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For further information contact:
Centre for Population and Urban Research
P.O. Box 11A
Monash University
Clayton, Victoria, 3800
Australia.
Phone: 61 3 9905 2965
Fax: 61 3 9905 2993
peopleandplace@arts.monash.edu.au

MEDICARE PLUS AND OVERSEAS-TRAINED MEDICAL DOCTORS

■ **Bob Birrell and Leslyanne Hawthorne**

Until the late 1990s the Australian Government's medical workforce policy focussed on limiting reliance on overseas trained doctors (OTDs). Since that time the reverse policy has been instituted. As a result, by 2004 there was a heavy reliance on temporary entry OTDs in areas of medicine that locally trained doctors were reluctant to service. The introduction of Medicare Plus in mid-2004 has been accompanied by additional initiatives to increase OTD recruitment. This article explores the implications of these policy developments.

At the time of writing (June 2004) the Coalition Government was engaged in a national advertising campaign, which spelled out the virtues of its Medicare Plus program. The program was the legislative outcome of the Government's effort to address public concerns about the decline in access to bulk billing arrangements for general practitioner services. This had become a political issue because, within the last few years, bulk billing rates were declining, not just in much of regional Australia but also in parts of the metropolises. The decline in bulk billing rates was one of several manifestations of a serious underlying shortage of doctors. Others included the difficulties state and local government health authorities were encountering in filling rural GP vacancies and in recruiting doctors to hospital medical officer and specialist positions within the public hospital system.

Medicare Plus promised to rectify these problems by recruiting more doctors and, at the same time, giving them additional financial inducements to bulk bill families with young children and residents of regional areas. The Government claims that Medicare Plus will provide an extra 1,500 full-time equivalent doctors, especially in areas which need them most — 'such as outer metropolitan, regional, rural and remote Australia'.¹

The vast majority of the additional doctors are being drawn from overseas-trained doctors (OTDs) recruited from overseas. This paper reviews the scale and sources of this recruitment effort. The numbers involved are very large. This outcome is a consequence of a government decision to 'pull out all the stops' necessary to augment rapidly the medical workforce in Australia. The consequence is a transformation of this workforce towards a high level of dependence on doctors resident in Australia on a temporary basis and, within the permanent workforce, on doctors trained overseas. The OTD workforce is increasingly filling the positions Australian-trained doctors are not available for or are unwilling to undertake because they do not find the location or working conditions attractive.² Comparable trends are occurring in other western countries such as the UK, Canada, the US and New Zealand. The disincentives for young Australian doctors to serve in rural general practice were summed up by a recent informant as follows:

A lot of it is to do with the number of doctors that are born and bred in the city and just never think of moving into the country. The city is their home — so why would they want to leave? For others it is a financial thing. A doctor in a clinic in Melbourne where there are maybe ten GPs

sharing costs and having an unlimited population could make more money. There is another concept that the skill requirement of a country GP has got to be a lot higher. In some bigger city clinics (while they are not specialists) one GP may have a special interest in diabetes, another in asthma and another one in sport injuries, and when a patient arrives at the clinic the reception staff can commit them to the person who has that speciality. That way one doctor can be the full-bag on something and doesn't have to be the full-bag on everything, which makes for an easier lifestyle. Then there is the view that if you have ten doctors in the one clinic you probably don't have to work 24 hours, seven days a week like in rural areas. People think you have to work too hard for too long in the country. Another factor is people think going to the country becomes a life sentence — if they want to move they can't move because there is nobody to buy that practice from them.³

Doctor shortages: a function of maldistribution or systemic undersupply?

The Medicare Plus package implies that the Coalition Government has finally buried, as a guide to policy, the argument of Australia's medical manpower planning body, the Australian Medical Workforce Advisory Council (AMWAC), that there is no shortage of doctors in Australia.⁴ This position dates to the Council's initial detailed assessment of the issue in 1995. The Council concluded that there was a maldistribution of doctors but not an overall shortage. It acknowledged that there was a spatial imbalance, with metropolitan areas being 'oversupplied' at the expense of an 'undersupply' in some regional areas. At the time this seemed a reasonable judgement. There had been a rapid increase in the numbers

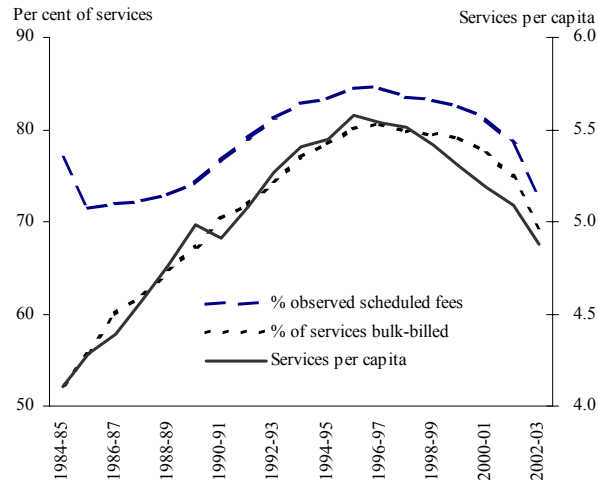
of doctors in Australia and a resultant decline in the population to doctor workforce ratio. Successive governments had also expressed concern about the budgetary costs of this outcome.

