

lower-middle and working-class backgrounds are so unsuccessful. Class, not ethnicity, is the problem. If there is to be any focus on the latter, it should be directed at the sources of disadvantage within the largest community of all, the Australian-born with Australian-born fathers.

Acknowledgment

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References

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MEDICAL STUDENTS AND THE CHANGING MAKE UP OF THE AUSTRALIAN MEDICAL WORKFORCE

■ Christopher Betts

The birthplaces of the existing medical workforce are not representative of the Australian population. When the students currently enrolled in Australian medical schools enter the workforce this situation will be accentuated.

The study of medicine can lead to high status, well-paid employment as a valuable and respected member of society. Many young people see entrance into a medical course as a desirable goal, and the competition for places is strong. Only students who score very highly in the assessment at the end of secondary school gain entrance. Given this, the relative performance of students born overseas in winning medical school places is a good indication of migrant achievement in Australia.

The competition for medical school places also helps shape the provision of medical care, since doctors of migrant origin may bring a knowledge of their particular community's needs

to their work, as well as relevant language skills. It is often argued that where migrant representation in a service profession is lacking then the service provided may be deficient from the point of view of the migrant community being served.

This article examines these questions through an analysis of students who were enrolled at the bachelor level in medicine throughout Australia in 1993 and were Australian citizens, New Zealand citizens and other permanent residents. It uses unpublished data drawn from Department of Employment, Education and Training (DEET) enrolment records. In 1993 there were 7,686 students enrolled in undergraduate medical courses who

Table 1: Undergraduate enrolments in medicine by major birthplace, Australian residents, 1993

Birthplace	Students	
	No.	%
Australia	4 591	59.7
UK & Ireland	359	4.7
South Africa	71	0.9
New Zealand	71	0.9
Malaysia	494	6.4
Vietnam	410	5.3
Hong Kong	316	4.1
Singapore	153	2.0
Sri Lanka	102	1.3
India	99	1.3
Other	1 020	13.3
Total	7 686	100.0

Source: DEET enrolment statistics, unpublished

Table 2: Birthplace by major countries and regions for medical students 1993, employed medical practitioners 1991 and the total Australian population 1991

Birthplace	Undergraduate students		Medical practitioners %	Aust. people %
	No.	%		
Australia	4 591	59.7	63.0	75.5
New Zealand	71	0.9	1.8	1.6
UK & Ireland	359	4.7	11.9	7.0
Western Europe	56	0.7	1.7	1.6
Southern Europe	30	0.4	1.5	3.9
Eastern Europe	62	0.8	1.9	0.8
USSR & Baltic	23	0.3	0.4	0.3
Middle East & Nth Africa	125	1.6	1.3	1.0
South East Asia	143	14.6	5.5	2.2
North East Asia	501	6.5	2.3	1.2
South Asia	216	2.8	4.3	0.7
North America	91	1.2	0.6	0.4
Other & Not stated	418	5.4	3.5	3.7
Total	7 686	100.0	38 819 100.0	100.0

Source: Medical practitioners, 1991 Census Matrix; Students, DEET enrolment statistics, unpublished; Population, 1991 Census

were Australian citizens or permanent residents. They will constitute a major component of the future medical workforce in Australia. This can be gauged from the fact that according to the 1991 census there were just 38,819 medical practitioners employed in Australia. In terms of birthplace, how representative of the population being served is the existing and future medical workforce?

MEDICAL STUDENTS, MEDICAL PRACTITIONERS AND THE AUSTRALIAN POPULATION

The major student birthplaces are shown in Table 1. Apart from the Australian-born (54.9 per cent) and the United Kingdom-born (4.7 per cent), the other major birthplaces are Asian, particularly Malaysia (6.4 per cent), Vietnam (5.3 per cent) and Hong Kong (4.1 per cent).

Table 2 shows the birthplace distribution of students, medical practitioners and the general population according to the major regions of origin.

It is clear that in 1991 there was already a mismatch between the birthplace origins of practising doctors and the Australian-resident population. Doctors from the UK and some Asian countries were over-represented while doctors born in Australia and Southern Europe were under-represented. This situation will not change when the current cohort of students start

practising. There will be a further accentuation of the Asian presence in the medical workforce, a major drop in the UK-born representation and a further decline in the share of Australian-born doctors. Also, no improvement is in sight for a larger share of Southern Europeans in the medical workforce. The DEET data do not indicate birthplace of parents, so it is not possible to establish whether second generation students from Southern Europe might be making up for the low representation of the first generation. However, if enrolments for the Monash medical school are indicative, this is unlikely. Only a tiny number of Monash medical students are second-generation Southern Europeans.

