



# Asian Report

## Australia, India and the Philippines

### *Macro and Micro Phases*

Brussels Steering Committee Meeting  
5/12/2011

# Asian Team

- **Philippines**
  - Dr. Fely Marilyn Lorenzo
  - Prof. Jennifer dela Rosa
  - Prof. Vanessa Manila
  - Prof. Susan Villegas
  - Prof. Royson Mercado
  - Dr. Kenneth Ronquillo
  - Dr. Christine Co
- **India**
  - Dr. Indrajit Hazarika
  - Dr. Sanghita Battacharyya
  - Dr. Adradhana Srivastava
- **Australia**
  - Dr. John Daly
  - Prof. Michele Rumsey
  - Dr. James Buchan

# Presentation Outline

- **Background of MoHProf Asia countries**
- **National summaries**
- **Key results of Asian MoHProf**
- **Experiences gained through micro research,**
- **Input to policy recommendations based on macro and micro research**

# MoHProf Asia Country Background

- India and the Philippines are developing countries and are source countries in health worker migration
- Australia is a developed country and a destination /transit country

# GNP/GDP comparison (IN, PHL, AUS)

	GDP (USD)			GNP (USD)		
	2000	2005	2008	2000	2005	2008
<b>India</b>	447.1	717.0	1061.3	442.3	711.7	1054.1
<b>Philippines</b>	996.1	1168.7	1865.9	1058.8	1264.7	2063.1
<b>Australia</b>	20879.8	36376.4	48252.8	20312.1	34959.8	20879.8

Note: Current US prices

Source: <http://data.un.org/CountryProfile.aspx>

# Country Profiles - India

- Globally, India is regarded as an important source of migrant health professionals notably doctors and nurses;
- Consistently ranked among the top nations in terms of outmigration of health professionals.
- With the total size of Diaspora numbering about 25 million, it ranks second only to China, in terms of its overseas community.

# Country Profiles- India

- Moreover, the country has consistently ranked first with regards to inward flow of remittances.
- Migration streams from India have largely moved to the Gulf, West and South East Asia.
- In these countries the Indian community has been able to successfully integrate itself with local communities and has been contributing to the economies and societies in the destination countries

# Country Profiles- India

- The dominant role of India plays in the global labor market is not surprising, especially if we examine the **demographic profile** of the country.
- With about 1.18 billion persons, India is the second most populous country in the world, comprising 17% of the world's population.
- The composition is largely young = 58 percent population in the age group of 15-59 years
- India is moving towards the last stage of demographic transition, and the crude birth rate,
  - The population has shown a declining trend over the years, more rapidly since the last decade.
- The annual exponential growth rate of population is 1.93 percent per annum. Majority of India's population lives in villages while 27.8 percent of the population is urban.<sup>3</sup>

# Country profiles - India

## Health System

- Health outcomes:
  - Life expectancy (at birth) - doubled from about 31.7 years in 1947 to 64.8 years in 2006 ;
  - IMR - declined from 148 in 1951 to 53 in 2008
- Extensive public health delivery system:
  - Sub-centers providing basic community health services in rural areas
  - Super-specialty teaching and research hospitals at the apex
- National Rural Health Mission - launched in 2005 to address the healthcare access, affordability and quality needs of the poor and rural population of India, has also increased community participation and ownership in health services.
- Economic liberalization (1990s) heralded a boom in private sector growth in healthcare, bringing in technological advancements and super specialty care comparable to global standards

# Country profiles - India

## Key health workforce issues:

- Distribution of health personnel in India is highly skewed- rural areas and small towns and public sector shortage.
- Shortage of human resources is one of the biggest problems in the health sector in spite of India's strong medical education infrastructure.
  - 2006, India had only 0.5 physicians and 0.13 nurses / 1000 population, compared to a world average of 1.5 and 1.2, respectively
- **India suffers domestic shortages of health personnel**, it also exports the largest number of health professionals to developed countries like USA, UK, Canada Australia and the Middle Eastern nations
  - There are estimated 60,000 doctors of Indian origin working in the UK and some 35,000 in the US (Kunmar, P and Simi TB, \_\_\_)

# Country profiles - India

- Paucity of data international migration - International migration flows from India to the industrialized and traditionally migrant receiving countries continue but there is hardly any Indian data on this phenomenon
- Difficult to assess how much of a "problem" outflow to other countries is in comparison to the numbers of underemployed or unemployed health workers in the country.
- Relatively little is known - experiences of health professionals now working in destination countries, in terms of their profile and future career plans (including likelihood of returning to source countries or onward movement to other countries)

# Country profiles- Philippines

- The Philippine population is relatively young with about 45% of the Filipinos living in the country under 1 year old to 19 years old.
  - Annual growth rate: 2.04% (NDHS, 2007); Fertility rate: 3.3% (NDHS, 2007)
  - Unemployment rate: 7.60% (NSCB, 2009); Underemployment rate: 19.8% (NSCB, 2009)
- As perceived by many destination countries, the Philippines is an ethical source of health professionals, especially of nurses.
- Generally education to labor migration of health professionals are driven by demand in other countries
  - Highs and lows of country surplus of unskilled health professionals
- Remittances have largely improved country's economic stability: increased from USD 7.6 billion in 2003 to 8.3 billion in 2005 and 16.4 billion in 2008;
- While there are migration benefits, there are also social costs related to migration experienced by the migrants and their families – family problems (e.g. drug dependency, marital separations, role reversals, depression)