AMWAC's conclusions were embodied in crucial legislation affecting the medical workforce at the end of 1996. This Coalition government legislation restricted the rights of locally trained doctors who graduated after 1996 and of OTDs who gained their Australian Medical Council (AMC) accreditation after 1996 to bill on the Medicare system. To do so they had to first complete the post-graduate family medicine program run by the Royal Australian College of General Practitioners. Entry to this vocational program was competitive, with an initial quota of 400 new entrants (lifted to 450 in 2003).

The effect of this legislation was to sharply reduce the annual number of new entrants to GP ranks by at least several hundred per year.⁵ Prior to the legislation any locally trained doctor or accredited OTD could obtain a Medicare Provider number allowing him/her to bill the Medicare system as a GP. Other related measures reinforced the Coalition's government anxiety to rein in the growth of the numbers of doctors billing on Medicare. These included restrictions on overseas students who had completed their medical degrees in Australia and doctors trained in New Zealand from billing on Medicare until ten years after being registered as a medical practitioner in Australia.

Figures 1 and 2 show the cumulative impact of these initiatives. Since the late 1990s, the number of general practitioners billing at least \$1,000 per year on Medicare has stabilised at around 21,000 (see Figure 2). Meanwhile Australia's population has been growing at some

Figure 1: Medicare non-referred attendances, Australia, 1984-85 to 2002-03



Source: Medicare Statistics, Tables C1A, C3 and C4, available at <http://health.gov.au/haf/medstats/>

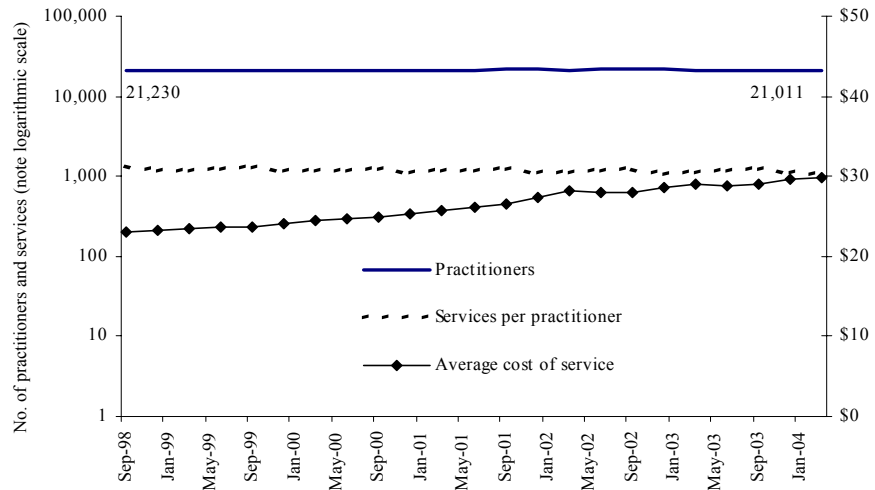
250,000 per year. Partly as a result the balance of market power between GPs and patients has changed — in favour of the GP. He/she can consider giving up bulk billing with less danger that patients will respond by moving to another bulk-billed practice. As a result, the proportion of services bulk billed has declined since the mid-1990s (see Figure 1). So has the number of non-referred attendances per capita — perhaps because of patients’ reluctance to contribute from their own pockets. The other side of the coin, as indicated in Figure 2, is that the average price for the service (reflecting the increased proportion of direct bill services) to the patient who does attend has increased.

In sum, the Coalition’s legislation has delivered a painful message to voters. Medical services are now less accessible and more expensive. This message has long been felt in regional areas. In recent years however, it is also being heard in suburban areas as well; thus the urgency of Medicare Plus.

The government’s 1996 legislation delivered a self inflicted wound. Even if AMWAC’s judgement that doctor shortages were not systemic was correct, the policy to cut back on the rate of entry to GP ranks should have been accompanied by measures to redistribute doctors. This did not occur. The Coalition has no more than tinkered with such measures. Ironically, the ‘success’ of the 1996 legislation has added to the problem. The increased scarcity of GPs with rights to bill on Medicare means there is even less pressure to relocate to ‘undersupplied’ areas than before the legislation was passed.

As it has turned out AMWAC was incorrect. There is a systemic problem. It is that the output of medical graduates since the mid-1990s (which has been stable) has been well short of the numbers needed to cover the growth in demand for the various medical specialties, for junior and career doctors within the hospital system and for GPs. As a consequence, shortages have worsened during the late 1990s and early

Figure 2: Professional attendances: number of practitioners, services per practitioner and average cost of service, September 1998 quarter to March 2004 quarter



Source: Health Insurance Commission, quarterly data, downloaded from <http://www.hic.gov.au/statistics/imd/forms/gpStatistics.shtml>

21st century. They have manifested most glaringly within the medical work which is the least prestigious and where work and living conditions are the most difficult. Hospital work, particularly in regional settings fits this category and as a result there are chronic shortages of doctors available and willing to do this work. By 2001, for instance, 283 overseas trained doctors lacking full local registration were employed in Victorian hospitals, together with an additional 114 in Tasmania.⁶ Likewise shortages of GPs have become acute in more remote locations. These outcomes have added to the political pressure on the Government to do something about the supply of doctors.

