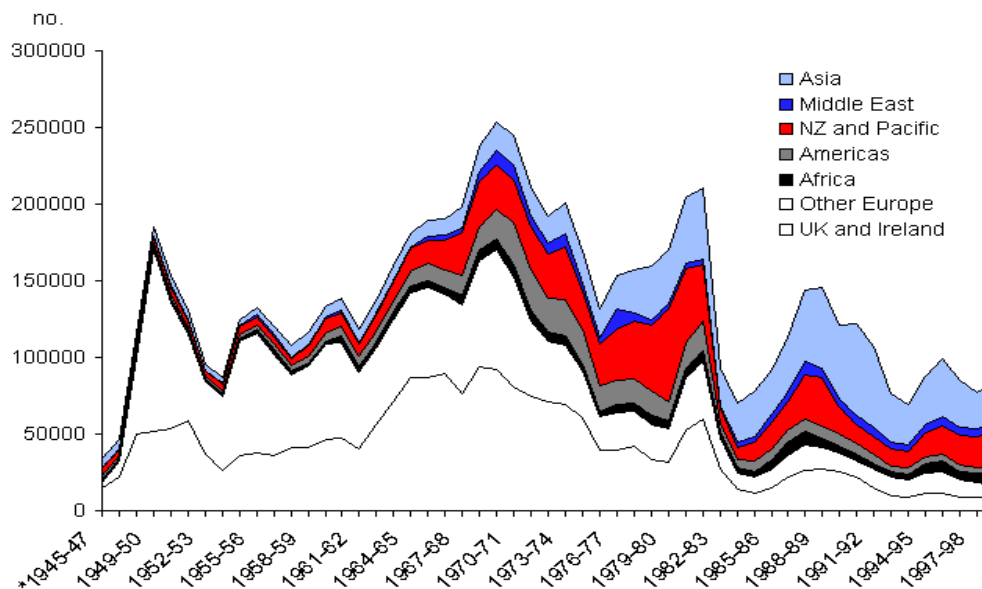


Figure 6: Increasing diversity of migrants

Source: ABS

6.1.1 Outward migration

Due to its cultural diversity, Australia is often seen as a nation of immigration, but recent statistics have shown that it is also a country of significant emigration (see Annex 4: Supplementary Tables/Data). Australia has seen a significant and gradual increase of those born in Australia leaving with the intention of not returning; by 2007 to 2008 this figure grew up to 39,144. This is over double the amount from 1997 to 1998 (12,771).⁽⁶⁷⁾

The estimated size of the Australian diaspora was 900,000.⁽⁸²⁾ Emigrating residents are generally younger and more educated than the general population⁽⁸²⁾. Major destinations are the developed economies of the United Kingdom, the European Union, and North America. However, an increasing percentage of the outflow is to Asian nations such as China and Singapore, where rapidly developing economies have experienced skills shortages. Whilst the United States remained one of the largest destinations departure levels fell between 2001 and 2005.⁽⁷⁰⁾

There are currently no widespread policies in place to attract Australians who have emigrated to other nations. Research suggests that Australia would benefit from developing a diaspora policy aimed at maximising benefits from the new 'brain circulation' of Australians going overseas and entry of skilled people. Knowledge of emigration within Australia is limited as it reflects only data obtained from the exit card when leaving Australia. A recent Committee for Economic Development of Australia report argues that Australia needs an international migration policy that embraces emigration and circulation as well as immigration.⁽⁸²⁾

6.1.2 Summary Table

Australia as country of origin	Australia as destination country
Push	Pull
Strong tradition of travel, particularly to Europe and particularly among young people. Many Australians have family/ancestral links to Europe as a result of Australia's migrant history	Already well-established migration links, migrant communities
Stick	Stay
EU provisions mean easier access to other European labour markets than the Australian market for EU nationals from many EU countries.	The number of foreign health professionals in Australia is high; Broad social acceptance of migrant populations and established migrant communities. Reliance on remittances for some (e.g. Pacific countries and/or Asia), but less so from the EU.

6.2 Migration of health professionals

According to the Australian Bureau of Statistics, a comparatively large proportion of Australia's health workforce was born overseas. While in 2006 22% of the total Australian population were born overseas, 50% of Generalist medical practitioners, 42% of Specialists, 47% of Dental practitioners, and 27% of Nurses were born overseas. This includes both those who are overseas-born who train after migrating to Australia and those who have trained overseas and subsequently migrate.⁽⁷⁸⁾

As with the broader population, the most common country of birth other than Australia was England, though a number of nationalities are over-represented in health sector, compared to the general community according to 2006 Census data. People born in India made up 0.7% of all people, but 5.4% of Generalist medical practitioners and 4.2% of Specialists. Similarly, people born in Malaysia made up 0.5% of all people in Australia, but 5.3% of Dental practitioners.⁽⁷⁸⁾

Nurses were more likely than the Australian average to have been born in England and New Zealand. People born in England made up 4% of the population but 7% of Nurses; and people born in New Zealand made up 2% of all people and 3% of Nurses. A comparatively large proportion of Nurses were also born in the Philippines: 2.0% of nurses were born in the Philippines compared with 0.6% of the population.⁽⁷⁸⁾

Table 7: Proportion of persons working in health occupations in Australia born in selected countries (2006)

	Generalist medical practitioners (%)	Specialists (%)	Dental practitioners (%)	Nurses (%)	Australia total (%)
Australia	48.2	57.2	51.1	70.6	70.9
England	6.3	8.1	5.6	7.1	4.3
New Zealand	1.7	3.2	2.3	3.0	2.0
China(b)	1.6	0.6	1.5	0.7	1.0
Italy	0.4	0.3	0.4	0.2	1.0
Vietnam	1.8	0.6	3.9	0.2	0.8
India	5.4	4.2	2.5	0.7	0.7
Philippines	0.8	0.4	0.6	2.0	0.6
Malaysia	5.1	3.1	5.3	1.4	0.5

(a) Selected countries incorporate the five most commonly reported countries of birth overall, and any of the four most commonly reported countries of birth for each occupation group that was not already included.

(b) Excludes SARs and Taiwan Province.

Source: ABS 2006 Census of Population and Housing. (11)

At the 2006 Census, there were 3,586 of recently arrived (i.e. within the last five years) Generalist medical practitioners, 1,566 recently arrived Specialists, and 10,995 recently arrived Nurses. India, England and South Africa were the most common countries of birth for recently arrived Medical practitioners, accounting for 36% of Generalist medical practitioners and 49% of Specialists.⁽⁷⁸⁾

Ten years earlier in 1986, the most common birthplace for recently arrived Generalist medical practitioners was England (22%), but by 2006 this had decreased to 10%. The proportion of recently arrived Medical practitioners born in India increased from 8% to 19% over the same period. A similar pattern is seen for specialists.⁽⁷⁸⁾

The most common countries of birth for Nurses who arrived to live in Australia in the past five years were England (25%), New Zealand (12%) and the Philippines (7.6%), while for recently arrived

Dental practitioners, the most common countries of birth were England (15%), India (15%) and New Zealand (8.2%) ⁽⁷⁸⁾. While the proportion from England has remained fairly steady, the proportion born in New Zealand has more than halved over the last ten years. Recent arrivals from South Africa and Philippines increased markedly over the same period.

Government policy currently restricts access to Medicare provider numbers for overseas-trained doctors to districts of workforce shortage (DOHA, 2008). A doctor must have a Medicare number in order for patients to receive the benefit of Medicare funding for the consultation, and so is essential to setting up a community practice. This is reflected in the higher proportion of Generalist medical practitioners who were recent arrivals in Remote and Very Remote areas of Australia. More than a quarter of General medical practitioners in remote and very remote areas are recent arrivals. ⁽⁷⁸⁾

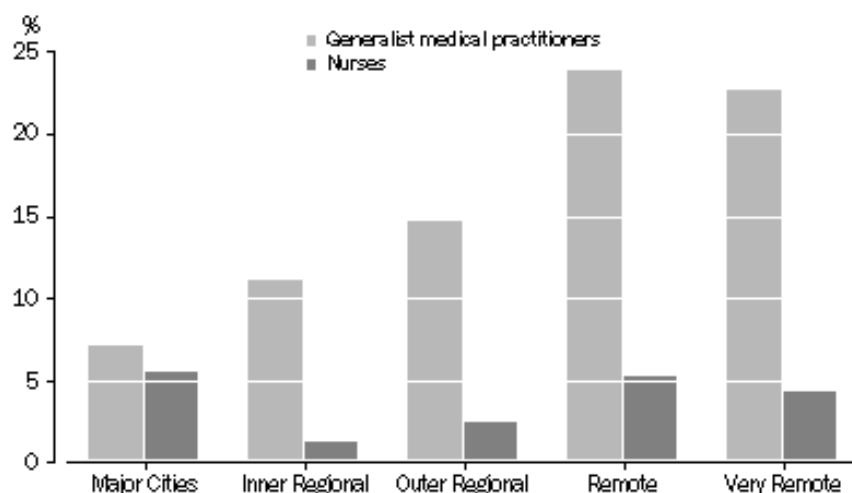


Figure 7: Proportion in each remoteness area who are recent arrivals

Source: ABS 2006 Census of Population and Housing ⁽⁷⁸⁾

According to the Department of Health and Ageing recruitment of international medical graduates to practice in Australia occurs in a variety of ways. ^(106; 69) Many medical position vacancies are advertised in international medical journals and are open to overseas based applicants; in addition, commercial recruiters may engage a medical practitioner to fill a vacancy listed with their agency. Alternatively, the practitioner or nurse may seek to move to Australia first and then apply or move to Australia for a working holiday, particularly in the area of nursing. State and territory departments of

health play a significant role in directly recruiting overseas trained graduates to work as salaried medical officers in public hospital services.

Of the 79 respondents surveyed from the Department of Health databases of medical and nurse migrants, the countries with the most representation were China (14 responses), Pakistan (13 responses) and India (11 responses). It should be noted that the sample came from a baseline survey sent to two state health department migration databases containing health professionals who are seeking jobs in Australia. It is therefore possible that individuals who responded to the survey were caught up in the lengthy process of both immigration and registration. The few individuals who were interviewed from competent pathway countries did not report that they had problems with immigration or registration.

6.2.1.1 Nurses

In Australia, the reported proportion of nurses born overseas has increased from 22.2% in 1986 to 27.3% in 2006. In 2006, there were 10,995 recently arrived nurses. The most common countries of birth for nurses who arrived to live in Australia in the 5 years prior to the 2006 Census were England (24.9%), New Zealand (11.7%) and the Philippines (7.6%). However the statistics obtained only indicate where these nurses were born and do not specify where these nurses were educated. The proportion of recently arrived nurses who were born in England remained relatively constant between 1986 and 2006, while the proportion born in New Zealand halved. In contrast, the proportion of recent arrivals born in South Africa increased from 1.8-7.1% between 1986 and 2006 and the proportion born in the Philippines increased from 4.6-7.6% ⁽⁷⁸⁾.

Nurses arriving in Australia were most likely to work in major cities, accounting for 6.4% of those in metropolitan regions and a snapshot of the nursing workforce is provided in **Error! Reference source not found..** In 2006-07, there were 3,090 visas granted to nurses under subclass 457. ⁽⁶⁸⁾

6.2.1.2 Medical Practitioners

According to the Department of Health and Ageing (84), based on the place of basic qualification, approximately 39% of the medical workforce in Australia are Overseas Trained Doctors (OTDs). Doctors who have applied to work in Australia have received initial medical training in 120 countries, and specialist qualifications from 91 different countries.

Distribution of country of first qualification of medical practitioners is shown in **Error! Reference source not found.**, by State. These data show that at State level between 65.5% and 82.5% of medical practitioners at State level were Australia trained.

As outlined in this report, the Federal government has sponsored legislative and policy changes which have increased opportunities for various employers in the Australian health industry to recruit highly skilled overseas health professionals. People seeking to migrate to Australia on the basis of their work skills receive bonus points if their nominated occupation is on the Migration Occupations in Demand List (MODL).

Table 8: Distribution of country of first qualification of medical practitioners 2005

Country of first Qualification	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Australia	N/A	13,050	7,524	3,095	3,777	1,056	980	N/A
New Zealand	N/A	311	243	159	104	39	54	N/A
UK/Ireland	N/A	683	704	688	236	150	73	N/A
Asia	N/A	705	358	320	517	—	—	N/A
North America	N/A	—	19	12	8	5	3	N/A
South Africa	N/A	—	188	210	62	—	—	N/A
Other countries	N/A	1,064	269	239	216	177	253	N/A
Not Stated	21,730	19	46	158	18	11	—	719
Total	21,730	15,831	9,352	4,881	4,938	1,438	1,363	719
% Australian Trained	N/A	82.5	80.9	65.5	76.8	74.0	71.9	N/A

Source: Australian Government, Department of Immigration and Citizenship Population flows, Immigration aspects 2007–08 edition

In a submission to a recent government Inquiry, the department of Citizenship and Immigration provided detailed information about the recent migration of overseas trained doctors, reproduced

Regional Sponsored Migration Scheme (RSMS) primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	150	130	130

Employer Nomination Scheme (ENS) primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	370	350	220

Subclass 457 primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	3 310	2 670	2 390

Source: Department of Immigration and Citizenship, 2011

Note 1: Figures rounded to the nearest 10.

Note 2: ANZSCO was introduced in DIAC on 1 July 2010. Applications lodged prior to that date using the Australian Standard Classification of Occupations (ASCO) 2nd Edition have been converted to an ANZSCO code using a standard DIAC mapping approved by the ABS.

