

# Health Workforce Migration – Australia

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FINAL EDIT 11 October 2011

## The Policy Context - Skilled Migration to Australia

The scale of skilled migration to Australia has grown rapidly in recent years, typically constituting 60 percent of permanent intakes<sup>1</sup>. Between 2004-05 and 2008-09, 358,151 permanent arrivals were selected through the General Skilled Migration (GSM) category, including 115,000 people in 2008-09. Few were derived from the major English speaking background (ESB) countries, defined as the UK, Ireland, the USA, Canada, South Africa and New Zealand. Eight of Australia's top 10 GSM source countries at this time were in Asia – in rank order India (21%), China (18%), UK (14%), Malaysia (6%), Indonesia (4%), Sri Lanka (3%), Republic of Korea (3%), South Africa (3%), Hong Kong SAR (3%) and Singapore (3%). In 2009-10 Australia's permanent migration target was set at 182,450 people. Fifty-nine percent of places were allocated to skilled intakes (108,100), 33 percent to the family category (60,300) and 8 percent to humanitarian entrants (13,750), with health-qualified migrants entering through all three. In 2010-11 a further 113,850 skilled migrants were recruited. (See Table 1)

*Table 1: Permanent Immigration Intakes to Australia by Major Category*

Program Numbers by Stream	1996-97	1998-99	2001-02	2006-07	2007-08	2008-09	2009-10	2010-11
Family	44,580	32,040	38,090	50,080	49,870	56,500	60,300	54,550
Skilled	27,550	35,000	53,520	97,920	108,500	115,000	108,100	113,850
Special Eligibility	1,730	890	1,480	200	220	300	300	300
Humanitarian	11,900	11,356	12,349	13,017	13,000	13,500	13,750	TBA

*Source:* Adapted by L Hawthorne from data in Department of Immigration and Citizenship, "Reform of Australia's skilled Migration Program and Key Inflows: We've Checked Our Policy Settings – Now What?", May-June 2010, Canberra.

In the coming decade, skilled migration is set to remain a national priority for Australia, with strong relevance to the health professions. Long-term workforce demand will be met through dramatically expanded domestic training (most notably with 40 percent of the youth cohort becoming bachelor degree qualified)<sup>2</sup>. Medium-term demand will be satisfied through General Skilled Migration. Short-term demand will be addressed through employer and state/ territory sponsored labour migration programs - most notably the uncapped 457 business visa which allows temporary foreign workers employment for up to 4 years. According to the Department of Immigration and Citizenship, Australia's policy is currently

<sup>1</sup> This paper is based on the following studies: *Competing for Skills – Migration Policy Trends in New Zealand and Australia Full Report*, L Hawthorne (2011), Department of Labour, Government of New Zealand, Wellington; and *Australia-Canada Round Table on Foreign Qualification Recognition – Australia Backgrounder and Annex*, L Hawthorne (2011), Public Policy Forum, Ottawa.

driven by the ‘three P’s - Population – the number of people in the economy. Participation – the average number of hours these people work. Productivity – the average output produced by these people for every hour worked.’ Immigration is deemed to contribute to all three by ‘increasing the working age population by bringing more people into Australia aged 15 to 64 years; raising workforce participation by bringing in people who have a higher propensity to work and are concentrated in the prime working ages of 25 to 44 years; and improving productivity by having a strong emphasis on permanent and temporary skilled migration’.<sup>3</sup> In terms of health, the aim is domestic self-sufficiency by 2025, based on rapidly expanding local student intakes.

## Health Workforce Migration – Recent Sources

Migrant health professionals to Australia are currently derived from six major sources, with five of these overseas-trained<sup>2</sup>. From 2005-06 to 2009-10 34,870 were sponsored as temporary 457 visa migrants, by definition recruited to pre-arranged jobs. The fields of nursing (15,960) and medicine (15,490) predominated. From 2004-05 to 2009-10 15,940 General Skilled Migrants with health qualifications also arrived, primarily qualified in nursing (8,250), medicine (2,330) and pharmacy (2,080). Source countries for both categories were highly diverse. (See Table 2.) Substantial numbers of health professionals also arrived from New Zealand, enjoying free entry rights under the Trans-Tasman Agreement, in a context where 12% of the New Zealand population is currently resident in Australia. Overall these three sources of migrant health professionals are associated with strong and early employment outcomes. Many have early remuneration rates approaching or matching Australian norms.

**Table 2: Top 10 Recent Source Countries for Permanent Compared to Temporary Migrant Health Professionals**

<b>Top 10 Permanent Source Countries: General Skilled Migration PA’s 2005-06 to 2009-10 (Total All Sources =13,880)</b>	<b>Top 10 Temporary Source Countries: 457 Long-Stay Business Visa PA’s 2005-06 to 2009-10 (Total All Sources =34,870)</b>
1. UK: 4,120	1. UK: 9,350
2. India: 1,510	2. India: 6,420
3. Malaysia: 1,300	3. Philippines: 1,850
4. China: 970	4. South Africa: 1,770
5. Philippines: 510	5. Malaysia: 1,570
6. South Africa: 500	6. Ireland: 1,560
7. Republic of Korea: 480	7. China: 1,380
8. Egypt: 420	8. Zimbabwe: 1,180
9. Singapore: 390	9. Canada: 950
10. Ireland: 350	10. United States: 830

*Source:* Analysis by L Hawthorne of unpublished 2005-06 to 2009-10 arrivals data provided by the Department of Immigration and Citizenship (May 2011).

