
The Ethics of Health Workforce Migration to Australia – Three Issues



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1. Recruitment – The Context

Federal aim:

- Self-sufficiency by 2025
- Health Workforce Australia National Training Plan

Scale and source of health workforce migration (5 years to 2009/10):

- Temporary skilled migrants: 34,780
- Permanent skilled migrants: 15,940
- Family/ refugees/ dependents: ??
- New Zealanders:

2006: 9,168 health professionals resident

2010: 12% of total NZ population living in Australia)

Top Source Countries for Migrant Health Professionals: Skilled Categories + New Zealand

Top 10 Permanent Source Countries: General Skilled Migration

1. UK
2. India
3. Malaysia
4. China
5. Philippines
6. South Africa
7. Republic of Korea
8. Egypt
9. Singapore
10. Ireland

Top 10 Temporary Source Countries: 457 Long-Stay Business Visa


1. UK
2. India
3. Philippines
4. South Africa
5. Malaysia
6. Ireland
7. China
8. Zimbabwe
9. Canada
10. United States

Source: Analysis of unpublished 2009-10 arrivals data provided by the Department of Immigration and Citizenship (May 2011).

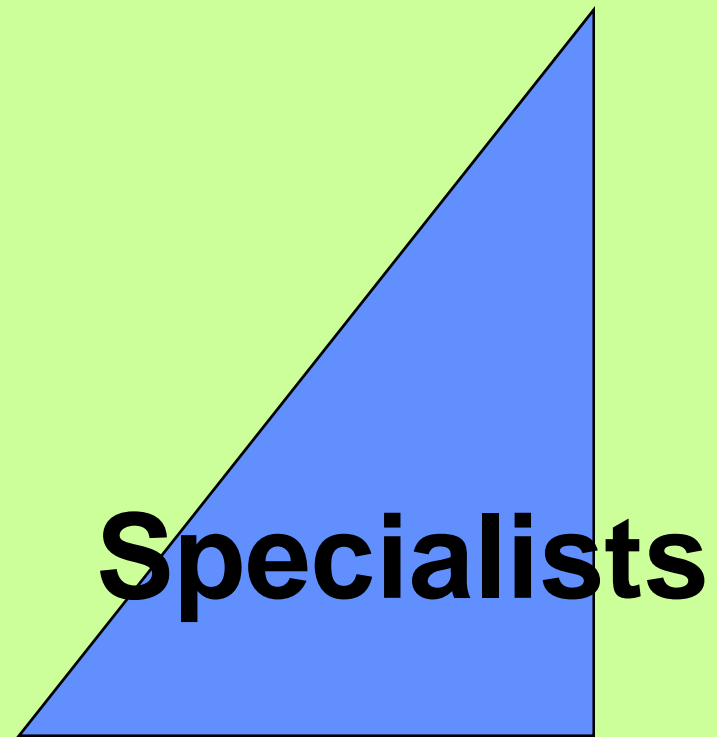
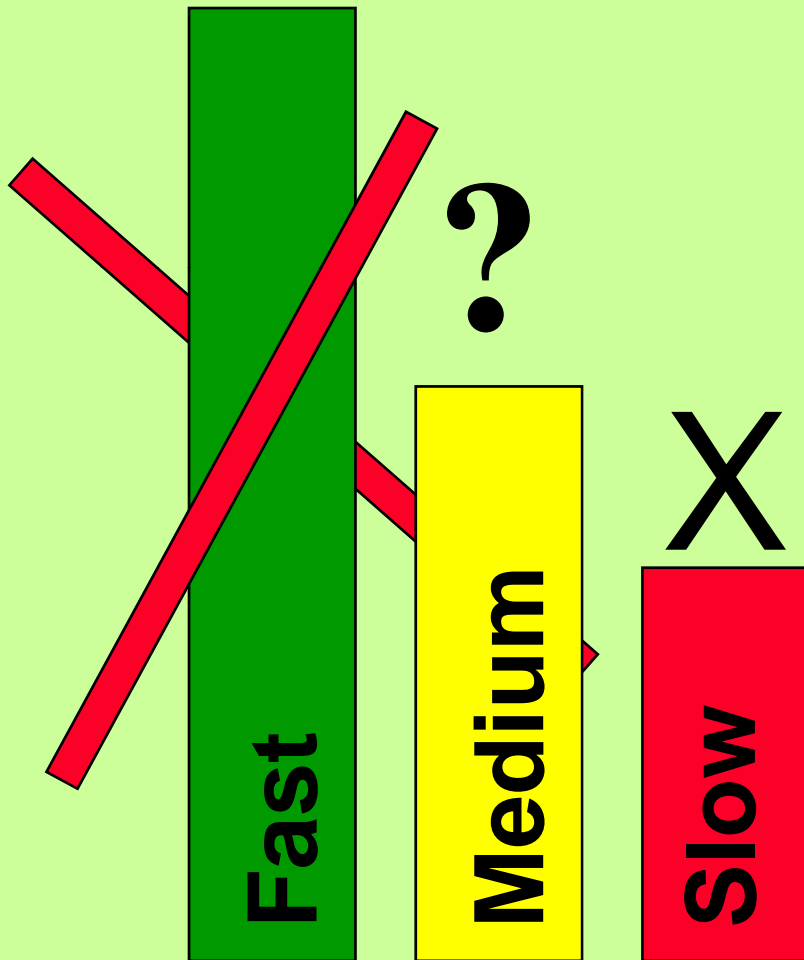
Temporary Health Professional Migration – 457 Visa Arrivals by Select Field (2005-06 and 2009-10)

