Supp. Submission No. 107.1
(Overseas Trained Doctors)
Date: 24/02/2011

Rural Health Workforce Australia

Submission to the Health Standing Committee

Parliamentary Inquiry into Overseas Trained Doctors

The 10-Year Moratorium

11 February 2011

This submission has been prepared by Rural Health Workforce Australia (RHWA). Rural Health Workforce Australia manages national programs that tackle the shortage of doctors and other health workers in rural and remote communities. This includes the recruitment of Australian and overseas trained doctors, locum support and encouraging university students to pursue rural health careers. A not-for-profit organisation, RHWA is also the peak body for the state and territory Rural Workforce Agencies.

Please contact Dr Kim Webber for further information.

Dr Kim Webber
Chief Executive Officer
Rural Health Workforce Australia
Suite 2, Level 5
10 Queens Road
Melbourne VIC 3004
Tel: 03 9860 4700

Glossary

19AB Exemption - *an exemption to the provisions of section 19AB of the Health Insurance Act 1973 which prohibits overseas trained doctors from participating in Medicare*

10-Year Moratorium - *the terms of the 19AB Exemption which permits international medical graduates to participate in Medicare providing the practice is in a district of workforce shortage, for a maximum of 10 years*

5-Year Overseas Trained Doctors Scheme - *a scheme which provides participating overseas trained doctors with a reduction in the 10-Year Moratorium for practising in the most challenging clinical settings*

AA - Additional Assistance Scheme - *a scheme which provides participating doctors with educational assistance to support them to achieve fellowship of either ACRRM or the RACGP*

AHPRA - Australian Health Practitioner Regulation Agency

AMC - Australian Medical Council

AMG - Australian Medical Graduate

ACRRM - Australian College of Rural and Remote Medicine

AoN - Area of Need

CS – Compulsory Service Scheme – *also known as community service scheme in some countries*

DoHA – Department of Health and Ageing

DWS - District of Workforce Shortage

GP - General Practitioner

GP Registrar - doctor undergoing training in general practice

IMG - international medical graduate – *also known as OTD or overseas trained doctor*

MPC - Multipurpose Centre

MBS - Medicare Benefits Schedule

OTD - overseas-trained doctor - *also known as IMG or international medical graduate*

RA – remoteness area – *Australian Standard Geographical Classification Remoteness Areas (ASGC-RA)*

RACGP- Royal Australian College of General Practitioners

RWA - Rural Workforce Agency

RHWA - Rural Health Workforce Australia

VR - Vocational Recognition

WHO - World Health Organization

Executive Summary

International medical recruitment continues to be central to Australia's efforts to redress rural health inequality. The 10-Year Moratorium (Moratorium) remains the key policy instrument by which international medical graduates (IMGs) are directed to regions that suffer the highest levels of health disadvantage. It is a practical necessity in an era of increasing urbanisation which sees rural communities worldwide suffering intractable health workforce shortages.

In summary, the main reasons for endorsing the continuation of the 10-Year Moratorium are:

1. The IMG recruitment strategy, and by implication the Moratorium, has been successful in increasing the number of general practitioners (GPs) practising in rural Australia. Department of Health and Ageing GP statistics reported 5,886 rural/remote GPs were participating in Medicare in 2000/01 and there were 7,385 GPs participating in 2008/09. This is an increase of 1,499 of which 82% (n.1,240) can be attributed to IMGs[1]. The GP to population ratio in rural Australia has improved markedly over this period and this is largely due to the influx of IMGs into these regions (refer Figure 2).
2. Compulsory rural service (CS) schemes such as the 10-Year Moratorium are a practical necessity in the absence of better alternatives. The World Health Organization report of 2010 alluded to 70 countries that have operated CS schemes to ensure rural health services are available[2].
3. IMG recruitment is beneficial for the nation and the medical profession. A diverse multi-racial health workforce is consonant with the composition of the Australian population in general. It is highly appropriate that the demographics of the health workforce fully reflect that of the community it serves.
4. Rural practice for IMGs is generally a positive and rewarding experience. To illustrate this, of the 96 IMGs who completed the 5-Year Overseas Trained Doctors Scheme in Western Australia, 70 of them are still practising rurally, that is 73%[3]. This is suggestive of a high degree of satisfaction.

Health disadvantage persists in rural Australia with people in these regions experiencing higher burdens of chronic illness and lower life expectancy. From 2004 to 2006 there were approximately 4,600 excess deaths outside of major cities - that is, deaths above the number expected if these rural areas had the same death rates as the major cities[4]. While mortality rates across all parts of the country fell steadily between 1997 and 2006, the mortality gap between the major cities and other areas remained fairly constant. The challenge of rural health inequality is set to continue and IMG recruitment and the 10-Year Moratorium are needed as part of the nation's ongoing policy response.

While a rigorous evaluation is yet to be undertaken of the efficacy of the 10-Year Moratorium, and while such CS schemes may not afford a permanent workforce for underserved groups, it is clear that they do have a role in Australia's plan for health workforce development and equitable distribution.

[1] Department of Health and Ageing 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table15.csv>.
[2] Frehywot et al. 2010, 'Compulsory service programmes for recruiting health workers in remote and rural areas: Do they work?, *Bulletin of the World Health Organization*, vol. 88, no. 5, <http://www.scielosp.org/scielo.php?pid=S0042-96862010000500014&script=sci_arttext&tlng=en>.
[3] Refers to a study conducted by RHWA to inform DoHA as to the level of rural retention associated with the 5 Year OTD Scheme (2010).
[4] Australian Institute of Health and Welfare 2010, Australia's Health 2010, Australia's health series no. 12, Cat. no. Aus 122. Canberra, p. 245.