# Country profiles - Philippines

## Health system

- Triple burden of disease: chronic diseases as leading causes of mortality among all age groups and infectious diseases as leading causes of morbidity; threats of emerging and re-emerging diseases
  - The leading cause of death is heart disease – steady increase in rates from 70 per 100,000 population in 1997, to 90 per 100,000 population in 2005
  - The slowing trend of reduction in child mortality, maternal mortality, as well as other indicators is attributable to the poor health status of lower income population groups and less developed regions of the country
  - Drug resistant TB, Malaria, SARS
- Life expectancy at birth for both sexes was about 72 years in 2007; women tend to live longer than men by five years
- Dual health system consisting of public (decentralized) and private sectors
  - overall governance of the health system is vested in the national government through the Department of Health (DOH); local government units are in charge of public health services delivery
- Promotion of Universal Health Care => equity framework of the health system
- HRH Master Plan 2005-2025

# Country profiles - Philippines

## Key health workforce challenges:

- Parallel and continues demand of health professionals in rural areas – shortages
  - Incentives to for health professionals especially doctors to live and stay in rural areas
- There are various problems related to determining and meeting the actual local demand for health workers.
  - Insufficiency of permanent government positions determined by the Department of Budget and Management
  - Local data limitations especially on the number of private health care practitioners, absence of data on active health care practitioners
  - Absence of standard health care practitioner to population ratio for an archipelagic country
- Migration data limitations
  - There is limited data on return migration; circular migration data is not being documented/ by the POEA
  - Obtaining experiences of migrants in destination countries was a challenge

# Country profiles- Australia

- Australia's population of 22.5 million is growing at a rate of 1.7% per annum.
  - The population is ageing with the average age projected to increase from its current average of 37.8 years to approximately 50 years by 2101
- In 2005, Australia was ranked sixth out of 111 countries on the world wide quality of life index with a score of 7.925 on a scale from 0 to 10 (5). Strong commodity prices have insulated it from the worst ravages of the global economic crisis.
- The health workforce is growing at a faster rate than the population, increasing 22.8% between 2001 and 2008, compared to a 6.6% increase in the Australian population over the same period
- Five to six thousand overseas trained nurses enter Australia annually, and 29% of the nursing workforce was foreign born in 2006

# Country profiles- Australia

- It is expected that for the foreseeable future, Australia will continue to encourage health professionals, along with other key skilled workers, to enter the country, with skilled migration continuing to form a significant part of entry quotas
- Challenges:
  - complex mix of private and public sector players
  - complex funding and administration including multiple levels of government
  - chronic diseases prevalent in ageing population
  - **labour shortages in health professions to enable sufficient care.**

# Country profiles - Australia

## Health System

- Health outcomes:
  - Life expectancy is high, at 78.7 for men and 83.5 for women.
  - Increasing %of Australians with a long-term health conditions ; it increased from 66.6% (1990) to 75% (2005) for men and from 69.6% (1990) to 78.4% (2005) for women.
- ‘World-class in both its effectiveness and efficiency’
- The Australian health system is currently undergoing significant reform.
  - The recent Hospital and Health Reform Commission recommended specific objectives to reduce inefficiencies generated by cost-shifting across health care jurisdictions, poor integration and continuity of care across the health sector, particularly between primary care and hospital services; to increase focus on prevention strategies, integrate acute services and aged care services, improve transitions between hospital and aged care, provide health services in rural areas, improve Indigenous health outcomes, and provide a qualified and sustainable health workforce.
- Medicare and Pharmaceutical Benefits Schemes subsidise payments towards medical services and medication to enhance access
- Improving State/Commonwealth coordination - a key plank in improving the performance and continuity of the health care system

# Country profiles - Australia

## Key health workforce issues

- Projected shortage and increased demand due to the ageing population
- Distribution of health workers, particularly doctors, in rural and remote areas
- The health workforce is ageing faster than the population, increasing projected shortages
- Feminization of the workforce, generational change and lifestyle choices resulting in health professionals working fewer hours per week
- Dependence on migrant health professionals
  - 22% of total Australian population - born overseas (2006)
    - 50% of Generalist medical practitioners
    - 42% of Specialists,
    - 47% of Dental practitioners
    - 27% of Nurses

# Country profiles - Australia

- Government policy currently restricts access to Medicare provider numbers for overseas-trained doctors to districts of workforce shortage.
- Recent government initiatives to inject significant funds to expand clinical training places and move further towards self-sufficiency in training health care workers domestically
- The multiplicity of data sources gives rise to inconsistencies and gaps in data, and there is no common factor which would allow datasets to be joined.

# Experiences from micro research

- All teams decided to focus on doctors, nurses Philippines added rehabilitation therapists;
- Delays for interview schedules due to ethical review considerations - Australia Still on-going
- Teleconference to discuss research challenges faced by teams early in Micro-phase ;
- All teams found that there were no adequate data bases to validate primary data with;
- Professional networks were difficult to reach and collaborate with;
- Snowball sampling – ended up with case reports and vignettes
- Issues of generalizability

# Experiences from Micro Research India

- Micro-phase focused on the push, pull, stick and stay factors which motivate health professionals to migrate out of India, and the factors which inspire them to return to their homeland after serving abroad for some years
- Interviews were conducted among doctors and nurses between September-December 2010, in four study states in India.