For the foreseeable future, immigration will not have much additional impact. This is because doctors are, for all practical purposes, debarred under the current selection system for the Independent and Concessional Family categories. Furthermore, all foreign-

trained doctors now have to pass the Australian Medical Council (AMC) examination, including those graduating from the UK, and there is an annual quota of two hundred on the number allowed to pass the written component of the exam. Of these, only about half pass the clinical test. There is a large backlog of candidates already in Australia. But their slow entry into the Australian medical workforce will actually add to the Asian share since, according to AMC records, the three largest country-of-origin sources for those sitting the examination are Egypt, India and Sri Lanka.

MEDICAL SCHOOL PARTICIPATION RATES

In order to assess the relative achievement of birthplace groups in winning medical school places, participation rates based on the size of the 15 to 24 age cohort from which most students are drawn have been calculated. For this exercise, only those medical students aged 24 or younger were included. They constitute 6,930 or 90 per cent of medical students with Australian citizenship or permanent residence.

Table 3 shows that the relatively high number of students from Malaysia, Hong Kong and Vietnam reflects a higher rate of success in competing for medical school places than is the case for overseas-born persons generally, and an even greater rate of success in comparison to Australian-born residents. In fact, residents from these three countries are five to ten times more likely to be studying medicine than the

Table 3: Participation rates of undergraduate medical students aged 15 to 24 by selected countries of birth

Country of birth	Base population (15 to 24)	No. of students	Participation rate*
Malaysia	22 672	478	21.1
Hong Kong	20 487	295	14.4
Vietnam	33 736	347	10.2
UK & Ireland	76 402	307	4.0
Greece	3 844	7	1.8
Lebanon	11 164	22	2.0
Philippines	11 761	15	1.3
Australia	2 336 377	4 143	1.8
All overseas born	409 781	2 787	6.8
All residents	2 746 118	6 930	2.8

* Participation rate is the number of students per 1000 base population. Source: Students, DEET enrolments statistics; Population, ABS *Estimated Residential Population by Country of Birth*, Cat. No. 3221

Australian born. The Vietnamese achievement is particularly noteworthy, given that the community from which these students are drawn is one of the most depressed in Australia, at least as judged by the level of unemployment and the extent of adult dependence on low-paid unskilled work.

MEDICAL SCHOOL PARTICIPATION OF RECENTLY ARRIVED MIGRANTS

Amongst the overseas-born medical students holding Australian-residence status, 594 or 19.2 per cent arrived in Australia between the years 1988 to 1992 (see Table 4). Considering the long (six years) duration of the medical course, this may seem surprising. It implies that such students probably started studying very soon after their arrival.

However, recent high rates of immigration from countries such as Malaysia and Hong Kong, mean that almost half the base 15 to 24 year-old population has arrived since 1986, so we would expect many students in these birthplace groups to be recent arrivals.

Nevertheless, the large number in the recently arrived category does raise similar questions to those put in a previous issue of *People and Place* by Dobson.¹ With the exception of the Vietnamese — most of whom arrived well before 1988 anyway — the recent arrivals come mainly from Malaysia, Hong Kong and Singapore. Dobson has noted that all these societies offer plenty of well-paid opportunities for professionals, opportunities that may well attract some back home. If those who do return have opted to pay their HECS fee via later taxation adjustments then they will make no contribution to the cost of their medical training at all.

This comment is not intended as a criticism of the training of private

overseas students. The DEET enrolment statistics indicate that there were 871 students (598 from Malaysia) studying medicine in 1993 who were classified as Temporary Entrants paying the full fee of more than \$23,000 per year. These enrolments were worth \$20 million per year to the universities.

Table 4: Time of arrival in Australia of resident overseas-born undergraduate medical students

Country of birth	Arrived < 1988	Arrived 1988-92	Total*
Malaysia	339	151	494
Vietnam	352	53	410
Hong Kong	213	96	316
UK & Ireland	330	28	359
Singapore	106	47	153
All overseas born	2 293	594	3 096

* Total includes time of arrival not known.

Source: DEET enrolment statistics, unpublished

CONCLUSION

In general, immigrant groups are very well represented in medical studies. The participation rate for all overseas-born Australians who are permanent residents is more than three times that of the Australian-born. In particular, immigrants from Asia are taking up medical studies at surprisingly high rates. It is encouraging to see some students from less well-off groups, such as Vietnamese migrants, being so successful in gaining places in medical courses.

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References

- ¹ I. Dobson, 'Fees in Australian higher education', *People and Place*, vol. 2, no. 1, 1994