ASP', *Working Paper*, Department of Finance, Canberra, October 1993

15 Public Service Commission, *Implementation of EEO in the APS 1993-94: State of the Service*, AGPS, Canberra, 1993, p. 4

16 Public Service Commission, *Equal Employment Opportunity, A Strategic Plan for the Australian Public Service for 1990s*, 1993, p. 29

17 This can be shown by totalling the proportion of the population that is NESB1 (Table 2) and NESB2 (Table 3). For example, for 25-34 year olds the proportion is about 24 per cent.

18 Public Service Commission, *Productive Diversity in the APS*, July 1995, and unpublished PSC data

19 ASOs 1 to 6, SOC, B & A and SES 1 to 3 are the standard classifications for the APS. However, there are a number of other classifications which in some cases are roughly comparable to these standard classifications. Therefore, the data in this figure includes persons at the named classifications and their equivalents.

20 For example, in 1993-94 there were 22,057 persons classified as ASO4 or equivalents, whilst there were only 367 persons at the senior SES2 level.

21 Methodology: Percentage of population by age for males and females from 1991 Census matrix table CSC6035. Percentage of APS by age classified as NESB1 obtained from unpublished Department of Finance data.

22 The data herein is based on where the father is NESB1. Therefore, it will include persons where both parents are NESB1 and where only the father is NESB1, but not where only the mother is NESB1. Therefore, the estimated numbers of NESB2 persons in Table 3 is likely to slightly underestimate their actual numbers.

23 Methodology: Percentage of population by age obtained from 1991 Census matrix table CSC6035 by totalling males and females. NESB2 calculated by subtracting children whose fathers were from English speaking counties (Australia, New Zealand, UK, Ireland, USA and Canada) from all second generation persons to obtain total number of NESB persons.

24 National Multicultural Advisory Council, op.cit.

25 Public Service Act Review Group, *Report of the Public Service Act Review Group*, AGPS, Canberra, December, 1994, p. 121

26 The Economist, 'Affirmative Action: Death by Judges?', The Economist, 17 June, 1995, pp. 34-35

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IMMIGRATION AND THE SURPLUS OF DOCTORS IN AUSTRALIA

Bob Birrell

Since the mid 1980s the number of overseas-trained doctors entering Australia as permanent residents or temporary residents has escalated. The Australian Government has sought to control this intake because it believes there is an oversupply of doctors especially in urban general practice. However, the Government's control measures have largely failed. As a consequence Australian medical schools have been told to cut their enrolments, beginning in 1996.

There is some dispute about the extent and nature of the alleged doctor 'oversupply'. But, from the point of view of the Australia government, the surplus is large, growing and expensive. Evidence for this surplus can be found in a swag of recent reports which argue that Australia's doctor-patient ratio is high by international standards and, in particular, that there are too many General Practitioners located in metropolitan areas.[1]

The federal government believes that overseas-trained doctors (OTDs) have added significantly to this oversupply. It has therefore sought to reduce the number of OTDs entering medical practice in Australia, either as temporary workers or as permanent residents, but to this point in time, with only limited success. There are three main reasons for this. The number of doctors being recruited to work on temporary visas has actually expanded since the early 1990s. Similarly, the number of doctors entering Australia as permanent residents, or changing their status to permanent residence after arriving as temporary workers or students, remains very high. The third reason concerns the implementation in 1992 of a quota capped at 200 on the annual number of permanent-resident OTDs permitted to gain accreditation. This has been the most effective barrier against the entry of OTDs to practise medicine here. It is now in disarray. On 7 August 1995 the government's own Human Rights and Equal Opportunity Commission (HREOC) issued a judgement which concluded that the quota contravenes the Racial Discrimination Act.

This article examines the origins and implications of these developments. The most striking of the implications is the

government's decision to reduce the enrolment of local medical students, beginning in 1996. In effect, some local students' prospects for careers in medicine are to be sacrificed to the larger cause of containing the costs of medical services, because the government has been unable to control the entry of OTDs into Australia's medical workforce. This sacrifice is to occur in a context where OTDs are already greatly over-represented as practising doctors within this workforce relative to the share of the overseas-born population in Australia.