Thousands of additional health professionals however arrive as the dependents of labour migrants, or through Australia’s family and humanitarian categories. Such migrants are unscreened in advance for human capital attributes, including English ability and credential recognition. Large numbers face

<sup>2</sup> Please note that very substantial additional numbers of health professionals arrived in Australia as children. First generation migrants (particularly the Asia-born) are disproportionately represented in elite fields such as medicine and dentistry, reflecting their high educational achievement. They are not considered here, given they face no employment barriers.

extended occupational displacement, as illustrated below, with significant dependence on English and pre-registration bridging programs. Until recently limited data existed on health workforce migration<sup>4</sup>. This situation is currently being addressed by Health Workforce Australia<sup>5</sup>.

## Medical Migration to Australia

In the recent decade, as affirmed by the OECD, Australia has developed an extraordinary dependence on international medical graduates (IMG's)<sup>6</sup>. By 2006 45 per cent of residents with medical qualifications were overseas-born, with an estimated 25 per cent overseas-qualified. Between 2001 and 2006, 7,596 doctors migrated across all immigration categories (double the number accepted from 1996-2000). The UK/Ireland, Other Sub-Saharan Africa, China, India, North Africa/ Middle East, Sri Lanka/ Bangladesh, South Africa and the Philippines dominated, across all immigration categories. According to the Australian Institute of Health and Welfare, by 2009 24.5 percent of Australia's 72,739 medically employed workforce was overseas-trained, including 6 percent of doctors from the UK/Ireland, 3 percent from New Zealand, and 16.4 percent (or 11,948) from 'other countries'<sup>7</sup>. This diversification of supply has proven challenging however. (See Table 3.)

**Table 3: Labour Market Outcomes for Degree-Qualified Australia/ New Zealand-born Medical Graduates, Compared to Migrant Medical Graduates Arriving 2001-2006 (2006 Census)**

Arrival Date	Birth Country	Employed				Other		Percentage (b)	Number
		Own Prof	Other Prof	Other Work	Sub-Total	Unemp	NLF		
	Australia/New Zealand	58.4	29.3	0.0	87.7	0.7	11.6	100.0	39,381
Arrived 2001-2006	UK/Eire (Ireland)	70.7	14.4		85.2		14.8	100.0	1004
	Northern Europe	51.3	17.9		69.2		30.8	100.0	39
	Western Europe	61.6	19.8		81.4	1.8	16.8	100.0	328
	South Eastern Europe	49.2	23.5		72.7	2.3	25.0	100.0	132
	Eastern Europe	30.6	25.6		56.3	5.6	38.1	100.0	160
	Viet Nam	23.4	25.0		48.4	4.7	46.9	100.0	64
	Indonesia	8.2	16.4		24.7	16.4	58.9	100.0	73
	Malaysia	62.1	5.3		67.4	2.6	30.0	100.0	227
	Philippines	49.6	27.0		76.6	4.7	18.8	100.0	256
	Singapore	63.1	13.8		76.9		23.1	100.0	65
	China (Not SARs/Taiwan)	5.6	47.3		52.9	10.8	36.3	100.0	590
	Hong Kong/Macau	39.5	39.5		78.9		21.1	100.0	38
	Japan/South Korea	13.7	28.4		42.2	9.8	48.0	100.0	102
	Other Southern and Central Asia	43.1	9.9		53.0	7.4	39.6	100.0	364
	India	61.2	12.2		73.4	7.2	19.4	100.0	1378
	Sri Lanka/Bangladesh	55.7	15.5		71.2	7.4	21.4	100.0	691
	Canada/USA	47.8	17.4		65.2	1.5	33.3	100.0	201
	Central/South America	40.2	29.9		70.1	12.8	17.1	100.0	117
	Other Sub-Sahara Africa	71.3	5.8		77.2	7.0	15.8	100.0	342
	South Africa	74.8	18.3		93.1	1.4	5.4	100.0	496
	North Africa/Middle East	46.6	13.1		59.8	9.8	30.5	100.0	564
	Other	55.6	19.7		75.3	2.5	22.2	100.0	365
	<b>Total migrants</b>	<b>53.3</b>	<b>18.0</b>		<b>71.3</b>	<b>5.5</b>	<b>23.2</b>	<b>100.0</b>	<b>7596</b>

**Notes:**

Excludes those for whom birthplace or year of arrival is unknown.

a = Many of the cells are based on very small numbers, therefore the results should be regarded as indicative only. Empty cells are where there are insufficient cases for reliable reporting and issues of confidentiality. E.g. there were just 14 degree-qua

b = Due to missing data, imputation and aggregation, numbers may not add up to 100%.

