Chapter 4

Workforce measures

Introduction

4.1 Term of reference (b)(iii) requires the Committee to consider:

> the Government's proposed workforce measures including the recruitment of overseas doctors;

4.2 The Medicare Plus package introduces a number of workforce measures that are additional to those contained in *A Fairer Medicare* Package.

4.3 *A Fairer Medicare* provided for: 234 new medical school places, bonded to areas of workforce shortage; 150 new GP Registrar training places, plus funding for 457 full time equivalent practice nurses.

4.4 Medicare Plus now adds:

- Funding for an additional 1500 full time equivalent doctors and 1600 full time equivalent nurses in the period 2003 – 2007.
- The creation of a new Medicare Item Number to enable a rebate of $8.50 to practice nurses undertaking immunisation and wound management. This will be in addition to a grant of $8,000 per Full Time Equivalent GP in a practice to assist in employing practice nurses in urban areas of workforce shortage.[1]
- The introduction of short term placements for trainee medical practitioners in outer metropolitan, regional and rural/remote areas in an attempt to address the current supply shortage.
- Incentives for Non-Vocationally Registered (NVR) doctors to practice in areas of medical shortage for a period of five years.
- Funding to increase the number of overseas-trained doctors (OTDs), directed to areas of workforce need.

---

1 Practice nurse incentives will also be available to practices that participate in the PIP, and which are located in these urban areas of workforce shortage.

- Measures, as yet unspecified, to encourage the continued practice of doctors in areas of workforce need, and to bring doctors who have ceased practice back into the system.[2]

4.5 The bonded medical school places remain from the previous package, but as recommended by the Committee, Medicare Plus will enable students willing to undertake postgraduate vocational training in rural areas to attribute the period spent (up to three years) against their bond term. Otherwise, the additional under- and post-graduate training places for GPs, as well as training places for nurses and allied health workers, remain from the original package.

4.6 According to the Hon Tony Abbott MP, Minister for Health:

> A key factor in maintaining the affordability of medical services is having an adequate supply of doctors and nurses. Medicare Plus is Australia's most extensive effort ever to attract and retain a larger medical work force. It makes an immediate and sustained investment in supporting the equivalent of about 1,500 more doctors and 1,600 more practice nurses by 2007. More than $1 billion supports these initiatives to 2006-07.
>
> More doctors will be trained, and more will be encouraged to work in areas of shortage.[3]

Reactions to the proposals

4.7 Although reactions to the proposal were mixed, most respondents welcomed the workforce component of the package as a move in the right direction, and considered it an improvement on the measures contained in *A Fairer Medicare*.[4] Uncontroversial elements of the package include: the concept of training more doctors and nurses in Australia, increasing access to care in aged care facilities; assisting ex-doctors to return to the medical workforce, and various measures to assist overseas-trained doctors (OTDs) to assimilate smoothly and productively into the Australian workforce.

4.8 However, many respondents were also dubious about the likelihood of achieving the stated objectives, particularly those relating to recruitment of 1,500 extra doctors

---

2 This proposal attracted little comment, but respondents were generally supportive of it. See, for example, Rural Doctors' Association of Australia, Submission 87, p. 29; Australian Medical Association, Submission 9, p. 3

3 The Hon Tony Abbott MP, Minister for Health, Second Reading Speech, *Health Legislation Amendment (Medicare)* Bill 2003, House of Representatives Hansard, 4 December 2003, p. 23331

4 See, for example, Australian Divisions of General Practice, Submission 91, p. 1; City of Darebin, Submission 42, p. 3; Australian Consumers' Association, Submission 36, p. 10; Catholic Health Australia, Submission 48, p. 10

and 1,600 more practice nurses.[5] Respondents question how such significant numbers can realistically be delivered, and suggest that government objectives are overly optimistic. The Australian Health Care Reform Alliance had this to say:

> It is totally unrealistic to suggest that an immediate increase of 1,500 in the number of full time equivalent doctors available to the system is achievable. Totally inadequate numbers of additional places for medical students and nurses in Universities and Colleges will not see us adequately address our long-term need for more professionals from these health disciplines.[6]