# Experiences from Micro Research India

- Study states were selected based on the following :
  1. states generally considered hubs for the migration of health care providers from India;
  2. states with high number of medical and nursing colleges (both public and private) or have large presence of the private sector hospitals; and
  3. location that provides a reasonable degree of diversity and geographical representation.

# Experiences from Micro Research: India

States	Prospective migrants		Returnee medical doctors
	Medical students/ professionals	Nursing students/ professionals	
Delhi	6	7	10
Andhra Pradesh	5	10	-
Karnataka	10	10	10
Kerala	5	5	4
<b>Total</b>	<b>26</b>	<b>32</b>	<b>24</b>

# Experiences from micro research

## Philippines

Utilized Skype and Face to Face interviews in Manila and selected areas where there were identified potential migrants and current migrants :

### Nurses

- Migrant Nurses - 4 (UK, Italy)
- Potential Migrant Nurses – 4
- Family of migrants – 2

### Doctors

- Migrant Doctors - 3 (Lithuania, Germany, UK)
- Potential Migrant Doctors – 1

# Experiences from micro research

## Philippines

### Physical and Occupational Therapists

- PT/ OT - 6 (UK, Ireland, Austria)
- Family of migrants -1

### Remittance respondents – 6

- Commercial Banks – 4
- Central Bank -1
- Western Union-1

### Migration Policies

- Recruitment agency -1 (UK recruiter; POEA accredited)

# Experience from Micro-Phase: Australia

- Baseline survey sent out to a total of 427 health professionals from two Department of Health databases in the two largest states in Australia including professional migrants who were invited in-depth interviews. These databases assist migrants in finding jobs.
- 79 individuals responded to the baseline survey and of 35 individuals responded to in-depth interview.
- Qualitative information may not be representative of the population of health professional migrants in Australia.