Select Field	457 Visa 2005-06	457 Visa 2008-09	457 Visa 2009-10	457 Visa Total 2005-06 to 2009-10
Nursing	2,660	4,070	2,710	15,960
Medicine	2,120	3,310	2,670	15,490
Dentistry	90	160	150	660
Physiotherapy	60	100	90	420
Pharmacy	50	20	20	160
Grand Total (All Fields)	5,300	8,190	6,020	34,870

Source: Analysis of unpublished Department of Immigration and Citizenship flows data, provided to HWA.



Ethical Bar? Competent Authority Pathway



2. Skills Utilisation: Dependents of Skilled Migrants, Plus Family and Humanitarian Category Migrants

Issues:

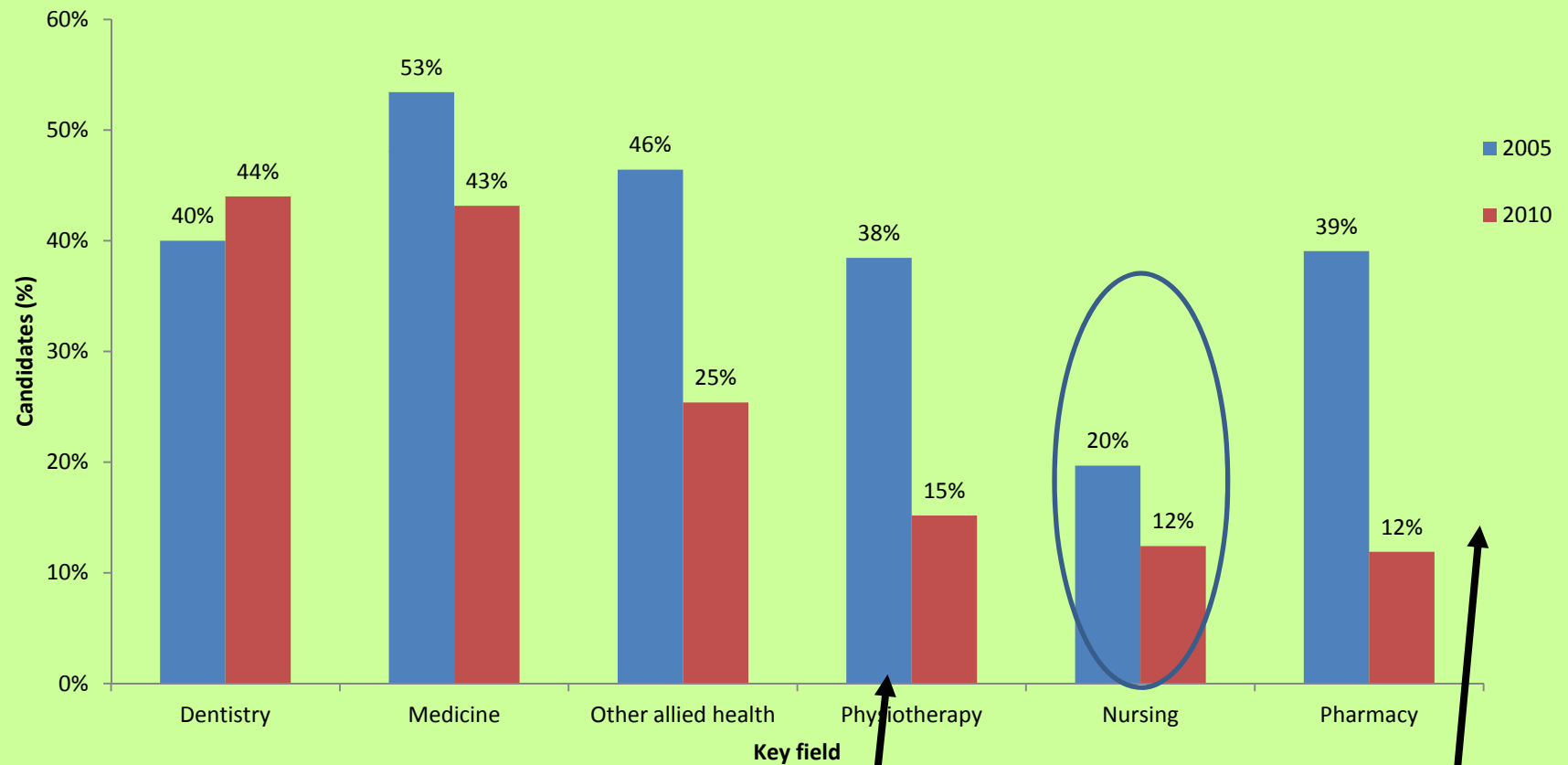
- **Unfiltered in advance** for human capital attributes (English, credential recognition)
- **Variability of training systems** (eg China, former Yugoslavia)
- **'Technological fit'** (eg Philippines)
- **Level of pre-migration workforce displacement** (eg refugees)
- **Length of post-arrival displacement** (including impact of gender)

