The Retention of Overseas Trained Doctors in General Practice in Regional Victoria

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Acknowledgments

This research is the first of the many studies concerning overseas trained doctors in post World War Two Australia to focus wholly on their experience. The authors would like to thank the substantial numbers of doctors who generously provided their time to explore the issues dealt with below, involving the completion of mailout surveys and (for 37 informants) participation in extended individual interviews conducted in 29 sites across Victoria. Equally, we would like to convey our thanks to the many spouses of OTDs who completed a separate survey, allowing us to gain important insights into family perspectives on the rural GP experience, including factors influencing retention.

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1. The Context of the Study

A. Medical Labour Market Demand

The past two decades have coincided with growing western reliance on overseas-trained doctors (OTDs) to provide rural general practice, public hospital and select specialist medical services, a phenomenon occurring to varying degrees across the UK, the US, Canada, Australia and New Zealand. By 1996 OTDs represented some 25% of all physicians practising in the US, with disproportionate numbers engaged in rural or public sector practice. Dependence on OTDs had simultaneously grown in New Zealand and Canada, where market forces had failed to deliver local graduates to remote area locations. In Canada, where it is estimated by 2011 100% of all net growth in the professions will depend on migration, a 1997 attempt by the Royal College of Physicians and Surgeons to restrict speciality examinations to Canadian and US-trained physicians led to major protests from provinces dependent on OTDs for remote area medical services[1].

Within the recent period Australia has been characterised by a dramatic growth in the ratio of general practitioners (GPs) to patients in metropolitan areas, but a diminishing proportion of locally-qualified GPs prepared to commit to regional work, despite the introduction of select incentive-based schemes[2]. The underlying reason for these shortages is that since the late 1980s there has been a significant slow down in the rate of growth of supply of doctors permitted to serve as GPs in private practice or in the hospital system. This slow down is largely a consequence of Commonwealth government policies which were directed towards this end, including:

a. A reduction in the number of medical school enrolments in Australia since the 1980s.
b. The introduction of measures designed to reduce the number of overseas trained doctors permitted to pass the Australian Medical Council (AMC) accreditation examinations.
c. A limitation on the number of entrants to the Royal Australian College of General Practitioners' (RACGP) post-graduate training program for GPs to 400 per year from 1995. (Please note this was increased to 450 in 2001-2, with the requirement that 250 be trained in rural areas. In recognition of growing GP shortages, the government has also agreed that from 2004 the cap will be lifted to 600 nationally, with 260 in the rural stream. In Victoria there will be 155 trainee places with 66 in the rural stream.)
d. Restriction on access to Medicare provider numbers to those who pass the RACGP training program since the passage of Amendments to the Health Insurance Act in December 1996.
e. Restriction on the rights of New Zealand trained doctors to bill on Medicare since 1997.
f. Restriction on the rights of recently arrived OTDs who are permanent residents of Australia and who pass the AMC accrediting exams to bill on Medicare until 10 years after registration since 1997.
g. Since the early 1990s various restrictions on the rights of OTDs to either migrate to Australia in the first place, or the circumstances in which they can practise if they enter with temporary medical appointments[3].

By the late 1990s, as intended, these combined measures had succeeded in producing a slow down in the number of full-time equivalent GPs billing on Medicare, in contrast to the late 1980s and early 1990s when GP numbers had been increasing by 4-5 per cent per year. Growth reduced to 1.4 per cent in 1996-97 and 0.9 per cent in 1997-98, shifting to a 0.5 per cent decline by 1998-99.

While this outcome may have been justified in the context of costs to the Commonwealth budget for health services at the time, the problem is that demand for medical services continued to grow. The Australian government failed to accompany these *supply* control measures with parallel measures to ensure that GPs permitted to bill on the Medicare system did so where they were *needed* rather than where they wished to serve, in a context where 29 per cent of the Australian population is rurally based, cf just 15.6 per cent of Australian doctors[4]. The Commonwealth

Government's inability to tie medical provider numbers to specific locations, in the face of strong opposition from the Australian Medical Association, is crucial to the current mismatch between supply and demand. As a consequence the government measures outlined above have generally exacerbated the already longstanding maldistribution of GPs in Australia[5].

Recent studies have demonstrated five issues to be critical in determining locational preference for 'mainstream' medical practitioners[6]:

- The growing significance of family-related issues (including access to appropriate spouse work, and quality education for school-age children);
- The rising participation of women in general practice (with females preferring urban to rural sites plus shorter working weeks);
- The cumulative impacts of heavy on-call loads and professional isolation for doctors engaged in rural or regional practice;
- Lack of access to locum services in these sites (to cover leave, study commitments etc); and
- An overall trend to decreasing lengths of stay for Australian doctors in rural/regional GP employment.

The disincentives for young Australian doctors to choose rural general practice were summed up by one key informant interviewed for this study as follows:

> *A lot of it is to do with the number of doctors that are born and bred in the city and just never think of moving into the country. The city is their home - so why would they want to leave? For others it is a financial thing. A doctor in a clinic in Melbourne where there are maybe ten GPs sharing costs and having an unlimited population could make more money. There is another concept that the skill requirement of a country GP has got to be a lot higher. In some bigger city clinics (while they are not specialists) one GP may have a special interest in diabetes, another in asthma and another one in sport injuries, and when a patient arrives at the clinic the reception staff can commit them to the person who has that speciality. That way one doctor can be the full-bag on something and doesn't have to be the full-bag on everything, which makes for an easier lifestyle. Then there is the view that if you have ten doctors in the one clinic you probably don't have to work 24 hours, seven days a week like in rural areas. People think you have to work too hard for too long in the country. Another factor is people think going to the country becomes a life sentence - if they want to move they can't move because there is nobody to buy that practice from them. There are all sorts of reasons that stop (local) doctors wanting go, and it is a supply and demand problem forcing (other types of doctors) to go out.*

In response to these entrenched distribution problems, Australia is now increasingly dependent on temporary and permanent resident OTDs whose qualifications have not yet been fully accredited, to work in four under-supplied medical contexts, currently competing to secure their services[7]:

1. As general practitioners located in 'areas of need' or other rural locations (the subject of this report);
2. At the level of interns required to fill the ranks of junior doctors and non-specialist Hospital Medical Officers in public hospitals;
3. In various public sector speciality programs, including in fields least attractive to Australian medical graduates (such as emergency medicine and psychiatry)[8]; and
4. As Occupational Trainees engaged in various specialist forms of practice in public hospitals.

A major problem exists however in terms of the stability of overseas trained doctors as a source of medical supply. While OTDs have indeed proven willing to shift to rural locations to provide primary health services, international studies have typically demonstrated only a brief length of stay, with replacement inflows regularly required. The aim of this study is to explore this phenomenon in the context of Victorian rural general practice, specifically in relation to overseas trained doctors employed in:

- The Rural Locum Relief Program (RLRP: 276 permanent resident doctors recruited to work in Victorian rural general practice from 1998/9 to 2001/2, the majority arriving in Australia prior to 1998, with 69 still in place by late 2002); and

- The Victorian Overseas Trained Doctor Rural Recruitment Scheme (VORRS: 86 temporary entrant doctors recruited since 1999, required to possess some form of recognised postgraduate qualification, with 85 appointees still in place by late 2002).

B. Temporary Resident Medical Migration

To meet the medical workforce shortages described above, increasing numbers of temporary entrant overseas trained doctors have been brought to Australia over the past 8 years under two major visa categories (with New Zealand doctors to be considered separately under permanent migration).

'Area of Need' Positions (Visa 422)

Between January 2000 and June 2003 5,304 temporary entrant OTDs were approved to come to Australia to fill 'area of need' positions, including 1,176 to Victoria, 2,049 to Queensland, 1,204 to Western Australia compared to just 204 to NSW. Total visas issued (Visa 422) rose from 664 in 1993-4 to 2,045 in 2001-2 and a further 1,197 for the six month January-June 2003 period. (See Table 1.) To date these temporary resident OTDs have been exempted from sitting for the Australian Medical Council (AMC) pre-accreditation examinations or the Occupational English Test, permitted to proceed directly into medical practice. By December 2002 a stock of 1,547 such doctors was resident in Australia, rising from 1,022 in June 2000 (a 51 per cent increase over a 30 month period).

Occupational Trainees (Visa 442)

A further 691 temporary resident medical practitioners reached Australia between 2001 and 2002 under the Occupational Trainee Scheme (Visa 442), a visa category originally intended to allow OTDs from third world countries to develop their skills in Australia, then return to make an enhanced contribution to health care in their home country. As demonstrated in a recent study by Birrell, Hawthorne & Rapson, by 2002 there were 306 such sponsorships for the field of surgery alone (almost all of which were accepted), with a further 151 approved for surgeons in the first five months of 2003[9]. Occupational Trainees were becoming a quasi-permanent feature of the Australian medical workforce.

Table 1: Temporary medical migration by state, 2000-2003 (category 442 visas issued)

State	2000-2001	2001-2002	1st Half 2002-2003	Total No.
Queensland	897	716	436	2049
Western Australia	456	472	276	1204
Victoria	406	508	262	1176
Tasmania	94	82	38	214
Northern Territory	84	98	55	237
New South Wales	58	89	57	204
South Australia	60	68	48	176
ACT	7	12	25	44
Total	**2062**	**2045**	**1197**	**5304**
Actual visa grants by principal applicant	1777	1923	TBC	

Source: Department of immigration Multicultural and Indigenous Affairs arrivals data 2000-1 to June 2003 (unpublished, provided August 2003).

C. Permanent Resident Medical Migration

Hundreds of OTDs also continue to arrive under the permanent migration program — mostly via the family reunion program as spouses. Further, significant numbers continue to arrive as

spouses of persons selected as principal applicants under the various skilled migration categories (eg the Independent Skills stream). Many of these doctors have secured medical employment under conditional contracts, typically in contexts of under-supply. (See Table 3.)

Another important component of these permanent resident doctors are those who hold New Zealand citizenship and thus have the right to move to Australia with most of the privileges of permanent residence. In recent years the great majority of these New Zealand citizens have been third-country migrants who originally immigrated to New Zealand holding medical qualifications usually gained in their country of origin. In the years 2000-01 and 2001-02, 843 medically qualified professionals arrived this way, with Victoria the second most popular destination after New South Wales (the choice of 25 per cent of arrivals cf 42 per cent). Interestingly, a mere 29 per cent of these 'New Zealand' doctors were in fact New Zealand-born – their primary birth countries (and probably country of qualification) being Bangladesh (15 per cent), India (8 per cent), Sri Lanka (7%), China and the UK/Ireland (6 per cent) and Iraq (5 per cent), out of a total of 47 countries listed in all. These doctors were not recruited by Australian medical employers. Their arrival via the 'backdoor' reflects the pull of possible medical employment in Australia. The 2000-01 year was atypical in this regard. The very high numbers in that year reflected the rush to enter Australia in order to secure Australian permanent residence before the tightened regulations regarding New Zealanders rights to permanent residence were introduced in late 2001[10].

Source Countries and Language Background of Permanent Resident OTDs

As a result of the continued flow of overseas doctors, as described above, Australia has a substantial pool of permanent resident medical migrants yet to complete their Australian accreditation and thus with a strong incentive to take up conditional medical employment pending the achievement of full vocational registration (VR). By 1991 40 per cent of all medical professionals in Australia were overseas-born, rising to 44 per cent by 1996 and 47 per cent in 2001 (22,706 out of the total 48,323 medical workforce). This growth had occurred despite the introduction throughout the 1990s of a range of measures designed to curb the scale of permanent medical migration.

Though the UK/Ireland had once dominated these medical migration flows, by 2001 the major source regions for overseas-born doctors based in Australia were as follows (see Table 2):

1. East and South-East Asia (6,568)
2. UK/Ireland (4,709)
3. Europe (2,716)
4. South/Central Asia (1,757)
5. The Middle East (1,453)
6. New Zealand (1,093)
7. North America (673)
8. Africa (1,561)

In the period 1996-2001 the majority of medically-qualified migrant arrivals were derived from the UK/Ireland (857), Southern and Central Asia (516, excluding India), China (489), India (430) and South Africa (363), with very substantial additional numbers arriving from Central and Western Europe (206), Eastern Europe (170) and Iraq (160).

Though most of these migrants have been categorised by Australia as being of non-English speaking background ('NESB'), it is important to note at the outset that this term in fact masks highly differential levels of English. Substantial numbers of professionals reaching Australia from former Commonwealth countries, or the Middle East, have in reality been virtual native speakers of English - using variants primarily differentiated from Australian norms by accent and intonation. Such professionals have frequently been wholly or partially educated in English, either within their country of origin or through completion of tertiary degrees in countries such as the UK or Australia. Many European professionals (from the European Union in particular) reach Australia with a sophisticated level of English due to repeated telecommunications exposure, travel and school education. In a world increasingly characterised by the mobility of skilled labour, still other NESB professionals have employed English as a lingua franca in multinational contexts, eg on contract employment within the Gulf States[11]. For all these reasons, the term 'NESB' may signify cultural and racial differences in migrant professionals, rather than substantial deficits in English.

This point has been insufficiently stressed in Australian studies to date, but is essential to bear in mind when examining medical employment integration issues. Further, a new term is increasingly being used to describe migrants derived from Commonwealth countries, such as India, Sri Lanka, Malaysia, Hong Kong etc: migrants of Mainly English Speaking Background ('MESB') origin. In relation to the proportion of such arrivals qualified in medicine, please see the data reported in Table 9.

Table 2: Persons aged 15-64 with degree in medical studies, by country of birth (2001)

	Year of Arrival in Australia					
Birthplace	**Pre 1991**	**1991-1996**	**1996-2001**	**Not Stated**	**Not Applicable**	**Total**
Australia					**25,617**	**25,617**
UK and Ireland	3,242	418	857	192		4,709
New Zealand	575	180	286	52		1,093
Other Ocean/Antarctica	218	29	68	7		322
South Eastern Europe	295	90	155	16		556
Eastern Europe	674	167	170	21		1,032
Other Europe	836	53	206	33		1,128
Lebanon	79	3	10	3		95
Iraq	18	50	160	12		240
Other M-East, Nth Africa	645	190	241	42		1,118
India	949	224	430	37		1,640
Other S & Central Asia	639	267	516	34		1,456
Philippines	161	41	81	18		301
Vietnam	580	30	25	18		653
China (excl. Taiwan)	814	304	489	49		1,656
Taiwan	109	28	21	3		161
Malaysia, HK & Singap	2,605	299	140	56		3,100
Indonesia	122	24	44	6		196
Other Nth and SE Asia	304	70	102	25		501
USA & Canada	281	54	104	20		459
Other Americas	149	15	35	15		214
South Africa	544	93	363	40		1,040
Other Africa	310	57	129	25		521
Not stated	72	49	46	3	345	515
Total	14,221	2,735	4,678	727	25,962	48,323
Non Aust born total	14,221	2,735	4,678	727	345	22,706
Overseas-born total	**14,149**	**2,686**	**4,632**	**724**		**22,191**

Source: Australian Bureau of Statistics (ABS) 2001 Census, customised matrix, Centre for Population and Urban Research

Within a transitional period such as our own, a critical issue for many skilled migrants can be the gulf in Australia between immigration policy and local employer (or in the case of doctors) patient preference. Immigration policy has typically advanced ahead of public opinion in Australia. Whatever the policy-level assumptions, 'employers (and patients) may not view the skills that migrants have acquired overseas in the same light as similar skills acquired in Australia'[12]. Despite the evolution of anti-discrimination and equal opportunity legislation in Australia through the past two decades[13], the onus for professional change and adaptation to date has rested primarily with migrant job seekers. Incoming professionals are expected to strive for success by making 'an active attempt to adapt their existing skills, acquire new skills, seek out job opportunities, and generally improve their knowledge of the Australian labour market'[14]. Employers have been largely absolved from blame or shared responsibility in this process, since in the view of Australia's Bureau of Labour Market Research:

The low value attached to pre-migration work experience does not necessarily imply discrimination. The skills some migrants bring to Australia may (genuinely) not be as useful to employers as similar skills acquired in Australia. Some skills are (context) specific and for that reason lost with change of job. Others, such as knowledge of professional practices and regulations, can be country specific and therefore lost through migration... Employers might find it hard to evaluate the job record of a migrant with little or no Australian experience. In addition, migrants may not have sufficient knowledge either about the labour market or the range of contacts to fully utilise the opportunities that do exist[15].

While acknowledging the truth of this view, it is also essential to recognise that perception of migrant professionals' worth may equally be mediated by ethnic and cross-cultural differences - particularly given Australia's acceptance of doctors from a constantly diversifying range of source countries.

Table 3: Permanent and temporary medical migration to Australia by visa class, including net gains (2001-2002)

Medical Practitioners																	
		2001 *Movement*								**2002** *Movement*							
		Arrivals				**Departures**				**Arrivals**				**Departures**			
		Residential status			Tot			Tot		Residential status			Tot			Tot	
Visa class		**Settl**	**Resid**	**Visit**	**Arriv**	**Resid**	**Visit**	**Dep**	**Net**	**Settl**	**Resid**	**Visit**	**Arriv**	**Resid**	**Visit**	**Dep**	**Net**
		Total															
	Australian Citizens	3	579	15	597	885	51	936	-339	1	559	14	574	948	36	984	-410
151-9	Other Perm. Residents		66		66	62	12	74	-8	2	105	1	108	54	2	56	52
	Australians	3	645	15	663	947	63	1,010	-347	3	664	15	682	1,002	38	1,040	-358
	Spouse*	154	9	13	176	15	43	58	118	175	11	9	195	14	59	73	122
	Other Family	42	17		59	6		6	53	33	13		46	11		11	35
	Independ Skill	74	6	1	81	7		7	74	70	6	1	77	5	1	6	71
	Other Skilled	36	2		38	3		3	35	33	6	1	40	2		2	38
	Humanit+	6			6				6	14			14	1		1	13
422	Medical Practition.			501	501		231	231	270			552	552		291	291	261
442	Occupat. Trainee			384	384		183	183	201			307	307		207	207	100
444	NZ Citizens	489	11	100	600	56	28	84	516	131	15	102	248	57	21	78	170
457	Business (Long Stay)			111	111		17	17	94			94	94		24	24	70
560	Student			216	216		60	60	156			97	97		61	61	36
	Other		1	203	204	6	127	133	71		3	459	462	8	183	191	271
	Total Overseas	801	46	1,529	2,376	93	689	782	1,594	456	54	1,622	2,132	98	847	945	1,187
	TOTAL	804	691	1,544	3,039	1,040	752	1,792	1,247	459	718	1,637	2,814	1,100	885	1,985	829

Source: Department of Immigration Multicultural and Indigenous Affairs arrivals data (provided August 2003). Spouse etc* includes prospective marriage; + almost all of these doctors would have arrived as dependants (usually spouses) of Principal Applicants with occupations other than medicine.

D. Differential Employment Outcomes for Overseas Trained Doctors

The Impact of Occupational English Test and Australian Medical Council Examinations

As can be seen from Table 4 (based on 2001 Census data), very substantial numbers of recently arrived medically-qualified permanent residents have struggled to find work in Australia – particularly those from non-English speaking backgrounds or less highly developed source countries. While 80 per cent or more of doctors qualified in New Zealand, the UK/Ireland and South Africa had found medical employment within 5 years of arrival, only a third of those from Middle Eastern, Eastern European or non-Commonwealth Asian countries had achieved professional integration, while medical migrants from Vietnam, China and Lebanon faced virtual exclusion from practice[16].

Table 4: Employment outcomes for medical migrants arriving 1996-2001 as of August 2001, by select country of birth (2001)

Country of Origin	Medic %	Oth Prof%	Adm/ Man%	SubProf/ Cler%	Unem %	NILF %
New Zealand (286)	84	5	1	3	2	5
UK/Ireland (857)	83	7	2	1	1	5
S Africa (363)	81	3	2	5	1	8
India (430)	66	5	1	2	10	13
HK, Mal, Sing (140)	59	4	0	6	2	29
Other S & C Asia (516)	39	2	0	12	11	32
Iraq (160)	37	4	0	4	24	31
Other Mid-E/ N Africa (241)	36	7	5	10	12	27
SE Europe (155)	35	6	0	15	12	32
Philippines (81)	33	7	9	20	7	38
E Europe (170)	24	5	0	13	12	41
Vietnam (25)	12	0	0	12	0	76
Lebanon (10)	0	0	0	0	60	40
China (489)	5	19	2	19	8	39
Total Overseas born arrivals (4,632)	53	7	1	7	7	22

Source: 2001 Census (Australia)

In large part the barriers these doctors faced were related to their difficulty passing the mandatory Occupational English Test (OET) and/or the Australian Medical Council (AMC) pre-registration examinations[17]. In 1996, for example, the Occupational English Test was shown by Hawthorne & Toth to have prevented or significantly delayed 43 per cent of all medical candidates from proceeding to the second stage of the qualifications assessment process, with 22 per cent of OTDs failing over repeated attempts, and candidates from select Middle Eastern, East and South East Asian countries particularly disadvantaged. (See Tables 5 and 6.)

As demonstrated in Table 7, over a 25 year period select country of origin doctors experienced even greater difficulty passing the Australian Medical Council Multiple Choice Question (MCQ) and Clinical examinations. Just 35 per cent of all candidates passed the MCQ on their first attempt between 1978 and 1993, with an additional 39 per cent passing on successive tries. Sixty-seven per cent of East European doctors failed the first time, compared to 79 per cent of candidates from select non-Commonwealth Asian groups and 39 per cent of doctors qualified in English speaking source countries. Similar patterns were evident in relation to the Clinical examination, with a high 81 per cent of Vietnamese, 79 per cent of Yugoslav, 75 per cent of Filipino, 64 of Polish, 50 per cent of Iraqi and 48 per cent of German candidates initially failing.