4.9 Uniting Care put it this way:

> The announcement of additional short term supervised placements in regional and rural areas for junior doctors is positive, however it will result in only an additional 70 full-time doctors every year, when it has been estimated that a total of 2,000 are needed.[7]

4.10 St. Vincent de Paul saw this problem in the wider context of a continuing inadequate investment in medical workforce training, coupled with disincentives and debt, and continuing large numbers of students who do not receive an offer of a place in university in medical courses.[8]

4.11 The Australian Health Care Reform Alliance pointed out that the provision of more training places alone would not necessarily result in more graduates, and that it was a matter of transforming the perception of general practice among potential medical students:

> [More training places for general practitioners] is indeed a hollow initiative given that the places currently available are not being filled so unattractive is the prospect of entering general practice for many young doctors. The funding of [additional] training places will be a good idea and indeed essential once the basic underlying problems that are deterring doctors from entering general practice have been solved.[9]

4.12 The Committee notes that the provision of funding for extra doctors and nurses does not constitute a guarantee of their delivery. Indeed, the Department of Health and Ageing emphasised that the funding related to full-time equivalent (FTE) positions,

---

5 See, for example, Public Hospitals Health and Medicare Alliance of Queensland, Submission 51, p. 3; Australian Consumers' Association, Submission 36, p. 10

6 Australian Health Care Reform Alliance, Submission 94, p. 19

7 UnitingCare, Submission 55, p. 8

8 SVDP, Submission 58, p. 10

9 Australian Health Care Reform Alliance, Submission 94, p. 19

and not necessarily to that many new workers.[10] In terms of new FTE positions which are filled by new entrants, many of the doctors will be drawn from overseas, and OTD entry targets were set through consultation with medical bodies such as the Australian Medical Council, rather than through specific modelling.[11]

4.13 The remainder of chapter four provides more specific commentary on those proposals which garnered most interest.

Implications for public hospitals

4.14 Concern was expressed at the prospect that the package might drain both doctors and nurses from the already stretched public hospital system. The Australian Healthcare Association expressed the following misgivings with regard to doctors:

> The AHA is concerned about the MedicarePlus proposal to release graduate doctors from hospital placements and put these doctors in general practice placements. The proposal does not offer any way for the public hospital system to recruit more doctors to replace the graduates, and the AHA fears that removing them from public hospitals will simply result in further doctor shortages. The Federal Government cannot remove doctors from under-staffed public hospitals without replacing them.[12]

4.15 Similarly, some believed the incentives to nurses in general practice would draw already scarce staff away from other areas of need, such as hospitals.[13]

4.16 The Department of Health and Ageing contends that the workforce initiatives aim to add to the pool of staff rather than re-distribute it between sectors. The Department argues that, alongside an increase in the number of people registering as nurses in recent years, the measure will encourage those who have left the profession to return, citing the provision for refresher courses as a facilitator in this regard.[14] With respect to doctors, initiatives such as more training places, increased use of overseas-trained doctors, and re-entry to the workforce by doctors who have left it, aim to bring about 'new' full-time equivalent practitioners to the system.

---

10 Mr Davies, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 49

11 Mr Wells, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 50

12 AHA, Submission 56, p. 3. See also Queensland Nurses Union, Submission 62, p. 6

13 See, for example, Moreland City Council, Submission 81, p. 3; National Rural Health Alliance, Submission 65, p. 9; Catholic Health Australia, Submission 48, p. 10

14 Department of Health and Ageing, Submission 54, p. 25

Overseas trained doctors

4.17 The most consistent criticism of the workforce proposals was related to the increasing use of OTDs, who form an integral part in the government's proposed solution to the current shortage, particularly in the short term. The effective and efficient utilisation of OTDs can be complicated because of the mechanics of migration, cultural differences, additional training requirements, and the associated need to evaluate foreign qualifications. The Committee became aware of such difficulties during the first inquiry, when it found:

> The Committee is concerned over the apparent lack of supervision over, and support for, some OTDs practising medicine in Australia without full accreditation. This situation places both the doctors concerned, and the communities they serve, in potentially dangerous situations. Part of the problem may be an imbalance between the onerous requirements for doctors to enter Australia as skilled migrants and gain accreditation, and other easier means by which they can enter and practice in areas of medical workforce shortage.[15]

4.18 Many respondents consider Australia's reliance on OTDs to be morally questionable, and argue that the nation has sufficient resources to train all necessary medical staff without resorting to encouraging practitioners from less fortunate areas to practice here.[16] The Australian Divisions of General Practice pointed to Australia's international obligations:

> Australia also has an obligation to observe the tenets of the Melbourne Manifesto endorsed by WONCA 2002[17]. The Melbourne Manifesto presents a code of practice for the international recruitment of health care professions, and has put the onus on every country to train enough health professionals to meet its own needs.[18]

4.19 Putting it somewhat more strongly, Mr Gregory submitted that:

---

15 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 204

16 See, for example, Australian Medical Association, Submission 9, p. 3; UnitingCare, Submission 55, p. 8; Australian Divisions of General Practice, Submission 91, p. 2; Queensland Nurses' Union, Submission 62, p. 6; Victorian Medicare Action Group, Submission 27, p. 5; Australian College of Non VR GPs, Submission 35, p. 3; Australian Nursing Federation, Submission 64, p. 5; Doctors Reform Society, Submission 16, p. 3

17 The Fifth World Organisation of Family Doctors World Conference on Rural Health, Melbourne, 30 April-3 May 2002.

18 Australian Divisions of General Practice, Submission 91, p. 2

> It is absolutely shameful that a country like this is in that situation and having a net impost on the world supply of doctors.[19]

4.20 During the first inquiry, the Committee found that:

> It is disturbing that Australia's medical workforce has become so dependent on imported medical professionals, particularly when there are so many Australians wanting to enter medical courses. As a matter or principle, the Committee takes the view that Australia, as a wealthy developed nation, should not be taking doctors away from nations where the need for qualified doctors may be even greater than our own.[20]

4.21 There was a perception among some that the use of OTDs was a 'bandaid' solution, failing to address underlying problems:

> It is a short term measure that does nothing to alleviate the chronic issues domestically that have resulted in our own workforce crisis. Improving pay and conditions, offering incentives to work in difficult to recruit areas, and encouraging and support[ing] undergraduate enrolment are all vital issues that need to be undertaken from a central, well planned perspective.[21]

4.22 The RDAA agreed, submitting that the use of OTDs:

> … must be recognised as a short-term measure – a stop-gap until Australia produces sufficient medical graduates to provide its own medical workforce adequate to meet the needs of all parts of the country.[22]

4.23 The RDAA also pointed out that reliance on OTDs left Australia vulnerable to competition in the international labour market, which is already experiencing a shortage, a factor not lost on Doctors Stewart and Brown, who noted that:

> EEC work practice legislation limiting hours of work and on call for doctors in Europe will lead to a huge demand for more medical practitioners in Europe. Australia will be competing for medical graduates in a world environment deficient in doctors.[23]

4.24 In its Submission the Department of Health and Ageing outlines a broad recruitment strategy for attracting overseas-based practitioners, anticipating the use of

---

19 Mr Gregory, *Proof Committee Hansard*, Canberra, Monday 19 January 2004, p. 92

20 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 204

21 Australian Nursing Federation, Submission 64, p. 5

22 Rural Doctors' Association of Australia, Submission 87, p. 26

23 Drs Stewart and Brown, Submission 40, p. 1

direct marketing activities, as well as internet based methods. A target of 725 doctors over four years has been set, and the Department indicated that it would not target developing countries in its campaign.[24]

4.25 Others saw the issue as less of a moral issue, and more of a practical one, questioning the medium- to long-term effectiveness of using OTDs, and the implications of patchy examination requirements, as well as lack of support, for quality of care delivered by OTDs.

