Community Services & Health
Industry Skills Council

The Community Services and Health Industry Skills Council Submission:

The inquiry into the current framework and operation of subclass 457 visa, Enterprise Migration Agreements and Regional Migration Agreements

April 2013

The Community Services and Health Industry Skills Council (CS&HISC) is the peak agency responsible for workforce development and for qualifications and occupational standards for the Vocational Education and Training sector of tertiary education for the Community Services and Health Industry. These qualifications support over 500 job roles undertaken by over 1.3 million workers in Australia.

The CS&HISC has a strong interest in policy on the framework and operation of the 457 visa, Enterprise Migration Agreements (EMAs) and Regional Migration Agreements (RMAs) as they relate to the community services and health industry workforce. The community services and health industry in particular relies on being able to use workers on 457 visas to fill short term gaps and persistent shortages in the workforce.

Our submission focuses on those points the submission criteria that have particular relevance to CS&HISC. These points are highlighted in bold below. We have declined to comment on reference points 'b', 'd', 'h' and 'i' as we consider them to be outside of our specific remit.

(a) their effectiveness in filling areas of identified skill shortages and the extent to which they may result in a decline in Australia's national training effort, with particular reference to apprenticeship commencements

(b) their accessibility and the criteria against which applications are assessed, including whether stringent labour market testing can or should be applied to the application process

(c) the process of listing occupations on the Consolidated Sponsored Occupations List, and the monitoring of such processes and the adequacy or otherwise of departmental oversight and enforcement of agreements and undertakings entered into by sponsors

(d) the process of granting such visas and the monitoring of these processes, including the transparency and rigour of the processes

(e) the adequacy of the tests that apply to the granting of these visas and their impact on local employment opportunities

(f) the economic benefits of such agreements and the economic and social impact of such agreements

(g) whether better long-term forecasting of workforce needs, and the associated skills training required, would reduce the extent of the current reliance on such visas

(h) the capacity of the system to ensure the enforcement of workplace rights, including occupational health and safety laws and workers' compensation rights

(i) the role of employment agencies involved in on-hiring subclass 457 visa holders and the contractual obligations placed on subclass 457 visa holders

(j) the impact of the recent changes announced by the Government on the above points

(k) any related matters.

The effectiveness of 457 Visas, EMAs and RMAs in filling areas of identified skill shortages and the extent to which they may result in a decline in Australia's national training effort

In response to item (a) in the terms of reference

To explore the relative effectiveness of the 457 Visa, EMAs and RMAs in filling areas of identified skills shortages in the community services and health industry and the extent to which they may result in a decline in Australia's national training effort, we have identified four key questions to be addressed:

1. What are the key factors affecting the demand for 457 Visa holders in the health and community services industry?
2. What do we know about the number and profile of 457 Visa holders currently working in the health and community services industry?
3. How are 457 Visas, EMAs and RMAs currently being used to fill the gaps in the health and community services workforce?
4. What contribution is the national training effort making to fill the gaps in the health and community services workforce, and what if any are the limitations of this contribution?

1. Key **factors affecting the demand for 457 Visa holders** in the health and community services industry include:

- A rapidly expanding community services and health workforce, particularly in respect to support roles, driven by an ageing population and Government policies such as the *National Disability Insurance Scheme* and *Living Longer, Living Better* as evidenced by:
    - Census data indicating that between 2001 and 2011, community services and health was the fastest growing workforce in Australia. For example the number of Aged and

Disabled Carers increased from 77,414 in 2006 to 108,216 in 2011 an increase of 40%[i]

- Department of Education Employment and Workplace Relations (DEEWR) estimates that the largest number of new jobs created between 2011/12 and 2016/17 will be in health care and social assistance[ii]
- Australian Workforce Productivity Agency (AWPA) projections showing that by 2025 the health and community services workforce will need to expand by between 427,000 and 910,000 workers, this equivalent to between a 35% and 77% growth[iii]
- the emergence of new roles in the health and community services industry for example the Clinical Support Officer and Assistants in Nursing as highlighted in CS&HISC's 2013 Environmental Scan[iv].

