

Self Sufficiency and International Medical Graduates – Australia

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1. Overview

Current shortages in health workforce supply and traditional workforce utilisation present major obstacles to improving health service delivery in Australia. Australia's health system is currently dealing with the effects of an underinvestment in its health workforce from the mid 1980s onwards and a traditionally conservative approach to the scope of practice of workers. These factors have influenced Australia's approach to health workforce self sufficiency and use of International Medical Graduates (IMG).

Australia has formally recognised health workforce self sufficiency as a goal since 2004. Principle 1 of the National Health Workforce Strategic Framework (the Framework) states:

Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.

The Framework was developed in 2004 to guide national health workforce policy and planning and Australia's investment in its health workforce to 2014. It was endorsed by Australian Health Ministers in 2004 and by the Council of Australian Governments (COAG) in 2006.

Macro level supply and demand modelling of the medical workforce in 2008 shows that Australia still needs to make further progress to achieve self sufficiency. Although there has been a dramatic increase in Australian medical school places since 2000, a gap remains between projected medical school graduates and workforce requirements. However, a range of recent and emerging policy directions have growing potential to move Australia closer towards medical workforce self sufficiency.

2. Background

Underinvestment

A number of factors have contributed to Australia's underinvestment in its health workforce. Since 1996, the Commonwealth Government has used a cap on medical school places to control the supply of the medical workforce (Simoens & Hurst 2006, 29). In the 1980s and early 1990s there was a perception of a doctor oversupply in Australia, particularly in metropolitan areas, and concerns about the growing Medicare expenditure, which is linked to the number of providers (Gavel et al 2000). As late as 1996 the Australian Medical Workforce Advisory Committee was estimating that Australia had an oversupply of doctors (Gavel et al 2000, 10).

However, by the early 2000s, shortages were emerging in the general practice workforce and in a range of medical specialties. The restricted number of undergraduate medical places was one contributing factor, whilst other factors included an unexpected reduction in hours worked across the medical workforce (AIHW 2008).

Since medical workforce shortages became apparent, Australia has adopted a number of policy responses:

- A sharp increase in medical school places to try and address shortages in the medium term
- Use of international medical graduates (IMGs) to meet workforce needs in the shorter term, particularly in areas of geographic and specialty need.

These approaches are being supplemented now with a strategic focus on the potential of health workforce reform to achieve productivity improvements.

Achieving self sufficiency in a federation

Australia's federal system of government adds complexity to the search for effective solutions to medical workforce self sufficiency. Under the federal system, Australia's six States and two Territories have the responsibility for provision of public hospitals and other health services, and regulating health professionals. However significant funding is provided by the federal government sometimes with conditions that determine policy directions.

The Australian Government has assumed responsibility for university funding, including the number of medical school places which is a key determinant of medical workforce numbers. However the States and Territories retain responsibility for most of the institutions that provide medical clinical training and employ significant numbers of medical practitioners.

The differing geographic, demographic and economic characteristics of the States and Territories and their individual policy directions can complicate the achievement of consensus and collaboration to achieve national workforce self sufficiency. Discussions on national initiatives are commonly progressed through Ministerial Councils, usually based on consensus decisions, and as a result the pace of any reform can be slow. Added to that, where legislative change is required, eight and sometimes nine, parliaments must agree.

3. Focus and research questions

Self sufficiency definitions

In 2004 Australia committed to the principle of self sufficiency through the National Health Workforce Strategic Framework. However, the Strategic Framework itself does not define self sufficiency, and the term is capable of different interpretations (Australian Health Ministers' Conference 2004, 16).

The Productivity Commission is an independent research and advisory body to the Australian Government on a range of economic, social and environmental issues. The Commission published a research report on Australia's health workforce in late 2005, commissioned by the Council of Australian Governments (Productivity Commission 2005). The report recognised Australia's current reliance on an internationally trained health workforce and acknowledged the need for a more sustainable approach. The Commission recommended a review of whether the self sufficiency principle is "...unduly restrictive given the international nature of the health workforce and, if so, how the principle should be interpreted in practice..." (Productivity Commission 40).

In the Commission's view, "...provided there is compliance with ethical protocols, it is appropriate for Australia to draw on suitably qualified, overseas trained, professionals 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 permanently. Importantly, access to internationally trained health workers provides a valuable avenue for skills transmission and through this productivity gains..." (Productivity Commission 39).

To date the self sufficiency principle has not been altered.

While the Framework does not define self sufficiency, it refers to the risks of unsustainable reliance on international graduates at a time of global workforce shortage, as well as the ethical issues involved in international health worker recruitment. However, it is clear that the Framework envisaged that some Australian trained doctors would continue to work overseas, temporarily or permanently, and similarly, IMGs would come to Australia.

