# Foreign-trained Doctors and Nurses in Australia: Past and Present

My Tran; John Tayu Lee; Mark Cormack, Fan Xiang, and Tomoko Sugiura.

## Summary

Australia relies substantially on overseas trained health professionals to address the problems of health workforce shortages and distribution. In the last decade, Australia has remained in the top ten OECD countries with the highest shares of foreign-trained health professionals.[1] According to the most recent OECD data, the share of foreign-trained nurses in Australia was 18%, tripling the United States' numbers. This 'Data Insights' identifies the recent trends in Australian foreign-trained health workforces, specifically doctors and nurses.

## Key messages

- The health workforce is a labour market characterised by demand and supply. In this market, shortages can be mitigated through increasing training or importing overseas workers.
- Australia highly depends on overseas trained health workforces to address the existing shortage gaps.
- The majority of our foreign-trained workforces are from the current or ex-Commonwealth countries, with China being the only exception.
- In the last 15 years, Australia has become more attractive as a destination for foreign-trained health workers, moving to the top-five countries of destinations.
- Heavy reliance on foreign-trained health workforces brings great benefits, but it also creates risks for Australia as well as for the source countries and our region more broadly. Balancing these benefits and risks in designing future immigration policies is critical for health workforce planning.

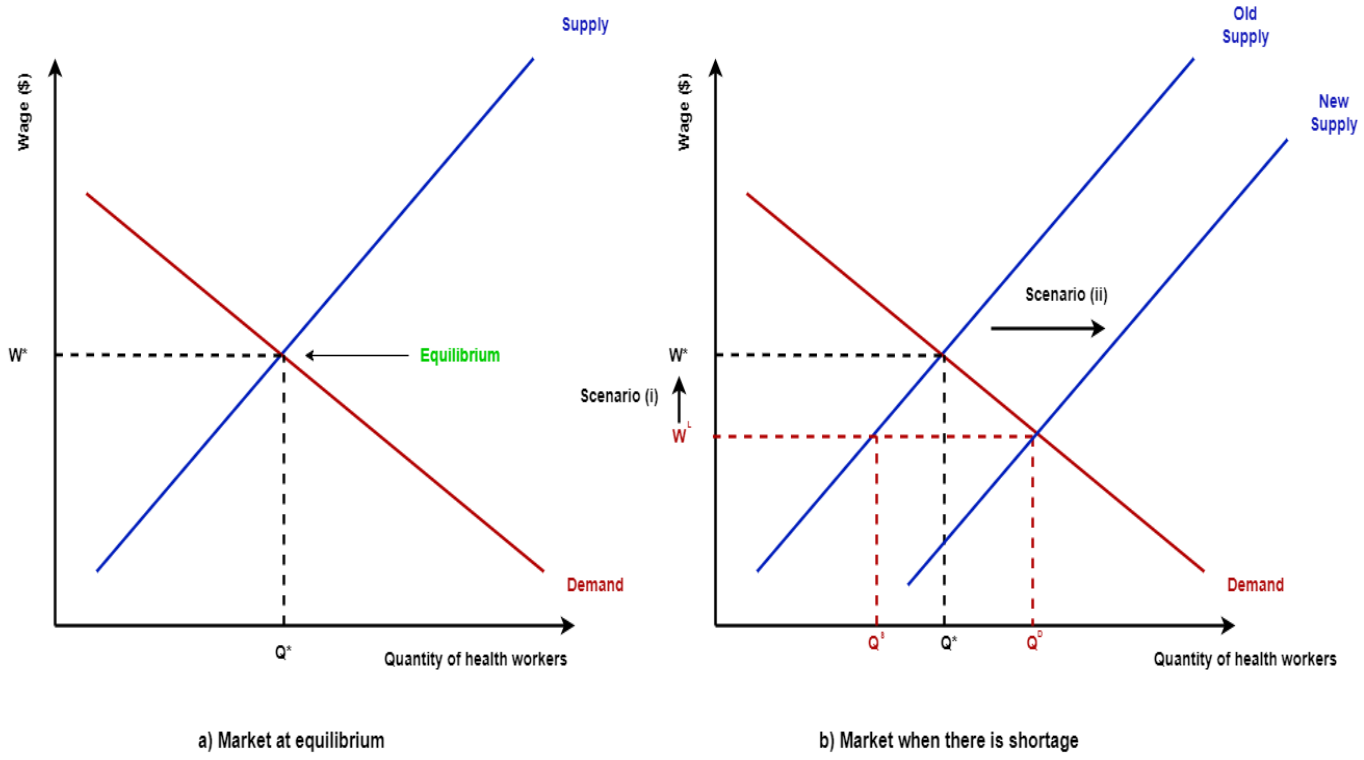
## Health workforce as a labour market

The health workforce is a labour market characterised by demand and supply. In this market, demand is influenced by factors including household income (i.e., the ability of consumers to purchase health services), the government fiscal capacity and policy settings as well as demographic and epidemiologic conditions of the population (e.g., aging and disease burden). The supply is driven by the stock (i.e., the accumulation of workers within a system over time) and flow (i.e., the number of health professionals entering or leaving this stock within a specific timeframe).

In a well-functioning market, the imbalance between demand and supply is short-lived as the wage rate can be flexible, incentivising workers' behaviours such that balance is restored ("equilibrium"). If demand exceeds supply, shortages can be mitigated by i) raising wages to attract more workers or ii) increasing training or importing overseas workers to increase the supply (see **Figure 1**). The latter has been Australia's and many other high-income countries' approach to addressing workforce shortages.

The balance may not be restored immediately because supply tends to respond slower than demand changes. For instance, medical training can take a long time (e.g., up to 10-12 years for specialists). Reliance on migrant health workforce could also result in an imbalance in global supply, exacerbating shortages in their home countries. On the other hand, raising wages is difficult in many countries due to legislative, industrial, and regulatory barriers.

Figure 1. The health workforce labour market – Stylised example.



