

AUSTRALIAN NURSING FEDERATION



RESPONSE TO AUSTRALIA'S HEALTH WORKFORCE: PRODUCTIVITY COMMISSION POSITION PAPER

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Australia's Health Workforce

Productivity Commission Position Paper

The ANF welcomes the opportunity to provide a response to the recommendations of the Productivity Commission outlined in their Position Paper: *Australia's Health Workforce*.

The ANF also welcomes CoAG's interest in and focus on the health workforce. However the Productivity Commission's response needs to consider the health workforce within a whole of system context and the complex arrangements between the federal, state and territory governments in relation to health policy, funding and delivery. There seems to be little point in recommending reforms to the health workforce if the system in which the health workforce operates remains the same.

The ANF considers that there needs to be an urgent response to the crisis in health workforce numbers and an immediate allocation of funded places in both the higher and vocational education sectors to ensure that there will be a sufficient number of health workforce graduates for the future.

Draft Proposal 3.1

In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

The ANF generally supports the National Health Workforce Strategic Framework and would like to see the Framework endorsed and actioned by the Australian Government.

The ANF is opposed to using international recruitment as a primary strategy for overcoming workforce shortages.

The ANF supports the Commonwealth code of practice for the recruitment of health workers.

The ANF considers that Australia should be self sufficient in relation to its health workforce. Recent reports from the World Bank and the Centre for Global Development suggests that Australia's skilled migration program is having a negative effect on developing countries (see Attachment 1).

The ANF has a policy on the international recruitment of nurses (see Attachment 2).

Draft Proposal 3.2

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

The ANF would support regular reporting by Governments on the implementation of the National Health Workforce Strategic Framework. These reports should be made public and the reviews should be an independent and transparent process.

Draft Proposal 4.1

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- *Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.*

The ANF is not opposed to the development of an advisory health workforce improvement agency but cautions that the primary aim must be the provision of opportunities for the existing health care workforce to develop innovative ways of meeting the future health and well-being needs of the Australian community, rather than on the development of “new professions” (see p.54 and p.97).

Figure 4.1 on page 43 appears to outline a process for developing a new type of worker rather than a systematic approach to expansion of the scope of practice for the current health workforce. It is important and much more cost effective for Governments to work with existing health professionals and support their continuing education needs as they develop competency in new contexts of work.

Safety and quality should be the main driver in this area as well as the development of a flexible and effective health workforce. Cost effectiveness is all too often based on short term gains rather than longer term efficiencies and therefore should not be the driving force for developments in this area.

Processes must be established so that the deliberations of such a body are transparent. The governance arrangements will be critical as well as the processes for obtaining expert advice from key stakeholders including the nursing profession.

There are many opportunities for nurses and midwives in the future health care workforce and the ANF would welcome a system that supported expansion of the role that nurses have in the provision of health and well-being services.

The International Council of Nurses uses the following definition which captures the broad role that nurses have in assisting people to achieve health and well-being:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of the health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environments, research, participation in shaping health policy and in patients and health systems management, and education are also key nursing roles.

The ANF generally supports the Queensland Nursing Council's definition of the scope of nursing and midwifery practice as this identifies the flexibility that is an integral part of nursing and midwifery work:

The scope of nursing and midwifery practice is that which nurses and midwives are educated, competent and authorised to perform. The actual scope of an individual nurse's or midwife's practice is influenced by the:

- *context in which they practice;*
- *client's health needs;*
- *level of competence, education and qualifications of the individual nurse or midwife;*
and
- *service provider's policies.*

It is the position of the ANF that this approach provides the appropriate guidance for job redesign and the expansion of the scope of nursing practice. Appropriate consultative arrangements are built into the decision making framework that accompanies the information about the scope of nursing and midwifery practice.

Draft Proposal 5.1

The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- *consider the needs of all university-based health workforce areas; and*
- *consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.*

The ANF strongly supports the establishment of an effective process for allocating and funding university based education for health workers including registered nurses.

