

Is health workforce sustainability in Australia and New Zealand a realistic policy goal?

James M. Buchan^{1,4} MA, PhD, DPM, Professor

Lucio Naccarella² BSc(Hons), GradDipMHS, PhD, Senior Research Fellow

Peter M. Brooks³ MD, FRACP, FFARM, FAFPHM, FRCP, Director

¹Queen Margaret University, QMU Drive, Edinburgh, EH21 6UU, UK.

²Australian Health Workforce Institute, University of Melbourne, 766 Elizabeth Street, Parkville, VIC 3010, Australia. Email: l.naccarella@unimelb.edu.au

³Australian Health Workforce Institute (AHWI), The University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences, Parkville, VIC 3010, Australia. Email: brooksp@unimelb.edu.au

⁴Corresponding author. Email: jbuchan@qmu.ac.uk

Abstract. This paper assesses what health workforce ‘sustainability’ might mean for Australia and New Zealand, given the policy direction set out in the World Health Organization draft code on international recruitment of health workers. The governments in both countries have in the past made policy statements about the desirability of health workforce ‘self-sufficiency’, but OECD data show that both have a high level of dependence on internationally recruited health professionals relative to most other OECD countries. The paper argues that if a target of ‘self-sufficiency’ or sustainability were to be based on meeting health workforce requirements from home based training, both Australia and New Zealand fall far short of this measure, and continue to be active recruiters. The paper stresses that there is no common agreed definition of what health workforce ‘self-sufficiency’, or ‘sustainability’ is in practice, and that without an agreed definition it will be difficult for policy-makers to move the debate on to reaching agreement and possibly setting measurable targets or timelines for achievement. The paper concludes that any policy decisions related to health workforce sustainability will also have to taken in the context of a wider community debate on what is required of a health system and how is it to be funded.

Introduction

In May 2010 the World Health Organization (WHO) Global Code on international recruitment of health professionals was approved by the World Health Assembly.^{1,2} The Code sets out a range of practical and ‘ethical’ aspects of international recruitment of health workers, including an emphasis on health workforce ‘sustainability’ (Articles 3.6 and 5.4). This places an emphasis on developed, ‘recruiter’ countries making more effort to meet their health workforce requirements from their own resources. The aim is both to reduce the potential negative effect of out-migration of skilled health workers from the developing world, and to encourage improvements in the efficiency of workforce planning at country level. As WHO had noted ‘The concept focuses on strengthening national health worker education. More broadly, achieving self-sufficiency or sustainability in the health workforce is about effective retention and deployment of available workers’.³

International migration of health workers is a complex issue, not fully captured by simplistic ‘brain drain’ arguments, as many health professionals move on their own initiative, for career development, security, or to find a job.² Active international recruitment of health workers can be a relatively low cost compared to meeting the expense of domestic training in Australia or New Zealand, it can be a flexible quick fix to national

health-worker shortages, and has been an attractive policy for governments in many countries. Australia and New Zealand have both been highly reliant on international recruitment to meet their health workforce requirements. Both countries cast their recruitment net widely, but have a pronounced effect on the Pacific islands.⁴ New Zealand is also a major ‘source’ country of international recruits – mainly for Australia – emphasising the point that some countries are both major ‘sources’ and ‘destinations’ for migrant health professionals.

The governments in both countries have also in the past made policy statements about the desirability of health workforce sustainability or self-sufficiency, a concept that could now take on a greater resonance and prominence with the adoption of the WHO Code. This paper assesses what health workforce ‘sustainability’ might mean for Australia and New Zealand, given the policy direction set out in the WHO Code, and within the broader context of health labour market dynamics and government policy in the two countries.

Background

Australia and New Zealand have a high level of dependence on internationally recruited health professionals relative to most other OECD countries. Fully comparative and reliable data are limited, but recent statistics from the Organisation for Economic

Co-operation and Development (OECD) gives some insight.⁵ In terms of ‘stock’ of health workers, one in three doctors in New Zealand was determined to be foreign trained, as was one in four doctors in Australia (see Fig. 1). Health workforce data collated by the Australian Institute of Health and Welfare^{6,7} confirm that about one in four doctors, and one in six nurses working in Australia is internationally trained.

The five countries with highest reported levels of foreign-trained doctors, out of 14 OECD countries for which there were comparable data, all were predominantly English speaking. There are significant flows of doctors, nurses and other health professionals within these English-speaking countries – for example, nurses from UK to Australia⁸ and doctors and nurses from New Zealand to Australia,⁹ but also significant inflows from less developed countries in Africa, Asia and the Pacific. Australia has placed a major reliance on international recruitment from countries such as India and South Africa to staff hard-to-fill medical posts in rural and remote health services.