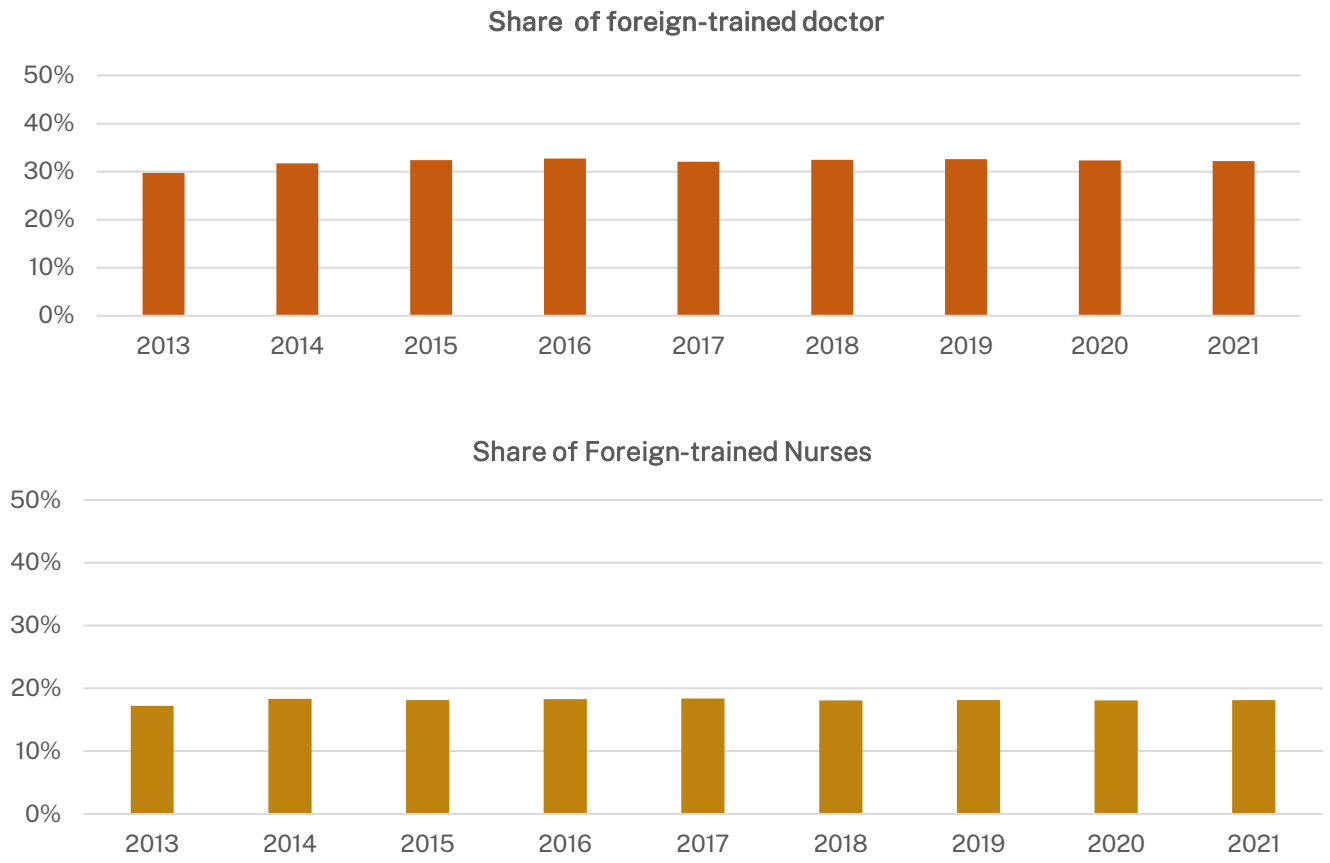

## Changes in foreign-trained health workforce in the last decade

Australia relies heavily on foreign-trained workforces to address shortages, especially in rural areas. In 2021, 33,216 overseas doctors and 59,665 overseas nurses were practicing in Australia. Over 30% of Australian doctors were foreign trained, whereas 17% of nurses were (**Figure 2**).

The share of foreign-trained doctors has increased since 2013 and peaked in 2016. It dropped by almost 2% in 2017 but recovered up to 2019. There was also a slight decline in the share of foreign-trained doctors after the COVID-19 pandemic, possibly due to the border closures and international travel restrictions.

Similarly, the share of foreign-trained nurses has increased since 2013 and peaked in 2017. After that, the proportion of foreign-trained nurses dropped by 2% and stayed stable until 2021.

**Figure 2. The shares of foreign-trained doctors and nurses in Australia, 2013-2021.**




Source: OECD (2023).