Accordingly, for the purposes of this paper, self sufficiency in the medical workforce is defined as where the number of international medical graduates entering Australia on temporary or permanent visas approximates the number of Australian doctors leaving Australia temporarily or permanently in any year, ie an empirical definition.

Possible measures by which the attainment of self-sufficiency can be assessed

Based on the suggested definition of self-sufficiency above, the following measures could be applied to assess the extent to which self sufficiency has been attained:

- Medical workforce shortages
- Numbers of international medical graduates entering Australia on short term visas (especially 457 and 422 visas)
- Trends in the use of Area of Need/Area of Workforce Shortage positions
- The geographical distribution of the medical workforce
- The composition of the medical workforce (numbers of permanent residents and citizens compared to temporary visa classes)

Ethical framework for recruitment of IMGs and repatriation of nationals working abroad

Recruitment of IMGs

The 2003 Commonwealth Code of Practice for the International Recruitment of Health Workers establishes a framework for ethical recruitment arrangements. Australia supports the Code principles, which include not targeting developing countries in international medical recruitment activities.

Any ethical framework needs to carefully balance the need to avoid draining the medical workforce in developing countries with the individual freedom of health workers to choose where to live and work.

Repatriation of nationals working abroad

Australia's strategies targeting self sufficiency do not have a strong focus on repatriating nationals working overseas in Australia. Given the numbers of Australian doctors working overseas (3,062 in 2006 or 4.7% of the practising workforce) repatriation has limited potential to assist with achieving self-sufficiency. Further, even relatively conservative concepts of self sufficiency such as the Framework accept that there will be a proportion of each nation's medical graduates that wish to spend some time working overseas.

Demand modelling

In 2006, the Council of Australian Governments agreed to the establishment of the National Health Workforce Taskforce (NHWT) to undertake projects which inform development of practical solutions on workforce innovation and reform. The NHWT is a national body created under the Australian Health Ministers' Advisory Council committee structure.

Prior to the establishment of the NHWT, a Stocktake of Current and Anticipated Jurisdictional Investment in the Health Workforce was conducted in which all jurisdictions reported undertaking profession-based supply and demand analyses, although approaches varied between jurisdictions. Profession-based modelling focuses on a health profession or discipline, rather than more broadly across a care group. Although profession-based studies can be thorough and detailed, they do not take account of the possible impact on or roles of other health professions and support staff. Traditional supply and demand approaches tend to "focus on how many practitioners of a certain profession or qualification are needed to deliver services within existing service models". Often this approach tends to exclude alternatives, such as workforce redesign, the potential for other workers to assume at least some components of the roles traditionally performed by specific professions, and the possibility for variations in service models ("particularly in response to changes in technology or a greater emphasis on community-based care").

The NHWT has undertaken national macro level supply and demand modelling of the Australian medical workforce, as well as more detailed modelling of individual medical specialties, building on the previous work of the Australian Medical Workforce Advisory Committee. The NHWT has also developed its own workforce planning tool to be used by Australian jurisdictions which has split migration into two components – immigrants and internal inward migration between Australian states and territories. This will allow the NHWT to provide advice to health ministers and policy makers on the number of medical graduates and entrants required to achieve self-sufficiency. Whilst a number of Australian states and territories run international recruitment programs, the bulk of IMGs entering Australia are not as a result of these programs, rather they are individual practitioners choosing themselves to make application to enter Australia. Analysis of trends over the last five years has shown that the numbers choosing this option has remained relatively constant, with modelling indicating that the proportion of IMGs relative to the total workforce has sat at about 13%, with a large number of these working in hard to staff areas. Planning for self sufficiency, therefore, has in the first instance assessed the numbers of IMGs entering Australia as remaining constant, however, this

will continue to be monitored and adjusted to reflect any change in trends if the number shrinks and as recruitment programs wind down when the increased numbers of domestic medical graduates begins to take substantive effect from 2012 onwards.

The increase in university places has resulted in a significant increase in the need for effective clinical training to develop practical clinical skills. The current and proposed increases in medical school places exercise substantial pressure on the current arrangements for clinical training, and it is clear that structural change will be necessary to improve capacity and achieve sustainability.

4. Findings and specific directions

Is the education system compatible with the need for a self-sufficient workforce? How have the number of undergraduate and postgraduate trainees evolved and are these the right numbers?

A better alignment between education and training and workforce needs is a key strategy to achieve health workforce sustainability. Whilst there is still a need to increase medical school places, Australia's tertiary education system has demonstrably adapted in response to the need for a self sufficient workforce, both in relation to medical school places and other initiatives discussed below.

There has been a recent substantial increase in medical school places in response to medical workforce shortages. In Australia, initial medical education is provided by university medical schools as five or six year undergraduate courses or as four year graduate entry courses. The number of domestic medical graduates expected to enter the Australian workforce each year is projected to rise from 1,586 graduates in 2007 to 2,945 graduates in 2012 – an 85.7% increase (Medical Training Review Panel, 17).

