‘Filipino nurses down under’: Filipino nurses in Australia

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Abstract
The developed world continues to face a critical shortage of nurses that is yet to become more acute with an ageing population, and as a consequence the chain effect of the brain drain or brain circulation will continue. Brain drain is a thoroughly researched and documented phenomenon where source countries such as the Philippines supply nurses to the world, thereby losing their best qualified nurses to developed countries. This creates losses to the source country that trained them, given many leave soon after gaining qualifications and preliminary experience for more lucrative salaries and better lifestyles in the developed world. The situation is particularly complicated in relation to the Philippines, which has positioned itself as a global supplier of nurses, making human resource export a national government strategy. This paper explores fundamental issues surrounding health professional migration in order to assess ways of creating a win-win situation for both source and receiving countries and individual workers, taking the Philippines as a case study. The purpose of this paper is to provide background information on Filipino nurses in Australia within the context of the Philippines as a global supplier of nurses.

This paper formed the foundation of an Australian Research Council Linkage Grant with Partner Organisations; Queensland Health and the University of Sydney, Griffith University, Queensland University of Technology and The University of Melbourne. Key collaborators also include York University and Queen Margaret University.

Abbreviations: AHPRA – Australian Health Practitioner Regulation Authority; ANMAC – Australian Nursing and Midwifery Accreditation Council; ASEAN – Association of South East Asian Nations; COAG – Council of Australian Governments; IELTS – International English Language Testing System; NMBA – National Nursing and Midwifery Board of Australia; OET – Occupational English Test; WHO – World Health Organization.

Key words: Migration of health workers; brain drain; Filipino nurses; ethical recruitment; international agreements; international workforce.

Introduction
The global shortage and misdistribution of nursing professionals is well documented. [1] Australia, like other English-speaking Western countries, may increasingly depend on recruiting health professionals educated abroad as a consequence of an ageing population, problems with nurse retention, issues of maldistribution and the outflows of local graduates. This is despite the establishment of a national goal of health workforce self-sufficiency by 2025. Concerns about health worker migration are manifold, with two prominent issues related to ethics and sustainability: how to provide mutual benefits to both sending and receiving countries, including individual nurses; and the long-term viability of this process in relation to the Australian health workforce. Bilateral agreements are slowly coming into force between several countries. One of the first countries to take action was the United Kingdom in relation

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to the Philippines. In 2010, the execution of the World Health Organization (WHO) Global Code of Practice on International Recruitment of Health Personnel was a key milestone that provides guidelines for member states to act ethically and responsibly within a global context.

This paper highlights the foundations that formed the basis of our Australian Research Council Linkage Project with Partner Organisation Queensland Health; Building an Ethical and Sustainable Model for Health Professional Recruitment to Australia; the Case Study of the Philippines (2010-2012). The purpose of this paper is to provide background information on Filipino nurses in Australia within the context of the Philippines as a global supplier of nurses. The ethical implications for Australia and the Philippines will also be considered.

Background

The Philippines is the largest provider of nurses for export in the world. [1] A remarkable 85% of the Philippine’s best-qualified nurses work outside the country. [1] In recent decades, Filipino-educated nurses have applied in large numbers for work in the United States, the Middle East and the United Kingdom where shortages have been common for 20-40 years. However the United States ceased recruiting nurses from the Philippines following 9/11 and the United Kingdom also shifted priority to securing nurses from the European Union when shortfalls in domestic supply occurred. While the top rated training institutions (such as the University of the Philippines) and hospitals in the Philippines have high standards and quality training, hundreds of colleges and institutions have entered the demand-market for nurses by offering courses which were of poor teaching and training quality. Standards are thus highly variable, in a context where there are few mandatory quality assurance mechanisms. [2] In order for Filipino nurses to apply for work in Australia, they and other migrant nurses are required to pass a mandatory Occupational English Test (OET) or International English Language Testing System (IELTS) test (with scores of IELTS Band 7 or OET B across all four bands of reading, writing, listening and speaking). [3] They must also pass specific examinations in Australian nursing theory and practice to obtain nurse registration, [4] or complete a registered nurse bridging program. These are based on Australian nursing standards and competency levels for safe practice in Australian hospitals. Cultural sensitivity issues of relevance to healthcare environments may also be different from those in hospitals back home. For instance, Filipinos rely heavily on family members to care for their aged population whereas Australians depend on the hospital system and geriatric care nurses to conduct the same duties.

