DOCTOR SHORTAGES AND THEIR IMPACT ON THE QUALITY OF MEDICAL CARE IN AUSTRALIA

Lesleyanne Hawthorne and Bob Birrell

Chronic shortages of Australian-trained doctors available for work in hospitals, in regional general practices and some speciality areas (like emergency) have prompted increased employment of overseas trained doctors (OTDs) brought in on temporary visas for this work. The numbers of permanent resident OTDs who have not been certified as reaching Australian medical standards yet are employed in these positions is also increasing. In the process, the quality of medical care in Australia is being threatened.

THE POLICY HERITAGE BASED ON THE ALLEGED OVERSUPPLY OF DOCTORS

Throughout the past decade medical workforce planning in Australia has been dominated by the view that there are too many doctors. When the Doherty Committee of Inquiry into Medical Education and the Medical Workforce reported to the Federal government in 1988, the rise in the numbers of overseas trained doctors (OTDs) securing professional registration was identified as a major issue in increased national health outlays via Medicare payouts.[1] In February 1992 the Medical Workforce Supply Working Party documented concern at Australia's 'persistent over-supply of doctors', with doctor/ patient ratios rising by around 67 per cent over a 20 year period, and immigration designated as 'the principal determinant of the shape and size of the medical workforce'.[2] In the case of Australia's capital cities, the number of patients per average full-time GP fell from 1407 in 1984-85 to 1045 in 1998-99.[3]

In response, during the 1990s a range of pro-active measures were introduced with the goal of reducing the rate of growth in the size of Australia's medical workforce. Key strategies included:

- Reduction of the number of medical school enrolments in Australia in the mid-1980s — since that time medical school intakes have remained at about 1250 per annum;
- Points penalties to doctors applying to immigrate, then (since mid-1999) removal of the right of doctors to apply for migration as permanent residents under Australia's points tested skilled migration categories;
- Limitation on the number of entrants to the Royal Australian College of General Practitioners' (RACGP) post-graduate training programme for GPs to 400 per year from 1995 (now 450);
- Restriction on access to Medicare provider numbers to those who passed the RACGP training program, following the passage of Amendments to the Health Insurance Act in December 1996;
- Restrictions on the rights of New Zealand trained doctors to bill on Medicare from 1997;
- Restrictions on the rights of recently arrived OTDs who are permanent residents of Australia and who passed the Australian Medical Council (AMC) accrediting exams to bill on Medicare until 10 years after registration from 1997; and
- Various restrictions on the circumstances in which OTDs could practice if they entered with temporary medical appointments from the early 1990s.[4]

THE POLICY SOMERSAULT

In recent years however, Government policy on recruitment of OTDs has taken a sharp U-turn. There has been a surge in OTD arrivals holding temporary resident visas (Category 422) who arrive with contracts to work as doctors in pre-arranged employment. The total number of 422 visas issued (not including accompanying family) was 1923 in 2001-2002, compared to 1777 in 2000-2001, 1419 in 1999-2000, 1209 in 1997-98, and just 664 in 1993-94.

Another way of gauging the extent of this growing reliance is to look at the pool of Category 422 OTDs in Australia. As of 30 June 2002 according to unpublished Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) data, there were 1392 in Australia, compared with 1237 on the same date in mid 2001 and 1022 in mid-2000. This figure compares to the total clinical workforce of doctors in Australia of about 46,000.

There has also been a sharp increase in the number of Occupational Trainees. These are OTDs who have temporary contracts to work in hospital training positions who are sponsored by one of the various medical specialities (like surgery or ophthalmology). They arrive on the Occupational Trainee visa category (442.) There were 700 of these 442 visas issued to doctors in 1999-2000. No comparable figures were available for later years. However data on arrivals for 2001-2002 indicate an increase of at least 50 per cent since 1999-2000. Though ostensibly a program to assist overseas doctors to gain skills here before returning home, another motive for increased recruitment of occupational trainees is to help fill gaps in the routine hospital work in the speciality in question.

This increase in arrivals of OTDs holding contracts for medical work in Australia is a reflection of the difficulties employers are having in recruiting local doctors. It is an expensive exercise to bring doctors from overseas which most employers would avoid if they could. The increase also reflects a new Commonwealth Government willingness to allow State, Local Government, hospitals and private providers to recruit OTDs in areas of serious medical manpower shortages.