# **National Summaries of Results from Macro-Micro Phases**

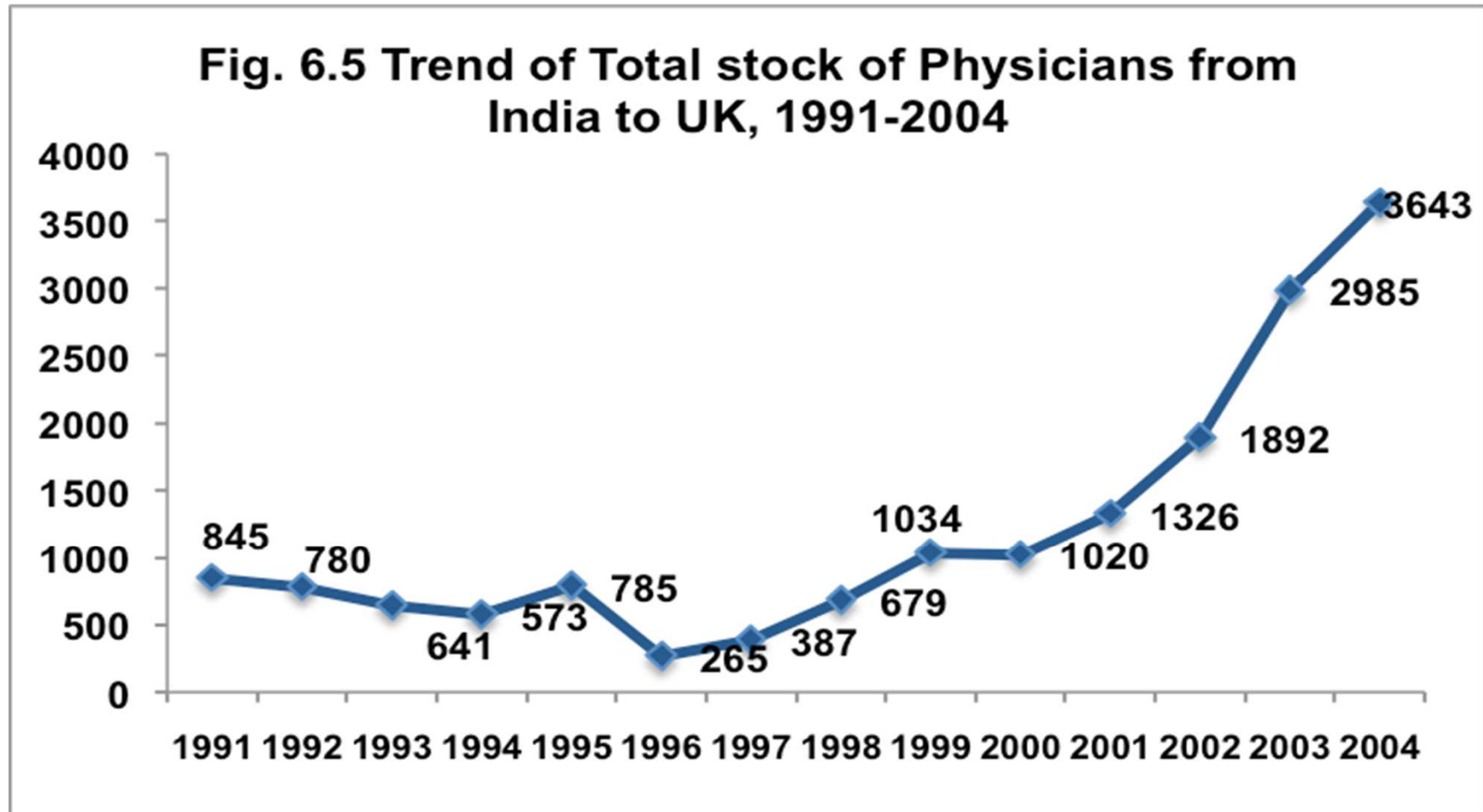
# India Key Findings

- Strategy of Indian Government has been to evolve a coherent, liberal and progressive migration policy; Appears to encourage international migration and remove barriers to the same.
- With skilled professionals, the policy has been largely laissez-faire, encouraging free movement of skilled manpower for overseas employment.

# India Key Findings

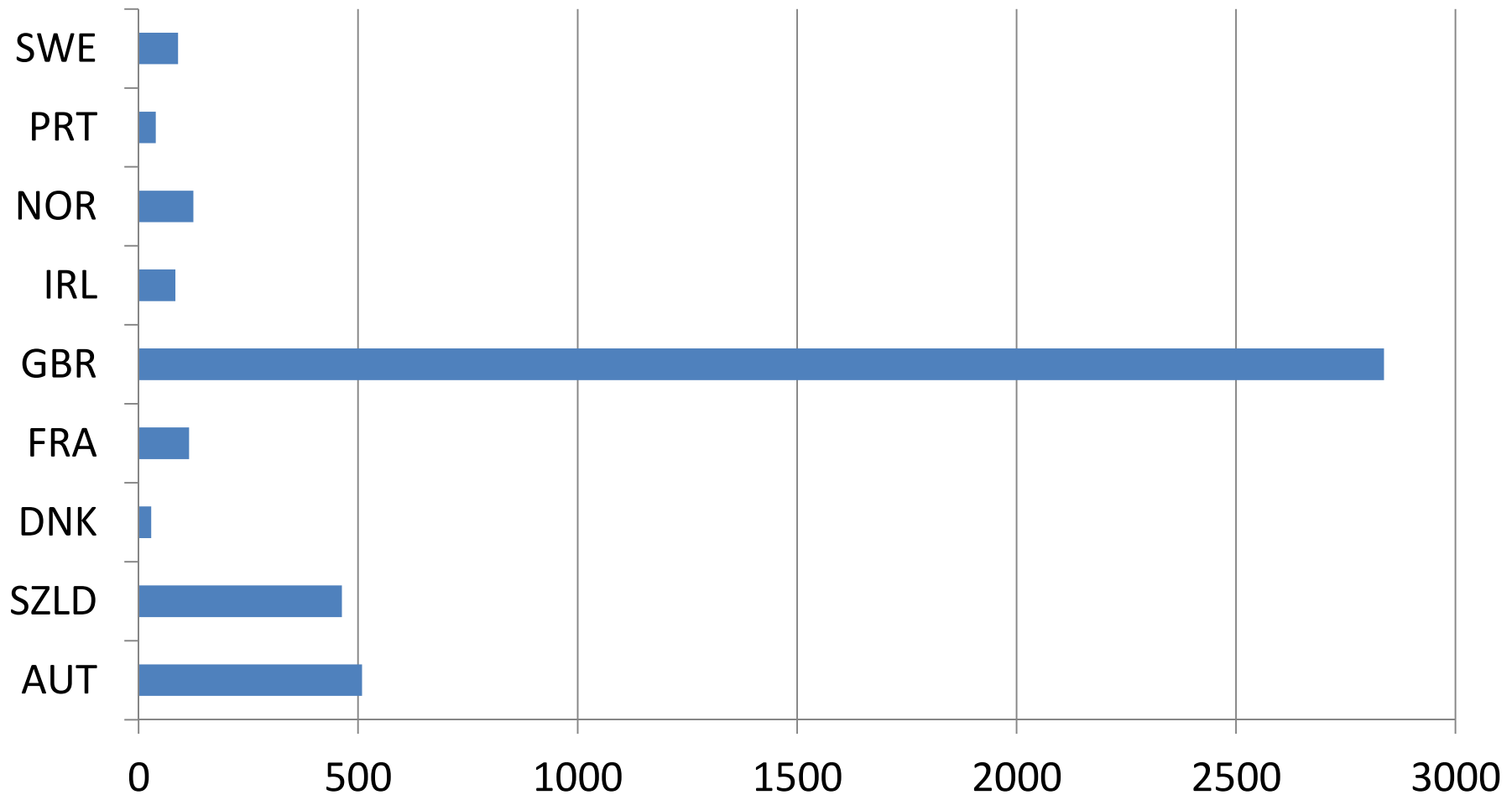
- India is considered as one of the countries that have intentionally invested in training of health workers for export.
- Medical education infrastructure has grown rapidly in the country over the years, indicating the growing popularity of medicine, nursing and healthcare as a lucrative career option, possibly guaranteeing employment opportunities abroad.

