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International Physician Migration – The Push for Self Sufficiency

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1 Medical Workforce Trends in Australia

1. The medical workforce in Australia has grown more quickly than the population in the last 30 years, with the number of doctors per 100,000 people more than doubling from 122 in 1971 to 283 in 2003[1]. However, like many other developed countries, Australia has in recent years faced increasing medical workforce shortages. Two important contributing factors have been increases in the demand for medical services from an ageing and wealthier population, and a steady reduction in average hours worked hours by doctors.

2. Total health expenditure in Australia increased from $AU35 billion in 1992/93 to $AU72 billion in 2002/03, rising from 8.2% of gross domestic product (GDP) to 9.5% of GDP over the 10 year period. Nationally, the average weekly working hours across all clinicians has fallen from 48 in 1997 to 44.6 in 2003, a decline of 3.4 hours or about 7%.[2] This represented a decrease in clinical medical workforce availability equivalent to 3,130 doctors or about 500 doctors per year.

3. The medical workforce shortages which have emerged vary in significance across geographic areas and medical disciplines.

2 Self Sufficiency Objective

4. In April 2004, Australian Health Ministers released the National Health Workforce Strategic Framework[3], which provides a policy direction for investment in workforce strategies in Australia. The National Strategic Framework document

[1] Australian Institute of Health and Welfare (AIHW), Medical Labour Force 1999 and AIHW Medical Labour Force 2003.

[2] AIHW (2004) Medical Labour Force 2002, AIHW cat. No. HWL30. Canberra

identifies seven overarching principles that guide workforce policy and development, the first of which requires Australia to focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market. The key stated strategy to achieve this over the longer term is ensuring the alignment of education and training supply with projected health service needs.

5. A review of Australia's health workforce being undertaken by the Australian Productivity Commission has, in a discussion paper released on 29 September 2005[4] recommended that the National Framework be formally adopted by the Australian Government and each of the State and Territory Governments.

6. At the same time, however, the Productivity Commission has expressed some issues with the wording of the self sufficiency principle. In its view, provided there is compliance with ethical protocols, it is appropriate for Australia to draw permanently on suitably qualified International Medical Graduates (IMGs) to supplement the locally trained workforce, and to recognise that its own health workers will migrate to other countries, either temporarily as part of their broader development, or on an ongoing basis. Accordingly, the Commission proposed that principle one by modified to "more actively embrace the international nature of the health workforce and …. [be] couched in terms of the need for Australia to produce sufficient numbers of health workers such that there is not an unsustainable reliance on health workers trained in other countries".[5]

3. Expansion of Physician Education and Training

7. The Australian Government is undertaking a major new investment in educating and training Australian doctors in an effort to meet, as far as possible, Australia's future medical workforce requirements from local sources. Since 2000 the Australian Government has increased the number of publicly funded medical school places across the tertiary education sector by more than 30% and created 5 new medical schools, an increase of one third on previous levels. Three further new medical schools are scheduled to begin operations by 2008.

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[3] National Health Workforce Strategic Framework, Australian Health Ministers Conference, April 2004.

[4] Productivity Commission 2005, Australia's Health Workforce, Position Paper, Canberra

[5] Productivity Commission 2005, page 34

8. It is projected that the number of Australian students completing university medical studies will grow from 1,300 per annum in 2005 to 2,100 per annum by 2011, an increase of more than 60%.

9. As it takes 9 to 13 years or more for doctors to be fully educated and trained, it will take some time for the impact of the increased investment in medical education now occurring to be fully felt in terms of increased medical workforce capacity. Other policy tools which can add to medical workforce capacity in the shorter term are also being pursued, one of which is the increased used of IMGs.

4 International Medical Graduate Workforce in Australia

10. Australia has supplemented the locally trained medical workforce with IMGs over a number of decades, both on a temporary and permanent basis. This is consistent with broader Australian policy that has imported skilled and unskilled labour across a range of sectors to expand both specific workforce groups and the population in general.

11. It has been estimated that IMGs account for 25% of the current Australian medical workforce, compared with 19% a decade ago.[6]

12. IMGs work both in the private sector (private rooms and private hospitals) and the Government sector (public hospitals run by the States and Territories). It is difficult to determine the exact number of IMGs in the Australia health care system as there is no single source of data. The problem of identifying and recording IMGs in the workforce is compounded by the multiple entry and exit points in the system with no consistent reporting between employing states and territories.

13. The Australian Institute of Health and Welfare (AIHW) has estimated that 50% of employed medical practitioners who obtained their initial qualifications overseas come from the United Kingdom, Ireland and New Zealand; 28% obtained their primary qualifications in Asia; and 22% from elsewhere.

14. The Australian population is concentrated along coastal fringes and sparsely located across central Australia. This creates challenges for service provision when

[6] Productivity Commission 2005, page 11

a basic tenet of the Australian health care system is equitable access to services. Rural and remote communities, in particular, find it difficult to attract and retain medical practitioners.