OVERSEAS TRAINED DOCTORS

The significance of OTDs became evident in the late 1980s when there was a surge in the arrival of permanent settlers holding medical qualifications. Table 1 indicates the number of OTDs who had gained employment as doctors as of 1991. The jump in numbers arriving between 1986 and 1991, when some 400 per year gained employment as doctors (compared to the annual number of local graduates of 1,100 to 1,200 per year) is clear. Since Table 1 refers to practising doctors, it is primarily limited to those who were able to get their qualifications recognised in Australia. This helps explain the dominance of the 875 British-born doctors within the ranks of those arriving during this period. At the time, they were automatically registered to practise by the state medical registration boards. However, as well as these practising doctors, a further 2,500 OTDs also arrived during the years from 1986 to 1991. They are not listed in Table 1 because they were not working as doctors by 1991. Most of these doctors managed to gain entry as permanent residents without having their credentials assessed overseas because they were sponsored by family in Australia or entered as accompanying family members of other principal applicants. If they had been assessed overseas they would have had to have taken the multiple choice question (MCQ) examination devised by the Australian Medical Council (AMC). Because they were not tested overseas there was, according to the AMC's records, a huge build up by 1992 in the numbers seeking accreditation in Australia to around 2,000. In addition, the number of visas issued to OTDs permitting practice on a temporary and restrictive basis (such as in hospitals or locum services) also appeared to be escalating.[2]

The accumulation of practising and prospective OTDs on this scale was a frightening prospect for the government in the context of concerns about the escalating budgetary cost of Medicare services. Health Insurance Commission records indicated that the number of GPs per head of the Australian population had increased by 15.8 per cent over the

Table 1: Persons employed as Medical Practitioners by major birthplace groups and time of arrival in Australia, and Australian population by birthplace, 1991

Birthplace	Time of arrival			Total[a]		Australian population by birthplace (percentage)
	Pre 1981	1981-1985	1986-1991	Number	Per cent	
Australia				24,455	63.0	75.5
New Zealand	417	94	194	710	1.8	1.6
UK & Ireland	3,444	237	875	4,605	11.9	7.0
Southern Europe	521	17	23	571	1.5	3.9
Other Europe	1,410	112	91	1,628	4.2	2.9
South East Asia	1,697	222	191	2,122	5.5	2.2
(Malaysia)	(1,063)	(148)	(127)	(1,347)	(3.5)	(0.4)
(Vietnam)	(130)	(41)	(9)	(180)	(0.5)	(0.7)
North East Asia	695	75	127	902	2.3	1.2
(Hong Kong)	(414)	(63)	(48)	(525)	(1.3)	(0.3)
South Asia	1,253	145	273	1,681	4.3	0.7
(India)	(873)	(66)	(143)	(1,088)	(2.8)	(0.4)
Other	1,398	243	400	2,145	5.5	5.0
Total	10,835	1,145	2,174	38,819	100.0	100.0

Source: Australian Bureau of Statistics, 1991 Census matrix 6355

[a] Total includes those who did not state their time of arrival.

1984-85 to 1989-90 period, yet with no diminution in the number of services provided per GP over the same time.[3]

THE AUSTRALIAN MEDICAL LABOUR MARKET

The government's main concern is the public costs of the Medicare services provided by doctors and pathologists. Federal payments for medical services and benefits reached $5.8 billion in 1994-95. These payments have been growing at 9.5 per cent a year since 1985-86 (5.2 per cent in real terms) mainly because the number of services provided has been growing at five per cent per annum. Population growth and the increased services associated with ageing accounts for 1.5 per cent of this expansion. But the rest derives from a sustained growth in the average number of services each Australian resident receives.[4] Total services per capita have increased from 7.2 in 1984-85 to a provisionally estimated 10.1 in 1993-94.[5] This expansion is almost entirely attributable to growth in the medical workforce. In other words, whether justifiable or not, most of the extra cost of Medicare services derives from an expansion in Australia's doctor/patient ratio.

An 'improved' doctor/patient ratio would not be regarded with such a jaundiced eye if the extra doctors were locating in rural hospitals, rural general practice or areas of specialist shortage like dermatology. Instead, the 'surplus' is accumulating primarily in General Practice in metropolitan areas where no-one argues there is a need for more. In the process, as the Australiam Medical Association has complained, the competition for patients is prejudicing the pay and conditions of its members. One index of the competition is the rapid growth in bulk billing. In 1994-95, 69 per cent of services were bulk-billed, compared with 58 per cent in 1989-89 and 45 per cent in 1984-85.