Source: *Migration and Education: Quality Assurance and Mutual Recognition of Qualifications – Australia Report*, L Hawthorne, UNESCO, <http://unesdoc.unesco.org/images/0017/001798/179842E.pdf>, Paris, 2008, Table 23

As demonstrated by analysis of the 2006 Census, 53 percent of IMG's secure medical employment in Australia in their first 5 years. Doctors from English-speaking background (ESB) countries move

seamlessly into medical employment, while Commonwealth-Asian doctors do fairly well. Outcomes are poor by contrast for a range of birthplace groups - for instance just 6% of doctors from China medically employed within 5 years, 23% from Vietnam and 31% from Eastern Europe. Many such doctors reach Australia within the Family and Humanitarian categories – untested in advance for their employment attributes and registerability<sup>8</sup>. Large numbers of migrant doctors are defined as ‘not in the labourforce’ (NLF) in their first 5 years – a proxy for learning English and/or trying to pass pre-registration exams. A forthcoming report, commissioned by Health Workforce Australia, details for example the devastating impact of English language testing in Australia, based on analysis of 2004-2010 data<sup>9</sup>.

Outcomes are significantly better for IMG’s selected through the General Skilled Migration program, or via temporary sponsored pathways<sup>10</sup>. Temporary flows (as demonstrated) are particularly strong - highly attractive to State/ Territory governments and employers given the potential to prescribe IMGs’ location as a condition of visa entry (eg to work in undersupplied regions). Between June 2000 and December 2002, 5,304 temporary IMG’s were allocated to ‘areas of need’, often sponsored to remote locations in the states of Queensland (2,049), Western Australia (1,204) and Victoria (1,176). This level of dependence has been maintained - in 2007-08 the source of 3,860 IMG’s selected by States/ Territories compared to 3,310 in 2008-09. Migrant doctors accepting ‘area of need’ positions work under supervision for up to 4 years (typically with various forms of conditional registration)<sup>11</sup>. This practice has become widespread in the past decade, despite growing concerns for the risk of developing what is termed ‘two-tier’ medical care<sup>12</sup>.

State competition to recruit and retain medical migrants has intensified. Australia secures essential workforce supply by this means. However there is significant debate on the conditional registration scheme, which allows thousands of IMG’s to practise on a supervised practice basis. Many require substantial occupational bridging – the challenge of delivering this exacerbated by remote location. Analysis of 28 years of examination data on IMG’s shows significant differences in pass rates by region of origin<sup>13</sup>. The highest cumulative Multiple Choice Question pass rates are achieved by doctors trained in the UK/Ireland (95 percent), South Africa (86 percent) and North America (86% percent), and the lowest for Other Americas (67 percent), East Europe (70 percent), and non-Commonwealth countries in South East Asia (70 percent).

Native English ability and training in directly comparable medical systems are highly advantageous. Candidates’ recency of training and age also exert a significant impact on results. While overall pass rates are high for the AMC multiple choice question and clinical exams (around 81 percent of candidates passing the multiple choice question test on first or subsequent attempts and 86 percent passing the clinical exam), substantial numbers of international medical candidates never complete Australia’s registration process – often because they have secured work at reasonable remuneration. The most detailed study of IMG’s to date, commissioned by the Department of Health and Ageing, demonstrated just a third of recently arrived medical graduates had attempted to pass the Australian Medical Council’s (AMC) pre-accreditation exams in the past decade. Of those commencing the process, 78 percent of IMG’s were found to be medically employed within 5 years, despite just 41 percent by that time having secured full registration<sup>14</sup>.

Between January 2008 and March 2009 4,939 IMG’s sat for the MCQ exam, the top 10 birthplace groups at this time being India (1,068), Sri Lanka (457), Pakistan (447), the Philippines (332), Iran (265), China (256), Bangladesh (216), Myanmar (189), Egypt (150) and South Africa (130)<sup>15</sup>. Many (as demonstrated by Table 4) were unlikely to secure full registration<sup>16</sup>. In the context of mounting concern the Australian government initiated in 2008 ‘a national assessment process for overseas qualified doctors to ensure appropriate standards in qualifications and training as well as increase the efficiency of the assessment process’<sup>17</sup>. Multiple pathways to practice have since been developed, including a fast-track ‘competent authority’ option for doctors qualified in New Zealand, the UK, Ireland, the USA and Canada. Eligible

source countries can opt out – Singapore and South Africa, for instance, choosing to do so in an attempt to minimise workforce loss<sup>18</sup>. For IMG’s requiring greater periods of adjustment, alternative pathways have been designed to provide enhanced supervision, address differential levels of training need, and increase readiness for specific locations of practice (eg remote practice and/or solo sites). From 2004-10 11,612 IMG specialist assessment applications were also received by the AMC. The majority were from males (69% of the total), with the top 5 specialist countries of training the UK, India, South Africa, the USA and Germany.

In March 2008 the Council of Australian Governments (COAG) also signed an Intergovernmental Agreement on the health workforce, to establish for the first time a single national registration and accreditation system for the ten key health professions (including doctors, nurses and dentists). Established in July 2010, a key aim of the Australian Health Practitioner Registration Agency (AHPRA) is to ensure ‘that a professional who has been banned from practising in one place is unable to practise elsewhere in Australia’<sup>19</sup>.