Note 3: Figures for 2010-11 are provisional and subject to variation.

General Skilled Migration (GSM) primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	450	1070	420

Regional Sponsored Migration Scheme (RSMS) primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	150	130	130

Employer Nomination Scheme (ENS) primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	370	350	220

Subclass 457 primary applications granted where the nominated occupation was Medical Practitioner (ANZSCO Minor Group 253)

ANZSCO Nominated Occupation	2008-09	2009-10	2010-11 to 31/03/11
Medical Practitioners	3 310	2 670	2 390

Source: Department of Immigration and Citizenship, 2011

Note 1: Figures rounded to the nearest 10.

Note 2: ANZSCO was introduced in DIAC on 1 July 2010. Applications lodged prior to that date using the Australian Standard Classification of Occupations (ASCO) 2nd Edition have been converted to an ANZSCO code using a standard DIAC mapping approved by the ABS.

Note 3: Figures for 2010-11 are provisional and subject to variation.

Figure 8: Migration applications granted: Medical Practitioners 2008 - 2011

Source: Department of Immigration and Citizenship (2011) (107)

6.2.1.3 Student migration

The internationalisation of education in universities has benefited Australia economically, providing an important revenue source for higher education institutions ⁽¹⁰⁸⁾. Currently, income related to international students rates third in import earnings, and the number of international students enrolling in higher education is increasing. In 2007-08, 21,421 international students were granted residency under various visa class applications, although the specific number who were health professionals is not known ⁽¹⁰⁹⁾. In Australia, most of these international students are from Asian countries ⁽¹¹⁰⁾.

The number of international students seeking to study nursing in Australia is also increasing. For example, in some institutions, such as the Australian Catholic University, international students constitute 28% of the total nursing student cohort, of whom many speak English as a second language (ESL) ⁽¹¹¹⁾

Accelerated second degree nursing programs have been introduced as a strategy to address the nursing shortage ^(112; 112; 113). These programs enable non-nursing graduates from various backgrounds to obtain a second degree and move into the nursing profession ⁽⁴⁸⁾. These programs are potentially attractive to individuals wishing to migrate to other countries, particularly if they result in achieving a qualification recognised by a professional regulatory body and also meet the criteria for designated workforce shortages ⁽¹⁰⁹⁾. Data regarding other health professionals is less available and potentially related to the lower number of placements and higher domestic competition for places.

The majority of migrating health professionals interviewed for this study migrated to Australia under a student visa. This allows them time to carry out the lengthy registration process under a recognised immigration status. Some interviewees had to keep enrolling in courses to extend their student visa to enable them to complete the registration process. On the other hand, health professionals who are able to migrate with residency/citizen status were then eligible for student loans which allowed them to participate in expensive bridging courses, reducing some of the barriers of registration.

Under the "point's test" of migration certain university courses, such as nursing and accounting, supply more points making them a faster, easier pathway to migration. In some cases the survey respondents were medical practitioners with qualifications not recognised in Australia who either enrolled in a Bachelor of Nursing course to gain migration entry, or worked as unregulated health care assistants.

The government has commissioned a strategic review of the student visa program, which is to report to government in mid-2011.¹¹ This process is also likely to impact on further policy review, with the terms of reference stating that “the integrity of the Student visa program has been challenged in recent years by the promotion of Australian education courses as a pathway to permanent migration” (114). While this review does not directly address the health sector, its scope includes relevant issues such as what language requirements should apply for students, what an acceptable level of working hours for those ostensibly in the country to study rather than work (115).

6.2.2 *Net migration of health professions.*

Australian Bureau of Statistics data shows that there is significant number of health professionals leaving Australia each year, as well as arriving (see **Error! Reference source not found.**). In 2001-2002, a total of 10,656 health professionals arrived in the country permanently or long term and 8,416 departed, leaving a net gain of 2,240 persons. Women comprised 68% of health professional arrivals and 71% of departures, which possible reflects the representation of nurses in the sample, which remains a predominantly female profession.

It should also be noted that the “not applicable” category in this dataset includes students, so may include persons who travel to Australia to study for professional health qualifications.

¹¹ Both a discussion paper and the submissions to the review are available at <http://www.immi.gov.au/students/student-submissions/>

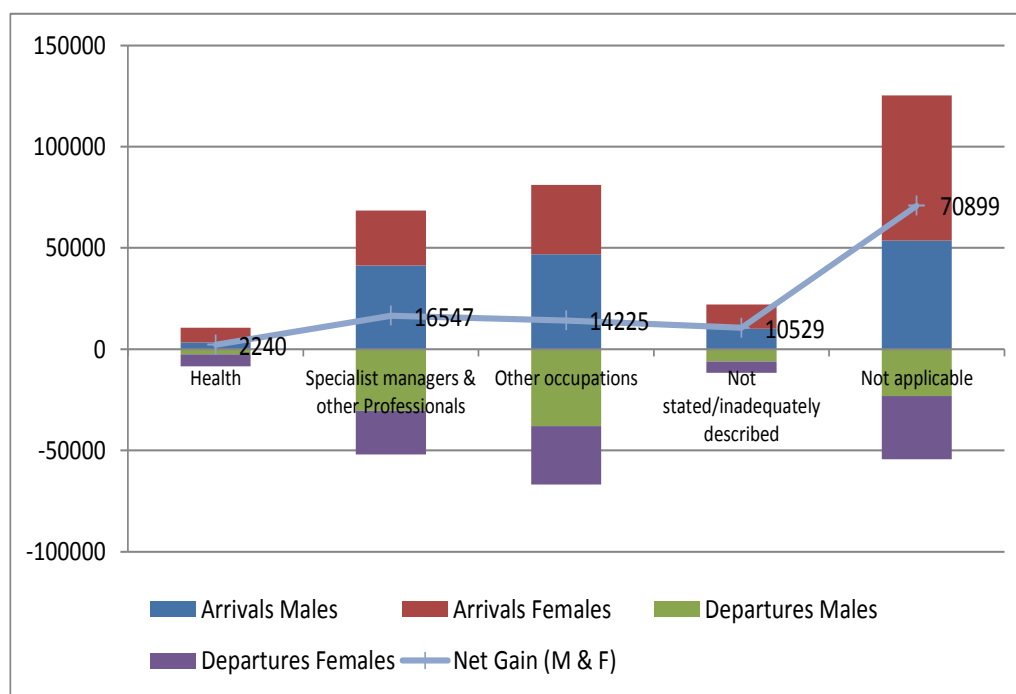


Figure 9: Persons aged 15 years and over, arriving and departing permanently or long term, by occupation by sex 2001 – 2002

Source: Adapted from ABS data ⁽¹²⁾.

Note: in the above chart, “not applicable” includes retired, pensioners, disabled, housekeepers, students and the unemployed.

6.2.3 Australia as “transit” country

There is currently no evidence to support the hypothesis that Australia acts as a ‘transit’ country in which health professionals gain qualifications and/or registration with the intent of moving on (for example, to Europe).

Available data sources are not able to shed significant light on the issue. Although existing data sources can identify the number of health professionals who obtained their qualifications overseas, and the number of health professionals leaving the country, there is no way to combine these

datasets to identify who amongst those leaving Australia may have originally been trained or resided in a country outside Australia. In addition, definitional issues of the length of time that is considered ‘transit’ are problematic in a country with such a high migrant population.

A recently published study of health worker migration in the Asia Pacific ⁽¹¹⁶⁾ region discusses global health care “chains of recruitment and supply”, and acknowledges that “the initial overseas destination may not be the intended final destination”. Transit states and regions mentioned include the Gulf and the United Kingdom, both identified as transit destinations for those ultimately heading for the USA, and Ireland ⁽¹¹⁶⁾. In interviews, stakeholders identified New Zealand as a transit country, and an OECD study has confirmed that New Zealand experiences significant inward and outward migration ⁽¹¹⁷⁾. However, Australia is not mentioned as a transit country by either source.

None of the key stakeholders interviewed as part of this study believed that Australia played a significant role as a transit country. This was further corroborated by the interview sample, which showed that individuals are, for the most part, intending to stay in Australia. For those migrants surveyed, the majority who did intend to move on from Australia would return to their country of origin.

While many health professionals migrate to Australia both from within and without Europe, anecdotal evidence suggests that this is generally either a permanent move or a very long term stay. The strong currency and high wages in Australia when compared to many countries in the region (especially South Asia and the Pacific) provide an incentive for health professionals to remain in Australia rather than move on. The importance of sending remittances home for the economies of many of these countries has been demonstrated ⁽¹¹⁸⁾. Some health professionals are able to gain right of residency and maintain a non-practicing registration in Australia, allowing them the option of moving back and forth between Australia and their home country over a period of years, or even decades.

6.2.4 Monitoring of immigration and emigration policies

As discussed above, there are a range of programs to encourage workers to alleviate the shortage of Australian professionals ^(74; 75). Skilled migration policies are actively implemented with what appear to be increased accessibility and reduced visa requirements. Skilled Migration is enforced on a federal level by the Department of Immigration and Citizenship (DIAC), however, the Minister for Immigration and Citizenship can delegate duties when they see fit. Airport Customs and Security also have a significant role, as they provide the first point of contact for those entering

Australia. Regulatory and registration bodies also play a role in monitoring compliance, as discussed in section 5.1.3.

6.2.5 Health workforce data availability & limitations

Data on the movement of overseas trained health professionals in Australia comes from a number of sources. Important sources of data include

- Registration data previously collected by largely state-based bodies but now the responsibility of the newly formed AHPRA. This includes information on new registration, qualifications and where they were obtained.
- The Department of Immigration and Citizenship, which collects basis arrivals and departures through information provided on landing cards, and is also the source of data on visas issued.
- The Australian Bureau of Statistics, which conducts a national population census every four years which includes a range of information such as country of birth, education level and occupation, place of birth and citizenship.
- Educational institutions, who hold data on overseas students
- Australian Institute of Health and Welfare.

Registered labour force dataset specifications are outlined on the Australian Governments METeOR website. This encompasses, but is not limited to, the ten professions requiring registration under the AHPRA. The standard outlines national reporting arrangements as follows:

“registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS¹² primarily comprises workforce data. ...

Data are collated annually for each profession. The period is determined by the national registration renewal period for health professionals and may differ between health professions.” ⁽¹¹⁹⁾

However, this specification predates the creation of the HWA, and is restricted to those data items collected as part of the registration process. Also, the multiplicity of data sources gives rise to inconsistencies and gaps in data, and there is no common factor by which datasets can be analysed. This places some serious limitations to the extent to which the flow of migrants in and out of the country can be analysed.

Further, stakeholder interviews identified that while there is significant optimism that the recent move to national registration will result in a more consistent and robust data collection and monitoring capacity via AHPRA, implementation issues remain. A first dataset of new registration data is not yet available, and the process of negotiating a national dataset has meant that in some cases, states will have a less comprehensive set of data available that they would have collected previously.

As discussed earlier, 2010 has also seen the first operation of the new Health Workforce Agency, and inevitably there is a certain initial lack of clarity and detail about its roles and responsibilities, and data collection, ownership and sharing and responsibility for analysis and reporting between HWA, AHPRA and the AIHW, which currently prepares a comprehensive annual report on the whole sector including a workforce chapter. Resolution of these issues should, at least in theory, result in a much strengthened national capacity for workforce data analysis, reporting, and planning. However, the difficulties in developing these new mechanisms for national coordination mean that these gains are unlikely to be realized in the short term.

¹² Data Set Specification

6.2.6 Summary table

Australia as country of origin	Australia as destination
Push	Pull
Possibility to work abroad in the short-term for health professionals is available for some countries e.g. UK;	Relatively easy recognition of health professional qualifications from some EU and Commonwealth countries Good knowledge of English language among many clinical staff from other countries (including many EU countries) Possibility to work abroad on the short-term for health professionals is available for some countries e.g. UK;
Stick	Stay
EU provisions mean easier access to other European labour markets than the Australian market for EU nationals from many EU countries.	The number of foreign health professionals in Australia is high; There is well established policy mechanisms to attract and keep foreign health professionals;

6.3 Policies particularly addressing the migration of health professionals

6.3.1 Responding to health workforce shortages

It is uncontested that the health professions in Australia are experiencing increased demand and the supply of the workforce is not meeting the needs of this demand, particularly in rural or remote areas. ⁽¹⁰³⁾ ⁽¹⁰⁴⁾ Australia is not alone in recruiting Overseas Trained Doctors (OTDs) to address the shortages in rural areas ^(103, 105) countries such as the United Kingdom and the United States have also implemented such strategies to facilitate the domestic supply ⁽⁴²⁾

As identified in earlier sections, the rising pressure and demand for health professionals can be seen as a result of an ageing population, increases in the cost of education, change in geographies (e.g. the expansion of areas in Queensland and Western Australia) and increasing expectations. There was a widely held belief in the 1980s and early 1990s that Australia was experiencing an oversupply of doctors, and policy during this period reflected this view. The impact of this policy is illustrated in **Figure 10**. This resulted in a number of strategies to ensure that Australia did not experience an oversupply of doctors, these included; restrictions on medical school placements,

restrictions on access to Medicare provider numbers and various restrictions on newly entered OTDs.⁽¹²⁰⁾