India:



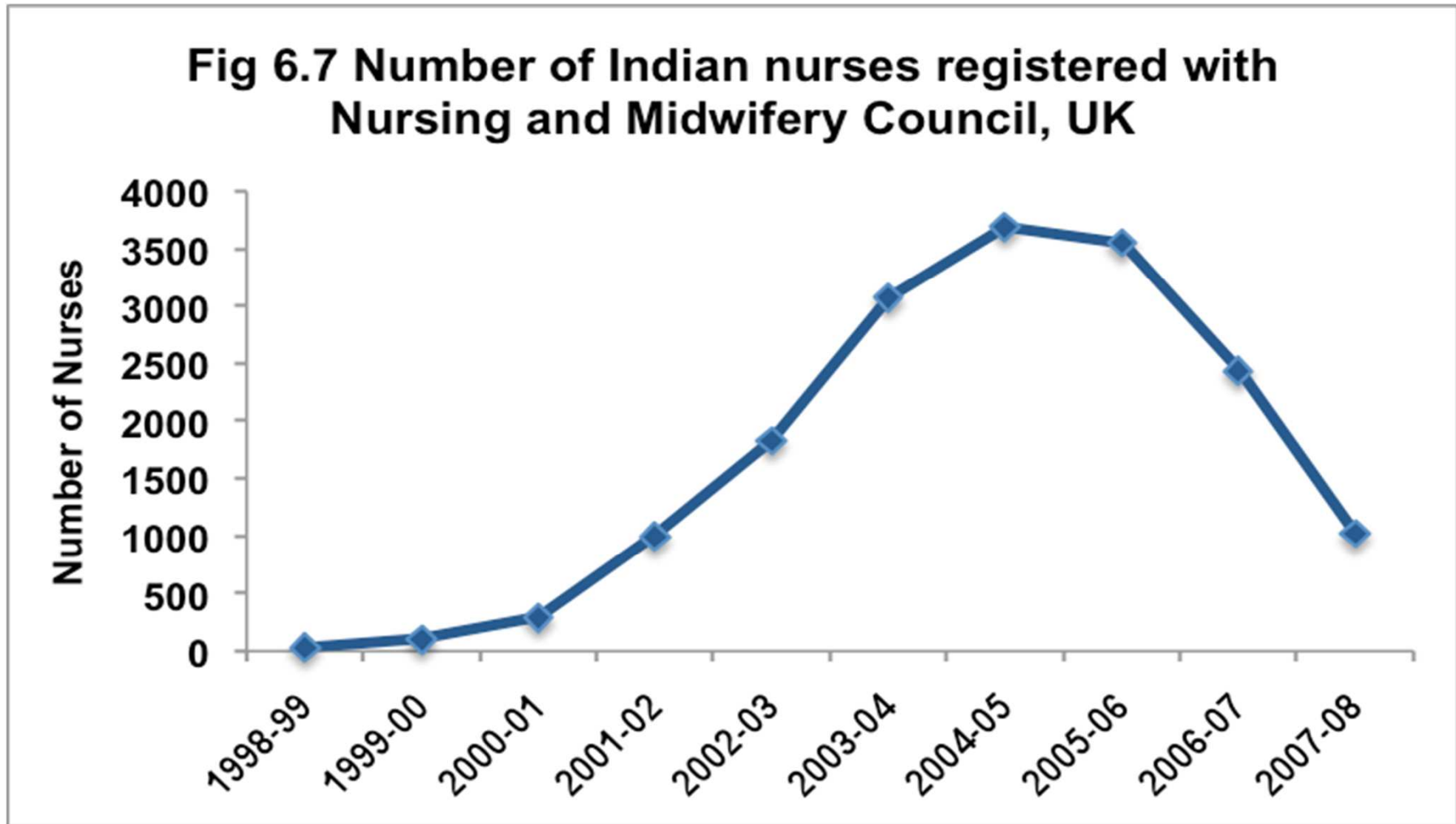
Source: World Bank

## India: Number of Indian Nurses in EU countries, 2000



Source: Dumont J-C and Zurn P. (2007) Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration, in International Migration Outlook, SOPEMI, Paris

India:



Source: Nursing and Midwifery Council

## India: Flow of remittances, 2005-2010

(US\$ million)	2005	2006	2007	2008	2009	2010
<b>Inward remittance flows</b>	21,293	25,426	37,217	49,941	49,256	55,000
<b>Outward remittance flows</b>	1,341	1,580	2,059	3,815	4,000	...

Source: World Bank, Migration and Remittances Fact book, 2011

# India: Immigrants in the Physician Workforce in the US, UK, Canada and Australia

US		UK	
Source Country	No. of IMGs (% of the workforce)	Source Country	No. of IMGs (% of the workforce)
India (1st Rank)	40838 (4.9)	India (1st Rank)	15093 (10.9)
Philippines	17863 (2.1)	Ireland	2845 (2.1)
Pakistan	9667 (1.2)	Pakistan	2693 (1.9)
Canada		Australia	
Source Country	No. of IMGs (% of the workforce)	Source Country	No. of IMGs (% of the workforce)
UK	2735 (4.0)	UK	4664 (8.6)
South Africa	1754 (2.6)	India (2nd Rank)	2143 (4.0)
India (3rd Rank)	1449 (2.1)	New Zealand	1742 (3.2)