Table 5: Occupational English Test medical candidates, 1991-1995: number of attempts

No. of Attempts	Pass (% of Candidates)	Fail (% of Candidates)	No. Total Candidates
1	57.4	16.2	1532
2	16.6	3.5	419
3	2.6	1.3	82
4	1.4	0.3	36
5 or more	0.2	0.2	10
Total	78.3	21.6	2079

Source: Hawthorne, L & Toth, J (1996), 'The Impact of Language Testing on the Registration of Overseas Trained Doctors', *People and Place*, Vol 4 No 3

Table 6: Occupational English Test medical candidates, 1991-1995: pass rates by select country/region of origin

Region of Origin	% of All Candidates	% Pass Rate
Not known	22.5	87
Oceania	1.2	96
South & West Europe	3.5	81
Former Yugoslavia	3.5	82
North Europe	0.4	88
East Europe	5.4	79
Former USSR	6.4	77
M East & N Africa	14.1	77
Africa (ex N Africa)	1.2	71
North East Asia	13.0	63
South East Asia	9.0	70
South Asia	17.6	83
Central America & Caribbean	0.6	69
South America	1.3	71
Total (no)	2,079	78

Source: Adapted from unpublished analysis of Occupational English Test results 1991-1995 for overseas qualified nurses, J Toth (1996)

Table 7: Australian Medical Council examination outcomes by select origin (1978-1993)

Country of Candidate	% Passing MCQ (1st Attempt)	Total No 1st Cand.	% Passing MCQ (Repeats)	% Passing Clinical (1st Attempt)	Total No 1st Cand.	% Passing Clinical (Repeats)
Hong Kong	74%	205	68%	58%	121	64%
UK	71%	56	50%	79%	28	100%
South Africa	63%	228	58%	72%	165	60%
Sri Lanka	49%	303	50%	38%	183	49%
India	34%	581	45%	38%	327	45%
Germany	29%	93	52%	52%	52	43%
Egypt	28%	406	36%	26%	225	38%
Iraq	23%	34	44%	50%	6	50%
Poland	23%	128	40%	36%	24	48%
Bangladesh	17%	48	37%	17%	18	67%
Yugoslavia	17%	69	24%	21%	28	55%
Philippines	11%	171	22%	25%	43	19%
France	6%	16	26%	60%	5	50%
China	0%	36	44%	75%	4	0%

Source: Derived from Australian Medical Council Incorporated; Canberra, 1993; Australian Medical Council Incorporated. *Annual Report, 1993-94.* Australian Medical Council Incorporated, Canberra, 1994.

The most recent AMC data (2002) reveals more encouraging trends, with Iraqi, Sri Lankan and Bangladeshi candidates achieving MCQ pass rates of 80 per cent or more on their first or subsequent tries (exceeding the rates for UK candidates). Disappointingly however, outcomes remained typically low for many first or subsequent candidates attempting the Clinical exam. Further, Indian and Chinese (PRC) candidates (numerically dominant groups in medical migration) continued to fare poorly – achieving MCQ pass rates of 47 per cent and 51 per cent respectively, and Clinical pass rates of 63 per cent and 57 per cent. (See Table 8.)

Though the fairness or otherwise of the Australian Medical Council examinations has been debated for decades[18], this issue cannot be examined here. The key points to note in relation to the current study (of great significance to RLRP doctors) are that:

- 1992 saw the introduction of an unprecedented formal quota system, defining only the top 200 candidates of each MCQ test as eligible to sit for the Clinical exam, regardless of the number actually passing[19]. This requirement persisted for a number of years before being overturned by a high court ruling[20].
- From 1994, the Clinical exam had to be passed in three successive attempts, or candidates had to re-qualify again through the MCQ examination[21].
- In the mid 1990s the number of administrations of each test type per year was reduced, with the number of Occupational English Test sittings dropping from 4 to 2 per year, and the MCQ and Clinical administrations generally reducing from 2 to 1 - reforms obliging candidates to face double the previous delay before re-sitting.
- The Department of Employment Education and Training halted its subsidisation of the courses which had evolved to assist migrant doctors prepare for the MCQ in Victoria from the late 1980s. An additional assessment of English language competence was also imposed in 1996, embedded into the Clinical examination right at the end of the pre-registration process.
- In 1996, as noted, Federal legislation was passed to ensure that even if permanent resident OTDs gained AMC registration, they had to wait 10 years before being able to bill on Medicare.

Table 8: Australian Medical Council examination outcomes by select origin (2002)

Country of Candidate	Candidate Numbers	% Passing MCQ (1st or Repeat Try)	Candidate Numbers	% Passing Clinical (1st or Repeat Try)
South Africa	17	88%	23	91%
Iraq	54	87%	65	66%
Sri Lanka	34	82%	34	65%
Bangladesh	81	80%	63	48%
Pakistan	36	75%	19	53%
Egypt	48	46%	30	73%
UK	38	74%	34	88%
China	69	51%	35	57%
India	133	47%	49	63%
Poland	4	50%	3	33%
Fmr. Yugoslavia	17	47%	17	47%
Philippines	33	33%	23	39%
Total candidates	**871**	**56%**	**559**	**62%**

Source: Derived from Australian Medical Council Incorporated. *Annual Report, 2002.* Australian Medical Council Incorporated, Canberra, 2003.

The consequence of high OET and AMC failure rates by the late 1990s was the development of a large pool of work-hungry permanent resident OTDs, characterised by forced career gaps and with access to only conditional Australian medical registration. In order to work in medicine, such OTDs were obliged to secure positions in areas of undersupply (most typically rural general practice or public hospital House Medical Officer or registrar positions), where employment on conditional terms is possible. This process applies to all RLRP doctors. By contrast the growing numbers of temporary resident doctors entering Australia by the late 1990s (including all VORRS doctors) have been able to by-pass the Occupational English Test and AMC exams, despite a

significant minority being derived from identical source countries to permanent resident OTDs (eg India), often similarly associated with high AMC failure rates.

This situation was regarded as deeply inequitable by large numbers of OTDs interviewed for this study, in a context where 28 per cent of the survey sample had reached Australia pre-1993 and 29 per cent between 1994 and 1998: all permanent residents. Within the process summarised above, permanent resident OTDs have had their initial labour market disadvantage compounded by yawning career gaps[22]. It was common for those in the research sample to report having been locked out of medical employment for 5 or more years, resulting in a level of skills wastage castigated by the Human Rights and Equal Opportunity Commission in 1992 and again in 1995[23].

An African doctor commented 'I mean it is unfair - being an Australian I didn't have the chance, while those coming from overseas on a temporary visa, they can get a chance (to work in medicine) in less than three or four months… (A colleague who recently arrived from a comparable source country) worked here just when he arrived. He didn't have to do anything, even the OET.' An East European medical specialist, by July 2003 still lacking either MCQ or Clinical passes 14 years post-arrival in Australia, described working for a decade across five locations in the Asia-Pacific region as well as in rural Australian towns (several states), in order to keep his medical skills alive:

> *I left my country 87, then I was approved by Australian government as refugee and they shifted me here. I was quite shocked initially. I showed them my papers and they said they don't care… For a couple of years I was out of job, on unemployment benefits. It was shocking. You can't imagine really, having some type of status, even coming from communist country as refugee and suddenly being nobody. On the other hand I had to get some money for my family. I did four or five different jobs, from taxi driver to building industry to painting things like that. Then I went overseas to get employment… If we are not fit to work, we should not be allowed. If we are fit to work, we should be free anywhere as an Australian doctor. OTDs can sit for exams for ever and nobody cares about that. It has been going on for 50 years that rural areas rely on overseas doctors and it's a little bit like experimenting on rural citizens, which is not right. Doctors should, if they are allowed to work, be accepted as Australian doctors and have unlimited times to sit exams. If (they are) not (acceptable), they should not be allowed to work as doctors at all.*

A South-East European doctor recalled how the imposition of the MCQ candidate quota compounded the pre-registration barriers he had initially faced:

> *It took for me five and a half years initially (to get my first Australian medical position). We arrived in 1992, my English was very wrong level. So I had to go through general English school, then I had to go through English for medical professionals, which is a three month course, and of course some further courses for preparation for the exam. I failed the MCQ exam so then I had to wait a further year to have a second exam because there was a court case and they did not organise any at this time (after all this still failing).*

The latest data indicate that waiting lists for the AMC exams are growing again rather than diminishing: 884 candidates sitting for the MCQ in 2001/2 cf 669 four years earlier, and 319 sitting for the Clinical exam cf 220. In 2001/2 522 candidates attempted the MCQ for the first time, compared to just 301 in 1998/9. This Australian Medical Council hurdle remains daunting for many overseas trained doctors, rendering alternative pre-registration pathways of continued professional interest. Many of those engaged in Victorian rural general practice have endured years of skills atrophy, frustration and poverty associated with this situation - disadvantages compounded by their age. As indicated in Table 9, around half of all OTDs in Australia are aged 45 years and over – a pattern replicated by this study's participants.

E. Australia's Growing Reliance on OTDs: Case Studies in Demand

It is Australia's level of medical maldistribution that is currently transforming overseas trained doctors' options - exacerbated (the authors would argue) by the underlying inadequacy of medical labour market supply. The historical significance of this shift should not be underestimated. There

is now unprecedented ease of access to medical employment in Australia for OTDs who have either wholly by-passed the 'mandatory' pre-accreditation examinations, or only partially satisfied their requirements. This trend is regarded as extraordinary in select other immigrant-receiving nations, eg within the European Union, Canada and New Zealand[24]. It is likely to ensure Australia remains a destination of continuing interest to migrant doctors for the foreseeable future.

Further, in 1996 (as we have seen) Federal legislation was passed to ensure that even once permanent resident OTDs gained AMC registration, they had to wait 10 years before being able to bill on Medicare. This measure is currently being exploited by Federal and state governments, with doctors willing to serve in areas of need for a minimum of 5 years eligible to bill on Medicare once they have passed the AMC or RACGP exams, and (in the case of temporary residents) to convert to permanent status. This creates strong incentive for VORRS as well as RLRP doctors to enter rural general practice, but none to remain there following completion of 5 years service.

General Medical Employment: Public Hospitals and Rural General Practice

Before proceeding to the RLRP and VORRS doctor study which is the focus of this report, it is important to contextualise Australia's growing reliance on OTDs by reference to comparable developments in three additional medical sectors.

By 2001 283 permanent resident OTDs were employed as junior doctors in the Victorian public hospital system, prior to passing their Australian Medical Council clinical examinations, with India and Iraq the primary source countries. A further 114 permanent resident OTDs were employed as junior doctors in the Tasmanian public hospital system[25].

In select specialty fields such as surgery and psychiatry, where public work is poorly remunerated and characterised by unfavourable practice conditions, dependence on conditionally registered permanent and temporary resident OTDs has also been rising markedly. This process has been sustained by growing medical specialist migration (see Table 9). The following case studies exemplify this process, extracted[26] from recent reports by Birrell and Hawthorne co-authored with select others - the trends being markedly similar to those creating reliance on OTDs in rural general practice medicine.

Case Study 1: 'The Outlook for Surgical Services in Australasia'
B. Birrell, L. Hawthorne and V. Rapson (2003)

Access to surgical services in non-metropolitan Australia is highly problematic - the key reason being a shortage of surgeons willing to practise in the public sector and/or in regional areas. According to senior Royal Australasian College of Surgeons (RACS) informants, while there is reasonable access to surgeons in regional Victoria, the situation can be described as 'acute' in New South Wales, pockets of South Australia and Western Australia, and 'disastrous' in regional Queensland. A range of towns in New South Wales wholly lack surgeons, or have surgeons unable to function due to unfilled related positions (eg anaesthetists). Dubbo, for instance, is reliant for surgical services on Royal North Shore Hospital. Virtually no ENT surgeons are available west of the Blue Mountains, and there is only one Advanced Surgical Trainee position west of the Great Divide. Tamworth has no urologist but is about to get one 'who will be the sole urologist in that vast area up to the north'. Queensland from Mackay to Gladstone is described as 'a black hole' in terms of surgery. The scale of these problems cannot be rectified by the RACS locum service.

Within this context Australia has become increasingly reliant on OTDs for the provision of surgical practice in three contexts. First (as previously noted) a substantial stream of overseas-trained surgeons enters Australia each year under the Occupational Trainee category. According to one senior informant,

> *Virtually all surgical units are dependent on having some overseas-trained surgeons there to help with the surgical workforce. At (major urban hospital) there are at any one time in the Department of Neurosurgery five to six overseas-trained surgeons… These people are all very helpful to us, because they provide a major workforce. We pay them very little. The ones from Japan and China are paid nothing. There are two from South Africa who retrained with us and stayed on to work as neurosurgeons, great successes!…*

Selection methods vary, some coming through institutional links, others through response to direct applications (of which) I get at least one a day.

A second category of surgical employment characterised by growing reliance on overseas-trained surgeons is 'area of need' positions in rural or regional Australia. Three streams of overseas-trained surgeons currently fill these positions: surgeons recruited from the United Kingdom, the European Union and select Commonwealth nations, of whom minimal professional adjustment is perceived to be required; South African surgeons, attracted by the prospect of securing permanent resident status in Australia; and permanent resident OTDs already in Australia, who have not been trained in Commonwealth countries and have failed to secure full Australian accreditation. Problems related to the skills variability of the latter group, including serious limits to the availability of medical supervision, were highlighted by a number of study informants.

The scale of these 'area of need' appointments in surgery is now substantial. While short term contracts were the norm until the late 1990s, overseas-trained surgeons are currently able to work in 'area of need' positions in NSW for up to ten years. According to a number of informants this can represent a potentially appealing option, particularly for overseas-trained surgeons required but finding it difficult to access highly competitive Advanced Surgical Training positions. At the same time the risk of exploitation for non-accredited OTDs can be serious in such sites:

I have to say – and it's a generalization – that there are a lot of employers (and area of health boards) out there who are using these overseas trained practitioners as cannon fodder, because they cannot or will not make their environment a safe and appropriate one, and they can get these practitioners to come and work with them under these conditions, because these poor people want to have a job… The overseas practitioner becomes a captive – they sit there for 10 years, they can't move anywhere else because they're not registered to do so, but the location is screwing them to the ground, paying them less, making them work in an unsafe environment, while they provide surgical services. You might say 'well at least they've got a job', but that's not in the public (or the surgeon's) interests.

In addition to the first two categories, there is a substantial pool of overseas-trained doctors also employed as 'non-accredited surgical registrars' – in theory for only a limited time (one to two years) but in practice again for far more extended periods. These surgeons are drawn from the pool of overseas-trained doctors who have failed to achieve full accreditation to date, and are unable to competitively secure Advanced Surgical Training positions[27]. While in the past a few lateral entry places were reserved annually to facilitate the entry of overseas-trained surgeons, this pathway has since been abolished. In consequence there is now a substantial pool of 'non-accredited surgical registrars' in existence, working on a demand-driven basis in positions offering similar pay to that of accredited Australian trainees, and performing a comparable range of surgical procedures (there being no formal definition of those which can or can't be undertaken by non-accredited surgeons). According to informants, public sector patients may have no knowledge of whether they are being seen by accredited or non-accredited surgeons. This can be problematic, as indicated by the following quotation:

Some people see benefits to the current system: Basic Surgical Trainee and other non-accredited surgeons getting experience (not being wasted), the workforce being fairly elastic, the potential to attract people to unfilled locum positions etc. Many ex-BST trainees become 'career medical officers', contributing to a ratio of around 50:50 accredited compared with non-accredited surgical registrars. Non-accredited surgeons get all the jobs accredited surgeons don't want to do (eg night duty, locum duty, rural/regional public sector employment). The College has no real idea how many overseas-trained surgeons are filling these surgical positions… Australia probably often uses overseas-trained surgeons – people unlikely to secure AST positions.

Table 9: General medical practitioners and specialist medical practitioners by birthplace, age and period of arrival (2001)

2001 Census			Total Medical Practitioners			General Medical Practitioners			Specialist Practitioners		
Birthplace			**Census Yr**			**Census Yr**			**Census Yr**		
			1991	1996	2001	1991	1996	2001	1991	1996	2001
Australia	Age	<35	8,915	7,502	6,429	6,826	5,459	4,715	2,089	2,043	1,714
		35-44	7,481	8,608	7,943	4,452	5,578	4,948	3,029	3,030	2,995
		45-54	4,011	5,356	6,996	1,897	3,106	4,576	2,114	2,250	2,420
		55-64	2,504	2,565	3,407	1,364	1,418	1,823	1,140	1,147	1,584
		65+	1,416	1,772	1,676	890	1,208	1,074	526	564	602
	Total		24,327	25,803	26,451	15,429	16,769	17,136	8,898	9,034	9,315
New Zealand	Age	<35	239	337	340	176	236	240	63	101	100
		35-44	194	288	322	87	134	171	107	154	151
		45-54	98	153	214	27	66	102	71	87	112
		55-64	93	104	104	36	43	46	57	61	58
		65+	31	56	62	15	35	29	16	21	33
	Total		655	938	1,042	341	514	588	314	424	454
Mainly ESB (MESB)	Age	<35	1,691	1,484	1,436	1,348	1,055	1,041	343	429	395
		35-44	1,564	1,624	1,902	881	1,011	1,181	683	613	721
		45-54	1,018	1,394	1,615	543	805	967	475	589	648
		55-64	765	778	829	495	490	470	270	288	359
		65+	382	481	488	254	347	312	128	134	176
	Total		5,420	5,761	6,270	3,521	3,708	3,971	1,899	2,053	2,299
Other Countries	Age	<35	2,106	2,930	3,549	1,793	2,402	2,991	313	528	558
		35-44	2,447	2,676	3,631	1,755	2,021	2,759	692	655	872
		45-54	2,156	2,880	2,900	1,474	2,128	2,256	682	752	644
		55-64	901	1,377	2,002	607	972	1,451	294	405	551
		65+	389	580	778	299	456	585	90	124	193
	Total		7,999	10,443	12,860	5,928	7,979	10,042	2,071	2,464	2,818
Not Stated	Age	<35	23	52	84	20	37	72	3	15	12
		35-44	16	33	86	10	24	50	6	9	36
		45-54	13	23	81	13	17	66	0	6	15
		55-64	12	21	55	6	12	38	6	9	17
		65+	3	12	30	3	9	21	0	3	9
	Total		67	141	336	52	99	247	15	42	89
TOTAL	Age	<35	12,974	12,305	11,838	10,163	9,189	9,059	2,811	3,116	2,779
		35-44	11,702	13,229	13,884	7,185	8,768	9,109	4,517	4,461	4,775
		45-54	7,296	9,806	11,806	3,954	6,122	7,967	3,342	3,684	3,839
		55-64	4,275	4,845	6,397	2,508	2,935	3,828	1,767	1,910	2,569
		65+	2,221	2,901	3,034	1,461	2,055	2,021	760	846	1,013
	Total		**38,468**	**43,086**	**46,959**	**25,271**	**29,069**	**31,984**	**13,197**	**14,017**	**14,975**

Source: 2001 Census (Australia)

Case Study 2: 'Victoria's Dependence on Overseas Trained Doctors in Psychiatry'
D. Barton, L. Hawthorne, B. Singh & J. Little (2003)

Virtually identical trends to those described above prevail in the field of psychiatry, as documented by the recent Barton, Hawthorne, Singh & Little study. Prestigious city hospitals remain characterised by strong training programs, a high degree of registrar loyalty, world-class research and a tradition of collegiality. By contrast mental health services in outer Australian cities as well as in regional and rural locations are increasingly characterised by a gross shortage of psychiatrists. According to Sir David Goldberg (a prominent UK psychiatrist) the 'exodus of Fellows' from public sector psychiatry in Victoria has resulted in the recruitment of psychiatrists from overseas who frequently 'do not possess the benchmark qualification for Australian psychiatrists'. A recent AMWAC survey of 52 of these overseas trained psychiatrists (OTPs) noted that 'no fewer than 45 per cent were employed in the state of Victoria'. Such OTPs are overwhelmingly concentrated in rural areas: 43 per cent of those surveyed, compared to just nine per cent of RANZCP Fellows across Australia.

In addressing such public psychiatry shortages, mental health authorities recruit from a number of source countries, including the UK, South Africa, Canada, the US, select Commonwealth nations, and a group of medically under-resourced nations. There are serious ethical issues here, including the appropriateness of wealthy western nations recruiting from countries in desperate need of their services. The global context however is one of sustained migration from south to north, from east to west, and from developing to developed nations. This movement shows no sign of abating. Once offered psychiatric employment, OTPs are registered in Australia by the relevant state Medical Board to practise for a year or more in a defined public health setting. Given the intensity of demand for mental health services, most have been expected to 'hit the ground running'. No period is provided for acclimatisation, training, or induction into the particular local skills required for practice of psychiatry in Australia.

While recognition protocols differ from state to state, OTPs are nominally required to complete the College's requirements within a period of four years, though this timeframe is increasingly lenient because of chronic undersupply. At their point of arrival most OTPs will have been deemed 'suitable for practice', but little more of their skills may be known. Within days the majority will find themselves consumed by the demands of public sector practice. In some instances they may be appointed Acting Director of Mental Health Services, before being even apprised of the relevant Mental Health Act, let alone trained in local pharmacology practices or treatment norms. Some may become the only professional psychiatrist in the public sector service, on call 24 hours a day seven days per week, across a vast geographical area. This reliance, as we have seen, is potentially exploitive of overseas trained doctors. To date attempts to secure Victorian government funding for provision of transitional training and examination preparation support have been unsuccessful.

In addition to this, it should be noted that large numbers of MBBS-qualified OTDs secure their first Australian medical positions in junior public sector psychiatry positions, regardless of their lack of specialist qualifications. Many such OTDs will be 'sojourners', moving on to more desirable positions as soon as these become available. In the interim they will be required to assess patients entering hospital in emergency situations, included attempted suicides and people who are acutely psychotic. Their lack of preparatory training for this work is inappropriate.

F. The Impact of Medical Under-Supply on Rural General Practice

As should be clear from the discussion above, Australia's growing problem with medical labourforce distribution has created unprecedented opportunity over the past decade for overseas trained doctors to practise prior to securing unconditional registration – a pattern replicated in select specialist fields. Following decades of labour market marginalisation, substantial numbers are currently accepting 'area of need' or other GP position/s. Further, a welcome alternative pre-registration pathway for many has opened up: the potential to combine full-time medical employment with satisfying Royal Australasian College of General Practitioner (RACGP) Fellowship requirements within a specified period (variably stated by OTDs to be two or five years), by examination or practice-based assessment.

We now turn to the focus of the present study. Between 1998-99 and 2001-02 276 permanent resident OTDs were approved to work in Victoria's Rural Locum Relief Program (RLRP), with 69 of these 276 accepting subsequent employment extensions. The numbers of these OTDs was supplemented by an additional 86 OTDs directly selected from overseas between 1999 and 2002 to work in the Victorian Overseas Trained Doctor Rural Recruitment Scheme (VORRS), with 85 remaining by late 2002 in rural general practice. (As we have seen, states such as Queensland and Western Australia were characterised by even higher degrees of dependence.

It should be acknowledged at the start, as noted, that rural service is a fundamentally 'coerced' employment option for both these populations. Moreover overseas trained doctors currently combine onerous clinical workloads with addressing these new medical registration requirements. For those uncertain of securing positive outcomes, particularly in regional or remote sites where training may be minimally available, return to city hospital-based work and the AMC track may ultimately prove more attractive. Public hospital employment in Victoria and different states provides access to training programs with a potential to assist OTDs pass the AMC exams, and thus secure unconditional medical registration. Recent research by Hawthorne and Barton demonstrates bridging programs can play a critical role in securing positive outcomes for overseas-trained medical, nursing and other professionals[28]. Despite the best efforts however of groups such as RWAV and the Divisions of General Practice, preparatory programs are frequently limited and costly in regional/rural Victoria, where many OTDs struggle to meet RACGP Fellowship or AMC requirements. Little is known at this stage of the proportion likely to pass them.