- Difficulty recruiting to occupations where there is growth in the numbers required and/ or that have less than attractive terms and conditions. This is evidenced by existing shortages in Aged and Disabled Carers (ANZSCO 4231) and Nursing Support and Personal Care Workers (ANZSCO 4233) identified by DEEWR[v] and potential future shortages in the nursing workforce projected by HWA[vi].
- Difficulties associated with recruiting to rural and remote locations as evidenced by:
  - descriptions of remote and rural services in the National Strategic Framework for Rural and Remote Health[vii]:

    'Rural and remote health services are more dependent on primary health care services, particularly those provided by General Practitioners (GPs). Facilities are generally smaller, provide a broad range of services (including community and aged care), have less infrastructure and locally available specialist services, and provide services to a more dispersed population.'

  - the disparity in the number of health care professionals between metropolitan and the most remote parts of the country. For example, Australian Institute of Health and Welfare data[viii] indicate that in 2006 'very remote' areas had:

    - 589 registered nurses per 100 000 population (compared to 978 per 100 000 in major cities)
    - 64 allied health workers per 100 000 population (compared to 354 per 100 000 in major cities)
    - 58 generalist medical practitioners per 100 000 population (compared to 196 per 100 000 in capital cities).

- persistent skills shortages in remote and rural areas as noted in the recent Health Workforce Australia publications[vii]

- Relative mobility of health and community service workers coupled with fluctuations and changes in the 'push' and 'pull' factors affecting individual decisions to immigrate to and migrate from Australia. Professor Hawthorne comprehensively explored the data and issues around global movement of health professionals in her recent report[ix] for Health Workforce Australia and noted that:

  'While Australia has clear capacity to attract migrant health professionals, it is essential to note high emigration rates persist - most notably of the Australia-born (48%) followed by health professionals born in New Zealand (14%), the UK (11%), Hong Kong SAR (3%), China (4%), Ireland, Malaysia, the USA, Philippines, Canada and South Africa (1% each). There is limited research on this issue. Many of these health professionals first arrived on a temporary basis. Global competition to recruit and retain the 'best' sources of migrant health professionals is rising, with attractive options developing in OECD sites, in addition to the Gulf States, Africa and Asia.'

2. The available evidence **on the number and profile of 457 Visa holders** currently working in the health and community services industry indicates:
   - According to recently published DIAC data (as at 28 February 2013)[x] there were 12,730 457 primary visa holders reported to be working in the Health Care and Social Assistance industry. This equates to 11.8% of all primary subclass 457 visa holders at that time.
   - Historical data on the use of the 457 visa in the health sector indicates an employer preference for high-level English ability (including native speakers), comparable health education systems, and perceived capacity to integrate at speed [ix].
   - DIAC reporting on the use of 457 visas is at a very high level. In order to gain a better understanding of how 457 visas are being used within an industry would require data at nominated occupation level, rather than just 'major occupational groupings' which are of limited use. Nominated occupation level data are not easily available.
   - Despite shortages identified in a number of occupations in health and community services, currently the only relevant occupation listed amongst the top 15 nominated occupations for primary 457 visa holders is 'General Practitioner' with 2,560 primary visa holders[x]. Again data at actual nominated occupation level would help industry and government to better understand how 457 visas are being used and to enable the development of more comprehensive industry labour force models that incorporate the use of 457 visas.

- A proportion of 457 visa holders in the health and community sector are graduates of Australian education and training programs.
    - The 457 visa might be an avenue for these graduates to gain early career experience in Australia or to gain permanent residency. For certain professional groups, doctors for example this early career experience is an essential requirement for professional registration.
    - Arguably, this group of 457 visa holders are better prepared to meet the demands of the Australian health and community services industry than those trained overseas. This argument is supported by Professor Hawthorne's analysis of Occupational English Test pass rates and employment rates for international health professionals who graduated from Australian institutions, compared to those who trained oversees[ix].
    - It is therefore important to be able to identify these visa holders as a separate group in routinely published data on the 457 visa, and to monitor the flow of international students into health and community services programs and through to employment.

