Submission to the Productivity Commission Health Workforce Study

People's Health Movement Australia

Background Paper on Australia and the Skills Brain Drain from Developing Countries

August 2005

This submission is the result of the first stage of work by the People's Health Movement in Australia on the issue of skilled health professional migration away from developing countries. It describes the range and extent of problems that brain drain encompasses and raises Australia's moral obligations as a wealthy nation. The current paper also canvasses a range of policy options for moving forward on Australia's role in the global brain drain.

The next phase of work on brain drain issues will include consultation with People's Health Movement networks both in Australia and abroad. PHM Australia will extend the analysis of policy options and make specific recommendations in light of our investigations and in response to the forthcoming Productivity Commission Draft Report. The result will be a further submission to the Study.

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EXECUTIVE SUMMARY

PHM is a global coalition of grass roots organisations that aims to establish health and equitable development in the national and international arena. The Victorian branch of PHM Australia has decided to focus on brain drain in health as it is an issue where Australian policies directly affect the health systems of developing countries. Australia has a moral obligation to calculate and reduce its role in where it negatively impacts on developing countries through employing their health professionals.

Brain drain is part of a complex pattern of movement of health professionals which is driven by a number of factors including the pull created by workforce shortages in rich countries and poor renumeration and working conditions in home countries. The costs of brain drain to developing countries include the loss of investment made in training, loss of valuable skills, difficulty planning health services due to high and unpredictable attrition rates, increased inequity and lost productivity of workers who cannot access health care. The migration of skilled health professionals away from developing countries is likely to overshadow the benefit of aid to many countries.

Traditionally overseas trained health professionals have immigrated to Australia from the United Kingdom and Ireland however the proportion arriving from developing countries is rising rapidly. Even a minor increase from small countries such as the Pacific island nations can have a devastating effect on their health systems. While ethical recruitment is an important base to work from, it is a limited and relatively ineffective method for addressing the negative impacts of brain drain. There is a need to calculate the financial gain Australia is making from developing countries by employing their health professionals in order to calculate compensation to be paid. It is essential that Australia introduces national human resources data collection with respect to all migrating health professionals.

Australia is a wealthy country with a well developed health sector and can well afford to train enough health professionals to be self-sufficient. The current mal-distribution of health professionals within Australia must be addressed for justice to be served both to underserved Australians and underserved communities of developing countries. While a number of proposed actions for Australia are presented, a second submission to the Study will detail specific policy responses that PHM Australia sees as necessary for addressing the brain drain issues raised here.

Contents

People's Health Movement (PHM) - Australia

The People's Health Movement (PHM) is a global coalition of grass root organisations that aims to establish health and equitable development as key priorities in the national and international arena. PHM supports the vision of primary health care described in the 1978 Alma Ata declaration. The People's Health Charter further develops the principles outlined in the Alma Ata declaration with a strong emphasis on health as a human right. It highlights the social, political and economic factors affecting health and is the most widely endorsed health document since the Alma Ata declaration (People's Health Charter).

The People's Health Movement is active in many developing countries and also established in some developed countries including Australia. PHM in Australia, also known as PHM Oz, is working on issues that affect health in Australia and globally with a strong focus on primary health care, Indigenous health, community participation and equity. PHM Australia has active associates all around the country with formally organised groups in Melbourne, Adelaide and Sydney.

The Victorian branch of PHM has initiated a working group which is looking at Australia's contribution to the international brain drain in health. The term 'brain drain' refers to the movement of skilled intellectual and technical labour from one area to other more favorable geographic, economic, or professional environments. The brain drain in health is a contributing factor to the health workforce crisis in many poor countries due to the increasing net migration of health professionals from resource-poor countries to resource-rich countries (Narasimhan 2004).

Brain drain in health is particularly appropriate to PHM Australia's mandate as

the recruitment policies and practices of Australia and other industrialised countries are directly affecting the ability of resource-poor countries to provide accessible affordable health care.

Australia's Moral Obligation

While debating the future of the Australian health workforce, PHM Australia believes Australian politicians, bureaucrats and professionals have a moral obligation to consider Australia's role as a global citizen and the impact we have on the health care systems in developing countries. This is particularly salient to consider at a time when the recruitment of overseas trained health professionals has increased and is seen as a response to workforce mal-distribution and shortages within our own country.