The policy response

With Medicare Plus has come an implicit acknowledgement that domestic medical training is inadequate. The Coalition Government has announced that it will increase the number of medical school places and open five new medical schools

at the following universities: Australian National University (2004), Bond (2005), Notre Dame (2005), Griffith (2005), and Western Sydney (2006). This follows the earlier establishment of a medical faculty at James Cook University. The gains in supply flowing from these announcements, of course, lie far in the future. As a consequence the Government has had no choice but to augment the medical workforce from the ranks of OTDs.

Entry via the General Skilled Migration Program

There have been a number of recent initiatives. The first to be discussed is the decision to add doctors to the Skilled Occupations List (SOL). This is the list prepared by DIMIA to guide persons wishing to apply in the Skilled Independent and Skilled-Australia linked migration categories. When the SOL was first put in place in mid-1999, it did not include doctors. This meant that doctors wishing to migrate had to do so via the family reunion program or by gaining an

employer sponsorship. DIMIA was reflecting the Government's medical manpower policy at the time, which was then governed by the goal of stabilising the medical workforce.

At this stage, the SOL initiative will only benefit OTDs who hold a qualification accepted by the Royal Australian College of General Practitioners as equivalent to their family medicine postgraduate qualification (including those trained in the UK, Ireland, Canada, South Africa and New Zealand) and former overseas students trained in Australian medical schools who have met Australian medical registration requirements. This is because DIMIA requires applicants to have obtained full medical registration from a State or Territory Medical Board before applying. Nonetheless, the numbers of overseas students in training is large. By 2002 there were 1,287 international students enrolled in medical courses in Australia, including 32 per cent at the University of Melbourne, 17 per cent at the University of Adelaide and 16 per cent at the University of New South Wales (the

dominant providers).⁷The great majority of these students were derived from Commonwealth Asian countries, most notably ethnic Chinese from Malaysia and Singapore. (See Table 1.) International medical students can currently complete their internship training in Australia on a temporary visa, following a progressive government policy reversal over the past two years. Once completed former students will now be able to apply for migration onshore under the Skilled Independent category. Their selection is certain because medical doctors have been added to the MODL (the list of occupations in demand in Australia) for which extra points are allocated. They will also be given priority in the processing queue on this account.

By March 2004 the University of Melbourne had 725 international undergraduate medical students (rising from 338 in 1999). An exit survey of the previous year's graduating class showed at least a third of completing international students had secured Australian internships, primarily in major urban or

Table 1: Source regions of international students enrolled in Australian medical/medical science courses: 1999 compared with 2002 enrolments

International medical students by major region and primary country of origin	1999 number of students	2002 number of students
Commonwealth-Asia: Malaysia ranked first and dominant (66% in 2002)	777	712
Non Commonwealth Asia: Indonesia ranked first (28% in 2002)	137	167
America: Canada ranked first (51% in 2002)	121	178
Europe: Norway ranked first (72% in 2002)	52	103
Oceania: Fiji ranked first (18% in 2002)	52	17
Africa/ Middle East: Botswana ranked first (32% in 2002)	26	96
Other sources	11	14
Total (including all other sources)	1,176	1,287

Source: Statistics provided by the Department of Employment Education Training and Youth Affairs (2000), and the Department of Education, Science and Training (2003), Canberra

regional hospitals located in Victoria, New South Wales and Western Australia. (See Table 2, which presents data based on a 40 per cent survey response rate.)

The implication of these statistics on overseas medical students is that over the next few years the numbers taking advantage of the new migration rules are likely to be substantial. For the longer term, if the current rules remain in place such numbers could escalate, since the privilege to migrate at the end of the training period will add to Australia's attractiveness as a location for medical training.

Category 422 temporary resident OTDs

A second set of initiatives concerns increased recruitment levels of temporary resident doctors. This initiative is not new — just intensified. Very soon after the passage of the 1996 legislation referred to above, State health departments, faced with increasing evidence of medical shortages during the 1990s, responded by increasing their recruitment of OTDs. In

the late 1990s the Commonwealth Government contributed by financially assisting new state-based rural recruitment agencies whose task was to help manage medical recruitment for regional areas struggling to fill GP vacancies. The number of visas issued to OTDs for the temporary entry visa category (422) designated for such workers increased from 664 in 1993-94, to 1,419 in 1999-2000 and 2,496 in 2002-03. Table 3 indicates the extent of particular state reliance on the program. It details the numbers of OTDs sponsored by the respective State Governments in the three years to 2002-03.

While not all of these nominations actually resulted in a visa being issued to an OTD, the vast majority did. The consequence was the very rapid increase in visas issued to OTDs detailed above. In order to justify the issuance of a 422 visa, the State authorities had to establish that the location in which they were nominated to serve was an 'area of need' in

Table 2: Internship destinations (2004) for international students who had completed medical studies at the University of Melbourne (2003)

Country of Internship	State	No.	Hospital	No.
Australia	Victoria	7	St Vincent's	2
			Box Hill	2
			Western	2
			Austin	1
	New South Wales	7	Bankstown	2
			Westmead	2
			Gosford	1
			Nepean	1
			John Hunter	1
	Western Australia	6	Fremantle	6
ACT	3	Canberra	3	
Queensland	1	Mackay Base	1	
Singapore		10	Hospital name unstated	
Malaysia		1	Hospital name unstated	

Number of survey respondents = 38 (40% of research sample)

% in Australia = around a third of graduating international students

Source: Statistics provided by Veronica Vele, Faculty International Unit, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne. Since these data were based on a 40% survey response rate, they may in fact represent an underestimate of the proportion of internships secured by international medical students in Australia.