Socio-cultural factors may also prove significant in terms of GP retention. As noted in relation to 'mainstream' GPs, the needs of spouses and children can be central to decisions concerning long-term location, including access to family and friends, educational and employment opportunities for children and spouses, it is important to note that OTDs placed in Victorian GP employment are currently derived from an extremely diverse range of source countries, potentially necessitating significant linguistic and cultural adjustment (not merely within employment but within social life). In 2001 the top 10 source countries for the 283 provisionally registered OTDs working in Victorian hospitals were India, Iraq, China, Sri Lanka, Egypt, Bangladesh, South Africa, Russia, Yugoslavia and Pakistan. Recent analysis of Medical Board of Victoria records by Hawthorne demonstrates OTDs engaged in rural or regional GP work to be equally diverse: catering to patient populations in contexts where they and their families may experience significant cultural and/or religious isolation. This issue is therefore addressed by the present study.

To summarise, despite the clear initial acceptability of rural GP work to substantial numbers of permanent and temporary resident OTDs, major problems have emerged in terms of long term retention after they gain full medical registration (in line with those reported in the international literature). OTDs and their families, while willing to move to country Victoria, remain characterised by a high degree of geographical and employment mobility.

In terms of the Rural Locum Relief Scheme (as noted), of 276 permanent resident doctors recruited to work in Victorian rural general practice from 1998/9 to 2001/2, just 88 remained in place by 2002 (a 68 per cent attrition rate). Even for RLRP doctors who have not gained vocational registration there is currently the potential for:

- Movement between medical sectors (eg between rural general practice and urban/regional public hospital employment);
- Response to demand in different states (eg move from Victoria→ Tasmania→ Western Australia); and
- Opportunities for further international movement (eg relocation from India→ Victoria→ South Africa or the Gulf States).

Additional opportunities exist for doctors arriving in Australia since 1996 who have gained AMC accreditation, but in principle cannot bill on the Medicare system until ten years have elapsed. These doctors have the right to move freely within the public hospital sector across Australia, as well as to GP posts offering conditional registration in areas of need nationwide.

Greater stability at the moment is evident for the 86 temporary entrant doctors recruited since 1999 under the Victorian Overseas Trained Doctor Rural Recruitment Scheme, with 85 appointees still in place by late 2002. The VORRS scheme however is relatively new at this time, with doctors yet to fulfil the threshold 5 year service provision requirement, to which temporary visa issue is tied. Their level of retention following this indentured 5 year period is yet to be tested.

It is within this complex supply-demand employment situation that the present study was undertaken - the first among Australia's many studies of OTDs to focus wholly on the views of overseas trained doctors themselves, while seeking to also incorporate the views and experience of their spouses.

2. The Research Aims and Methodology

A. The Aims of the Study

In line with the priorities of the Rural Workforce Agency, Victoria, the commissioned study (undertaken between April and August 2003) had four major aims:

1. To identify the potential availability of temporary versus permanent entrant overseas trained doctors to work in regional general practice in Victoria, based on detailed analysis of RWAV records, immigration arrivals and departures, 2001 Census and Australian Medical Council examination data.
2. To explore OTDs' experience of and level of satisfaction with rural general practice in Victoria, including factors contributing to their potential retention or loss.
3. To explore the level of support that OTDs and their families have received, including any strategies likely to increase their ultimate retention.
4. To assess the impact of permanent residency and full registration on the likely retention of OTDs in GP employment in rural/regional Victoria, including ultimate choice of medical employment location.

In line with these aims, substantial use is made of the data derived from interviews conducted with OTDs (see D. below), in order to complement the statistical survey analyses, and to allow for the inclusion of a range of authentic voices.

B. The RLRP cf the VORRS Schemes

Key attributes of the RLRP cf the VORRS schemes are briefly defined below, given the importance of distinguishing differences between the two groups in terms of satisfaction with Victorian rural practice, and the subsequent likelihood of doctor retention:

Rural Locum Relief Scheme:

- 276 permanent resident doctors recruited to work in Victorian rural general practice from 1998/9 to 2001/2 (the majority arriving in Australia prior to 1998);
- Required to pass the Occupational English Test and the AMC or RACGP exams prior to securing unconditional medical registration;
- Obliged to wait ten years before being able to bill on Medicare once full registration has been secured, unless willing to serve 10 years in 'areas of need' or other high demand medical areas of practice;
- As noted, 88 remaining in Victorian service by late 2002 (including 69 on service extensions).

Victorian Overseas Trained Doctor Rural Recruitment Scheme:

- 86 temporary entrant doctors recruited from 1999 (all arriving in Australia between 1999 and 2002);
- Required to have some form of recognised postgraduate qualification, with doctors possessing postgraduate qualifications from New Zealand, Canada, the UK, South Africa, the USA and Singapore viewed as immediately eligible, *or* equivalent general practice experience to enable them to sit the FRACGP exam within 2 years;
- Not required to sit the Occupational English Test or AMC exams - instead able to proceed immediately into medical practice;
- Participants required to obtain the RACGP Fellowship qualifications within two years of commencement of rural service, and eligible for permanent migration on achievement of the FRACGP and unrestricted Australian employment following 5 years of rural area service (securing capacity to bill on Medicare);
- As noted, 85 appointees still in place in Victoria by late 2002.

C. Analysis of Secondary Data

To provide an appropriate context for the study, four major sets of secondary data concerning OTDs were accessed and analysed in addition to the published literature listed at the end of this report:

- All 1998-2003 Department of Immigration Multicultural and Indigenous Affairs (DIMIA) arrivals and departure data for OTDs, by permanent versus temporary status, by state of initial location, by country/region of origin, by visa category and age;
- 1996 and 2001 Census data identifying employment outcomes for overseas trained doctors by country and region or origin in Australia;
- Australian Medical Council examination outcomes data for the periods 1978-1993 and 2001-2002;
- Occupational English Test examination outcomes data for 1989-1995 (provided by the test administrator, Language Australia); and
- Select Rural Workforce Agency, Victoria databases for both Rural Locum Relief Program and Victorian Overseas Trained Rural Recruitment Scheme overseas trained doctors.

D. Mailout Surveys: Overseas Trained Doctors and Their Spouses

A comprehensive survey was developed and mailed out to the following populations of overseas-qualified rural and regional GPs currently employed in Victoria (245 people in all), with a variation of the survey enclosed for spouse completion:

- All past and present participants in the Rural Locum Relief Program;
- All past and present participants in the Victorian Overseas Trained Rural Recruitment Scheme.

Prior to the mailout the eight page OTD survey was circulated for comment to members of the Steering Committee convened by RWAV for this project (including three overseas trained doctors). The survey was piloted on a sample of five OTDs, with three responses received. Minor content changes were made as a result of this process. Please see the Appendix to this report for copies of both the OTD and spouse surveys.

An estimated 86 responses were required from the OTD survey population (initially assumed to be 276) in order to assure an appropriate level of statistical power based on Kish's 1965 formula[29] for population sampling. In defining an adequate response size we assumed 25 per cent of doctors to have stayed in the scheme (affirmed by RWAV), a sampling error of 0.05, a test size of a=0.05, and power = 0.80. The OTD population by the time of the survey administration had reduced to 245. Seven surveys were returned stating doctors to be no longer at the practice address. The response rate of 38 per cent (84 OTDs) achieved following two survey mail-outs in April and May thus fully satisfied the statistical power requirements. Spouse surveys were returned by 56 cases, representing 77 per cent of all OTDs reporting being partnered.

In terms of the 84 OTD respondents, the following characteristics should be noted:

Table 10: Characteristics of the OTD survey sample

Attribute	OTD Survey Sample
Employment scheme:	62% of respondents were employed under the RLRP scheme cf 38% under the VORRS scheme.
Country of birth:	The sample were derived from 32 countries of origin, the major sources being the former USSR and the UK/Ireland (14% each) followed by China, Egypt and South Africa (7% each), India and Poland (5% each) and Iraq and Bangladesh (4% each).
Region of birth:	To create large enough cell sizes for the purpose of statistical

	analysis, OTD respondents were categorised into the following regions of origin: 1. *Europe* (31%): x26 OTDs from the former USSR (12), Poland (4), former Yugoslavia (3), Bulgaria (1), Romania (2), Brazil (European origin, 1), the Netherlands (1), 2 unstated 2. *Asia* (30%): x25 OTDs from China (5), India (4), Sri Lanka (3), Bangladesh (3), Fiji (Indian origin x2), Malaysia (2), Pakistan (1), Philippines (2), Vietnam (2), 1 unstated 3. *Africa* (13%): x11 OTDs from South Africa (5), Kenya (2), Nigeria (1), Uganda (1), 2 unstated 4. *UK/Ireland* (12%): x10 OTDs from UK (7), Ireland (2), Australia[30] (1) 5. *Middle East* (12%): x10 OTDs from Egypt (5), Iraq (3), Iran (1), Syria (1)
Period of arrival:	28% of OTDs had arrived in Australia prior to 1993 (these doctors almost certainly characterized by permanent resident status, career gaps, and considerable AMC frustration). An additional 29% had come between 1994-1998 (prior to the introduction of the VORRS scheme), with the remainder (43%) arriving far more recently (from 1999-2003).
Migration category and applicant status	32% of OTDs migrated in the Family category, 21% as skilled Independents, 20% via the Temporary 422 visa, 13% in the Refugee/Humanitarian program, 9% in the Employer Nomination Scheme, 4% from New Zealand, plus small clusters in other schemes (eg on student visas). 60% of all informants were Principal Applicants at the time of migration, with 30% non PAs, and the remainder not knowing (or missing data).
Gender and family status:	62% of all respondents were male cf 38% female. The great majority of OTDs were partnered (87%), with 91% of those with children currently living with them (at least part of the week).
Age:	Over half of all respondents (56%) were aged 40-49 years, with a further 23% aged 30-39 and 20% aged over 50.
Religion:	57% of OTDs reported being Christian (including a number from the Middle East), followed by no religion (17%), Islam (12%), Hindu (7%) and Buddhist (4%).
English ability at time of arrival (self-assessed)	16% stated they had had native English skills at time of arrival, 43% with excellent or very good English, and 17% with nil or poor English (the latter exclusively RLRP scheme doctors).
Languages spoken at home:	24 languages were listed as spoken at home, with English the most common (41%), followed by Russian (15%) and Arabic (8%) – many OTDs speaking two languages and some speaking up to five.
Number of medical qualifications:	Survey responses suggested OTD respondents to be a well-qualified group: 58% reporting possession of two qualifications and 34% with three to four. Such qualifications had not necessarily been secured in country of birth – the international student experience often being a precursor to subsequent migration.
Length of medical experience pre-migration:	16% of OTDs had 5 years or less medical experience pre-migration, compared to 34% with 6-10 years and the remainder 11-30 years (reflecting OTDs' relative seniority in terms of age).

Medical registration status:	69% had only achieved conditional medical registration in Australia by the time of the survey cf 31% having unconditional registration.
Employment location:	61% were located in small Victorian towns, 25% in regional cities, and 13% in outer Melbourne.

Data Analysis

Following collation, the survey data were entered and verified.

Missing data were imputed using two procedures. Where a datum was missing on either a doctor or spouse survey and the question had been asked of the partner, the partner's datum was present and the question was one which related to both partners, the missing datum was assigned the partner's value (eg migration category). Where a datum was missing which was not amenable to this procedure, hot deck imputation was used where the deck was defined as all doctor or spouse surveys respectively. Where there were grounds for assuming the datum was unique to an individual (eg qualification level or age), no attempt was made to impute the value.

Statistical procedures used for discrete data included frequency counts, chi-square (χ^2) for contingency tables, and where the chi-square assumptions regarding data distribution were violated Fisher's Exact test. To compare the likelihood of discrete events, odds ratios (OR) and 95% confidence intervals (95%CI) were also calculated.

For the analysis of continuous data, where the data were normally distributed ANOVA was used. Where data were continuous but skewed, prior to analysis the data were transformed using either log or square-root transformations. In these cases, in the interest of interpretability, the original data have been presented although the analyses were based on the transformed data. For non-normally distributed continuous variables which were not amenable to transformation Kruskall-Wallis one-way ANOVA was used instead. Where overall significant differences were reported, to investigate which groups were significantly different, the data were post-hoc analysed with the Tukey-Kramer Multiple Comparison Test.

To identify related variables exploratory factor analysis was used, and for estimating the reliability of constructed scales internal consistency was examined through Cronbach alpha. Finally, for predicting outcomes of interest multiple linear regression was used. Mindful of the limited sample size and potential for multiple collinearity, iterative stepwise procedures were used to produce the most parsimonious solutions without violating sample size requirements. For significance, the conventional $\alpha = 0.05$ was accepted. Although no adjustment has been made, because of the number of analyses the test size was strictly interpreted. The data were analysed in SPSS, EpiInfo and Instat[31].

E. Individual Interviews: Overseas Trained Doctors

Initially it was hoped to undertake three to four regional case studies to provide detailed insight into OTDs' perception of general practice employment, the nature of their partners' and children's experience, and the ultimate determinants of any decision to stay or pursue alternative destinations. Given low response rates to mailout invitations to attend three regionally-based information sessions (April), direct phone contact was made by the researchers to OTDs located throughout Victoria, in order to explain the need for individual interviews and to assure potential participants that personal anonymity would be respected.

On this basis 37 OTDs agreed to participate in audiotaped interviews conducted by Assoc. Professor Hawthorne and two senior research assistants (Ms Lesley Burgell and Dr Nelson Nheu) of the Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne. Face to face 30-90 minute interviews were conducted from mid-July to late August in 21 rural/regional

locations, with phone interviews conducted in a further 8 sites – a process significantly increasing the time required to complete the study. Though research sites cannot be named in order to preserve doctors' anonymity, an excellent state spread was achieved, with source regions including the following:

- Central Victoria: 9 locations
- Eastern Victoria: 9 locations
- South-west Victoria 7 locations
- North-west Victoria: 6 locations
- North-central Victoria: 4 locations
- Outer-metropolitan Melbourne: 2 locations

Factors relevant to the study aims were explored in these interviews from OTDs' individual perspectives, including their migration trajectories, their pathways into regional general practice, their experience within their current posts, and the strategies most likely to increase their ultimate rural retention. The basic demographic attributes of the 37 interviewees can be summarised as follows:

- *Countries of origin*: 19, the primary sources being India (5), the UK (4), the former USSR and Iraq (3 each), Poland, the former Yugoslavia, Egypt, China, South Africa, Romania and Pakistan (2 each)
- *Gender*: 54% male cf 46% female
- *Employment category:* 70% of informants employed under the RLRP scheme cf 30% under the VORRS scheme

The RLRP doctors were derived from a more diverse set of source countries than VORRS doctors – ranked in terms of region of origin clusters as below:

- *Europe*: Former USSR (x3), former Yugoslavia (2), Poland (x2), Romania, the Netherlands, the UK
- *Asia*: India (x2), China (x2), Pakistan, Malaysia
- *Middle East*: Iraq (x3), Iran, Syria, Egypt
- *Africa*: Sudan, South Africa, Kenya

It should be noted however that VORRS doctors were also more diverse than initially expected in terms of origin, with interviewees derived from the UK (x3), India (x3), Pakistan, South Africa, Nigeria, Zimbabwe, and Egypt. According to key informants, VORRS doctors were increasingly being drawn from non-Commonwealth source countries, such as China. As noted a range of such countries (eg India) have historically been associated with fairly low AMC pass rates.

All 37 interviews were fully transcribed for thematic analysis, with informants' anonymity preserved in line with standard ethical procedures. (Hence no higher level of demographic detail can be provided.) For the same reason, while a wide range of quotations from these interviews have been integrated into the analysis that follows, only region rather than country of origin is stated for each quote, and no locational detail is provided.

F. Individual Interviews: Australian Key Informants

Supplementing the perspectives of these 37 OTDs, a further 15 30-90 minute phone interviews were conducted with Australian key informants by Assoc. Professor Hawthorne and Ms Burgell, with informants derived from 14 locations across Victoria:

- North-east Victoria (4 informants)
- South-east Victoria (4 informants)
- Central Victoria (3 informants)
- North-west Victoria (2 informants)
- South-west Victoria (2 informants)

All key informants were selected for their longstanding experience in relation to OTDs in rural/regional general practice, based on advice given to the researchers by the RWAV. The professional roles of those interviewed included five senior executive positions and one workforce officer position within the Victorian Divisions of General Practice (x6), CEOs of district hospitals or

regional health bodies (x4), RWAV senior administrators/ area managers (x4), and the head of a rural clinical school (x1). As with the overseas trained doctors, all interviews were fully transcribed to permit thematic analysis.

3. The Research Findings: OTDs and Their Spouses

The key research findings related to overseas trained doctors are summarised below under ten headings:

A. The issue of hypermobility
B. Motivation to relocate
C. Prior medical experience in Australia
D. Experience in current general practice position
E. Level of colleague acceptance
F. Remuneration levels (including patient demand)
G. Provision of training and support (including examination preparation)
H. Support from the Divisions of General Practice and RWAV
I. Factors likely to impact on doctors' retention in current positions (including the significance of VORRS cf RLRP status and region of origin)
J. Spouse perspectives on rural general practice and retention

Comments related to spouse perspectives are largely confined to J, while the views of Australian key informants are dealt with separately in Section 4 of the report.

A. The Issue of Hyper-Mobility

In line with the introductory analysis presented above, overseas trained doctors in the survey sample reached Australia through virtually every immigration category:

- 32 per cent in the Family category
- 21 per cent as Independent Skill migrants
- 20 per cent via the Temporary 422 visa category
- 13 per cent in the Refugee/Special Humanitarian Program
- 9 per cent through the Employer Nomination Scheme
- 4 per cent from New Zealand
- Additional small clusters within other migration schemes (for example on student visas)

At the time of arrival 60 per cent of all respondents stated they were Principal Applicants, with 30 per cent non Principal Applicants, and the remainder unsure. Their settlement intentions were mixed at the point of entry, with 70 per cent planning to stay permanently, 26 per cent uncertain, and 4 per cent planning only temporary sojourns. By the time of the survey however 51 per cent of all OTDs had become citizens (almost half of these having secured it by 1997), with a further 32 per cent reporting permanent resident status, and 16 per cent remaining on a temporary basis.

It is important to note the high proportion (close to a third) of all OTDs arriving uncertain in terms of their future goals. This 'fence-sitting' is not surprising. Perhaps the most critical finding of this study is the entrenched hyper-mobility of overseas trained doctors currently located in Victorian rural general practice. Sixty-six per cent of all respondents reported 5 major geographical moves prior to their current position (migrating to one or more countries and then additionally within Australia). Thirty per cent had made 3 to 4 moves, with 5 per cent reporting an extraordinary 6 to 8. The qualitative interviews graphically illustrated this process, revealing up to 10 geographic relocations undertaken by a single informant.

When analysed by region of origin, Asian-origin doctors were found to be 5 times more likely to have reached Australia via a third country when compared to the others (all regions combined, OR 4.95 [95%CIs: 1.42 – 17.78]) - a highly significant difference. Such patterns, once established, may not be easily broken, making long-term commitment to a randomly chosen rural location unlikely.

Pre-Arrival Migration Patterns

The pre-migration international movement described by OTDs took many forms:

1. Just under half the research sample (49 per cent) had migrated to Australia directly from their country of birth. A high 51 per cent had come via multiple relocations[32]: 36 per cent after living in one other country, 11 per cent after living in 2 other countries, and 5 per cent following a series of moves involving 3 or more distinct international relocations.
2. Common patterns in relation to this emerged from the survey and interviews, including:
    - The strategic 'funnelling' of OTDs from developing to developed nations (most notably doctors from India);
    - Migration to Australia via preliminary migration to NZ (where access is traditionally easier); and
    - Entry to Australia via temporary migration to/work within South Africa or the Gulf States (countries also characterized by medical shortages).
3. Overall 41 per cent of such respondents reported working in 2 countries, 20 per cent in 3 countries, and 6 per cent in 4 to 5.
4. The number of years spent working in a second country could be very extensive, with 28 per cent of such informants stated they worked for just one year in country 2, but 63 per cent stating they had worked for 2-7 years before moving on to Australia. Stays of 5 years or more did *not* therefore signal permanent retention.

The following descriptions from overseas trained doctors of their migration trajectories exemplify this process:

> *I'm from (South Asia), but I worked in South Africa. From Africa we went to the UK, then I went to Canada, then to New Zealand and to here. We felt isolated in New Zealand, because we had a lot of friends and relatives in Australia. I (found a job advertised and) worked in the base hospital in a small town as a Senior Medical Officer in emergency and other specialities. I was also doing some locum (GP work) in a Medical Centre. I finished that for six months and then there was a practice in (another Victorian country town). The GP Division at the hospital asked if I was willing to go. And so after that I came here.*
>
> *I was born and bred and went to University in (African country) and I left there and worked in South Africa for six years and from there I moved to the Middle East and worked in Bahrain. There it is a very temporary situation and after three years we thought we had had enough. I saw an advert in the British Medical Journal for the practice I am in now. So I thought I would come over and have a look.*
>
> *I was born in (East Asia), and I studied there. I did my MBBS in medicine and after that I did a Master of Medicine as well. After that I went to New Zealand and did my PhD there. I came to Australia six years later, then worked in two country towns as well as Melbourne.*

It should be recognised in relation to this that such OTDs had invested years in multiple medical relocations in order to secure improved opportunity. For many such doctors rural Victorian posts would be no more than an additional step along the way to their ultimate goal: maximising family lifestyle, quality of income, and personal security.

B. Motivation to Relocate

Migration to Migrate to Australia

Improved lifestyle and opportunities for children were stated to be the primary reasons overseas trained doctors elected to come to Australia (40 per cent), their comments making clear that such motivations were inextricably linked. Additional reasons cited were pre-existing family links (23 per cent), security/safety (21 per cent), career opportunity (12 per cent), and adventure or sea-change, particularly at a critical junction in life (4 per cent). The point to note here is that career opportunity was relatively unimportant in determining Australia as a destination choice – an issue

indicating the extent to which OTDs might let non-career factors determine their future practice locations.

Interestingly no significant differences between doctors in terms of motivation to migrate were found by RLRP cf VORRS status. In terms of region of origin, OTDs from the UK/Ireland were found to be over 4 times more likely to report coming to Australia for family/lifestyle reasons than other survey respondents (OR: 4.36 [95% CI: 1.10 – 17.71]). No other region of origin differences proved significant - an interesting phenomenon in itself, suggesting that safety/security issues were just as important for VORRS doctors migrating from South Africa as for the 13 per cent of RLRP doctors who had entered Australia first under refugee visas.