It was a positive first step that ethical issues in overseas recruitment were acknowledged in the Productivity Commission Health Workforce Study Issues Paper released in June. PHM Australia calls for the ethical aspect of skills importation to be given greater attention in the Productivity Commission's forthcoming report. This submission aims to increase understanding of the issue and to provide an outline of the ways in which Australian policy makers can begin to address the negative impacts of Australia's role in health professional migration.

PHM Australia recognises that Australians living in rural, remote and disadvantaged metropolitan areas also experience a health professional brain drain away from their regions. We acknowledge that many immigrating health professionals are recruited specifically for those areas of need and encourage the development of measures to correct this mal-distribution of health workers within Australia. PHM Australia supports the position taken by the National Rural Health Alliance with regards to balancing the needs of rural Australians

and the developing world (NRHA 2004).

The Global Situation – Source and Recipient Countries

Movement of health professionals from poorer to richer countries is part of a broader pattern which includes movements within countries from public to private sectors; from rural to urban areas and from disadvantaged to more advantaged neighbourhoods. This type of flow occurs in all countries including Australia and has proved difficult to regulate with few countries successfully resolving imbalances particularly between rural and urban areas. The concentration of health professionals in urban areas is particularly pronounced in developing countries compared to developed countries although some countries such as Thailand have been more successful than others at regulating distribution of health professionals (Zurn 2004). Flows also occur between developing countries with more affluent nations such as South Africa receiving health professionals from its neighbours (Bundred 2000). Finally there is also considerable flow between developed countries such as the case of Canada's significant net loss of physicians to the United States despite also being a major importer of health professionals (Bourassa Forcier 2004).

Many health professionals from developing countries cite poor working conditions and salaries, lack of job opportunities and career paths with few prospects for improvement, political instability and corruption in their home country as a reason for leaving (Pang 2002). All these reasons were cited in replies from many Zimbabwean health professionals in a brief report about brain drain in the British Medical Journal (Levy 2003). In nursing the poor career structure and lack of professional recognition in some developing countries makes it a more attractive option to work in developed countries where nursing is better recognised as a profession (Buchan 2004). Structural adjustment packages imposed

on many countries during the last twenty years have led to worsening conditions in government employment (Wyss 2004).

The main recipient countries for health workers are the United States of America, the United Kingdom, Canada, New Zealand and Australia (Hawthorne 2003). The USA has a particularly high number of overseas trained health professionals. Health workforce shortages are projected to grow in these countries particularly in nursing, with the USA alone projected to need an additional million nurses over the next ten years (Martineau 2004). Commonwealth developing countries are particularly burdened by brain drain because their medical education is largely in English, most of the recipient countries are English-speaking and professional qualifications are more often formally recognised (Johnson 2005). For example, 6% of doctors in the USA come from sub-Saharan Africa with most of these coming from Nigeria, Ghana and South Africa. A recent study found that most of these doctors came from only 10 medical schools suggesting that an active policy decision not to recruit from these areas could make a significant difference (Hagopian 2004).

The inability of many developing countries to staff their health system is aggravating their economic problems and increasing global inequality (Lee 2003). The brain drain of skilled health professionals has been identified as a key issue that is impacting on provision of health care for the treatment and prevention of HIV/AIDS in developing countries by the Secretary General of the World Health Organization (Lee 2003).

Costs of the Health Brain Drain to Developing Countries

The following section outlines the costs to drained developing countries of the migration of their health care professionals to more developed countries like

Australia as seen from a societal perspective.

Cost of training : Source countries lose all or part of the investment in training health professionals when they migrate. It was estimated that training the 600 South African doctors who were registered in New Zealand by the year 2000 cost South African tax payers US$37 million (Bundred 2000). More recently, training each doctor has been estimated to cost up to US$184 000 (Pang 2002). With an estimated one third to one half of the medical graduates from South African universities going overseas to work, this has a significant economic impact on the drained country (Pang 2002).