Table 3: Number of 422 nominations by state, 2000-2001 to 2002-2003

State	2000-01	2001-02	2002-03
Western Australia	456	472	597
Victoria	406	508	581
New South Wales	58	89	176
Tasmania	94	82	89
South Australia	60	68	133
ACT	7	12	50
Northern Territory	84	98	97
Queensland	899	716	1,016
Total	2,062	2,045	2,739

Source: DIMIA unpublished

which no local doctor was available. Thus they were recruited to serve in the front line of medical needs, usually as GPs. As demonstrated by a recent study conducted by the authors, many also served as junior doctors or registrars in public hospitals.⁸

The attraction of these OTDs to the State Governments was that, unlike Australian medical graduates who can serve where they please, a condition of the OTD visa is that the recipient is tied to employment in the 'area of need' location. Further, there was no requirement that their medical qualifications be first assessed by the Australian Medical Council. This is also the case for OTDs who are permanent residents of Australia and wish to practise medicine here. Since most of the 422 visa recipients have been recruited from Britain or other Commonwealth countries this was not considered a problem. However, it is becoming an issue. Table 4 indicates the country-of-origin of 422s who arrived in Australia in recent years. The numbers coming direct from the sub-continent of India, in particular, have increased sharply by 2002-2003. In the past OTDs trained in these locations have struggled to pass the AMC accreditation examinations (see Table 9 below).

Under Medicare Plus, the effort to recruit more OTDs under the 422 visa category (and the Occupational Trainee

category discussed below) has intensified. As a consequence of Medicare Plus, all 422 visas are now granted for four-year terms (compared with two years previously for those without AMC or specialist college accreditation). In addition, the Commonwealth Government has put this selection process to tender early in 2004 amongst workforce recruiting agencies, with a number of private companies as well as public sector agencies (such as the Australian Rural Workforce Agencies group) now selected.

Both the Commonwealth and State Governments have initiated programs to familiarise temporary resident OTDs with the medical circumstances they encounter in Australia.⁹ This process builds on recent initiatives aimed not just at doctors in Australia on 422 visas but also permanent resident OTDs (discussed further below) who hold conditional appointments pending completion of the AMC accreditation process. These initiatives include the following:

- A \$400,000 2 year pilot program funded by the Commonwealth government in Tasmania, run by the state's Postgraduate Medical Institute as part of the National Hospital Development Program, and designed to improve the recruitment and retention of OTDs in the Tasmanian public hospital system (with a target of 75 OTDs).¹⁰
- Development of a Victorian medical bridging program by the Postgraduate Medical Council of Victoria, funded by the Department of Health from 2003. (This followed a 2002 review of the State's growing reliance on OTDs to fill public hospital junior doctor positions. The course focus is on developing standardised pre-registration assessment of OTDs 'medical skills

Table 4: Short-term and long-term temporary entrants under visa classes 422 giving their occupation as Medical Practitioner by birthplace, first entry only, 1997-98 to 2002-03

Birthplace	Year ending 30 June					
	1998	1999	2000	2001	2002	2003
Papua New Guinea	1	-	1	5	-	7
Fiji	3	-	1	12	5	8
UK & Nthn Ireland	259	317	298	270	383	309
Ireland	53	33	52	48	52	51
Germany	6	10	10	11	23	26
Netherlands	2	2	9	14	11	24
Switzerland	2	1	1	3	2	5
Egypt	2	-	-	4	3	6
Malaysia	7	8	2	7	18	22
Philippines	3	2	2	7	7	20
Singapore	1	2	2	6	5	3
Thailand	-	1	1	-	3	4
Other SE Asia	-	-	-	4	1	18
China	-	-	1	2	3	5
Japan	-	-	1	2	5	-
Bangladesh	-	-	4	9	11	15
India	23	24	46	51	57	126
Pakistan	3	5	10	19	17	27
Sri Lanka	3	5	4	9	33	32
Canada	3	8	10	2	12	9
USA	9	6	12	9	8	23
Kenya	2	-	2	3	5	8
Sth Africa	62	61	78	84	93	87
Zimbabwe	4	2	5	5	6	15
Other	25	27	42	56	66	87
Total	473	514	594	642	829	937

Source: DIMIA, overseas arrivals and departures, unpublished

and clinical knowledge, cross-cultural and communication skills', to facilitate comprehensive additional training in communication and cross-cultural ability, pre-employment orientation to the Australian and Victorian health systems, and 'more rigorous and monitored supervision and ongoing assessment' of OTDs in public hospital sites.)¹¹

According to informants, while these are very positive measures, there are a number of potential concerns related to the MedicarePlus initiative. Firstly, while some form of medical assessment process will be implemented, the form and rigour of this process is not yet clear (with a

working party established to address the issue). Secondly, there is no certainty candidates must have trained in WHO-approved medical universities. Thirdly, the Australian Medical Council MCQ and Clinical examinations will be modified in a range of probably justifiable but currently undefined ways.¹² Finally, a range of new urban-fringe areas have become eligible for this OTD program, carrying the risk that fewer overseas-trained doctors will elect to serve in remote or regional sites compared to previous years.