Although the OECD ‘stock’ data do not tell us when these doctors arrived in the country, or by which route, it does give some indication of how achievable a target of ‘self-sufficiency’ or sustainability might be, if this is a concept based on meeting health workforce requirements from home-based training. There has been significant recent growth in the intakes to medical schools in Australia. This will lead in turn to an increase in ‘new’ supply. By 2014 it is projected that the number of medical-school graduates will increase to 3786, an increase of almost 77% from 2008 and 170.4% from 1999.¹⁰ This may reduce future reliance on international recruitment, but currently both Australia and New Zealand fall far short of meeting their own staffing requirements, and continue to be active recruiters.

What is sustainability?

Article 3.6 of the WHO Code notes that ‘Member States should strive to create a sustainable health workforce and work towards establishing effective planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel’. The Code places the onus on member states to

become more effective in their own training and planning, to become more sustainable in their use of their own health human resources and so reduce their level of reliance on international recruitment. The Code also makes it clear that individual health workers should have the right to migrate if they wish.

The concept of self-sufficiency and sustainability has already been highlighted, if not fully debated or realised in Australia and New Zealand. In Australia health workforce ‘self-sufficiency’ was formally recognised as a policy goal in 2004, as principle 1 of the National Health Workforce Strategic Framework,¹¹ which stated: ‘Australia should focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market’. The Framework was developed to guide national health workforce policy and planning to 2014. It was endorsed by Australian Health Ministers in 2004 and by the Council of Australian Governments in 2006.¹²

However, the Strategic Framework itself did not define self-sufficiency, and it was recognised that the term was capable of different interpretations. An alternative view was set out by the Productivity Commission report on health workforce in 2005.¹³ This recognised Australia’s current reliance on an internationally trained health workforce and acknowledged the need for a more sustainable approach, but also recommended a review of whether the self-sufficiency principle was ‘...unduly restrictive given the international nature of the health workforce and, if so, how the principle should be interpreted in practice. . .’ (p. 40), also noting that: ‘importantly, access to internationally trained health workers provides a valuable avenue for skills transmission and through this productivity gains. . .’ (p. 39).

More recently, the interim report of the Australian National Health and Hospitals Reform Commission has noted that high levels of reliance on internationally recruited doctors ‘is neither sustainable, nor ethical’ and has recommended that ‘Australian health workforce policy should be guided by the long-term aim of ensuring that we are self-sufficient on a net basis across all categories of health professionals’.¹⁴ This issue was less evident in the final full report from the NHHRC.

The case of Australia highlights that making a general policy statement about health workforce self-sufficiency is easier than

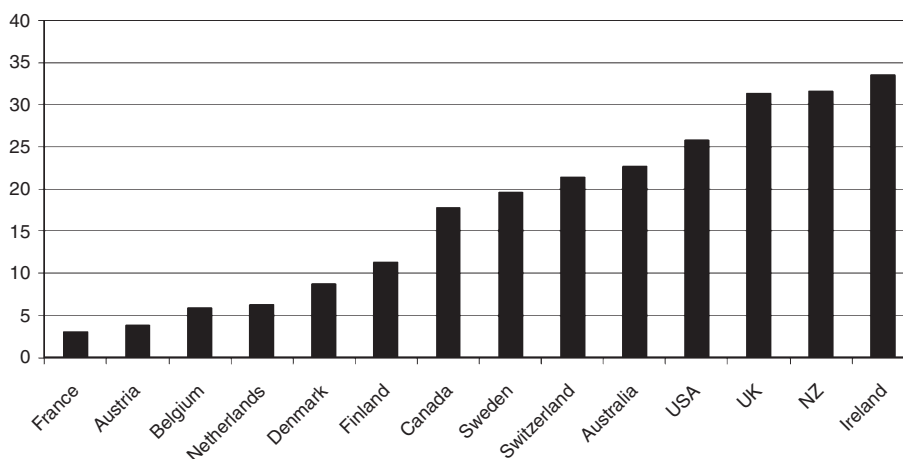


Fig. 1. Share of foreign-trained doctors, selected OECD countries, 2007 (or latest year available). Source: OECD 2009.⁹

reaching agreement on what that actually means in policy terms. The limitations of making a simple high level policy commitment to health workforce sustainability, without thinking through the implications of being just one resource constrained health labour market connected to many more has been highlighted by the case of New Zealand. New Zealand is the developed country identified by OECD with the highest level of inflow and outflow of health professionals.⁹ It recruits from many countries but also loses many doctors and nurses, including recently international recruits, to Australia. In part the high level of international recruitment to New Zealand is an attempt to compensate for the high level of outflow of doctors to Australia.