Introduction

This submission has been prepared by Rural Health Workforce Australia for the Parliamentary Inquiry into Overseas Trained Doctors (OTDs aka IMGs). It specifically addresses the role of the 10-Year Moratorium (the Moratorium) in ensuring that rural Australians have adequate access to general practitioner (GP) services. The 10-Year Moratorium, as it has come to be known, is related to section 19AB of the Health Insurance Act 1973.

"Section 19AB of the Act applies to overseas trained doctors and foreign graduates of an accredited medical school (FGAMS) who gained their first medical registration on or after 1 January 1997. Section 19AB of the Act restricts their access to Medicare provider numbers and requires them to work in a 'district of workforce shortage' *(DWS) in order to access the Medicare benefits arrangements. OTDs and FGAMS who are subject to section 19AB of the Act are generally required to work in a DWS for a minimum period of ten years from the date of their first medical registration[5]".*

The 10-year Moratorium is the policy instrument used by the Australian Government to direct recruited international medical graduates (IMGs aka OTDs) to rural practice locations. It puts effect to the Government's strategy to engage IMGs to help remedy the maldistribution of GPs which sees rural communities underserved in terms of access to primary medical services.

Importantly, while the Moratorium is a key policy enabler, any future review of its effectiveness needs to be undertaken with reference to the other 'levers' currently employed by Government to reduce the maldistribution of GPs across Australia, namely:

- Education interventions e.g. Establishment of Rural Clinical Schools, Rural Medical Bonded Scholarships, etc.
- Regulatory interventions e.g. 19 AB Provider Number exemptions.
- Financial incentives e.g. Rural GP Retention Payments, Rural Relocation Payments, HECS Reimbursement Scheme, Rural Practice Incentives, Rural Other Medical Practitioner Scheme, Infrastructure Grants, etc.
- Workplace supports e.g. Rural Workforce Agency practice support services, GP Divisions Rural Practice Support Programs.

Therefore, the 10-Year Moratorium should be viewed as part of an inter-related suite of longstanding policy interventions. No single strategy can work on its own. Without all of these elements in place, effective distribution of the workforce will not occur. However, IMG recruitment to the 10-Year Moratorium should be viewed as the single most effective strategy for tackling rural and remote workforce shortages (refer Figure 1).

[5] *Work as a doctor in Australia* 2010, Department of Health And Ageing, <www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-s19AB%20factsheet-factsheet>.

Preamble

With the acceleration of urbanisation across developed and developing countries, rural communities are struggling worldwide to retain essential services. The experience in Australia mirrors that of many other geographically large countries, with nations across the globe struggling to meet the challenges of sustaining essential human services to highly distributed rural populations. Countries like Australia, Canada, North America, China and Brazil, with vast land masses are particularly challenged in maintaining the basic fabric of health services. Paradoxically the challenge of service provision applies not only to areas in decline but also to the new conurbations that are springing up to accommodate those migrating from the rural areas. In China, the number of cities has grown from 136 in 1949 to 666 in 1998 and reportedly twenty new cities continue to be constructed each year[6]. In Australia the flamboyant population growth rate in the capital cities is another expression of this global trend toward the mega-city. These rapid population movements constitute serious political, policy and environmental challenges for all - those left in the regions and those in cities aspiring to a higher standard of living. Those moving to a city have a heightened expectation of access to services which is often unrealised as provision lags well behind population growth. The resources boom in Australia incurs another challenge for policy makers as health services in remote mining regions in Western Australia and Queensland experience overwhelming population pressures. Mining communities are increasingly in competition with established farming areas for a scarce rural GP workforce.

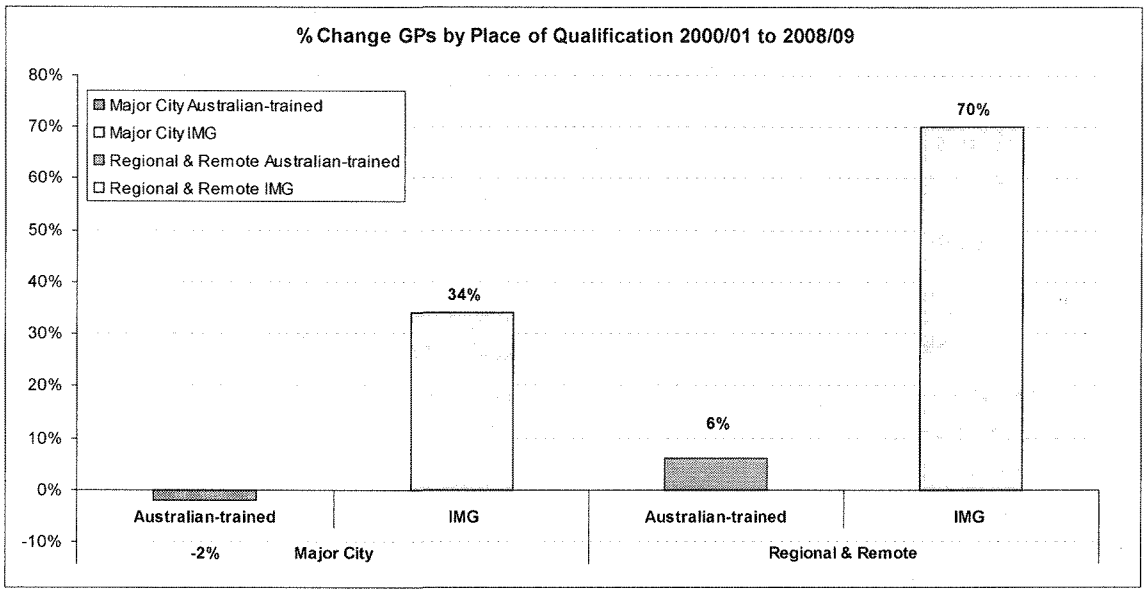
Urbanised communities with their higher population densities afford economic efficiencies and convenience in terms of access to business, employment, health, education, social and cultural opportunities. In the face of rural decline, professions of all kinds have experienced increasing difficulty in retaining the critical levels needed for sustainable service delivery. For decades rural communities across Australia have lamented the demise of their banks, schools, law firms and perhaps most regrettably, their hospitals and GP practices. While this submission focuses on health services it is important that policy makers contextualise their thinking in terms of the wider economic, social and demographic trends that are contributing to global rural decline. This is particularly important when one considers the emerging national and international market for healthcare providers including doctors, nurses and allied health professionals. Policy interventions that fail to appreciate the inter-relatedness of what is a complex web of factors will have limited success. As experience has shown with the recruitment of overseas trained doctors to rural towns, retention requires consideration of a host of factors with no direct or apparent linkage to health services namely, spousal employment, children's schooling, community acceptance, etc. Likewise, the movement of health professionals between countries is impacted by factors which are often unclear and not amenable to influence by one nation in isolation. No doubt social anthropologists would be able to offer insights into why peoples worldwide develop aspirations which are best pursued in cities.