Education places are a major issue in nursing as the most recent Australian Government report from the Australian Health Workforce Advisory Committee, (August 2004 *The Australian Nursing Workforce-An Overview of Workforce Planning 2001-2004* www.healthworkforce.health.nsw.gov.au) estimated that for supply to meet demand, between 10,182 and 12,270 new graduate nurses are required to enter the workforce in 2006 and between 10,712 and 13,483 in 2010. They also estimated that new enrolled nurse requirements were between 5,734 and 6,201 in 2010. The numbers quoted reflect completions not commencements.

The completion rate for nursing students was only 5320 in 2003 although this was an increase on 4732 completions in 2000.

The ANF is not convinced that transferring the responsibility to another department of the Australian Government will result in a more efficient process. The Australian Government has previously commissioned reports that provide advice to increase the number of nursing places in the higher education setting and this advice has been generally ignored (for example, The National Review into Nursing Education known as the Heath Report and the Inquiry into Pricing Arrangements in Residential Aged Care known as the Hogan report). It is acknowledged that some additional places were allocated but not the quantum recommended in these reports to the Australian Government.

A multi-jurisdictional advisory body may be a better option if both health and education are represented. The ANF does not support a state college system as the health workforce is a national priority and decisions should be balanced to meet needs across the country rather than in one state or territory. This step must be closely aligned to the health workforce planning processes identified in the position paper.

Draft Proposal 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- *opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and*
- *their implications for courses and curricula, accreditation requirements and the like.*

The ANF is not opposed to the establishment of an advisory board to consider education and training issues. The governance arrangements will be critical to its success as well the methods used to prepare advice about education and training needs.

Immediate issues requiring consideration are continuing education options to meet the future health and well-being needs of the Australian community; and funding for clinical education and clinical placements for students including increased access to the private, community and aged care sectors.

There is patchy support for nurses and midwives undertaking further education so they are better prepared for expanded scopes of nursing practice and this requires redress. Nurses and midwives are expected to pay significant up-front fees for postgraduate courses and yet receive minimal compensation for any courses that they complete.

The ANF does not support the separation of education and training in the higher education sector from that in the vocational education sector. The two sectors should be integrated to allow seamless articulation from one sector to the other.

The ANF strongly supports articulation arrangements that assist health care workers to progress vertically in their careers, for example, starting as an assistant in nursing and progressing through enrolled nursing courses and into an undergraduate nursing program.

The ANF would like to be advised as to how a health workforce education and training council would relate to the Community Services and Health Industry Skills Council.

Draft Proposal 5.3

To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- *improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;*
- *examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;*
- *better linking training subsidies to the wider public benefits of having a well trained health workforce; and*
- *addressing any regulatory impediments to competition in the delivery of clinical training services.*

The ANF supports a greater focus on clinical education of nurses and other health care workers. High quality clinical placements are needed for all health care students and providing a greater range of settings would help to address current shortcomings in the availability places. The ANF strongly supports a project to identify the costs associated with clinical education and a process to provide adequate funds for high quality clinical education for every student.

Nursing workloads have a significant effect on the ability of nurses to assist with student education. Clinical nurses are no longer in a position to provide the necessary support and guidance needed by students as they prepare for practice as nurses. This is a critical phase for students and experiences impact on their decisions to follow through with health care careers. The ANF supports the appointment of clinical educators with responsibility for supporting nursing students as well as involvement with the continuing education needs of nurses.

The ANF also recommends that clinical education issues for students at rural universities and for students with rural clinical placements be addressed. There have been some improvements in recent years for medical students with accommodation and resources provided but there has not been a flow-on for other health students. In particular, these students often experience serious economic hardship as they are often required to pay rent in two places and they are not able to work despite having a job. The National Rural Health Alliance has prepared a position statement and this can be found on their website, www.ruralhealth.org.au.