INCREASED EMPLOYMENT OF MEDICALLY REGISTERED PERMANENT RESIDENT OTDS

This resort to overseas recruiting for temporary resident doctors is well known. State health departments, the various federally financed agencies like the Rural Workforce Agencies, local governments, hospital networks, private recruiting agencies amongst others are all involved in recruiting OTDs.[5]

There has been a conspicuous silence, however, about a more recent tendency for medical employers to engage the services of permanent resident OTDs before they have had their skills accredited. It has long been the policy in Australia to require permanent resident OTDs (except those who came from Britain), to gain accreditation through the Australian Medical Council (AMC) before being allowed to practice here. In the early 1990s this policy was broadened to include all permanent resident doctors, including those from Britain. The reason for this policy was partly to control the growth in the number of doctors practicing in Australia and partly to deal with concerns about an increasing flow of permanent resident doctors into Australia who had been trained in non-western medical schools. There was often very little known about the standards and the

curriculum taught in these schools. However, in recent years this policy has been effectively thwarted as State Medical Boards have provided 'conditional registration' to permanent resident OTDs who have not completed their accreditation or have failed in their attempt to gain this accreditation.

These 'conditional registrations' allow the OTDs in question to practice (under circumstances explored below.) As a result there are currently many hundreds of OTDs who are graduates of non-Western medical schools, who are practicing medicine in Australia but who have not been accredited at the minimum standards required of Australian medical graduates. It is this aspect of the shortage of doctors which is the main focus of this paper. A paper to follow in December 2002 ('A Medical Specialty Case Study: Victoria's Dependence on OTDs in Psychiatry') explores the significance of this trend in relation to a major specialty.

Temporary resident OTDs are also not required to undertake any Australian assessment of their qualifications or skills before being allowed to practice medicine (on a conditional basis) in Australia. This is because the great majority come from Britain, South Africa or other societies with medical schools similar to those in Australia. While undoubtedly a double standard, the policy has a rationale, in that medical employers believe that graduates from Britain and South Africa are comparable with those produced in Australia.

The debate about doctor shortages

Despite Australia's growing reliance on OTDs the official view of the Government's medical manpower agency (Australian Medical Workforce Advisory Committee [AMWAC]) is that there continues to be an oversupply of doctors. Its position is that there is a distribution problem, not a deficiency problem. In the case of GPs it is true that, if the ratio of GPs to population in metropolitan centres could be reduced to the level prevailing in regional centres, and if those displaced moved to non-metropolitan areas, this would 'solve' the well known shortage of GPs in these areas. The problem with this argument is that metropolitan GPs show no inclination to move even though there have been some increased inducements to practice in non-metropolitan areas.

For its part, the Australian government's position is contradictory. On the one hand, as noted earlier, since 1996 it has made it mandatory that local graduates not be permitted to practice as GPs until they have completed the RACGP family medicine training program. This is justified as part of a commitment to quality of service. Yet on the other hand this policy is contributing to shortages of GPs which have led to additional (government endorsed or initiated) programs to recruit OTDs without such training to fill vacancies in the system.

As for the Australian Medical Association (AMA) it has argued strenuously that there is no surplus of GPs in metropolitan centres. It cites a trend towards reduced bulk billing as evidence. But the great majority of GP services in metropolitan Australia are still bulk billed, even in allegedly underserviced outer suburban areas. The AMA claims this is because the patients can't afford direct billing. We are sceptical of the AMA's position since, if it is patient finances which determine the level of bulk-billing, why is the level of bulk billing in regional (and poorer) Australia much lower than in metropolitan Australia?

There is endless debate about doctor shortages in the media. But it is a debate which has largely been shaped by the

Australian Medical Association's claims for more remuneration. The AMA implies that if the Australian Government increased the fee for GP services somehow the supply problem would be solved. There may be a case for higher fees. But it is hard to see how higher fees would increase supply. Some doctors who might be thinking of giving up may be encouraged to continue practicing. But others who have target incomes in mind might reduce their hours of work because of the boost in payments per service. Furthermore, if there is a major increase in Medicare fees for GPs it will further diminish any financial incentive for GPs working in over-serviced metropolitan locations to move to regional locations. The only sure way to increase supply (other than to draw more heavily on OTDs) is to increase the pool of doctors graduating from Australian universities.