Loss of skills : Valuable skills are lost through migration. Well-trained and more experienced professionals will find it easier to get work overseas and are the most actively sought by recruiters. A reduced supply of health care providers is likely to increase wages in the private sector and so increase cost of access to care. Further, a reduced formally-trained health workforce may result in increases to the informal sector and services financed through "under the table" payments. Increasing costs of health care borne by patients will result in patients presenting when sicker or alternatively not accessing preventative programs.

Difficulty planning health services : The unpredictable loss of skilled health professionals within the health system makes the task of planning for health care more difficult and reduces the effectiveness and accountability within the system. The loss of health professionals places an additional burden on the remaining health care providers and services. In this regard, it has been suggested that overworked health professionals can make more mistakes and under-trained or unsupervised staff are required to undertake tasks for which they are not adequately prepared (Stilwell 2004). The loss of colleagues exacerbates the cycle of attrition and job dissatisfaction as staff left behind continue with

an increased workload in a dysfunctional system. This further increases their incentive to leave. There is likely to be a reduction in health prevention work as scarce resources are concentrated on the pressing visible problems of caring for sick people.

Increased inequities : The cost of the brain drain in resource-poor regions exacerbates inequities in access to care in both rural and poor urban areas, with the most vulnerable populations at greatest risk. The inverse care law (that is, that the sickest have the worse access to care) was first articulated in the context of the United Kingdom and applies to an even greater extent in poorer countries where health systems are under greater strain (Hart 1971, Zurn 2004).

Opportunity costs : There are substantial opportunity costs resulting from a shift of health care labour from resource-poor countries to resource-rich countries. One example is the barrier to scaling-up access to antiretroviral medications to treat AIDS patients. The lack of skilled health staff has been cited as the major barrier to achieving the health-related Millennium Goals with a recent report stating that the workforce needs to more than double if the goals are to be achievable (World Health Organization 2004). The cost in productivity lost through the preventable early death of the youngest and most productive members of society to HIV/AIDS has been well documented. The shortage of skilled health professionals is also impeding progress in the fight against tuberculosis (TB) with 18 of the 22 countries which experience the greatest burden of TB nominating staff shortages as the major obstacle to reaching the World Health Organization nominated goals to fight TB (Figueroa-Munoz 2003).

Employing foreign staff : Countries need to spend scarce foreign exchange if they are to import medical skills. This reduces funds for medication, equipment and training. Alternatively staff may be provided by industrialised countries as

part of an aid package. However, this is not a sustainable solution as staff from resource-rich countries need substantial training to work in resource-poor environments and usually work only for short periods. The flow of health professionals to rich countries usually far outweighs any flow back to poor countries.

The example of Ghana

Health workforce patterns in the Western African country of Ghana provides an illustration of the tangible costs of brain drain. Ghana spends $9 million per annum on medical education but has a ratio of 9 doctors per 100 000 population (Australia 1:500, WHO target 1:1000). It is estimated that between 1993 and 2002 in excess of 12 365 health professionals left Ghana with 60% of all doctors trained in the 1980s having migrated away. (GhanaWeb 2003, Johnson 2005, Nullis-Kapp 2005). There are estimated to be more Ghanaian doctors who live outside of Ghana than in Ghana itself (Scott 2004). In Ghana there are currently 350 000 people living with HIV, 71 000 require treatment with antiretroviral therapy. Despite a commitment of US$14 million by the Global Fund to Fight AIDS, Tuberculosis and Malaria, only 2.8% of people who require antiretroviral treatment are currently receiving it. The project is noted as having staff attrition due to migration that may be impeding the progress of this project (Global Fund 2004).

Extent of the Brain Drain Caused by Recruitment of Health Professionals to Australia

Nurses

A study of nursing migration in several developed countries including Australia found that most nurse migration to Victoria was from developed countries (Buchan 2004). This contrasts with the United Kingdom where a relatively large proportion come from resource-poor countries (Buchan 2004). According to the

Victorian Nursing Board Annual Report for 2004, an estimated one fifth of newly registered nurses (1,732) were born overseas. Most did come from developed countries but there were significant numbers from the Philippines (204), India (83), South Africa (100) and Zimbabwe (48). The report noted an increase in new nursing registrations from the Philippines (62%) and India (118%) compared to the previous twelve months.