British doctors typically described frustration with working conditions in the UK, or the desire for a better quality life as their primary aims:

> *Came here for a number of reasons really. General dissatisfaction with how the system was running in the UK really, and also wanted to improve the life of my family… Came and visited a couple of practices and have a holiday for about 3 weeks to get a general feel for the place. Essentially in the UK not uncommonly particularly during the flu season you would see 55/60 patients in surgery a day and then perhaps 4 or 5 home visits on top of that on a daily basis. It wasn't for me, I couldn't sustain that workload. Here I see probably 5 patients an hour whereas my workload is 8 patients an hour. I got precious little satisfaction from it (in England). I didn't feel I got through medical school and training to actually be just doing that the rest of my life. So I am actually able to practise medicine here. The standard of investigative facilities here is excellent. Far exceeding the UK.*

South Africa-based doctors reported being far more satisfied with their quality of life in Africa, but increasingly concerned by the risk of violence, like this doctor of South Asian origin:

> *The only thing was that the violence, the insecurity was gradually going up. We heard these sort of stories every day. Some professional has been targeted or shot by somebody. So it just make you greatly fear that it could happen to anyone. It was sort of like fear and insecurity was cropping up. I mean I got small kids and they're not going to school at this moment, but tomorrow they have to go alone. I don't know how long it would be like constant fear for their life that something was wrong. So we were trying to find a safe place where we can go.*

A number of RLRP doctors had fled acute refugee situations, or crumbling communist regimes. Often such doctors were accepted by New Zealand first, which allowed easier migration access – transferring as of right to Australia once citizenship had been gained in order to improve their prospects of medical employment:

> *The reason for leaving Yugoslavia is quite simple as I mentioned, the war at that time - that atmosphere of hatred and killing all around. And the only permanent residence that would be quick was New Zealand. We couldn't go to Canada or Australia even with our profession. And then we spent five years in New Zealand. We studied English very hard as we couldn't speak it ten years ago. And then I heard from some friends that in Australia you don't have to wait until you pass all exams to start working but you can work and study at the same time. We found it perfect that Australia would give that opportunity. And so that was the main reason why we left New Zealand and moved here five years ago, because we loved New Zealand, but I couldn't get a job.*

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For other doctors migration to Australia came as part of a sequence of carefully strategised moves, designed to transplant families from third to so-called 'first world' countries where they could secure significantly greater career rewards. This pattern was particularly associated with OTDs of Asian origin:

> *I was born in (South Asia) and when I got married I moved to a major city. When I didn't get the speciality I wanted I went to (the European Union) to do my qualification there. From there I came back to (South Asia). It was a bit difficult financially so I felt I would go out to the Gulf States. I worked in one of the hospitals there for 18 months. It was a*

completely different culture for me. Then we went to New Zealand and we had to search for jobs at that time with no family support there. We were a bit frustrated financially so one of our friends who worked in Southeast Asia said, "Why don't you come here?" We moved there for a number of years, but my qualification was not recognised. So we debated whether to do some studies or migrate to a different place where we could both get a job. Then we decided on Australia, as we had New Zealand citizenship. I came first.

Choice of State and Current Location

In marked contrast to choice of country, career opportunity was the primary reason overseas trained doctors reported they came to the state of Victoria (39 per cent), followed by access to family/friends (38 per cent), the intrinsic attractiveness of Victoria as a state (14 per cent), and RWAV's rural GP recruitment scheme (4 per cent).

A high 61 per cent of OTDs stated that job-related reasons had been the critical determinant in coming to their current rural location - suggesting if positions proved disappointing they might have minimal incentive to stay. Importantly a substantial number of doctors stated that they saw this site as their 'only' current medical option (in other words a highly constrained choice). It is important to recall here that many such OTDs were indeed 'captive'. As previously stated 69 per cent of all respondents had achieved only conditional medical registration by the time of the survey in April 2003. The majority of permanent residents had attempted without success to pass the 'mandatory' pre-registration exams, meaning they were eligible to work as general practitioners only in 'areas of need' or comparable sites. Those with full registration were working to reduce the period required for eligibility to bill on Medicare from 10 to 5 years. Visa conditions for temporary resident OTDs were similarly constrained in terms of GP location options.

C. Prior Medical Experience in Australia

OTDs reported having secured their first medical registration in a range of states, confirming the willingness of those established in Australia to shift to improve their career options. While 27 per cent of all respondents had been placed in their current position immediately on arrival in Australia (including all selected through the VORRS scheme), 22 per cent had been without work for 4-12 months post-migration, 10 per cent for 1-2 years, and 30 per cent for 2 or more years (including some for very extensive periods). Within this interval RLRP doctors had become desperate to secure medical work, after years spent trying to pass AMC exams in relative isolation, convinced that clinical exposure would assist them to do this while they earned.

As public sector House Medical Officer positions became available to OTDs (reportedly from the mid to late 1990s), these were readily taken up. Such employment however could be far from ideal in terms of work/ study/ family combinations. An African doctor recalled his professional transition, following years of unemployment:

In the base hospital in the Emergency Department it was very long hours, minimum 10 to 17 each day. And the toughest was the night shift because it runs from 8 to 9 in the morning. Weekends were really very hard, because you are left alone in the Emergency Department and you are responsible for the whole hospital. That is like a hundred beds including the ICU, the Mental Ward, plus on top of all this the Emergency Department. We had just one day off, but if it was like five nights in a row, then actually we did not have a proper day off. You would just go sleep for the whole day, and then the following morning you would come back, which was really draining. I can say all the Emergency doctors were from overseas. Three from (the Middle East), one from Vietnam or Thailand, two from India or Sri Lanka. I am sure everybody is not happy there. But they cannot complain. For the locally trained doctors, they work a maximum of ten hours. I didn't see any one of them who had more than ten hours. Plus the payment was not done equivalent to the hours you are working, so it is a lot worse. I am sorry to say that it is exploitation. There were no local doctors working overnight unless it is like a locum under very restricted circumstances. No time even for my social life. It was really very hard. My family was living in (a capital city interstate) so it was very hard for both sides.

Other doctors described comparable exploitation in their initial non-GP work. A South Asian doctor recalled:

> *I remember after two days of transport, I landed in (a Queensland regional centre). I started the Tuesday in (a small outback town). The person that relieved already left on the Sunday because she had other work to do, so the hospital didn't have anybody for the Monday. On the Tuesday I had to start the practice and I had absolutely no idea of Medicare, how it worked. I asked the secretary. What I'm saying is that in Australia's rural areas it can be very tough. In fact you must remember that I was in charge of a hospital by myself. I was the only doctor in that hospital of 55 beds. I was on call for three weeks non-stop. You know it would have been better if you prepared a chap better because then he would be happier and feel more secure and your population will then have a good doctor looking after them. And of course that is not a family life to be on call every night for three weeks and then have three days off. It's just not, you can give me all the petrol and money in the world but it gets on top of you. So that's why we left Queensland. While I was in Queensland the Director of Medical Services of (a regional town) came to me and he said, "Oh, we definitely need doctors down in Victoria. Why don't you come and work for us?" I said, "All right." So then I flew down here and I was interviewed. I have now worked in two rural towns in Victoria.*

Like many, this doctor's pre-migration mobility patterns were reinforced by shifting to three successive Australian locations, including ultimately his current rural general practice work. In the course of analysing the qualitative interviews, geographical moves were mapped for all 37 overseas trained doctors. Table 11 describes the moves made by a randomly selected group of 10 (with specific identifying information again suppressed). As will be noted later, in terms of hypermobility significant differences were found between region of origin groups (Fisher Exact test, p=0.05), with VORRS doctors more likely to have worked in 3 countries than RLRP doctors (Fisher Exact test, p=0.04), and Asian-origin OTDs to have migrated to Australia after multiple sojourns (including in New Zealand or South Africa). Any notion that VORRS doctors have been recruited direct from their country of origin to work in Australia are simplistic. As stated before such doctors were fulfilling a carefully designed sequence of migrations, with the aim of achieving superior opportunity/safety for themselves and their families.

Within their first medical employment in Australia it was common for OTDs like those above to feel inappropriately placed – given excessive levels of responsibility with minimal or transitional training, like this second Middle Eastern informant.

> *I did Emergency for six months and then I did Psychiatry, I did Obstetrics, it was very hard. Then I moved to (western Victorian town) and did a bit of Emergency Registrar work - things I hadn't done for a while. I'd say you feel always unhappy, you would like to be more sure. You'd like probably someone to say, "Yeah, you're doing the right thing." Instead of going home and thinking, "Oh, should I be doing this, should I be doing that?" I found most of the hospitals, they are very hungry for someone to fill in to Emergency, you have no problem getting into Emergency. But at the same time I think you need someone who has been doing that for a year rather than putting anyone or at least who doesn't know the system well, let's put it this way. You shouldn't be putting him straightaway into Emergency.*

For other informants hospital work proved a benign introductory experience. Many described the relief of at last preparing for AMC exams within some kind of medical context. ('It is worthless leaving migrant doctors just waiting at home, to try and learn what they need to by books. The best way is to put people into public hospital positions for periods of supervised practice, because that is what is going to skill them up in terms of the medical knowledge and infrastructure awareness that is so essential to passing exams!') A number described excellent experiences: welcomed by respectful and sensitive staff, who devised carefully structured hospital rotations.

By definition however all the OTDs surveyed or interviewed for the present study had made the decision to leave public hospital positions – often for income or work pressure reasons, but sometimes because these were sited in untenable locations. A third Middle Eastern doctor, once located in Tasmania, recalled:

There was no (appropriate) church and the other thing the children's school was not available except for Years 9 and 10 and we had to move to Hobart for higher education for Years 11 and 12 so it was very critical for me. There was a big issue here also I can tell you with my spouse's work. Searching for a job was hard in Tasmania. (My spouse) used to be a manager in the Gulf States and we lost huge money for coming here but that is our choice. We came here for children's education and we are hoping to get what we want to do.

Table 11: Geographical relocations reported by a random sample of OTDs in the interview research sample

Movement Trajectory
East Europe→ New Zealand→ Melbourne→ Central Victoria (regional city) → Central Victoria (small town)
East Europe→ European Union→ Melbourne→range of international locations→ Tasmania (small town)→ Melbourne→ Northern Victoria (small town)
Middle East→ Perth→ Melbourne→ North-west Victoria (regional city)→ Central NSW (regional city)→ South Western Victoria (small town)
Middle East→ Gulf States→ Melbourne→ Western Australia→ East Gippsland (regional city)
South Asia→ South Africa (3 rural and 1 urban location)→ Queensland (x2 rural locations)→ North Victoria
South Asia → UK→ South East Asia (x 2 countries)→ North America→ New Zealand→ Central Victoria (regional city)→ Central Victoria (small towns x2)
South-east Asia→ India→ Melbourne→ Sydney→ Central NSW (small town)→ East Gippsland (small town)
East Asia→ New Zealand→ Brisbane→ North-west Victoria→ Melbourne→East Gippsland (small town)→ East Gippsland (additional small town)
Africa→ Middle East→ Gulf States→ Perth→North-west Victoria (regional city)→ North-west Victoria (small town)
Africa→ UK→ other African countries (x2)→ South-east Asian countries (x3)→Sydney→South-east Asian country→Sydney→South-west Victoria (small town)

Once the opportunity of rural general practice positions emerged, permanent resident doctors swiftly transferred to the Rural Locum Relief Program – an option many regarded as infinitely preferable to the rigours of HMO work. Describing his transition, the African doctor quitting the exploitive base hospital position (above) reported 'Double the money for half the hours!' VORRS doctors, as we have seen, were recruited from the start to undertake GP work. It is important to recognise however that some, as indicated by Table 11, had reached Victoria after GP stints in other states. For all OTDs, whether permanent or temporary origin, work in alternative Australian locations and other countries remained a viable option. Moreover while access to the RACGP pre-accreditation pathway was a welcome prospect for most - an opportunity to leave the failure associated with repeat AMC attempts behind them – it was only presumed in advance to be more benign. Many at the point of interview had not actually tried it (see G. below).

D. Experience in Current General Practice Position

Thirteen per cent of all OTDs surveyed stated that they had been in their current location for 4-5 years by April 2003, 56 per cent for 2-3 years, with the balance being far more recent arrivals (2002-3). Encouragingly, 40 per cent of respondents reported being very satisfied with the nature of their GP work, compared to 56 per cent who were only reasonably satisfied and 4 per cent who were dissatisfied.

To measure satisfaction with general practice overall, the nine items probing satisfaction with different aspects of their work were entered into an exploratory factor analysis (see Q58 in Appendix 1; the item "Opportunity to prepare for AMC examination/s" was omitted since this was not

relevant for all respondents). This factor analysis revealed that all nine items were measuring a single underlying construct (eigenvalue = 4.27) explaining 46 per cent of the variance. All items loaded on this vector >0.60. The pivotal items were satisfaction with professional support, specialist access and medical resources. The internal consistency of the resulting satisfaction scale was Cronbach α = 0.85, suggesting a high degree of reliability. Based on summation, the general practice satisfaction scale score range was 9-36, where lower scores indicated a higher level of satisfaction. The mean score was 17.65 (sd = 4.95; n = 84), indicating that overall satisfaction levels were at the 68 per cent scale range; which was just marginally lower than the 'gold' standard for satisfaction proposed by Cummins[33]. The interpretation was that study participants were reasonably well satisfied with their work as GPs.

When satisfaction was examined, there were no statistical differences (ANOVA, F = 0.77, p = 0.55) by region of origin or by VORRS/RLRP status (ANOVA, F = 0.52, p = 0.47). The interpretation is that although there were individual differences as described below, across study participants there was broad agreement regarding satisfaction with GP work.

When asked to rate their level of satisfaction with select aspects of rural general practice however, highly variable outcomes were reported. (See Table 12 for categorization by rank order.) In brief, doctors were pleased with the majority of work-related issues, including the perceived friendliness of their town. Many felt they had developed positive relationships with peers and achieved a good level of professional support. In terms of work the main areas of disappointment were the provision of assistance to pass the mandatory pre-registration exams and (to a lesser extent) the quality of training/supervision available as well as the salary level cf initial expectations. These issues will be examined separately below.

While satisfaction with access to work for partners, nearness to family/friends and ethnic communities were rated low overall, it is important to state up front that such issues were not necessarily critical for all OTDs, as will be shown in the analysis to follow. The impact of lack of spouse employment depended entirely on whether a spouse at a current point in time sought work – many OTDs with young children viewing their wives as 'happy to be at home with the kids' for the time being. Similarly doctors stating they were far from their ethnic communities often explained at interview that this issue was in fact of minimal concern, for example for VORRS doctors who had already made three or more global moves, and were used to preserving their cultures in exile.

By contrast a number of other issues were repeatedly raised by OTDs at interview as central to their personal and professional ease, thus influencing their retention. These concerns will be dealt with in turn below, along with the significance of spouse, family and culture-related issues for OTDs indicating such factors were important.

Table 12: Proportion of OTDs satisfied or very satisfied with select aspects of current GP position

High satisfaction factors	Reasonable satisfaction factors	Low satisfaction factors
The nature of GP work (95%) Relevance of the position to their medical skills (89%) Friendliness of the town (88%) Medical location (87%) Access to specialist services (80%)	Relationships with colleagues (76%) Level of local professional support (76%) Access to other medical resources (72%) Location and size of town (72%) Range of town facilities (70%)	Quality of schools (63%) Salary level (62%) Quality of training/supervision (62%) Access to partner's job (46%) Nearness to family/friends (41%) Level of support/time available to help pass pre-registration exams (31%) Access to ethnic community (27%)

I. Factors Associated with High Level OTD Satisfaction

The Nature of GP Employment

The great majority of OTDs, as we have seen, expressed a high degree of satisfaction with general practice employment (95 per cent), viewing the work as extremely relevant to their skills, and supported by good access to specialist services. The following UK doctor contrasted many aspects of Victorian rural employment favourably to his previous GP work for the National Health Service in Britain:

> *(It was) primarily the practice. The size of the building looked nice, it had a number of partners so you could rotate the on-call. The size of the town I was pleasantly surprised by - I was expecting a town of 20-30,000 and when I got here (the total area) was about 50,000. And there are a lot more facilities here than I thought there would be so that has actually been a great bonus for us. The climate is fantastic, the people are tremendous and have been very welcoming. My wife has commented on this. She has a lot of dealings out in the community and people have been very welcoming and very willing to try and make us feel at home and so that's been a huge advantage on arriving… I think probably 6 weeks in I thought it was great.*

For substantial numbers of OTDs regional general practice offered a better quality of life, including access to more diverse medical work in intrinsically attractive locations, as reflected in the following extracts from British and West European informants:

> *I knew that it would be a big change in the way I worked. It's been a positive one. I'm doing things clinically that I wasn't doing, I've had to up-skill. There was some pressure initially there but I thought hard before I chose to make the step… My interests are mainly outdoors, sailing, cycling, walking so for us they're better here because there are less people and less traffic. I drive the same distance to work here that I did in the UK and it takes me 20 minutes here where on a bad day in England it could take you an hour and a half. And it's a lovely drive. The countryside around (location) is fabulous.*

> *Family and friends in this area, lifestyle, the local circumstances are from a work perspective excellent. I work in a good practice, it's a relatively young group of GPs, there are registrars here whose education is interesting, evidence-based medicine, so it's very stimulating. I'm able to work and for the family it's a very pleasant environment to live. Not too far away from family and friends so it's the best of both worlds, I would say.*

Friendliness of the Town

While in general British-origin doctors reported the most streamlined transitions, many from diverse cultures reported a similarly benign start. An African of non-British origin had achieved excellent social and professional acceptance, despite being both racially and culturally isolated in his current town:

> *For me and my family I don't think we can ask for more. We get a lot of invites, you know, people come around all the time checking on us. My kids are enjoying themselves in school. They've got very good support, you know, from friends and families. My wife also. And we've got (Africans from our culture) in Melbourne. They come down here, we go down there, because it's not far anyway. So we can't really complain.*

Many OTDs took immense satisfaction in the nature of rural practice – large numbers having grown up in small rural towns so that such settings in Victoria did not seem wholly alien. ('I didn't mind the location. I came from a smaller country town in the Middle East. My family's a farming family so there's not much difference here.') After the anonymity of city hospital work, OTDs commented positively on the kindness they could receive – including occasional willingness to make provision for children, and assistance with transport if required. Others embraced the opportunity to provide holistic medical care, with patients' families known including many factors impacting on medical status. Doctors were also pleased by the diversity of the patient conditions they saw:

We start at 9 o'clock in the morning and have a break from one to two, which is never a good break actually because of demand, and then again from two to five-thirty. Plus after that you would still be on call three nights a week as we are just two doctors here. That's why we are keeping the mobile on. We deal with a lot of variety: diabetics, hypertensives, asthmatics - all these basic things; injuries of course in general, and especially weekends here when they have footy and netball. You really know where the main health issues are because you know everything in the community. You know, just when the patient is entering your surgery what is wrong with him, yeah, because you really understand the whole situation in his family (and work) and that is very helpful.

Others commented favourably on the quality of the Australian medical system, despite the practices they entered being highly diverse, with some involving demanding workloads and others associated with 40 hour weeks. In terms of this issue, as illustrated by the comments below, there were no observable distinctions between RLRP and VORRS doctors:

(South Asian VORRS doctor) *This is essentially a non-procedural practice, we do general practice medicine and we don't do any emergency work as there is a public hospital nearby. We do hostel care and we deal with patients in private hospital but most of our work is around prevention and minor ailments, treatment of chronic illness, vaccinations … this is not a very rural practice as we have a main hospital down the road. But the main issue is that there are a lot of patients, it is very busy. The challenge is meeting the expectations, getting to see them. The other challenge is we don't have accessibility to specialist care, limited accessibility so you have to manage most of the issues. You have to use a lot of insight.*

(British VORRS doctor) *I am a salaried doctor in a clinic with about five other doctors. I am the only female doctor and I work four days a week about 37 hours and one Saturday morning in four. I also do some work at an after-hours clinic. That involves me maybe working a couple of evenings a month from 7.30pm till 10.30pm at night. I am very happy with those kind of hours, it is nice for me to have a full day off. We have very good facilities. We have a main surgery in (one town) but we also have three branch surgeries in some of the smaller towns round about. I feel that is a useful thing to do for the patients in that they don't always have to travel too far from their homes in order to access medical services. The whole ethos of the clinic in which we work is that it does good for the people round about it rather than simply as a business to earn money.*

(South Asian – via South Africa – VORRS doctor) *Rural practice is good, personally very satisfying and morally very satisfying because you know you are doing it where you are wanted most. And for me I am doing it for the real purpose of wanting to do good. I get a monetary thing out of it but I am not interested to see one thousand patients walk through the door. For me the real game plan is getting them better, a commitment to society.*

(UK RLRP doctor*) Oh, it's very different, it's much easier in a lot of ways, I mean the resources at my disposal here are amazing. I never cease to be amazed that I can order a CT scan and have the results back in two days! In the UK a GP would not have been able to order it, and secondly it would have been months before it would have got done.*

(East European RLRP doctor) *I liked it and I love it too now. I come from a relatively poor country not well organised, so it is still all amazing for me. Organised, well planned in advance, ongoing education. It is unreal for us. You can get any information, any support, anything you need in terms of your medical problems - you can do anything. I was pleasantly surprised and I'm enjoying it.*

(East Asian RLRP doctor) *In my country there is no assistance like the General Practice. When I first came to Australia I was amazed at the continuity of care and preventative medicine which is wonderful. I made up my mind that if I could have my exam I want to be a general practitioner.*

Many doctors reported satisfaction in the rapport they felt they had established with patients:

> (Middle Eastern VORRS doctor) *The good thing is the type of patients here. I love them, really I love them. I have been one and a half years of working here and so far I have found people are friendly and as you give them they give you love and care and thank you and are grateful for what you are doing for them. Maybe in (this town) I am lucky because they are classy people and are stylish, and these type of people give me great job satisfaction. I am well accepted, well appreciated and they always talk about my qualification and you know it gives me a bit of confidence.*

An East European doctor stated:

> *People are undemanding and appreciate that I am here as a doctor. They say they are very happy as they have heard that I will stay here for longer and appreciate a steady sort of appointed doctor. No drugs or violence in this town which is also good. I like my town and the people, I get on well with my colleagues and this would probably be enough to make me think like that.*

It is important to note however that consistently high demand – particularly in 'two doctor' decentralised towns with constant on-call burdens - could render rural practice a short-term rather than a long-term option:

> (African VORRS doctor) *The practice we are looking after is in two towns so we are looking at about 6000 patients on the books. We have two hospitals that we look after and your day is hectic from beginning to end, so you do all your ward rounds and check out your hospital patients to start with and then come into the rooms and do your day-to-day consulting. You are forever disturbed by the hospital and emergencies that you have to sort out at the same time. There is a lot of travel for us, the two towns are about 35 kms apart, and so we are running back and forwards between the two. On-call is pretty heavy especially weekends when we do Friday, Saturday and Sunday and there is only one of us to look after the whole area. Weekdays we each do one and half weekdays and we also look after a couple of little out stations, like I will do (town X) which is about 60 kms away and I do clinic out there once a week and that in itself adds quite a lot of pressure. It is tiring, and I can see why people get burnt out pretty quickly in the country.*

II. Factors Associated with Moderate Level OTD Satisfaction

Many OTDs (76 per cent) reported receiving valuable assistance from colleagues when they relocated their families and commenced their GP positions, with an equal proportion considering there to be a good level of professional support, as illustrated by the following four interview excerpts. Doctors often commented favourably on the nature of their location (72 per cent) and the quality of town facilities (70 per cent), regarding access to medical resources as reasonable in most cases (72 per cent). For informants located 200 kilometres or less from Melbourne, distance did not necessarily impose an insuperable burden – a number keeping their families based in the capital city, and perhaps even commuting themselves on a daily or weekly basis. As we shall see later however, a minority of OTDs considered colleague attitudes and geographical location to be far less appropriate – issues with clear implications for long term comfort and retention.