3. In relation to **how 457 Visas, EMAs and RMAs currently being used** to fill the gaps in the health and community services workforce, it is understood that:
    - The key features of the 457 Visa are that they are temporary and that they can be tied to a particular region and/or occupation of need, also individuals on a 457 visa can only change their jobs a maximum of two times. These features enable the 457 to be used strategically to fill specific gaps in community services and health industry. Good examples of this strategic use of 457 visas are their use to fill 'areas of need' in the medical workforce and to 'support better occupational distribution' in nursing and midwifery[ix].
    - A proportion of 457 visa holders are amongst those health and community service workers emigrating from Australia whilst others opt to stay in Australia more permanently. Data reported by Professor Hawthorne indicates that for health professionals (e.g. doctors, nurses and dentists) on 457 visas an increasing number are converting to General Skilled Migration status, in 2008-1009 this figure was 39,170[ix].

4. Our understanding of **national training effort contribution to filling the gaps** in the health and community services workforce is that:
    - Appropriate, high quality training has an important role to play in addressing shortages in the health and community services workforce; particularly when responding to a new or increased need for particular role.

- There are a range of training and workforce development programs that CS&HISC is involved in that will help fill existing or anticipated gaps in the health and community services workforce. For example:
    - The application of Certificate III qualification in health administration to support the training and introduction of Clinical Support Officers, a new role of which there are now over 500 employed in the NSW public health system
    - Targeted support in the development of a more sustainable age care workforce for the future, through the establishment of Age Care Workforce Innovation Networks (WINs) which provide workforce development support for the age care sector.
- However, the ability of the national training effort to fill gaps in the health and community services workforce is limited; increased or improved training is unlikely to be able to address persistent shortages that are due to the relatively negative perceptions of the role, its remuneration, conditions and societal views on ageing and disability; or difficulties associated with its remote or rural location.
- Furthermore the development and delivery of appropriate and high quality education and training require time and sufficient resources before any discernible impact on workforce shortages be made.
- There is also potential to use the high quality national training infrastructure in Australia to support and enhance the use of temporary 457 workers through international engagement activities that look to:
    - identify potential temporary and permanent international workers
    - to support and develop individuals and infrastructure to help ensure the best fit for the needs of the community services and health workforce

  Should this be found to be an attractive option, resources would need to be identified to support implementation.

To summarise, CS&HISC is of the view that 457 visas should not be used in place of national efforts to train, recruit and retain an appropriately qualified sustainable workforce. However, 457 visas along with RMAs and EMAs have been demonstrated to be an essential tool for filling those shortages and gaps that would otherwise not be filled. We would argue that to ensure that these tools are used appropriately and effectively, better and more easily accessible data on 457 visa usage, particularly at nominate occupation level and concerning international students, are required. These data could be used to help industry/ peak associations such as CS&HISC and Government better inform each other on issues relating to supply and demand in the health and community services workforce.

The process of listing occupations on the Consolidated Sponsored Occupations List

In response to item (c) in the terms of reference

The Consolidated Sponsored Occupations List (CSOL) should reflect current occupation shortages and be responsive to information from employers about changes in supply and demand for existing and emerging roles. The CS&HISC is concerned that the CSOL is not sufficiently responsive to changes in supply and demand within the community services and health industry workforce and as a result does not include occupations such as those roles involved in personal care (which includes Aged and Disabled Carers and Nursing Support and Personal Care Workers) for which there is an identified shortage[v]. A particular issue for the Community Services and Health Industry is the need for the CSOL to have the ability and flexibility to accommodate the new and emerging roles.

We understand that the current methodology for listing occupations on the CSOL is complex and would recommend that consideration be given to making it more transparent. In particular, clear and transparent processes for employers and peak bodies such as CS&HISC to report important information on current and anticipated workforce shortages to the Department of Immigration and Citizenship are required.

The adequacy of the tests that apply to the granting of the 457 Visa, EMAs and RMAs and their impact on local employment opportunities

In response to item (e) in the terms of reference

Of the tests and requirements that apply to the granting of the 457 visa, EMAs and RMAs, other than the requirement for inclusion in the CSOL, the most significant for the health and community services industry is the requirement for sufficient English language ability. English language, literacy and broader communication skills are recognised as being of high value across the community services and health industry.