A similar pattern was seen in New South Wales in 2004 with newly registered Division 1 Nurses including 114 from the Philippines, 240 from South Africa and 349 from Zimbabwe out of a total of 2 425 newly registered nurses from overseas (Nurses and Midwives Board of New South Wales 2004). Although the recruitment of nurses from developing countries is not occurring at such a high rate in Australia as the United Kingdom, it is increasing and the global nursing shortage is likely to exacerbate the trend.

There is concerning evidence of a growing shortage of nurses in Australia with the Department of Health and Aging submission to the Productivity Commission Health Workforce Study noting that population growth between 1996 and 2001 was 6.1 % whist the nursing workforce only grew by 2.4% (DoHA 2005). Nurses are in such short supply in industrialised countries that they are being sought out globally (Stilwell 2003). The drain of nurses from small Pacific countries is particularly troubling since recruitment of relatively small numbers of nurses from these countries is likely to have major effects on their health systems.

Doctors

Medical migration to Australia has increased in recent years and in particular recruitment to work in areas of need has jumped dramatically from 677 in 1992/1993 to 2 899 in 2000/2001(Hawthorne 2003). There are about 25 000 permanent resident non-specialist medical practitioners in Australia compared to about 2 000 doctors on visas designed to fill general practitioner posts in area

of need and around 1 000 overseas trained doctors working as occupational trainees in hospitals. The high proportion of overseas trained doctors compared to Australian trained doctors has been due to active policy decisions taken by the Federal government in response to doctor shortages and falling bulk billing rates (Birrell 2004). Up until about six years ago, most medical migrants came from the United Kingdom and Ireland. However, this has now changed with a much larger proportion of doctors arriving from developing countries. Between 1996-2001, a total of 4 678 doctors arrived in Australia of which British and Irish doctors were the largest group (857) but there were significant numbers from Southern Central Asia (516), China (489), India (430), Middle East and North Africa (411), South Africa (363) and the Philippines (81) (Birrell 2004).

Most of the doctors who arrived in the period 1996-2001 were employed but there were significant proportions from developing countries who were not in the labour force in 2001 including 39% from China and 29% from Middle East and Northern Africa (Birrell 2004). This constitutes significant brain waste and is perhaps due to difficulty with accreditation of their skills. It is possible that some of the doctors who had employment were actually not employed as physicians. This unemployment and employment outside the profession represent a potential source of new doctors which will not result in further depletion of the workforce in developing countries.

There is also an increasing reliance on overseas trained doctors to fill specialist positions such as surgeons and psychiatrists with a significant proportion being recruited from poorer countries who face far greater shortages than Australia. The hospital system is also now reliant on overseas trained doctors who often do the jobs that local residents will not fill (Hawthorne 2003). In a Victorian study, many of the doctors complained of long hours and lack of support in the hospital system (Hawthorne 2003).

The drive to recruit overseas trained doctors has increased, as incentives to get Australian trained doctors to relocate to regional and rural areas are not likely to meet projected demands especially given shortages in outer metropolitan areas. There is also competition for our physicians from other industrialised countries. Australia needs to introduce geographically defined provider numbers for physicians as the current system is clearly flawed and incentives to encourage doctors to work in underserved areas are not working.

Australia is currently the only country that allows general practitioners to immigrate and commence practice without first passing an examination if their qualifications are accepted as equivalent to the Australian qualifications and they agree to work in an area of need for a specified time. Overseas trained doctors are now eligible to migrate permanently after staying in areas of need for five years if they pass a family medicine exam within the first two years (Birrell 2004). There are also schemes to allow doctors who have not passed the Australian Medical Council Exams to work in hospitals for a specified time period. These policies ensure Australia is a relatively attractive destination for overseas trained doctors given that some other developed countries have more stringent requirements (Hawthorne 2003).

There are signs that overseas trained doctors are particularly mobile with many willing to move between countries and within countries to achieve their aims (Hawthorn 2003). Their average length of stay in rural Victorian general practice was about half that of Australian trained doctors (Kosmina 2004). Their reasons for leaving rural practice are similar to those of local graduates and include poor career prospects for their partner, lack of educational facilities, onerous workloads and lack of income (Kosmina 2004). Recruiting overseas trained doctors to fill rural vacancies is not a viable solution to the mal-distribution of doctors within Australia. However, the Department of Health and Aging submission to the Productivity Commission Study notes that it expects that over

700 doctors will have immigrated by 2007 (DoHA 2005).