Meanwhile, despite this abundance, shortages in non-metropolitan areas actually seem to be worsening. According to the Department of Employment, Education and Training's (DEET) skill vacancy index (based on job advertisements), the index for Health Diagnosis and Treatment Practitioners has risen from 100 in February 1992, to 326 in July 1995.[6] It is evident that the solution for these shortages does not lie in adding more doctors into the equation, including OTDs. The latter appear to be just as reluctant to take up non-metropolitan positions as are Australian graduates.

Doctors' reluctance to move to areas of shortage reflects the relatively poor pay and conditions offered in non-metropolitan practice, the lack of opportunities for further training (particularly in specialist areas), lifestyle issues and, in the case of some OTDs such as the Vietnamese and Poles, the lack of clustered communities of co-ethnics. The consensus amongst those advising the government is that further growth in doctor numbers in General Practice will result in a parallel expansion of services, mostly in allegedly over-serviced metropolitan areas.[7] Each additional provider number is estimated to cost the government $176,000.[8] Doctors are said to be 'target earners' who can initiate services sufficient to meet their income objectives because there is no financial constraint either on consumer demand (due to direct billing) or on the Health Insurance Commission to pay the bill. Thus, despite the fact that over the years 1989-90 to 1993-94 the number of full-time GPs increased from 12,119 to 14,225, the number of services they each performed remained virtually unchanged at around 6,500 per annum.[9]

THE COMMONWEALTH GOVERNMENT'S 1992 POLICY INITIATIVES

Because an increase in the number of GPs leads directly to an increase in costs, the government has tried to limit the supply. The initial focus was on the OTD component of Australia's medical workforce. In 1992, with the endorsement of State Ministers of Health (at the 1992 Australian Health Ministers Conference), it was decided to cap the annual entry of OTDs holding permanent resident status into the Australian medical workforce at 200 per annum. This number was to include those completing the AMC's examination overseas and in Australia, those receiving specialist recognition, and New Zealand graduates, who do not need to take the AMC examination. Simultaneously, the Department of Immigration and Ethnic Affairs (DIEA) incorporated a ten point penalty on doctors seeking permanent-residence visas under its Independent and Concessional points-tested selection system. The 1992 Conference also agreed to a Commonwealth proposal to reduce the inflow of temporary OTDs. Under Labor Market Agreements, there was to be a 'phased national reduction

of not less than 20 per cent of temporary visa holding OTDs currently occupying needs-based service positions, commencing January 1993'. Later, State Ministers accepted a restatement of the government's position that the 'phased national reductions were to be 20 per cent per annum from a reducing base over five years commencing January 1993 resulting in a final figure of about 33 per cent of April 1992 levels'.[10] As it turned out, none of these measures was fully implemented.

OUTCOMES

Temporary Residence OTDs

The number of temporary residence OTDs entering Australia actually increased after 1992, in direct contradiction to the agreement just cited. Table 2 indicates that the number of temporary residence medical practitioners (visa category 422), and Occupational Trainees (visa category number 442) increased from 743 in 1991-92 to 1,005 in 1993-94. Though many other OTDs enter Australia annually as lecturers, business persons and such like, these are the two visa categories for which State Medical Registration Boards approve medical work in Australia, though under restrictive conditions. Occupational Trainees are mainly doctors visaed to work in hospitals while simultaneously receiving post-graduate training. Since January 1994, individual training plans for people in this category have to be approved by the relevant specialist college before DIEA is permitted to issue a visa. The data are reasonably reliable because they do not depend on data entered on the passenger card by the doctor when disembarking in Australia. When a person arrives who has been visaed in one of these two categories, information already validated by DIEA officers from the earlier visa issuing process is incorporated into the arrival file.

The reason for the increased recruitment of temporary residence doctors was, as noted, the unwillingness of accredited doctors to take up the positions offered. So long as the states (particularly Queensland – see Table 3) can continue to recruit temporary-residence OTDs, nothing much will change. This is because the option of recruiting OTDs diminishes the pressure to make the conditions of employment attractive to local doctors.

Employers could also have had recourse to the ranks of the several thousand OTDs already in Australia who have not yet achieved AMC accreditation. The State Medical Registration Boards may, if they wish, give limited registration to such OTDs if they are appointed to temporary positions. In some cases, they have done so, as in psychiatric hospitals. But whether because of employer preference or Registration Board reluctance to accept non-British OTD credentials, relatively few OTDs holding permanent-residence status in Australia have been appointed to these positions. As Table 2 indicates, employers almost exclusively draw on British doctors to fill their temporary residence positions.