Draft Proposal 6.1

The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- *It would develop uniform national standards upon which professional registration would be based.*
- *Its implementation should be in a considered and staged manner.*

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

The ANF does not support a single national accreditation agency for health care workers. There are significant professional differences between the professions and it would not be beneficial to develop uniform national standards.

The ANF would support giving the Australian Nursing and Midwifery Council greater powers to direct nursing and midwifery regulatory authorities on issues of importance such as the accreditation processes for courses, national standards and codes of conduct.

The Australian Nursing and Midwifery Council is making progress on the development of principles guiding accreditation processes for nursing and midwifery regulatory authorities in each state and territory.

The Australian Government has already trialed this approach with the development of the national practice standards of the mental health workforce. These standards have not been implemented as there has been limited support for incorporating them into professional standards. While the linkage to registration of licensure is not present in the project, it demonstrates that ownership of professional standards is a key feature.

Please note that in table 6.1, on page 91, reference is made to accreditation of nursing specialty courses by specialist nursing groups. Specialty nursing groups are generally involved in developing curricula for and evaluating specialist nursing courses but there would be few courses that are formally accredited by a specialist nursing group. Some of the nursing and midwifery regulatory authorities continue to be involved with accrediting postgraduate courses such as mental health nursing and all accredit postgraduate midwifery courses as they are entry to practice programs.

The ANF does not support exclusion of the vocational education and training sector from accreditation processes. Enrolled nurses are educated in the vocational education sector and are licensed health care providers.

Draft Proposal 6.2

The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practice in different work settings.

The Australian Nursing and Midwifery Council have responsibility for assessing competency for overseas nurses seeking entry to Australia under the general skilled migration category. Nursing and midwifery regulatory authorities are responsible for assessing the competency of other nurses coming to Australia for work purposes.

The system works well and ensures that nurses coming to Australia, for the long or short term, meet the standard expected of nurses working in Australia.

The ANF has consistently opposed introducing any shortcuts towards licensure as occasionally proposed by bureaucrats negotiating free trade agreements.

Draft Proposal 7.1

Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

State and territory nursing and midwifery regulatory authorities are focusing on registration using nationally agreed professional nursing standards.

The ANF opposes any changes to the effective and efficient systems in place for the nursing profession merely because those systems have not been accessed by or are not working for other professional groups.

It is the position of the ANF that assistants in nursing and personal care assistants should be licensed because of their role in providing aspects of nursing care to vulnerable members of the community.

Box 7.1 on page 106 states that aged care providers see state-based registration systems as a barrier to efficiency in recruiting nurses to the aged care area but there is no evidence to support this statement and it should be removed as it is misleading.

<p>Draft Proposal 7.2 <i>States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.</i></p>	<p>All Australian nursing and midwifery regulatory authorities already have mutual recognition arrangements in place and that all the states and territories, except Western Australia, have signed the Trans Tasman agreement allowing easy movement between Australia and New Zealand.</p> <p>The Australian Nursing and Midwifery Council has a fee waiver policy in place but the ANF would support giving this policy a higher profile and monitoring its implementation to see that nurses and midwives are using the option when they are working in more than one state or territory.</p>
<p>Draft Proposal 7.3 <i>Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.</i></p>	<p>The ANF acknowledges that this proposal is worth considering further for the delegation of tasks by licensed health care professionals to unlicensed workers such as assistants in nursing and personal care assistants. A cautious approach is required however. You cannot ask a health practitioner to retain responsibility for clinical outcomes and the health and safety of a patient if they have no input into the scope of practice or educational preparation of the person to whom they are delegating or any control over the skill mix of employees which is determined by the employer. There needs to be protection in place for licensed nurses who make a professional decision not to delegate aspects of nursing care to an unlicensed worker but are required by employers to delegate.</p> <p>Nurses are autonomous health care professionals and it would be a backward and unacceptable step if this proposal was designed to place further control of patient care in the hands of medical practitioners. Nurses work as part of the health care team and they contribute to the provision of health and well-being services in conjunction with other members of the team including doctors and allied health care providers.</p>

Draft Proposal 8.1

The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- *the range of services (type and by provider) covered under the MBS;*
- *referral arrangements for diagnostic and specialist services already subsidized under the MBS; and*
- *prescribing rights under the Pharmaceutical Benefits Scheme.*

It should report publicly on its recommendations to the Minister and the reasoning behind them.