The AMA, like other sections of organised medicine, has claimed that Australians receive a high standard of medical care, which they are the guardians of. Yet we have not heard a peep about the implications for medical care of the increased reliance on OTDs in Australia. The increased reliance on 'conditional registrants' is an embarrassment to the medical profession. It is well known, worried about, yet rarely admitted because of its troubling implications for the quality of medical care.

In our view the current shortage of doctors will not be resolved by increasing doctor remuneration. These shortages are chronic and are inherent within the structure of the medical workforce. More doctors are needed. But as shown below, the present policy of relying on OTDs as a stopgap is problematic. More doctors should be trained in Australia. The shortage is evident:

- At the level of interns needed to fill the ranks of junior doctors and non-specialist Hospital Medical Officers in public hospitals;
- In inadequate numbers of places available under the Royal Australian College of General Practitioners training program for GPs. The consequence is a chronic shortage of doctors able or willing to serve as GPs, particularly in regional areas. This situation feeds into further shortages of doctors prepared to fill locum positions; and
- Insufficient medical school graduates to fill the places available in the various public sector specialist programs. (This deficiency is most marked in specialities which are among the least attractive to medical graduates.)

THE POOL OF 'WORK HUNGRY' OTDs

As indicated above, the utilisation of OTDs recruited from overseas on temporary visas to fill particular positions in Australia can be readily documented from the visa statistics. In the case of the 422s over half of the 1,923 visaed in 2000-2001 were drawn from those with UK citizenship (692 people or 40 per cent). Those with South African citizenship constitute 200 (or 11 per cent) and those with Irish citizenship 104 (or six per cent). The remaining 43 per cent come from a great diversity of European, North American and Asian sources.

The origin of OTDs drawn from persons who are already Australian residents is quite different. The size of the pool of such doctors who by the early 1990s were not in medical employment was both large and diverse. Table 1 provides an indication of this. It is limited to those migrants who arrived in Australia

Table 1: Labour market outcomes for overseas trained doctors by country/region of birthplace, 1994-96 arrivals, as of 1996 Census

Birthplace	Employment outcomes in Australia, per cent							
	Doctors	Other professionals	Administration/ management	Sub-professional	Unemployed	NILF *	Total	Total No.
Sth. Africa	75.3	11.1	3.7	0	0	9.9	100	81
UK/Ireland	74.8	11.5	1.3	1.3	0	10.4	100	469
India	50.2	4.5	0	2.3	11.7	31.3	100	265
HK	40.5	25.7	0	21.6	4.1	4.1	100	74
Malaysia	38.7	19.4	0	0	9.7	32.3	100	31
Vietnam	30	0	0	7.5	15	47.5	100	40
S Europe	10.2	0	0	0	30.5	59.3	100	59
Philippines	7.9	7.9	0	10.5	23.7	50	100	38
China	3	11.2	0	15	12.9	57.9	100	394
USSR/Bal	2.7	2.7	0	10.7	16.1	67.9	100	112
Lebanon	0	0	0	0	0	0	100	0
Other	39.9	8.3	1	6	10.8	33.8	100	1,241
Total o/seas	39.9	9	0.7	6.5	9.7	33.8	100	2,804

Source: 1996 Census, customised matrix, Centre for Population and Urban Research, Monash University
* Not in labor force

between 1994 and 1996 with degree qualifications in medicine. The Table shows that of the 2,804 in this category only 40 per cent were employed as doctors. The other 60 per cent, or 1,682, were not employed as doctors as of 1996.

Since 1996 some 400 or more additional doctors have arrived as settlers each year. They are entering mainly through the family reunion and humanitarian programs. New Zealand is another source, particularly of 'third country' entrants, that is persons who immigrated there and after gaining New Zealand citizenship have moved to Australia. In 1999-2000, out of 253 doctors with New Zealand citizenship who entered Australia indicating they intended to settle permanently, 204 were from third-country birthplaces (mostly from Southern Asia).[6]

The bulk of these doctors have graduated from non-Western medical schools in Asia and the Middle East and Eastern Europe. Their training varies greatly in quality, relevance to the kinds of health problems encountered in Australia and preparedness for the advanced technology they encounter in Australia's hospital environment. This is why Australian medical authorities have in the past insisted they first gain accreditation before being allowed to practice here.