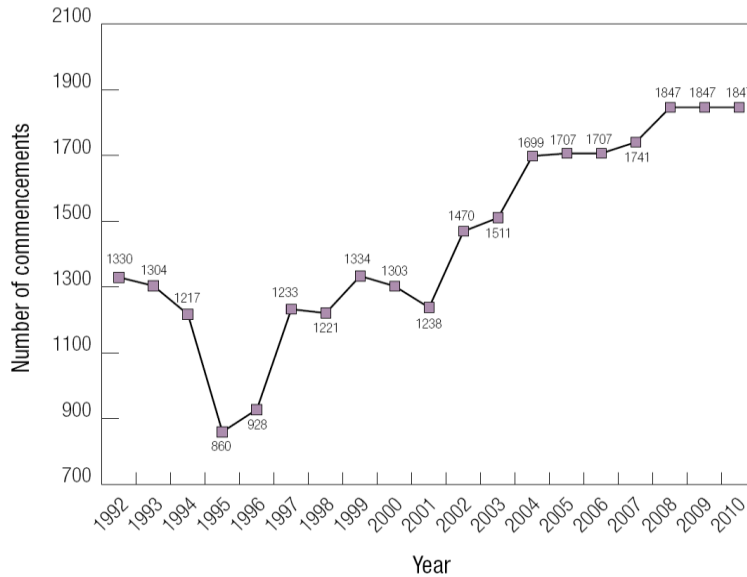


Figure 10: Medical students, commencements, Australian citizens and permanent residents, 1992- 2010

Source: Australian Government Biennial Review of Medicare Provider Numbers⁽¹⁰⁶⁾ p29

As previously discussed, it has not been until recent years, that Australia has begun to significantly increase the number of medical school enrolments available and reduce the barriers to OTDs in order to rectify the undersupply created by previous policy. Hawthorne and Birrell have described this process as the “*policy somersault*”.⁽¹²⁰⁾ It can therefore be argued that past policies have created an undersupply of doctors in Australia; however others contend that it is not an undersupply rather an underutilisation.⁽⁶⁵⁾ A number of policies and programs are in place to specifically address this deficit through migration. These policies exist on state, federal and international levels. As discussed above the most significant health workforce shortages exist in rural and remote areas. Many of these shortages are more acute among medical practitioners with greater stability of the nursing workforce.⁽³⁸⁾ There are many strategies to address rural workforce shortages in Australia (see section 5.1.4), but the two most often reported are the rural clinical school program and the recruitment of international medical graduates (IMGs).

The total number of IMGs in Australia is steadily increasing.⁽⁷⁵⁾ Many IMGs are recruited to rural and remote areas of unmet need, with corresponding location-restricted provider numbers. While nationally they comprise at least 25% of the general practice workforce, more than a third of rural general practitioners are IMGs (37% in 2005–06).⁽⁸¹⁾

In November 2010 the national Senate commenced an Inquiry into Registration Processes and Support for Overseas Doctors, and is conducting public hearings as well as inviting written submissions. At time of writing, 131 submissions had been made to the inquiry¹³. The report will be tabled in national parliament when complete, and will inform future policy in this area⁽⁹⁰⁾. .

6.3.2 Summary table

Australia as country of origin	Australia as destination country
Push	Pull
Australian health professional education and standards generally well regarded in Europe. English language widely accepted in many parts of Europe.	Good employment prospects for health professionals, particularly in designated areas of need. Possibility to work abroad in the short-term for health professionals is available for some countries e.g. UK; Good knowledge of English language among many clinical staff from other countries (including many EU countries)
Stick	Stay
Australian health professional education and standards generally well regarded in Europe.	Likelihood of ongoing strong demand for health professionals.

6.4 Analysis of factors influencing Australia's health workforce

Internationally health workforce is a challenging area and is subject to not only epidemiological, professional and cultural issues but also market forces^(121; 70; 74). The Council of Australian Governments (COAG) established a new agency to direct the reforms necessary to the Australian health workforce, Australian Health Workforce Ministerial Council⁽¹²²⁾. The COAG has

¹³ Most submissions' are publically available at
<http://www.aph.gov.au/house/committee/haa/overseasdoctors/subs.htm>.

recommended the following health reforms embracing increasing supply and reforming the current workforce. Key strategies to be undertaken in Australia include:

- Increasing the capacity of the health sector to provide clinical placements for academic and vocational courses
- Facilitating immigration of overseas trained health professionals and develop recruitment and retention strategies.
- Increasing funding and payment mechanisms for expanding multidisciplinary models of care
- Reconfiguring roles and creating evidence based alternative scopes of practice.
- Developing strategies for aligning incentives surrounding productivity and performance of health professionals and multi-disciplinary teams
- Identifying and addressing service gaps, particularly in rural and remote areas and Indigenous health

In December 2008 the Commonwealth and the States committed to a reform package of \$1.6 billion investment in the health workforce, comprising \$1.1 billion of Commonwealth funding and \$540 million in State funding (note all figures are in Australian Dollars, at the time of publication \$1 AUD = \$0.86 USD). Health workforce reform is also a key strategy for the National Hospital and Health Reform Agenda. Australia's current reform agenda, embracing a systems wide approach underscores the importance of developing a workforce that is responsive to issues facing Australian society within a global context. Microeconomic reform providing alternatives to funding models and responsibility for providing education and funding to provide health service is recommended.

Current projections of workforce demand, service and workforce models, and shortages will continue over the short to medium term. Zurn et. al provides a useful model for analysing factors relating to Human Resources for Health. ⁽¹²³⁾ This model recognises the complex interplay between supply and demand within a global context. Factors such as the global financial crisis and the international challenges in human resources for health cannot be excluded in analysis of the Australian setting. ^(121; 124; 125) Further changes in population structure and social, political and economic factors contribute to workforce characteristics. The regulated structure of Australia's

health care system relative to other countries dictates a synergy between workforce characteristics and the health care system.

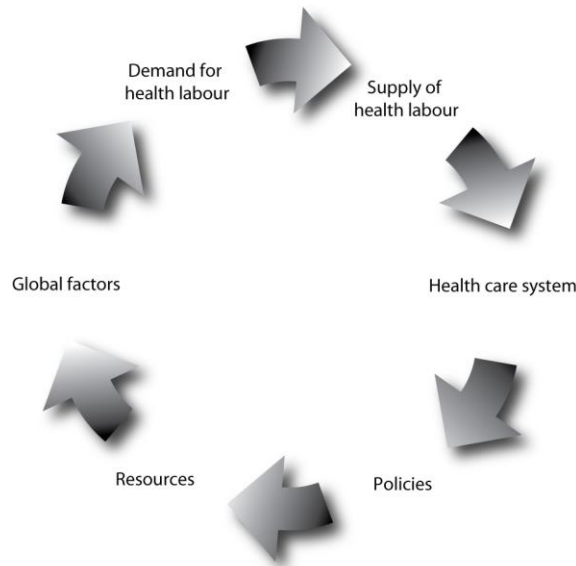


Figure 11: Zurn model of workforce development

6.4.1 Summary Table

Push	Pull
Possibility to work abroad on the short-term for health professionals is available for some countries e.g. UK; Good knowledge of English language among many clinical staff from other countries (including many EU countries)	Significantly superior financial conditions for physicians from some EU countries. Already well-established migration links, migrant communities
Stick	Stay
EU provisions mean easier access to other European labour markets than the Australian market for EU nationals from many EU countries.	There is well established policy mechanisms to attract and keep foreign health professionals; Current reforms point to continued growth of the Australian health sector. Policy reforms currently being implemented should increase opportunities for professional mobility within Australia after registration.

7 Factors impacting on the mobility of health professionals

7.1 Policies and programs

7.1.1 *Government policy and regulation*

Government policy and professional regulation are the most significant factors impacting on the mobility of health professionals into the country. The workforce is highly regulated, and so health professionals cannot legally practice unless they have been assessed as holding the correct qualifications, regarding as equivalent to Australian requirements.

Australia observes strict quotas on the number of migrants entering the country, but most health professionals benefit from being regarded as having desirable skills, as these professions are designated areas of need. While this provides an opportunity to emigrate to Australia that might not otherwise exist, it provides some particular difficulties and complications in that it means that health professionals must negotiate both the system governing professional regulation and registration as well as the system governing immigration and visas in order to gain entry to the country and practice.

Health professionals interviewed as part of this study were well aware of the critical nature of these requirements, and expressed a range of complaints related to

- The time taken to complete the various processes
- The way that different processes interacted with each other
- The cost to applicants
- The level, accuracy and currency of information available in their country of origin regarding requirements and processes, and
- The “constant change” in policies and processes.

Prospective migrants can expect further change in the policy environment, with major reviews and inquiries underway in respect of both international student visas and the processes and supports provided to overseas trained doctors. Both of these reviews are expected to report in 2011.

7.1.2 The role and impact of Commonwealth & WHO Codes

At State level, there have been some bilateral contracts used to develop approaches to recruit health workers (e.g. South Australia and Vietnam).

In addition, the Trans-Tasman Mutual Recognition Arrangement (TTMRA) is a non-treaty arrangement between Australia and New Zealand that permits movement between the two countries, although the Australian Nursing and Midwifery Accreditation Council (ANMAC) maintains the right to request registration to local Nursing authorities. Medical practitioners are exempt from the TTMRA, but mutual recognition-type arrangements already exist for doctors whose qualifications were obtained in New Zealand and Australia.

In terms of broader trade and migration issues, fifteen Pacific Islands Forum states agreed in 2009 to begin negotiating a new trade agreement between Australia and New Zealand, and 13 Pacific island countries (PACER-Plus). In addition, Australia is actively pursuing the development of closer bilateral links with a number of countries in the region (e.g. Papua New Guinea, Vietnam, Solomon Islands). As these links develop, they may have implications for regional labour mobility, as well as regional skills development and the further development of higher education and training capacity. (126; 127; 128)

While most key stakeholders interviewed as part of this study were aware of the existence and principles of the Commonwealth and WHO codes of practice for international recruitment of health workers, most did not see the codes as playing a significant role in modifying or influencing decision-making in a direct way. However, all parties noted the need to ensure ethical behaviour on the recruiting process, and informants indicated that the Commonwealth Department had established a list of 'preferred' recruiters as a measure to ensure appropriate practice¹⁴.

¹⁴ Rural Health Workforce Australia is the national manager for the International Recruitment Strategy (IRS). This provides a free recruitment service to rural and remote general practices for the complex activities required to recruit an overseas-trained doctor, funded by the Australian Government to help address rural doctor shortages⁽¹⁴³⁾. In addition, the Government's website provides links allowing prospective employers and employees to check whether recruitment agencies are members of the Australian Association of Medical Recruitment Agents (AAMRA). All members of AAMRA must comply with codes of practice and standards established by the Recruitment and Consulting Services Association⁽⁷⁶⁾.

Most parties interviewed were aware of the possible impact on source countries through the loss of local health professionals, but were equally cognisant of the significant role played by remittances in some countries and some families. In addition, some stakeholders cited instances where the Codes had been successfully utilised to address inappropriate or unethical recruitment practices. However, interviews conducted with migrants showed that most do not send remittances home. This could be due to the majority being predominantly here on student visas. In fact, it was found that the process of migrating and registering in Australia was so expensive that extended family in the country of origin sometimes provide financial support for the migrant.

7.1.3 *Culture, family and personal motivation*

In the sample of 35 migrant health professionals who had an in-depth interview, it was shown that the most common reasons for coming to Australia are: better job opportunities; better working conditions; qualification opportunities; new experiences, cultures and language; and a higher standard of living. The greatest reasons for remaining in Australia are: better job opportunities and a higher standard of living in general.

7.2 Perceptions of the migration experience

7.2.1 *Processes and procedures*

Interviews with migrating health professionals revealed a level of dissatisfaction with the existing approach. Respondents felt there was a lack of awareness amongst policy makers about a range of issues related to the registration process. OTDs, particularly those who have not completed their medical degree in a “competent authority pathway” country (United Kingdom, New Zealand, United States of America, Canada, South Africa, Republic of Ireland), found the registration process was characterised by lengthy waiting times and expensive testing mechanisms.

Qualitative research conducted as part of this research suggests that the processes and requirements for gaining the professional registration necessary to practice in Australia is a significant burden for some prospective migrants, particularly from some countries. English language testing was perceived as both complex and lengthy by prospective migrants. The two main areas of frustration were:

Key issues identified during interviews with migrants were:

- Language testing – International English Language Testing System (IELTS) expires after two years, after which time it must be passed again. Included in this is a stipulation that the

registration application process must be started within 12 months of passing the IELTS. As well, all four sections of the test must be passed in one sitting

- IELTS has four parts and each part must be passed at a level 7 every time. Individuals often found they would have to sit the test more than 10 times and each time they would get a 6.5 in a part that they may have already received a level 7 in. Many interviewees expressed how demoralising this process was
- Registration process too long particularly for OTDs (causing expiry of language assessment before all other registration requirements can be met)
- Visa requirements not in line with registration
- Expensive
- Constant changes to the requirements for both immigration and registration.

The key stakeholders interviewed indicated that they were aware of a level of sensitivity around the stringent language requirements. However, most expressed the view that they believed this was a key element of proving safe and high quality care, and should therefore be maintained, despite its impact on prospective migrants.

A recent submission to a Government Inquiry also highlights delays and lack of clarity in the information available, the processes to be followed and the responsiveness and respective roles of the various agencies involved (129). Registration and immigration processes did not always line up – many of the barriers expressed by migrants were around the lengthy times in both immigration and registration processes including the fact that they don't overlap in anyway. This means often students had to keep re-enrolling in courses to maintain their legal status under a student visa while going through the registration process. On occasions, jobs had been offered but security checks took so long that the job opportunity disappeared before it could be taken up, even though the process is coordinated through DIAC and employer.