The Philippines is a major source country for a number of reasons. The country deliberately educates and produces health professionals, particularly nurses, for export. [5] In 2001 alone, 13,500 nurses, equivalent to a quarter of the nurses employed in Philippine hospitals, left the country for foreign jobs. Remittances from those working abroad are a significant source of foreign capital for the economy, but little of that money is invested in the country’s health system. [6] However, serious ethical concerns are generated by four compelling statistics: (i) health expenditures in the Philippines declined from 3.5% of GNP in 1997 to 2.0% in 2003; (ii) although the number of nursing schools in the Philippines increased from 170 to 470 between 1999 and 2005, the quality of nursing education is not improving; (iii) because of the shortage of nurses and other health professionals, 200 hospitals in the Philippines have closed and 800 have partially closed; and (iv) ratios of health professionals to the population are declining, with reductions in rates of immunisation and medically attended births. [6]

Global ethical debates on health workforce migration are complex, with the Philippines the prime global example of a source country which facilitates rather than discourages skilled worker departures in this field. The government supports the production of ‘excess’ professionals in order to expand remittance flows (the key national development strategy). [2] Competing developing countries, such as Indonesia are also following trends from the Philippines, and are also emerging as nurse-export countries. For example Indonesia produced 34,000 nurses and the Philippines produced 60,000 nurses in 2007 [7] and despite the overproduction of nurses, both countries experience a shortfall in nurse employment at subnational levels. [7] While governments may over-produce for export, they may maintain frugal domestic employment strategies, regardless of health sector need.

The impact of the global financial crisis limited the scope for migration opportunities for nurses in the Philippines, which unfortunately exacerbated the scale of nurse volunteerism-for-a-fee (a longstanding practice). [8] The national policy of producing excess nurses for export [2] intertwined with an imbalance in supply and demand, is a major driving force behind high nurse unemployment rates in the Philippines, where the national health system was never intended to support the scale of graduate supply. Developed countries importing nurses from the Philippines have the potential to assist the oversupply situation by maintaining migration pathways. To facilitate this, they need to help generalist nurses secure full registration to practice, a process that research evidence suggests may take years.
Greater incentives would also be needed for the redistribution of Filipino nurses to work in rural areas of their country, including the provision of adequate salaries and conditions. Health Secretary of the Philippines, Enrique Ona, recently advised students to avoid nursing and to take on specialist courses in other fields to prevent an even greater number of unemployed nurses. Enrique Ona stated that 200,000 nurses were unemployed in 2010 and also confirmed the closure of several schools, following a government-mandated review of quality and nursing standards.

[9] The migration of nurses and other health professionals occurs as a result of several push-pull incentives, most notably to secure higher wages and salaries in developed countries; better working conditions; to provide financial support to assist family members; to gain permanent residency in a developed country; and to enhance professional skills and experience, just to name a few. [10,11] A WHO Western Pacific Region Press Release affirms that 250,000 families in the Philippines encounter financial hardship as a consequence of healthcare costs. [12]

Without government initiatives such as rebates and assistance to families, poor and lower-middle class groups will continue to encounter ill health and poverty due to lack of healthcare aid. It is simple to understand the attractiveness for Filipino nurses working abroad, which not only assists their families, but has the potential to exchange the poverty cycle for a good quality of life. Furthermore, the universal right to obtain a better standard of living cannot be argued, but the long-term sustainability of healthcare in developing countries could be compromised as experienced nurses, nurse educators and graduates exit the home country, which also impacts the quality of nursing education and training.

Filipino nurses in Australia

More than 1,000 Filipino degree-qualified nurses migrated to Australia from 2001 to 2006. The Philippines is thus the second main source country of international nursing graduates after the United Kingdom/Ireland (2,081 nurses). [13] However the major study of nurse migration to date found they have major barriers to securing employment. Even once registered, they are 840% more likely to be clustered in the geriatric care sector.