As indicated, the barriers to entry are managed by the AMC. In order to gain full registration as a permanent resident doctor in Australia anyone with overseas training must complete the Occupational English Test and the medical knowledge and clinical tests (the latter two tests being administered by the AMC). Most of the permanent resident migrant doctors in question have struggled to gain this accreditation. As Table 1 demonstrates, substantial numbers of medically-qualified 1994-96 arrivals were categorised by 1996 as Not in the Labour Force or as Unemployed up to two years post-arrival. The majority of these OTDs were likely to have been attempting to pass the mandatory three pre-registration hurdles:

1. *The Occupational English Test* (OET) which failed 22 per cent of

medical candidates over successive attempts, and barred or significantly delayed 43 per cent of all candidates during the period 1991-1995 from proceeding to the next stage of the pre-registration process.[7]

2. *The Multiple Choice Question (MCQ) examination of medical knowledge*: which 71 per cent of UK candidates passed on their first attempt between 1978 and 1993, compared to 34 per cent of Indian, 24 per cent of Vietnamese and six per cent of French candidates (cf an average of 35 per cent of candidates overall).[8]

3. *The Clinical Test*: which 79 per cent of UK candidates passed on their first attempt in the same period, compared to 38 per cent of Indian candidates and just 19 per cent of Vietnamese (cf an average of 42 per cent of candidates overall).

Collectively, these three pre-registration hurdles have contributed to the creation of a substantial pool of OTDs keen to get into the practice of medicine, despite their failure to secure full professional registration. This 'backlog' was quantified at 4500 by the Human Rights and Equal Opportunity Commission in 1995, including 800 who had passed the MCQ but not completed the Clinical exam, 1250 of whom had attempted but not passed the MCQ, and 2,400 of whom had lodged a formal application and were still waiting to sit the tests.[9]

Given past anxiety about maintaining the quality of the Australian medical workforce it would seem unlikely that doctors who were not accredited would be allowed to practice. It might be expected that this would particularly be the case where candidates had unsuccessfully tried to pass the AMC exams. Yet in reality there is a growing dependence on permanent resident OTDs who have been unable to obtain full AMC registration or who are still trying to obtain it. This dependence has been legitimised by state Medical Boards through a range of new measures, including the easing or complete removal of the requirement to pass AMC exams within a set period of practice. In New South Wales, for instance, changes introduced to the Medical Board's Conditional Registration Policy in May 1999 included that:

> Temporary and permanent resident overseas trained doctors are now considered against the same criteria for conditional registration and supervision in Area of Need positions. The registration period is now unlimited and is determined only by the granting of continued 'Area of Need' status for that position. Overseas trained doctors regardless of their status with the Australian Medical Council will be able to be conditionally registered in Area of Need positions. Continued registration will be based solely on satisfactory supervisor's reports to the NSW Medical Board.[10]

This outcome is a manifestation of the chronic shortage of fully registered doctors in Australia referred to earlier.

A pilot survey of OTDs in Victoria initiated by the authors gives some insight into this process. We provide brief details from this survey before describing the employment locus for non-accredited OTDs. The focus is on Victoria and Tasmania, though similar situations are emerging elsewhere in Australia.

2001 interview-based survey of recently arrived OTDs (Victoria)

During 2000-01 a telephone interview survey of 77 Victoria-based OTDs who had migrated to Australia in the past 10 years was conducted. Those chosen for

interview were a relatively select group in that they had been engaged in pre-AMC exam preparatory programs subsidised by Government. The majority of informants (75 per cent) were still seeking full registration, with 40 per cent having passed the MCQ and 35 per cent yet to pass either examination. In terms of region of origin, 24 per cent of the interviewees were from non-Commonwealth Asia, 23 per cent from Eastern Europe, 20 per cent from Africa/Middle East, and 19 per cent from Commonwealth-Asia.

Of those who were still to complete the accreditation process, 58 per cent of MCQ-only doctors, and 42 per cent of those who were yet to pass either AMC exam were employed as doctors, almost all in public hospital settings. The pathways into medical employment described below were typical of their experience.