**Table 4: Australian Medical Council MCQ and Clinical Examination Outcomes by Select Country of Training (1 January 1978 to 31 December 2010)**

Select Country of Training	Total MCQ Candidates	Total MCQ Passes	Total Clinical Candidates	Total Clinical Passes	Candidate Total
India	6241	3183	2870	1600	9111
Sri Lanka	2169	1517	1220	708	3389
Egypt	1990	825	1230	541	3220
Pakistan	2316	1103	742	414	3058
Philippines	2056	639	689	260	2745
Bangladesh	1614	862	941	470	2555
China	1587	781	843	547	2430
Iran	1204	726	484	314	1688
UK/ Ireland	992	791	650	368	1642
Iraq	895	586	623	371	1518
South Africa	924	683	564	444	1488
Myanmar	998	602	446	231	1444
Germany	531	325	296	186	827
Nigeria	504	214	117	70	621

*Source:* Derived from examination data provided in select tables in Australian Medical Council (2011), *Submission to the House of Representatives Standing committee on Health and Ageing Inquiry into Registration Processes and Support for Overseas Trained Doctors*, Australian Medical Council, Canberra, 4 February.

## Nurse Migration to Australia

Recent decades have also coincided with the rapid globalisation of the nursing profession. Within Australia there has been rising dependence on internationally educated nurses (IEN’s), to compensate for chronic nurse shortages due to the continued exodus of Australian nurses overseas and to emerging opportunities in other professions. Between 1983-84 and 1994-95 30,544 IEN’s entered Australia on either a permanent or temporary basis, counter-balancing the departure overseas of 23,613 nurses who were locally trained and 6,519 migrant nurses (yielding a net gain of just 412 nurses in all). The period 1995/6 to 1999/2000 saw an additional 11,757 permanent or long-term IEN arrivals, with nursing a constant priority field in Australia’s skilled migration program. This pattern of reliance on IEN’s is a

phenomenon simultaneously occurring in New Zealand, the UK, the US, Canada and the Middle East – the globalisation of nursing reflecting growing OECD demand, in addition to the agency and participation of women in skilled migration (their desire for improved quality of life, enhanced professional opportunity and remuneration, and adventure)<sup>20</sup>.

From 2001-06 6,680 degree-qualified nurses migrated to Australia, compared to 3,100 from 1996-2001 (across all immigration categories). By 2006 24% of all nurses in Australia were overseas-born. Sixty-three per cent secured employment within their profession within 5 years (strong outcomes in global terms, for example compared to Canada). Numbers have grown rapidly since, in the context of sustained national shortages. From 2004-05 to 2008-09 6,400 nurses reached Australia as GSM PA's, rising to 7,676 once partners are counted. Substantial additional numbers arrived in the Family and Refugee categories. These permanent flows are dwarfed however by the scale of 457 visa temporary employer-sponsored arrivals, in a context where 'health and community services' has emerged as the top sponsored industry sector. In 2007-08 3,270 temporary registered nurses were selected, rising to 3,850 in 2008-09. Overall 14,950 registered nurses were sponsored to Australia from 2004-05 to 2008-09, in addition to registered mental health nurses and midwives. Many such nurses went to highly dispersed sites: primary states of sponsorship in 2008-09 being Victoria (1010), Queensland (780) and Western Australia (750). As with medicine, migrant nurses secured highly variable outcomes in the first 5 years, as demonstrated by Table 5 for 2001-06 arrivals.

**Table 5: Employment Status of Australia/New Zealand Degree-Qualified Nurses, Compared to Overseas-Born Nurse Arrivals 2001-2006 (2006 Census)**

Arrival Date	Birth Country	Employed				Other		Percentage (b)	Number
		Own Prof	Other Prof	Other Work	Sub-Total	Unemp	NLF		
	Australia/New Zealand	62.4	2.0	14.5	78.9	0.7	20.4	100.0	121,704
Arrived 2001-2006	UK/Eire (Ireland)	76.1	1.7	7.2	85.1	1.3	13.6	100.0	2081
	Northern Europe	64.7		2.6	67.2		32.8	100.0	116
	Western Europe	54.1	1.6	16.8	72.4		27.6	100.0	185
	South Eastern Europe	46.7		20.0	66.7		33.3	100.0	45
	Eastern Europe	44.4	9.5	4.8	58.7	4.8	36.5	100.0	63
	Viet Nam	25.0		50.0	75.0		25.0	100.0	12
	Indonesia	24.2		27.4	51.6	10.5	37.9	100.0	124
	Malaysia	64.4		11.9	76.2	5.9	17.8	100.0	101
	Philippines	57.6	0.3	19.0	76.9	2.3	20.8	100.0	1009
	Singapore	86.4			86.4	4.5	9.1	100.0	132
	China (Not SARs/Taiwan)	53.4		15.2	68.5	4.8	26.7	100.0	356
	Hong Kong/Macau	59.3		3.5	62.8	10.5	26.7	100.0	86
	Japan/South Korea	41.5		14.4	55.9	2.9	41.3	100.0	383
	Other Southern and Central Asia	58.8		5.9	64.7	5.9	29.4	100.0	51
	India	72.1		9.0	81.1	2.0	16.9	100.0	455
	Sri Lanka/Bangladesh	63.2		21.1	84.2		15.8	100.0	38
	Canada/USA	57.4	1.2	6.6	65.3		34.7	100.0	242
	Central/South America	30.8		30.8	61.5		38.5	100.0	39
	Other Sub-Sahara Africa	67.8		12.2	80.0	0.9	19.1	100.0	335
	South Africa	79.1		6.4	85.5	0.9	13.6	100.0	330
	North Africa/Middle East	32.6		7.0	39.5	5.2	55.2	100.0	172
	Other	44.9		12.3	57.2	4.0	38.8	100.0	325
	Total migrants	63.2	0.8	11.2	75.2	2.3	22.5	100.0	6680