15. In 1997, legislative changes were introduced that limited International Medical Graduates to districts of workforce shortage if they wish to access a Medicare provider number to bill the Australian Government funded Medicare payment system for doctors operating in the private sector. A district of workforce shortage may be a geographic location or a specialty area where shortages exist. The States and Territories impose similar restrictions on the registration of IMGs working in the public sector to ensure they take up employment in areas of the public hospital system experiencing medical workforce shortages.

16. These regulatory controls have assisted in improving the distribution of the medical workforce in Australia over time, particularly in rural and remote areas.

5 Recruitment of IMGs

17. Employers in the private sector and public hospitals have traditionally been responsible for the recruitment of IMGs. Medical vacancies have existed across the whole health system and employers have recruited IMGs to fill positions in public and private hospitals and specialist and general practices. Employers have recruited IMGs directly from overseas and / or used recruitment agencies to identify appropriately qualified IMGs to fill positions.

18. Some State Governments have also undertaken recruitment activities to obtain International Medical Graduates and, more recently, the Australian Government in November 2003, announced a range of measures to increase the opportunities for IMGs to enter the Australian medical workforce. These measures included recruitment initiatives to assist employers to obtain permanently or on a temporary basis, appropriately qualified IMGs to fill vacancies in districts of workforce shortage. The Australian Government has contracted sixteen medical recruitment agencies to place IMGs in medical vacancies, without employers having to meet the cost of a placement fee for this service.

19. This has resulted in the filling of a number of vacant Medicare billing positions in districts of workforce shortage. Over 220 IMGs have been placed in districts of

workforce shortage as at October 2005 and more than one hundred further doctors have signed employment contracts and will commence work in the near future. Three quarters of the doctors placed have been general practitioners with the remaining one quarter being medical specialists. Approximately 65% of the IMGs placed are working in locations outside of the capital cities.

20. Recruitment agencies hold contracts with the Australian Government and are paid a fee for each applicant placed, with higher payments applying when vacancies in rural and remote locations are filled.

6 Ethical Recruitment Issues

21. The Australian Government supports the principles contained in the Commonwealth of Nations Code of Practice for the International Recruitment of Health Workers, which has established a framework for ethical recruitment arrangements. Consistent with the Code, the Government is not targeting developing countries in its international medical recruitment activities.

22. International medical recruitment agencies contracted by the Australian Government are prohibited from undertaking recruitment marketing activities in, or directly approaching doctors residing in, developing countries. Countries where recruitment action is being undertaken include the United Kingdom; the United States; Europe – including Austria, Belgium, Denmark, Germany, Norway, Scandinavia, Spain, Sweden, Switzerland, and the Netherlands; and Asia – including Hong Kong and Singapore.

23. Doctors from developing countries may enter Australia through general migration programs or directly approach Australian employers and/or Australian Government contracted recruitment agencies to arrange assistance to enter the Australian medical workforce. This is permissible under the Commonwealth Code of Practice for the Internal Recruitment of Health Workers which states that Governments should not limit or hinder the freedom of individuals to choose where they live and work.

24. Under Australia's *Human Rights and Equal Opportunity Commission Act (1986),* which incorporates the international convention concerning occupation and

employment, employers cannot discriminate against an IMG on the basis of their country of origin.

25. Table 1 below provides data on the country of original medical qualification of Medicare billing IMGs who were registered prior to 1997 and those registered after that time. This provides an indication of changes in the mix of IMGs entering the Australian medical workforce over time. The table illustrates that:

- Australia has considerably reduced its dependence on the UK as a source of IMGs, but doctors with a UK qualification remain the single largest group of IMGs practising under the Medicare arrangements in Australia.

- The proportion of IMGs coming from the Indian sub-continent has also fallen significantly, but remains the second largest group of IMGs practising under the Medicare arrangements.

- The proportion of IMGs coming from South Africa, the USA, Canada, Europe (excluding the UK) and New Zealand has increased significantly over the past decade.

Table 1: Percentage of all IMGs that billed Medicare in 2004

	Registered Pre 1997	Registered Post 1997	Variance
UK	32	19	-13
Indian Sub continent	23	17	-6
Malaysia and Singapore	5	1	-4
Rest of Asia	9	7	-2
Australia	3	3	0
Rest of Africa	7	7	0
Rest of America	0	0	0
Unknown	4	5	1
Rest of Europe	9	12	3
US and Canada	1	5	4
New Zealand	4	9	5
South Africa	6	15	9

26. Data from the Department of Immigration, Multicultural and Indigenous Affairs indicates that there were about 4000 temporary residence visas provided to IMGs in 2004/05 to work as doctors in Australia under employer sponsorship arrangements (422 visas). 21% of these visas were for less than 12 months and 50% were for less than 2 years. This suggests that a considerable proportion of IMGs who work in

Australia return, within a reasonably short period of time, to their country of origin, having gained additional experience and expertise through working here.

7 Assessment of IMGs

27. It is important that IMGs meet an appropriate quality benchmark to practise medicine in Australia,and that the initial assessment processes carried out by each State and Territory Medical Registration Board for deciding whether an IMG is suitable to practise are robust and consistent.