The increased places have been achieved through a mix of more places at existing medical schools and opening new medical schools. In 2007 there were 17 medical schools with 12 producing graduates. Two more medical schools commence during 2008 and are expected to produce graduates by 2012 (Medical Training Review Panel 2007, 9).

In addition to the broader initiatives discussed below, Australia has:

- Established an annual workforce meeting of Health and Education Ministers to consider health workforce priorities and the education sector's response
- Worked to establish pre-vocational medical training in the private health sector and is working to establish post graduate training settings in the private health sector to expand training capacity.

Stocks and flows of physicians

Health workforce

Medical workforce shortages are part of broader health workforce shortages. There are growing health workforce shortages in Australia and overseas. The Australian health workforce also shows evidence of maldistribution.

It has been estimated that 37% of the 2002 aged care nursing workforce and 26% of the rest of the nursing workforce will retire by 2012, resulting in a loss of 65 000 nurses, while the number expected to enter the workforce will be substantially less. Doctors in rural areas are also ageing, and new medical students are increasingly female who on average work fewer hours once they are trained. Allied health disciplines show the same trend in declining hours. For example, the most recent data on Victoria's physiotherapist workforce, which is over 70% female, shows a decline in working hours of 4% since 2003 to 29.7 hours per week. More people will be required to fill equivalent full time positions as nearly 38% of Australia's health workforce work part-time and less than 35 hours per week.

The ageing of the Australian population is expected to increase the demand for health services over coming years driving a commensurate increase in demand for health workers. This will take place at the same time as the population of working age becomes comparatively smaller, and the health sector faces increasing competition from other sectors of the economy for staff. Between 1996 and 2001 the number of health professionals in Australia grew by over 11%, nearly double the growth rate of the population. This rate of growth will not be sustainable into the future.

Australia has in recent years relied on internationally trained health workers to supplement domestic supply. Increases in domestic training of health workers have not yet achieved self sufficiency.

However, Australia recognises that it is only one of many countries seeking health workers in an international market characterised by general labour shortages.

Physicians

In Australia in 2005-06, there were a total of 82 289 registered medical practitioners. The number of registered medical practitioners working in medicine in Australia was 62 461 compared to 53 991 in 2002, an increase of 15.6%.

Medical practitioners worked an average of 43.3 hours per week in 2006, a decrease from 44.4 hours per week in 2002. However, in 2006, on average, 39.9 hours were spent in clinical work, an increase from 39.6 hours in 2002.

Despite a decrease in average total hours worked from 2002 to 2006, the supply of employed medical practitioners increased from 271 to 290 full time equivalent medical practitioners per 100 000 population over that period.

Further data including demographic information are at Attachment 1.

What are the various measures and tactics that have been adopted to achieve self-sufficiency in your country, if any?

Australia has adopted a range of measures to move closer to self sufficiency. Some measures focus on increasing supply whilst others concentrate on workforce reform.

Australian commentators, such as the Productivity Commission, have recognised that supply responses have limits and will not by themselves be sufficient to provide the health workforce required now and into the future. Strategies to maximise productivity and improve the efficiency, effectiveness and responsiveness of the health workforce by fully utilising the skills and knowledge of workers will therefore be critical to achieving workforce sustainability.

Strategies to increase supply are:

- Progressively increasing locally trained medical graduates. To achieve this, clinical training capacity will need to be increased through initiatives such as expanded training settings, more use of simulated environments with an emphasis on geographic and clinical areas of workforce shortage, including indigenous health services.
- Improving the capacity and productivity of education and training.
- Continuing to develop effective recruitment, retention and re-entry approaches.

Workforce reform strategies are:

- Improving workforce productivity and skill levels, thorough new approaches such as:
 - Exploring how work in priority service areas could be reorganised to minimise duplication and make best use of available staff
 - Extending existing roles and scopes of practice to provide greater workforce flexibility, such as through greater use of nurse practitioners
 - Creating new professional or assistant roles to meet current and evolving patient needs, such as trials of physician assistants in Queensland, South Australia and Western Australia
- The development of a national workforce core competency framework which is focussed on the capabilities of a flexible workforce across the health service sectors. Such a framework has the capacity to cover all levels of health workers, include health workers who currently have no competency requirements, open pathways for new health workers and role redesign and support the improvement of articulation pathways between the VET and university sectors. A focus on shared competency standards will also support a move away from the time served models of clinical training towards competency-based assessment

- Shared competency standards will inform and strengthen interprofessional learning to provide greater workforce and clinical training flexibility
- Consideration of how to better align incentives for productivity and performance of health professionals and multi-disciplinary teams.