[6] Chaolin et al. 1998, 'Growth of new designated cities in China', *Chinese Geographical Science*, vol.9, no.2, pp. 97-106.

The contribution of overseas trained doctors to the rural GP workforce

Beyond the cultural enrichment which ensues when people from other countries join the Australian community it is apparent that overseas trained doctors continue to make a vital contribution to the wellbeing of the Australian community. Increasingly, international medical graduates (IMGs) are becoming the new mainstay of the GP workforce in regional centres, and rural and remote settings. The following graphs evidence a trend which may see a fully internationalised GP workforce in rural Australia within 25 years with retiring rural GPs almost exclusively replaced by IMGs. Of the 1,452 additional GPs in regional, rural and remote areas between 2000/01 and 2008/09 (n. 1,196) 82% were IMGs. In 2000/01 IMGs constituted 30% of the rural GP workforce and in 2008/09 this had increased to 40%. The trend is mirrored in the cities but the rate of change is slower at 34% compared with 70% in regional and remote areas.

Figure 1: % Change GPs by Place of Qualification 2000/01 to 2008/09[7]



Thus a profession-wide trend is emerging which may see IMGs comprising the majority of GPs in rural and urban Australia within a few decades. The extent to which this trend will be influenced by the increasing number of domestic GP training positions is unclear as the competition from medical specialities is also set to grow. Even with the increased GP Registrar intakes announced recently, the proportion of medical graduates 'allocated' to general practice will fall in comparison to the projected numbers entering the other hospital-centric medical specialties. The demand for doctors from all disciplines is set to burgeon as a result of population ageing.

[7] Department of Health and Ageing 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table%2018ra.pdf>.

The evidence suggests that international medical recruitment will continue to be crucial to efforts to sustain access to rural GP services. Indeed, without the influx of IMGs experienced over the past decade, rural health services would have been thrown into an extremely parlous state. Examples abound where IMGs have served to retain rural health services which otherwise would have proved unsustainable. The Government's 10-Year Moratorium has been central in directing the IMG workforce to the regions experiencing the worst shortages. Those advocating the removal of the Moratorium need first to consider the impact that this will have on those communities who have become wholly reliant upon a predictable and ongoing flow of IMGs.

Table 1, based on Medicare activity statistics and ABS population figures[8], shows that between 2001 and 2006 GP service access decreased by 3% nationwide. In 2001 there was one GP Fulltime Workload Equivalents (FWEs) for every 1,137 persons but in 2006 there was one GP FWE for every 1,173 persons in Australia - in crude terms each fulltime GP needed to look after an additional 36 people.

Table 1: GP Fulltime Workload Equivalents to Population by Remoteness Areas Census 2001 and 2006

	RA 1	RA 2	RA 3	RA 4	RA 5	Total
2001	999	1,459	1,606	1,909	3,441	1,137
2006	1,101	1,301	1,425	1,614	2,490	1,173
% Change	-10.2%	10.8%	11.2%	15.5%	27.6%	-3.2%
Access Impact	Decreased	Increased	Increased	Increased	Increased	Decreased

Note: RA 1 = Major Cities, RA 2 = Inner Regional, RA 3 = Outer Regional, RA 4 = Remote, RA 5 = Very remote

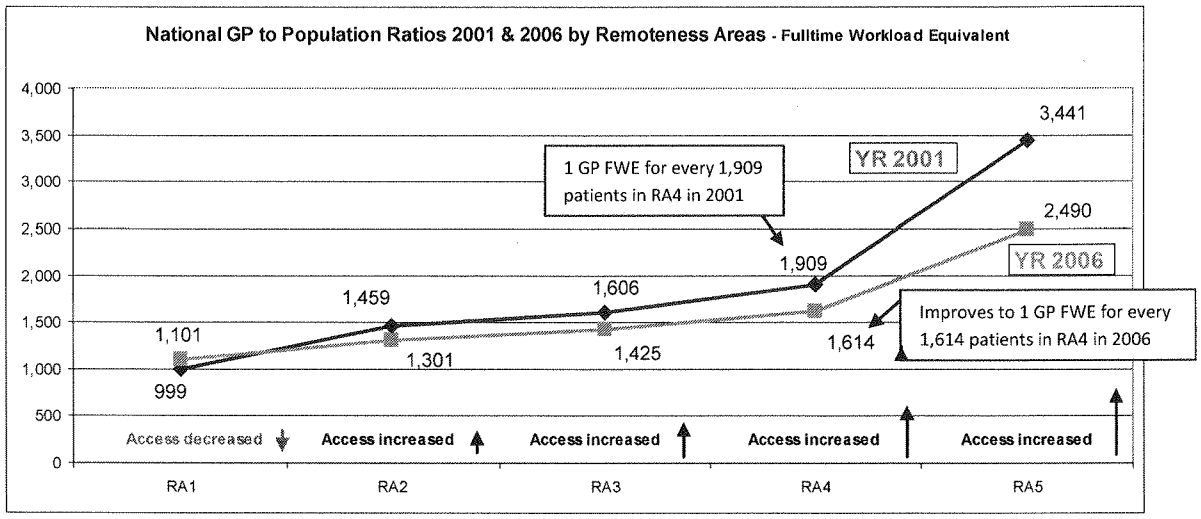
This was the result of a 10% decline in FWEs[9] to population ratio in the major cities. Figure 2 (below) shows that all rural remoteness areas (RA 2 to 5) categories experienced significant growth in access. However in 2006, they all still have noticeably less access than the capital cities (RA 1). The improvements in GP access in RA category 2 to 4 locations can be attributed, to the greater part, to the increase in IMGs practising in rural areas. The increase in access in RA 5 is perhaps more attributable to an increase in the number of Australian-trained GPs working in the most remote locations although the ratios for RA 5 need to be construed with caution[10].