The ANF fully supports the establishment of an independent standing review body to provide advice on the coverage of the Medicare Benefits Schedule and some related matters.

While there has been movement in recent time with the allocation of MBS item numbers for services provided by nurses in general practice and allied health care providers, the approach has been piecemeal and the rebate has not reflected the value of the work undertaken by the nurse or allied health care provider or their autonomous role in the delivery of health care.

A number of areas require urgent action such as the funding model for MBS and PBS services provided by nurse practitioners and midwives.

The ANF also does not support the concept that access to the MBS should always be through the general practitioner.

<p>Draft Proposal 8.2 <i>For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:</i></p> <ul style="list-style-type: none"> • <i>the service would be billed in the name of the delegating practitioner; and</i> • <i>rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.</i> <p><i>This change should be introduced progressively and its impacts reviewed after three years.</i></p>	<p>While the ANF is not opposed to a rebate for delegated services, it is our contention that MBS item numbers should be allocated for the service being provided and be available to any health care practitioner providing that service, such as medical practitioners, nurses or allied health care professionals.</p> <p>The ANF also does not support the concept that access to the MBS should always be through the general practitioner.</p> <p>Nurses are autonomous health care providers and work with other members of the health care team to provide health and well-being services. Nursing work does not replicate medical work although similar interventions may be provided by both nurses and general practitioners.</p> <p>There should be an independent process for determining rebates considering all the elements involved in the service being funded. Rebates should be set at a reasonable rate, for example, the rebate for nurses in general medical practice is too low and does not reward the practice for employing nurses.</p>
<p>Draft Proposal 9.1 <i>Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.</i></p>	<p>The ANF supports rationalisation of the health workforce planning processes and has been disappointed with the timeliness of the work undertaken by AHWAC and the government response to AHWAC's subsequent reports. Processes and systems must be in place however so that effective workforce planning takes place for all health care workers.</p> <p>There should be a transparent process identifying the projects undertaken by the secretariat. Funding and other resources should be available so that the processes are completed in a timely manner.</p>

<p>Draft Proposal 9.2 <i>Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:</i></p> <ul style="list-style-type: none">• <i>be based on a range of relevant demand and supply scenarios;</i>• <i>concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and</i>• <i>be updated regularly, consistent with education and training planning cycles.</i>	<p>Supported.</p>
<p>Draft Proposal 10.1 <i>The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.</i></p>	<p>Supported.</p>

Draft Proposal 10.2

The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- *assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and*
- *as appropriate, consider major job redesign opportunities specific to rural and remote areas.*

Supported although it must be noted that many nurses and midwives in rural and remote areas have expanded roles already that may not be reflected in their job descriptions. There should be greater acknowledgement of the critical role that nurses and midwives have in continuing the provision, often without clinical or managerial back-up, of high quality and safe health care in rural and remote areas.

The role of nurses and midwives in rural and remote areas must be better supported. Access to continuing education, retraining as the models of care change, professional support networks and adequate resources to provide care must be in place if nurses are to perform at the highest level in these isolated settings.

The early development of nurse practitioner roles occurred because nurses in isolated areas, including rural and remote settings, were providing their clients with advanced health care but there were legislative barriers in place that needed to be overcome such as prescribing rights, and rights to refer and to order pathology and radiology tests.