4.26 A number of respondents commented on the low examination pass rates achieved by many OTDs. The point was made by a number of respondents that OTDs who are placed in rural and remote areas, where the need for their services is greatest, face an uphill battle because the professional and social support infrastructure is smallest. Accordingly, there needs to be a commitment to support programs.[25]

4.27 Associate Professor Hawthorne provided the Committee with the most comprehensive analysis of the issue, based on her extensive research and publication on issues surrounding the use of OTDs, particularly in Australia. Associate Professor Hawthorne stressed the important role of OTDs in the current Australian medical landscape, and detailed a number of problems which present themselves for efficient utilisation of OTDs in Australia.[26]

4.28 Professor Hawthorne reports that OTDs, particularly those seeking permanent residentcy, are having significant problems qualifying for work in Australia, primarily because of a ban *against* OTDs applying under the skilled migrant program. As a result, a decidedly different cohort of entrants arrive, with applicants entering Australia through generalised, non-profession based criteria (such as general migration), often without proven competency in either English or in medicine. These doctors can find exams such as those from the Australian Medical Council (AMC) a great challenge, and failure rates are high. The Australian Healthcare Association added that:

> While the recruitment of overseas doctors is a good notion in principle, in practice Australia has encountered major problems … includ[ing] the high rate of failure for the AMC test. Part 1 of the AMC is an English comprehension and multiple choices and Part 2 is a practical oral examination of patients and conditions. At present, 2,000 doctors have passed Part 1 of the AMC but have not completed Part 2. Another 3,000 doctors have expressed interest in sitting Part 1 but have not yet felt

24 Department of Health and Ageing, Submission 54, p. 28; See also Mr Wells, *Proof Committee Hansard*, Canberra, January 20 January 2004, p. 51

25 Drs Stewart and Brown, Submission 40, p. 1; Rural Workforce Agency (Victoria), Submission 90, p. 6

26 Associate Professor Hawthorne, Submission 88, pp. 3-8

> confident to sit the exam. The AHA has said that overseas students may need extra assistance and training before sitting the exam, including spoken English practice …
>
> [T]he government acknowledged the problems with the low pass rate for the exam and as part of Medicare Plus has said it will change the system to increase the pass rate. This raises issues of concern for the AHA, as the test is based on final year medical student tests and therefore meets Australian standards. If the AMC is changed and made 'easier' the AHA is worried that quality will be compromised. Quality should be a key factor in recruiting doctors from overseas and the government must ensure that testing is maintained at the Australian standard, regardless of the low pass rate[27]

4.29 However, this does not preclude many of these applicants for *permanent* residency from practicing without relevant testing. Associate Professor Hawthorne submits that:

> Due to demand-driven processes, substantial numbers of these OTDs have entered Australian practice prior to passing one or both of the AMC exams.[28]

4.30 Obversely, Professor Hawthorne reports that *temporary* resident OTDs are able to by-pass the Occupational English Test and AMC exams at point of entry, proceeding immediately to medical practice. In this context, she argues for the reform of OTD entry requirements through, among other things:

- the lifting of the ban relating to medically trained applicants within the skilled migration program; and
- the adequate resourcing of professional transition training for both temporary and permanent OTDs, particularly pertaining to appropriate and accessible preparatory bridging programs for the purposes of professional competency.[29]

4.31 However, Professor Hawthorne stopped short of endorsing full equity in qualification requirements between temporary and permanent OTDs, saying:

> On equity grounds there seems a clear case for extending the administration of the Occupational English Test and AMC exams to temporary entrant OTDs. However this is a complex decision which would require careful government consideration for several reasons.