Immigration processes into Australia are very rigorous and time consuming when nurses apply for Permanent General Skilled Migration visas, where principal applicants are tested pre-migration for human capital attributes (including English language ability and the likelihood of foreign credential recognition). Large numbers of Filipino applicants do not succeed in this process. For example, they secure exceedingly low pass rates in English language testing, compared to all other migrant groups. [14,15] By contrast, turnaround is swift in terms of applicants for a 457 Long Stay Temporary Work visa, which may be used as a stepping-stone towards permanent migration. [16] Due to Australia’s flexibility in meeting supply and demand for nurses, temporary nurse flows have grown rapidly. In 2008-09 around 1,500 permanent nurses arrived per year while 3,850 nurses arrived on a temporary sponsored basis to Australia. [2] These nurses are subjected to preliminary screening, and are the most likely to secure work. Large numbers of Filipino nurses however also arrive as family category migrants, untested in advance for human capital attributes. Within five years of arrival in Australia, 58% of Filipino nurses secure nursing employment (combining all immigration categories). Twenty-one per cent are categorised as ‘not in the labour force’, typically struggling to secure professional registration. [2] Many of these nurses hold de-skilled positions or are excluded from the nursing workforce for years due to challenges in English testing and qualification recognition.

Pre-migration, the Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for screening a prospective migrant nurses’ qualifications, including school accreditation. Once foreign trained workers arrive in Australia, several registration processes are involved before a nurse can start employment. The national Nursing and Midwifery Board of Australia (NMBA) is the national body that governs codes of practice and regulates the registration of nurses and midwives before they can work in Australia. Registration with the NMBA is lodged through the Australian Health Practitioner Regulation Authority (AHPRA). The second major hurdle is English language testing in which Filipino nurses do particularly poorly relative to all other groups. [14,15,17]

Migration of Filipino nurses to Australia is not occurring in high numbers like that from Ireland and United Kingdom due to these serious employment barriers. [18] As Australia continues to attract and employ nurses from source countries like Ireland and United Kingdom, these developed countries then recruit more nurses from developing countries like the Philippines, emphasising the global nature of health worker migration. [13] Supply and demand in the nursing profession in Australia is highly cyclical. It is affected by demographic shift; the economic situation (which influences health budgets); and the impact of economic global downturn which encouraged local nurses back into the workforce. [18] Given this volatility, there is potential for a situation...
of undersupply to transform to a glut – with serious consequences for the employment prospects of Filipino nurses. With an average nurse age of 50, Australia however is likely to experience nursing shortages in the future. Many will have been trained in developing countries, with highly variable systems (arriving through all immigration paths). Serious issues exist in this context, including effective communication in Australia’s multicultural society and the quality of training. Patient care may be compromised if nurses are unable to effectively communicate with a team of doctors, nurses and patients. Local Australian nurses may also fear job security if a surge of migrant nurses are employed in the country, leading to possible competition and conflict as nurses compete for terms and conditions. The research we aim to conduct will include interviews with nurses, managers and peers in Australia and key informants in the Philippines to explore whether migration, communication, employment opportunities, skills and training are current areas of concern.

The Philippines has a national policy of over-producing professionals, in an environment where worker export and remittance-generation are major development goals. Growing attention is now being paid to Filipino quality assurance, in a context where private sector institutions have rapidly proliferated and few are covered by quality assurance processes (as in the United States). Incentives need to be provided for institutions to commit to national accreditation (a mere 19% currently covered, with 221 higher education institutions now being assessed). [19] The quality of Filipino training remains highly variable, with subjects assessed rather than the quality of institutions and staff. Improved quality assurance in line with global norms appears to be a policy imperative, while the mismatch between education and domestic employment demand will continue to ensure out-migration. [19]

**Ethical considerations**

Good ethical behaviour – treating other people and the world well – and sustainable practices that pay close attention to overall long-term consequences are fundamental in achieving the ideal of integrity within health workforce recruitment systems. [20] Ethical and sustainable recruitment, however, is complicated on a global scale, with varying legal rules, macro and micro policies, politic-social values, institutions, governments, and varying interpretations of defining ethical goals and values. The formulation and adoption of well-functioning legal and ethical rules is rarely sufficient per se for the achievement of integrity. First, legal rules and ethical norms need to be consistent. Ethical norms unsupported by legal rules to impose consequences on those who fail to live up to those norms are a ‘knave’s charter’; but legal rules are ineffective unless they are informed by ethical standards which give them meaning, guide their interpretation and help officials understand their duties. Accordingly, ethical standards and legal rules need to be mutually supportive and avoid giving contradictory guidance. Secondly, legal and ethical norms need to be supported by institutional arrangements that keep those norms consistent, give guidance to officials in both the originating and recruiting countries, ensure that the relevant rules are observed and check that the claimed outcomes are achieved and the benefits for both countries are delivered. [20]