As to the Occupational Trainees, their diverse origin is a

Table 2: Country of birth of temporary Medical Practitioners and Occupational Trainees entering Australia on long-term and short-term visas[a], 1991-92 to 1993-94

Country of birth	Temporary Medical Practitioners visa category 422			Occupational Trainees visa category 442		
	1991-92	1992-93	1993-94	1991-92	1992-93	1993-94
UK	309	418	513	70	81	96
Indonesia	-	-	-	43	23	16
Malaysia	11	5	4	40	17	40
Philippines	-	-	-	9	5	5
Singapore	-	1	-	16	4	42
Thailand	-	1	1	1	16	23
PR China	-	-	1	54	35	13
Hong Kong	14	-	-	15	3	24
Japan	1	-	-	22	22	20
India	8	6	8	78	44	39
Sri Lanka	-	2	-	10	4	20
South Africa	13	3	8	1	-	-
USA	1	3	2	3	3	54
Other	16	13	28	4	49	48
Total	377	452	565	366	306	440

Source: Bureau of Immigration, Multicultural and Population Research, unpublished

[a] Short term visa count is based on a sample of relevant visas.

Table 3: Intended state of residence of temporary Medical Practitioners and Occupational Trainees arriving in Australia, 1993-94

State of intended residence	Medical Practitioners		Occupational Trainees	
	Number	Per cent	Number	Per cent
New South Wales	100	17.7	220	50.0
Victoria	28	5.0	72	16.4
Queensland	346	61.2	13	3.0
South Australia	1	0.2	93	21.1
Western Australia	77	13.6	40	9.1
Tasmania	7	1.2	-	-
Northern Territory	2	0.4	-	-
Aust. Capital Terr.	4	0.7	2	0.4
Total	565	100.0	440	100.0

Source: Bureau of Immigration, Multicultural and Population Research, unpublished

matter of concern from the point of view of the quality of the medical service they offer hospital patients while in Australia. Some informants argue that Occupational Trainees are regarded by hospital specialists as a way of getting the routine specialist hospital work done cheaply without adding to permanent-resident numbers within the specialty in question.

Settler arrivals

Doctors arriving in Australia as permanent settlers declined only marginally from 588 in 1991-92, and 480 in 1992-93, to 445 in 1993-94. Most of the latter 445 managed to avoid the tougher points test introduced in 1992 by entering as spouses sponsored by Australian residents or as spouses accompanying principal applicants.[11] Nevertheless, DIEA continued to arrange for the AMC's MCQ test to be taken overseas (around 100 sat overseas for the April 1995 examination). This was despite the government's desire to slow the intake and despite the fact that high performers overseas displaced from the quota some OTDs already resident in Australia. Meanwhile the majority entered Australia without overseas assessment thus adding to the queue seeking AMC accreditation here.

The AMC quota

The 1992 Conference decision to put a quota on the numbers eligible to take the AMC's clinical test was implemented. (This test is taken after the MCQ and is the final hurdle for OTDs seeking full registration.) Whereas in 1990-91, 455 new candidates were permitted to advance from the MCQ test to the clinical test, only 298 were allowed to do so in 1991-92 and around 200 in 1992-93 and 1993-94. The AMC achieved this contraction by limiting access to the top performers in Australia or overseas who 'passed' the MCQ test. To pass a candidate must answer 50 per cent of the questions correctly. As a consequence some of those who 'passed' had to start all over again at the next MCQ test. Not surprisingly, OTDs and their support groups campaigned vigorously against the system. Their campaign included claims of racial discrimination before the HREOC, the results of which are discussed below.