There are also specific strategies focusing on medical workforce distribution at the Commonwealth and State/Territory level.

In the short term, Australia is developing and implementing a range of initiatives to improve self sufficiency. However, utilising internationally trained health professionals is likely to remain a necessary short term strategy to alleviate workforce shortages until other strategies take effect.

What strategies, if any, have been adopted to link short-term workforce planning strategies with the long-term objective of striving towards self-sufficiency? If none, what approaches would you suggest?

Australia has adopted the following strategies to link short-term workforce planning strategies with the long-term goal of self sufficiency by:

- Developing consistent national data collections on health occupations, that will be incorporated into a new national accreditation and registration scheme, to ensure that workforce planning is supported by accurate and current workforce data
- Establishing a new national workforce planning model to:
 - Enable timely and accurate projections of medical workforce supply and demand
 - Allow the success of short term workforce planning strategies to be evaluated and progress towards self sufficiency to be tracked
 - A major project on clinical education that focuses on improved outcomes for clinical training, system and cost efficiencies and increased capacity, through:
 - Revised or newly developed system management, relationships, organisation of, and funding arrangements, for clinical placements and training. This means proposing reform to current provider relationships, benchmarking requirements, education models and placement arrangements.
 - Major revision and proposed reform of policy governing funding arrangements throughout clinical education pathways.
 - Development of common competencies across the health workforce as a means of improving the efficiency and relevance of training that promotes multidisciplinary workforce models and interprofessional learning models and supports role redesign.
 - Increased employment of Vocational Education and Training (VET) skilled workers in health through improved articulation and alternate pathways across health qualifications.
 - Major revision of existing accreditation of clinical training and progress towards national standards that improve quality, effectiveness and efficiency.
- A national accreditation and registration scheme to establish consistent requirements across all States and Territories and potentially improve health workforce supply, distribution and deployment.

Are there regional disparities in medical workforce distribution, particularly in rural/remote areas, that have resulted in inter-regional or international “poaching”?

Australia's medical workforce distribution is characterised by regional disparities, particularly in rural and remote areas. In 2006, in major cities, there were 332 FTE medical practitioners and 98 FTE primary care practitioner clinicians per 100,000 population. In comparison, the respective rates for inner regional areas were 184 and 87 FTE; in outer regional areas, 154 and 86 FTE; and in remote/very remote areas, 191 and 108 FTE.

Workforce distribution remains a policy priority in Australia, with a range of strategies targeted to improve distribution. Many strategies focus on the medical workforce, such as bonded rural scholarships and other national initiatives (Department of Health and Ageing 2008(2)). States and Territories are able to declare areas of medical workforce need. However, Australia's use of IMGs is particularly apparent outside metropolitan areas.

The following extract from the 2008 *Audit of Health Workforce in Rural and Regional Australia* by the Commonwealth Department of Health and Ageing summarises the issues (p. 12):

- "Rural and remote Australia has experienced workforce shortages for some time, particularly in general practice and some specialist services such as obstetrics and gynaecology.
- Numbers of GPs in proportion to the population decrease significantly with greater remoteness, with the lowest supply to 'very remote' areas, particularly in New South Wales and Western Australia.
- In recent years, the medical workforce in rural and remote Australia has increased modestly, mostly due to restrictions on Medicare provider numbers for overseas trained doctors to encourage them to work in rural and remote areas of workforce shortage.
- One-third of doctors currently working in Australia were trained overseas.
- The proportion of overseas trained doctors is significantly higher in rural and remote areas where 41% of all doctors have trained overseas."

Attachment 1 contains further data on medical workforce distribution.

In terms of inter-regional movements, there are no impediments to the free movement of the Australian workforce between different States and Territories. Factors that may contribute to health worker movement include:

- Pay scale differences and issues related to private/public practice
- Inter-state disparities – rates of pay, financial incentives/disincentives.

What measures have been taken to optimize the scopes of practice of the various health professions to increase the self-sufficiency of your country's health workforce?

The self sufficiency goal in the Framework applies to all health occupations. Strategies to optimise workforce productivity and scope of practice similarly extend across the workforce. Role or scope of practice measures that may contribute to medical workforce sustainability include:

- Increased use of nurse practitioners. A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice. (Australian Nursing and Midwifery Council, 2006).
- Physician assistants – Queensland, South Australia and Western Australia are trialling a physician assistant role to expand the capacity of the medical workforce
- Practice nurses assist general practitioners by contributing to a range of services, including chronic disease management and population health activities, to improve prevention and management of chronic disease and to reduce workforce pressure in general practice. Employing practice nurses has enabled general practitioners to spread their workload, allowing them to focus on more complex cases.
- Since 2006, GPs, psychiatrists and paediatricians have been able to directly refer patients with mental disorders to clinical psychologists, psychologists, social workers and occupational therapists for Medicare-rebatable services.