> (UK VORRS doctor) *I have been more than happy with the help that I received from (my practice) and that has certainly made the relocation much easier. They arranged accommodation for the whole family and provided us with a car for the first year, which certainly made the whole process of relocation much easier. I think that is probably something that is quite important when attracting doctors is how difficult the whole process is going to be. In professional life in medicine issues at the beginning were learning how the system works, learning how things like the TAC and the Work Cover, Centrelink and all these things and what they are and what they do and all that kind of thing, that takes a bit of getting used to. The idea of having two sorts of prescriptions, a PBS and Authority scripts was novel to me and that took a bit of getting used to.*

(South Asian RLRP doctor) *I'm very lucky where I am working. My mentor, she's a very sweet lady. Whenever I have any problems - basically the first six months it was a bit difficult because it's a completely different environment and different problems from the hospital set-up. But she was very supportive. Though I was not getting much income because I used to get a good income at the hospital but when I moved into general practice I had to pick up my own practice she was supportive, she gave me some of her patients to look after in the nursing homes and hostels so that I would get a little income.*

(African RLRP doctor) *I have to say it has been entirely positive and very supportive for me. When I started, I hadn't done general practice for a long time, about 15 years, so it was quite a fast learning curve for me, things have changed quite a lot. But the practice was excellent. It's a small practice, we're only really two other full time doctors there, and a registrar and another part time doctor. But one of the other full time GPs, the principal of the practice, he was just fantastic. The first month, he put aside an hour a day where I could just talk to him about problems and issues, discuss things with him. And then you know, it was really up to me how often. When I felt more confidence it went down to an hour twice a week or three times week. And that was really good. And you know, I do appreciate that an hour out of his time is an hour where he is not consulting and not earning. Asking me round to dinner and introducing me to people who would be good social contacts for me. And finding a house to rent and a school for my daughter. All those little things they were just really great. And made me feel welcome, and valued and well supported.*

(East European RLRP doctor) *Very positive, very good experience, I'm very happy. I didn't expect it, probably at some stage I said 'please can you help us a little bit less frequently' because they were bombarding us with information with sessions, seminars, lectures. It has been fantastic in keeping us up to date really from any point of view, any field of medicine. (In my prior job – hospital) colleagues, I would tell you probably 99.9% are ok. There was one colleague who was unnecessarily rude. But he was under stress, I understood him and he apologised later. This was probably the only minor incident.*

Despite the overall positive nature of such comments, it is important to note that significant differences in terms of level of satisfaction were found between doctors by region of origin. When complex statistical analysis was undertaken, doctors from Asia, Africa and the Middle East proved 3 times more likely to be only reasonably satisfied or to be actively dissatisfied with the nature of their work when compared to survey respondents from the UK/Ireland or Europe (Chisq = 5.19, p = 0.02. OR: 3.00 [95%CI: 1.04 – 8.80]). This finding is important to bear in mind in relation to select issues that follow, including level of satisfaction with relations with peers.

III. Factors Associated with Low Level OTD Satisfaction

As noted in Table 12, a cluster of factors were associated with far lower doctor satisfaction ratings, including the quality of local schools (63 per cent), salary levels (62 per cent), access to training/supervision (62 per cent), access to a partner's job (46 per cent), nearness to family/friends (41 per cent), the level of support/time available to help pass pre-registration exams (31 per cent), and access to ethnic communities (27 per cent). A range of these issues emerged as so significant in the interviews that they are dealt with separately in the sections that follow. Preliminary comments here concern the perceived adequacy of schools, spouse employment and the experience of cultural isolation – the latter mentioned again in relation to the spouse survey analysis to follow.

Quality of Schools

As stated in the Introduction, overseas trained doctors are highly aspirational migrants – their aspirations being not merely for themselves but extending to cross-generational opportunities for their children. In interpreting this, please recall that when motivation to migrate to Australia was analysed, opportunity for children and safety for families were shown to be respectively the first and third most important 'drivers' for survey respondents – highlighted as the most powerful issues by 40 per cent and 21 per cent of informants (in contrast with just 12 per cent of respondents stating they had selected Australia for personal career opportunity).

Given this, it is not surprising to find doctors were willing to live in rural/regional Victoria while their children were young, or if OTDs were childless. By contrast those entering rural general practice when their children had reached the critical teenage years held serious concerns – fearful that they would limit their children's academic aspirations if unable to afford superior schools (eg boarding school in regional cities, or location in Melbourne). Like contemporary Australian doctors, many had imposed a time limit on their stay in regional Victoria on this basis, as illustrated by the interview quotes below. The first is derived from a doctor who - like some quarter of all those interviewed - had habituated himself to 'living as a bachelor' in order to secure his children's future:

> (East European RLRP doctor) *They're living in Melbourne. It's not ideal I know but I've got that experience of living like a bachelor on my own for four and a half years in (my previous HMO position). So I'm getting slowly used to it, living on my own and seeing my family on weekends. It would be hard to resist (a chance to live with them in Melbourne). To go home from work and have dinner with your family and stay at home all day with your family is something that I would say is normal. But for the next two years I will definitely be here.*

A second East European doctor, similarly placed, commented that if he had kept his children living with him:

> *… you would feel you were disadvantaging them. I visit them on weekends from (current GP town). They are 14 and 19, and when we migrated they were 3 and 8. That other doctor had to leave because from an education point of view it was very poor and the closest place is (a regional city) and it is about an hour by bus. The money that I was earning in (my location) wasn't extremely good. No complaints but it wasn't enough to put my child in a boarding school. And the other thing is the partner, there wasn't any chance for her to find work. She used to be a scientist so there was no way she could find the work. She worked as a personal care assistant for a while (but it wasn't satisfactory).*

A South Asian VORRS doctor who had stayed in his regional location while his oldest child completed Year 12, felt he had actively restricted her opportunities by doing so – a pattern he was determined not to repeat with his younger child:

> *The children all have to go to school in (a regional city) – there's no high school here. The children travel one hour in the morning and one hour in the evening to school. And in between with all the school activities my wife has to go and pick them up, about 40 kms from here. When they get home it's very late. The children always complain about that, we don't have facilities here, we don't have a library here – they have to go to (the regional city) but we don't have time for that!… They want to study hard for their exams but it's not easy to do that. They don't have the opportunity to score high marks like the people in Melbourne. This is the biggest problem that everybody is facing here, that children are totally left out and they're not able to (meet their) aspirations… I've spoken to some friends from some other remote areas and they feel the same problems. Left out, and no opportunity for the children. It happened when my child finished Year 12 and wanted Medicine, but unfortunately was spending so much time here going up and down, she could get up to 97 score couldn't get into Medicine. She was only a rural candidate, but we had only been here for 2 years, so nobody looks at us - you have to be here for 5 years (to get benefits!). So she was left out, missed out. She wanted to be a rural GP like me – but now look at us!*

Regrettably, a few doctors reported having found rural schooling impossible given their children had suffered racist antagonism, as in the following case reported by a Middle Eastern doctor:

> *We have suffered a lot. We are heroes to do all this. In this countryside there's one high school and my son is dark colour and this (town) is a very Australian closed society, there's no multiculturalism, not people from any other nations. There's just a few recent Asians because of the Australians going to marry some who are coming here. They also have two takeaways owned by Asian people, but other than that there's no other*

nationalities in that town. Very big difficulty with my son, going to that school all these years, every day Saddam Hussein always on the news, you are from Iraq, go back to your bloody country. He had all that kind of racism, made me transfer him to three high schools (including one an hour's drive away)… My kids are now going to Melbourne so I have to move to Melbourne to be at least with my kids, be paid better, not be (suffering) racism.

Spouse Employment

In terms of spouse employment, four major patterns were cited:

1. As previously stated, wives with young children were often satisfied to be out of work for a limited period, particularly when doctors could bring home good earnings.
2. Secondly, wives with nursing qualifications could often readily find rural/regional work – nursing, like medicine, being associated with significant Australian employment shortages[34]. Alternatively, spouses could become practice managers, once an OTD had bought in (typically taking over a clinic from an ageing Australian practitioner).
3. Where spouses did want work, marital separation – as for the children's secondary schooling – was regarded as a viable option (at least in the short term). A range of interview informants had lived separately from their families for years, a decade being the most extreme case reported.
4. In at least one case, lack of suitable spouse employment was associated with private plans to return to country of origin (in Africa).

These trends are illustrated briefly in the quotations that follow, then addressed later in the spouse survey analysis. While one doctor was now divorced, it was impossible to assess the level of tension that 'forced' separations could impose on OTD marriages.

> (African VORRS doctor) *She is a nurse and she found work pretty quickly but she doesn't work now because of the children. There has been a little bit of concern there because professionally she would love to work again but with my hours and commitment it has been impossible for her to sort out shifts without getting someone to look after the children.*

> (British VORRS doctor) *He works with me, he's my business manager and that's why setting up this practice was a really positive thing for us. (Before this) I would say it was much harder for him because I was already building up social support with the people I worked with.*

> (East Asian RLRP doctor) *If your husband is not able to find a job in the rural area it is very hard for them to stay. Like my situation, my husband works in Melbourne so I cannot ask him to move this way and to travel all the way to the city. We need to balance our career and our family and I think that family will be more important, especially with three children and my youngest only being a baby. It is not very practical for me to commute to work in very rural areas.*

> (African RLRP doctor) *I'm actually divorced, and my son lives with my ex-husband in Melbourne, so it's important for me to be not too far from Melbourne so he can come up and down.*

A number of doctors described their concern as they witnessed relatively isolated colleagues 'unravelling', as in a recent case noted in one decentralized area:

> *We have doctors from the Middle East, South Asia and East Asia. Other doctors from Asia and East Europe came and left. One doctor is by himself. He has been here a year alone, and his family remains in their country. We can see how he's deteriorated since he's come back. Now he is taking time off to go back to see his family.*

Unsurprisingly, many OTDs commented on the way their families missed access to their ethnic community. A South Asian doctor said 'The only thing missing is relatives. We had plenty of relatives in Johannesburg. Every weekend we would go out together, eat together, and we can't

even imagine going out and eating here.' Some felt concerned that their children were growing up not knowing or being adequately socialised into their parents' cultures ('I am not very convinced by this culture, especially kids outside at a younger age and living with a partner or friend before marriage'). An East European doctor commented on her family's lack of access to an Orthodox church:

> *We go occasionally to Melbourne and we visit the church and we have a chance to see other people (of our culture). But we don't know them. You just need to see someone who talks the same language. We have a friend, a very good friend who comes from another country town and visits us, and we go and visit. So that keeps the language alive. But you do feel terribly isolated lots of times.*

For many spouses, separation from family and friends could be a major source of tension – some spouses promising they would accept rural placement for 2-3 years, others actively lobbying for a return to capital cities. A Middle Eastern doctor noted:

> *Well if it's up completely to me, (I'd stay) forever! But it's not completely up to me. The wife still nags. She wants her family. They come to visit us every now and again and we go back to Sydney every month, two months, four months for a visit weekend or a holiday. When the children get a school holiday we go there for a few days, they enjoy it there.*

Even where spouses were happy, life in rural towns could occasionally be unsettled by racism, as explained by this South Asian doctor:

> *My spouse is very happy. But in the beginning my children were not very well accepted because they were the only ones who were brown skinned. My son would ask, "When will I become white?" So in the beginning it was a bit painful because there is not much multiculture here. But Melbourne is multicultural and we have friends there at least. So sometimes we feel: are we doing the right thing?*

E. Level of Colleague Acceptance

Despite doctors' generally positive experience with peer relations (reported above) it was clear from both the survey responses and the individual interviews that many had encountered problems with professional colleagues – select themes being repeatedly raised, with clear potential to impact on ultimate retention.

While 76 per cent of survey respondents indicated that they had established positive relations with peers, this had often been difficult, including for a number of British-origin South African doctors (suggesting this issue was not wholly culturally based). When statistical analysis of response patterns was undertaken, there was first found to be no significant difference in response from doctors across the 5 regions of origin, although similarities between some regions were noted suggesting the presence of two different groups by this factor. To investigate this further, given how powerfully concern re level of satisfaction with peers was articulated in the 37 individual interviews, further analyses were undertaken. Those regions of origin which appeared to be similar were tested and, when this was confirmed, were combined. These were the UK/Ireland, European and Asian origin doctors in one group and the Middle Eastern and African OTDs in the other. 'Satisfaction' with peer relationships was then dichotomised into 'very satisfactory/satisfactory' and 'fair/unsatisfactory'. Analysis of the resulting contingency table showed that doctors coming from a UK/Ireland, Asian or European background were three times more likely to be satisfied with their professional colleagues when compared with doctors from the Middle East or Africa (OR = 2.94; 95%CI: 1.07 - 8.07). This highly significant finding should be borne in mind in the subsequent discussion of factors influencing retention.

<u>Four key themes in relation to colleagues' attitudes repeatedly recurred in the interviews:</u>

1. Peer wariness or distrust of medical outsiders (in some cases perceived as downright hostility);

2. Lack of respect for the overseas-trained doctor's skills, including his/her ability to deal with a range of cases without vetting;
3. Reluctance of other doctors to refer on an adequate flow of patients (despite OTDs' recognition of the commitment made by many Australian colleagues to building up patient lists); and
4. Unwillingness to allocate the OTD sufficient remuneration (an issue dealt with separately in the following section, and a critical issue for many).

While OTDs often viewed these as transitional problems, responding with equanimity, many continued to find colleague attitudes both problematic and painful. It is important to recall in relation to this that OTDs were relatively senior in terms of age: over half of all respondents (56 per cent) aged 40-49 years, with a further 20 per cent aged over 50. Moreover these doctors reported possession of a significant number of postgraduate qualifications: 58 per cent with two medical qualifications and 34 per cent with three to four - for a number of informants these qualifications having been secured in the UK or other western countries. Many OTDs had adapted to and been found acceptable within multiple global contexts of medical employment. South African doctors, in particular, reported a high degree of past autonomy in relation to professional work. Within this context any slighting attitudes from Australian colleagues could be offensive as well as wounding, as indicated by the range of quotations provided below. This did not necessarily indicating paranoia. As will be clear from the discussion of key informant views (Section 4) OTDs were at risk of being perceived as medically inferior, including by Australian medical students.

> (African RLRP doctor) *Look, let's be honest - what happens is that after you've been an independent GP for 20 years, you become comfortable with what you can and what you can't do. And then to be submitted again to being basically an intern, I found it a bit degrading. You know, I had to do caesarean sections with a gynaecologist for a whole year before they said, "Ok, you can do them on your own." In the meantime, I've been doing them for 20 years in Africa! I've probably done more than the gynaecologist! I'm not allowed to do tonsillectomies. I've been doing tonsils for 20 years, you know. So there are little things that are irritating just because they say, "Well, look, we've got a specialist who does it here and I think you are too much at risk if you do it." You know, I understand it's a different country and I understand that that's the way it works, but for me then to just give all my skills away and say, "Look, all right, I'm just happy to see patients" I'm not ready for that, I'm too young, you know. And if I can't do it here, I'll go and do it elsewhere, you know. I'll go back and do it in Africa where they need me.*
>
> (Middle Eastern VORRS doctor) *Amongst the staff here (you get) a stigma. It was really something personal and they looked at overseas-trained doctor as if they know nothing. Initially there were some comments from one of the partners but he learned in time that I was not happy and to address it in a different way. You need to address your colleagues not just (as) an overseas-trained doctor, you should respect your colleague - not act as if being from overseas means that I am less experienced than him or different from him. It was not a nice thing or a pleasant thing and it is one of the reasons that maybe if I leave this place it would be because of the doctors.*
>
> (Middle Eastern RLRP doctor) *People look at you because you're overseas, they always look at you with, is she making the right decision or not, that's a very big issue. Ordinary people you don't probably have a problem with, but you certainly always have suspicion from your colleagues. I haven't got a problem really with the specialists when I ring but usually with the registrars, especially, like I said, in the first few months. And I don't know whether I changed or whether that was probably just bad luck. When I first started I had a group of registrars that were not very cooperative but I think a lot of the medical registrars the first few months when I had them, they were struggling themselves.*
>
> (European RLRP doctor) *Truly (peer relationships are) a difficult area because I don't feel that I'm really accepted. I feel that other doctors are not happy. I feel that my patients, they really like me. A lot of patients, they're glad to see me. But I don't feel accepted by other doctors. Definitely I have a lot of problems with other doctors in the Clinic, little problems because in many situations I just let go because it's no point arguing and*

making more tension in the Clinic. In the first few months I wasn't given the key to the front door, I was kept outside with the patients until it was time to get in. Then I was given the key only to one lock, so I can't get into the Clinic after hours. I don't feel that I'm trusted.

The majority of doctors interviewed felt they had established positive relationships with patients. However as will be clear in the discussion of remuneration below, many also felt they were the doctors of 'last resort', with patient demand disappointingly slow to develop.

F. Adequacy of Remuneration (Including Level of Patient Demand)

Overseas trained doctors had serious concerns about their level of remuneration in country Victoria – in some cases an issue improving over time, but in others leading them to consider precipitately leaving practices (eg returning to their country of origin in the first 12 months). By the time of the survey (April-May 2003) only two-thirds (62 per cent) of all survey respondents reported being satisfied or very satisfied in terms of remuneration, despite many having spent substantial periods already in their current location. When complex statistical analysis was undertaken, no significant differences were found related to this in terms of doctors' region of origin, or VORRS cf RLRP status.

It is worth noting here that several Australian key informants perceived OTDs to be highly aspirational in terms of wealth acquisition – perhaps insufficiently considering the relative age of these doctors, their underlying insecurity, and the length of years many had experienced in under- or unemployment.

(Australian informant) *One thing I have learnt is that they not only have an aspiration to come to a new country but that as new immigrants they aspire to a very good way of life. They are working for the long-haul to establish themselves, not just in Australia but they want to build wealth, they are very driven by wealth, they want to build high-income lifestyles, that is the driver to come from wherever they have come from. Many are refugees who have had to move for other reasons but once you gone down that pathway for their life, it is a life decision, they are not going to go half-hearted, and they are very driven people. They know what they want to get too, they know exactly what they want for their children and they have said, "Well, if we are going to do this we are going to work hard and have it all." A number of them have been obviously quite well off and wealthy and privileged where they have come from and many of them are disappointed that this is not the case when they get here. We don't have the expectation that they do. They are very pro-active in their businesses. They build strong businesses.*

The range of OTD concerns on remuneration can be divided into three main categories. Firstly, doctors were very concerned to secure start-up support – some, as we have seen above, coming to practices that provided this as standard, compared to others who found they were financially on their own. For those without cash reserves, access to bank loans to purchase a car was an immediate critical issue: the foundation requirement for entering rural practice:

(South Asian VORRS doctor) *We went around and we were told you can't access Medicare unless you are a permanent resident. And we had to take private cover and we don't get the 30% subsidy for people who are permanent resident. So we had to bear I think $350 every month for Medicare. But still we don't have dental cover. The other thing it is difficult to get a bank loan for someone who comes straight here. Difficult to buy a car or a house. Nobody gives us a loan (because we had no credit rating here).*

A second problem reported – the main concern for most - was the length of time taken to build up patient lists – doctors of non-European races particularly likely to report at interview being viewed as the 'doctor of last resort', the one whom patients would see when they had exhausted all preferred options. OTDs' grievance in relation to this was not merely the income effect, but that they had received minimal advance indication that the situation would occur, or advice on the proportion of their earnings that would be allocated to support the practice.

(South Asian – via South Africa - VORRS doctor) *Some agents don't tell you a lot of things. They did mention the gross income, but they don't tell everything, how much tax you will have to pay, what will be other expenses and this and that. Nearly one year on I'm trying my best to build up my patient pool. I am still struggling. I don't know, I can't explain. Maybe the other GPs are here for many years, they have established practice. Mostly I see patients I have not seen before. Either they're new in the town or something like that. So that's taking time to pick up. I see the other people working less but if you look at the income they make more money.*

(South Asian via South Africa – VORRS doctor) *It's a dual practice clinic. There are three other doctors who had been here about 20 years. I joined as a fourth doctor so slowly building up patients is disappointingly quiet. Some days you get about 5 to 10 patients. Sometimes when one of the (other doctors) are on leave I tend to see more patients, mostly their patients who can't get appointment as they are on holidays. So financially it has not been very exciting… To be frank it is a bit disappointing for me. We had a better quality of life in South Africa. We both were working, now I'm the only one working. The (local doctors) put a real effort to bring in patients for me. They put an article in the paper that I am here and working. They try and tell patients who come there is a new doctor in the practice. If it is difficult for you to see one of the other doctors but he is available and he can see you if you need to see a doctor today. But financially I never had a proper talk with them. I didn't know how it works out. Still don't know how it works out! There's a minimum they are supposed to pay. And I think 50% goes to the clinic, including tax. That's to pay the infrastructure and the clinic. I haven't questioned there how they split the money and how much they give me. I actually haven't had a real talk yet, how it works it out. So that way it would have been better if I had had an open talk with them before I started work here. Have to have everything on paper.*

(Middle Eastern RLRP doctor) *When I first came, I came on a salary so it did not matter that much how much I see patients at all. But after I knew that was very little – they gave me $800 per week – which I was very happy to take as I didn't know much because I wasn't working before, and I could still pay tax out of that $800, rent and everything. Then another doctor I met said to ask the AMA. So I did ask the AMA, and they said no, that's very minimal and we can negotiate for you if you want. So they negotiated for me and they put my salary up to $1200 at first, then $1500.*

The doctor just cited has stayed long term in this position, and ultimately built up a very satisfactory practice. He knows however that level of demand is built on constrained patient choice. He and his compatriot partner are currently sole providers in a small town practice, with a range of patients electing to travel 80 kilometres to the nearest regional city unless requiring emergency treatment:

It took a while to get their trust, more than a year. Now they are coming back here, not because they like me, they just can't afford paying the increased fee in (the regional town). We see a lot of patients who still go there, but they come to us in emergency only and that's what we don't like. We tell that to the patients. If you like going for repeats you're going to X, but if you have urgent problem with the heart or lungs you come straight to me. That's not fair.