Though the quota did cut back the numbers of OTDs entering the Australian medical workforce, it did not reduce the number to the specified level of 200. This is mainly because more New Zealand doctors were entering Australia than anticipated. Data from the Health Insurance Commission on the net number of New Zealand-trained doctors added to the active provider list indicated an increase from 53 in 1991-92 to 94 in 1992-93 and 108 in 1993-94.[12]

THE NEW COMMONWEALTH POLICY REACTION IN 1995

The awareness that little progress had been made in controlling the entry of OTDs into the Australian medical workforce prompted a new round of Commonwealth policy declarations at the time of the 1995 budget. These included the following:

a) A re-affirmation of the quota limiting the number of overseas-trained doctors entering medical practice in Australia to 200 each year – in effect this meant a reference to the AMC to consider reducing the number of OTDs eligible for the clinical examination in order to accommodate the increased New Zealand inflow.

b) A direction to DIEA to change its regulations so as to prevent any further doctors from being visaed under its points tested categories.

c) A requirement that New Zealand-trained doctors first practice in areas of need for a prescribed period.

d) More restrictive rules on temporary residence OTDs designed to ensure they do not

moonlight outside the terms of their medical registration.[13]

e) A decision to continue negotiations with the States and Territories 'to reduce the number of OTDs filling positions which could be filled by Australian-trained doctors'.[14]

f) The announcement of an intention to negotiate with Australian universities to reduce the annual intake to medical schools from 1,200 per annum to 1,000 per annum.

SECOND ROUND OUTCOMES

The minutes from the June 1995 Australian Health Ministers' Conference held in Alice Springs have not yet been published, but it is known that the Commonwealth was largely rebuffed on the policy items listed above which required state co-operation. However, the Commonwealth has increased the penalty factor which is applied to doctors seeking permanent-residence visas under the points-tested categories, from 10 to 25 points. Nevertheless, doctors may still enter through the family migration categories or via employer nominations.

REJECTION OF CONTROLS OVER THE RECRUITMENT OF TEMPORARY OTDS

The idea of requiring New Zealand graduates to do a stint in the 'bush' came to nothing. More seriously, the States did not accept the proposal to further limit temporary OTD entry. Victoria and New South Wales generally favour a restrictive position. But Western Australia, Northern Territory and Queensland, motivated by concern to fill the medical vacancies in hospitals and non-metropolitan areas, opposed the proposal. They successfully demanded that the recruitment of temporary doctors should actually be 'freed up' rather than constricted. This implies a return to the pre-1992 situation. In effect, the work involved in negotiating Labor Market agreements, designed to reduce temporary OTD migration since 1992 has amounted to nothing. If anything, given the vacancy situation, the prospect is for a greater inflow of OTDs. Furthermore, as part of the 'freeing up' process, the Minister, Dr Lawrence, has agreed to request DIEA to revise the visa regulations for OTDs so as to allow temporary visas to be issued for up to four years. The present arrangements limit temporary visas to two years – though an extension can be negotiated upon application.

THE 'SIDDIQUI JUDGEMENT' AND THE IMPLEMENTATION OF THE AMC QUOTA

As noted, the imposition of the AMC quota in 1992 led to a test case before the HREOC. In this case, Dr Siddiqui, a doctor trained in India, challenged the very foundation of the quota system. In its 7 August 1995 judgement, the HREOC declared that the operation of the quota contravened the Race Discrimination Act of 1975. On 5 September 1995 the government announced it would appeal this judgment. But, as the matter stands, the judgement declares that those who pass the MCQ test (that is they get 50 per cent or more of the questions right) should be able to proceed to the clinical test. There are some 280 doctors in Dr Siddiqui's position who achieved the 50 per cent level but were not included in the 200 top MCQ performers at the time they sat the exam. If the AMC allows Dr Siddiqui to take the clinical test it will have to let the other 280 do so as well – thus severely breaching the quota.

Without going into the legal niceties, the essence of the HREOC judgement is that the quota system violates an alleged 'human right to work' (which derives from article 5 (e)(i) of the International Convention on the Elimination of all forms of Racial Discrimination, of which the Australian government is a signatory). According to the judgement, the quota does this by unreasonably discriminating against persons on grounds linked to their common race, colour, descent or national or ethnic origin.

There is no question that Dr Siddiqui deserves our sympathy. He has been in Australia since 1987 and became an Australian citizen in 1992. Since 1992 he has achieved more than 50 per cent on the MCQ test three times, but in each case has not been amongst the top 200 performers. He has therefore had to start anew each time.