Other health professionals

There are also shortages of pharmacists and allied health professionals but it is not clear how many are migrating to Australia from developing countries. Academics have noted an undue emphasis on the study of doctors at the expense of nurses and allied health professionals in the literature and policy debates about brain drain (Narasimhan 2004).

Impacts on our neighbours

Australia must be particularly mindful of the problems caused by skilled health professional migration for our near neighbours. Fiji is estimated to have lost 510 doctors to emigration between 1987-2002 whilst only producing 284 local graduates during this time (Baravilala 2004). The impact of losing even a few doctors from small countries such as Fiji, Tonga and East Timor can have a huge impact on the health system in those countries. If not addressed in a meaningful way, the impact of health brain drain to Australia from these countries will diminish or outstrip the impact of Australian aid given to these countries for health and development.

Issues in Overseas Recruitment

Global and regional stability

The advent of new diseases such as SARS and avian influenza has shown how vulnerable all countries are to emerging diseases especially when an epidemic starts in a country that is unable to control it effectively due to a lack of capacity. It is in in Australia's best health interests to have effective and well-functioning health care systems in developing countries, particularly our nearest neighbours. This reasoning can also be applied to health as one of the determinants in the contentedness of populations and the likelihood of civil unrest. Australia invests a significant amount of resources in assisting our

neighbours, such as Papua New Guinea, in security operations which may be undermined as the deterioration of health systems affects people's lives and livelihoods.

Freedom of movement

In the increasingly globalised economy, the flow of skilled labour between countries occurs in most professions and is rising. The flow is not always in one direction with some health professionals from industrialised countries working in poorer countries. Health professionals from developing countries defend their right to pursue their ambitions and career paths and provide a better life for themselves and their families by working in developed countries (Cash 2005). Rich countries do not have the right to restrict the right of health professionals from poorer countries working in their country. Moves to restrict entry of health professionals from developing countries could be interpreted as a discriminatory policy that is reminiscent of earlier now discredited restrictive immigration policies and is seen by PHM Australia as undesirable.

However, all countries regulate the flow of people into their countries, based largely on what is seen to be as in the national interest. When considering its recruitment policies Australia is in a financial position to take into account the effect these policies will have on less developed countries. The relatively small number of Australian health professionals working in poorer countries usually on short term contracts, does not compensate for the flow of health professionals from poorer countries to Australia. The flow of health professionals from poorer to richer countries should not be prevented but rather regulated in order to serve the interest of both the home and recipient countries or at least not have a detrimental impact on developing countries.

Remittances

Remittances are a larger source of income for most overseas countries than

foreign aid and countries such as the Philippines, India and more recently China train more health professionals (particularly nurses) than their health system has had the capacity to employ. These migrating workers form a vital part of the country's economy and some proportion will return with valuable skills. This migration from poor countries is likely to increase due to the global shortage of nurses (Buchan 2004). However, even countries such as India and the Philippines have recently noted that the growing recruitment of nurses to developed countries and their own growing needs has meant that they are finding it difficult to fill local posts (Nullis Kapp 2005). Remittances are not invested back into the health care system but into the general economy of the country (Van der Weyden 2004). For countries such as Ghana and South Africa with serious shortages of health professionals, the loss to their health system caused by the migration of health professionals far outweighs the gains from remittance (Scott 2004).

Training Health Professionals in Australia

International students

An increasing number of students (in excess of 7000 in 2004) from overseas are currently doing medical or allied health courses in Australia (DoHA 2004). Some of these are from resource-poor countries including African, Middle Eastern and South East Asian nations. They will be encouraged to settle here given that medicine is now on the skilled occupation list for immigration visas (Birrell 2004).