[8] Department of Health and Ageing 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table%2018ra.pdf> & Australian Bureau of Statistics, Census 2001 and 2006, Population by Remoteness Areas <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008>.

[9] Full-time Work Equivalent (FWE) is a measure of service provision maintained by Medicare Australia that takes into account doctors' carrying workloads. It is generally considered to provide a good overall indicator of medical workforce supply. FWE is calculated by dividing each doctor's Medicare billing by the average billing of full time doctors for the reference period.

[10] Some commentators have expressed concern that Medicare billings as a measure of GP activity in RA5 is erroneous given the level of GP services that are funded by other mechanisms including Aboriginal Community Controlled Health Organisations, Royal Flying Doctor, etc.

Figure 2: National GP Population Ratios by Remoteness Areas (Fulltime Workload Equivalent)[11]



Note: RA 1 = Major Cities, RA 2 = Inner Regional, RA 3 = Outer Regional, RA 4 = Remote, RA 5 = Very remote

It would appear that the high rate of population growth in the capital cities (10%-15% every 5 years), and associated patient demand, will continue to outstrip the current level of growth in urban GP numbers. Between 2006 and 2009 the increase in GP numbers in RA 1 was 6% compared with an estimated growth of general population of about 10% (1.7 million people). Importantly, virtually all nett growth in GP numbers in RA 1 and RA 2 locations in the last 10 years is also attributable to IMGs.

These data further highlights the nation's reliance on international medical graduates to not only improve access to services in rural areas but also to meet the needs of a growing urban population.

The state of rural health in Australia in 2011

People living in rural and remote areas of Australia have lower levels of access to GPs and other primary health care services than their urban counterparts and the demand for services continues to outstrip supply. Rural and remote communities have higher rates of sickness suggesting the need for higher levels of access to primary care services. From 2004 to 2006, there were about 4,600 'excess' deaths in rural areas when compared with the death rates in the major cities. While the mortality rate continues to decline steadily across all regions of Australia, the mortality gap between rural and urban areas has remained fairly constant at about 10%. People living outside major cities are much less likely than their city counterparts to report their health status as excellent or very good.[12] Health inequality is particularly the case for indigenous Australians but living in a rural area is a risk factor in itself.

[11] Some commentators are of the view that Medicare activity understates the level of GP services being provided in RA 5 (Very Remote) locations. Many GP-style services are funded by non-Medicare arrangements in Aboriginal Medical Services. As such the GP to population ratio for RA 5 should be viewed with caution.

[12] Australian Institute of Health and Welfare 2010, Australia's Health 2010, Australia's health series no. 12, Cat. no. Aus 122. Canberra, pp. 245-248.

The lack of access to health services in rural areas impacts upon the whole health care system through higher rural and remote rates of preventable hospitalisations[13]. Rural people also suffer additional travel and accommodation costs when accessing urban-based services and may well incur lost earnings. There are many reasons why it is in the nation's interest to reduce health inequalities including economic and social cohesion concerns.

Although the number of GPs practising in rural and remote areas has grown over the past nine years, the rise has not been sufficient to remedy the much lower GP to population ratios evident in small rural and remote communities. Worryingly some small communities have lost their GPs with little prospect of a replacement being found. This illustrates the somewhat arbitrary nature of shortages with some communities enjoying a small increase in GP numbers while others are totally without a resident GP. The age profile of rural GPs is likely to engender a new set of workforce challenges even in those communities currently experiencing reasonable service levels.

As Figure 1 shows, the increased number of GPs in rural Australia is almost totally attributable to the nation's success in recruiting IMGs. Despite the recent increase in domestic medical student numbers, rural Australia is likely to remain reliant upon IMGs for the medium to long term. This reliance brings with it certain obligations, including ensuring that IMGs are provided with appropriate orientation prior to undertaking practice in rural and remote Australia. Recent actions by the Council of Australian Governments have seen the introduction of national medical registration seeking to optimise professional practice standards in the interest of service quality and public safety. This increased focus on public safety needs to be accompanied by a commensurate focus on supporting IMGs to meet and maintain the necessary standards of clinical practice. Recent high profile cases of medical misadventure involving IMGs highlights the need to adequately assess all doctors before commencing in practice and better resourcing their transition into autonomous clinical practice in Australia. Sufficient evidence now exists to show that Australia's IMG assessment and support processes are in need of an overhaul. Such review is in the interest of IMGs and the communities that they are to serve.

The factors contributing to the declining level of Australian-trained rural GPs are complex and include:

- structural ageing of the rural GP workforce;
- inadequate numbers of medical graduates choosing general practice, and of those, fewer still choosing rural general practice;
- increasing numbers of GPs seeking to work part-time and this is generally not compatible with rural practice;
- solo and small group practices which predominate in rural areas are proving unattractive to new graduates and;
- the overall economic decline of some rural communities.