Source: NEJM, October 27, 2005

## India

### PUSH

- low salaries
- poor working conditions
- lack of respect particularly for the nursing profession
- heavy workload
- lack of proper infrastructure & facilities
- non-adherence to rules/protocols
- less opportunity for higher education
- poor quality of education
- lack of opportunities for professional growth
- restrictive hierarchical system

### PULL

- lucrative salary packages
- better working conditions, with modern facilities
- adherence to systems/protocols
- respectful treatment
- lesser workload
- opportunities for professional growth and skill development
- opportunity to work with better technology
- better future career opportunities
- good lifestyle

# India

## STICK

- family responsibilities and ties
- cost of immigration process
- lack of information and unfamiliarity regarding the immigration process
- socio-cultural and language differences
- requirement to re-qualification and its associated costs
- familiarity with home country health systems
- uncertainties about the destination country job market
- desire to work for own country
- prospects for professional growth, development and learning

## STAY

- good income
- work satisfaction
- flexible system more conducive to migrants (migrant-friendly policies)
- dignity for the nursing profession
- marriage and family
- better working conditions
- better quality of life

# Philippines: Key Findings

There are different reasons for health professional migration:

- Doctors – Post graduate training and education (clinical and others)
- Nurses – Economic advancement
- Therapists – Further career prospects – to learn new skills and practices

# Philippines: Key Findings

- Nurses consider migration in their decision to pursue nursing; return migration negligible and undocumented;
- Doctors and PT/OT consider migration **after** their training
- Migration numbers are dropping due to competition and policy changes in destination countries
- Significant Health professional labor effects – surplus of nurse production and consequent unemployment and underemployment

# Philippines: Key Findings

- New markets are being explored by the country : Encouraging migration to solve unemployment and underemployment
- Bilateral agreements forged with new and traditional markets to better manage migration: investments and quality management, rationalize numbers of migrants
- Macro phase findings largely hold for push, pull, stick, stay factors

# Philippines : Key Findings

- Remittances are important for nurses- no data specific to nurses and health care professionals;
- National data shows that of remittances sent 90% of remittances are savings accounts ; while of all ,25% covered by pick-up agencies (Western Union)

# Philippines

## Push

- Unfavorable socio-political-economic condition; unsatisfying quality of life
- Low national priority placed on health
- Limited opportunities for employment
- Low salary; Lack of attractive benefits/ incentives- work environment
- Knowledge of the English language or language of the destination country
- Lack of policies/ programs to support independent practice
- Presence of a family member in destination country
- Easy access to US NCLEX review and examination in the Philippines
- Presence of POEA and recruitment agencies that facilitate and ensure overseas employment and safety

## Pull

- More socio-political-economically stable
- Better quality of life and future of the children in terms of education and career opportunities
- Basic needs are subsidized
- More professional growth/career advancement opportunities; higher salaries
- High demand for professionals and services; active recruitment
- Autonomous system of practice
- Opportunity to travel to other places; exposure to different cultures
- Opportunity to migrate with the family (permanent migration)
- Ability to remit and help their families

# Philippines

## Stick

- close family ties; need to take care of ageing parents and/or younger family members; assured family and social support
- perceived differences in culture and the environment in destination country
- economic capacity to migrate
- entrepreneurial opportunities
- language barriers
- job satisfaction; high motivation at work
- serve in the country's health system
- difficulty establishing practice in new environment
- Undesirable experiences of health workers such as abuse, exploitation, discrimination, de-skilling and other risks
- The health professional cannot pass the licensure exam given by the destination country
- The destination country of choice is not open for hiring

## Stay

- migration of the whole family to destination county
- established own family and support in place of destination
- better salary
- better benefits/incentive packages
- high regard for the profession by patients/clients
- established stable professional practice
- well-developed system for supporting research and publication
- clear career opportunities and ladder

## EU Destination Countries of Temporary Health Worker Migrants (Doctors, Nurses, PT/OTs), Philippines

Destination Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
Austria			2							6
Belgium			1							1
Cyprus					1		6	1	1	9
Denmark								1		1
Ireland	126	1529	919	211	196	297	248	129	36	3691
Italy		1	1	1			1	5		10
Malta	1									1
Netherlands		34	10		24					68
Spain					3					3
United Kingdom	2,615	5,383	3,089	1,567	832	560	159	44	56	15307
<b>TOTAL</b>	<b>2,742</b>	<b>6,947</b>	<b>4,022</b>	<b>1,779</b>	<b>1,056</b>	<b>857</b>	<b>414</b>	<b>180</b>	<b>93</b>	<b>19,097</b>

Source: POEA 2009

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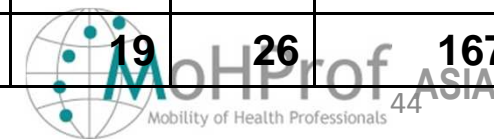
## EU Destination Countries of Permanent Health Worker Migrants (Doctors, Nurses, PT/OTs), Philippines