MEDICAL SETTINGS WHERE THERE IS RELIANCE ON CONDITIONALLY REGISTERED OTDS

A. The public hospital situation

According to published Medical Board of Victoria data, by 2001 there were some 283 OTDs who were permanent residents of Australia, who had not completed the clinical component of their AMC registration, yet were employed in Victorian public hospitals as junior staff doctors. They were employed in metropolitan and regional hospitals, with particularly heavy usage in outer metropolitan hospitals. Their hospital positions were equivalent to that of first or second year interns. Most of these doctors were from Asia, with the top countries of medical training being India, Iraq, China, Sri Lanka, Egypt, Bangladesh and South Africa. With the exception of those trained in South Africa, they came from source countries characterised by low pass rates in the MCQ and Clinical examinations (see Table 2).

These permanent resident OTDs were employed in the Victorian public hospital system because there are not enough local graduates to fill the junior doctor or House Medical Officer rosters. There are currently about 800 junior doctor positions funded by the State Government, yet there are only about 350 graduates from Victorian medical schools who begin their first intern year. Some of these do not continue into a second year, leaving a gap of several hundred junior positions to be filled from outside the ranks of these graduates. To ensure continuity of basic services, the public hospitals have appointed permanent resident OTDs still to complete their AMC accreditation to these positions. There are relatively few temporary resident OTDs filling these positions, largely because of the short term nature of the appointments and the expense of bringing OTDs from overseas.

This situation is unsatisfactory for both the OTDs and the patients they encounter. While they lack AMC accreditation, the OTDs in question tend to move from short term contract to short term contract, sometimes across states (involving significant family disruption). They have no job security nor guaranteed access to the systematic training which might increase their chance of accreditation, particularly in rural sites. From the patient's point of view it is alarming that there are not always mechanisms in place to ensure that these non-accredited OTDs are capable of performing the work involved. The hospitals do their best to secure those whom they think can cope, but in the absence of any independent

assessment of the applicant's qualities, are obliged to make employment judgements on whatever information is available.

The following case studies illustrate fairly common trajectories. A South Asian doctor migrated to Australia via a second developing country, passing the Occupational English Test in the early 1990s. He sat the MCQ in subsequent years, ultimately passing on his third attempt. Following this he attempted the Clinical three times, each time failing. Despite this failure, within two years of his arrival in Australia this doctor had secured psychiatric work in a major regional hospital, a full five years before he passed the MCQ. This position was followed by a sequence of registrar or medical officer appointments in general medicine settings — all located in major Melbourne teaching hospitals, and most held before he had passed the MCQ.

An East European doctor, reaching Victoria in the mid 1990s, passed the OET after three years study. He found his first Hospital Medical Officer (HMO) position in a major Melbourne teaching hospital for a 2 year period. He was next appointed to surgery-related HMO work in regional Victoria, followed by a 12 month return to Melbourne, in a lower position. Completing this he returned once again to the country, accepting a fourth public hospital appointment, this time in psychiatry-related work. Six years after reaching Australia he finally passed the MCQ, but failed his first attempt to pass the Clinical.

Extended career gaps are not uncommon within this process. A doctor from East Asia, arriving in Australia on a student visa in 1990, subsequently secured permanent resident status as a refugee. To support himself while studying English, he took a range of sub-professional jobs, passing the OET in the late 1990s on his fourth attempt. A year later this doctor succeeded in passing the MCQ at his third try. In 2000 he attempted the Clinical exam but failed. By this stage this OTD had been excluded from medical employment for at least 10 years. Despite this, in 2001 he secured a public hospital position in a regional location.

Many comparable cases could be cited, applying to OTDs from a wide range of countries of origin. Such cases confirm that the AMC accreditation standards no longer govern access to medical practice in Australia.

The Tasmanian situation

The dependence on conditionally registered OTDs in Tasmania is equally marked. As of late 2001 there were 114 OTDs employed in public hospitals in Tasmania. The problem is not so much at the junior doctor level because the 50-60

Table 2: Initial and overall pass rates by select country of origin for the MCQ and Clinical examinations, 1978-1993 candidates

Country	% Passing MCQ (1st attempt)	Total number 1st candidate	% Passing MCQ (repeats)	% Passing Clinical (1st attempt)	Total number 1st candidate	% Passing Clinical (repeats)
Iraq	23.0	34	44.0	50.0	6	50.0
India	34.0	581	45.0	38.0	327	45.0
China	0.0	36	44.0	75.0	4	0.0
Egypt	28.0	406	36.0	26.0	225	38.0
Sri Lanka	49.0	303	50.0	38.0	183	49.0
Bangladesh	17.0	48	37.0	17.0	18	67.0