## Origins of foreign-trained workforce in Australia

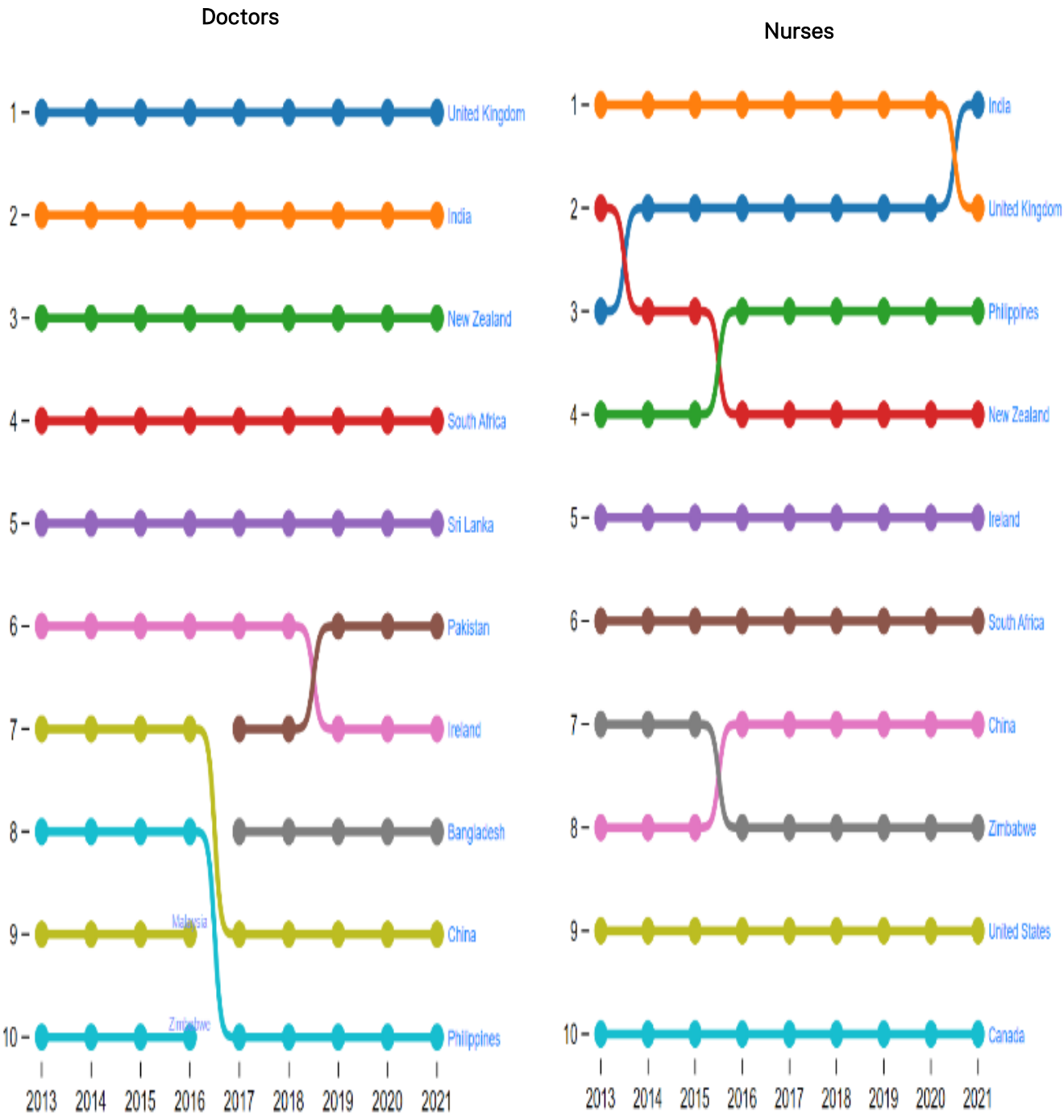
Most of our international workforce is trained in the United Kingdom (UK), New Zealand, South Africa, and Southeast and South Asian countries. As of 2021, over 50% of international doctors were trained in the UK, India, New Zealand, South Africa, and Sri Lanka. Approximately 80% of the international nurses qualified in the UK, India, the Philippines, New Zealand, and Ireland. We are using the OECD data, which collects detailed information on the country of qualification ("*Country of origin*") to examine the changes in immigration patterns for doctors and nurses over time. We first calculated the shares for each country of origin by dividing the number of professionals trained in the country by the total number of foreign-trained professionals. Then, we ranked the Country of origin based on this calculation.

**Figure 3** shows the changes in Australia's top ten countries of origin for international doctors and nurses. UK-trained doctors comprised most of our international doctors, followed by India, New Zealand, South Africa, and Sri Lanka. While the top five have been stable, substantial changes for the 6$^{th}$-10$^{th}$ positions have occurred. In 2017, Pakistan and Bangladesh entered the top ten for the first time and replaced Malaysia and Zimbabwe. Since 2016, China and the Philippines have dropped in the ranking from 7$^{th}$ and 8$^{th}$ to 9$^{th}$ and 10$^{th}$. Malaysia and Zimbabwe took the 11$^{th}$ and 12$^{th}$ positions on the ranking.

Historically, the majority of international nurses were trained in the UK. However, India has taken over the 1st place in 2021. New Zealand's position in the top five has decreased over time, replaced by the UK and the Philippines. Ireland, South Africa, the US, and Canada's places in the top ten remain stable over time. In 2015, China and Zimbabwe switched positions between 7$^{th}$ and 8$^{th}$.

These patterns strongly reflect historical trends in the Australian immigration policy. Since qualifications from the UK, Ireland, and New Zealand are equivalent to nurses qualified in Australia,[2] there are fewer barriers for them to move and practice in Australia. The expansion of health workforce from India and Philippines can be a result of "train for export" model being implemented in these countries. This model led to a rapid expansion in the number of private sectors nursing schools, training nursing graduates to meet both domestical and international demand.[3]

**Figure 3. Changes in the top ten countries of origin for nurses and doctors in Australia, 2013-2021.**




Source: OECD (2023).