Destination Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
Austria		2	3	1	2	1	1	2	4	16
Belgium		1		2						4
Denmark						1				4
France		1		1			1			4
Germany	3	4	3	1	4	1	3	2	4	37
Greece									1	1
Ireland						2	2	3	3	10
Italy	2		1	1		1	2	1	3	11
Netherlands	3	1	3	3			1	1	1	14
Spain	1	1	1	4	1		1	1	1	11
Sweden	1	2	2	1	1	1	2		3	13
United Kingdom			1	2	6	8	9	9	6	42
<b>TOTAL</b>	<b>10</b>	<b>12</b>	<b>14</b>	<b>16</b>	<b>14</b>	<b>15</b>	<b>22</b>	<b>19</b>	<b>26</b>	<b>167</b>

Source: CFO 2009

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# Philippines

	Nursing	Medicine	PT/OT
Top destination countries	Saudi Arabia, UK, USA, UAE, Ireland, Singapore, Kuwait, Qatar, Libya, Canada and Australia	USA, Saudi Arabia, Canada, Australia, and UK	Saudi Arabia, USA, UAE, Kuwait, Qatar, UK and Ireland

	Nursing	Medicine	PT/OT
<b>1. Primary reason for migration</b>	Economic/ financial reasons	Post-graduate studies	Continuing professional development
<b>2. Migration process</b>	<ul style="list-style-type: none"> <li>• Direct hire</li> <li>• Recruitment agency</li> <li>• Dependent of husband who is also a nurse</li> </ul> <p>Interview, TOEFL/IELTS, visa application (5 to 6 months before they were able to leave for the UK)</p>	<p>University scholarship / sponsorship</p> <p>Application and process and support documents from the university for visa</p>	<ul style="list-style-type: none"> <li>• Direct hire</li> <li>• Thru a relative who was already a citizen in destination country.</li> </ul> <p>Interview, IELTS, written exam, visa application in PHL. Fast recruitment process (2 weeks – 4 months)</p>

	Nursing	Medicine	PT/OT
<b>3. Work experience in EU, societal/cultural assimilation</b>	Nursing adaptation or bridging program	Full-time student; No formal adaptation program but experienced difficulty adjusting to life in Europe; Learn new language	Underwent hospital-sponsored adaptation period

Remittances	Nursing	Medicine	PT/OT
<b>Regularity of sending remittances</b>	Varying frequency - regular for those supporting family members; irregular for a nurse who has other siblings supporting parents;	Does not remit regularly (remits on demand); Sometimes still supported by family at home	Majority remit monthly on a regular basis. Others do not need to remit to family in the PHL because family is already stable.

Remittances	Nursing	Medicine	PT/OT
<b>Purpose of sending remittance (beneficiary)</b>	Pay house / family bills Support living expenses and health care (e.g. medicines)of parents Build a house Support education expenses  Varying % of monthly salary remitted: 7- 60%,	To pay for his/her own bills (e.g. credit card bills); Emergency reasons	Family (parents and siblings)  Financial obligations: Medical expenses of parents, education of siblings and purchase of properties
<b>Mechanisms for sending remittance</b>	Banks; [Informal] Filipino stores in UK; Money Transfer Operators (Western Union, DHL)		

# Australia: Proportion of Australian Health workers working in health occupations born in selected countries (2006)

	GPs (%)	Specialists (%)	Dental practitioners (%)	Nurses (%)	Australia total (%)
Australia	<b>48.2</b>	<b>57.2</b>	<b>51.1</b>	<b>70.6</b>	<b>70.9</b>
England	<b>6.3</b>	<b>8.1</b>	<b>5.6</b>	<b>7.1</b>	<b>4.3</b>
New Zealand	1.7	3.2	2.3	<b>3.0</b>	<b>2.0</b>
China(b)	1.6	0.6	1.5	0.7	1.0
Italy	0.4	0.3	0.4	0.2	1.0
Vietnam	1.8	0.6	3.9	0.2	0.8
India	<b>5.4</b>	<b>4.2</b>	<b>2.5</b>	0.7	0.7
Philippines	0.8	0.4	0.6	<b>2.0</b>	<b>0.6</b>
Malaysia	<b>5.1</b>	<b>3.1</b>	<b>5.3</b>	<b>1.4</b>	<b>0.5</b>

(a) Selected countries incorporate the five most commonly reported countries of birth overall, and any of the four most commonly reported countries of birth for each occupation group that was not already included.

(b) Excludes SARs and Taiwan Province.

Source: ABS 2006 Census of Population and Housing. (11)

**AUSTRALIA**

Australia as country of origin	Australia as destination
<b>Push</b>	<b>Pull</b>
<ul style="list-style-type: none"> <li>• economic crisis</li> <li>• oversupply of labour, particularly recently trained health professionals.</li> <li>• broaden experience</li> <li>• professional development opportunities (including specialization)</li> <li>• travel and lifestyle</li> <li>• established family/heritage links</li> </ul>	<ul style="list-style-type: none"> <li>• better job opportunities; better working conditions including technology and support staff;</li> <li>• educational opportunities; shared/similar curriculum with United Kingdom, Ireland, United States, Canada and New Zealand means almost automatic recognition of qualifications;</li> <li>• new experiences, cultures and language;</li> <li>• strong economy; a higher standard of living</li> <li>• shortages on the labour market, including health sector; aged care</li> <li>• tradition of inward migration</li> <li>• active recruitment by employers, supported by government</li> <li>• relatively easy recognition of qualification from some countries</li> <li>• clear health professional career path</li> <li>• health sector reforms – inc. Health workforce</li> </ul>