A feeling of exploitation was not uncommon – a belief that terms and conditions should have been better clarified at the time of recruitment. A South Asian doctor explained:

This is my only dissatisfaction, I feel exploited because when I came here, I have been a GP for fifteen years and for eleven years I worked on my own and I managed so well. When I came here, 40% of my earnings go to the principal GP and they say that this is the practice everywhere. Fine, but I have worked for a year now and nobody has signed any contract with me - I have to be here for ten years. Luckily they have counted the three years I worked in (another state), so I have got another six years, I don't mind working here, that is fine. I am happy but I can't keep paying 40% because it becomes very unfair. After awhile I have my own patients so why should I give 40%? Nobody used to take 40% from me in (previous Australian state of practice), they gave me a room and said you

work and just pay us for the rent and the overheads, that was all and I was so happy. I was earning much more, much better than what I earn here.

A third remuneration issue raised (by a far smaller number of doctors) related to long-term earning prospects within a position. A significant minority of those who stayed in place over time had secured unconditional registration, either buying into or taking over the practices that had initially employed them – exactly the model of long-term retention hoped for by the Victorian government and RWAV, with OTDs succeeding retiring Australian doctors. Those doing so in general expressed long-term commitment to these towns, having typically redeveloped and/or expanded practices. A few other OTDs wished to do the same – expressing acute frustration if blocked from doing so, like the following VORRS doctor:

The first thing I offered the people here when I came for the interview was I said very clearly that I want to come with a view to be a partner. They said yes, you come and maybe after six months or so we can talk about it. Then I signed the contract and after a while I was pushing for that, as I wanted it to be done… Here is what happened. They asked for a huge amount of goodwill, which was ridiculous, and I told them 'there's no equation to justify that'. They said 'well we are not going to sell it cheap'. But I am not going to sell myself as well, I am not going to pay money for ten years and just wait for ten years for money to come back. I felt in my heart that I don't deserve to be deep down in the rural area in Victoria because this wasn't my choice from day one and I have to continue what I have planned for my life.

G. Provision of Training and Support (Including Examination Preparation)

Before analyzing OTDs' situation in relation to pre-accreditation exams, it is important to reprise key attributes of the survey sample. As we have seen, for many overseas trained doctors the process of migration had been associated with deferred gratification and the fear that pre-registration hurdles might prove insuperable. For those funneling through New Zealand, relative ease of entry had typically translated to an inability to secure recognition or local medical work. A recent report has highlighted the difficulty such doctors have faced, including the elaborate pre-registration pathway currently being devised to assist them[35]. For OTDs coming via South Africa, an excellent standard of living and immediate medical employment had ultimately insufficiently compensated for law, order and security fears. By the time OTDs were placed in Victorian GP employment, virtually all were highly motivated to overcome the last pre-accreditation hurdles, the ultimate goal being to establish and run independent practices (whether in rural or urban sites) in an unconstrained way. In terms of age they were relatively senior: 56 per cent aged 40-49 years. Many of the RLRP doctors had experienced years of frustration in attempting to pass Australian Medical Council pre-accreditation exams. VORRS doctors understood their eligibility to stay in Australia would depend on passing the alternative RACGP Fellowship requirements, in theory within two years.

Australian Medical Council Examination Outcomes (RLRP Doctors)

By April-May 2003, 62 per cent of all survey respondents had secured only conditional medical registration. In other words three quarters could be described as a 'captive' medical labour market in terms of eligibility to work. Overall:

- 43 per cent of all respondents had taken some kind of course to prepare for AMC exams.
- 26 per cent had taken one or more English courses (some up to 3) to assist with this.
- 29 per cent had completed 1-2 courses to prepare for the Multiple Choice Question exam.
- 21 per cent had completed 1-2 Clinical exam preparation courses.
- 5 per cent reported having taken some additional preparatory courses in order to further boost their accreditation chances.

In terms of actual outcomes relative to attempts:

- 55 per cent of OTDs had sat for the Occupational English Test in Australia, the majority (63 per cent) passing the first time, but a high 37 per cent after only 2-3 attempts. These outcomes were typical for OTDs in Australia, with an analysis of all Occupational English

test outcomes in Australia by Hawthorne and Toth showing 33 per cent failure rates to be normal[36].

- 66 per cent of doctors had attempted the MCQ exam: 37 per cent once, 19 per cent twice, and 15 per cent on 3-5 occasions.
- 83 per cent of respondents who had attempted the MCQ had passed it by the time of the survey but 17 per cent still had not – 8 per cent of such doctors passing by 1993, 65 per cent between 1994-8, and the remaining 28 per cent between 1999-2002.
- 53 per cent of all respondents had attempted the Clinical exam: 20 per cent once, 16 per cent twice and 13 per cent on three occasions (acute frustration being associated with these years of attempts/failures, in addition to career gaps, income loss etc).
- By the time of the current survey 60 per cent of OTDs attempting the Clinical had passed it – of those who were ultimately successful 4 per cent passing by 1993, 46 per cent between 1994-1998 and 50 per cent in subsequent years.

When analysed by region of origin, no significant differences in MCQ or Clinical pass rates were found between survey doctors.

RACGP Fellowship Requirements (VORRS and RLRP Doctors)

Within this complex pre-accreditation context, the RACGP Fellowship pathway represented an important new option for RLRP doctors as well as the standard requirement for VORRS doctors:

- 48 per cent of all respondents were planning to attempt the RACGP exam: 36 per cent of these attempting it once to date but some reportedly already up to 3 times.
- 62 per cent of these respondents were accessing the alternate pathway program, 28 per cent using GPREP and 11 per cent GPEA preparatory examination support (adding a significant cost burden).
- Only 37 per cent of survey respondents reported that they had yet satisfied the FRACGP requirement - virtually all since 2000.

Unsurprisingly, given this, the availability of AMC examination or Fellowship preparation support was found to be a critical issue for overseas trained doctors, and a key cause of current dissatisfaction in rural sites. Just 31 per cent of all survey respondents believed the level of support/time available to assist them in passing exams was currently adequate – an issue noted as only fair or very unsatisfactory by many. Those interviewed contextualized their frustration by recalling past experience in taking the AMC exams, like the following East European doctor (still lacking both MCQ and Clinical passes more than a decade after arrival):

> *I am not complaining and I am not bitter, I try to give you the full idea. The people there, maybe they want good for us, but what we had done for ten years was nothing, it was zero. Real life, real medicine starts here. Which I couldn't agree with. It came to a final situation (during a visit to a Melbourne hospital as part of an exam preparation course). They said, great, you have to forget about everything and accept what's going on. To start from zero. Then you pass exam and you start again. I couldn't get it. You know what I found? I started to lose my self confidence. You realise that even if you pass exam and you lost confidence you are not a good doctor any more. And I tried to get something to preserve this confidence for me, professional confidence. The people in the bridging course we are trying to impress, and they are destroying our confidence completely.*

Four major issues were raised in the interviews:

1. The appropriacy of being required to take Australian pre-registration exams (typically by UK/Ireland informants);
2. The need to receive appropriate preparatory mentor and training support (with a range of excellent models being cited);
3. The need to access training programs in convenient sites – offsetting the disadvantage experienced by OTDs in remote cf less decentralised locations, with RWAV perceived to need to take a more pro-active and timely role in terms of exam support provision; and
4. The need to secure some form of funding support in order to prepare for RACGP or other exams.

According to a British-origin VORRS doctor, the requirement to pass the RACGP exam came as a major jolt:

> *I'm a competent GP, nothing over the ordinary - I know my work and I've been practicing 8 or 9 years as principal GP with no problems. To have to come here and jump through the FRACGP hoop (was a real ask). It's not to say that I didn't want to do the FRACGP. I mean I was always intending to do the membership exam in England but the practice I was in was just so busy there was no time to study. But to actually make that a pre-condition of permanent residency is a huge disincentive, and probably my fault but I just kept putting off taking the exam when I got here.*

An African VORRS doctor challenged the appropriacy of Victorian authorities making rural GP appointments, then simply leaving candidates to prepare in isolation:

> *Let's say you get a doctor apply, he's from a university that's on your list, what you do is that you interview him, they go through RWAV, and then you become eligible to come and work. You put him in a rural area and leave him there. Very strict things now, he must get his Fellowship within two years but he is just left. There is a course now that we have to pay $9000 of which RWAV will pay $4,500 back. But it's a lot of money, even if RWAV would pay half of it.*

A second African doctor described how such 'disinterest' in providing support could sabotage doctors within the exam process:

> *It's just so easy to pass the Fellowship (in capital cities), when you've got all those supports around you there, you mix with those people. I've written the Fellowship twice and I've failed it and I can see why, because I was not prepared for it. I will not speak for all the South Africans, but the outlook there was a bit different from Australia. The first time I looked for help, but there was no help. So I went to write it again and I made exactly the same mistakes. But still they have this hammer over your head and say, "Pass or you can't carry on with the five-year plan." I see myself very much as an Australian doctor but I think after such hardships it's very difficult to go to exams, and I never, ever, ever failed an exam before. I have three degrees - I went through them quite easily. Now my colleagues said, if they don't like the way that you do it, you might never get this exam. Someone at the College said to me, "Oh we're confident you will eventually pass it." And the word 'eventually' is a terrible thing.*

A South Asian doctor, like the African candidate above, described preparing in isolation ('When I got the Fellowship, which is looking back about a year and half ago, there was virtually no support. I did it by myself, nobody has helped me, and nobody said, "This is the book you should read. Can we help you?"). A range of OTDs felt RWAV could be more active in providing such support. One stated, 'Bodies like RWAV, I had to wait around 18 months to attend their orientation program. I did attend it, and they are (more) active the last 6-9 months. But before that I thought that we could have got more help from them to settle down easily.' An African doctor said:

> *I feel RWAV could do a bit better in that regard. I feel you know you have the pre-exam course which is for everybody and is a one day thing. The pass rate is very low for all of us OTDs. So I feel there should be a structured learning programme that's tailored towards the exam, the approach you know to answering questions in the exam and all those things, which I think is very important.*

Though preparatory support is now available through College affiliates on a fee for service basis, location, cost and delivery mode all represent serious hurdles to OTDs. Accessibility was almost invariably viewed as problematic ('They've got the facility but it is standard for everybody who is living 50 kms from Melbourne, not somebody living 500kms from Melbourne'). An African doctor highlighted the investment currently involved – difficult for OTDs to finance when in the process of building slow practices:

> *It's a lot of money you know I spent for the Fellowship: $9000 at first, and I'm heading for over $20,000. I was just horrified to know that 30% of (candidates are from) overseas,*

and it seems like that was said with pleasure - you know you had a feeling that at the College it was their way of sorting out the foreign people. It's a huge resentment.

Once doctors had prioritised passing the exam, this could prove an all-consuming process – as in the following case of an East European doctor who had had secured wonderful local support:

For the previous three and a half years I was sleeping, working, studying. I didn't think about anything else. I appreciated actually having no one around me to hinder my studies. Strange but true (family in Melbourne). Re the GP exam, I had lots of support from (the local base) hospital. We formed a study group organised for not only medical staff but also nursing staff once or twice a week. This was very important for me. X-rays, practicing orthopedics, all fields of medicine, short seminar studies, deep discussions for one hour a week within work time which was so helpful. And I had theatre preparation.

A South Asian doctor affirmed it was regionally based colleagues, on a voluntary basis, who had made the critical difference given the dearth of other support:

At the end, when I was preparing for the AMC at the hospital where I used to work, the consultants were very, very good and we used to have classes that they organised to teach us, Australian methods of examination and whatever. So they were very supportive in a way. And at this point, I didn't find very much happening apart from the Division level or the CME activities. I found them a little bit helpful, you know, but from the RACGP point of view I don't think there's much going.

A Middle Eastern doctor spoke for many when he stated he regarded the emerging preparatory support structures (eg General Practice Education of Australia) as good – just impractical for someone like him located 6 hours drive from Melbourne, working an excessive number of hours when compared to doctors in urban practice:

It would be very good, I think it's called GP Education of Australia, that address (the needs of) people preparing for the Fellowship exam and even for AMC exam as well. This runs about every six months. We try to get that but we need funds because it's expensive - it's about $10,000 and that is through the satellite or through the computer. It would be good actually if you can get funding to help us with that. I'm going next week for one of the courses of RWAV, actually. It's Women's Health, which is good and helpful but is nothing to do with Royal College exam. The target is to pass the Royal College, but AMC for me now is easier because half of the exam is passed. We need support (either way), and the other thing for OTDs is we need more support (because) we're working longer hours than they work in big cities. And we get more responsibility because you not only run the clinic, you get the hospital on call, you get nursing calls, so you get a lot of duties and you have to support them. We have a shortage of specialities which make us more stressful. We have only one physician here, and one surgeon, usually booked out for six months or three months. So you have to treat the patient immediately and you follow him up, and of course if it's acute you refer to another big centre. There is no problem for sitting Royal College exam, while you pay the fees. For AMC you pay double fees and end up (with them not giving) you the place you want - every time you want to sit in Sydney, they give you Adelaide. I reckon you (should give a message) to the AMC from the doctors working in rural areas. They are all sitting the exam to be full registered doctors, which I try since '99. They didn't give me any place until now. Waiting list for three years, and I never see a (course) anywhere to prepare myself for this exam.

Clearly, significant attempts have been made in the recent period to provide more training in decentralised locations, as embraced by one East European informant:

(I am enrolled in) an eighteen-month course by distance. I chose seven subjects, and so I'll get all this information and I'll start to do my assignments and study. I'm going to sit the Fellowship exam next year and also have help from Vic Division. We are having every Tuesday a teleconference; we are discussing the cases and medicine and also we have a (local) doctor from (central Victoria). He comes to our town once a fortnight or every three weeks, and doctors (in surrounding locations) come to our place and we all

have discussion about medical issues and how to pass exams and to think about what is actually expected from us.

Face to face training however was almost invariably considered a superior option to distance provision – a South Asian doctor commenting 'I feel that they should provide some kind of proper training sessions, where they would prepare us in person, not over the phone.' In terms of ultimate retention, provision of timely, subsidised, and accessible exam preparation was a critical issue to OTDs – one, we have seen, that many believe should be pro-actively advocated by RWAV.

H. Support from the Divisions of General Practice and RWAV

Unsurprisingly, in the light of the above, overseas trained doctors had three major expectations of the Rural Workforce Agency, Victoria and the General Practice Divisions:

1. Provision of orientation support as they entered rural general practice;
2. Assistance with examination preparation, together with continuing medical education; and
3. Provision of select forms of social support (at times on a family basis).

In the case of RWAV, three further expectations were often layered on:

4. Performance of an effective advocacy role for OTDs at the macro level (eg securing subsidised RACGP examination preparation support);
5. Provision of micro level support (eg negotiating, where required, for better remuneration ratios within a specific general practice); and
6. Provision of advice/ assistance in dealing with bureaucratic requirements (for example related to the renewal of visas for temporary residents, and conditional registration).

The Problem of Red Tape

This issue of red tape will not be dealt with in depth here, however as indicated by the following quotes it represented a running sore for many OTDs, who wanted to focus wholly on establishing their Victorian practices. Such doctors, unless advised in advance, lacked knowledge of the bureaucratic requirements and timelines involved, including the degree to which their legality in Australia could be jeopardised by not meeting hurdles. Most lacked sufficient knowledge to know what questions to ask - assuming in advance that advice would be provided related to this by the 'brokering' agency (often RWAV):

> (UK/Irish VORRS doctor) *One of the downsides of the system which I'm sure you'll find is replicated over and over again by OTD is they make a huge commitment to come here in terms of uprooting their family and their family ties. Yes, looking for a better life as it were and a better mode of practice. It's leaving their established foundations behind both professionally and in the family - and to have that effectively not recognised and to come here as a temporary resident you have to battle on a yearly basis the bureaucracy of getting visas renewed, it's a huge disincentive. I nearly packed my bags on more than one occasion and said it's not worth it. I love practice here. You know this is the best time I've ever had professionally but that sort of uncertainty, particularly if you are bringing your wife and children in the midst of education, it's a bit of a risk that you are taking the leap in the first place.*

> (UK/Irish RLRP doctor) *(Red tape associated with) the whole process of getting registration. The guy who interviewed me to assess my clinical skills frankly knew less about general practice than I did. I had been given information which he'd contradicted about how to get my registration. He sent me on a wild goose chase that was totally inappropriate, and I began to look an absolute fool, although the information I had been given initially was correct. I did get my provider number, I got my registration and it was quite by accident that I discovered that nobody would remind me when my registration was coming to a close. When I did check this out, they said there were a thousand forms to be filled in, including assessment from this practice. Well, nobody had bothered to tell*

me or the practice that that was the situation and then they did not bother to pass on the information that because that was happening, my provider number would cease, and suddenly I found that my claims for all the work I was doing were cancelled, and there was a lump of chaos for a couple of days and the practice again sorted that out. Well, I just think it would have been really nice if at the beginning of my working here, the practice had been given an algorithm that said, you know at x y and z the following have to be done. I don't think that's too much to ask, rather than find it all out by default.

On a positive note, it was clear from the interviews that both RWAV and select Divisions of General Practice were in the process of substantially improving the level and range of support offered to OTDs over time – in essence professionalising what had initially been ad hoc services. Comments related to the perceived value of both structures frequently had a 'then/now' aspect – doctors stating that while little had been offered to them in the preliminary period (eg 2-3 years back), they were aware of far more services being around now. The recently arrived VORRS doctors interviewed for this research were sometimes receiving a high level of personal support – in several instances weekly or monthly contacts, including on a trouble-shooting basis. The range of assistance such doctors received included the following (depending on need):

- Support in terms of resolving financial difficulties with practices;
- Quasi-legal advice (eg if a doctor had a potential case related to unfair treatment);
- Information about access to loans (eg to purchase a car in the start-up period);
- Advice on accessing continuing medical education or exam preparation support;
- Provision of or referral to specialist training courses related to select aspects of medical practice – with the following services rated as particularly 'useful' or 'very satisfactory' by OTDs who had used them in the mailout survey: emergency skills training (75 per cent), clinical skills training (65 per cent), mentoring and/or supervision (51 per cent), RACGP examination support (47 per cent), and OTD orientation support (43 per cent); and
- Provision of family-focussed social support, on an initial welcome as well as a continuing basis.

Beyond this overall trend (ie both organizations perceived as 'professionalising' their support for OTDs over time), interview comments proved highly variable. Some GP Divisions for example had become very attentive to OTDs' needs, while others provided only a basic service. While RWAV courses were generally conceded to be useful, doctors three hours or more from Melbourne regarded them as practically inaccessible, unless subsidized attendance could be provided. Moreover the breadth and timeliness of recruitment information and subsequent orientation could be contested, as well as the appropriacy of placing OTDs in locations which appeared to have minimal demand for their services. The comments below were selected to represent the range of these views related to each agency.

Rural Workforce Agency, Victoria

(Middle Eastern VORRS doctor) *I need to say a word of thank you about (RWAV) actually. They did all the papers right and the supportive letters, it was great and they gave me what I need for this position which was great as well. I think they were ready to keep supporting me.*

(African VORRS doctor) *You know I think when you select somebody into the five-year plan, you must be so sure that this person will suit a rural community in Australia. He must have the personality to suit that situation, number one. And he must have the qualifications of course behind him to do that. The second thing is that I feel that once you've selected him for that you must give him all the opportunities and everything to make sure that he very quickly is given support. And then I feel that once you have been selected for the five-year plan, and you have been six months in place, they should say to you, "Right, here's the money, you go and do that course." Where do you get the time to study? Because it's really an extremely busy time.*

(Indian VORRS doctor) *RWAV come to talk to me regularly. They call at least once a month to talk things through. So I wasn't really keen to give them any negative (feedback re patient lists and income). It's too early. I am slowly picking up patients but it is very*

quiet. I was just wondering who talked to them about a need for a GP in (my location)? Did they actually go through assessment process, looking for the demand for a GP, (and consider whether) it is better to bring a GP to some other place where there is a real need? I think it is a very important thing when it comes to the employer, there must be clear transparency about financial matters. It would be nice to have it on the table. 'OK doctor, this is how it works. We are going to take 50% of what you earn, this is the number of patients you are expected to see and if your number of patients increases you will get an increase in income. You know – a real financial plan. That would be great so that the doctor knows what to expect. And before the doctor come they must know about medical insurance. We never knew how difficult this would be for us to. This is something you must talk to the doctors and tell them you must have private medical and how much it is going to cost. And they must know about indemnity and all things they are expected for each cover. I must have an orientation program. RWAV have workshops in Melbourne, but it is difficult for a rural person to go to there and attend all these workshops. There is no financial support for these workshops. The workshops are free, but all the aspects of attending a conference the GP has to pay for himself. Buying the air ticket, arranging the accommodation, it is a bit tough you know.

(South Asian VORRS doctor) *I am sorry for anyone who is coming to this place – (it needs) some cultural changes. I suppose the RWAV can play a big role – (helping OTDs) get to know people, get professional orientation. Now they're looking at getting people together, talking about other cultures. I've been to a meeting and they're (planning) that now. (Religious access) wasn't a big hurdle for us. It's like any small township – it's not that easy to interact with the people immediately. It takes a while I guess. I'm getting into the Rotary and my wife is getting into the Red Cross. That helps us to mix with the people here. In the last few months (RWAV) have had more frequent meetings, and I've been to the meetings. It's helping. I hope to a certain extent it will eliminate some of our problems…*

(UK VORRS doctor) *RWAV made nominal contact just to say when you get over here can you please come for an interview. RWAV has had a couple of sessions, an on site orientation session, a women's issues course. You had to go down to Melbourne though. I can do that a couple of times a year, but I don't think many GPs do. I mean having to take a weekend away and leaving the family is not really an option I want to do on a regular basis for my education. I don't see enough of them anyway.*

(South Asian VORRS doctor) *The Rural Workforce has clinical meetings every so often, emergency care, and they have women's health. They are very good meetings, excellent, but we haven't had one around here. I think there are quite a few things that should be done. Firstly when the OTD comes to the area - fortunately for me coming from South Africa I was in an adequate financial position - they would be pretty low on their cash (eg from India) and need a little bit of assistance, that is a house stay for three months or six months and we will pay the rent and we will sort that out for you until you can find something else. Here is a car, use this car for two weeks or a month. They need help until they get on their feet and then once you get on your feet you will find the doctor will pay for this. I think the only person I really had and I used to appreciate was the Practice Principal. He would take me out to dinner and I spent Christmas at his place, things like that.*

Divisions of General Practice

(UK VORRS doctor) *In terms of professional development the Division has been good. They have set up an OTD scheme essentially in preparation of the Fellowship exam. A teleconferencing type group on an evening, some of which you are able to get to, some of which you are not due to family or time constraints. But primarily that's my fault - they've put the effort in. In terms of professional development RWAV did run a couple of courses but we're out here in regional Australia and they were Melbourne-based. You can get down to perhaps one but you can't do that on a regular basis. And Monash University have run a couple of excellent courses up here. They have run at least one pre-exam course which was tremendous. Probably (the presenter) encompassed more in a one or*

two day session about what was involved in getting through and passing the exam than probably any other resource I have managed to get hold of.