27 Australian Healthcare Association, Submission 56, p. 9

28 Associate Professor Hawthorne, Submission 88, p. 3

29 Associate Professor Hawthorne, Submission 88, pp. 3-5

> Firstly, the introduction of these measures would almost certainly reduce the attractiveness of Australia as a medical destination to prospective temporary resident OTDs—not an outcome desirable in the current shortfall situation. Secondly, the application and assessment process of temporary entrant OTDs would be significantly delayed. Thirdly, substantial numbers of current applicants would be likely to fail, if we extrapolate AMC and OET pass rates by country of origin to temporary resident OTDs (eg from India). Fourthly, as we have seen, demand-driven processes have ensured that substantial numbers of permanent resident OTDs lacking AMC [accreditation] are currently engaged in 'area of need' practice, despite the fact that they are theoretically required to sit these exams and secure passes.
>
> For all these reasons I make no simple recommendation to the Senate regarding this issue - rather identifying it as one meriting very careful consideration.[30]

4.32 Professor Hawthorne also suggested requiring permanent resident OTDs to serve in areas of need for a defined period, as is currently the case with temporary applicants.[31]

4.33 Putting aside morality and numerical effectiveness, the ACA did not see how recruitment of OTDs would necessarily ease the burden caused by the current maldistribution, and commented that doctors:

> …[C]an be expected to have the same geographic preferences as their established colleagues. Many are likely to wish to practice in areas where there is already adequate GP supply and, given the profession's history of ignoring blandishments to move to areas of need in which they do not want to live, this problem will continue to be extraordinarily difficult to solve.[32]

Expanding the role of nurses

4.34 A key new plank of the package is the expansion in the role of nursing staff within the general practice setting, as recommended by government Senators in the first inquiry. This would be partly achieved through the creation of a new MBS number for nurses to carry out prescribed procedures relating to immunisation and wound management, which would attract a rebate of $8.50.[33] To complement this, the practice grants program from *A Fairer Medicare* will be carried over to Medicare Plus.

---

30 Associate Professor Hawthorne, Submission 88A, p. 1

31 Associate Professor Hawthorne, Submission 88, p. 4

32 Australian Consumers' Association, Submission 36, p. 10

33 This rebate will increase by $5.00 where the service is bulk billed and performed on a concession card holder or child under 16 yrs.

4.35 The proposal is generally supported, with comments focusing on the potential for widening its scope.[34] The Australian Divisions of General Practice would expand the list of claimable items to include:

- monitoring and clinical management (such as reviewing blood pressure after alteration in treatment);
- providing early disease detection services (such as diabetes screening in high risk groups);
- input to chronic disease management (such as providing asthma education);
- home visits, including protocol-driven health assessments under the supervision of a GP; and
- conducting Pap smears.[35]

4.36 The Department of Health and Ageing does not rule out the expansion of the list of rebateable items for nurses in the future, but points to the fact that practice nurses have never attracted a rebate before, and that a measured approach needs to be taken in the introduction of the initiative.[36]

4.37 The ADGP also pointed out the need for clear definition of what the package intends by 'broad supervision', where the doctor is required to monitor a nurse's activities.[37] While the ADGP broadly supports the initiative, it considered that the proposed rebate of $8.50 'demeans' the level of knowledge and expertise required by nurses, and should be increased.

Bonding of Medical School Graduates

4.38 This measure was carried over from the *A Fairer Medicare* package, and much of the evidence received by the Committee in the first Inquiry was mirrored in the second. In its first report, the Committee acknowledged the difficulties likely to be encountered with the scheme, but expressed support for the bonded places under the proviso that students be allowed to begin working off their bond during postgraduate

---

34 See, for example, Rural Doctors' Association of Australia, Submission 87, p. 27; Doctors Reform Society, Submission 16, p. 3

35 Australian Divisions of General Practice, Submission 91, p. 6

36 Mr Davies, *Proof Committee Hansard*, Canberra, 20 January 2004, p. 48

37 Australian Divisions of General Practice, Submission 91, p. 6

vocational training as Registrars.[38] The Committee's findings in this regard are set out in more detail in its first report.[39]

4.39 In Medicare Plus, the government acceded to this recommendation. However, the Committee again received some evidence critical to the measure.