But is the HREOC intervention into medical manpower planning the appropriate way to deal with the situation, and is the conclusion that racial discrimination was involved justified? As the HREOC acknowledges, it has applied a 'generous or benevolent' construction of the Racial Discrimination Act.[15] The HREOC commissioners have managed to convert a generalised 'right to work' into a right to work in one's chosen profession and to interpret the AMC's quota rules, which cover all doctors

trained overseas (including those born in Australia or trained in Britain), as discrimination linked to the racial or ethnic characteristics of the persons affected. The judgement argues that the discrimination derives from the fact that Australian medical students only have to gain a bare pass when they take a similar MCQ test designed to test their medical knowledge, whereas those taking the AMC exam have to do better if they are to meet the requirements of the quota. In other words 'the minimum standard of the MCQ examination (is) beyond that which is comparable with the level of knowledge expected of accredited medical schools'.[16]

These are highly subjective judgements, delivered without any consideration of the downstream costs to the taxpayer, or acknowledgment of other differences in the training of AMC candidates relative to Australian graduates. The Race Discrimination law does not require the HREOC to consider such issues. But its concern about equal opportunity should have aroused an interest in the implications of its judgement for local aspirants to medical careers. The competition for places in medical schools which they face is about to intensify partly because of the government's difficulties in controlling the inflow of OTDs. It is not entirely fanciful to imagine that some of those who just miss out on gaining entry will take their case to the HREOC. There are at least two grounds for such a case.

i) The AMC accreditation tests involve no evaluation of the general academic standing of those who graduate from overseas medical schools or of the quality of the training they receive in these schools. Graduates from any such school, so long as it is listed by the World Health Organisation, may take the AMC test. (Listing by the WHO involves no Who assessment or accreditation.) It is likely that few AMC applicants would have experienced the fierce competition for entry into medical school which local applicants have to surmount. Nor is there any assurance that AMC applicants receive the systematic training in medical science required of Australian medical schools. It could therefore be argued that in lifting the quota the government is discriminating against local students.

ii) OTDs are already over-represented in Australia's medical workforce (see Table 1). True, many are British, but country of origin is not relevant to the issue of local opportunity. A cut in domestic enrolments will make the OTD over-representation worse, as will any breaching of the AMC quota following Siddiqui. AMC applicants derive primarily from countries already over-represented in the medical workforce. Of the 812 candidates who sat the MCQ test in 1992-93, 30 per cent were trained in Southern Asia, 12 per cent in Egypt and most of the rest elsewhere in Asia or in Eastern Europe.[17] Local students could therefore raise access and equity issues in any claim to the HREOC.

THE REDUCTION IN AUSTRALIAN MEDICAL SCHOOL ENROLMENTS

In May 1995 the Commonwealth announced it intended to begin negotiations with the medical schools to reduce the local intake of medical students from 1,200 per year to 1,000. Perhaps because this is one area where the Commonwealth has the power to take action independent of State resistance, these 'negotiations' have turned into directives. On 9 August all universities received a paper from DEET which informed them of the government's determination to proceed with the matter and offered them a way to make the cuts which would be budget neutral. The universities are invited to redirect their medical student load to other 'high priority purposes', as long as it does not lead to the production of doctors. The universities are advised that 'the Commonwealth anticipates that in most, if not all, cases, funds and student load freed up by reductions in medical school intakes from any university will remain solely with that university.' The location of the reductions is to depend on the medical workforce needs of particular states and the viability of smaller medical schools. Short of risking a cut in their budget allocations and the Commonwealth's enmity it appears the universities have little choice but to comply.

The medical schools have mounted a plausible case that to introduce these cuts would diminish their larger research and public health role. But the more central principles at stake concern the fair access to medical careers for young Australians and the maintenance of a high quality medical workforce, trained according to the needs of Australian patients. As the matter stands, the opportunities for some young Australians to become doctors are about to be sacrificed

because the government has been unable to control the entry of OTDs into the medical workforce.

The equity issue is especially pointed in regard to Australian-born students. Their opportunity has already narrowed. Medical school enrolment data for 1994 indicate that of the 7,643 'local' students (those who are not full-fee paying overseas students), only 61 per cent were born in Australia. This is a remarkably low percentage given that about 80 per cent of the relevant age cohort from which medical students are drawn is Australian-born. This under-representation is not just a reflection of the well-known capacity of migrant-origin students to outperform their Australian-born counterparts. Nearly half of the overseas-born local medical students (1,217 students or 16 per cent of the total local student body) arrived in Australia in 1986 or later. In the case of the University of Sydney and Melbourne medical schools, such students made up 24.5 per cent and 18.4 per cent respectively of the local undergraduate student body. The implication is that when these students graduate they will add to the existing imbalance between the country-of-origin of the medical workforce and that of the population being serviced. As indicated in Table 4 most of the recent arrivals come from Asian countries, particularly Malaysia, which are already greatly over-represented in Australia's medical workforce.