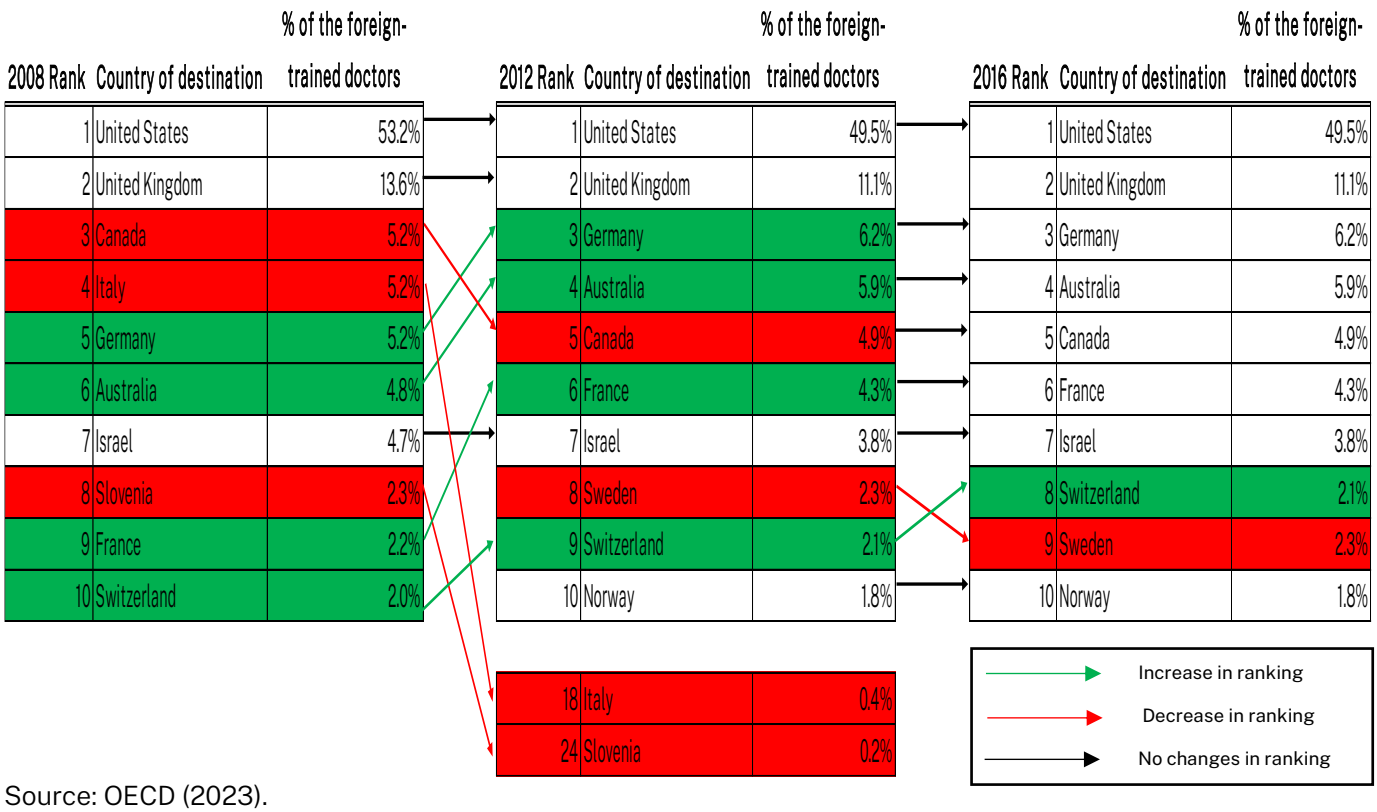
## Australia as an immigration destination for foreign-trained health workforces

In the last 20 years, Australia has competed with other high-income countries for foreign-trained health workforces. According to the OECD data, over 50% of the foreign-trained nurses and doctors worked in the US, the UK, and Germany. More recent OECD data is available, but the data for the US, a significant player in this market, is missing in some years. Thus, the ranking discussed below was limited to the years when both Australian and American data were available. The data for the nursing workforce was only available for two years. Thus, we will not report the ranking for the nursing workforce. We first calculated the shares for each country of immigration ("*Country of destination*") by dividing the number of professionals migrating to a country by the global number of foreign-trained professionals. Then, we ranked the Country of destination based on this calculation.