28. The Department of Health and Ageing is currently working towards a nationally agreed assessment model for IMGs seeking to enter general practice. This work involves all State and Territory health departments, medical boards and major medical organisations.

29. The major features of this model include:

a. Primary Source Verification of IMG qualifications, which minimises the risk of fraudulent applications being lodged.
b. International Screening Examination, which will allow IMG candidates seeking registration in Australia to sit an initial examination conducted by the Australian Medical Council offshore. This will enable improved checking of IMGs knowledge prior to their arrival in Australia. This measure will commence after July 2006.
c. A Standardised English Language Examination, with a national standard in this area having already been agreed by State and Territory Medical Registration Boards.
d. Individual Assessment of IMGs for a position against a National Reference Panel category or scale, and a clinical interview/examination.
e. Post Registration supervision, which is set by the medical board and takes into account the doctor’s level of competence and experience. Supervision is monitored by the Boards.
f. Participation in Continuing Professional Education (CPE) by IMGs as part of the conditions of registration.

g. Encouragement for IMGs to achieve Fellowship of a medical college, or pass the Australian Medical Council examinations which entitles them to receive general medical registration without conditions, within a specified period.

30. The assessment model for IMGs entering general practice is expected to be finalised by the end of 2005 or early in 2006, with a view to implementation by the medical boards as soon as possible thereafter. States and Territories are currently considering adapting this model for IMGs applying for public hospital positions.

8 Training and Support Issues

31. It is also important that adequate ongoing training and support arrangements are in place for IMGs, particularly those wishing to make a longer term commitment to the Australian workforce.

32. The Australian Government is providing a range of programs to assist in achieving this, including:

- Funding to support the establishment of up-skilling positions which provide selected overseas trained specialists with up to 24 months of additional clinical training in public hospitals to assist them with gaining College Fellowship.

- The Royal Australian College of General Practitioners has been engaged to assess those permanent resident IMGs in Australia who are not currently in the medical workforce and determine which of them could potentially practise medicine here. The College is developing an individual learning plan for a number of these doctors to assist them prepare for the Australian Medical Council examinations to obtain medical registration.

- Funding for case management of IMGs working in rural areas as general practitioners to assist them upgrade their qualifications and obtain Fellowship of the Royal Australian College of General Practitioners.

- Funding for the Queensland Centre for International Medical Graduates to develop and maintain an online cultural orientation program for IMGs.

9. Other Measures for IMGs

33. The Australian Government has also introduced other measures to encourage an increased flow of suitably qualified IMGs to work on a temporary or permanent basis in Australia.

34. The Government is allowing temporary resident doctors to remain in practice in Australia for longer. The maximum visa validity period for temporary resident doctors (subclass 422) visa was extended from two to four years in December 2003, and the visa may be renewable after that time. Since then, over 1600 temporary resident doctors have been granted a visa for greater than two years.

35. In addition, medical practitioners are now listed as a skill in demand for the purposes of migration to Australia. This change came into effect in May 2004 and means that medical practitioners who satisfy state and territory medical board requirements for general medical registration will no longer require a sponsor to migrate here.

36. From April 2005 the process of accessing visas by sponsors and doctors has been expedited, with applicants now being able to apply for a Temporary Business Entry (subclass 457) visa on the internet. The Department of Immigration and Multicultural and Indigenous Affairs has also introduced priority processing of visa applications for medical practitioners.

37. A new website for IMGs and Australian employers, DoctorConnect, was launched by the Department of Health and Ageing in May 2005. This aims to facilitate recruitment by providing a national authoritative source of information on working as doctors in Australia. Since its launch, there have been over two million website hits on DoctorConnect, over 100,000 visitors and over 1,00 email enquiries.

8 Australian Trained Doctors working Overseas

38. An estimated 3,000 Australian registered medical practitioners, or 4.5% of the medical workforce, are currently working overseas. The proportion of Australia doctors working overseas has been 4.0 to 4.8% over the period 1997 to 2003. Many of these doctors are working temporarily overseas and will return to the Australian medical workforce with enhanced skills and experience.

39. Australia supports medical education through funding grants to medical schools in the Asia Pacific region, including the Fiji medical school.

40. AusAid, Australia's international aid agency, coordinates volunteer surgical teams that visit neighbouring countries to provide surgical services, as well as skills development for local surgeons. This provides local surgeons with access to a network of peers where they can access a second opinion or information on surgical case management.

41. Post graduate training opportunities exist for the exchange of medical staff which are generally coordinated and managed at a local level, such as fellowship trainee exchanges with Australia's Pacific neighbours.

42. Programs are also in place to provide medical aid as part of emergency relief with a recent example being the emergency medical assistance provided by Australian medical personnel following the 2004 tsunami in Asia.

43. In 2004, Australia's medical schools provided upward of 400 medical school places filled by international fee paying students, the bulk of whom will return to their country of residence on the completion of medical studies here.