**Notes:**

Excludes those for whom birthplace or year of arrival is unknown.

a = Many of the cells are based on very small numbers, therefore the results should be regarded as indicative only. Empty cells are where there are insufficient cases for reliable reporting and issues of confidentiality. E.g. there were just 12 degree-qua

b = Due to missing data, imputation and aggregation, numbers may not add up to 100%.

Source: *Migration and Education: Quality Assurance and Mutual Recognition of Qualifications – Australia Report*, L Hawthorne, UNESCO, <http://unesdoc.unesco.org/images/0017/001798/179842E.pdf>, Paris, 2008, Table 24.

To assess registered nurse qualifications, State and Territory Boards collectively formed and control the Australian Nursing and Midwifery Council (ANMC, now ANMAC), which assesses pre-migration

principal applicants on a fee for service basis. Between 2007 and 2010 ANMAC received 11,051 applications from nurse primary applicants seeking a skilled migration assessment. The principal source countries at this time were India (2,437), the UK (2,358), China (1,316), the Philippines (957) and Zimbabwe (471). As in Australia, migrant nurses were a highly feminised group (85 percent of applicants). Substantial numbers from 2007-10 were deemed suitable for migration purposes (10,029). However just 16 percent secured full recognition while 75 percent were given modified approval (with pre-accreditation assessment/ training required on arrival in Australia). The remainder (9 percent) were deemed unsuitable or pending<sup>21</sup>.

This scale of migration has resulted in a dramatic diversification of Australia's nursing workforce. The major Australian study of migrant nurses to date demonstrated while ESB nurses pass seamlessly into employment, nurses from non-English speaking backgrounds (NESB) are obliged to address three major hurdles. Firstly, mandatory English language testing bars up to 67 percent of NESB nurse principal applicants from eligibility for GSM migration, and 41 percent of those reaching Australia from proceeding to pre-registration courses. Secondly, pre-migration qualification screening in the 1990s resulted in immediate recognition for 97 percent of ESB nurses compared to a mere 29 percent of NESB nurses. Thirdly, while the introduction of competency-based assessment courses represented a very significant Australian qualifications recognition reform from 1989 (producing 90-95 percent pass rates in Victoria and 55-71 percent rates in NSW), funding for these courses has been unstable and inadequate, with courses restricted to IEN's resident in Australia. Finally, while both ESB and NESB nurses secure professional employment once registration has been gained, significant and persistent labour market segmentation is evident for many NESB nurses, with East European and non-Commonwealth Asian nurses disproportionately concentrated in the geriatric care sector (in the 1990s found to be at 840 percent greater risk of this than ESB nurses).

By 2007 the International Section of the ANMC was actively engaged in bilateral/ multilateral agreement negotiations with Japan, ASEAN, China, Malaysia, Chile and the Gulf Cooperation Council on Free Trade Agreements, of potential relevance to future recognition of foreign nursing qualification.

## **Migration in Other Allied Health Fields**

Dentistry also features on Australia's Skilled Occupation List, along with virtually every major health profession. Despite the scale of intakes being small, the significance of dental migration is rapidly growing. From 2004-05 to 2008-09, 512 GSM PA's were admitted, including 151 in 2008-09 (two-thirds selected offshore). The scale of arrivals has tripled since 2004-05, when just 62 PA's were selected. A further 590 dentists arrived through the 457 temporary category in these 5 years, including 160 in 2008-09 (compared to 80 five years earlier). By 2006, 52 percent of Australia's dental practitioner workforce was overseas-born, with 22 percent selected from 2001-06 (a major proportional contribution). India was the primary source at this time (320), followed by the UK/ Ireland (125), North Africa/ the Middle East (128), the Philippines (88) and Central/ South America (78).