Threat – extended (permanent?) labour market displacement:

- **Registration access, salary level, position status (etc)**

Impact of Occupational English Test on Professional Registration (2005 and 2010)

Proportion of candidates passing OET by key field, 2005 and 2010



Access to Vocational Registration in Nursing (Pre-Migration Assessments)

2007-2010 ANMAC Data:

Suitable for migration purposes:

- 10,029

Full registration on arrival:

- 16%

Modified approval (full assessment/ training required on arrival):

- 75%

Unsuitable or pending:

- 9%

Employment Outcomes for Migrant Doctors 2001-2006 Arrivals (All Categories)

2006 Census:

- **Overall:** 53% of 2001-06 arrivals employed in medicine within 5 years
- **Most likely:** South Africa (75%), Other Sub-Saharan Africa (71%), UK/Ireland (71%), Singapore (63%), Malaysia (62%), West Europe (62%), India (61%)
- **Modest performers:** HK (59%), Philippines (50%), West Europe (54%), SE Europe (49%), South America (40%),
- **Poor outcomes:** East Europe (31%), Vietnam (23%), Indonesia (8%), China (6%)
- **'Not in the labourforce' within 5 years:** China = 36%, Eastern Europe = 38%, Vietnam = 47%, Indonesia = 59%



Skills Utilisation – The Issues

Differential entry pathway and outcomes -

1. New Zealand flows (Trans-Tasman agreement)
2. International students (study-migration pathway)
3. Temporary labour migration (457 visa)
4. Permanent skilled migration (GSM)
5. Dependents of GSM migrants
6. Family and Humanitarian category migrants

Which policy levers to use to effect this, including location?


What level of investment – bridging options?

3. International Student Recruitment: The 'Study-Migration' Pathway

Compared to migrant health professionals:

1. Fully recognised qualifications
2. English testing exemption
3. Youth
4. Local experience
5. Acculturation

Field	1996	2000	2002	2004	2008	2009
Dental science	98	124	155	227	341	387
Medicine	963	1117	1287	1505	2665	2772
Nursing (basic)	762	839	790	1623	5451	6124
Nursing (post-basic)	545	2336	3591	3109	2631	2566
Physiotherapy	79	173	197	239	392	365



Incentives to Stay (Ethical Bar = Sponsored Students)

Malaysia:

- **Preferential treatment of native Malaysia**
- **Discrimination against Chinese and Indian citizens**
- **Limited PG training options, employment conditions**
- **Current medical oversupply**

Singapore:

- **Employment conditions (hours, remuneration etc)**

Canada:

- **PG training access**
- **Migration pathway, diasporic links, weather....**

Outcomes from the 'Study-Migration' Pathway

2004/05 to 2009/10:

- **35-52%** of all permanent skilled migrants selected onshore

Employment outcomes (Graduate Destination Survey):

- **2006-2010 respondents:** 2,227 former international nursing students, 675 medical students, 98 dental students, 141 physiotherapy students
- **Survey date:** 4 months after graduation
- **Employment @ 4 months in 2010:**

↑ **Medicine:** 98.9% employed full-time (99.7% of domestic students)

Dentistry: 93.8% employed full-time (93.6% of domestic students)

Nursing - 70% employed full-time (93% of domestic students) and 21% part-time in the field (5%)/

Salary rates for full-time workers: Comparable or higher than for recent Australian graduates

Ethical Complexity of Governing Health Workforce Migration - Examples

- 1. Hyper-mobility of migrant health professionals:**
 - Migrant doctors (60% = 6 or more major geographic moves)
 - Family opportunity = driver
- 2. Source country policies:**
 - Philippines
 - India and China
 - OECD 'trade' – eg nurses
- 3. Impact of globalisation:**
 - Destination of Malaysian medical students (if not retained by Australia)