Identify strategies to ensure optimal use of the medical workforce through the various stages of their careers (e.g. late-career initiatives)

Australia has an ageing population and a shrinking labour pool. The Australian Government has recognised the importance of extending working life, and has introduced a number of policy initiatives to strengthen workforce participation amongst older Australians (Department of Treasury 2007).

In relation to the medical workforce, Australia has been studying the career intentions of postgraduate doctors, to assist in the targeting of medical workforce strategies. The first study was conducted in 2002, repeated in 2004, and to be repeated again in 2009.

National strategies currently tend to focus on the beginning and end of medical careers, rather than the mid career period. There are a range of strategies focused on achieving better geographic distribution of new medical graduates. Other national strategies are currently focusing on late career safety to practice, given the ageing demographics of the Australian medical workforce. For example, Australia is establishing a national registration and accreditation scheme for a number of health occupations including doctors, to replace the current registration legislation in each State and Territory. The national scheme will provide an opportunity to standardise requirements for continuing competency of practitioners. However, career stage specific strategies may be operating at the state and territory level.

When providing IMG data, provide a breakdown of foreign nationals who are trained internationally and recruited to the country as compared to nationals who are trained internationally.

The majority of IMGs take up positions as general practitioners in outer metropolitan or rural and remote areas, and in hospitals as junior medical officers and registrars (Medical Training Review Panel). It is difficult to determine the exact number of IMGs in Australia, as there is no single source of data. There are difficulties distinguishing between IMGs who are citizens or permanent residents and considered to be part of Australia's permanent population and workforce, and those working in Australia on temporary visas (Lennon 2005).

Australia has two key sources of data on IMGs – from the Medical Registration Boards and the Australian Institute of Health and Welfare Medical Labour Force Survey.

Numbers of IMGs

The following numbers of IMGs were compiled from medical registrations reported by Medical Registration Boards and Councils in their 2005-06 Annual Reports. They show that in 2005/06 IMGs comprised 13.42 % of the total Australian medical workforce, reflecting that Australia still has a significant reliance on IMGs.

	WA	TAS	QLD	VIC	NSW	SA	ACT	NT	Total
General	6659	1991	8447	16596	23253	5623	1894	1329	65792
IMG's	1223	367	1872	2596	2843	998	150	149	10198
Total	7,882	2,358	10,319	19,192	26,096	6,621	2,044	1,478	75,990
	15.52%	15.56%	18.14%	13.53%	10.89%	15.07%	7.34%	10.08%	13.42%

Data from the 2006 AIHW Medical Labour Force Survey (unpublished)

In the 2006 AIHW Medical Labour Force Survey, the country of first medical qualification was collected from employed medical practitioners in all jurisdictions for the first time. However, there are limits on the data. It covers all employed medical practitioners, including those who have been resident in Australia for many years and have general registration, in contrast to conditionally registered medical practitioners who are either in Australia temporarily or seeking general registration.

As conditionally registered medical practitioners are not included in the survey population in Queensland and conditionally registered non-specialists are not included in Tasmania, care should be taken in interpreting the data on country of first qualification.

Western Australia had the highest proportion of employed medical practitioners who stated that they had obtained their first qualification in a country outside of Australia (34.8%), whilst Victoria had the lowest (18.3%).

Employed medical practitioners: country of first qualification, states and territories, 2006

Country of first qualification	NSW	Vic	Qld ^(a)	WA	SA	Tas ^(a)	ACT	NT ^(b)	Total
Australia	16,204	13,438	7,749	4,080	3,829	1,029	971	625	47,925
New Zealand	600	350	314	191	79	34	53	18	1,640
UK/Ireland	895	637	766	870	249	116	75	95	3,702
Other countries	3,390	2,022	911	1,118	888	170	216	96	8,811
Not stated	91	38	34	57	65	2	25	32	342
Total	21,180	16,485	9,774	6,315	5,111	1,350	1,340	866	62,421
% Australian trained	76.8	81.7	79.6	65.2	75.9	76.3	73.8	74.9	77.2

(a) The number of medical practitioners in Queensland and Tasmania are underestimates as the benchmark figures did not include all registered medical practitioners (see Appendix A).

(b) Northern Territory estimates for 2006 are based on responses to the 2007 Medical labour force survey weighted to 2006 benchmark figures, giving an estimated response rate of 28.6%. Care should be taken when interpreting these figures.

Source: AIHW Medical Labour Force Survey 2006.

What means have been adopted to integrate IMGs into the educational and practice environments in your country?

Australia has adopted a range of approaches to integrate IMGs into the educational and practice environments. The approaches vary according to location, immigration status and specialty. Individual State and Territory Health Departments have developed their own induction and orientation programs.