Dental science courses are accredited by the Australian Dental Council (ADC), which develops national accreditation standards for education and training leading to registration as dental practitioners and specialists (in addition to technologists, therapists and hygienists)<sup>22</sup>. The ADC is also the gazetted authority to assess international dental graduates' (IDG) qualifications pre and post-migration for GSM purposes, in addition to access to full registration on arrival. By 2006, just 37 percent of IDG's secured dental employment in Australia in their first 5 years. Outcomes were poor for a range of birthplace groups - for instance just 5 percent of dentists from Central/ South America securing dental employment, 7 percent from the Philippines, 21 percent from China, and 23 percent from India (a rapidly growing major source)<sup>23</sup>. These outcomes contrasted markedly with those for recent IDG's qualified in South Africa (89

percent employed as professional dentists), Malaysia (84 percent - many who had qualified in Australia), and the UK/ Ireland (82 percent).

Only New Zealand trained dentists to 2010 were accorded automatic recognition, in line with the Trans-Tasman Agreement. In April 2010, the Dental Councils of Canada and Australia also agreed to mutual recognition – subject to Canada’s requirement for Australian graduates to sit the national exam (in line with Canadian graduates). Once their paper-based applications have been assessed, non-recognized IDG’s are required to sit and pass Australia’s Occupational English Test (to assess migrant health professionals’ English competence in speaking, listening, reading and writing tests in 13 fields) and the ADC MCQ and Clinical exams. From 2000 to 2009 1,048 IDG’s were deemed eligible for registration in Australia through the ADC assessment pathway – an extraordinary contribution. Demand for assessment has grown markedly since. For example in 2000 just 105 IDG’s took the Preliminary exam, with a 15% success rate, compared to 608 in 2010 (27 percent passing). Clinical pass rates were higher that year, at 43 percent. Candidates’ diversity, differential training systems, and levels of English represented major challenges, along with the resources available to deliver the requisite Clinical exams in the context of rising dental migration. By 2011 the ADC was assessing candidates from 120 source countries, trained in over 400 dental schools, including multiple schools within a single university (for example in India).

Pharmacy is not a key health workforce migration field to date for Australia, in contrast to Canada. By 2006, there were just 4,962 degree-qualified migrant pharmacists resident – 8 percent of the total pharmacy workforce, including 749 who had arrived in the previous 5 years. Reflecting this, limited public data exist on their employment or registration outcomes. However (as with dentistry) the migration situation is dynamic. From 2004-05 to 2009-10 2,080 pharmacists were admitted as GSM migrants. The challenges they face are comparable to those for other migrant health professionals in Australia; noting fewer bridging options exist given the scale of flows. In 2009-10 the top countries of training for stage 1 Australian Pharmacy Council eligibility assessments were Egypt (38 percent), India (25 percent) the Philippines (10 percent), South Africa (6 percent) and Nigeria and Pakistan (3 percent each). A Competency Assessment of Overseas Pharmacists examination is then administered for eligible overseas trained pharmacists four times a year, in London, Auckland and Australian capital cities. This includes the National Forensics, Ethics and Calculations Examination, which assesses candidates’ capacity to apply their knowledge to an Australian context. The primary source countries for Stage 11 assessment in 2009-10 were Egypt (52 percent), India (17 percent, Zimbabwe (4 percent), Pakistan, South Africa and Nigeria (3 percent each)<sup>24</sup>.

Unlike pharmacists, physiotherapists are currently included on Australia’s Skilled Occupation List. Their numbers however are also very modest to date - just 2,409 degree-qualified overseas-born physiotherapists resident in Australia by 2006, including 469 arrivals the previous 5 years. An additional 394 migrants arrived in this period with diploma qualifications (unlikely to secure registration at the professional level). Australian courses are accredited by the Australian Physiotherapy Council (APC). To secure registration to practice, overseas-trained physiotherapists confront comparable hurdles to other migrant health professionals.

## **Former International Students as a Health Workforce Resource**

Australia has an important further health migration resource – former international students, who have self-funded to meet Australian requirements. By definition former students are characterised by:

- Youth (their average age being 24 years)
- Exemption from English language testing (with IELTS scores of Band 6.5 or 7 required for course commencement)
- Full medical or allied health vocational registration



- Significant acculturation
- Training to Australian professional norms (including completion of regional as well as urban rotations)

In 1999, following Australia’s removal of a three year eligibility bar, international students became immediately able to migrate. Within a year of the policy change, around 50 percent of GSM applicants held local degrees. From 2002 former international students were permitted to apply onshore - ideally placed to secure the requisite points if they possessed a recognised vocation-related degree, were aged between 18 and 29 years, had advanced English language ability (with testing exempted), and an Australian qualification of 2 years in a field in a high priority field (covering virtually all health professions)<sup>25</sup>. In 2010, according to a recent study, 242,711 international students were enrolled in Australian university courses – including 139,902 in Bachelor degrees, 80,935 in Masters degrees, and 13,355 in Doctoral courses (around 8 percent completing health courses). Commencements in medical and allied health programs have continued to rise, from 6,255 in 2008 to 6,993 in 2010, yielding 18,487 total enrolments<sup>26</sup>. As demonstrated by Table 6, these international students constitute a major health workforce resource – by December 2009 including close to 3,000 medical students, and around 10,000 enrolled in entry to practice nursing degrees (numbers rising further since).