(African RLRP doctor) *(The Division has been) mainly helping in this (regional town) - lectures fortnightly and even some lectures held (in smaller local townships). There are some Australian doctors who are very helpful actually. Like giving group discussions or even some illustrative CDs, I mean teaching ones. Calling even like a social meeting and then discussing some of the clinical issues or the practice.*

(Middle Eastern RLRP doctor) *When I first came I did not know anything about medical defence, no idea. The practice when I came to work for them did all of that and they didn't tell me what level of insurance I had, what I'm allowed to do, not allowed to do and all that. I didn't know, I didn't have an idea. Now I know all of that, so I don't need any support. But I think now the Division are doing better because I didn't know there was something called Division for the first year and a half. The Division is now running educational courses or sessions to help the overseas doctors. Like the first Saturday of the month we bring two or three cases, similar to ones to the Fellowship exam, few questions, discuss and something like that. And there is also a teleconference every Tuesday, the same case, with our facilitator and GP we run through the others.*

I. Factors Likely to Impact on Doctors' Retention in Current Positions (Including the Significance of VORRS cf RLRP Status and Region of Origin)

Fifty-two per cent of all survey respondents reported that they expected to stay in their current location long-term (6-10 years more), compared to 24 per cent who planned to stay for 4-5 years, 8 per cent for 1-12 months more, 5 per cent for 2 more years, and 6 per cent for 3 more years. This finding was surprising, given the poor retention to date for RLRP doctors previously noted. The following comment was typical of doctors planning long-term stays in their current locations – though it is important to note that even contented doctors stated a range of locations would *not* be acceptable to them long term in Victoria:

(UK VORRS doctor) *We're happy here. Kids are very settled now. They have their own circle of friends. (My wife) likes the town. And I'm very happy with the practice and can't see any advantage in moving. Only thing is perhaps a few years down the line. Probably talking 10 to 15 years moving somewhere slightly more coastal. We will probably explore that but not until the kids have grown up and moved to university and gotten settled… I think it must be incredibly difficult for somebody working in a small remote town with little professional support, having to make difficult decisions about patients alone... It's a long way to the nearest hospital. I don't know what you do about that to be honest. I don't think I could practice in that situation for any period of time without the stress levels beginning to tell. It's too isolated. You're almost too central to everything. The on call must get very wearing having to do it so frequently. So yeah, I would find it difficult for me to go and work in that environment. I don't think I could.*

Clearly, the majority of RLRP OTDs do *not* choose to serve long-term once they have less constrained options. Table 13 lists the number of RLRP appointments approved in Victoria since 1998 – these 276 appointments resulting by 2002 in just 88 such doctors remaining in rural general practice (a low 32 per cent level retention rate). According to the original RWAV project brief,

Experience of this program is that RLRP doctors move locations often and have poorer retention rates. RWAV exit interview research has indicated that keeping track of these doctors has proved difficult, however RWAV does have a database of RLRP doctors.. Research into GP movements indicates that there are many reasons why GPs leave a practice including access to schooling, heavy workload, spouse or family unhappiness and isolation. RWAV is keen to identify whether there are additional factors for OTDs such as cultural or religious reasons.

According to RWAV, VORRS appointees - while more recent than RLRP doctors - have to date been associated with far stronger retention rates.

> *VORRS is funded by the Victorian Department of Human Services. Since its inception in 1999, more than 86 doctors have been selected to the scheme from overseas and 5 doctors have left the Scheme. Selected doctors are required to obtain Fellowship qualifications within 2 years and will be provided with permanent residency and the freedom to work anywhere within Australia after 5 years of work in rural areas. RWAV has good information on the movement of VORRS doctors.*

However it is essential to note this scheme is relatively new. The majority of doctors within it were two years or less into their appointments at the time of the survey (typically 2000-2 arrivals). Moreover while RLRP doctors have permanent resident status in Australia (hence permitting shifts to the city and public hospital positions), VORRS doctors are at risk of jeopardizing their visa status if they leave their regional postings. Nor is much yet known about the rate at which they will pass the RACGP exams relative to RLRP doctors. In terms of ultimate retention, it may be premature to say that VORRS doctors are predisposed towards longer periods of rural service.

Table 13: RLRP provider number approvals since 1998 (Victoria)

Year	New Approvals	Extensions	Total
1998-1999	65		65
1999-2000	82	15	97
2000-2001	74	21	95
2001-2002	55	33	88
Total	276	69	345

Factors Determining Retention: Overall Findings

In analyzing key factors determining OTD retention, it is important to note that 26 per cent of all survey respondents chose not to respond to this question. Moreover 22 per cent of those who did believed that their spouses wished to stay in the current location for just 1-12 months more, with a further 6 per cent believing spouses would stay for 2-3 years. This issue will be taken up in the analysis of the spouse survey (J.).

Overall, the following factors appeared to be critical in terms of determining the future retention of OTDs in rural general practice employment:

- Family issues were paramount, with access to good education for children cited by 97 per cent of all OTD respondents as fundamental to determining long-term location, followed by access to a good/well paid medical job (ranked as very important or important by 95 per cent), a higher salary (89 per cent), improved medical facilities (88 per cent), and better collegial support (87 per cent).
- Access to examination preparation training courses was considered to be very important or important in terms of long-term retention by 77 per cent of all OTDs, an issue closely followed by access to better medical training (76 per cent), shorter working hours (76 per cent), provision of a formal contract (75 per cent), location near family/friends (73 per cent), metropolitan location (70 per cent), better supervision/mentoring (62 per cent), and access to religious facilities (62 per cent).
- Proximity to ethnic community was cited by just 35 per cent of OTDs - a far less important determinant of future retention than initially expected. As we shall see however this was an issue perceived as important to select spouses, who did not have the distraction and satisfactions of GP work.

Just two interview quotations are provided in relation to this, given the extent to which these themes have already been illustrated by OTD views in the previous sections. A South Asian doctor and an African doctor summed up their feelings as follows:

> *(I feel) very, very captive, very captive, which was like everybody else. OTDs have their ambitions and why should they after a few years be limited because they are OTDs?*

That's an issue because I think after three and a half years in this area I have put in … I started this practice with one doctor and now there are probably five or six doctors, so it is branch medicine but we don't get anything out of it. There is no financial gain in (this location). That is what makes us captive because we should be given the same opportunity after a while like any other doctor.

So I was in Australia for four and a half years living like this and in fact it's very difficult, after having such a tough time, to change me now into a full Australian. I think it caused a lot of resentment and eventually when you get a clearance you just go to where the least problems are and you go and join your fellow chaps in the cities.

In all, 78 per cent of OTDs stated at the time of the survey that they intended to stay for the immediate future in their current position. Of the 22% already planning to move on:

- 7 per cent expected to seek some type of medical employment in Melbourne;
- 5 per cent were hoping to secure an alternative GP position in a regional Victorian location;
- 3 per cent were planning to change states, 3 per cent were planning to change countries, and 3 per cent had some other unstated plan; and
- 1 per cent were planning to accept public hospital employment in Melbourne.

Factors Impacting on Doctor Retention (by RLRP cf VORRS, and Region of Origin)

Given RWAV's interest to explore potential differences in RLRP cf VORRS doctor retention rates, a complex statistical analysis was undertaken of all survey data, to check for variability between OTDs explicable in terms of:

- Region of origin; and/or
- RLRP cf VORRS status.

Please recall that in categorising OTDs by region of origin the following groupings had been made:

- *Europe* (31%): x26 OTDs from the former USSR (12), Poland (4), former Yugoslavia (3), Bulgaria (1), Romania (2), Brazil (European origin, 1), the Netherlands (1), 2 unstated
- *Asia* (30%): x25 OTDs from China (5), India (4), Sri Lanka (3), Bangladesh (3), Fiji (Indian origin x2), Malaysia (2), Pakistan (1), Philippines (2), Vietnam (2), 1 unstated
- *Africa* (13%): x11 OTDs from South Africa (5), Kenya (2), Nigeria (1), Uganda (1), 2 unstated
- *English speaking background (UK/IRELAND)* (12%): x10 OTDs from UK (7), Ireland (2), Australia[37] (1)
- *Middle East* (12%): x10 OTDs from Egypt (5), Iraq (3), Iran (1), Syria (1)

A range of important findings are summarised briefly below, or relevance to long term retention.

i. Motivation for coming to Australia

In terms of motivation, no significant difference between region of origin groups was found for coming to Australia, selecting Victoria or for choosing OTDs' current general practice location (Fisher Exact test, $p = 0.09$, 0.17 and 0.10 respectively). Different region of origin groups however were characterised by very different periods of arrival: African OTDs most likely to be recent arrivals under the VORRS scheme (many arriving 2001-2003), Middle Eastern OTDs mainly migrating from 1995-1998, and those of UK/Irish origin arriving from 1999-2003 (Fisher Exact test, $p<0.01$). In terms of hypermobility significant differences were found between region of origin groups, with VORRS doctors far more likely to have worked in 3 countries (Fisher Exact test, $p=0.02$) and Asian-origin OTDs to have migrated after multiple sojourns (including in New Zealand or South Africa).

ii. VORRS cf RLRP schemes: differential attributes of doctors

Interestingly, no significant differences in terms of intention to stay at the point of arrival were found between RLRP and VORRS doctors (Fisher Exact test, $p = 0.59$) – confirming that many of the latter were exploring Australia from the start for potential permanent migration. In terms of motivation for accepting their current rural GP position, however, VORRS doctors were significantly more likely to have been influenced by family and lifestyle reasons than RLRP doctors (Fisher Exact test, $p<0.01$).

As expected, pre 1998 arrivals were typically permanent resident OTDs employed through the RLRP scheme, in marked contrast to 1999-2003 arrivals who were largely temporary entrants under the VORRS scheme ($\chi^2 = 56.69$, $p<0.01$). OTDs migrating from Africa were typical of the latter (Fisher Exact test, $p<0.01$). Despite the majority having reached Australia only recently on a temporary basis, these doctors had secured virtually immediate medical work, in sharp contrast to European OTDs (typically from Eastern Europe), almost half of whom had taken two years or more to access any initial form of medical employment (Fisher Exact test, $p<0.01$).

Statistical analysis revealed English language ability to be a major reason for this timelag experienced by East European OTDs – the sole region of origin group characterised by significantly lower levels of English at time of arrival, and the group most likely to report having nil or poor English ($\chi^2 = 28.94$, $p<0.01$). VORRS-recruited doctors, by contrast, were most likely to be native speakers of English (Fisher Exact test, $p<0.02$). In terms of medical registration status European-origin OTDs (again primarily derived from East Europe) were found to be significantly less likely than other groups to have passed the RACGP exam (Fisher Exact test, $p=0.04$). Pass differences were not relevant in terms of the alternative Australian Medical Council MCQ and Clinical exams, as VORRS doctors had simply bypassed these.

It seems reasonable to assume that VORRS doctors' combination of superior English language ability, RACGP status and minimal career gap would make these applicants of particular interest to prospective medical employers. Indeed, when period of current appointment was analysed by region of origin, VORRS OTDs were revealed to be a disproportionately favoured group – 50 per cent having secured semi-permanent contracts cf just 23 per cent of RLRP doctors. RLRP employees, despite their permanent resident or citizen status, remained largely on short-term contract status (77 per cent of cases, $\chi^2 = 7.22$, $p=0.03$). This outcome is important to note given the temporary status of the majority of VORRS doctors, in contrast to RLRP doctors who were far more likely to already be citizens ($\chi^2 = 39.36$, $p<0.01$). It is an outcome clearly indicative of employer 'valuing'.

iii. Level of OTD satisfaction with current position

Despite the differential employment and accreditation status noted above, the statistical analysis revealed *no* significant difference in the level of employment satisfaction reported by RLRP and VORRS doctors, nor any major differences between OTD groups by region of origin (ANOVA, $F = 0.52$ and 0.77, $p = 0.47$ and 0.55 respectively). All reported variable levels of satisfaction with the nature of GP work, the rate of payment secured, relationships with colleagues and patients, and access to training/examination preparation support. For example 89 per cent of all OTDs wanted improved salaries, 88 per cent felt better collegial support was important, 79 per cent were keen to have shorter working hours, 58 per cent wanted improved supervision and mentoring (etc).The sole significant differences found related to access to medical resources, with RLRP doctors being more likely than VORRS doctors to think such access was only 'fair' (Fisher Exact test, $p=0.02$), despite there being no significant differences between the groups in terms of employment location (Fisher Exact test, $p = 0.07$).

Although there were not significant differences by region of origin, sub-group analysis based on dichotomizing region of origin into UK/Ireland/Europe and Asia/Africa/Middle East showed that doctors from Asia, Africa and the Middle East were 3 times more likely to be only reasonably satisfied or to be actively dissatisfied with the nature of their work when compared to survey respondents from the UK/Ireland/Europe group (OR: 3.00; 95%CI: 1.04 – 8.80). This finding is important to bear in mind in relation to level of satisfaction with relations with peers.

iv. Intention to stay in current location

Study participants were asked about 16 factors likely to influence where they would work in the future (see Appendix A, Q64). To identify the common themes, these items were all entered into an exploratory factor analysis (varimax rotation). Three factors were identified as likely to impact on OTDs' future willingness to stay in current GP locations, namely:

- The perceived opportunity of the appointment in terms of medical career development needs (Eigenvalue = 3.48, Cronbach α = 0.82). These items were: access to training courses, better medical training, provision of adequate supervision/mentoring, having a formal contract, access to ongoing medical education, and better collegial support.
- The perceived adequacy of the location in terms of socio-cultural support (Eigenvalue = 2.83, Cronbach α = 0.72). The items were: access to ethnic community, closeness to family/friends, living in a metropolitan location, access to religious facilities and pre-AMC training courses.
- The importance of prestige in terms of career options (Eigenvalue = 2.05, Cronbach α = 0.57). Items here were: access to a good well paid medical position, higher salary, and improved medical facilities.

The Cronbach α values for scales #1 and #2 were within the accepted range; the lower Cronbach α for #3 may be explained by the fewer number of items and the diverse content of those items. Given this was an exploratory analysis, the obtained value was only just outside that accepted for preliminary work[38]. The three factors and their items were used to construct three scales, using summation. Due to the skewed nature of the scales, the scales measuring medical career development and prestige were log transformed prior to data analysis.

When the three scales were examined, significant differences were found as follows by region of origin:

- There were no significant differences in terms of the importance of medical career development (ANOVA, $F = 2.41$, $p=0.06$), nor the importance of prestige in terms of career options (ANOVA, $F = 1.61$, $p=0.18$) between any of the region of origin groups.
- There were however significant differences in relation to the importance of socio-cultural support by region of origin (ANOVA, $F = 5.69$, $p<0.01$). To identify which regional groups were significantly different, comparisons between all groups were made. The results showed that Middle Eastern OTDs were significantly more likely to rate access to socio-cultural support as important in determining their long-term retention plans, in comparison to UK/Ireland (Tukey-Kramer Multiple Comparisons Test, $q = 4.26$, $p<0.05$) and African OTDs ($q = 5.43$, $p<0.01$). Asian OTDs also rated socio-cultural support significantly more highly than did Africans ($q = 4.97$, $p<0.01$), as did European OTDs compared with African OTDs ($q = 4.77$, $p<0.05$). In summary, Middle Eastern, Asian and European OTDs rated socio-cultural support more highly than did UK/Ireland or African OTDs, as a factor likely to contribute to decisions re their long-term retention.

In seeking to explain these findings, it is worth noting that African OTDs were significantly more likely to report that being near to family and friends was 'unimportant', and that UK/Ireland and Asian ODTs were more likely to report being near to family and friends was 'not very important' (Fisher Exact test, $p=0.02$).By contrast, Middle Eastern OTDs were significantly more likely than others to plan for future employment locations close to their ethnic community (Fisher Exact test, $p=0.01$), whereas UK/Ireland and African-origin doctors viewed this issue as of negligible importance. Not a single doctor from these two latter groups endorsed this as a 'very important' issue - perhaps since they most closely approximated the ethnicity of rural Victorians (the great majority of Africans surveyed being of British origin). Consistent with this, access to metropolitan location was shown to be unimportant to the African OTDs and minimally important to doctors of UK/Irish origin. It was however of significant importance to the other region of origin groups (Fisher Exact test, $p<0.01$).

Interestingly, access to religious facilities was rated of low importance by all groups – family/friends and culture being far more important, with significant difference between groups found (Fisher Exact test, $p=0.26$). Finally, access to better medical training was found to be of negligible interest to African OTDs, who seemed sanguine about their future RACGP status (Fisher Exact test, $p=0.02$).

When the same three scales were analysed by VORRS cf RLRP doctors:

- Major differences once again were found in terms of access to socio-cultural support – a factor revealed as more important for RLRP doctors when compared with VORRS respondents (ANOVA, F = 12.00, p<0.01). In other words, VORRS doctors appeared less likely to leave rural Victoria to co-locate in Melbourne or other regional sites with compatriots.
- There were no significant differences between VORRS/RLRP OTDs on either of the other two scales (ANOVA, F = 1.37 and 0.08, p = 0.25 and 0.78 respectively) related to opportunities for medical career development and prestige.
- Closer analysis of the data revealed that VORRS OTDs were significantly less motivated than RLRP doctors to secure access to better medical training (Fisher Exact test, p=0.03) – preparation to pass the Australian Medical Council examinations being of little perceived relevance to them at this stage (Fisher Exact test, p=0.04). (This factor may become far more important in the future.)
- For these and the other reasons highlighted above, the 'temporary' resident VORRS doctors indeed seemed more likely to choose to remain in rural general practice locations – or at least for the requisite 5 year period.

v. Predicting OTDs' length of stay

To predict length of stay, two multivariate regression models were developed as described in the methods section. The dependent variable was length of time (months) in current position and the future intended length of stay in current position (months). The predictors were the key characteristics outlined in the study, including demographics (gender, age, marital status, whether the OTD had dependent children, residential status, and religion), employment characteristics (location, time since arrival in Australia, time since achieving medical registration, status in terms of passing the RACGP Fellowship examination, medical employment history) and job satisfaction.

Regarding the significant predictors of OTD retention in current jobs (ie how long they had been working in their current job), the final model contained four predictors which after adjustment explained 32 per cent (ie adjusted R^2 = 0.32) of the variance in job retention. The model (unstandardised β coefficients) was:

$$M_j = 203.79 + (Y \cdot -0.10) + (S \cdot -0.04) + (R \cdot \textit{-0.11}) + (G \cdot -0.39) + e$$

Where Mj was the number of months in the current job, Y referred to the year of first registration as a doctor in Australia, S was the level of job satisfaction as measured on the satisfaction scale reported above, R the religious status (Christian, Other, None reported), G whether an ODT had passed the RACGP Fellowship requirements, and e the error term (ie. the unexplained variance).

Briefly, the findings showed that those in their jobs for shorter periods of time to date were doctors who:

1. Had gained unconditional registration recently (β = -0.10, 95%CI: -0.15 - -0.05);
2. Had passed the RACGP Fellowship examination (β = -0.39, 95%CI: -0.74 - -0.04);
3. Had reported lower satisfaction with the nature of their work (β = -0.04, 95%CI: -0.08 - -0.01); or
4. Were of non-Christian origin or with 'no religion' (β = -0.11, 95%CI: -0.20 - -0.03).

To assess the key predictor/s of intended future length of stay in current position (ie retention), a similar regression analysis was performed. Only one variable proved significant: OTDs' level of satisfaction with the nature of their current GP employment. The model explained 22 per cent of intention to stay (ie. adjusted R^2 = 0.22). The model (unstandardised β coefficient) was:

$$I_j = 126.72 + (S \cdot -3.25) + e$$

Where I_j was the intended number of months staying in the current job, and S the level of job satisfaction. The findings showed that those who were satisfied intended to stay longer (β = -3.25,

95%CI: -4.95 - -1.55), regardless of RLRP or VORRS, region of origin status, or any other variable in the dataset.

J. Spouse Perspectives on Rural General Practice and Retention

The impact of spouse experience on overseas trained doctors' retention in rural general practice was an issue of significant interest to RWAV, as indicated by the following tender statement:

> *Family support and family issues such as employment opportunities for spouses and children's schooling opportunities are a key factor in the retention of rural GPs. The Rural Medical Family Support Scheme (RMFSS) provides support to families of General Practitioners (GPs), registrars, other medical practitioners and locums in rural and remote areas. The scheme is centrally administered by the Australian Rural Workforce Agencies Group (ARRWAG) and in Victoria is managed by RWAV. In Victoria, the RMFSS funds a range of programs including 'meet and greet' orientation programs, family activity programs, family programs at GP conferences, telephone counselling services, spouse careers counseling, spouse educational bursaries. This project is keen to gain further information on the level of support provided to OTD families and family support needs of OTD families.*

As described in the Methodology, a spouse survey was mailed out to all OTDs, designed to elicit basic demographic information together with spouse input concerning the perceived satisfactoriness of rural general practice from personal, family and work-related perspectives. Fifty-six responses were received, compared to 84 from OTDs – an excellent outcome. Key findings are summarized below, followed by more complex statistical analysis of the data designed to check for any significant differences in response patterns between spouses by region of origin, by VORRS cf RLRP status, by qualifications level or by gender. A range of the qualitative survey comments are integrated throughout, together with comments derived from the OTD interviews where these are relevant to the research findings.

Demographic Characteristics of Spouse Survey Respondents

The critical point to note – in an age associated with the growing feminization of medicine (internationally as well as overseas) – is that it is erroneous to assume that medical 'spouses' are female or that they have inferior qualifications to their partners (regardless of whether they are female or male).

As stated at the start of this study, 62 per cent of all OTD survey respondents were male, with 38 per cent female. Further, more than half OTD respondents (56 per cent) were aged 40-49 years, with an additional 20 per cent aged over 50. Reflecting this pattern, 57 per cent of the spouse respondents were female cf 43 per cent male. Ninety-four per cent reporting having children, in the great majority of cases still living with them – the typical number (as with Australian families) being 2 (43 per cent) or 1 (23 per cent). In terms of age however it was unlikely that these children would be young. Like OTDs, spouses were a middle-aged group, with 64 per cent aged 40-49 years and a further 11 per cent aged 50-59 years (compared to just 25 per cent aged below 40). Any concerns re the location of children's senior or tertiary schooling would thus be serious.

In terms of region of origin, 29 per cent of all spouse respondents had been born in Europe, followed by 23 per cent from Asia, 20 per cent from the UK/Ireland, 18 per cent from Africa and 11 per cent from the Middle East. English was the dominant language spoken at home (by 38 per cent), followed by Arabic (7 per cent), Russian (5 per cent), and a wide scattering of other languages (Afrikaans, Polish, Dutch, Kurdish, Hindu, Sinhala, Tamil, Telugu etc). Two-thirds of spouses reported being Christian (70 per cent, including Coptic Christians), followed by 'no religion' (11 per cent), Moslem (9 per cent), Hindu (5 per cent), Buddhist, Jewish and Sikh. In contrast to the RWAV hypothesis, access to religious facilities for spouses did not appear to be a major issue.