We argue that training for most health professionals from developing countries would be best provided in their own country as the health problems and resources available are significantly different to those found in industrialised countries. Training in industrialised countries can be less useful than hoped because the skills obtained are too specialised and require access to expensive

technology (Bourassa Forcier 2004). Furthermore both the direct and indirect costs of study can be reduced when studying in the home country and it reduces or prevents long separation from family. Industrialised countries should consider how to also assist in providing training and support within developing countries, as training in industrialised countries often leads to permanent migration (Cash 2005). Industrialised countries should assist developing countries to retain their health staff including providing funding for salaries and incentives, and assistance with human resource management (Martineau 2004). Where possible, Australian funding for health development in developing countries should be directed to supporting local or regional training efforts rather than bringing students to Australia (Cash 2005).

Unemployed health workers already in Australia

Australia could improve the training opportunities it provides to health professionals who have permanently migrated to Australia and whose qualifications are currently not recognised. A recent study of overseas trained doctors employed in two Victorian schemes that recruits doctors to work in rural areas of need found that there was a lack of educational support for these doctors. Some of these doctors had been unable to work for extended periods due to difficulties in passing the Australian Medical Council exam and were now working in isolated and unsupported situations (Hawthorne 2003).

There has been a reduction in the subsidised training provided to candidates for the Australian Medical Council exam in Victoria and other states. There are a large number (> 3000) of overseas trained doctors who migrated since 1990 who have not passed the Australian Medical Council examination (AMC) with many of these practitioners still wishing to work as doctors (Birrell 2004). Many are understandably angry that they have not been given support to pass medical examinations whilst more recent arrivals from comparable countries have been able to work with very limited assessment (Birrell 2004). A bridging course in

New South Wales resulted in an 85% pass rate of the AMC examination that is higher than the expected 50% pass rate (Birrell 2004). There is a particularly strong case to be made for additional subsidised support for those doctors and other health professionals who arrived in Australia as refugees. A significant minority (13%) of doctors recruited into two Victorian rural general practice schemes for overseas trained doctors were refugees (Hawthorne 2003). This kind of brain waste has also been described in nurses from developing countries in international studies (Buchan 2004). Anecdotal evidence suggests there are many well qualified nurses from developing countries who must work as nursing assistants in industrialised countries (Buchan 2004).

Ethical Recruitment – A Starting Point

Adopting ethical recruitment practices can help prevent the active exploitation of the recruited workforce, and is an important start for Australia's workforce recruitment strategy. The United Kingdom has been a leader in ethical recruitment. It was the first nation to produce international recruitment guidelines based on ethical principles and the first nation to develop a robust code of practice for international recruitment.

Important elements of the Commonwealth Code to which Australia is a signatory:

- International recruitment should only be considered when it will have no adverse effects e.g., when there is a documented skill sufficiency in the recruit's home health care system.
- Developing countries will not be targeted for recruitment unless there is an explicit government to government agreement.
- The recruiting country will generate a list of countries that should not be targeted under any circumstances.
- Recruitment agencies who are listed as having committed to the code of conduct should be the only ones considered for providing services.
- An induction program to protect the welfare of the recruited staff, and an adaptation program to ensure the recruits are familiar with the delivery and

philosophy of health care in the recruiting country must be in place.

- Applicants will not be charged fees
  - to gain employment
  - for any part of the induction process or for any part of supervised practice
- Costs of work permits will be met by the employer.
- The recruited workers will be employed under the same terms and conditions of employment as other employees.

The *Melbourne Manifesto* was developed and approved at the WONCA (World Organization for Family Doctors) World Rural Health Conference in Melbourne in 2002. It states that countries wishing to recruit should develop a Memorandum of Understanding (MOU) with source countries. This MOU should cover the benefits to each country, the nature and amount of compensation to be provided and support and training for overseas trained health professionals in the recipient country. The *Melbourne Manifesto* has been adopted by the National Rural Health Alliance and some of its member organisations.

Despite the ethical recruitment strategies available, questions have been raised if these strategies are enough on their own. The Commonwealth Code is voluntary, as are other ethical recruitment strategies, and it does not cover the private sector. The United Kingdom still relies heavily on overseas trained health professionals from poor countries despite a strong commitment to ethical recruitment (Willetts 2004). Since the adoption of more rigorous ethical recruitment practices, the numbers of immigrating skilled health professionals have continued to climb rapidly in the United Kingdom (Willetts 2004).