All IMGs must be registered with one of the State or Territory's medical registration boards. Registration involves an assessment of qualifications, language proficiency and experience, in relation to their medical position and role. Registration may be approved subject to conditions (MTRP 2007).

In 2006 the Council of Australian Governments agreed to establish nationally consistent assessment of IMGs, with different pathways for specialists and non specialists. The scheme is in the process of being implemented, and elements include:

- Standardised pre-employment assessment, including an off-shore screening examination
- Assessment of competence against a standardised position description and, if necessary, a structured clinical interview by an AMC-accredited provider before obtaining limited registration
- Orientation to the job, the Australian health care system and to communication and cultural issues
- Standardised supervision and supervisory reporting
- A requirement for compulsory continuing professional development for re-registration
- Workplace-based assessment
- Assessment by an AMC-accredited provider before gaining full registration and
- Consistency of assessment for specialists by specialist colleges.

How have immigration regulations and patterns in your country impacted on the flow of trainees and fully qualified doctors?

Similar to medical school intakes, the approach to immigration regulation and patterns has varied depending on the extent of medical workforce shortages, and perceptions of over or under supply.

According to the Department of Immigration and Citizenship's website www.immi.gov.au Australian employers may sponsor medical practitioners from overseas for temporary entry of up to four years to fill positions that cannot easily be filled by an Australian doctor through 457 or 422 visas.

Doctors have been able to apply for the Temporary Business Long Stay visa (subclass 457) since April 2005. This visa allows applicants to take advantage of streamlined processing arrangements which include the ability to lodge applications over the internet using a special online application form.

The subclass 422 Medical Practitioner visa is still available as an alternative temporary entry visa for doctors. This visa is appropriate in certain situations, such as where a rural community or local council is seeking to sponsor a doctor to work in a sole person practice without a direct employer.

Applicants for temporary entry need to possess appropriate qualifications and at least have conditional registration to work in Australia as a medical practitioner. Medical practitioners with full medical registration may also be eligible to apply for permanent residence under any of the General Skilled Migration categories.

Medical practitioners were placed on the Skilled Occupation List and the Migration Occupations in Demand List in 2004.

Other distributional measures include restrictions on area of practice for IMGs working in private practice through the *Health Insurance Act 1973*. Section 19AB of the Act requires the medical practitioner to work in an Area of Workforce Shortage for a period of up to ten years. As at February 2008, there were 4 669 IMGs, including GPs and specialists, with current section 19AB exemption status according to the Department of Health and Ageing (2008, 13).

Salaried medical practitioners working in the public or private sector do not require a Medicare provider number and are not identified in Medicare data (Department of Health and Ageing, 36).

What prognosis can you offer in terms of the likelihood of achieving self-sufficiency and what approaches/priorities can you recommend?

Substantial progress has been made towards achieving medical workforce self sufficiency in Australia over the last few years. However, more remains to be done. The current initiatives to expand supply and optimise the scope of practice of the health professions will continue to be policy directions in the short to medium term. In addition, the major national policy reviews currently underway may establish new directions to contribute to progress towards self sufficiency. Finally, the Council of Australian Governments has agreed to ask the Productivity Commission to undertake a further review of the health workforce by July 2011 which will review the success of these initiatives.

5. Discussion of the findings

Issues for the future

In Australia, self sufficiency must be viewed as much on a distributional basis as on a whole of country approach. Australia is exploring a range of solutions to move it towards health workforce self sufficiency. Some strategies focus specifically on the medical workforce, whilst others consider the health workforce as a whole. Many strategies have their genesis in the Productivity Commission's 2005 report on Australia's health workforce and are currently being implemented by the Council of Australian Governments (Productivity Commission 2005).

The supply and distribution of skilled health professionals has been constrained by ongoing problems of recruitment, training and retention within existing models of care. Microeconomic reform of the health workforce including inter-disciplinary teams and fully utilising workforce skills and knowledge has potential to improve capacity, maximise productivity and increase the efficiency, effectiveness and responsiveness of the workforce. To date, Australia has not explored this path in the way that a number of countries already have. Future health workforce policy directions are likely to continue to focus on these goals and opportunities.

Allowing greater role substitution to occur within the health workforce through greater use of advanced practitioners, and potentially the introduction of new health workers assistants, would improve service delivery capacity. This would also allow highly trained medical practitioners to focus their work on tasks that require their level of expertise rather than performing services that could more sensibly and cost effectively be provided by other health workers. Work roles may be reviewed and redesigned across or within traditional professions:

- Within a traditional profession, the focus will be on delegating more technical/less skilled tasks so that professional staff can focus on applying their high level skills more consistently and/or take on more challenging roles. This approach requires the development of competency-based training for new support roles, and may require advanced-level training for professional staff.
- The second approach to workforce change will be to develop composite roles tailored to service streams, combining competencies currently viewed as belonging to different professions. This involves an exploration of the possibility of new roles, often linked to the development of new models of care delivery.