Table 4: Undergraduate medical school enrolment of local students 1994, by major country of birth, by time of arrival in Australia, and Australian population by birthplace, 1991

Country of birth	Time of arrival		Total		Australian population by birthplace (percentage)
	Pre 1986	1986 or after	Number	Per cent	
Australia			4,644	60.8	75.5
UK & Ireland	272	61	333	4.4	7.0
PR China	14	34	48	0.6	0.5
Hong Kong	155	173	328	4.3	0.3
India	67	31	98	1.3	0.4
Malaysia	257	285	542	7.1	0.4
Singapore	89	72	161	2.1	0.1
Sri Lanka	44	50	94	1.2	0.2
Taiwan	11	88	99	1.3	NA
Vietnam	293	103	396	5.2	0.7
New Zealand	60	17	77	1.0	1.6
Other	520	303	823	10.7	13.3[a]
Total	6,426	1,217	7,643	100.0	100.0

Source: Department of Employment, Education and Training, unpublished
[a] Includes Taiwan.

CONCLUSION

The Commonwealth government will have difficulty diminishing the inflow of OTDs while the Australian medical labour market operates as it does at present. The open-ended, state-guaranteed payment system with its minimal constraints on where doctors can practise and the number or type of services they can provide, functions like a giant commons. All doctors who gain entry to Australia can graze freely on its fields, as long as their credentials are recognised. It is no wonder that OTDs are so resourceful in finding ways around every barrier placed against their entry as permanent residents, or that those who obtain entrance as temporary doctors often find ways of staying on.

The irony of the present situation is that current increases in temporary-entry recruitment are likely to further add to the AMC queue. The number of temporary doctors who subsequently successfully change their status while in Australia is substantial and increasing. Over 100 doctors succeeded in utilising this route in 1994-95, mostly on the grounds of marriage to an Australian resident but also, in a minority of cases, through employer nominations. Most enter Australia first on temporary work visas (categories 422 and 442).

Another potential source is full-fee paying overseas students trained in Australia. Their numbers could rise if the universities increase these enrolments to take up the slack resulting from reduced local training. Some 60 to 70 of these full-fee overseas students (mostly from Malaysia) finished their intern year in 1994 and a similar number will do so

in 1995. Thereafter, the number of completions will double. If the past record can be taken as a guide, many will seek to practise in Australia. Though they are no longer guaranteed intern positions in Australia, all have currently found places and all appear to be registering with the State Medical Boards. If they can obtain permanent-residence status, as by marriage to an Australian resident (a likely prospect given their length of stay here and financial outlook), or by gaining a nomination from an Australian employer, they can practise immediately. The State Medical Registration Boards contacted were unable to indicate the number who are doing so. The pattern of entry to Australia of Malaysian doctors arriving as settlers in the years 1990-91 to 1993-94 does, however, offer some indications. Around 145 arrived during this time yet, according to AMC records, only four persons trained in Malaysia entered the AMC accreditation process. The implication is that most were Australian trained and thus were already accredited to practise here.

There is a simple solution to this imbroglio. The Commonwealth, with the agreement of the States could simply refuse to register any permanent resident (including New Zealanders) for medical practice who had not been trained in Australia as a local student. Appropriate exceptions could be made for those OTDs who arrived here as permanent residents in earlier years. This exception might best apply to those arriving before 1992, by which time the government had made it very clear that additional OTDs were not welcome. Such a measure would remove much of the pressure for back-door entry via spouse nominations from overseas or on-shore.

A less satisfactory, but partial measure would be to announce that all OTDs entering Australia from now on must take their place in the AMC accreditation queue on a first-in-first-served basis. This would reduce the incentive for doctors to migrate here.

There is much to admire in Australia's generous Medicare system. But, for the system to operate within reasonable financial bounds, the government must erect external barriers to stop it operating as a commons to the rest of the world – at least as far as the supply of doctors is concerned. If the local commons is effectively restricted to Australian-trained doctors they would surely have to accept reciprocal obligations to provide a more equitable distribution of medical services. These might include a requirement that individual doctors work for certain periods in under-serviced areas, and an acceptance of limitations on the number of Medicare provider licences issued in over-serviced areas.

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