**Table 6: Growth in International Student Enrolments in Australian Entry to Practice Medical and Allied Health Degrees (1996-2009)**

Field	1996	2000	2004	2007	2009	% Change 2007-2009	% Change 1996-2009
Dental science	98	124	227	331	387	17%	295%
EP Medicine	963	1117	1505	2304	2772	20%	188%
Nursing (basic)	762	839	1623	4546	6124	35%	704%
Nursing (post-basic)	545	2336	3109	2090	2566	23%	371%
Physiotherapy	79	173	239	370	365	-1%	362%

*Source:* Analysis by L Hawthorne, A Langley, A To & A Song of Department of Education Employment and Workplace Relations unpublished international student enrolment data, major medical and allied health courses (February 2011).

Former international students experience none of the barriers associated with overseas-trained migrants. As demonstrated by annual analysis of Australia’s Graduate Destination Survey (2006 to 2010) they achieve comparable employment and salary outcomes to domestic health professionals within 4 months of graduation. In medicine 98.9 percent were employed full-time in 2010, compared to 99.7% of domestic medical graduates. The rate for dentistry was 93.8 percent. Two-thirds of former international nursing students were also employed in their field full-time, with an additional 20.8 percent working part-time<sup>27</sup>.

Large numbers of former international students wish to migrate – acclimatisation to Australia, access to clinical training positions (in medicine), and perceived opportunity relative to ‘back home’ being major motivators. In terms of medicine, for instance, analysis of the Medical Schools Outcomes Database and Longitudinal Tracking Project suggested 69 percent of recent international medical students were planning to stay, most notably those derived from Brunei Darussalam (89 percent), Singapore (75 percent), Malaysia (74 percent) and Canada (72 percent). Former international students, like New Zealanders, have satisfied in advance Australia’s pre-registration requirements. By contrast large numbers of overseas-trained migrant health professionals (particularly those selected in the family and humanitarian categories) as demonstrated struggle to secure full professional registration. Thousands will take years - if ever - to achieve this.

## The Ethics of Health Workforce Migration

While the ethics of student migration remain a matter of debate, parents rather than source countries have resourced their education (sponsored students being barred for three years from skilled migration). From an ethical perspective their recruitment can thus seem less problematic than the OECD migration norm—selection of mature-age professionals fully trained by their countries of origin. As demonstrated by the Australian case study, two more serious ethical issues have been raised by health workforce migration. The first concerns the ethics of recruiting migrant health professionals from developing countries (an issue compellingly addressed by recent WHO and OECD studies)<sup>28</sup>. The second concerns the imperative for immigrant-receiving countries to use rather than waste the skills obtained. Across the OECD this represents a major current policy challenge.

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<sup>1</sup> This is based on statistical data provided to L Hawthorne by the Department of Immigration and Citizenship, Canberra (2010-11).

<sup>2</sup> Government of Australia (2008), *Skilling Australia for the Future – Discussion Paper 2008*, Canberra; Rudd, K, Swan, W, Smith, S & Wong, P (2007), *Skilling Australia for the future – Election 2007 Policy Document*, Australia Labor Party, Canberra.

<sup>3</sup> Department of Immigration and Citizenship, *Population Flows – Immigration Aspects 2008-09 Edition* (Canberra: Department of Immigration and Citizenship 2010): 95.

<sup>4</sup> Australian Institute of Health and Welfare (2010), *Australia's Health 2008*, Australian Institute of Health and Welfare, Canberra, p. 436.

<sup>5</sup> Health Workforce Australia has identified migration as a major priority for policy research, commencing with a recently completed study, *Health Workforce Migration to Australia – Policy Trends and Outcomes 2004 to 2010*, L Hawthorne, Health Workforce Australia, Adelaide (2011).

<sup>6</sup> Organisation for Economic Co-Operation and Development (2007), *International Migration Outlook, SOPEMI Annual Report 2007*, OECD, Paris, pp.191-192.

<sup>7</sup> Australian Institute of Health and Welfare (2011), *Medical Labour Force 2009*, see Tables 5, 9, B1, and A2, Australian Institute of Health and Welfare, <http://www.aihw.gov.au/publication-detail/?id=10737419680>; and p. 9 of 14 for 'Explanatory Notes of the Medical Workforce'.

<sup>8</sup> Hawthorne, L (2008), *Migration and Education: Quality Assurance and Mutual Recognition of Qualifications – Australia Report*, UNESCO, <http://unesdoc.unesco.org/images/0017/001798/179842E.pdf>, Paris.

<sup>9</sup> See Chapter Three in *Health Workforce Migration to Australia – Policy Trends and Outcomes 2004 to 2010*, L Hawthorne, Health Workforce Australia, Adelaide (2011).

<sup>10</sup> Bob Birrell, Leslyanne Hawthorne and Sue Richardson (2006), *Evaluation of the General Skilled Migration Categories*, Commonwealth of Australia, Canberra; Hawthorne, L (2011), *Competing for Skills: Migration Policies and Trends in New Zealand and Australia*, Department of Labour, Government of New Zealand, Wellington.

<sup>11</sup> Department of Immigration and Multicultural Affairs (2005), *Sponsoring a Temporary Overseas Employee to Australia*, Booklet No. 11, November, p. 18.