The macro and micro aspects of global health professional recruitment are an intricate area with bilateral, multilateral legal-political elements intertwined with government bodies, agencies and institutional stakeholders. Each relevant institutional organisation will declare and hold values and interests distinct from those in other organisations, and moulding those entrenched values to align with a coherent global ethical code is very challenging. [20]

Global integrity systems are needed for the ethical international recruitment of health workers. Recruitment of migrant nurses spans social, economic, cultural, political and ethical dimensions between regional, national, local and individual levels. Potential damage that developed countries can do by exporting their best qualified and highly experienced health professionals is one manifestation of this social, political and economic complexity. Health professionals, particularly nurses, are migrating in larger numbers usually at the expense of the developing countries that pay for their education and training. Further consequences include costs to the home country’s domestic health systems, where the best qualified nurses work abroad and other essential health professionals tend to retrain as nurses in order for migration opportunities. A clear example has been that of trained Filipino doctors who retrain as nurses to gain foreign employment, as a result of push-pull incentives. According to the WHO study on health workforce resources, there is now an estimated shortage of 1,164,001 doctors, nurses and midwives in South East Asia, and 817,992 in Africa – eight times higher than in OECD countries. [19] Few experts believe it will be possible to halt this scale of movement and with governments such as the Philippines, supporting the production of excess’ professionals in order to expand remittance flows, it could be damaging local health services delivery and quality of training. [19]
Recognition of the ‘brain circulation’ has led to the development of ethical norms and codes to guide the recruitment of health professionals [21] with more recent advances headed by the WHO Code of Conduct on International Recruitment of Health Personnel. This Code dictates the need for developed countries to consider sustainable health services planning, training and education in order to reduce reliance on migrant health workers. [22] Unfortunately, these ethical guidelines are generally seen to be abstract, inadequate, unfair and unsustainable [23] and have lacked grounding and support within sustainable governance regimes. In 2007, the British National Health Service signed bilateral agreements with the Philippines to address the ethical migration of nurses [24] while the Japan-Philippines Economic Partnership Agreement was also executed in December 2008, both of which include provisions on health worker migration. Mutual agreements in the United Kingdom, South Africa, Philippines, United Arab Emirates, China and ASEAN Mutual Recognition Agreements have all come into force, which also endeavour to address gaps in ethical health worker migration.

The Australian Government has in place a bilateral agreement with the New Zealand Government, which standardises nursing qualifications, and hence graduates in New Zealand are accepted at the same standard to that in Australia. This eases and speeds the registration process for health workers applying to work from New Zealand. However, 21% of New Zealand’s nurses were trained abroad. [11] The indirect route of nurses also increases ethical challenges where a Filipino nurse is likely to work in several developed countries like the United Kingdom, the Middle East or New Zealand before eventually settling in a permanent location. [11] As remaining countries gradually pursue these developments, [25] bilateral trade agreements encourage and facilitate nurse migration, but is this beneficial for developing countries which already experience staff shortages, maldistribution of nurses and heavier workloads for non-migrating nurses? On the other side of the ethical debate, there is the individual right for people to move for better work and lifestyle and more often that involves a move from a country such as the Philippines to a developed one.

Frequent monitoring of international recruitment policies and agreements is needed to ensure adherence to those policies and agreements, to ensure that they reflect the values they are intended to uphold, and to reduce loop holes and corruption vulnerabilities. Strong and stable institutional ethical standards, incorporating the activities of government agencies, corporations and professions, are required on a global scale for reliable ethical standards to be achieved. [20] Such arrangements should guide agencies and officials in the execution of their duties and confirm whether mutual benefits are forthcoming. On this front, e-governance initiatives [26] may provide a potential ethical advantage, encouraging use of technology and web display to ensure transparency and accountability; and remittance income may be reinvested into quality training and the healthcare sector in developing countries. The innovation of technological schemes under a regulating body would be ideal, but initial set up costs for governments in developing countries would be high, which is where developed countries could step in.

Our ARC Linkage study with Queensland Health is projected to begin answering some of these questions. The research team will develop a system of employer support (in this case Queensland Health) for the growing potential of health recruitment from the Philippines, taking into consideration orientation, communication, cultural sensitivity, work arrangements and community engagement. Queensland Health plays a vital role in the conduct of the study, aiming at enhancing its standing as an employer of overseas trained health professionals, and at providing national leadership in this area. Ethical and sustainable nurse recruitment is a fundamental constituent in providing equitable and accessible healthcare services to the public and crucial for workforce planning.