It is of concern to PHM Australia that the submission from the Australian Department of Immigration and Multicultural and Indigenous Affairs to the current Productivity Commission Health Workforce Study focused on making Australia a more attractive destination for overseas health professionals

without any apparent concern for ethical issues (DIMIA 2005). It must be noted that due to the reliance on skilled immigration in other industrialised countries such as the United States, United Kingdom, Canada and New Zealand even recruitment from these places is problematic.

Human Resources Data Collection

It is widely acknowledged that the lack of data on skilled health professional migration is a hindrance to developing meaningful solutions to the negative impacts of human resource migration (Diallo 2004). Australia must develop the means to gather data on where our internationally recruited health workers are coming from, what their skills are and where within Australia are they going. Professionals in Australia for short term work or training need to be distinguished from permanent migrants. Immigration from politically unstable countries such as Zimbabwe and immigration in the family reunion/refugee category must be considered separately to immigration of health professionals from politically stable but poor countries.

Furthermore, Australia has an opportunity as a well-off country to assist other countries in developing health personnel record systems.

Compensating Drained Countries

Rich countries such as Australia are not investing sufficient resources in training health professionals. This is the major cause of the loss of the investment made in training health professionals by poor countries, investments they can ill-afford to lose.

Health professionals will continue to migrate to Australia even if they are not

actively recruited. PHM Australia calls upon the Australian Government to develop methods for making meaningful contributions as a means of compensation to those resource-poor countries from which health professionals arrive here to work. This should be directed towards countries that have health workforce shortages and must be carried out in such a way that funds are used within the health sector. For example, compensation may be paid through financial support for additional in-country training places.

There is a real need for reliable estimates to be calculated of the financial losses incurred to developing countries through brain drain. This will be important in calculating compensation for drained countries and is a task the Productivity Commission should undertake as part of the Health Workforce Study.

Moving Forward

This section briefly outlines some proposed actions for Australian governments and relevant organisations. Specific policy responses to Australia's role in the international brain drain will be the subject of a forthcoming submission to the Productivity Commission Health Workforce Study by PHM Australia.

- Develop an Australian ethical recruitment code of practice that should be used by all jurisdictions. The *Melbourne Manifesto* provides an excellent starting point.
- Use only the services of professional recruitment agencies that use the approved ethical code of practice.
- Initiate the development of an international body to regulate professional recruitment agencies and acceptable recruitment methods.
- Develop Memorandums of Understanding with countries from which Australia is recruiting in accordance with the *Melbourne Manifesto*.
- Consult source countries about strategies to help reduce brain drain within their countries such as providing aid specifically to improve conditions for health professionals in source countries.
- Improve data collection on health professional migration to and within Australia.
- Provide direct, concrete compensation to countries drained by Australia.
- Speed up efforts to achieve national health workforce self-sufficiency.
- Target recruitment from countries that do not have documented skills shortages or target at areas such as Eastern Europe that may have an oversupply.
- Support in-country training programs over training programs based in Australia.
- Implement exchange programs which aim to assist health education programs in poor countries (Cash 2005).
- Assist developing countries with professional training curricula (Bundred 2000).
- Introduce occupational training visas to facilitate exchanges that are primarily for training rather than a means to relieve work force shortages

(Bourassa Forcier 2004, Birrell 2004).

- Investigate ways to mobilise the diaspora of health professionals to contribute to health sector development in their own country. This could occur through funded return visits for training and curriculum development, the development of professional support networks and actual labour in areas of need.
- Exclude all health services from the General Agreement on Trade in Services and encourage all other countries to do the same.
- Increase support and training for overseas trained doctors who are permanent residents and have not yet passed the Australian Medical Council examinations.
- Provide similar support for other health professionals who are permanent residents and have not yet passed the necessary examinations.
- Consider ways to encourage overseas students studying medicine or other health professional courses to return to their home countries if they are from a resource poor country.
- Further develop Australian policies that will aid retention of local health professionals and improve their distribution within the country.
- Explore innovative ways to provide health services in both rural/remote and metropolitan areas with a focus on primary health care.
- Advocate for all industrialised countries to follow the relevant actions above.

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