4.40 Some respondents saw bonding as a short-term solution, and foresaw negative consequences further down the line, as bonded doctors grew to resent the compulsion to remain in areas of need, and deserted them at the conclusion of their term.[40] The Royal Australian College of General practitioners put it this way:

> The future of General Practice requires that our recent medical graduates see General Practice as an exciting career choice. The bonding of medical graduates and changes to the higher education sector are likely to dissuade some of our potential doctors from this career path which is likely to impact on the future numbers of GPs. The RACGP calls on the Government again to remove the bonding of medical student places and to support the long term viability of Australian general practice.[41]

4.41 However, some respondents favoured bonded *scholarships*, and the Rural Doctors Association of Australia sets out a number of options for these arrangements in some detail.[42] The National Rural Health Alliance offered 'conditional support' for the concept of bonded scholarships, where:

> … students receive substantial funds to assist them to undertake a medical degree in exchange for a commitment to practice in specified areas in the future. With the right details in place and full disclosure by both parties these may be seen as fair contracts in which a genuine benefit is provided by one party in return for services made available by the other.[43]

4.42 Alternatively, the Australian Health Care Reform Alliance promoted the expansion of an existing program:

> Far better [than creating bonded places] is the program already provided by the Federal Government which sees affirmative action programs find

---

38 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, p. 107

39 Senate Select Committee on Medicare, *Medicare – healthcare or welfare?*, pp. 97-111

40 See, for example, Rural Doctors' Association of Australia, Submission 87, p. 24

41 Royal Australian College of General Practitioners, Submission 67, p. 4

42 See, for example, the National Rural Health Alliance, Submission 65, p. 11; Rural Doctors Association of Australia, Submission 87, p. 3; Australian Medical Association, Submission 9, p. 3

43 National Rural Health Alliance, Submission 65, p. 11

> additional places for medical students from country areas in our medical schools with a significant amount of their training carried out in country clinical schools.[44]

4.43 The RDAA agrees, suggesting the enhancement of the existing Medical Rural Bonded Scholarship introduced in the 2000-01 Budget. Each of 100 Scholarships is worth around $21,000 per annum, and they are offered to students contracted to complete six years of rural practice on completion of their training. The RDAA also points out that initiatives aimed at encouraging post-graduate doctors to rural areas may be leaving things too late:

> …[C]onsiderable research now indicates that influencing people toward rural medicine should begin much earlier than post-graduate training. One Australian study reported that 'interest in rural practice wanes as medical education progresses'.[45]

Funding for rural GPs doing procedural work

4.44 The importance of having GPs capable of conducting procedural work in rural regions was espoused by the Rural Workforce Agency, Victoria:

> The importance of rural GPs to community and hospital services is a critical issue, particularly the maintenance of GP proceduralists … [m]any Victorian rural communities are not large enough to support their own specialist services. In these communities, GPs provide much of the procedural work to their local hospitals and communities including emergency services, obstetric, anaesthetic and surgery services … [o]ur data shows that the 2nd biggest rural specialist deficit is surgeons. The need for rural GP proceduralists to continue to be able to deliver these services in a supported clinical environment is clear.[46]

4.45 The RDAA agreed, reporting that only about 24% of rural doctors practice obstetrics, and 16% anaesthetics. The Association points out that:

> While the decline in each area is problematic in itself, a loss or deficiency in one area of procedural practice inevitably leads to losses in the others, as for example, surgeons are unable to practice when there is no anaesthetist.[47]

---

44 Australian Health Care Reform Alliance, Submission 94, p. 21

45 Rural Doctors' Association of Australia, Submission 87, p. 25. Study cited is Laurence *et al*, Increasing rural activity and curriculum content in the Adelaide University Medical School, *Australian Journal of Rural Health*, 2002

46 Rural Workforce Agency (Victoria), Submission 90, p. 10

47 Rural Doctors' Association of Australia, Submission 87, p. 28

4.46 The government's proposal to support procedural GPs through extra payments available through the Practice Incentive Payment (PIP) program was welcomed by most respondents who commented on it. Catholic Health Australia:

> The Government's proposal … will go some way toward assisting GPs who have retained more than 10 percent of their practice as procedural. The proposal will assist in the retention and continuing comprehensiveness of practice of some rural GPs. The quantum of funding is unlikely to attract additional procedural GPs back to areas where they have left.[48]

4.47 The Australian Healthcare Association echoed these remarks:

> The AHA is pleased to observe the new MedicarePlus package deals with workforce issues, including additional funding for rural GPs with a minimum of 10% MBS procedural practices. This will relieve some of the pressure on rural healthcare. The emphasis on retraining and refresher courses in the package is a positive initiative by the Government, as it will encourage a higher level of quality in the sector.[49]

4.48 However, the RDAA points to the need for further consultation and refinement in the implementation of the initiative, so that the chance of achieving objectives is maximised. An example is the provision of up to $10,000 per year for locum services to enable procedural upskilling. The RDAA supports the measure, but calls for flexibility in implementation, as the availability of locum services in rural areas, and hence the time a doctor can be absent from their practice, is severely restricted.[50]

Enhanced rebate for Non-VR GPs in areas of shortage

4.49 This proposal attracted little comment. Notably, supporters of this initiative include the Australian College of Non-VR GPs.[51] The College pointed out, however, that areas of need were defined by Statistical Local Area (SLA). It was argued that SLA was an inappropriate unit of measurement, and that assessment should occur by individual suburb.[52]

Conclusion

4.50 This package is not a panacea for workforce problems, particularly in rural areas. There are also severe doubts in the opinion of the Committee that the overall number

---

48 Catholic Health Australia, Submission 48, p. 11

49 AHA, Submission 56, p. 8

50 Rural Doctors' Association of Australia, Submission 87, p. 29; Australian Medical Association, Submission 9, p. 3

51 Australian College of Non-VR GPs, Submission 35, p. 1-2

52 Australian College of Non-VR GPs, Submission 35, p. 1-2

of ‘new’ practitioners and nurses which the Government anticipates will come online, is actually achievable.

4.51 However, the package does represent a substantial effort to redress many of the difficulties being faced by both providers and consumers as a result of workforce shortage. Taken, then, as an overall package of initiatives and assuming a substantial increase in the number of new practitioners and nurses can be achieved, it is commendable.

4.52 Notwithstanding its positive attributes, there is one major element of the proposal which is problematic. The increasing reliance on OTDs should represent both a moral and practical warning signal to policy makers. While Australia’s recruitment from overseas of a number of doctors roughly equivalent to those Australian doctors choosing to leave is broadly defensible, the country’s continuing status as a net importer of practitioners is morally questionable, and substandard from a policy perspective.

4.53 However, training new doctors does take many years and Australia continues to suffer a doctor shortage. OTDs represent an important resource in this context, and for as long as we continue to require their services in any great number, the government must reform entry and work mechanisms, including the lifting of the disincentive relating to medically trained applicants within the permanent skilled migration program. The government should also ensure adequate resourcing of professional transition training for both temporary and permanent OTDs, particularly pertaining to appropriate and accessible bridging programs for the purposes of professional competency.

4.54 The government should give careful consideration to developing ways of bringing about parity in the entry and work requirements for temporary and permanent resident OTDs without dissuading temporary residents from continuing to serve Australia’s needs. This is consistent with the Committee’s findings during the first inquiry.

4.55 While there is a foreseeable risk that increased incentives for nurses in general practice will draw much-needed staff away from public hospitals, the fact remains that nurses working in general practice provide a highly valuable service, and that the risk is worth taking. The real answer to the problem lies in training enough nurses to meet demand in both sectors.

4.56 The Committee also urges the government to look more closely at bonded scholarships for those medical students wishing to practice in areas of workforce shortage. While supporting the proposed bonded medical school places, the Committee concludes that the expansion of existing scholarship programs could play a highly beneficial role in both recruitment and retention of doctors to the bush.

4.57 The Committee supports the proposals.