Source: L Hawthorne and J Toth, 'The Impact of Language Testing on the Registration of Immigrant Doctors'', *People and Place,* vol. 4, no. 3, 1996

local medical graduates each year have been sufficient to fill these ranks. (This situation may soon change because, according to an officer from the Postgraduate Medical Institute of Tasmania, this year's graduates have been canvassed by the Victorian Government to consider intern positions in Victoria.) The hospital shortages in Tasmania are more at the non-specialist Hospital Medical Officer level. The major regional hospitals, like those in Burnie and Devonport, are almost totally reliant on OTDs to fill these positions.[11]

Most of these 114 OTDs appear to hold conditional registration. This is currently a source of great concern to the public hospitals because in July 2001 the Medical Council of Tasmania introduced time limits on the length of conditional registration. Henceforth, conditional registrants must complete the clinical component of the AMC exams within three years of completing the MCQ. If this does not occur they will be denied further registration, thus threatening the capacity of these hospitals to provide services. Some 80 OTDs working in the public hospitals are potentially affected by this rule change since they only have to the end of 2004 to pass the clinical test.[12]

One of the areas OTDs are most likely to serve in Tasmania and Victoria is in emergency. It is hard to fill rosters from local graduates in this area. These are front line positions where any deficiencies in communication ability, medical knowledge and facility in the use of hi-tech medical equipment could have severe consequences for patients. Yet as indicated above the appointment process to these positions does not guarantee such skills. At present in Victoria and Tasmania there is no independent agency which is tasked to assess the competence of OTDs who have not satisfactorily completed or have failed their AMC assessment. For their part the OTDs are shunted from pillar to post looking for the next short term contract, while simultaneously trying to prepare for their AMC examinations.

Generalisations about the capacities of OTDs to do their work are inherently problematic. The AMC examination process has long been contentious, with debate on its appropriateness as an assessment mechanism. Any criticism is likely to be regarded as racist or motivated by Australian medical protectionism. Because of this, it is rare to find any on-the-record comment by medical authorities. Behind the scenes however, it is a different story. Anecdote and rumour based on concerns about the quality of medical care provided by some conditionally registered OTDs abound. These concerns were confirmed by the medical employers we interviewed. That said, we also found evidence of great satisfaction with the performance of some conditionally registered OTDs, particularly in communities desperate to attract GPs. Many hospitals also affirm strong skills development over time, especially those providing structured training programs. No firm conclusions on this issue can be drawn because of the absence of an independent evaluation of the situation.

B. The General Practitioner situation

In regional Victoria, as in the regional areas of other states, there has been a growing reliance on OTDs to serve in 'areas of need'. Much of regional Australia could in fact be said to be an 'area of need' because the full-time equivalent GP numbers per thousand of the population in regional areas are about 50 per cent lower than in the metropolitan areas. In practice, 'area of need' means locations where there are GP vacancies which are proving difficult to fill. The temporary resident migration program (category 422) has been the mainstay here. The Victorian government has been one of the main sponsoring agencies for these OTDs, exceeded only by the Queensland and Western Australian governments. Some 406 were approved by Victorian authorities in 2000-2001 (though not all took up the visa), compared with 897 in Queensland, 456 in Western Australia, but only 58 in NSW.

The problem here, once again, is a structural one. There are not enough local graduates from Australia's GP training program to fill the positions available. (As noted earlier the Australian government only funds 450 places each year.) Only candidates who complete the training program can now gain access to a Medicare provider number. Except for some scholarship initiatives which tie the recipients to service in regional settings, there are also no mechanisms to ensure that those who do graduate fill the vacancies which are the most pressing.

Because of the overseas recruitment costs, the 422 temporary resident OTD program is an expensive option. It is also usually a temporary expedient because most of the OTDs only work in Australia for short periods. In the case of those from the UK they are often recent graduates looking for travel and adventure before pursuing their careers in the UK.

Partly as a consequence the Commonwealth Government has facilitated alternative arrangements designed to circumvent its own restrictive policies. Regional recruitment organisations, including the Rural Workforce Agency, Victoria (RWAV) have been empowered to recruit OTDs on a longer term basis, via the Victorian OTD Rural Recruitment Scheme established by the Commonwealth and State Government and funded by the State Government in 1999. If an OTD is prepared to serve in a District of Workforce Shortage and within two years achieve the Fellowship of the RACGP, he or she can obtain permanent residence after five years service. At this point he or she will be permitted to obtain a Medicare provider number without geographical limitation. OTDs who follow this procedure do not have to undertake the AMC accreditation process. About half of the sixty doctors a year being appointed via this route in Victoria are coming direct from overseas. The other half consist of OTDs already in Australia on temporary visas or OTDs with permanent residence who have yet to complete their AMC accreditation.