Registration processes were perceived as being excessively lengthy, particularly for doctors. The AMC Part 1 (the multiple choice test) can gain the doctors specific registration. For unlimited registration the AMC Part 2 (clinical test) must be passed. However, the waiting list for AMC Part 2 is approximately 18 months long. If not timed correctly the IELTS can expire in the meantime making the process a lot more difficult and time consuming.

However, the extent to which requirements such as these present a barrier will vary according to factors including the prospective migrant's country of origin and their profession. For some, mutual recognition agreements will facilitate the transition. In addition, prospective migrants' existing expectations of, and experience with, bureaucratic and regulatory processes may influence their perceptions of the process.

Despite the dissatisfaction expressed, the international health migrants interviewed during this research said they had not lodged complaints to the registration board or immigration departments regarding the sometimes confusing and lengthy processes they got caught up in. It is therefore unlikely that the kinds of concerns raised by participants in this research were raised with key policy makers through administrative channels. However, a large proportion of the 145 submissions to the House of Representatives Standing Committee on Health and Ageing's Inquiry into Registration Processes and Support for Overseas Trained Doctors have been made by doctors who are either in the process of, or have experienced, the registration process. Many are taking the opportunity to submit to government detailed descriptions of the process the frustrations associated with it.

7.2.2 *Future intentions*

The majority of health professionals (65%) interviewed as part of this study intended to remain in Australia after migration, and a further 22% were unsure, though some of these noted it was because they were unsure of whether they would be successful in gaining visas or registration. Four respondents, 11% of those asked, did not intend to stay.

Most had emigrated directly from their country of birth, and although a number of respondents had considered moving to Europe, only five people in the group had emigrated from Europe, and only one of those had not been born there.

7.3 Areas for further research

As discussed in relation to data, there are currently significant gaps in the information available on migration. Information about the health professions who leave Australia is one area where the need for further research has been identified. Research focus could include include:

- Migration history and background
- Rationale and motivation of migrants

- Intention regarding permanent/temporary migration

.As discussed earlier in this report, there are a number of areas where there is either significant change underway or high levels reviews being undertaken. These, and their implications, could potentially have significant impacts for the future of migration of health professions in Australia and the various government policies which impact of them. As such, they are worthy areas of further investigation, evaluation and include:

- The establishment and development of the Health Workforce Agency, and its program of work
- The relatively recent establishment of a national-level registration and regulation of health professionals (AHPRA)
- The current House of Representatives Inquiry into the Registration Processes and Support of Overseas trained Doctors
- The current Strategic Review of the Student Visa program

The survey and interviews carried out as part of this research was designed to provide a qualitative, experiential view of the migration process, and as such added useful context to the other parts of the research as well as providing 'triangulation' for some of the points raised. However, there are a number of issues raised which could provide useful and interesting avenues for research during the course of these investigations. Possible types of further investigation include:

- Broad based survey research on motivations and experiences involving a large and representative sample of migrants from different states, backgrounds and professions
- Longitudinal studies which follow migrants through their careers to determine further migration (if any) or changes in travel patterns or relationships with home countries.
- Subject to privacy and confidentiality constraints, further work to link and interrogate different data sources such as registration data, immigration information, and employment outcomes.
- Evaluations of policies such as the introduction of IELTS to determine the impact (if any) on patient safety and care.

- Further research into the global labour market of health professionals, and whether better understanding of this global market can help countries to better respond to and manage their own health human resources, continues to be a challenge for researchers worldwide.
- Evaluations over time of the impact of the WHO Code of Practice, including both the extent to which it is implemented domestically to bring about change, and the extent to which it impacts on the global market and competition for valuable health human resources.

8 Conclusion

The following identify key social, political, health and economic trends impacting on workforce issues. Some of these key considerations are outlined below

- Australians enjoy one of the highest life expectancies in the world, at 81.4 years
- Relative to other countries Australians enjoy political stability and social cohesion
- Health inequity is evident particularly in those living in rural and remote Australians and indigenous people
- Australia supports a program of universal health care coverage although there are increasing moves to privatisation
- Death rates continue to fall and life expectancy to rise, but the fertility rate remains below the replacement level.
- The ageing of the health workforce remains a concern
- A range of reform in the health and education systems is emerging to address the increasing burden of chronic disease and population ageing
- People from non-European countries, particular Asia, now comprise a large proportion of health professionals migrating to Australia.

Mobility of health professionals needs to be considered within the context of global financial, economic and political contexts. It is evident that the mobility of health professionals in Australia is complex and multifaceted and diverse across different State, Territory and national jurisdictions.

Factors including a well-developed and well-regarded system for higher education, good standard of living, safety and security, and the relatively strong economy mean that Australia continues to be an attractive destination for health professionals seeking job opportunities and new life experiences. However, stringent requirements in regard to English language testing, the lengthy registration process for many, and a lack of coordination between systems for professional registration and immigration create significant barriers for many health professionals seeking to migrate, and

contribute to high reported levels of stress as well as having significant financial implications in terms of both direct costs and earning power.

Some of these barriers and inconsistencies are currently being considered by a major parliamentary inquiry into the entry and support provided by overseas doctors, though at the time of finalising this report the outcomes of that inquiry were as yet unknown. A separate inquiry into student visas, which will consider a range of matters including the number of hours that those on student visas are allowed to work, may also have implications for migrating health professionals, a number of whom first enter the country as students.

Recent government initiatives have included the injection of significant funds to expand clinical training places and move further towards self-sufficiency in training health care workers domestically. However, it is expected that for the foreseeable future, Australia will continue to encourage health professionals, along with other key skilled workers, to enter the country, with skilled migration continuing to form a significant part of entry quotas. Though not without its challenges, particularly in relation to language and acculturation, this is generally seen as a positive contribution both in respect to the skills gained by the Australian sector, and to the professional development and work opportunities that migrating health professionals enjoy

Australia is likely to continue to rely on international recruitment of health professionals, both short term and longer term migration, in order to meet increasing health needs of the population, even as it invests in training more of its own to become health professionals. Given the relative strength of its economy, combined with additional pull factors related to career choice, attractive pay and education prospects, and lifestyle factors, it will be able to attract these health professionals from other countries.

The extent to which this impacts on EU countries will be differentiated, depending in part upon reliance on well-established flows from English speaking countries such as the UK and Ireland. Australia does not recruit health professionals "from the EU"- it has different types of links with different countries. It is likely to continue to target most prominently those countries that have English speaking health professionals, be they in Europe, Asia or elsewhere. Neither can it be regarded as a transit country for most health professionals. Most recruitment of health professionals is linked to long term migration to Australia, and the attractive combination of pull factors also acts a very powerful retention mechanism once the health professionals are working in Australia.

8.1 SUMMARY OF PUSH/PULL/STICK/STAY FACTORS.

Ref.	PUSH	PULL
3.1	Relative isolation of country makes travel to other countries expensive and time consuming. High cost of living compared to some European countries Many Australian-born health professionals have family ties in Europe	Shortages on the labour market, including health sector; Changes in age structure – future increase in demand for health and care services; English language means many source countries share language, but constraints on non-English speaking countries. Ageing/ growing population – more demand for aged care
3.2	High cost of living in Australia relative to some European countries	Oversupply of labour, particularly recently trained health professionals. Impacts of Global Financial Crisis on job and career opportunities Shortages on the labour market, including health sector Strong economic growth Strong dollar improving relative value of Australian wages Good quality of life, safety and security according to key indicators.
3.3	Less affordable social supports (e.g. childcare) available than are the case in some EU countries. Fewer annual days leave available as a standard employment condition than available in some EU countries. Some limitations in care available through public health system (e.g. dental care private)	Oversupply of labour, particularly recently trained health professionals. Impacts of Global Financial Crisis on job and career opportunities. Shortages on the labour market, including health sector; Comparatively strong economy Strong dollar improving relative value of Australian wages Good quality of life, safety and security according to key indications

Ref.	PUSH	PULL
4.1	Poor record of progress on indigenous health	Relatively high health status of population (with exception of indigenous people). Relatively high living and practice standards May be significant personal risk associated in health care delivery in some origin countries. Significant challenges to achieving significant health gains in catchment population for health professionals in some areas.
4.2	Some limitations in capacity to provide high-level training in some specialty areas. Some limitations on scope of practice meaning fewer opportunities for some professions (e.g. to date, limited role of nurse practitioners or nurse managed practices)	Better tools to diagnose and treat certain diseases than in some other less developed countries (e.g. in cardiac diseases), so good career possibilities for these specialists from other countries (mainly less developed); Relatively well funded health system. Clear organisation and financing of the system; Relatively high expenditure on health means scope for acceptable conditions of work, access to new technologies and new medicines, efficient information system, access to support staff; Constraints on health sector funding in some EU countries. Poorly developed health infrastructure in some countries limits professional opportunities and job satisfaction.
4.3	Skills shortages in some areas can result in increased workload for remaining staff, resulting in stress and burnout.	Current shortages for health professionals create good employment opportunities
4.4	Historically weak policy and planning links between health industry workforce needs and education/training provision.	Identified areas of shortage for most health professions, particularly in rural areas. Projections suggesting ongoing need for health workforce growth due to demand increases and

Ref.	PUSH	PULL
		ageing of current workforce. Health workforce planning and development currently area of significant policy development and reform
4.5	Australian education and training of health professionals highly regarded internationally. Shortage of, and high level of competition for, some professional education and training pathways (e.g. medicine and specialty places).	Reliance on international recruitment to fill posts in rural/ remote health services Strong tertiary education system with high level of international recognition. Shared/similar curriculum with some Commonwealth countries [e.g. UK] means almost automatic recognition of qualifications; Need to go to e.g. Australia for post basic training (and basic training for physicians) means that international links are established during training [some Asia/ Pacific countries] Scope to establish valuable professional contacts in Australia, allowing for further professional mobility and development; On the whole the education of health care professionals in Australia is highly regulated in both the education and vocational setting. Constraints on health sector funding in some EU countries
5.1	EU provisions may result in greater/more diverse work opportunities for health professionals once approved to practice in Europe. Most professions able to spend extended periods of time in Europe while maintaining registration to practice in Australia. European Working Time Directive, if observed, may mean less demanding working conditions for some health	Established migrant networks and connections in Australia: Long tradition of immigration from European countries (and more recently from Asia-Pacific) ; specific tradition of migration links with Commonwealth countries (e.g. UK) Policies in place at State and Federal level to actively recruit health professionals from other countries Some health professionals are “fast tracked” for immigration- given priority in allocation of qualification

Ref.	PUSH	PULL
	professionals.	points for entry. Limited professional development opportunities for recently qualified clinical staff in current environment in Some European countries Impact of global economic crises means that funding for health sector is constrained in some EU countries
5.2	Codes of Practice of recruitment likely to have little impact on European nations' willingness to recruit from a highly developed nation such as Australia.	Policies in place at State and Federal level to actively recruit and support health professionals from other countries. Arrangements in place to recognise professional qualifications for some European countries. Limited professional development opportunities for recently qualified clinical staff, Impact of global economic crises means that funding for health sector is constrained in some EU countries
6.1	Strong tradition of travel, particularly to Europe and particularly among young people. Many Australians have family/ancestral links to Europe as a result of Australia's migrant history	Already well-established migration links, migrant communities
6.2	Possibility to work abroad in the short-term for health professionals is available for some countries e.g. UK;	Relatively easy recognition of health professional qualifications from some EU and Commonwealth countries Good knowledge of English language among many clinical staff from other countries (including many EU countries) Possibility to work abroad on the short-term for health professionals is available for some countries e.g. UK;
6.3	Australian health professional education and standards generally well regarded in Europe.	Good employment prospects for health professionals, particularly in designated areas of need.

Ref.	PUSH	PULL
	English language widely accepted in many parts of Europe.	Possibility to work abroad in the short-term for health professionals is available for some countries e.g. UK; Good knowledge of English language among many clinical staff from other countries (including many EU countries)
6.4	Possibility to work abroad on the short-term for health professionals is available for some countries e.g. UK; Good knowledge of English language among many clinical staff from other countries (including many EU countries)	Significantly superior financial conditions for physicians from some EU countries. Already well-established migration links, migrant communities

Ref.	STICK	STAY
3.1	Family ties Professional status Language and culture	Good quality of life, safety and security. Lifestyle and climate
3.2	Language and culture	Good quality of life, safety and security. Economic growth and career development prospects Generally good terms and conditions of employment compared to many countries Good prospects for future generations.
3.3	Costs of relocation – and reduced value of assets outside Australia as a result of strong Australian dollar.	Good quality of life, safety and security. Economic growth and career development prospects.
4.1	Status of health professionals, particularly in areas of workforce shortage	Relatively high health status of population (with exception of indigenous people). Relatively high living and practice standards

Ref.	STICK	STAY
4.2	Potential for development of particular medical, nursing and allied health professional specialisations. Stronger opportunities for secure public sector employment for some professions (e.g. dental services primarily private sector in Australia, but extensive public dental services in UK)	High level of health care in Australia. Good access to high quality infrastructure, pharmaceuticals and equipment Strong wage growth
4.3		Projections indicate ongoing areas of shortage for some health professionals, indicating strong employment and career prospects into the future.
4.4		Move to national registration likely to simplify registration process and enhance opportunities for health professional mobility within Australia. Ability to retain registration through extended periods of non-practice.
4.5	Potential for development of particular medical, nursing and allied health professional specialisations, accompanied by financial support for practitioners of this specialisation	Clear path of professional career offered, with scope to select speciality, location of work (for most); Potential to earn high salaries;
5.1	Ability to gain residency and/or citizenship in some European countries may depend on continuous long-term stays. EU arrangements create opportunities for ease of travel and access throughout Europe if European passport can be obtained.	Availability of incentives and settlement support for highly sought-after occupational groups.
5.2		Availability of incentives and settlement support for highly sought-after occupational groups.
6.1	EU provisions mean easier access to other European labour markets than the Australian market for EU nationals from many EU	The number of foreign health professionals in Australia is high;

Ref.	STICK	STAY
	countries.	Broad social acceptance of migrant populations and established migrant communities. Reliance on remittances for some (e.g. Pacific countries and/or Asia), but less so from the EU.
6.2	EU provisions mean easier access to other European labour markets than the Australian market for EU nationals from many EU countries.	The number of foreign health professionals in Australia is high; There is well established policy mechanisms to attract and keep foreign health professionals;
6.3	Australian health professional education and standards generally well regarded in Europe.	Likelihood of on-going strong demand for health professionals.
6.4	EU provisions mean easier access to other European labour markets than the Australian market for EU nationals from many EU countries.	There is well established policy mechanisms to attract and keep foreign health professionals; Current reforms point to continued growth of the Australian health sector. Policy reforms currently being implemented should increase opportunities for professional mobility within Australia after registration.