**Figure 4** presents the changes in the top 10 destinations ranking for foreign-trained doctors. While the rankings did not change significantly for the nursing workforce, there were substantial changes in the top 10 destinations for the medical workforce between 2008 and 2012. In 2008, Canada was in the top three for the most foreign-trained doctors but dropped to 5th in 2012. Italy and Slovenia dropped out of the top 10, moving down to the 18th and 24th positions in the ranking. On the other hand, Germany, Australia, France, and Switzerland have gained positions over time. Germany replaced Canada in the 3rd position, while Australia took the 4th place. France gained three places in the ranking, from 9th to 6th. From 2012, the ranking remains unchanged for most countries, except for Switzerland and Sweden.

Changes in Australia's ranking between 2008 and 2012 may reflect changes in immigration policies. In 2008, the Australian Government announced a 30 percent increase in the permanent skilled migration places. Skilled migration comprised 70 percent of the 2008–09 Migration Program, with 133,500 places allocated within a total Migration Program of 190,300 places — the most extensive program on record.[4] At the same time, the Australian Government announced the shift to a "demand-driven" model for permanent skilled migration, focusing on employer and Government-sponsored migration that would meet specific skills needs in the economy. Under this model, applications for employer-sponsored visas were fast-tracked and given priority over applications for independent skilled visas.[5] The global financial crisis and the collapse of the global housing market also served as a driver of emigration to Australia for health workers.[6]

**Figure 4.** Top ten countries of destination for foreign-trained doctors, 2008-2016.




Source: OECD (2023).

## Issues of over-reliance on foreign-trained health workforces

Heavy reliance on foreign-trained health workforces brings great benefits but also creates risks.

Firstly, changes in other countries' demands will also affect our health workforce, e.g., if a large competitor like the United States started recruiting more aggressively from abroad, it could lead to a more considerable workforce shortage in Australia.

Secondly, heavy reliance on a foreign-trained workforce leaves the health system vulnerable when there is a disruption in international mobility. For example, we observed a 2% reduction in both foreign-trained doctors and nurses after the COVID-19 pandemic, potentially due to global travel restrictions.

Thirdly, international recruitment is beneficial in the short run but needs to address structural issues in domestic workforce retention and recruitment, e.g., wages, workplace safety, work condition, training and educational pipeline issues, coordination between the education sector and health sector.

Fourthly, there is concern that the current visa scheme does not incentivise migrant nurses' long-term retention beyond the years specified in their employment or visa conditions. For example, the Temporary Skill Shortage (Subclass 482) visa only requires the sponsored applicant to remain employed with the sponsor for four years or until another eligible skilled visa is submitted.[7] This is particularly an issue in the regional Australia, as over 25% of migrants in these regions move out them within five years.[8] Moreover, health professionals from different countries face different barriers. For example, migrant nurses qualified in the UK and NZ gain easier entry as nurses in Australia compared with migrant nurses qualified in India and the Philippines.

Fifthly, Australia, as a nation, has obligations under the WHO Code on Practice on the International Recruitment of Health Personnel.[9] The Code provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries, countries with economies in transition and small island states. Although Australia has committed to be "self-sufficient", recent OECD analysis highlighted that between 40 to 50% of our foreign-trained nurses come from lower-middle-income countries.[10] After the pandemic, international recruitment activity has also been reported to increase rapidly across Australia.[3]

Lastly, work visas can bring the risk of exploitation, particularly in the care sector. Being on a work visa may further exacerbate workers' vulnerability by limiting workers' options to quit/change jobs. They are also at higher risk of being underpaid. According to the 2022 Grattan Institute estimates, immigrants working in the Health Care and Social Assistance industry are twice more likely to be underpaid.[11] Even when the workers on work visas want to change employers, they will need their new employers to get a new nomination approved, which has time and cost implications for both the employers and employees.[12]

## Concluding remark

Australia relies heavily on foreign-trained workforce compared to most OECD countries. Existing literature suggests that importing health professionals can be a double-edged sword. "Borrowing" health professionals can address shortages in the short run, but it does not address the structural issues in the health system. Moreover, additional risks from disruptions in international mobility, breaching the global code of conduct, and exploitation are associated with immigration policies. Australia needs comprehensive short- and long-term health workforce strategies to address acute and chronic workforce shortages.

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## Data sources

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