[13] Australian Institute of Health and Welfare 2010, Australia's Health 2010, Australia's health series no. 12, Cat. no. Aus 122. Canberra, pp. 245-248.

Health workforce shortages are now the single largest risk to the implementation of government health reforms seeking to improve the health status of people living in rural and remote Australia. It is therefore imperative that service and program plans consider workforce implications. Planning needs to recognise that in many rural and remote areas, primary health care service providers are also working in the aged care and acute care sectors. Therefore, cross-sector workforce planning will need to occur. As alluded to earlier, a strategy of recruiting overseas health professionals to rural Australia remains central to the nation's efforts to alleviate rural health inequalities. The Moratorium provides the legislative 'lever' which directs IMGs to these underserved and disadvantaged rural communities.

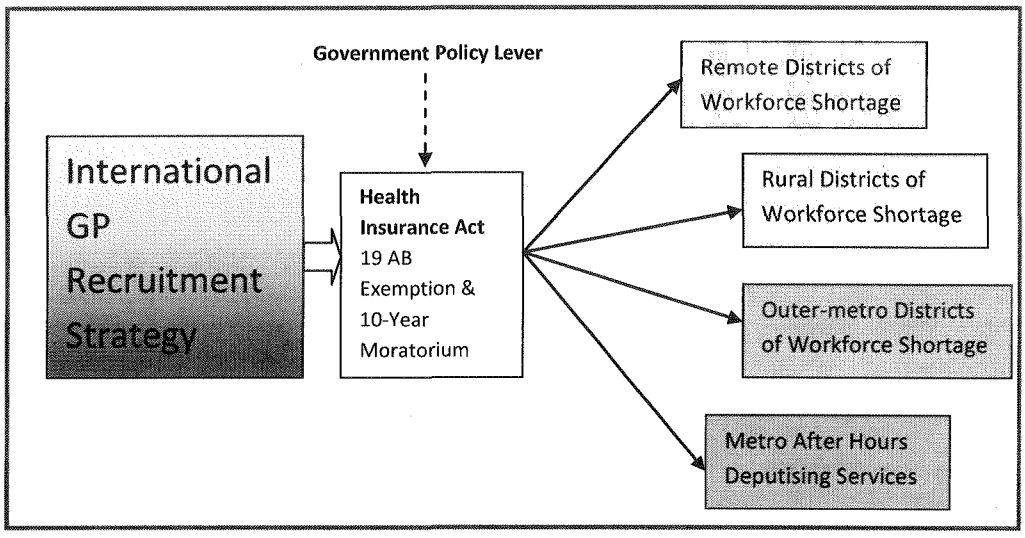
The philosophical underpinnings of the 10-Year Moratorium

Internationally, compulsory service programs such as the 10-Year Moratorium may be viewed as *"instruments of social justice, an exercise in health equity, in that they enable governments to direct or augment health services to geographical areas that are not well served and in communities that are not favoured by market forces and health worker preferences"*[14]. A literature review conducted by the World Health Organization identified over 70 countries with current or past compulsory service programs[15].

In those countries that require domestic graduates to undertake a service obligation the underlying premise is that the country has expended significant resources in their training and therefore a 'return of service' period is warranted. In Australia, the rationale for the introduction of section 19AB of the Health Insurance Act (known as the 10-Year Moratorium) remains open to historical conjecture but ostensibly it operates to constrain the practise of approved international medical graduates to underserved populations. By inference, the Australian Government is using its legislative powers to direct those overseas doctors desirous of living in Australia to those sections of the health economy unattractive to domestic graduates. As such it is a 'distributive' policy measure designed to work in conjunction with the nation's international recruitment strategy (refer Figure 3 below). It is important that the Moratorium is viewed as a policy enabler for the IMG strategy and not an end in itself. Any changes to the Moratorium need to be considered in tandem with the strategy it serves.

[14] Frehywot et al. 2010, 'Compulsory service programmes for recruiting health workers in remote and rural areas: Do they work?, *Bulletin of the World Health Organization*, vol. 88, no. 5, <http://www.scielosp.org/scielo.php?pid=S0042-96862010000500014&script=sci_arttext&tlng=en>.
[15] Ibid.

Figure 3: The 10-Year Moratorium as a policy enabler for the IMG strategy



The 5-Year Overseas Trained Doctors Scheme is related to the 10-Year Moratorium in that it 'discounts' the Moratorium period for those locations where recruitment and retention is found to be particularly problematic. The 19AB provisions and the Moratorium remain controversial in some quarters and this is discussed later in the submission under 'The Australian context'.

The international experience of dealing with medical shortages in rural areas

A World Health Organization (WHO) report published in 2010 notes that conditions of compulsory service (CS) programs often apply in countries where all health professionals are required to work for the government. In most of these countries the costs of training are fully covered by the tax-payer and as such a rural 'return of service' is considered reasonable. This WHO report observes how Australia adopted a type of CS program in 1999 when it legislated to require IMGs to work in 'districts of workforce shortage' as a condition of access to Medicare (i.e. the 10-year Moratorium).

Some countries like Australia apply incentives along with a compulsory service requirement. For example, countries such as Vietnam require medical graduates to practise in underserved areas as a prerequisite for entry to specialist training. Compulsory service arrangements linked to incentives include standalone or bundled initiatives involving educational, employment or living-provisions such as subsidised housing and vehicles. Countries including Malaysia, Mexico, Venezuela and Iraq require compulsory service but without incentives.

Outcomes for CS programs are generally not available with only Norway consistently measuring a variety of factors related to those who choose to remain in an underserved area after their service obligation has been discharged. However, this data has yet to be analysed. While retention outcomes are to the greater part unknown, evidence exists to show how compulsory service programs operate to increase access to medical services in underserved communities. Countries such as Thailand, South Africa, Puerto Rica and Mozambique report significant improvement in doctor access as a result of CS programs.