In NSW the Rural Doctors Network (the NSW counterpart to RWAV) has given priority to the recruitment of permanent resident OTDs (who are still to complete their AMC accreditation). The latter take up their positions as conditional registrants, though according to the Network are given a ten week formal training program before they begin their appointments.

In Victoria there is also a Rural Locum Relief program which is run by RWAV and which is currently placing about 90 doctors a year. These are permanent resident OTDs who are drawn from the

ranks of the same doctors being recruited into the public hospitals. To be eligible for this program however, they must have finished the MCQ component of their AMC accreditation and have had 12-18 months hospital experience. The basis of their appointment is an interview conducted by RWAV.

The cases made by 'area of need' services make harrowing reading, going something like this:

> There are only four GPs in our district, servicing a small hospital and three general practice clinics catering to a dispersed population of 60,000 characterised by significant socio-economic disadvantage. Two of these doctors are aged over 70, and would like to retire. One recently had a major health problem, and has diminished work capacity. Our third doctor is a temporary resident overseas-trained doctor, who is about to leave. Our remaining doctor is desperately overworked, despite the needs of a young family. We have advertised repeatedly, but no Australian applicants have yet applied. We would ask that this application to sponsor Dr X is given urgent attention.

Three brief case studies again illustrate fairly typical trajectories for OTDs in this category of service. A British doctor was recruited on a temporary basis to serve a two year period in an 'area of need' in remote Victoria, garnering excellent reports, and extending her period of service. A South Asian OTD was recruited via South Africa, sponsored by a community practice desperate to secure his services to replace a second OTD about to leave. Entering via a 422 visa, this doctor also worked immediately as a GP, making a strong commitment to the local town and working in the local hospital as well as in a range of private practice sites. Within a year of his arrival he had applied to sit for the RACGP exams, failing his first attempt. A range of referees suggested he had settled extremely well. He planned to stay on permanently, with the sponsorship of the town.

Permanent resident OTDs report far more complex pathways into general practice, taking 'area of need' positions following years of attempting the AMC exams and short-term public hospital appointments. An OTD with qualifications from the Middle East exemplifies this process. He arrived on a temporary visa and converted to permanent resident status within two years. He then spent seven years trying to pass the AMC exams, relocating mulitple times between two states and three Victorian regions. Ultimately he exceeded the 'maximum time' for conditional registration but was finally accepted for 'area of need' general practice in rural Victoria, which opened up an alternative pre-registration pathway for him.

C. Demand in select specialisms

Finally, in specialist fields such as psychiatry and emergency medicine where public work is poorly remunerated and characterised by inferior practice conditions, dependence on conditionally registered temporary and permanent resident OTDs appears to be increasing. As psychiatry will be the subject of a separate analysis in the December issue of *People and Place*, no detail on OTDs with specialist qualifications is given here. Multiple case studies however, confirm the likelihood for OTDs to 'drift' into HMO or registrar level work in undersupplied fields, typically in public hospital settings.

Again, this situation derives from the underlying structure of the medical supply situation. The number of local graduates in medicine is now well below the number of first-year training places in the various

medical specialties. These are estimated by AMWAC to total around 1480 a year.[13] Thus applications for less favoured specialties, like psychiatry, have lagged well below what is required in the field.

Given the dearth of qualified specialists available in the public hospitals, it is likely that some OTDs will have minimal supervision. Nor will they have access to advanced training designed to develop the skills required for these positions. It is not uncommon for OTDs to secure their first medical appointments as psychiatric registrars or HMOs, including in Melbourne-based Area Mental Health networks. The first position frequently leads to a sequence of such appointments — some OTDs ultimately deciding to sit for the College exams, to formally qualify for the specialty. Many OTDs find themselves trapped in accident and emergency medicine, including a Central Asian OTD who secured three such appointments in Melbourne and a range of regional sites, all the time attempting and failing to pass the two AMC exams. In such contexts, OTDs become 'de facto' specialists: working in fields they haven't chosen because the level of demand lets them in. In the process they skill up. But some informants have concerns about their degree of competency in the transitional process, particularly in the many sites where expert training and/or supervision is unavailable.