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Annex 1: Summary of Theoretical Questions

Extract from: Eckert et al (2010) Deliverable No. 1 Research Guidelines

The theoretical approach will prepare the ground for the qualitative research. Theoretical questions are in fact resulting from empirical research identifying major trends affecting mobility of health professionals. Considering the nature of the project these questions are critical for explaining and measuring the relative importance of mobility factors.

Below is a non-exhaustive list of factors, which could influence the movement of health professionals to, from and within the EU. The qualitative survey will verify if those hypotheses are sound. The survey will also allow underlining some issues that have not been well identified in the theoretical approach.

For each issue here is a suggested hypothesis followed by items that link theory to the relevant variables to measure the impact of each item.

Factor #1: Wages

Hypothesis: Low wages do not encourage health workers to stay in their home country, especially when they know that wages are higher in other countries for the same work.

National level in the scale of wage may have separate impact on mobility than differential between countries.

Factor #2: Working conditions

Hypothesis: Poor working conditions encourage the mobility, towards better work environment

Factor #3: Professional recognition

Hypothesis: Professional recognition is an incentive for workers

Factor #4: Career opportunities

Hypothesis: A health professional with no potential of professional evolution will be more willing to move

Factor #5: Workforce planning

Hypothesis: Established plans on human resources will affect workforce retention or recruitment.

Factor #6: Employment rights and labour representation

Hypothesis: Workers may be drawn to working environments in which they feel themselves involved in a national group that protect their rights

Factor #7: Labor market

Hypothesis: if the labor market is recognized to be very open, and if there is a lack of health workers in the country, migrants are more willing to come.

Factor #8: Language

Hypothesis: It will be easier for a health worker to migrate in a country, where s/he can speak the language

Factor #9: Historical links

Hypothesis: countries with historical connections may witness higher rates of migration

Factor #10: Policies about migration (see other contribution)

Hypothesis: a country with restrictive immigration law will limit the migration flow

Factor #11: Processes of recruitment

Hypothesis: The modalities for recruitment in the countries can facilitate, limit or regulate the migration

Factor #12: Data on migration

Hypothesis: Availability of data on migration will affect policy, patterns and level of information for migrant populations

Factor #13: Personal security

Hypothesis: The lack of security in the personal or professional context may influence migration.

Factor #14: Personal factors

Hypothesis: Personal factors (quality of life, family reunification, etc.) can also influence mobility.

Annex 2: Interviews with key stakeholders: Questions and summary of responses

A series of qualitative interviews were conducted with a range of key stakeholders. This included one or more representative from regulatory bodies, state and national governments, educational institutions and key research and policy development bodies.

In each case, one or more individuals were interviewed. Stakeholders represented a wide range of professional roles, responsibilities and fields of expertise. The roles of stakeholders interviewed included

- Chief Nursing Officers from various jurisdictions
- Consultants
- Senior managers, including Chief Executives, Directors and Managers
- Lecturers and professorial incumbents
- Policy analysts
- Workforce advisors
- Registration experts
- Information, data analysis and planning experts.

A summary of findings from those interviews is provided below.

What are the current priorities and challenges for the national health system?

A range of issues were raised by stakeholders when asked about current priorities and challenges. There was, broadly speaking, a strong consistency in responses, with the differences primarily reflecting issues of priority among a number of common themes. Those themes were

- Responding effectively to emerging health issues, in particular chronic diseases and the impact of ageing. The need to modify the system to get the “right mix” of acute and primary care, and the need to strengthen the primary care sector was mentioned a number of times in this context
- The national reform agenda, and efforts to better coordinate the efforts of state and national governments in health care, and in particular the effective introduction of national registration for health professionals, and reform in workforce roles and flexibility.
- The demand and supply of the healthcare workforce, and the various mechanisms needed to achieve a better balance between the two, working toward greater self-sufficiency in the health workforce including more effective recruitment, training capacity.

- Distribution of service providers particularly in rural and remote Australia, and addressing health disparities in health between indigenous/non-indigenous people, with indigenous health described by one stakeholder as “an embarrassment for everyone in the health system”. Rural/urban and rich/poor disparities were also noted.

Other issues mentioned by a fewer number of stakeholders included

- The need for better, more robust workforce planning mechanisms, including data and information. One stakeholder noted that there was “no consensus” on the size of the gap between need and availability, let alone the best way to respond.
- The problems posed by ‘jurisdiction shopping’ , in which those moving within or across borders found the easiest paths the registration, and the potential for loopholes to emerge. For example, one stakeholder expressed the view that criminal check requirements were less stringent in New Zealand, although favourable arrangements meant that New Zealand registration was an easier path to registration in Australia.
- The current system of “uncapped” funding for medical services through the Medicare system, and its sustainability. This was referred to by one respondent as “the elephant in the room”. Another referred to the populations “insatiable demand” for healthcare.

What do you understand by the term ‘migration of health professionals’?

There was a disparate range of responses when stakeholders were asked to define what they meant by ‘migration of health professionals’. Perhaps the greatest areas of commonality in responses is that all appeared to share the view that the term implied a range of different cases and practices, including both temporary and permanent mobility.

These included the experiences of health professionals who

- arrive on a short term basis but with a “real” intention to stay if possible
- embark on a programme of education or professional development in Australia with the intention of returning to their source country, described by one person as a “glorified work placement”
- successfully gain registration in Australia and subsequently move back and forth between Australia and their source country. This was cited with particular reference to English speaking migrants from Western Europe.
- are Australian based, but go to Europe for a limited period to gain experience and skills and “enhance their CVs”
- move within Australia to work in different states or territories (which given the size of the country could represent a significant geographical as well as cultural shift). It was noted that this was a particularly interesting area of study as many OTDs initially were placed in rural areas, yet there was little

awareness the proportion that stayed there beyond the period initially required.

- Are students undertaking qualifications in Australia, either with the intention of settling or returning to their source country?

A key definitional issue that was raised in response to this question was how the length of time was assessed. For example, the division between what was regarded as “short-term”, “long-term” or “permanent” was described by one stakeholder as “fuzzy round the edges”.

Does your organisation monitor migration of health professional in general?

The majority of stakeholders interviewed did not monitor the migration of health professionals. Most expressed the view that some organization other than their own should be undertaking such monitoring.

Perhaps reflecting in part both the difficulties experienced in attempt to establish a national approach for the first time, there was little commonality in views about who exactly should be responsible. Comments included:

“Immigration should be doing it”

“It’s part of HWA’s brief” or “HWA might do it”

“It’s monitored by regulatory boards” and “don’t currently know how many registered because many registered in more than one state”.

“AIHW interrogate various data”

Despite this, there was a certain amount of confidence expressed that recent reform initiatives including the establishment of AHPRA and HWA would yield positive results, though the anticipated delay in this being delivered was described by one person as “a blow”.

In your expert opinion what are the main impacts of migration of health workers?

Many respondents noted that the impact of migration would vary considerably according to the source country of the migrating professional in question. It was, one noted, a very different case to moving from Africa to Australia than moving from the United Kingdom to Australia.

It was commonly seen a key strategy for health professionals to achieve personal and professional improvement through exposure to different health issues and health systems. Conversely, this change was also recognized as a source of “adjustment problems”, particularly for professionals of non-English backgrounds or coming from countries with vastly different social and cultural norms. This was sometimes exacerbated by lack of support, and difficulties in family settlement. For instance, in remote areas there were often limited job opportunities for professionals’ spouses, making settlement difficult.

The economic benefits to migrants were also acknowledged by a number of stakeholders, both in terms of salaries and work opportunities that may compare

favorably to their source country (depending on origin) and that remittances sometimes played an important role.

A number of stakeholders also acknowledged that there was a potential to “create an imbalance between supply and demand at the other end”, negatively impacting on other countries’ health systems by exacerbating shortages.

The benefits to rural health provision gained by the migration of health professionals was noted by a number of stakeholders. It was recognized that migrating professionals were often working where others “did not want to go”, and that the migration of professions to rural areas could help ameliorate the “dangerous” upward pressure on wages in rural areas, where competition for professionals (especially doctors) is already exerting upward pressure on wages.

Other comments included Migration of health professionals (in particular the limited registration available for those in rural practice) represented “a trade-off between what people are prepared to accept to have the provision of health services”.

What have been the main trends and impacts in the last 5 years with respect to migration of health workers to and from Europe?

Most migrants from Europe continue to be from the UK, according to all stakeholders. This is reflected in the data discussed earlier in the report. One stakeholder commented that “we are incredibly accommodating to the UK”. Another state-level representative indicated that 7.5% of the State’s medical workforce comes from Europe, including the largest “supplier”, the UK, but also Ireland and Germany. (India was second largest supplier overall.) The migration from parts of Europe other than the UK was regarded as “negligible”.

A number of respondents mentioned the impact of the Global Financial Crisis (GFC) on migration of health professionals. All stakeholders who mentioned the issue were unanimous in believing that the combination of the strong Australian dollar (meaning strong relative wages) and reduced job prospects in many European countries, in particular Ireland and the UK, meant that many health professionals from those areas were very keen to migrate. The strengthened desire for individuals to come to Australia resulted in less need or inclination for active recruitment overseas. There were also anecdotal reports that recruiters were now being approached by more senior clinicians actively seeking opportunities for senior clinical posts in Australia.

Conversely, it was also noted by one stakeholder that the GFC’s impact on house prices in Europe was dampening this effect in at least one case, relating a circumstance when the person’s inability to sell their house in the depressed real estate market of Ireland was preventing them from coming. This may be a widespread concern, as the Australian dollar is currently at historically high levels against the pound, meaning that the Australian “buying power” of UK capital and savings is reduced. As one stakeholder noted, “we’ve become 50% richer”, but also that the situation was “quite volatile depending on employment prospects but also the value of savings and equity”.

The other significant development noted by stakeholders was the introduction of the Competent Authority Pathway in July 2008, which meant that some additional qualifications could be directly recognized, this was seen as reducing the barriers from the UK. However, it was unclear whether this had had a significant impact.

Does the socio-economic situation in Australia affect migration of health professionals to and from Europe?

As noted in the discussion above (see3.2), the socio-economic situation of Australia relative to Europe is seen as having a major impact. As one stakeholder noted, “over the next few years there will be a big opportunity to recruit from England”

However, the strong exchange rate was also making Australia a much more expensive place to study, and education providers were seeing reduced enrollments from fee-paying students. Studying in the UK or the USA may therefore become a more attractive option for potential students.

Are you aware of any evidence regarding health professional using Australia as a transit (migrants stay for a short period only, usually for career development or educational purposes) country?

Stakeholders did not see Australia as a transit country. As one remarked, in a comment typical of the views of all stakeholders:

“we have no sense of Australia being a transit country at all. South Americans come to train then go back, usually sponsored by their government, but they are not using Australia as a stepping stone. Several hundred each year in each state come for 6 months to 2 years to do specialist training, and then go back”

Others mentioned scholarships to allow those from Burma and other countries to be here for limited periods, but also believed they generally returned to their home country. Europe was generally believed to be also generally a two-way flow, there and back, while the Pacific countries were seen as primarily a source of permanent migration.

A number of stakeholders expressed the view that New Zealand may act as a transit country, as it generally has less stringent immigration requirements and restrictions.

What are the advantages or disadvantages of migration of health professionals for Australia?

The following table describes the key advantages and disadvantages of migration for Australia. There was a high level of consensus in response to this question

Table 9: What are the advantages or disadvantages of migration of health professionals for Australia?

Advantages	Disadvantages
• “fill holes” in the current workforce including rural areas and to provide service to different ethnic minorities. • Increase cultural diversity • Bring new ideas and perspectives • Educational opportunities for all concerned • Current policies allow doctors to be directed to rural areas • Cheaper and quicker than training health professionals locally	• Difficulties in integrating migrants into the community and currently inadequate support • Can be some element of clinical risk depending on background and training of the personnel • Sometimes a patient preference for non-immigrants, at least in GP settings • Overseas students may put pressure on the availability of training places, resulting in exclusion of local candidates • Over-reliance on migrant health professionals perpetuating unsustainable training levels and allowing inadequate investment in education.

What are the advantages or disadvantages of migration of health professionals for the country of origin?