There has also been an increased effort to keep temporary OTDs in Australia on a permanent basis. The

numbers changing their status on account of employer sponsorship have escalated. In 2001-02, 54 category 422 visa holders were sponsored under the permanent residence employer nomination program. In 2002-03 the parallel numbers increased (Australia-wide) to 225. The numbers sponsored under the Regional Sponsored Migration Scheme have also jumped, from 26 in 2001-02 to 176 in 2002-03.

For those seeking permanent residence, a new set of regulations has been initiated which allows OTDs to change their status to that of permanent residence if they serve in an area of need for a period of five years and if, within the first two years, they pass a 'Family Medicine' examination said to be equivalent to the post-graduate family medicine qualification which since 1996 governs entry to general practice on the part of local medical graduates. At the end of this period there is the additional carrot that such doctors can then bill on the Medicare system wherever they wish. This provision over-rode the requirement applicable to other permanent resident OTDs that they could not bill on Medicare until ten years after registering as a doctor.

Occupational trainees

Another lesser known but very important aspect of Australia's increased reliance on temporary medical workers is the use being made of Occupational Trainees. Their numbers are more difficult to trace because DIMIA does not keep statistics on the number of visas issued to Occupational Trainees by occupation. This visa category is available across a spectrum of occupations. DIMIA requires that the sponsor designates a relevant training program in the profession or trade in question before it will issue a temporary entry visa (category 442). It is widely used within the medical specialties, including surgery. In the case of surgery, hospitals nominate persons with surgical qualifications, usually for 12

months, during which time the OTD assists with routine surgical work under supervision. However, OTDs are being increasingly appointed as Occupational Trainees in hospitals at the junior doctor level, especially in NSW.

A recent study by the authors demonstrated that a substantial stream of overseas-trained surgeons are now entering Australia each year as one component of OTDs who are sponsored under the Occupational Trainee category. In 2002 there were 306 such surgical sponsorships in Australia, almost all of which were accepted, and 151 in the first five months of 2003. A random audit of 68 of the total 749 individual Occupational Trainee case files was examined in the Medical Board of Victoria in 2002. This showed that twenty-two per cent of the individual files surveyed were engaged in some form of surgical training. There was a range of source countries involved, with England being the largest single source but overall most came from various Asian countries. It seems fair to assume the Occupational Trainee scheme may represent a significant means of entry for overseas-trained surgeons to Australia — perhaps even more important in parts of Australia characterised by more acute surgical shortages.¹³

There are clear advantages in recruiting OTDs as Occupational Trainees. As with the 422 category, there is no requirement that the appointee be assessed in advance by the Australian Medical Council or, in the case of the specialties, that the appointee has achieved a fellowship in the relevant specialty. Second, the State health authorities and specialties do not have to 'labour market' test as is the case for 422s.

As indicated, it is difficult to assess the scale of this practice or the origin of the OTDs appointed as Occupational Trainees. Table 5 provides an indication

Table 5: Short-term and long-term temporary entrants under visa classes 442 giving their occupation as Medical Practitioner by birthplace, first entry only, 1997-98 to 2002-03

Birthplace	Year ending 30 June					
	1998	1999	2000	2001	2002	2003
Papua New Guinea	2	1	-	5	5	7
Fiji	5	2	6	4	1	3
UK & Nthn Ireland	199	171	238	193	158	191
Ireland	12	12	20	16	12	4
Germany	15	15	17	12	11	13
Netherlands	3	1	4	12	4	1
Switzerland	11	7	5	2	4	4
Iran	1	2	1	2	4	3
Iraq	-	1	1	1	1	2
Saudi Arabia	-	2	1	4	3	10
Egypt	1	-	2	1	2	3
Malaysia	32	25	48	42	36	47
Philippines	6	6	12	8	10	13
Singapore	15	7	7	7	11	20
Thailand	3	15	5	9	9	21
China	8	15	15	20	14	22
Japan	12	11	14	13	14	11
Bangladesh	4	2	1	-	1	2
India	55	77	70	52	78	91
Pakistan	8	3	7	7	1	7
Sri Lanka	15	24	18	47	41	46
Other Sthn Asia	2	-	3	1	1	4
Canada	4	5	5	5	11	5
USA	10	10	6	15	7	8
Kenya	2	-	4	3	1	2
Sth Africa	4	8	12	6	7	8
Other	70	68	65	57	60	83
Total	499	490	587	544	507	631

Source: DIMIA, overseas arrivals and departures, unpublished

of the increased entry of OTDs recruited as Occupational Trainees at the national level. This table is based on DIMIA arrival statistics which provide information on the occupation of all Occupational Trainees. As with the 422s, the trend is towards greater reliance on persons born outside developed countries. An additional indicator of the scale of reliance on occupational trainees is the State Medical Registration Board statistics. According to the NSW Medical Board, of the numbers of postgraduate trainees (the Board's term for Occupa-

tional Trainees), 369 were conditionally registered in 2000-01, 486 in 2001-02 and 786 in 2002-03. The Board indicates that by mid-2004 there was a stock of around 1,400 who were registered in New South Wales. Some of these are employed as specialists, but many are being employed as junior medical officers in hospitals. It seems that in NSW the government has prioritised Occupational Trainees relative to category 422 OTDs. As shown in Table 3, the NSW Health Department has initiated a relatively small number of 422 sponsorships.