<p>Draft Proposal 10.3 <i>The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:</i></p> <ul style="list-style-type: none"> • <i>the provision of financial incentives through the MBS rebate structure versus practice grants; and</i> • <i>'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.</i> <p><i>There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.</i></p>	<p>Health care is a team based service and the contribution of all team members must be acknowledged and supported in order that the team functions effectively. Appropriate incentive programs must be considered for all members of the health care team as nurses have already experienced significant amounts of Australian Government funds directed towards medical practitioners despite experiencing the same problems.</p> <p>Scholarship schemes have been introduced for nurses and they are an important incentive scheme for nurses working in rural and remote areas.</p> <p>The ANF strongly supports regionally based education and training options, whether at university or in the vocational education sector, although there is concern about potential downgrading of these facilities because of changes taking place in the education sector. The important role of regional centres in preparing the health workforce for the future must be protected and enhanced rather than reduced.</p>
<p>Draft Proposal 11.1 <i>The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.</i></p>	<p>Supported.</p>

Other comments:

The ANF is concerned that the Productivity Commission Position Paper does not give due recognition to the achievements of the nursing profession in many of the areas covered in the Paper. For example, nursing already has national competency standards and has had for many years. Registration nationally is based on these competency standards. Nursing already has national, fair and transparent processes in place for the assessment for registration of overseas qualified nurses. Nursing has mutual recognition processes in place, not only within Australia but which encompass New Zealand as well, which are readily accessed by nurses. The nurse regulatory authorities are also working on national accreditation standards. Many of the recommendations of the Productivity Commission may well have a negative impact on the processes that nursing has established.

The ANF is also concerned that the major focus of the Productivity Commission has been on those professions educated exclusively in the higher education sector. Nursing encompasses both the vocational and the higher education sectors. There needs to be a seamless articulation between the two sectors not barriers created which make it difficult for workers to progress from the vocational education sector to the higher education sector when seeking further education.

The ANF would also point out that enrolled nurses are licensed practitioners and are educated in the vocational education sector. It is the ANF's view that all practitioners who are providing direct care have the potential to cause harm and should be licensed. The purpose of licensing is predominantly to protect the public and provide them with an avenue for redress should an adverse outcome occur.



Australia worst culprit in 'brain gain' scourge

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AUSTRALIA'S immigration policy of luring professionals and skilled workers from poorer countries is damaging the countries they leave behind, depriving them of desperately needed doctors, nurses, nation-builders and reformers, two new studies have warned.

A report released overnight by the World Bank finds that more than 75 per cent of all graduates from Tonga and Samoa and 62 per cent of all graduates from Fiji have emigrated. Most are now in Australia and New Zealand.

The situation is worse in the Caribbean, where as many as 89 per cent of all graduates have emigrated, mostly to the West, where their skills earn them much higher incomes. Australia looms large in the reports, both as a pioneer of the skilled **migration** policies now spreading through the West and as the world's largest importer of skilled workers relative to its population.

In 2000, Australia was the world's biggest beneficiary from "brain gain". It had more than 1.5 million migrants with tertiary education, more than any country except the United States and Canada, and far outnumbering the 116,723 tertiary-educated Australians living overseas. The net brain gain of 1.4 million people made up 11.4 per cent of all Australian residents of working age, twice the share in the US and seven times the average for the West.

The second study, by Washington think tank the Centre for Global Development, reports that many thousands of doctors have emigrated from African countries facing the AIDS epidemic to take higher-paying jobs in Europe, the US or South Africa.

A survey of doctors trained in Ghana found that within 10 years of graduating, three-quarters had emigrated. This has left the country with 16,129 people per doctor, as against 417 per doctor in Australia.

The reports suggest countries such as Australia have a moral responsibility to address the problems their policies create for the countries migrants leave behind.

The centre's report, *Give Us Your Best and Brightest*, by Devesh Kapur and John McHale, says this could include financial compensation to countries that paid for migrants' education and reforms to take in unskilled workers, perhaps temporarily.

Countries should not rely on immigration to make up for shortages of skilled workers caused by "poor human capital planning", they say.