CONCLUSION

State and Commonwealth Governments and the various arms of organised medicine in Australia face an unpalatable dilemma. There is a deep reluctance to admit the seriousness of the doctor shortage in Australia as well as the extent to which gaps in medical service are being plugged by OTDs who are conditional registrants and who have not been accredited as meeting minimum Australian standards of clinical expertise and sometimes of medical knowledge.

The problem will not go away. To rectify it will require a major expansion in Australian medical training and accompanying policies to ensure doctors serve where they are needed. Commonwealth and State Governments appear to be unwilling to consider this option. Perhaps, behind the scenes, these Governments concede that they do not have the constitutional authority or political will to direct doctors to where they are needed or to meet the costs of the financial incentives needed to accomplish this end.

There may well be a tacit acceptance that it is cheaper and easier to make do with greater use of OTDs. Governments don't have to pay the costs of training more Australian residents, and they can direct OTDs to areas of medical service need as a condition of allowing them to practice in Australia. John Horvath, Chairman of AMWAC has come very close to acknowledging that this is the strategy. In relation to the great challenge of getting doctors to serve in areas of greatest need, he says:

> [It] is more easily done for overseas entrants as often location of practice is a condition of entry to the country. And overall the increasing attraction of overseas trained doctors can be explained by their more immediate impact on supply coupled with the possibility of some influence on location.[14]

If this is to continue to be the strategy, Governments and medical authorities should be prepared to accept some of the corollaries involved. Foremost is the requirement to ensure that conditionally registered OTDs meet Australian medical care standards. Currently there is no such

guarantee for temporary or permanent residents. There is a willing and under-employed medical workforce already in Australia. Most of these OTDs are keen to undergo additional study. If they are to play a major role in meeting the growth in demand for medical services they should be acknowledged for what they are, which is 'doctors in training'. Their utilisation is not costless. At the same time Governments should provide the resources in training, evaluation and supervision needed to guarantee that the service OTDs provide is equivalent to that of graduates of Australian medical schools and specialist training programs.

References

1. Committee of Inquiry into Medical Education and Medical workforce, *Australian Medical Education and Workforce into the 21st Century*, Australian Government Printers, Canberra, 1988, pp. 470-491
2. Human Rights and Equal Opportunity Commission (HREOC), *The Experience of Overseas Medical Practioners in Australia: An Analysis in the light of the Racial Discrimination Act 1975*, HREOC, Sydney, 1992, p.17; See also B. Birrell, 'Implications of controls on access to medicare billing for GPs', *People and Place*, vol 5, no. 1, 1997, pp 67-68
3. Australian Medical Worforce Advisory Committee, *The General Practice Workforce in Australia, Supply and Requirements 1999-2010*, AMWAC Report, 2000.2, August 2000, p. 58
4. B. Birrell, 1997, op cit; L. Hawthorne and J. Toth, 'The impact of language testing on the registration of Overseas Trained Doctors', *People and Place*, vol. 4, no. 3, 1996
5. Australian Medical Workforce Advisory Committee, *Temporary Resident Doctors in Australia*, AMWAC Report 1999.3, June 1999
6. B. Birrell and V. Rapson, 'New Zealanders in Australia: the end of an era?' *People and Place*, vol. 9, no. 1, 2001, p. 70
7. See Hawthorne and Toth, op. cit., for a detailed analysis of the impact of the Occupational English Test on the professional registration of Overseas Trained Doctors (OTDs), based on analysis of outcomes for 2,079 candidates.
8. Australian Medical Council (AMC), 1994
9. HREOC, 1995
10. Information Service for Overseas Trained Health Professionals, OSDOC Newsletter August 1999, North Sydney, New South Wales
11. A. Egan, Ed., *Overseas Trained Doctors in Tasmania, A Symposium*, Postgraduate Medical Institute of Tasmania, November 2001. (See comments from Dr Michael Hodson.)
12. ibid.
13. J. Horvath (Chairman of AMWAC), *Keynote address*, Confederation of Postgraduate Medical Education Councils, 6th National forum, 2 November 2001, ibid, p. 2
14. ibid, p. 3