This is in part evidenced by the disproportionate numbers of sponsored health professionals from English speaking countries: 43% for permanent general skilled migrants and 45% for 457 visa holders as compared to only 17% of the general skilled migrant program as a whole. Furthermore, data show that the Occupational English Test, used in as a test of English language ability for health professionals who have qualified elsewhere and wish to practise in Australia, presents a significant barrier for migrant health professionals with an overall pass rate of just 34% in 2010[ix].

Expectations for English language ability for employees in the health and community services are relatively high and relate to a broader set of communication skills required to perform different roles

within the industry. The current minimum requirement of five in each of the four domains is adequate for setting a minimum standard in English language ability for all temporary migrant workers. Beyond the tests that apply to granting the 457 visa, employers need to be mindful to ensure that the skills offered by the 457 visa holder are a good match for the requirements of a given role.

The economic benefits and social impact of the access to and use of the 457 Visa, EMAs and RMAs in the community services and health industry

In response to item (f) in the terms of reference

It is difficult to quantify the economic and social impact of the community services and health industry having access to the 457 Visa, EMAs and RMAs without robust indicators of social impact. It is possible however to identify the key advantages of the temporary migration system from both an economic and social point of view are that it can used to:

- address specific short-term workforce shortages without having to make long term commitments to individual migrants which affords Australia with time to address the shortages through training the domestic workforce
- fill persistent shortages in regional and remote areas; enhancing the viability and sustainability of rural services.

A recent AWPA report describes the important role migration has *in 'buffering the economy against the volatility of the economic cycle, acting as a 'shock absorber' in the Australian labour market*[xi].' This is true of the impact of migration in the health and community sector where in addition to economic impacts of generic migration, the essential nature of the services delivered by the health and community services workforce mean that any persistent shortages or gaps in the workforce will have a negative impact on patients, other service users and their carers. Therefore temporary migrant health and community service workers play a crucial role in ensuring high quality and effective care and services are provided to the Australian population, both in urban and remote and rural areas.

The role of better long-term forecasting of workforce needs, and the associated skills training in reducing the current reliance on the 457 Visa, EMAs and RMAs

In response to item (g) in the terms of reference

The CS&HISC believes that there is a need for improved modelling on health workforce supply to inform future planning. The National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015[vi], highlights the need for enhanced workforce planning capacity, both

nationally and jurisdictionally, taking account of emerging health workforce configuration, technology and competencies. We would encourage any workforce planning activity to inform policy on the 457 Visas, EMAs and RMAs engage with this strategy, the Health Workforce Agency and other key organisations involved in the development of the health and community services workforce.

It is acknowledged that due to the large number of variables affecting demand and supply in the health and community services industry, it is difficult to do this accurately particularly when making long-term projections. Furthermore, even with improved long term projections we would anticipate that there are some shortages in the health and community services workforce such as those in remote and rural areas that will continue to rely on temporary international workers. We would however, encourage an approach that allows for continuous improvement of forecasting methods by making improvements based on comparisons between projections and actual workforce data. We also agree with Professor Hawthorne who recommends the inclusion of data related different cohorts of migrant health professionals into this modelling process, including estimates of early productivity, likely registration status, hours worked and length of retention[ix].

The potential impact of the recent changes to the 457 Visa, EMAs and RMAs announced by the Government

In response to item (j) in the terms of reference

We note the recent changes to the 457 Visa, EMAs and RMAs announced by Government, may result in a tightening of controls and limitations being placed on their accessibility. CS&HISC is of the view that any tightening of controls or limitations on the availability of 457 visas, EMAs and RMAs that are implemented without due consideration of persistent workforce shortages will have a detrimental impact on the ability of the health and community services industry to deliver care and support to patients and service users. To ensure that patients, other service users and their carers are protected from the negative impact of shortages in the health and community service workforce we recommend:

- a review of the methodology for the Consolidated Sponsored Occupations List to make it more transparent and responsive to changes in supply and demand
- inclusion of sponsored occupation level data and data on international students in DIAC reports on the 457
- improved mechanisms for Government to engage with the health and community industry on issues relating to workforce supply and demand.

References

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