The reports also highlight the benefits that flow to poorer countries from having a diaspora in richer countries. But they see these benefits as coming more from unskilled

workers, such as the millions of Mexican labourers and domestic servants in the US who send money home, or from dynamic entrepreneurs who use the knowledge they gain in the West to set up businesses at home. They point out that talented people who migrate are those who, if they stayed in their country, would become its entrepreneurs, creators of national institutions, researchers on national problems and reformers spreading ideas and pressing for democracy.

"If rich countries are to live up to their promise to be development-sensitive in their actions, they cannot avoid paying attention to the effects of their immigrant selection policies on developing countries," professors Kapur and McHale conclude.

BRAIN GAIN

Net gain as percentage of adult population

AUSTRALIA 11.4%

CANADA 10.7%

UNITED STATES 5.4%

SWITZERLAND 3.8%

NEW ZEALAND 2.9%

SWEDEN 2.3%

BRITAIN -0.5%

OECD AVERAGE 1.6%

BRAIN DRAIN

Percentage of skilled workers emigrated

JAMAICA 85%

TONGA 75%

FIJI 62%

GHANA 47%

KENYA 38%

SRI LANKA 30%

PNG 29%

VIETNAM 27%

INDIA 4%

CHINA 4%

BANGLADESH 4%

AUSTRALIA 3%

THE AUSTRALIAN EQUATION

SKILLED IMMIGRANTS 1,539,670

SKILLED EMIGRANTS 116,723* NET BRAIN GAIN IS EXCESS OF SKILLED IMMIGRANTS OVER SKILLED EMIGRANTS. ALL FIGURES ARE TO END OF 2000.

SOURCE: WORLD BANK



Bleeding the Third World: our \$5 billion-a-year skills windfall

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Australia's benefit from poor-nation migrants is twice our aid budget.

MALAWI is the world's poorest country. Its people live on the equivalent of \$16 a week, about 2 per cent of our income. One in seven of its adults has AIDS. Average life expectancy is just 37 years.

Part of Malawi's problem is that it lacks doctors and nurses. In 2003, in fact, 91 per cent of surgical posts in its central hospitals were vacant. One hospital authorised to employ 24 surgeons in fact had just one. In the entire country, only 28 per cent of nursing posts were filled.

It is not that Malawi never trained doctors and nurses. They have emigrated, seizing the openings in the West or mineral-rich southern Africa for doctors, nurses, teachers, professionals and skilled workers.

One in three highly qualified Africans now lives in the West. Countries such as Australia celebrate this because it enhances our skills base, increases our output, and increases our ethnic diversity. But what does it do for those left behind?

Two new reports, one by the World Bank and one by Washington think tank the Centre for Global Development, conclude that it can be damaging. In the short term, it hurts countries' ability to deliver health, education and other services. In the long term, it takes away the natural leaders who would otherwise set up businesses, create institutions, spread ideas and promote reform, democracy and innovation.

This is the dark side of global immigration, little studied, yet entrenching the global poverty that our governments are trying to fight.

The scale is staggering. In round figures, Australia imports about 50,000 professionals and skilled workers a year from developing countries. Assume that on average they bring human capital with a replacement cost here of \$100,000 each. That implies an aid flow from developing countries to Australia of \$5 billion a year - twice the \$2.5 billion that Australia gives them in foreign aid.

Look ahead, the two reports warn, and these flows will escalate. Ageing populations will force Western countries to target far bigger immigration flows; even Japan will open its doors to foreign workers as its baby boomers retire. This could be a force for good, or for disaster.

Both reports support immigration. The main message of the World Bank report is that it can do a lot of good for the source countries, if unskilled workers emigrate and send home remittances, or potential entrepreneurs - such as India's diaspora in Silicon Valley - then invest back home.

But it is another matter when rich Western countries such as ours plunder the doctors, nurses, teachers, academics and engineers of poorer countries, because they failed to train enough of their own. The effects back home can be harmful, subtle, far-reaching and long-lasting.