Frehywot et al. (2010) observe that internationally such programs are routinely criticised by health professional groups with complaints over substandard clinical infrastructure, poor or unsafe living conditions and inadequate educational facilities for children, etc. Another weakness associated with such schemes is the high turnover routinely encountered when participants complete their service period. Frehywot et al. (2010) suggest that high turnover is a 'given' with such schemes and cite the views of policy makers and strategists who state that 'service with predictable turnover is far preferable to no service at all'. Accusations that such schemes breach the individual's human right to exercise choice of employment location are often leveled but rebutted by the view that scheme participants are aware at the outset of their obligations. The Australian experience with CS schemes (i.e. the 10-year Moratorium) will be discussed in the next section.

The success (and failure) of compulsory service programs is thought to be associated with:

- The quality of planning associated with the scheme;
- The level of preparation that program participants receive (e.g. clinical skills);
- The level of supportiveness within the broader health system for program participants (e.g. access to mentors and/or supervision);
- Quality of expectation management;
- The consistency of enforcement; and
- Level of community support that participants experience.

Frehywot et al. (2010) stress the importance of supporting scheme participants with due consideration given to pay and conditions, housing, supervision, clinical back-up, etc. These may serve as a useful 'checklist' to assess the adequacy of Australian schemes including bonded scholarships.

As stated earlier no rigorous international evaluation has been undertaken of the efficacy of compulsory service obligations, and while such schemes may not afford a permanent workforce for underserved groups, it is clear that they do have a role in a nation's plan for health workforce development and equitable distribution. Omole et al. (2005), when studying the effects of their 'community service' scheme in rural hospitals in South Africa concluded that:

> *"Community service has improved health services delivery, alleviated work pressure, and improved the image of hospital managers. In addition, it has provided a constant supply of manpower, and increased the utilisation of health services in the community. The negative perceptions identified included a lack of experience and skills, poor relationships with rural health team, lack of support structures for community service doctors, poor continuity of care and budgetary constraints (associated with increased utilisation)"*[16].

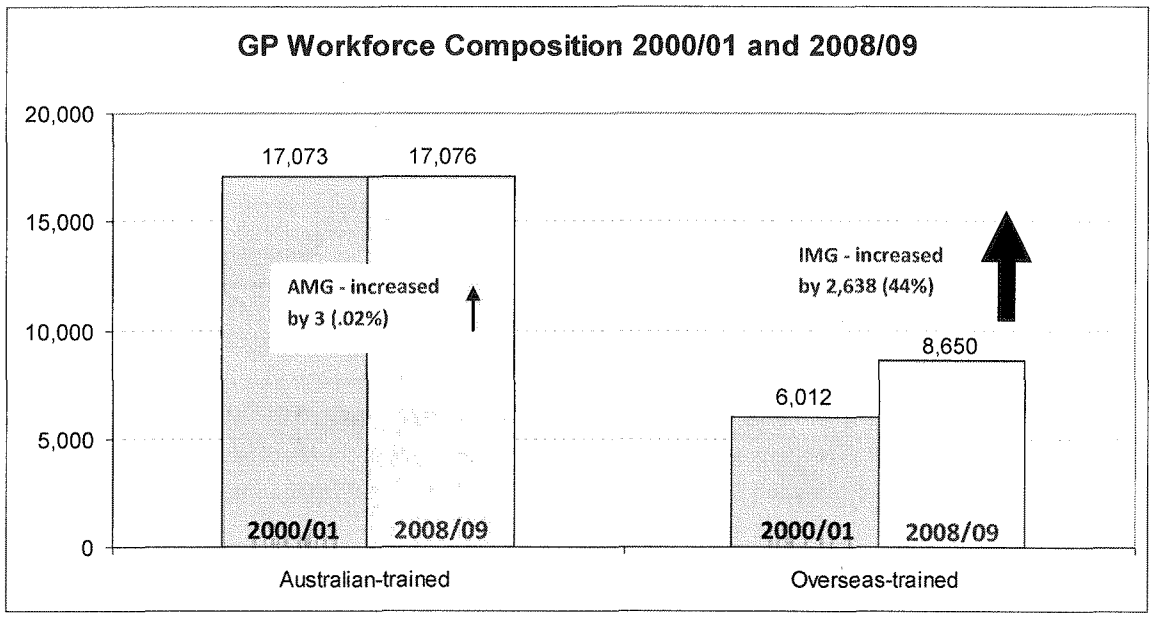
While this analysis speaks only to the experience of hospital doctors it does afford potential insights to CS schemes operating in the community sector.

[16] Omole et al. 2005, 'Perceptions of hospital managers regarding the impact of doctor's community service', *South Africa Family Practice*, 2005:47(8), p. 55.

The Australian context

If the number of GPs is to be used as the sole metric for assessing the effectiveness of IMG recruitment (and the Moratorium) then one could conclude that they have been highly successful in Australia. Figure 4 illustrates the contribution that IMG recruitment has made to the growth in the Australian GP workforce since 2000/01. Over the period to 2008/09 the nett increase in the IMG component of the Australian GP workforce was 2,638 while the nett increase of Australian-trained GPs was just three doctors.

Figure 4: Nett changes in the composition of the Australian GP Workforce – 2000/01 and 2008/09[17]



[17] Department of Health and Ageing, 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table%2018a.pdf>.