Table 10: What are the advantages or disadvantages of migration of health professionals for the country of origin?

Advantages	Disadvantages
• Health professionals can gain skills in Australia that they take back to their source country. • Professionals gain expertise, opportunities and develop international networks • Remittances	• Source countries may lose highly skilled health professionals: “brain drain” • Source countries do not get the return on their investment in training, and as a result may stop investing in education

What do you know about the main motivations, reasons or aspirations for individuals to migrate?

Lifestyle issues, such as an affluent lifestyle, good recreational opportunities, and a safe and well-resourced environment to raise children were seen as key motivations for many migrating health professionals by most informants. A variety

of different motivations were noted. As one stakeholder remarked “it’s about people, as people and what they aspire to in life”

Economic issues were also seen as very important, both as a means for health professions to increase their own level of financial security, and because there was evidence that there was a significant flow of remittances back to source countries for many migrants, particular for migrants from the pacific and parts of south-east Asia.

Depending on their country of origin, stakeholders also believed that improved career prospects was often a significant factor, particularly if their source country either had a poorly resourced health system or a high level of political and civil instability. The ability for Australian, with its contemporary and well-resourced health system (by international standards) to offer challenging work opportunities was seen as part of the career attraction.

What policies, legislation and codes impact health professional migration to and from Australia

In regard to Codes of conduct, most stakeholders were aware of the codes (including Commonwealth and WHO) but few seemed to regard them as being of direct relevance to their work. In some cases there was ambivalence, meaning that they “hadn’t looked at them for a while”. In other cases, there were more stringent views, with one stakeholder commenting that the WHO Code “doesn’t mean anything”, and that Australia gives “lip service” to them.

However, it was noted that there had been instances where the codes had been used as a means to put an end to some unscrupulous recruiting practices, and it was reported that at least one state in Australia “used to quote (the codes) endlessly”.

One stakeholder remarked that one reason the codes had limited impact was that “we are not a culprit” and “are generally clean” where recruitment practices are concerned.

The most important factors influencing migration were seen to be

- Registration and accreditation requirements as being far more significant factors impacting on migration of health professionals. Some regarded these as being too stringent, with Colleges behaving like a “closed shop”. However, others noted the importance of these requirements in maintaining standards and safety.
- The access to Medicare numbers which dictate whether a doctors can become part of the public health system
- Visa requirements

What is the role and relevance of recruitment agencies in Australia?

Stakeholders generally did not express a strong view about the role of recruitment agencies, and many expressed limited knowledge of their operations. As was noted by some, the decentralized model of management existing in States such as

Victoria (where health services are run by independent boards who are the employers) means that central agencies do not have a direct role in recruitments and may not always be aware of the extent to which recruitment agencies are used. Some stakeholders noted that many rural agencies – where shortages are most keenly felt – “would struggle” without recruitment agencies, especially the smaller agencies who may not have the resources to conduct extensive searches in-house.

It was noted however, that the national government has established a list of ‘preferred providers’ and that these agencies have been “vetted” to ensure that they conduct their business in a proper and ethical manner.

It was noted in the course of discussion that recruitment is currently “passive” in many states and territories, with information available on websites for those seeking to migrate, who then initiate the process independently. This reflects the current global environment in which Australia is seen as an attractive migration destination for health professionals. Many of these websites also provide information on how candidates can identify job opportunities. As a result, remarked one interviewee, recruitment agencies were “not as powerful as they used to be”. It was noted however, that not all regions have effective internet access, and that this could inhibit access. In addition Rural health Workforce Australia was coordinating a lot of recruitment

It was evident from discussions with stakeholders that agencies also play a lobbying role, as stakeholders were aware that they had expressed concern about the regulatory standards and the barrier they could form to migration. A representative from a body dealing with registration matters remarked that they could be “a thorn in our sides” at times.

What is your opinion on the impact of incentives and restrictions on migration of health professionals?

The method of payment for medical services, which is effectively uncapped fee-for-service model was seen by one stakeholder as the biggest incentive.

Stakeholders were also aware of the range of incentives offered at state level in efforts to increase the supply of health professionals in rural areas, including reimbursement of recruitment costs, OTD support, and grants to meet relocation costs. At least one state was also implementing a rural locum scheme in an attempt to provide better working conditions for rural practitioners. However, one stakeholder regarded these as not having a significant effect, as migration was “so attractive” anyway. Further, one stakeholder cautioned that such incentives could have the effect of “polarizing the workforce”, as some locally trained rural doctors may feel that support is provided to OTDs that they are not able to access, though they experience the same issues of workload, isolation, and limited access to professional development and support.

It was also noted that such incentives don’t generally apply to nurses, where the density in rural and city areas was not very different, though there were areas of need.

The "ten year moratorium" on OTD was also noted as a significant issue, described by one stakeholder as "draconian, but effective" in providing a means to ensure service provision in remote areas.

The other major restriction commented on often throughout the interviews was the language requirement, which had presented a significant barrier to many aspiring migrants – including some (e.g. Indian and Filipino nurses) who had previously worked in EU countries such as the UK, but had been unable to register in Australia. Suggestions made included moving to an exam-based system under which all applicants – including those locally trained – would be required to pass. However, a number of stakeholders also commented on the importance of good English skills in order to provide good quality care, particularly in settings such as aged care where communication could be challenging.

What do you think the social impact of health professional migratory remittances is, in both Australia and the source country?

Many stakeholders expressed concern about the impact of remittances on families of migrating health professionals, where the migration has caused family separation. One stakeholder described this as "more important than the ethical issues of shortage", as "you can replace professionals, not parents".

However, other stakeholders acknowledged that remittances could play a significant role in the family income in developing countries, and as such was very important.

Stakeholders also noted the possible impact of paying remittances on the standard of living and quality of life of migrant health professionals, but none were aware of the extent to which this may be an issue.

Most believed that remittances were not a significant issue for those European migrants that most commonly enter Australia, the majority of whom come from the more affluent parts of Europe.

What countries have equivalent standards and educational requirements for health professionals as Australia does?

When asked which countries have equivalent standard and educational requirements for health professionals as Australia, all stakeholders nominated Canada, the UK and Ireland USA and New Zealand. Other countries mentioned included France, Singapore and Hong Kong and South Africa, and one stakeholder noted that the leading medical schools in India were very comparable.

The increasing global standardization of nursing standards, helped by efforts of organizations such as the International Council of Nurses, was also noted.

What barriers are there to enable health professional migrants to succeed e.g. Regulation, academic preparation, social and language?

Most stakeholders believed that there were a significant number of barriers facing health professionals seeking to migrate. In the words of one interviewee, "there are so many barriers its surprising anyone makes it."

The process for doctors was regarded as time-consuming and laborious, with candidates needing to start at least 12 months in advance, with extra steps added to the process if they are seeking permission under limited registration to practice in a rural area. In these cases, the successful candidate will then wait 3-4 years before permanent registration is granted, during which time they may receive little support, and families may be separated, as they often remain in the cities where they can access good quality schools and other services and amenities. Another significant barrier was the potential isolation of a non-working partner, particularly in rural areas where there may be less chance of there being an established community of fellow immigrants from the same area, and fewer job opportunities.

For this reason, the initial destination was seen by one stakeholder as a significant determinant of the quality of the migrant experience, which could be “stressful but short-lived”. The diversity of the Australian population was seen as a mitigating factor, as it created opportunities for health professions to connect with other members of their own country’s diaspora.

Language requirements, as mentioned above were also seen as a significant barrier, both in terms of professional life and in social settlement. The social and cultural barriers were regarded as a particular barrier by many stakeholders, particularly for health professionals who are non-English speaking, or arrive with backgrounds very different from Australia. This was seen as much less of a barrier for migrants from the United Kingdom, Ireland and other Western European countries.

Some stakeholders also reported anecdotal evidence that the visa application and approval process could be lengthy.

Do you have any access to, or use, migratory data collection and migratory tracking information? E.g. Immigration regulation, educational institutes

When asked if they had access to migratory data collections or tracking information, most respondents simply answered “no”.

Most believed that there was some information available collected during registration. Data collected by the immigration department was also cited, though it was noted that “DIAC (the Department of Immigration and Citizenship) have less interest in those leaving than those coming”.

One exception was representatives from Victoria cited a labour force survey that had formerly been conducted which could be used to identify the country of birth, and the place of qualification of all health professionals. However, they believed that the move to a national data set was likely to result in a less comprehensive view being available in future.

A level of confusion was evident in response to this question, with the new workforce agency Health Workforce Australia expressing interest in developing a workable dataset, but many of the other stakeholders believing that data available through AHPRA, the new national registration agency, being the most likely future source. This most likely reflects the early stage of development of both

stakeholders, resulting in a persisting lack of clarity, at least in the perception of stakeholders, about their respective roles.

Which national agencies have a responsibility to monitor/track health professional migration to and from Australia? Which data is collected?

Some of the ambiguity in the roles and responsibilities of the newly related HWA and AHPRA, as well as extant organizations such as the Australian Institute of Health and Welfare (AIHW) was evident in responses to this question. One stakeholder suggested that this may still be contested territory, as “the best national dataset is an ongoing debate”. None of the stakeholders were aware of anyone who was publishing national data which was able to assess both leaving and arriving. One stakeholder remarked it was “still in a muddle”

It was recognised by many stakeholders that there were significant challenges to be overcome, including issues of data consistency and privacy law: “you need agencies whose databases can legally talk to each other” APHRA noted that while it could collect a significant amount of data, it would have no access to data on those exiting the country “so we only have one part of the equation”.

The role played by the Australian Bureau of Statistics was also acknowledged, though it was described by one stakeholder as “not very helpful” and that a request for special analysis was required in order to analyse the data from a migration perspective.

If there was to be national minimum data set to monitor health professional migration, what data items should be included and who would be responsible for collating the data?

As discussed above, it seems that a consensus is yet to emerge as to the level of data required and which of the various agencies is best placed to collect it. Key points emerging from stakeholder interviews included

- The information is important and a better approach to it is required for future policy development and planning. Some support for a mandatory data collection was expressed.
- APHRA will hold a lot of pertinent information gleaned during the registration process, and were regarded by many as the most logical agency to develop the role, but it is primarily tasked with registration, rather than migration policy or analysis.
- The HWA could play an important role over the coming years in developing a minimum dataset, but there seemed to be limited knowledge of how this would evolve.
- There were concerns about data protection, privacy, and the use to which data would be put (though the nature of these concerns was not elaborated).

One stakeholder also posed the question “why would we want to know more about health professionals than other professionals?”

Annex 3: Survey Instruments

Email text

Dear Colleague,

We are inviting you to be part of an international study on the current trends of mobility of health professionals, a research project which is being conducted in 25 countries worldwide and funded by the European Commission.

The work in Australia is being conducted by Professor John Daly, Professor James Buchan and Michele Rumsey at The World Health Organization Collaborating Centre, University of Technology Sydney. Australia is part of the Asian Research Team which also includes India and the Philippines. This team is managed by Professor Marilyn Lorenzo at the University of Philippines, Manila.

The study is focussing on people who have moved to Australia and the link below includes some background questions. If you wish to participate in the study please provide us with your contact details (in question 15) so we can conduct a follow up interview based on your personal story. Any information that is obtained in connection with this study and that can be identified with you as an individual person will remain confidential and will not be disclosed.

Please click on the link below to be taken directly to the survey (or if you are not directed to the survey paste the link into your browser). If you are unable to access the questions but wish to be part of the study please send us your email to jodi.thiessen@uts.edu.au or call Michele Rumsey on 0417 933 519.

<http://www.zoomerang.com/Survey/WEB22BPWEPXG52>

The research team appreciates your help, thank you.

Survey 1

19/05/2011

Mobility of Health Professionals Resear...



UTS:
WORLD HEALTH ORGANIZATION COLLABORATING CENTRE
 FOR NURSING, MIDWIFERY & HEALTH DEVELOPMENT

THINK
 CHANGE
 DO

Mobility of Health Professionals Research Project

We are inviting you to be part of an international study on the current trends of mobility of health professionals, a research project which is being conducted in 25 countries worldwide and funded by the European Commission.

In Australia, the work is being conducted by The World Health Organization Collaborating Centre, University of Technology Sydney and managed by Professor John Daly, Professor Jim Buchan and Michele Rumsey. Australia is part of the Asian Research Team which also includes India and the Philippines. The leader of the Asian Team is Professor Marilyn Lorenzo from the University of Philippines, Manila.

The study is focussing on people who have moved to Australia and below are some background questions which should only take 5 minutes to complete. If you wish to participate in the study please provide us with your contact details (in question 15) so we can conduct a follow up interview, by phone or in person, based on your personal story. Any information that is obtained in connection with this study and that can be identified with you as an individual person will remain confidential and will not be disclosed.

1 Gender

male

female

2 Age

3 Level of education, please select the highest qualification that applies

Highschool

Diploma

Degree

Postgraduate degree/qualification

Other, please specify

4 What is your profession and specialisation?

5 Family status

zoomerang.com/.../WEB22BPWEPXG52

19/05/2011

Mobility of Health Professionals Resear...

Single
Married/Defacto
Dependents
Other, please specify

6 What is your immigration status?

Australian citizen
Australian resident
Temporary resident
Work visa
Student visa
Visitor
Other, please specify

7 What is your country of birth?

8 Which country did you migrate to Australia from?

9 In what country (or countries) did you receive your professional education?

10 How long have you been in Australia?

11 How long do you intend to stay in Australia?

12 Part of this study is to find out whether Australia is a transit country (a country where health professionals come for a short period of time but intend to move to another country). Do you intend to move on from Australia? If yes, to work in which country?