<b>Australia as country of origin</b>	<b>Australia as destination</b>
<b>Stick</b>	<b>Stay</b>
<ul style="list-style-type: none"> <li>• family connections</li> <li>• travel and lifestyle</li> <li>• professional status</li> <li>• good job opportunities for some professional areas (e.g. advanced practice nursing)</li> <li>• familiarity with systemic, organisational and administrative culture of home health system</li> <li>• for some EU countries, with some barriers to gaining registration to practice in Australia</li> <li>• limitations on visas available to practice in Australia, and associated possibility of required long term rural/remote posting.</li> </ul>	<ul style="list-style-type: none"> <li>• good standard of living including domestic safety and security and public infrastructure</li> <li>• strong economy; job opportunities; Strong wage growth</li> <li>• established migrant communities</li> <li>• high level of health care in Australia</li> <li>• good access to high quality infrastructure, pharmaceuticals and equipment.</li> <li>• opportunities for continuing professional development</li> <li>• universal coverage of health system</li> <li>• availability of incentives and settlement support for highly sought-after occupational groups.</li> <li>• broad social acceptance of migrant populations and established migrant communities.</li> <li>• reliance on remittances for some (e.g. Pacific countries and/or Asia), but less so from the EU</li> </ul>

# Policy Recommendations :Philippines

## Nurses

- Nurses should have relevant experience before coming to the UK. They should come as nurses not as students

# Policy Recommendations : Philippines

## Nurses

- Suggestions for agencies regulating migration:
  - create an Adaptation Program - -accreditation, school based - would determine the person's ability to adapt well in the UK
  - reciprocity between UK Nursing and Midwifery council and Philippines
  - get the UK Council be familiar with how we produce nurses in the Philippines

# Policy Recommendations :Philippines

## Doctors

- Do not recommend migrating permanently to Europe, but encourages health professionals to get higher education and training there to broaden one's perspective and experience
- Discourages permanent migration because of the cold weather and the “coldness” of foreigners, which is in sharp contrast to the warm disposition of Filipinos
- Would recommend studying in Europe, especially if it's on a scholarship

# Policy Recommendations : Philippines

## PT/OT

- Recommend migrating to EU for the purposes of achieving personal and professional development, and uplifting the socio-economic status of their families in the PHL. Only one views migrating as not worth it because it played a big factor on her failed marriage.

# Policy recommendations: India

## Migration process:

- Easier access to information for aspiring migrants;
- Decentralize and expedite the migration process;
- Conduct orientations for students in medical and nursing colleges;
- Campus recruitment, particularly for nurses;
- To facilitate return migration, need for the Government to recognize foreign qualifications;
- Government should also facilitate re-employment of returnees.

# Policy recommendations: India

## Medical education in India:

- Increase seats specialization/super-specialization, possibly introduce a combined MBBS-MD program;
- Eliminate reservation of seats, especially at the post-graduation level;
- Reform the post-graduation examination system, to make it more oriented towards testing of clinical skills;
- Increase options for higher research in medicine through introduction of research / PhD programs or by expanding research facilities;
- Introduce common licensing prior to registration, for standardization of quality;
- Improve the quality of medical education institutions by improving infrastructure and quality of education; reform teaching system by orienting it towards clinical skills;
- Modernize medical education system with better training, more avenues for research and skill building, more job opportunities and encouragement to greater accountability and ethics in practice.

# Policy recommendations: India

## Service Conditions:

- Increase salaries of health workers in public sector, especially at the junior levels (interns/ junior residents);
- Ensure basic facilities like toilets and safe drinking water and improve the quality of infrastructure, equipment and supplies at public hospitals and health centers, especially in rural areas;
- Introduce systems to bring in accountability, such as performance appraisal;
- Rationalize staff working hours, especially in public facilities;
- Recognition, respect and value to the work of health care professionals;
- Increase the number of staff postings in public hospitals and suitably expand infrastructure to cope with the high patient load;

# Policy recommendations: India

## Service Conditions:

- Introduce a system of universal insurance coverage for health, as in the US or Canada; this will help cover all essential medical costs for people, and will prevent doctors who are compelled to deny care to the poor on account of non-affordability;
- Hospitals in large cities now have advanced equipment, but staff are usually not trained in using them; such training needs to be imparted;
- More information sharing was desirable between practitioners, especially at community level healthcare, not just at the national or regional levels;
- In the private sector recruitment should be merit-based, and not influenced by commercial considerations.

# Conclusions

- Migration trends are projected to continue but with varying magnitudes: mostly market driven;
- Both Philippines and India will continue as source countries; Australia's role continues to evolve;
- There are health system effects as the health system is more fragile due to high turnover of nurses and doctors – internal and external

# Conclusions

- Migration can and should be mutually beneficial to both source and destination countries;
- Mutually beneficial migration can be achieved by managing the migration process : addressing push, pull, stay factors and maximizing potentials of stick factors;
- Need to promote effective implementation of bilateral agreements to better manage migration process;

# Conclusions

Need to:

- Effectively implement retention policies :  
Implement HRH master plans
- Promote country sufficiency with rationalized sharing of health professionals to promote patient safety and achieve national health outcomes ;
- Participate in the crafting of international policies – WHO :code for International Recruitment; Retention Guidelines, Scaling up of Transformative Education

**Thank You!**