Victoria and Queensland have in the past put more emphasis this category. This may be changing. According to the Victoria Medical Board, the number of Occupational Trainees registered as of 30 September 2003 was 702, up from 571 in 2002.

Non-accredited permanent resident OTDs

The direct recruitment of OTDs via the two visa categories (442 and 422) has been the main priority of medical employment authorities since the mid-1990s. However, there has also been an increasing draw on the stock of permanent resident OTDs already in Australia. As indicated, it had been government policy until 2004 to

prohibit entry of doctors under the main skilled migration categories. Nonetheless, there has been a substantial intake of OTDs, mainly via the family reunion program and from New Zealand since the mid-1990s. Tables 6 and 7 shows the intake of settlers indicating their occupation was medical practitioner by major birthplace by these two arrival categories. Persons from non-western countries dominate, including those with New Zealand citizenship.

The result of this accumulation of OTDs by the 'back door' is shown in Table 8. By 2001, there were 4,678 persons in Australia who had arrived between 1996 and 2001 who claimed to hold medical qualifications at the degree level.

Table 6: Medical practitioners arriving as settlers under the Family reunion visa category by birthplace, 1997-98 to 2002-03

Birthplace	Year ending 30 June					
	1998	1999	2000	2001	2002	2003
Fiji	1	2	1	1	3	2
UK & Nthn Ireland	21	16	14	17	23	25
Ireland	3	1	1	5	3	-
Germany	3	3	8	7	5	4
Former USSR & Baltic States	5	9	7	15	13	13
Other Europe	11	10	10	16	11	17
Middle East	9	6	10	15	15	19
Egypt	8	7	2	6	3	3
Indonesia	3	3	2	-	2	1
Malaysia	3	6	9	3	3	4
Philippines	5	4	1	1	7	4
Singapore	1	-	1	-	3	-
Vietnam	6	9	4	3	8	7
China	32	47	24	24	28	33
Hong Kong	1	1	2	1	-	1
Japan	1	-	1	-	1	2
Bangladesh	2	1	1	2	4	5
India	8	10	13	14	17	25
Pakistan	-	1	5	1	4	4
Sri Lanka	7	6	7	11	12	6
Other Asia	3	7	2	11	6	8
Canada	3	3		5	-	2
USA	5	2	2	6	7	6
Sth Africa	3	5	3	3	-	2
Other	17	7	8	6	15	18
Total	160	164	137	172	190	209

Source: DIMIA, overseas arrivals and departures, unpublished

Table 7: Medical practitioners arriving as settlers under the New Zealand citizen visa category by birthplace, 1997-98 to 2002-03

Birthplace	Year ending 30 June					
	1998	1999	2000	2001	2002	2003
New Zealand	33	48	49	77	42	37
Fiji	1	1	-	4	3	2
UK & Nthn Ireland	3	16	13	13	9	12
Former Yugoslavia	1	8	20	19	2	6
Former USSR & Baltic States	1	1	6	9	1	1
Iraq	-	2	2	30	4	-
Egypt	1	-	6	13	3	3
Malaysia	-	2	2	7	1	1
Philippines	-	-	2	7	1	1
China	2	4	12	42	3	3
Hong Kong	-	2	4	6	1	1
Taiwan	1	3	7	5	8	3
Bangladesh	6	6	76	108	15	8
India	3	3	25	53	6	3
Pakistan	1	1	3	11	1	1
Sri Lanka	3	2	10	40	7	3
Sth Africa	5	3	4	14	9	3
Other	7	9	12	34	15	8
Total	68	111	253	492	131	96

Source: DIMIA, overseas arrivals and departures, unpublished

At the time, only 2,465 (or 53 per cent) were working as medical practitioners. As the table shows, most of those born in New Zealand, the UK and South Africa were practising as doctors. Doctors from India, Malaysia-Hong Kong-Singapore were also doing reasonably well. However, only a minority of the other OTDs were employed as Medical Practitioners. In the case of the 2,735 persons with degree-level qualifications in medical studies who arrived during the years 1991 to 1996, 66 per cent were working as medical practitioners. As with the post-1996 arrivals, those born in western countries were much more likely to be employed as doctors.

The consequence is that, on this accounting, there were present in Australia, as of census date 2001, a stock of some 3,142 overseas-born doctors who arrived between 1991 and 2001 and who were not employed as doctors. Some of these will have found other satisfying work. But to

judge from applications to the AMC for accreditation, the majority want medical employment. Their location out of the medical workforce was a consequence of difficulties getting through the various phases of the medical assessment process — the language test, the multiple choice test of medical knowledge and the final clinical assessment.