Additional Comment

zoomerang.com/.../WEB22BPWEPXG52

19/05/2011

Mobility of Health Professionals Resear...

13 Why did you come to Australia? (please choose all that apply)

- Education
- Economic gain
- Family
- Work
- Quality of life/improve living standards
- Social recognition of working abroad
- Other, please specify

14 Do you send remittances (money sent home on a regular basis) to friends or family?

Additional Comment

- 15 We are conducting more indepth interviews, on the phone or in person, on the barriers, challenges and quality of life issues of migrating. If you would like to tell us any issues you've had or your story please provide your details below, or contact us at jodi.thiessen@uts.edu.au. Any information that is obtained in connection with this study and that can be identified with you as an individual person will remain confidential and will not be disclosed.

NOTE: This study has been approved by the University of Technology,

Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Name

Email

Phone number



Survey 2

19/05/2011

Mobility of Health Professionals Resear...



UTS:

WORLD HEALTH ORGANIZATION COLLABORATING CENTRE
FOR NURSING, MIDWIFERY & HEALTH DEVELOPMENT

THINK
CHANGE
DO

Mobility of Health Professionals Research Project

We are inviting you to be part of an international study on the current trends of mobility of health professionals, a research project which is being conducted in 25 countries worldwide and funded by the European Commission. In Australia, the work is being conducted by The World Health Organization Collaborating Centre, University of Technology Sydney and managed by Professor John Daly, Professor Jim Buchan and Michele Rumsey. Australia is part of the Asian Research Team which also includes India and the Philippines. The leader of the Asian Team is Professor Marilyn Lorenzo from the University of Philippines, Manila.

The study is focussing on people who have moved to Australia and below is a full questionnaire which should take approximately half an hour to complete. Please don't hesitate to contact Jodi Thiessen on 0413 999 107 with any questions. Any information that is obtained in connection with this study and that can be identified with you as an individual person will remain confidential and will not be disclosed.

- 1 Please provide your email so we can obtain your consent form. This email will not be linked with your answers to this questionnaire.

- 2 Gender

male

female

- 3 Age

- 4 Level of education, please select the highest qualification that applies

Highschool

Diploma

Degree

Postgraduate degree/qualification

Other, please specify

- 5 What is your profession and specialisation?

Registered nurse in Australia

Nurse (have not fulfilled registration in Australia)

19/05/2011

Mobility of Health Professionals Resear...

Other, please specify

6 Family status

Single

Married/Defacto

Dependents

Other, please specify

7 What is your immigration status?

Australian citizen

Australian resident

Temporary resident

Work visa

Student visa

Visitor

Other, please specify

8 What is your country of birth?**9** What nationalities do you have?**10** Which country did you migrate to Australia from?**11** When?**12** In what country (or countries) did you begin your training as a health professional?

19/05/2011

Mobility of Health Professionals Resear...

- 13 Are you currently in any apprenticeship/further training/advanced training?

- 14 A brief history of your professional training

- 15 Does your current job correspond to your qualification?

What is it?

- 16 Did you come to Australia prior to moving here?

- 17 How long have you been in Australia?

- 18 Do you intend to move on from Australia?

Yes	No	Maybe
1	2	3

- 19 Where would you move?

- 20 How long do you intend to stay in Australia?

21 - - - - -

19/05/2011

Mobility of Health Professionals Resear...

Additional Comment

22 Did you ever consider moving to Europe?

Where?

23 Why did you come to Australia? (please choose all that apply)

General economic situation in country of origin

General political situation in country of origin

Worse situation of the health care system in country of origin

Low status of my profession in country of origin

Better job opportunities in Aust.

Higher income in Aust.

Better working conditions in Aust.

Safer job in Aust.

Qualification opportunities in Aust.

Career opportunities in Aust.

Getting the qualification in order to work better as a health professional in the country of origin

Encouragement of family in the country of origin

New experiences/cultures/languages

Love of adventure

Higher standard of living in Aust.

Safer life in general

Future prospects for successive generations

Other, please specify

24 If you want to stay - at least for the present - in Australia, what are the reasons for that?

Better job opportunities

Higher income

Better working conditions

Safety at work

19/05/2011

Mobility of Health Professionals Resear...

Support of family in country of origin
 Independence from family/from social circumstances in country of origin
 Higher standard of living in general
 Safer life in general
 Future prospects for successive generations
 Family ties brought along to Australia
 Family ties incurred in Australia
 Other social benefits in Australia
 Existent community from country of origin
 Acquired entitlement to a pension
 Lack of jobs in country of origin
 Political obstacles to return
 Other, please specify

25 Did your family influence your decision to emigrate?

Which family members? How?

26 Do you have a partner and/or children?

Partner
 Children
 All of them live in Australia
 All of them live outside Australia
 Some live inside and some live outside Australia
 No partner
 No children
 Other, please specify

27 If you have family that lives outside Australia what consequences does your emigration have on those family members?

Emotional consequences
 Financial
 No consequences
 Comments

19/05/2011

Mobility of Health Professionals Resear...

- 28 Do you send remittances (money sent home on a regular basis) to friends or family? (If no, please skip to qu. 37)

Additional Comment

- 29 Who do you send remittances to?

parents

family members

friends

Other, please specify

- 30 How often do you send remittances?

monthly

yearly

when I can

Other, please specify



Annex 4: Supplementary Tables/Data

Table 11: Number and rate of health professionals employed in selected OECD countries in 2000 and 2005

	Australia		New Zealand		Canada		USA		UK	
Occupation/year	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
General practitioners^(b)										
2000	26,202	1.4	3166	0.8	30,636	1.0	262,922	0.9	37,236	0.6
2005	29,221	1.4	3013 ^(c)	0.7 ^(c)	33,508	1.0	287,706	1.0	42,566	0.7
Medical specialists										
2000	21,170	1.1	2653	0.7	33,818	1.1	384,508	1.4	77,922	1.3
2005	26,863	1.3	2946 ^(c)	0.7 ^(c)	36,111	1.1	415,796	1.5	102,074	1.7
Dentists										
2000	8991	0.5	1591	0.4	17,314	0.6	168,000	0.6	25,234	0.4
2005	10,069	0.5	1662 ^(d)	0.4 ^(d)	18,688	0.6	na	na	28,463	0.5
Nurses										
2000	200,910	10.5	36,796	9.6	310,887	10.1	2,249,440	8.0	495,000	8.4
2005	222,974	10.9	38,484 ^(c)	9.5 ^(c)	321,585	10.0	na	na	546,717	9.1

(a) Number of workers per 1000 population

(b) Figures for general practitioners for Australia include 6632 hospital non-specialists to be consistent with the OECD definition

(c) 2004 figures

(d) 2003 figures

Source: OECD 2007; 2005 data for Australia are from AIHW Medical and Nursing and Midwifery Labour Force Surveys 2005, AIHW DSRU Dental Labour Force 2005

Table 12: Rate of practising nurses, dentists and pharmacists in selected OECD countries in 2003

OECD country	Practising nurses ^(a)	Practising dentists ^(a)	Practising pharmacists ^(a)
Australia	10.2	0.5	0.8
Canada	9.8	0.6	0.7
France	7.3	0.7	1.2
Germany	9.7	0.8	0.6
Ireland	14.8	0.5	0.8
New Zealand	9.1	0.4	0.8
United Kingdom	9.7	0.5	0.6 ^(c)
United States	7.9 ^(b)	0.6	0.7 ^(c)
OECD average	8.2	0.6	0.7

(a) Number of workers per 1000 population

(b) Data is for 2002

(c) Data is for 2000

Note: These figures are head counts, not FTEs

Source: OECD 2005

Table 13: Number and rate of selected health populations

Health occupation	1986	1996	2006
Generalist medical practitioners			
Total number	23,715	29,061	35,452
Rate per 100,000 persons ^(b)	152.6	163.7	178.6
in capital cities	181.8	191.2	207.1
in remainder of Australia	103.0	117.3	128.5
Specialists			
Total number	8973	14,950	18,259
Rate per 100,000 persons ^(b)	57.7	84.2	92.0
in capital cities	73.3	105.8	116.1
in remainder of Australia	31.3	47.7	49.4
Dental practitioners			
Total number	6294	7600	9071
Rate per 100,000 persons ^(b)	40.5	42.8	45.7
in capital cities	47.0	50.5	55.4
in remainder of Australia	29.4	29.7	28.5
Nurses			
Total number	173,102	186,166	219,788
Rate per 100,000 persons ^(b)	1113.7	1048.7	1106.9
in capital cities	1153.1	1062.8	1091.9
in remainder of Australia	1047.0	1024.8	1133.4

(a) Number of workers per 100,000 population

(b) Rates calculated using 2006 Census usual resident count

Source: ABS 2006 Census of Population and Housing

Table 14: Persons employed in the health services industry as a proportion of persons employed, and labour force

Year	Employed in health services industry ^{(a)(b)}	All employed persons ('000)	Proportion of all employed persons (%)	Civilian labour force ^(c) ('000)	Proportion of civilian labour force ^(c) (%)
1986	483,900	6,928,900	7.0	7,512,100	6.4
1991	569,100	7,650,300	7.4	8,424,100	6.8
1996	579,100	8,332,800	6.9	9,070,300	6.4
2001	655,000	9,040,000	7.2	9,683,000	6.8
2006 ^(d)	743,800	10,168,000	7.3	10,647,600	7.0
2001 to 2006 increase (%)	13.6	12.5	-	10.0	-

(a) Because of a definitional change in "employed" and "unemployed" persons, there is a break in the series for data at the detailed industry level after 1996. Some care should therefore be taken in comparing numbers of employed people within the health industry over time

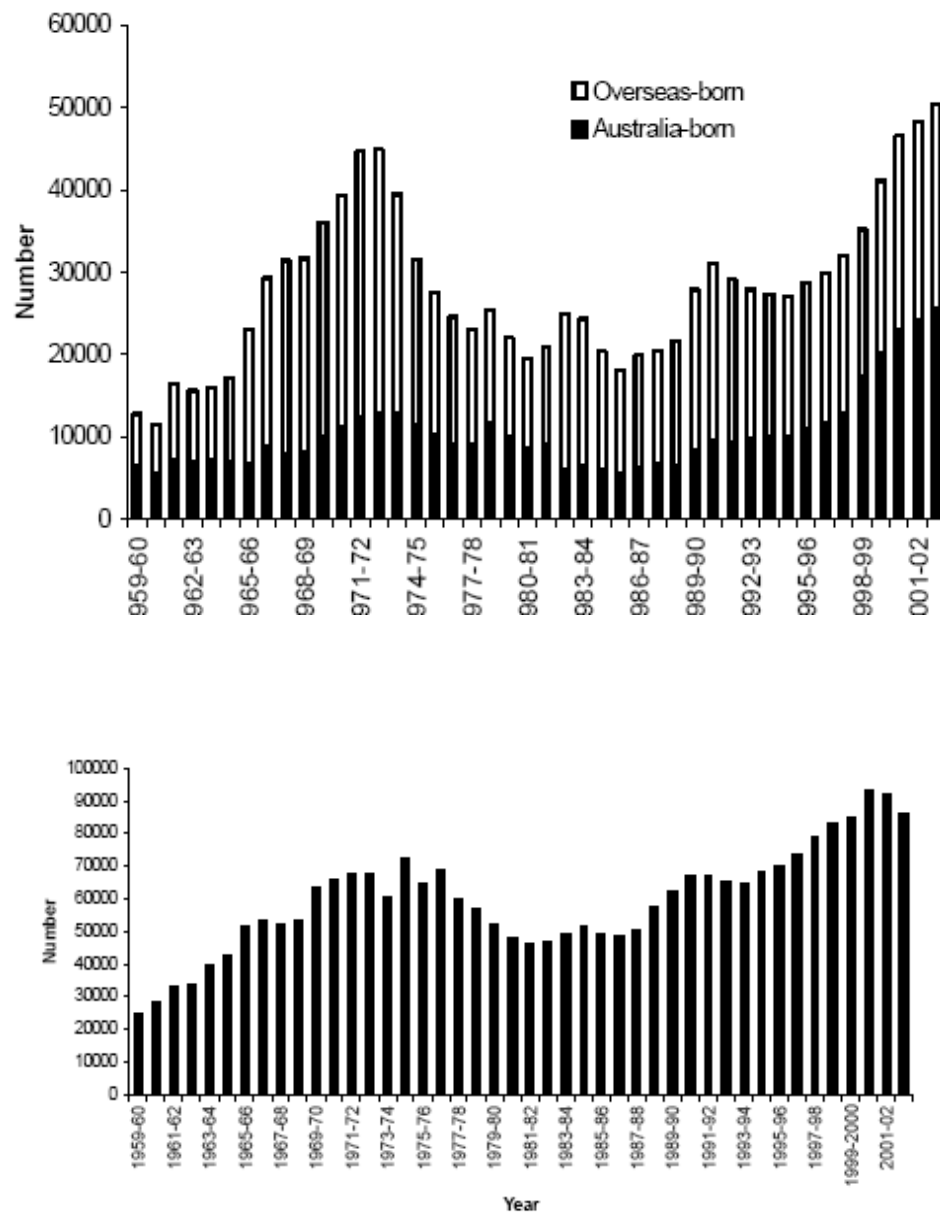
(b) Excludes persons employed in veterinary services

(c) Includes unemployed persons looking for work. Civilian labour force excludes members of the permanent defence forces, certain diplomatic personnel of overseas governments customarily excluded from Census and estimated population counts, overseas residents in Australia, and members of non-Australian defence forces (and their dependants) stationed in Australia

(d) Numbers in this Table are for August quarter 2006, whereas estimates in Table 6 are based on an average of all quarters in 2006

Source: Unpublished data from ABS Labour Force Surveys 1986. 1991. 1996. 2001. 2006

Figure 12: Australian resident long-term departures from Australia, 1959-60 to 2002-03



Source: DIMIA, *Australian Immigration: Consolidated Statistics and Immigration Update*, various issues; DIMIA unpublished data

Annex 5: AHPRA fact Sheet: Registration Types

Source: AHPRA ,www.ahpra.gov.au

General registration

This type of registration may be granted to practitioners who meet the eligibility and qualifications requirements set out in sections 52 and 53 of the National Law, and who meet any registration standards issued by the Board. In general, practitioners who hold general registration have graduated from a Board approved, accredited program of study in the profession and completed any required period of supervised practice or internship.