Figure 5: Nett changes in the composition of the Australian GP Workforce - Urban verse Rural

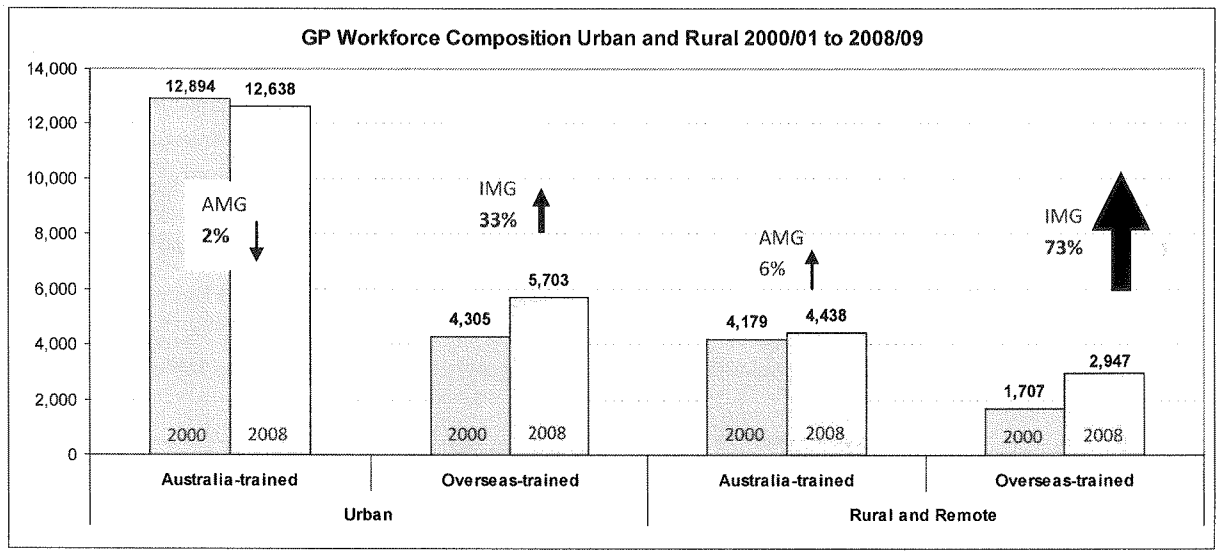


Figure 5 shows that the IMG contribution to the increase in the GP workforce has been significant in both urban (n. 1,398) and rural areas (n. 1,240). This highlights the increasing reliance that both rural and urban communities have on IMG recruitment. The 73% growth in the overseas-trained GP workforce in rural and remote areas evidences the effectiveness of the Moratorium in bolstering the medical workforce in these under-served regions. Presumably the 33% (n.1, 398) increase in IMGs working in urban centres relates to overseas-trained GPs working in outer-metropolitan districts of workforce shortage and rural IMGs relocating to the cities having extinguished their Moratorium obligations. Importantly significant numbers of IMGs also work in cities providing after-hours services in approved medical deputising services.

The Australian GP workforce would have been at risk of absolute decline between 2000/01 and 2008/09 if not for IMG recruitment. Therefore the importance of the international market for primary health medical practitioners cannot be overstated. An ongoing international recruitment effort is essential along with internal policy instruments that can direct IMGs to medically underserved communities, be they rural or urban. Until the impact of the increasing number of GPs in training is fully understood, the nation's reliance on IMGs and the Moratorium will continue. The experience of the last decade has shown that the array of incentive programs offered to induce Australian-trained GPs to practice in rural areas have had limited success. On average, in spite of a raft of financial and other incentives, an increase of only 28 GPs was achieved per annum in the size of the Australian-trained component of the rural GP workforce. Over the same period, IMG recruitment averaged an input of 138 GPs per annum, almost five times that of the domestic incentive programs. This means that over a comparable period when on average 400 GPs[18] completed their training each year, the Australian-trained rural GP workforce grew by only 28.

[18] Refers to graduates of the Australian General Practice Training Program and is based on the years 2005 to 2009.

In crude terms this suggests that the domestic contribution to the rural GP workforce has effectively been less than 10% of the total annual GP graduate pool. It is moot therefore that the increased GP Registrar intakes of recent years will have a material effect on the size and distribution of the rural GP workforce. Modeling is needed to quantify the effect that the increased numbers of GP Registrars will have on the rural workforce but the impact is likely to be modest[19]. Generational trends are likely to militate against the possibility of a major influx into rural practice. The upcoming generation of doctors is likely to continue to prefer urban practice over rural practice[20] and incentives may have minimal effect. While studies need to be undertaken to explore the veracity of these 'anecdotal' trends it is clear that rural health practice is associated with rural background so while rural students are underrepresented in medical schools, the nation is unlikely to produce graduates in sufficient numbers willing to work in rural settings.

A recent study conducted by Rural Health Workforce Australia in late 2010[21] suggests that rural practice for IMGs can be a positive and rewarding experience. This study involving five states/territories showed that of the 168 IMGs who have completed the 5-Year Overseas Trained Doctors Scheme, 118 (70%) remain working in rural areas. These 118 doctors, having completed their reduced Moratorium requirements have elected to stay in rural practice. This suggests a measure of satisfaction with life as a rural GP. These figures, while encouraging, do not detract from the reality that some IMGs have a negative experience of rural practice and research is needed to understand how things can be improved for these doctors. No doubt this inquiry will play an important part in identifying ways in which the experience of all IMGs can be improved.

Rural Workforce Agencies are very active in their support of international medical graduates with services including:

- Recruitment and relocation case management;
- Facilitation of immigration processes;
- Facilitation of IMG assessment and registration;
- Facilitation of Medicare Provider Number (including 19 AB exemptions);
- Fellowship examination preparation (i.e. Additional Assistance Scheme); and
- IMG family support (i.e. Rural Medical Family Network).

[19] Rural Health Workforce Australia 2008, 'Will more medical places result in more rural GPs?' <www.rhwa.org.au/site/index.cfm?display=32639>.
[20] Rogers et al. 2010, 'Why do junior doctors not want to work in a rural location and what would induce them to do so?', *Australian Journal of Rural Health*, vol.18, p.181.
[21] Refers to a study conducted by RHWA to inform DoHA as to the level of rural retention associated with the 5 Year OTD Scheme (2010).