The most recent outcomes from the AMC examinations give an indication of these difficulties, especially for applicants from non-English speaking background countries. Slightly more than half of those taking the MCQ and Clinical tests in 2002 (in many cases after multiple attempts) passed. There are therefore thousands of OTDs caught up in the process of attempting to gain accreditation yet eager to practice medicine in Australia.

Representatives from the Overseas Trained Doctors' Associations are very critical of this state of affairs. They have

Table 8: Persons aged 15-64 with a degree in Medical Studies by year of arrival, birthplace, labour force status and occupation in 2001

Year of arrival and birthplace	Total persons	Labour force status and occupation per cent						Total
		Manager, Admin-istrator	Medical Practitioner	Other Profes-sional	Other employed	Unem-ployed	Not in Labour force	
1996-2001								
New Zealand	286	1	84	5	3	2	5	100
Other Oceania/Antarctica	68	0	74	0	4	4	18	100
UK and Ireland	857	2	83	7	2	1	5	100
South Eastern Europe	155	0	35	6	15	12	32	100
Eastern Europe	170	0	24	5	18	12	41	100
Other Europe	206	1	52	19	6	1	19	100
Lebanon	10	0	0	0	0	60	40	100
Iraq	160	0	37	4	4	24	31	100
Other Mid East, Nth Africa	241	5	36	7	12	12	27	100
India	430	1	66	5	4	10	13	100
Other Sthn & Central Asia	516	0	39	2	14	11	32	100
Philippines	81	0	33	7	14	7	38	100
Viet Nam	25	0	12	0	12	0	76	100
China (excl Taiwan)	489	2	5	19	27	8	39	100
Taiwan	21	0	57	0	0	0	43	100
Malaysia, Hong Kong & Indonesia	140	0	59	4	6	2	29	100
Indonesia	44	14	9	7	14	7	50	100
Other Nth and SE Asia	102	0	20	9	22	9	41	100
USA & Canada	104	3	53	9	9	6	18	100
Other Americas	35	0	46	9	9	0	37	100
South Africa	363	2	81	3	5	1	8	100
Other Africa	129	0	65	7	5	9	14	100
Not stated	46	0	17	20	20	20	24	100
Total	4,678	1	53	7	10	7	22	100
1991-1996								
New Zealand	180	0	83	5	7	0	5	100
Other Oceania/Antarctica	29	10	79	0	0	0	10	100
UK and Ireland	418	2	83	4	4	0	7	100
South Eastern Europe	90	0	70	0	7	3	20	100
Eastern Europe	167	4	41	19	14	2	20	100
Other Europe	53	0	62	6	6	6	21	100
Lebanon	3	0	0	100	0	0	0	100
Iraq	50	0	76	6	12	6	0	100
Other Mid East, Nth Africa	190	0	70	6	11	4	9	100
India	224	0	83	4	7	3	3	100
Other Sthn & Central Asia	267	2	72	4	2	3	17	100
Philippines	41	0	49	7	37	0	7	100
Viet Nam	30	0	20	40	0	40	0	100
China (excl Taiwan)	304	3	15	29	22	6	25	100
Taiwan	28	0	36	11	11	0	43	100
Malaysia, Hong Kong & Indonesia	299	2	92	0	0	1	5	100
Indonesia	24	0	25	0	38	0	38	100
Other Nth and SE Asia	70	0	46	4	26	0	24	100
USA & Canada	54	0	56	39	0	0	6	100
Other Americas	15	0	40	20	20	0	20	100
South Africa	93	0	87	6	0	3	3	100
Other Africa	57	0	74	11	11	0	5	100
Not stated	49	0	39	0	12	12	37	100
Total	2,735	1	66	9	9	3	12	100

Source: ABS, Census 2001, unpublished census matrix held by CPUR

long claimed that the AMC accreditation process is biased against persons from non-English-speaking backgrounds

(NESB). On the other hand they acknowledge that OTDs should be assessed before being allowed to practise.

Table 9: Australian Medical Council examination outcomes by selected countries of training, 2002

Country of candidate	Candidate numbers	% passing MCQ (1st or repeat try)	Candidate numbers	% passing Clinical (1st or repeat try)
South Africa	17	88	23	91
Iraq	54	87	65	66
Sri Lanka	34	82	34	65
Bangladesh	81	80	63	48
Pakistan	36	75	19	53
Egypt	48	46	30	73
UK	38	74	34	88
China	69	51	35	57
India	133	47	49	63
Poland	4	50	3	33
Former Yugoslavia	17	47	17	47
Philippines	33	33	23	39
Other	307	45	164	61
Total candidates	871	56	559	62

Source: Derived from Australian Medical Council Incorporated. *Annual Report, 2002*,

We endorse this view. Persons graduating from the diverse medical schools of Asia, the Middle East and Eastern Europe bring a variety of skills, knowledge and experience with them. There is however no guarantee that their training is relevant to the Australian setting — including contemporary practice as regards medical procedures, forms of therapy, awareness of the current repertoire of drugs and technical equipment. A good knowledge of English and the patient setting is also required for effective medical practice.