The centre's report sums it up in its ironic title, Give Us Your Best and Brightest. Written by economists Devesh Kapur and John McHale, it highlights the short and long-term damage that countries can suffer when their doctors and nurses, teachers and researchers, engineers and knowledge workers leave home.

The long-term damage is that the best and brightest are no longer at home to be agents of change, drivers of growth, innovators, founders, and reformers. The authors quote historian Barrington Moore's dictum: "No bourgeoisie, no democracy."

The short-term damage can mean death for many. Take Ghana, one of Africa's relative success stories.

Almost half its university graduates have emigrated. And the result? Ghana now has one doctor for every 16,129 people, Australia one for every 417.

Of Ghana's medical graduates between 1985 and 1994, half left the country within five years of graduating. Three-quarters had gone within 10 years. How can it conquer AIDS, malaria, or high child and maternal mortality when the West keeps recruiting its doctors and nurses?

In the most important chapter of the bank's report, International **Migration**, Remittances, and the Brain Drain, Frederic Docquier and Abdelslam Marfouk estimate that by 2000, between 80 and 90 per cent of all graduates from some Caribbean countries had emigrated, mostly to the US.

In the Pacific, they say, more than 75 per cent of graduates from Samoa and Tonga, and even 62 per cent of Fijian graduates had emigrated by 2000. We know where they went: Australia and New Zealand. Even from Papua New Guinea, 28.5 per cent of graduates had emigrated.

Where do they go? Relative to size, the biggest beneficiary is Australia, which for 30 years has run an immigration policy increasingly targeting skilled workers. And let's be honest, we do it because it is cheaper to import doctors and the like from developing countries than to train our own.

Docquier and Marfouk estimate that by 2000, Australia had imported more than 1.5 million professionals and skilled workers (many of them, of course, from Britain, New Zealand and other Western countries), while just 116,723 qualified Australians were overseas.

What should we do? Both reports stress the responsibility of countries such as Australia to tackle the problems their policies are causing, but are vague on solutions. The centre's report suggests we should compensate source countries with some of transfer payment, and rule some areas of migrant recruitment off limits.

But the solution that makes most sense is to stop relying on poorer countries to supply our knowledge workers, and train enough of our own.

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anf policy

australian nursing federation

recruitment of nurses from overseas

Where the term 'nurse' is used it includes all licensed classifications including, but not limited to: registered nurse, midwife, enrolled nurse, nurse practitioner.

It is the policy of the Australian Nursing Federation that:

1. The migration of nurses is an international phenomenon and can positively contribute to the personal and professional development of individual nurses, to the nursing profession and to the provision of nursing care in Australia.
2. The global shortage of nurses can only be solved by improvements in the status of nursing at the local level in countries, and in the planning and management of the nursing workforce.¹
3. Migration programs are neither an effective nor desirable instrument to overcome labour market deficiencies and should not be used as a primary strategy to overcome nursing shortages in Australia.
4. Employers wishing to recruit nurses overseas must demonstrate:
 - that they have introduced a range of strategies aimed at attracting, recruiting and retaining nurses residing in Australia; and
 - that they will offer migrant nurses identical employment conditions to nurses in Australia.
5. Prior to the recruitment of nurses overseas, the following avenues for nurse employment are to be explored in the following order of priority:
 - employment of nurses who are made redundant as a result of services closing;
 - employment of nurses already practising;
 - non practising nurses encouraged to return to the workforce using a range of incentives;
 - nurses recruited from interstate; and finally
 - nurses recruited from overseas.
6. Nurses employed from other countries should be provided by the employer with orientation, mentoring and support to make a successful transition to employment in Australia.
7. Procedures for the assessment of nursing qualifications from other countries must be equitable and fair, and be based on a proficiency in the English language and clinical competence, and recognise previous experience and prior learning, in addition to formal educational qualifications.

8. Employing agencies seeking specialist nurses from other countries must demonstrate a commitment to the specialist education and training of nurses already residing in Australia.

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references

1. World Health Organisation 2003 *International nurse mobility, trends and policy implications* Geneva p.5