Policy statements by New Zealand governments have highlighted that 'consideration should be given to New Zealand becoming net self-sufficient for medical graduates' (p. 19)¹⁵ but as the authors of the recent OECD report⁹ on the NZ healthcare labour market noted 'the fact that the idea of self-sufficiency has gained importance in New Zealand might be surprising. New Zealand is indeed a very open economy and immigration plays an important role in most economic sectors . . . In this context, it is not totally clear what self-sufficiency means and which policies will ensure it' (p. 23).

The debate on health workforce self-sufficiency or sustainability in Australia and New Zealand has therefore highlighted two important issues. First, there is no common agreed definition of what health workforce 'self-sufficiency', or 'sustainability' is in practice, and there are differing views on its desirability or achievability under any working definition. Second, now that there is a Global Code, without an agreed definition it will be difficult for policy-makers nationally and internationally to move the debate on to reaching agreement and possibly setting measurable targets or timelines for achievement. Similar conclusions have been drawn about the issue in other policy contexts.¹⁶

Measuring sustainability

The WHO definition of sustainability as set out in the Code is broad brush. Another recent WHO publication¹⁷ does give a specific measure of 'national HRH self-sufficiency': the proportion of nationally trained health workers in the health workforce (p. 29). This simple measure of workforce 'stock', derived from the type of data used by OECD and shown in Fig. 1, would point to both Australia and New Zealand being well short of self-sufficiency. This measure has utility as a simple indicator, and as such will be attractive to policy-makers, and has prospects of becoming the most used indicator. It does, however, have limitations that will have to be acknowledged. First, it does not capture the dynamism and possible change in level of health workforce flows. It cannot show if most international health workers have just arrived in the country, or have been in the country for many years. Another issue is the monitoring focus at 'national' level. In federated countries with devolved responsibility for health policy and health workforce, there can be significant variations in approaches to international recruitment, and different levels of 'self-sufficiency'. For example, NIHW data in Australia⁷ show that about one in six nurses (15.5%) in 2007 indicated that they obtained their first qualification in a country outside of Australia, but there was marked variation at State level.

Western Australia had the highest proportion of overseas-trained nurses (26.3%), whereas Tasmania had the lowest (5.8%).

Can health workforce sustainability be achieved?

The linked, but bigger question is not can sustainability be measured, but can it or should it be achieved? This question clearly carries with it additional policy baggage within the health and education sectors – funding streams, resource allocation, expansion of education facilities, implications for clinical placements, relative and absolute pay levels, etc. It also raises broader questions about a country's policy stance towards immigration of skilled and qualified personnel. Where there are extant and strong migration links between 'developed' countries such as New Zealand to Australia, this will also have to be taken into account.

The New Zealand case emphasises the importance of linking policies across sectors and highlights the potential risks of uncoordinated and inconsistent approaches to HRH migration and broader aspects of HRH planning. If WHO (and by implication Australia and New Zealand) are to be serious about national level health workforce sustainability as a policy target, this will require a coordinated action across different government departments, underpinned by a commitment to shifting reliance away from high level active international recruitment, with all the commensurate policy shifts and resource challenges that this would require. Expansion of home-based training, improved retention, and more effective skill mix may all be policy goals in their own right, and may contribute to achieving greater degree of sustainability, but cannot be achieved overnight. They also bring complex challenges of policy co-ordination and calibration. In particular, expansion of home-based training is not a quick fix. The training pipeline for health professionals is between 4 to 15–20 years, depending on the profession and the extent of specialisation – much longer than the term of most governments. The current increase in home-based training of doctors in Australia, for example,¹⁰ will take 10 to 20 years and more to achieve a full-policy pay back. Many of the politicians and policy-makers that have to deal with the increased supply of doctors next decade will not be the same ones who made the decisions to increase domestic training at the beginning of this decade.

Policy decisions to increase or decrease the size of the inflow to home-based training are often criticised years later for having 'got it wrong' – for training too many, or not enough. This is another reason why international recruitment is attractive to policy-makers. It can be 'switched' on or off relatively easily, with staffing increases or reductions happening in a matter of months rather than years. Many national policy-makers will be reluctant to let go of the flexible policy switch that is international recruitment.

Any discussion and subsequent policy decisions related to health workforce sustainability will also have to be taken in the context of a wider community debate on what is required of a health system and how is it to be funded. Governments in Australia and New Zealand have a great opportunity and a responsibility to drive significant health system restructuring to allow for a greater focus on prevention, a broadening of roles for health workers and an increased focus on productivity across the acute and chronic care sectors. This restructuring would of

itself have significant effects on health workforce requirements and thus affect the international flows of health workers.

Competing interests

The authors declare that no conflicts of interest exist.