In addition to existing strategies, there is potential for new approaches to emerge from broader health system reforms. The recently elected Australian federal Labor government has signalled a significant change in policy direction and announced a long-term program for reform of the Australian health system. A number of the reform areas have an explicit focus on utilisation of the health workforce, and may contribute to workforce self sufficiency.

- The National Health and Hospitals Reform Commission is developing a long-term health reform plan which will address a range of specific issues, including the need to provide a well qualified and sustainable health workforce into the future. The Commission has noted critical shortages of many health professionals, often exacerbated by skewed distribution of services and providers, poor morale and retention and rigid adherence to narrow professional roles.
- The federal government is developing a Primary Health Strategy, including an examination of workforce roles
- The federal government has established a Preventative Health Taskforce, and signalled that its strategy will be central to improving workforce participation and productivity
- The federal Department of Health and Ageing is developing a Rural Health Strategy and there have been indications that it will incorporate workforce initiatives

- A new Australian Health Care Agreement for health funding is being negotiated between the Commonwealth and State and Territory Governments, and the Commonwealth Government has signalled that this is an opportunity for reform.

Despite the increases in medical school places that have already occurred, further increases are likely to be required to achieve medical workforce self sufficiency once a better understanding is reached on the international flow of medical practitioners. This will need to be accompanied by a significant increase in clinical training capacity. In the meantime, other reforms and strategies such as optimising the scope of practice of other health professionals also have potential to contribute towards medical workforce self sufficiency.

Attachment 1 - Data

Medical Registration Board data

Of the medical registrations reported by the boards and councils in their 2005–06 annual reports, 83.3% were reported as general registrations and 16.7% as conditional/limited/non-general registrations. The proportion of general registrations varied across jurisdictions, from 79.0% in Tasmania to 86.6% in Queensland.

General and conditional medical practitioner registrations reported by state and territory registration boards, 2005–06

Registration type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	Number								
General registrations	22,630	16,014	12,744	6,465	5,586	1,926	1,894	1,307	68,566
Conditional registrations	5,288	3,174	1,973	1,178	925	511	398	276	13,723
Area of need registrations	249	150	1,311	538	190	n.a.	n.a.	159	2,597
Total registrations	27,918	19,188	14,717	7,643	6,511	2,437	2,292	1,583	82,289
	Per cent of total registrations								
General registrations	81.1	83.5	86.6	84.6	85.8	79.0	82.6	82.6	83.3
Conditional registrations	18.9	16.5	13.4	15.4	14.2	21.0	17.4	17.4	16.7
Area of need registrations	0.9	0.8	8.9	7.0	2.9	n.a.	n.a.	10.0	3.2

Sources: State and territory medical registration board annual reports. The Northern Territory provided the information via correspondence.

IMG Numbers

	WA	TAS	QLD	VIC	NSW	SA	ACT	NT	Total
General	6659	1991	8447	16596	23253	5623	1894	1329	65792
IMG's	1223	367	1872	2596	2843	998	150	149	10198
Total	7,882	2,358	10,319	19,192	26,096	6,621	2,044	1,478	75,990
	15.52%	15.56%	18.14%	13.53%	10.89%	15.07%	7.34%	10.08%	13.42%

Australian Institute of Health and Welfare Medical Labour Force Report

The following information on the medical practitioner labour force is based primarily on estimates derived from the 2006 Australian Institute of Health and Welfare (AIHW) Medical Labour Force Survey. This survey collects information on the demographic and employment characteristics of medical practitioners registered in Australia. It is conducted annually by state and territory health departments, with the questionnaire administered by the medical registration boards in each jurisdiction, in conjunction with the registration renewal process.

The main findings of the report are:

- In 2006, there was an estimated 71,734 medical practitioners registered in Australia and most of these (62,421 or 87.0%) were working in medicine in Australia. The other 13.0% were on extended leave, not working, working in an area other than medicine or working in medicine overseas. The number of employed medical practitioners in 2006 was 15.6% higher than in 2002 (62,421 compared to 53,991 respectively).
- Most employed medical practitioners working in medicine in 2006 were clinicians (93.2%), of whom 39.5% were primary care practitioners, followed by specialists (34.8%), specialists-in-training (13.1%), hospital non-specialists (11.3%) and other clinicians (1.3%).