<sup>12</sup> Hawthorne, L & Birrell, R (2002), 'Doctor Shortages and Their Impact on the Quality of Medical Care in Australia', *People and Place* Vol 10 No 3: 55-67.

<sup>13</sup> Hawthorne, L, Hawthorne, G & Crotty, B (2007). *The Registration and Training Status of Overseas Trained Doctors in Australia*, Department of Health and Ageing, Canberra, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D949ABAA95DCE77FCA2572AD007E1710>.

<sup>14</sup> Hawthorne, L, Hawthorne, G & Crotty, B (2007). *The Registration and Training Status of Overseas Trained Doctors in Australia*, Department of Health and Ageing, Canberra,

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<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D949ABAA95DCE77FCA2572AD007E1710>.

<sup>15</sup> Australian Medical Council (2009), Unpublished Country of Training Statistics, MCQ Examinations for Period January 2008 to March 2009, generated 24 March, Australian Medical Council. Canberra.

<sup>16</sup> Australian Medical Council (2011), *Submission to the House of Representatives Standing committee on Health and Ageing Inquiry into Registration Processes and Support for Overseas Trained Doctors*, Australian Medical Council, Canberra, 4 February.

<sup>17</sup> McLean, R & Bennett, J (2008), 'Nationally Consistent Assessment of International Medical Graduates', *Medical Journal of Australia*, Vol. 188: 464-468. [http://www.mja.com.au/public/issues/188\\_08\\_210408/mc111344\\_fm.html](http://www.mja.com.au/public/issues/188_08_210408/mc111344_fm.html), p. 464.

<sup>18</sup> Australian Medical Council (2011), *Submission to the House of Representatives Standing committee on Health and Ageing Inquiry into Registration Processes and Support for Overseas Trained Doctors*, Australian Medical Council, Canberra, 4 February, p. 9; McLean, R & Bennett, J (2008), 'Nationally Consistent Assessment of International Medical Graduates', *Medical Journal of Australia*, Vol. 188: 464-468. [http://www.mja.com.au/public/issues/188\\_08\\_210408/mc111344\\_fm.html](http://www.mja.com.au/public/issues/188_08_210408/mc111344_fm.html), p. 464.

<sup>19</sup> Department of Health and Ageing (2008), 'National Accreditation and Registration Scheme', <http://www.ahwo.gov.au/natreg.asp>, accessed 27 December 2010; Australian Health Practitioner Regulation Agency (2010), Website, <http://www.ahpra.gov.au/Registration/2010-Graduates.asp>, accessed 27 December 2010.

<sup>20</sup> Hawthorne, L (2001), 'The Globalisation of the Nursing Workforce: Barriers Confronting Overseas-Qualified Nurses in Australia', *Nursing Inquiry*, Vol 8 (4): 213-229, Blackwell Science; Hawthorne, L (2002), 'Qualifications Recognition Reform for Skilled Migrants in Australia: Applying Competency-Based Assessment to Overseas-Qualified Nurses', *International Migration Review*, Volume 40 (6): 55-92, Geneva.

<sup>21</sup> Unpublished data provided to L Hawthorne by the Australian Nursing and Midwifery Assessment Council, February 2011.

<sup>22</sup> Australian Dental Council (2011), 'The Mission and Purpose of the ADC', Australian Dental Council, Melbourne. The same paper, by R Broadbent (March 2011), is the source of the recent registration data provided.

<sup>23</sup> Hawthorne, L (2008), *Migration and Education: Quality Assurance and Mutual Recognition of Qualifications – Australia Report*, UNESCO, <http://unesdoc.unesco.org/images/0017/001798/179842E.pdf>, Paris.

<sup>24</sup> Australian Pharmacy Council Limited (2010), *Australian Pharmacy Council Limited Annual Report July 2009-June 2010*, <http://www.pharmacycouncil.org.au/PDF/APC%20AR%202009%202010.pdf>, accessed 8 April 2011.

<sup>25</sup> Hawthorne, L (2010), 'How Valuable is "Two-Step Migration"? Labour Market Outcomes for International Student Migrants to Australia', Special Edition, *Asia-Pacific Migration Journal*, Vol 19 No 1: 5-36

<sup>26</sup> Deloitte Access Economics (2011), *Broader Implications from a Downturn in International Students*, Deloitte (prepared for Universities Australia), 30 June, p. 11.

<sup>27</sup> Hawthorne, L (2011 forthcoming), *Health Workforce Migration to Australia – Policy Trends and Outcomes 2004 to 2010*, Health Workforce Australia, Adelaide; Graduate Destination Survey tables 2005-2010 prepared by A To.

<sup>28</sup> See World Health Organisation (2006), *Working Together for Health – The World Health Report 2006*, WHO, Geneva; Zurn, P & Dumont, J-C (2008), *The Looming Crisis in the Health Workforce – How Can OECD Countries Respond?*, OECD Health Policy Studies, Paris; Simoons, S & Hurst, J (2006), 'The Supply of Physician Services in OECD Countries', OECD Health Working Papers, Paris.