Acknowledgements

Professor Buchan was supported in travel and accommodation costs by a grant from the University of Melbourne Knowledge Transfer (KT) Fund, which enabled him to meet with Australian counterparts

References

- 1 WHO Global Code of Practice on the International Recruitment of Health Personnel. Sixty Third World Health Assembly WHA 63.16. Agenda item 11.5 21. Geneva: World Health Organization; 2010. Available at <http://www.who.int/hrh/migration/code/practice/en/index.html> [verified 7 March 2011].
- 2 Buchan J. Analysis: Challenges for WHO code on international recruitment. *BMJ* 2010; 340: c1486. doi:10.1136/bmj.c1486
- 3 A World Health Organization code of practice on the international recruitment of health personnel – Background paper. Geneva: World Health Organization; 2009: para 4.1.4. Available at <http://www.emro.who.int/rc56/media/pdf/EMRC56INF08en.pdf> [verified 7 March 2011].
- 4 Negin J. Australia and New Zealand's contribution to Pacific Island health worker brain drain. *Aust N Z J Public Health* 2008; 32(6): 507–11. doi:10.1111/j.1753-6405.2008.00300.x
- 5 Health at a Glance 2009. Paris: Organisation for Economic Co-operation and Development; 2009. Available at http://www.oecd.org/document/11/0,3343,en_2649_33929_16502667_1_1_1_37407,00.html [verified 7 March 2011].
- 6 Medical labour force 2007. National health labour force series no. 44. Cat. no. HWL 45. Canberra: Australian Institute of Health and Welfare; 2009. Available at <http://www.aihw.gov.au/publications/index.cfm/title/10723> [verified 7 March 2011].
- 7 Nursing and midwifery labour force 2007. National health labour force series no. 43. Cat. no. HWL 44. Canberra: Australian Institute of Health and Welfare; 2009. Available at <http://www.aihw.gov.au/publications/index.cfm/title/10724> [verified 7 March 2011].
- 8 Buchan J, Seccombe I. Difficult Times, Difficult Choices: The UK Nursing Labour Market Review 2009. London: Royal College of Nursing; 2009. Available at http://www.rcn.org.uk/__data/assets/pdf_file/0010/271297/003554.pdf [verified 7 March 2011].
- 9 Zurn P, Dumont J. Health Workforce and International Migration – Can New Zealand Compete? OECD Health Working Paper no. 33. OECD Paris; 2009. Available at <http://www.oecd.org/dataoecd/46/41/40673065.pdf> [verified 7 March 2011].
- 10 Medical Training Review Panel. Thirteenth report. Canberra: Medical Training Review Panel; 2010. Available at [http://www.health.gov.au/internet/main/publishing.nsf/Content/3431E8E659990C72CA2577490019113E/\\$File/mtrp13ex.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/3431E8E659990C72CA2577490019113E/$File/mtrp13ex.pdf) [verified 7 March 2011].
- 11 Australian Health Ministers' Conference, National Health Workforce Strategic Framework. Sydney: National Health Workforce Secretariat; 2009: 15. Available at <http://www.ahwo.gov.au/documents/National%20Health%20Workforce%20Strategic%20Framework/AHMC%20National%20Workforce%20Strategic%20Framework%202004.pdf> [verified 7 March 2011].
- 12 Carver P. Self Sufficiency and International Medical Graduates. Melbourne: National Health Workforce, Taskforce, Australia; 2009: 3. Available at <http://www.ahwo.gov.au/documents/NHWT/Self%20Sufficiency%20and%20International%20Medical%20Graduates%20-%20Australia.pdf> [verified 7 March 2011].
- 13 Productivity Commission. Australia's Health Workforce. Productivity Commission, Melbourne; 2005. Available at http://www.pc.gov.au/data/assets/pdf_file/0003/9480/healthworkforce.pdf [verified 7 March 2011].
- 14 National Health and Hospitals Reform Commission. A Healthier Future for all Australians – Interim Report December 2008. NHHRC, Commonwealth of Australia, Canberra; 2008.
- 15 Training the medical workforce 2006 and beyond. Wellington, New Zealand: Ministry of Health; 2006. Available at [http://www.moh.govt.nz/moh.nsf/pagesmh/4791/\\$File/training-medical-workforce-06.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/4791/$File/training-medical-workforce-06.pdf) [verified 7 March 2011].
- 16 Little L, Buchan J. Nursing Self Sufficiency/Sustainability in the Global Context. Geneva: International Centre for Human Resources in Nursing/ International Center for Nurse Migration. International Council of Nurses; 2007. Available at http://www.ichrn.com/publications/policy_research/SelfSufficiency.pdf [verified 7 March 2011].
- 17 Dal Poz MR, Gupta N, Quain E, Soucat ALB, editors. Handbook on monitoring and evaluation of human resources for health: with special applications for low- and middle-income countries. Geneva: World Health Organization; 2009. Available at http://whqlibdoc.who.int/publications/2009/9789241547703_eng.pdf [verified 24 March 2011].

Manuscript received 5 March 2010, accepted 22 August 2010