- The average age of medical practitioners in 2006 was 46.1 years, compared with 46.6 years in 2002.
- Females continue to increase their share of the medical practitioner workforce. In 2006, 33.7% of medical practitioners were female, compared with 31.6% in 2002. The female share varied considerably within the medical workforce. In 2006, 21.6% of clinical specialists (and 7.9% of clinical surgery specialists) were female. In comparison, 40.9% of clinical specialists-in-training and 48.9% of clinical hospital non-specialists were female.
- Registered practitioners employed in medicine who identified themselves as Indigenous represented about 0.3% of registered practitioners employed in medicine in 2006.
- Medical practitioners worked an average of 43.3 hours per week in 2006, a decrease from 44.4 hours per week in 2002. In 2006, on average, 39.9 hours were in clinical work, an increase from 39.6 hours in 2002. Female medical practitioners worked fewer hours, on average, than their male counterparts (37.6 hours per week compared with 46.2).
- Despite a decrease in average total hours worked from 2002 to 2006, the supply of employed medical practitioners increased from 271 to 290 Full-Time Equivalent (FTE) medical practitioners per 100,000 population over that period. The supply of primary care practitioner clinicians decreased between 2002 and 2006, from 101 to 97 FTE per 100,000 population.
- In 2006, in Major cities, there were 332 FTE medical practitioners and 98 FTE primary care practitioner clinicians per 100,000 population. In comparison, the respective rates for Inner regional areas were 184 and 87 FTE; in Outer regional areas, 154 and 86 FTE; and in Remote/Very remote areas, 191 and 108 FTE.

Labour force status	NSW	Vic	Qld ^(b)	WA	SA	Tas ^(b)	ACT	NT ^(c)	Australia
Employed in medicine in this state	21,180	16,485	9,774	6,315	5,111	1,350	1,340	866	62,421
On extended leave	357	305	142	55	57	31	16	18	980
Employed in medicine overseas	1,430	771	422	172	169	39	39	21	3,062
Employed elsewhere, not in medicine	373	185	65	50	59	20	24	21	798
Not employed	1,304	339	178	378	256	105	151	37	2,748
Retired	470	536	240	225	149	47	44	14	1,725
Total registered	25,113	18,621	10,821	7,196	5,800	1,592	1,615	977	71,734
Percentage of practitioners employed in medicine	84.3	88.5	90.3	87.8	88.1	84.8	83.0	88.6	87.0

The number of clinicians grew by 16.6% from 49,895 in 2002 to 58,163 in 2006. This is equivalent to an increase of 22 clinicians per 100,000 population (from 254 in 2002 to 281 in 2006).

The average age of clinicians decreased slightly over the five year period, from 46.3 years in 2002 to 45.7 years in 2006. The proportion of clinicians who were females rose over the same period, by 2.3 percentage points, to 33.8% in 2006.

Growth in the number of primary care practitioners from 2002 to 2006 was relatively small (5.2%) compared with that for other clinicians. The number of Royal Australian College of General Practitioners (RACGP) trainees increased by 67.6% over the same period. Hospital non-specialists and specialists-in-training, in particular, experienced relatively high rates of growth (35.9% and 39.4% respectively). The number of specialists rose by 14.1% from 2002 to 2006.

Specialists-in-training

The number of specialists-in-training increased by 39.4% between 2002 and 2006, from 5,474 to 7,632 (Table 5). This equates to a rise of 6 per 100,000 population to 34 per 100,000 in 2006 (Table 6). Trainee numbers in surgery rose by 64.3% while trainees in internal medicine increased by 49.5%.

In 2006, 40.9% of specialists-in-training were females, almost double the proportion of specialists. The average age of specialists-in-training (33.0 years in 2006) was relatively young compared to specialists and primary care practitioners.

Overall, the proportion of specialists-in-training who were females remained relatively steady (41.0% in 2002 and 40.9% in 2006). However, between 2002 and 2006, the proportion of trainees in surgery who were female increased from 16.0% to 19.8%.

Australian Medical Council data

The number of IMGs presenting for Stage 1 of the Australian Medical Council's Multiple Choice Questionnaire exam increased from 544 in 2003-04 to 1 819 in 2006 -07 (a 234.4% increase). (MTRP 11)

Countries in which most IMGs have trained prior to entering general practice in rural and regional Australia include South Africa, Nigeria, India, Pakistan and Sri Lanka. (Audit p 36)

Department of Immigration and Citizenship data

According to the Department of Immigration and Citizenship, data on nominated occupations for visa grants in 2007/08 for General Medical Practitioners show 1 630 in 2006/07 increasing to 1 990 in 2007/08, a 22% increase. However care needs to be taken in interpretation because applicants were previously encouraged to apply under another visa category (422).

In the category of Medical Practitioner In Training there were 1 290 applications in 2006/07 increasing to 1 320 in 2007/08, an increase of 2%.

Data on the Top 15 Nominated Occupations for Primary Visa Holders in Australia as at 02 July 2008 for General Medical Practitioners by State and Territory

ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Not Spec	Total
40	830	120	320	140	50	670	150	0	2 310

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