Specialist registration

This type of registration may be granted to practitioners who meet the eligibility and qualifications requirements set out in sections 57 and 58 of the National Law, and who meet any registration standards issued by the Board. The Ministerial Council has approved the 'recognised specialties' for which specialist registration may be granted under the National Law. It has also approved the specialist titles for each recognised specialty.

From

from www.ahpra.gov.au

- Dentistry (13 recognised specialties: Dento-maxillofacial radiology,
- Endodontics, Oral and maxillofacial surgery, Oral medicine, Oral
- pathology, Oral surgery, Orthodontics, Paediatric dentistry, Periodontics,
- Prosthodontics, Public health dentistry (Community dentistry), Special
- needs dentistry, Forensic odontology)
- Medicine (23 recognised specialties)
- Podiatry (1 recognised specialty: Podiatric surgery)

Some practitioners may be eligible for - and may hold - both general registration and specialist registration at the same time. Others, for example, people who qualified overseas and do not hold an approved undergraduate or entry level qualification, may hold specialist registration but may be limited to practising only in their specialty.

Limited registration

This type of registration may be granted to practitioners who do not qualify for general or specialist registration, but who meet the eligibility and qualifications requirements set out in sections 65-70 of the National Law and any registration standards issued by the Board. Under section 72 of the National Law, limited registration may not be renewed more than three times, but a new application may be made.

There are four sub-types of limited registration:

1. Limited registration for postgraduate training or supervised practice This type of registration may be granted to practitioners who hold qualifications in the profession, but who are required by the Board to practise under supervision or to sit an examination or assessment, to qualify for general or specialist registration.

2. Limited registration for area of need This type of registration may be granted to overseas trained practitioners who do not qualify for general or specialist registration but who have skills and qualifications considered sufficient to work under supervision in a particular role or position in a geographic location or specific health service. Under section 67 of the National Law, it is the responsible Minister (or delegate) in a State or Territory who decides whether an area of need exists. An area of need is when there are insufficient health practitioners to meet the needs of people living in the area.

3. Limited registration for teaching or research this type of registration may be granted to practitioners who are not qualified for or do not intend to engage in clinical practice, but are qualified to fill a teaching or research position in the profession.

4. Limited registration in the public interest this type of registration may be granted to practitioners who do not qualify for general or specialist registration, but who hold qualifications in the profession and who may be visiting from overseas for a short period, filling a locum position or exchanging practice with a local practitioner. The Board must be satisfied that it is in the public interest for the practitioner to practise the profession given the practitioner's qualifications and experience.

Provisional registration

This type of registration may be granted to a practitioner who meets the eligibility and qualifications requirements set out in sections 62 and 63 of the National Law, and any registration standards issued by the Board.

This type of registration is intended for practitioners in a profession who have completed a Board approved, accredited qualification in the profession, but are required to undertake a period of supervised practice or internship to be eligible for general registration.

Under the National Scheme only three professions have internship requirements for general registration: medicine, pharmacy and psychology.

Non-practising registration

This type of registration may be granted to a practitioner who meets the eligibility and qualification requirements set out in sections 62 and 63 of the National Law, and any registration standard issued by the Board. This type of registration is available to practitioners who have previously held general or specialist registration in a profession, but who do not wish to practise the profession during the registration period. The National Law states that a practitioner who holds non-practising registration in a profession must not practise the profession. To 'practise the profession' has been defined by National Boards as:

Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

Student registration

This type of registration is granted to people who are enrolled in an approved program of study that qualifies them for general registration in a profession, or people undertaking clinical training that has been arranged by an education provider, with the exception of psychology students who are enrolled in an Australian Psychology Accreditation Council (APAC) accredited higher degree. These psychology students are required to be registered as a provisional psychologist from the commencement of their enrolment. They will need to apply for provisional registration if they are not registered in their State or Territory on 30 June 2010.

Students enrolled in approved programs of study do not need to make an application for registration. After they have enrolled in the program of study, their education provider is required to provide the relevant National Board with list of enrolled students. On receiving this list, the National Board will register the students. A student's registration ends when they have completed their program of study, or when the student ceases to be enrolled in the program of study.

The Board's power in relation to registered students are limited to students who:

1. may be suffering from an impairment

2. have been charged with or found guilty of an offence punishable by 12 months imprisonment or more or

3. have breached a condition of their registration.

Students who are not already registered with a State or Territory Board will not be registered in the national scheme until March 2011.

Annex 6: Survey results: Summary of reasons for moving to Australia

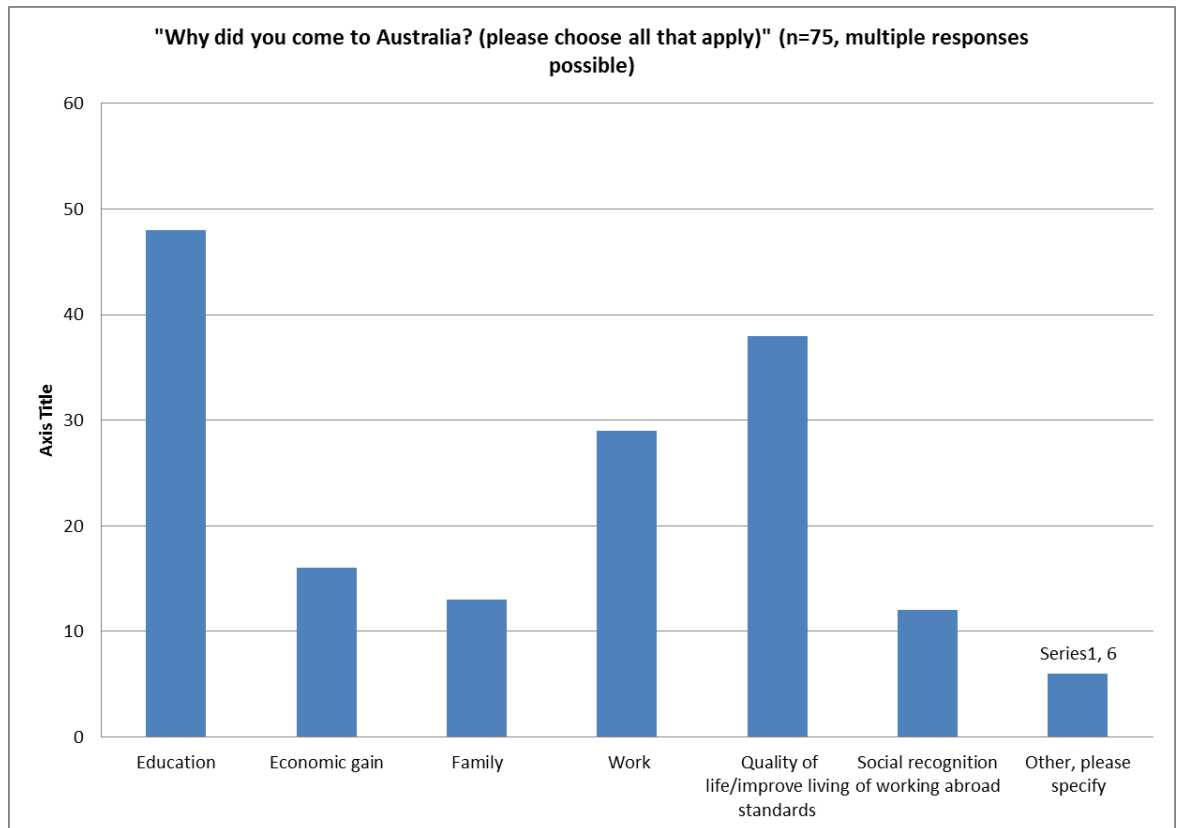


Figure 13: Survey results: Reasons for coming to Australia

Annex 7: Interview results: Summary of Push/Pull, Stick/Stay factors

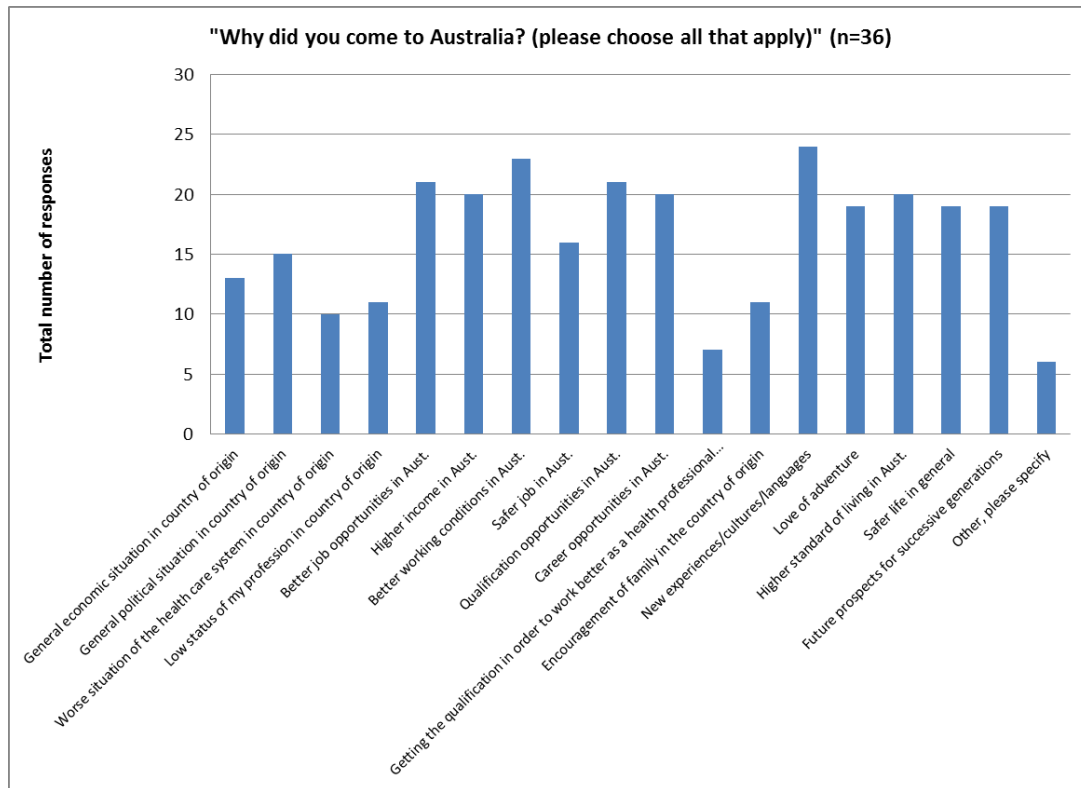


Figure 14: Micro Interviews: Reasons for coming to Australia

Annex 8: Points test for certain skilled migration visas

1 July 2011 - Points Test for Certain Skilled Migration Visas

The points test is a mechanism used to help select skilled migrants who offer the best in terms of economic benefit to Australia. The points test creates a selection process that is transparent and objective, awarding points to the skills and attributes considered to be in need in Australia. The 1 July 2011 points test is designed to select the best and brightest skilled migrants who will make the optimum economic contribution to Australia. It does not give undue weight to any one factor and recognises a broader range of skills and attributes, focussing on:

- better English levels
- more extensive skilled employment
- higher level qualifications obtained in Australia and overseas
- better targeted age ranges

Points will no longer be awarded for specific occupations, although all applicants must still nominate an occupation on the Skilled Occupation List (SOL) and have their skills assessed in their nominated occupation.

The pass mark is the total amount of points needed to be eligible for grant of a visa and will be set at 65 points. A table summarising the points awarded can be found at the end of this fact sheet. The points test only applies to applicants for the following visas:

- Subclass 475 Skilled – Regional Sponsored
- Subclass 487 Skilled – Regional Sponsored
- Subclass 175 Skilled Independent
- Subclass 885 Skilled Independent
- Subclass 176 Skilled Sponsored
- Subclass 886 Skilled Sponsored

Information about eligibility requirements

To apply for one of the above visas, applicants need to satisfy the following threshold requirements:

- be under 50 years of age at the time of applying for a visa.
- meet the threshold English language requirement of competent English.
- nominate and hold a skilled assessment for an occupation on the Skilled Occupation List at the time of lodging their application.
- provide evidence of recent skilled employment in a skilled occupation or have recently completed the Australian Study requirement.

Applicants eligible for 8 February 2010 transitional arrangements

Transitional arrangements apply for certain students and former student visa holders announced on 8 February 2010.

They may also be eligible for points for an occupation on the former Migration Occupation in Demand List (MODL).

See: www.immi.gov.au/skilled/general-skilled-migration/pdf/points-test-transitional.pdf