These IMG-specific supports are in addition to the other assistance provided to all rural GPs and rural practices including:

- Provision of subsidised locums;
- Practice business support; and
- Continuing professional development opportunities.

It is important to note that the new 'scaling' arrangements introduced from 1 July 2010 mean that the 10-year Moratorium service obligation for IMGs is effectively reduced by remoteness. As a result, no IMG commencing on the Moratorium after 1 July 2010 will have to serve the full 10 years. In addition to this new scaling initiative, many rural IMGs also have the opportunity to discharge their Moratorium obligation much sooner, from as little as three years in the hardest to fill locations under the pre-existing 5 Year OTD Scheme.

In summary, the main reasons for endorsing the continuation of the Moratorium are:

1. The IMG recruitment strategy, and by implication the 10-year Moratorium, has been successful in increasing the number of GPs practising in rural Australia. Department of Health and Ageing GP statistics reported 5,886 rural and remote GPs were participating in Medicare in 2000/01 and there were 7,385 GPs participating in 2008/09. This is an increase of 1,499 of which 82% (n. 1,240) can be attributed to IMGs[22]. The GP to population ratio in rural Australia has improved markedly over this period and this is largely due to the influx of IMGs to these regions (refer Figure 2).
2. Compulsory rural service (CS) schemes such as the 10-Year Moratorium are a practical necessity in the absence of better alternatives. The World Health Organization report of 2010 alluded to 70 countries that have operated CS schemes to ensure rural health services are available[23].
3. IMG recruitment is good for the nation and the medical profession. A diverse multi-racial health workforce is consonant with the composition of the Australian population in general. It is highly appropriate that the demographics of the health workforce fully reflect that of the community it serves.
4. Rural practice for IMGs is generally a positive and rewarding experience. To illustrate this, of the 96 IMGs who have completed the 5-Year OTD Scheme in Western Australia, 70 of them are still practising rurally, that is 73%[24]. This is suggestive of a high degree of satisfaction.

[22] Department of Health and Ageing 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table15.csv>.
[23] Frehywot et al. 2010, 'Compulsory service programmes for recruiting health workers in remote and rural areas: Do they work?, *Bulletin of the World Health Organization*, vol. 88, no. 5, <http://www.scielosp.org/scielo.php?pid=S0042-96862010000500014&script=sci_arttext&tlng=en>.
[24] Refers to a study conducted by RHWA to inform DoHA as to the level of rural retention associated with the 5 Year OTD Scheme (2010).

Health disadvantage persists in rural Australia with people in these regions experiencing higher burdens of chronic illness and lower life expectancy. From 2004 to 2006 there were about 4,600 excess deaths outside of major cities - that is, deaths above the number expected if these rural areas had the same death rates as the major cities[25]. While mortality rates across all parts of the country fell steadily between 1997 and 2006 the mortality gap between the major cities and other areas remained fairly constant. The challenge of rural health inequality is set to continue and IMG recruitment and the 10-year Moratorium are needed as part of the nation's ongoing policy response.

While a rigorous evaluation is yet to be undertaken of the efficacy of the 10-year Moratorium, and while such CS schemes may not afford a permanent workforce for underserved groups, it is clear that they do have a role in a nation's plan for health workforce development and equitable distribution.

Conclusion

International medical recruitment continues to be central to Australia's efforts to redress rural health inequality. The 10-year Moratorium remains the key policy instrument by which international medical graduates are directed to regions that suffer the highest levels of health disadvantage. It is a practical necessity in a global era of increasing urbanisation which sees rural communities suffering intractable health workforce shortages. The level of competition for IMGs between developed countries is set to heighten as population ageing fuels patient demand. It is timely therefore that the Australian Government reviews the processes it uses to facilitate IMGs into practice so that Australia continues to be a destination of choice.

[25] Australian Institute of Health and Welfare 2010, Australia's Health 2010, Australia's health series no. 12, Cat. no. Aus 122. Canberra, p. 245.

References

Australian Bureau of Statistics, Census 2001 and 2006, Population by Remoteness Areas <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008>.

Australian Government Department of Health and Ageing 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table15.csv>.

Australian Government Department of Health and Ageing 2010, General Practitioner Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table%2018ra.pdf>.

Work as a doctor in Australia 2010, Australian Government Department of Health And Ageing, <www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-s19AB%20factsheet-factsheet>.

Australian Institute of Health and Welfare 2010, Australia's Health 2010, Australia's health series no. 12, Cat. no. Aus 122. Canberra, pp. 245-248.

Chaolin, G, Feng, Z, Youliang, Q & Shunzan, Y 1998, 'Growth of new designated cities in China', *Chinese Geographical Science*, vol.9, no.2, pp. 97-106.

Frehywot, S, Mullan, F, Payne, P & Ross, H 2009, 'Compulsory service programmes for recruiting health workers in remote and rural areas: Do they work?, *Bulletin of the World Health Organization*, vol. 88, no. 5, <http://www.scielosp.org/scielo.php?pid=S00429686201000050014&script=sci_arttext&tlng=en>.

Omole, O, Marincowitz, G & Ogunbanjo, G 2005, 'Perceptions of hospital managers regarding the impact of doctor's community service', *South Africa Family Practice*, 2005:47(8), p. 55.

Rogers, M, Searle, J & Creed, PA 2010, 'Why do junior doctors not want to work in a rural location and what would induce them to do so?', *Australian Journal of Rural Health*, vol.18, p.181

Rural Health Workforce Australia 2008, 'Will more medical places result in more rural GPs?' <www.rhwa.org.au/site/index.cfm?display=32639>.