Ethical models will be studied and compared to those in other countries in order to develop an appropriate ethical and sustainable health recruitment model for Australia and the Philippines. Our study will consider if unintended consequences are occurring, such as whether this type of system may encourage Philippine-trained health professionals to migrate to developed countries in greater numbers, whether it will create pressures to lower income and/or standards of practice of existing health professionals, and whether it can be developed to ensure the appropriate distribution of those professionals to areas where they are most needed. Issues such as permanent residency and career goals of migrant Filipino nurses will also be investigated. In seeking to answer those questions, the research team will map out an integrity system for ethical and sustainable nurse recruitment including legal rules, administrative rules and practices, transparency and the potential for watchdogs, auditors or ombudsmen to ensure structures and processes are functioning as intended. The study will also suggest and consider institutional arrangements to ensure that ethical standards for recruitment are maintained and the claimed benefits to Australia and the Philippines delivered.
Our study will make substantive contributions within the field of health workforce management by supporting the development of bilateral agreements with developing countries, in this case the Philippines. Furthermore, the research outputs meet several national and international goals on ethical healthcare migration; the Millennium Development Goals are supported as Australia works in collaboration with the Philippines to assist in governance reform; and the ethical model developed for the Philippines could also be applicable to other jurisdictions of low- and middle-income countries, such as Papua New Guinea and Fiji. Significance of health migration research is also timely with the release of the WHO Global Code of Practice on International Recruitment of Health Personnel [27] encouraging all countries to act ethically in the migration of health workers. Another substantive contribution the project will have is on Australia's National Research Priorities: Promoting and Maintaining Good Health and Ability to Safeguard Australia, as it is aims to enhance access to health services in Australia more generally through recruitment. Nursing shortages are a significant barrier to equitable access to healthcare, especially in rural Australia, where low nurse:patient ratio levels stand in the way of good quality care. The ideas and evidence generated by this research will enhance understanding of the policies and practices in nurse migration and education within the Philippines and Australia and assist with recruitment procedures in a manner that is of benefit to both countries.

**Conclusion**

Health professional migration has led to apparent distortions in healthcare delivery and human resources; experienced nurses depart overseas resulting in a shortage of skilled, specialised and experienced nurses and nurse educators in the Philippines; a proliferation of nursing schools affected the quality of nursing education; and demand-driven factors shifted preferences of doctors to study nursing. As a consequence, the oversupply of nurses in the Philippines resulted in volunteerism-for-a-fee in the temporary situation, yet the developed world faces a critical shortage of nurses that is set to become more acute with the ageing population. Developed countries are unlikely to be able to reach self-sufficiency in nursing in the foreseeable future, and will continue to rely on attracting and retaining international nursing graduates. However, such recruitment drains valuable human capital in which the developing country has invested scarce resources. The global thirst for nurses trained in developing countries needs to be turned from the ‘brain drain’ into a phenomenon that is mutually beneficial. Central to the sustainability of such an arrangement is a regime that underpins good relationships between health systems – by putting back more than it takes out, the smooth integration of professionals from different cultural and training environments and the continuing attractiveness of employers as a destination for international graduates. The challenge remains in how to recruit overseas-trained nurses in an ethical and sustainable manner, especially as developed countries continue to recruit the most able and mobile; this means they are lost to the healthcare systems in which they trained. Creating a positive-sum game will secure lasting benefit for both health systems in which both recruiting and source countries benefit while ensuring the rights of individual health professionals. Further empirical research is required to address gaps in health worker migration and health workforce integration in both developed and developing countries.

**Competing Interests**

The authors declare that they have no competing interests.

**References**

3. AHPRA. English Language Explanatory Note. Melbourne: Nursing and Midwifery Board; 2010.
14. To A, Hawthorne L. The impact of English language testing of nurses’ migration and registration outcomes. Melbourne: International Health Workforce Unit, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne; 2011.

15. Hawthorne L, To A. Nurse migration flows, registration and employment outcomes. Melbourne: International Health Workforce Unit, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne; 2011.


24. Pagett C, Padarath A. A review of codes and protocols for the migration of health workers. The Regional Network for Equity in Health in East and Southern Africa (EQUINET) with the Health Systems Trust And in co-operation with the East, Central and Southern African Health Community. 2007;50:40.