It is thus a matter of some aggravation to the resident OTDs that the data detailed above show that the State Health departments have focussed their recruiting on additional OTDs from overseas on 422 and 444 visas — effectively ignoring the stock of permanent resident OTDs already here. Adding to this chagrin is their awareness that an increasing proportion of these overseas recruits from NESB backgrounds are entering Australia on a temporary basis to take up medical appointments without having to pass an equivalent test to the Australian-resident doctors from these backgrounds. An African doctor

described this process in the following way in a recent study:

I mean it is unfair — being an Australian I didn't have the chance, while those coming from overseas on a temporary visa they can get a chance (to work in medicine) in less than three to four months... (A colleague who recently arrived from a comparable source country) worked here just when he arrived. He didn't have to do anything, even the Occupational English Test!¹⁴

The OTD organisations argue that a more productive and just way of spending Government money to deal with the present medical supply crisis would be to devote more funds to bridging courses which would assist permanent resident OTDs to complete their AMC accreditation requirements. Such an approach would avoid the heavy relocation costs of bringing OTDs to Australia, many of whom stay for a very limited time, thus requiring a repeat of the same costly process. Bridging courses for permanent resident OTDs do seem to work. An example is the pilot clinical bridging course conducted by the University of New South Wales and

supported by the South-West Sydney Area Health Service in 2003. Approximately 85 per cent of the enrolled OTDs passed the AMC clinical test after completing the bridging course.

According to the recent Senate Medicare review,¹⁵ a range of subsidized medical bridging programs will be provided to support the transitional training needs of those seeking to pass the AMC examination. (‘These bridging programs [will] help prepare candidates for the Australian Medical Council examinations... to obtain either conditional or full medical registration ‘.)¹⁶ Additional support will be provided for medical specialists (such as psychiatrists and surgeons) who require ‘upskilling.... to meet specialist recognition requirements’. The OTD advocate groups are still waiting for adequately resourced action on this front — funding allocations to date having been miniscule.

On the other hand, however, such is the shortage of doctors in Australia that in practice (as noted in the introduction) large numbers of permanent residents OTDs who have not completed their AMC assessment have been employed in ‘area of need’ positions and in public hospitals on the basis of ‘provisional registration’ by the State Medical Registration Boards. Our enquiries indicated that there was no systematic assessment of the capacity of these doctors to perform the work required. Since 2002, the Victorian State Government has initiated a review (not yet published) with the objective of establishing a mechanism to assess this capacity.

Conclusion

The supply measures described above represent a fundamental change in medical manpower policy in Australia. The medical profession has long prided itself on its commitment to ensure all

Australian patients received quality professional care. This was based on a policy of ensuring all medical personnel serving in Australia undertook a long and intense training program directed to the needs of Australian patients.

Yet, as a consequence of the supply measures described, there are currently several thousand temporary resident doctors practising in Australia, an increasing minority of whom may not have experienced a training program equivalent to that prescribed for local doctors. Very few have had to undergo rigorous examination of their skills prior to practice commencement. An increasing proportion is coming from nations where the training programs are not tailored to the health profile characteristics of Australian patients. When such doctors have been required to undergo the AMC accreditation examinations, the proportion succeeding has been modest.

Having belatedly acknowledged the depth of the medical supply crisis, the Australian Government has had little choice but to depend on OTDs recruited on a temporary basis. This policy is in part a consequence of the inadequacies of the advice received from its workforce planning agencies including the Australian Medical Workforce Advisory Council (AMWAC). But the reliance on temporary OTDs flowing from this situation should not be allowed to obscure the reality that this is a costly and imperfect solution. It has resulted in an increased dependence in areas of medical shortage on temporary workers who have to be continually recycled at great expense in recruitment and relocation costs.

The best way to appreciate the scale of the Medicare Plus and earlier initiatives in drawing on OTDs is to compare their numbers with the stock of permanent resident practising doctors. According to

unpublished DIMIA records, as of 30 September 2003, there were 1,950 OTDs on 422 visas in Australia, up from 1,022 on 30 June 2000. No parallel can be provided for OTDs here as Occupational Trainees but there must be well over 1,000 currently practising. This number of about 3,000 or more, compares with a permanent resident non-specialist medical workforce of between twenty and twenty-five thousand.

The initiatives announced with the Medicare Plus package will result in even further reliance on both temporary and permanent-resident OTDs in Australia's medical workforce.

For the long term the solution must be greater commitment to the training of more local doctors, in addition to supporting the entry of permanent-resident OTDs into the medical workforce. The Commonwealth and State Governments have been tardy in committing the funds needed to fill the gaps in supply with the far more stable medical workforce potentially available from permanent-resident OTDs who have not yet had their credentials recognised. There are the thousands

of these persons eager to practise in their adopted country. Many could play an important role if additional resources were devoted to funding the bridging programs which most need if they are to meet AMC accreditation standards.

There has been a remarkable silence about these developments from the medical profession. The AMA leadership have from time to time voiced concerns about excessive reliance on OTDs and about the difficulties some of these doctors face when thrown into the service of remote communities. But there has been no sustained campaign on the issue. The acceleration of entry of temporary resident OTDs consequent on the Medicare Plus initiatives has passed without comment.

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- ⁹ Medicare Plus website, <http://www.health.gov.au/medicareplus/aboutotds/factsheets/refgroup.htm>.
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