Unsurprisingly, spouses reported the primary motivation for rural location to be their OTD partner's general practice appointment, sometimes in association with other positive attractors. At

the time of the survey administration, 25 per cent had lived in their current location for up to a year, 30 per cent for 1-2 years, 32 per cent for 2-3 years, and the remainder (13 per cent) for 3 years or longer. The following qualitative survey comments were typical of spouse motivations:

Wife offered a job…
My husband work here…
Limited choice due to OTD status…
Dependant on spouse…
Husband got this job via RWAV…
To join my wife in her selection of rural scheme. Also it is near Melbourne…
I have friends and relatives here…
Brother-in-law living in Victoria…
Most forward-looking state…
Weather/lifestyle opportunities…
The best package altogether…
Beauty and good facilities for an 'area of need'…
Best job offer, better earning potential than some smaller towns, medical 'politics' within area seemed fine…
I live in Melbourne.

Qualification Level and Work Location

The survey analysis became more interesting once spouses' level of qualifications and work engagement were examined. In brief:

- OTD spouses possessed a high level of qualifications: 79 per cent describing themselves as having some form of tertiary qualification, 9 per cent having completed Year 12, and 13 per cent not responding to this question. Substantial numbers described possessing more than one undergraduate diploma or degree, with others reporting a range of postgraduate qualifications (including masters degrees).
- In terms of field of qualification, spouses were highly diverse: the primary clusters being in medicine (13 per cent of respondents) and allied health (including dentistry and pharmacy, though nursing was most common - 13 per cent). Other individuals were qualified across a range of classic professions (eg engineering, accounting, teaching, architecture, science and childcare), many likely to be associated with minimal opportunity in small towns.
- In line with their level of qualifications, and the relative maturity of their children, spouses were characterized by a high degree of work attachment: 69 per cent stating they were currently working, with 39 per cent stating they held a professional position, 18 per cent engaged in clerical, retail or personnel work, and a mere 5 per cent in unskilled employment.
- Confirming the trend noted in the OTD interviews, the price of rural general practice positions was often sustained family separation: substantial numbers of spouses choosing to work in Melbourne (27 per cent) – more than double the proportion of OTDs reporting their practices to be located in Melbourne's outer suburbs (13 per cent).
- As Table 14 makes clear, such spouses were choosing to 'vote with their feet' – securing capital city work unavailable when practices were located in small towns and regional cities. Seventy-five per cent of doctors and spouses were in agreement on where they lived (Kappa = 0.60), even though this meant substantial numbers maintained separate households. The most common situation was where the spouse was in Melbourne and the doctor was practicing in a small or regional town (N=9).

Unsurprisingly, given this, work satisfaction was found to be very important to OTD spouses. Of those in employment:

- 35 per cent stated they were currently 'very satisfied' with work, compared to 58 per cent who were reasonably satisfied, and 8 per cent who had found no satisfactory option to date. A significant number had already held two or three positions in Australia.
- Two-thirds of all spouses in current employment considered their positions to be relevant to their skills (35 per cent stating the degree of relevance to be 'very satisfactory' and 30 per cent stating it to be 'satisfactory').

- Relationships with colleagues were also rated highly (43 per cent 'very satisfactory' and 33 per cent 'satisfactory').
- While less satisfied overall with the level of remuneration (48 per cent stating 'satisfactory' cf 8 per cent 'very satisfactory'), few areas of serious work dissatisfaction were evident in the survey responses. Spouses were clearly willing to be based in Melbourne, regardless of the distance from OTDs' homes/ GP practice locations. This process may substantially skew doctors' long term locational choices.

Table 14: Spouse location of employment cf OTD work locations (survey data)

Employment Location	OTD Responses	Spouse Responses
Melbourne	(outer Melbourne) 13%	27%
Regional city	25%	20%
Small town	61%	50%
Other	0%	4%

The Impact of Spouse Work on Family Co-Location

It was unclear from the survey which spouses lived with OTDs, and which maintained separate households in Melbourne or other locations, as reported in many of the OTD interviews. Despite the strains such separations might impose, it seems reasonable to assume respondents considered themselves in viable marriages, since by definition OTDs had passed on surveys for spouses to fill in. Indeed, a striking feature of the survey data was that any concerns re the issue of spouse separation remained unraised – simply not featuring in any of the spaces inviting individual qualitative comment.

In analyzing responses re level of spouse satisfaction with current general practice location, it is therefore essential to recognise that some spouses lived in these locations none or part of the time – the interviews revealing that it was doctors rather than spouses who typically commuted (regardless of gender), with Melbourne having the added attraction of superior schooling. Such commuting generally occurred on a weekend (though sometimes a daily) basis, as described in the following interview extracts:

> (South Asian VORRS doctor) *I live in Melbourne, my wife and daughter live in Melbourne that is the only problem. I travel every weekend.*
>
> (East Asian RLRP doctor*) If your husband is not able to find a job in the rural area it is very hard for them to stay. Like my situation, my husband works in South Yarra so I cannot ask him to move this way and to travel all the way to the city. The patients are quite friendly and they respect the doctor a lot as there is a shortage and they appreciate that I am from the city. They are moved, one lady came to see me one morning and it was very foggy and she said to me "I got up this morning and I was thinking of you and how can you come here driving along way on the freeway". We need to balance our career and our family and I think that family will be more important especially with two daughters and my youngest only being fourteen months. (Family based in the city, and OTD commuting daily.)*
>
> (European RLRP doctor) *It's a nice start. Initially, I thought we were (all) going to move over there. But I'm thinking of my children. I want my son to go to near to city to go to school next year. It will be a bit hard for him if I move (him) over here. My future plans are to finish my AMC program. To have my modules to finish all of them. And to sit this exam. And in the future to try to move a little bit closer so I can be with my family. I mean I'm thinking basically as a doctor you have to chose. Family or professional life, you can't have both. (Living apart from her husband and family who are in Melbourne.)*

Some OTDs had gotten round the lack of suitable spouse employment by appointing them practice managers if they had the chance to buy in, as previously noted:

(UK/Irish VORRS doctor) *He works with me, he's my business manager and that's why setting up this practice was a really positive thing for us. Most important for him was that we managed to buy a house fairly early on because when we were in rental accommodation, for him having come from running his own business to being in rental accommodation, I would say it was much harder for him because I was already building up social support with the people I worked with.*

Others had located no acceptable spouse employment option to date, like the following South Asian VORRS doctor with a highly-skilled wife, for whom commuting was not compatible with young children:

(Work) is very very important (to her). It is critical. We were even thinking about going back because she can't find a job here. She has been assigned the domestic dependent-wife job which was very unusual for her. In South Africa we both were working and had domestic help, people who stayed with us in our house, live-in domestic help. I come back from work (here) at 5 and still I have to go through till 9 o'clock - we were busy cleaning the house, feeding the kids, ironing the clothes and stuff, so it was a big shock, it was so different. She was so excited initially to come to Australia, that is why she resigned her job…. (Now) she says there's nothing for her to work for, nothing to look forward to. Very bored. We tried everywhere. RWAV was very helpful. They gave us a lot of people (to contact). We contacted most of them and we still haven't worked out.

Spouse Views on Factors Likely to Influence Future Retention

In general, around two-thirds of all spouses expressed a reasonable degree of satisfaction with select aspects of the current general practice location – whether or not they personally lived there on a full-time basis, or doctors worked at the cost of family separation. The quality of their partner's medical work, the size of the town, its perceived friendliness and access to religious facilities were all rated well overall, though less satisfaction was evident in relation to quality of facilities, access to good schools, and closeness to ethnic community or family and friends.

In general, respondents affirmed a surprisingly high degree of future commitment to their spouse's current location: 70 per cent indicating that OTDs were willing to stay, cf 30 per cent stating this was not an option. In terms of likely length of future retention, 7 per cent estimated 12 months or less, 18 per cent 2-4 years, 25 per cent 5-8 years, compared to half of all respondents (50 per cent) stating quasi-permanently (10 years or more).

When asked however to indicate the most important issue in determining whether or not OTDs would stay, 80 per cent of respondents responded with qualitative comments indicating at best highly *provisional* intentions to stay in the country, contingent on a complex interplay of factors as indicated by the following:

We are looking constantly for possibilities…
Satisfied at the moment…
(Want) further work opportunities/study/visit children…
(OK here) for foreseeable future…
Unsure, maybe no change…
Depends on my husband…
Access to family members, schools….
Spouse continuing to stay…
Children's university education…
Better lifestyle, access to good education for my goods…
Meeting needs of our children at high school level…
(Dependent on) whether having family overseas becomes an issue…
Employment…
Because of partner's job I will have to stay here…
I want to stay because I am studying at TAFE to gain a teaching qualification…
Lack of modern life necessities, lack of international culture…
We live in our permanent home (not in country) and husband has to travel…

Several spouses described their family needs at more length, as in the following examples:

> *Greater non-professional help (is needed), eg from RWAV and other agencies. More information (support re housing, community, access to assistance, tax issues etc. Greater freedom to move to other locations where better transport facility is available. Better family support/advice etc (not much from RWAV at all).*

> *There is a lot of uncertainty regarding our immigration status. It should not be connected with passing Fellowship exam with RACGP. I feel insecure regarding my permanent residency here and security is one of the main reasons my family move to Australia.*

Spouses had a range of suggestions in terms of the strategies perceived as likely to maximize long-term OTD retention (some of which would require a transformation of rural Victoria). Four themes were typically mentioned:

1. Access to more substantial training/education opportunities, including exam preparation support;
2. Better access to spouse employment in OTD sites, and provision of 'acceptable' schooling; and
3. Provision of guaranteed permanent resident status for VORRS doctors within a defined period of time, and/or reduction of immigration/employment related red tape;
4. Greater access to support groups to relieve isolation.

The following qualitative comments indicate the tenor of these views, including once again a very substantial underlying dissatisfaction:

> *I am changing myself to survive – what about you? (ie the system)…*
> *Review acceptance of overseas training and provide consistency and understanding and less paperwork…*
> *Help partners to find a job…*
> *Give families a chance to gain employment and to share their skills and at the same time gain support…*
> *Partners need to be catered for, schools need to be acceptable…*
> *Training/education opportunities…*
> *Should create jobs for spouses by RWAV…*
> *Transport – fast train, frequent schedule for travel…*
> *A possibility to work as principals in the practice on a subsidised basis…*
> *Security in future employment – no exams just for overseas trained doctors…*
> *Better 'sales pitch', need to extol the virtues of regions – eg environment, lifestyle opportunities, experience…*
> *Simplify registration…*
> *N/A – never lived in rural Victoria…*
> *I live in Melbourne…*
> *Support for wives/children (social/advice etc)…*
> *May I take this opportunity to say that partners and spouses of OTD may wish to study, especially the younger ones. Would be great if some sort of assistance was in place in such cases. Sincerely.*

Key Variable Analysis: Factors Likely to Influence Retention

Statistical analyses were undertaken in order to determine any significant differences between spouses in terms of gender, level of qualifications, region of origin, or VORRS cf RLRP scheme status. In brief very few were found with any likelihood of shaping current satisfaction, or impacting on ultimate retention.

The most powerful differences between spouses related to gender and level of qualifications: crosstabulation revealing that male spouses were far more likely to currently work than females (χ^2 = 6.98, p<0.01), to be working in a professional occupation (Fisher Exact test, p<0.01), and to be 'very satisfied' with their work (Fisher Exact test, p=0.04). By contrast female spouses possessed lower level qualifications, were more likely to be currently out of the workforce or not working, and to describe being only 'reasonably satisfied' with their positions if employed. When these data were re-analysed, removing all spouses not currently working, highly significant

differences by level of qualifications were confirmed, with professionals more likely to report being 'very satisfied' or 'satisfied' with their jobs cf respondents with clerical status (Fisher Exact test, $p<0.01$), and low skilled workers being more likely to frequently change jobs (ANOVA, $F = 4.60$, $p<0.01$). The two unskilled working spouses in the survey rated their jobs as 'unsatisfactory'.

In terms of region of origin or VORRS cf RLRP status every major variable was tested but few significant differences were found between spouse groups, in relation to either employment or general life satisfaction (including all aspects associated with country towns). The sole exceptions to this were as follows: UK/Irish spouses were marginally more likely to be satisfied with their current work than other region of origin groups (Fisher Exact test, $p=0.05$). No differences were found between spouse groups in terms of length of likely stay or ultimate intentions.

The final analysis involved a correlation between OTDs and spouses related to future locational intention. As previously stated, 75 per cent of spouses and OTDs had been in agreement as to where they currently lived, even where this meant maintaining separate households (Kappa = 0.60). In terms of how long the OTD was likely to stay in his/her current location in the future only fair agreement was found: 65 per cent of couples being in accord on this issue (Kappa = 0.46), but 35 per cent disagreeing.

The situation from OTDs' family perspective was summed up as follows by an Australian key informant from Eastern Victoria interviewed for the study:

> *I think particularly in the area that I came from, the social infrastructure is so deficient, it is very difficult to attract local graduates to areas like that, and I think that would apply to 80% of the rural areas. They don't have the schools that have the trust of professional people to send their children to. They don't have the social infrastructure - it's very difficult to get to know people. The partner of the doctor sits at home, doing nothing, struggling to try to develop a social network, because they don't work and they don't get the opportunity to try and socialize so much. And so the doctor often has an unhappy partner at home because they don't like where they live, because they don't know any one, they don't do anything and they don't have racial groups. There is a lot of suspicion from the Anglo Saxons in town who have been there a long time, about who these people are. Especially if they look Middle Eastern, it's a big problem. That's obviously racism, but it does exist and it's quite strong. And it can be quite subtle – people can just chose not to socialize with these people. So you've got those issues, and others like you can't get take away noodles after 6 o'clock, restaurants shut at 8 o'clock. The movie theatre is maybe miles away or non existent, and opportunities to go out to do things in the evening are very limited in most of these rural settings. Most of the people we try to employ are people who have either babies or young children before school who would likely be so tied up in their family lives that they would not notice the problems around them and schooling is not an issue. They usually stay for a few years and when their children got to school age that was a time they would depart.*

4. Key Informant Perspectives

A wealth of input was provided by Victorian key informants in relation to overseas trained doctors in rural Victoria, including analysis of the perceived factors likely to influence ultimate retention. As outlined in the Methodology, fifteen 30-90 minute interviews were conducted and fully transcribed, informants being derived from 14 locations across the state, and in terms of work status including five senior executives/ one workforce officer employed by the Victorian Divisions of General Practice, 4 CEOs of district hospitals or regional health bodies, 4 RWAV senior administrators or area managers, and the head of a university rural clinical school.

Substantial consensus existed between these informants on the critical issues, with five recurrent themes explored in turn below:

A. Victorian demand for OTDs;
B. Issues for practices;
C. Level of remuneration (expectations cf reality);
D. Examination preparation support; and
E. Family and personal issues impacting on retention.

A. Victorian Demand for OTDs

As established in the Introduction, Australia's reliance on OTDs has revolutionised over the past decade. Though the presumption prevailed through much of the 1990s that locally-trained doctors could be lured to the country to work, more recent years have coincided with growing recognition that OTDs are not 'a short term fix' but a primary labourforce resource – a process confronting Australian state recruitment and support structures with dilemmas as to which doctors to recruit, and what level of support to provide them with. State bodies such as the Rural Workforce Agency, Victoria are themselves relatively new: in the case of RWAV only incorporated in 1997 and funded from 1998, 'inheriting' the pre-existing Rural Locum Relief Program. Significant differences in terms of medical access for OTDs existed at this time, making Victoria a relatively attractive choice. According to one informant,

> *NSW has always been much tighter, and much more sensible in the sense of protecting the community. Victoria was extremely open, and almost any doctor could get in. No one would check the CVs, there was no reference checking, and there was no interview. Doctors walked in, filled in the paperwork, and if they found a place to work they'd start. WA and Queensland were given substantial funds in the earlier days to actively recruit, and they went overseas and established contacts in various countries, particularly WA. In SA, WA, and NSW they receive a million dollars every year to support locum and professional development, and we received nothing in the early years. Our support from the state health department now is for the 5 year scheme, the Rural Medical Family Network, and a staff position to support continuing professional development so we've been very limited in our capacity. The Federal Government's funding to Rural Workforce Agencies has remained about the same for 5 years. It's essentially $14.4 million plus partial CPI nationally - a tiny amount if you look at the overall requirements for rural workforce and workforce planning.*

By mid 2003, rural Victoria was characterised by marked variability in its level of reliance on OTDs - informants' estimates by region varying from 10-25 per cent of the GP workforce to 50 per cent or higher (particularly in small towns and relatively remote locations like Mildura or Swan Hill). Recruitment processes had evolved ad hoc, with significant advice and support consequences for those OTDs securing employment. RLRP doctors typically self-selected for rural work, contacting RWAV once practices had been found, compared to the highly coordinated recruitment process (from 1999) developed for choosing VORRS doctors. According to an RWAV informant, RLRP doctors frequently rejected preliminary counselling in their urgency to secure medical work:

> *It is out of our hands a lot of the time. Usually what happens is the CVs go to the Area Managers, who forward them to the Divisions. And it goes from there - they are never put*

into practices, they identify practices, they talk with practice principals. The issue we have with them is they ignore a lot of advice - either don't understand it, or don't want to hear it. They don't take advice initially about contractual arrangements between themselves and the practice they are going into, about numbers of patients, support from the practice when they are settling in, understanding they are not going to be earning as much as the practice principal, probably in five months even, or advice about family (and school related issues) - looking for communities that will work for their families. Those things will tend to go by the board and they just go and find something that looks good to them.

Within this context RWAV provides basic face-to-face screening interviews for RLRP doctors (without incorporating clinical or OSCE scenarios), advises on the level of supervision required, and makes occasional site visits – typically 3-6 months following appointments. This level of follow-up is conceded to be inadequate in terms of likely RLRP doctor needs for support:

The Area Managers stay in touch with them until things settle down, but we do not have the capacity to do what we would really like, which is get in there, case manage them all the way through, ensure that the contract they are developing with their practice principal is reasonable, ensure they are not being ripped off, and ensure they are getting the supervision that they really need. (Current support is) just not adequate. Bottom line, it's the best we can do.

The VORRS scheme, by contrast, requires OTD applicants to be interviewed face-to-face (more recently with the added option of video conference in-country). Clinical scenarios are utilised, pitched at FRACGP level, and (in the case of doctors qualified in category 3 and 4 countries – ie non-Commonwealth 'developing' nations) clinical OSCE assessments are also employed at the FRACGP level. Around 85 per cent of candidates are reportedly accepted by this process. Selection of VORRS doctors is followed by placement in locations designed to provide 'appropriate' transitional supervision, if required. Within the initial employment period, these OTDs receive regular funded RWAV support, supplemented where available by additional tailored help from local Divisions of General Practice.

According to informants from both organisations, RWAV undertakes the following functions where possible at this point in time, though clearly constrained by resource limitations:

- Management of OTD selection, including verification of qualifications, completion of background checks, and organisation of peer-controlled interview processes;
- Provision of advice to applicants regarding potential GP sites (with a range of practice choices and preliminary visits offered);
- Delivery of referral and advice related to likely level of remuneration, contract options, and family or lifestyle infrastructure issues;
- Following formal appointment, provision of regular meetings with Area Managers for 'case management' assistance, advice and trouble-shooting during the preliminary establishment period, including access to database information concerning potential training and exam preparation resources (etc); and
- Organisation of a range of social support functions, a number targeting OTDs, with others extending to spouses as well as children (eg 'meet and greets', and events organised via the Rural Medical Family Network).

Divisions of General Practice offer complementary forms of support – a number making sterling contributions in terms of continuing medical education, exam preparation and mentor support, as well as select social integration initiatives. The following excerpt exemplifies pro-active GP Division transitional support - in contrast to other Divisions which reportedly 'just leave OTDs and practices to get on with it!':

We endeavour to put as much as we can in. They of course are a small business and whether or not they take up the options is up to them. What the Division has done since starting up new practices is to find appropriately trained staff, and we've tried to put in people who have worked in practices before, who know the ropes and can up-skill them in those areas. We've set up their computer systems, we've assisted them from day 1 in having policy and procedure accreditation flows naturally through the process, rather than starting some time down the track. We've provided them with pamphlets and all that to

hand out to their patients. We've assisted them in finding extra work, eg running an immunization clinic for a lot of people to make it much easier initially. We've involved them in Division activities, so they might be on a reference group initially to see what the local initiatives are, without us having to go out and train them in it, through peer interaction. We've supported their families where possible - you know, assistance with networking, getting into schools, that sort of thing.

Both organisations provide advice to OTDs on dealing with red tape – for example information regarding the operation of the Health Insurance Commission and Medicare, the merits of working in select Rural, Remote and Metropolitan Areas classification (RRMAs), and the need to apply in a timely fashion for visa renewal as well as conditional medical registration. This support is essential to OTDs, in particular to recent VORRS arrivals. Key informants freely concede however it is possible for OTDs to be appointed and to receive minimal support, with infrequent visits the norm in more remote Victorian areas.

B. Medical Transition Issues for Victorian Practices (RLRP cf VORRS OTDs)

A major issue in terms of provision of OTD support is their perceived skills variability, in a context where informants suggest that most assistance may be given to those who need it least: the VORRS rather than RLRP scheme doctors (the latter characterised by substantial career gaps, and trained in medical schools typically viewed as less prestigious).

While supervision may be deemed necessary for those entering RLRP service, in practice it may be virtually non-existent. (VORRS doctors, by contrast, are considered ineligible for appointment if judged to require clinical support.) According to one GP Division informant, 'In the past (RLRP doctors) came out, they got the address of the surgery and there was no real support. If there was another partner at the practice they were lucky. If they were on their own, they sank or swam!' According to a second, isolated Victorian settings 'will take almost anyone, supervision minimal - it's almost farcical at times. The supervisor does the best they can, but they're sort of press-ganged. They're busy, they have a practice of their own, and given the distances we are talking about it's not practical.' The threat in terms of perceived quality of service provision is obvious:

At the moment I think the reality is that people in isolated rural areas are getting a second-class service. The most dangerous settings that I see are where you have OTDs setting up a rural practice, sometimes because they couldn't get through their AMC exams. They are in an area of need, and they have no or minimal supervision. (Despite AMC failure) they are happy to go out into the deep wilderness, where there is no possible chance of any local graduate going, no supervision, and it's very dangerous.

A second stated:

(Supervision) is done mostly by phone. Sometimes the (local) doctor will have a half day off and they will go and sit in an opposition practice in another town and just observe. But the problem there is they are doing it for nothing on their half day off and it makes it easy to burn out. One of the complaints from our Australian doctors is they tend to say 'What's the point of putting the work in if this person only stays for six months?' Practices are sometimes reluctant to employ an OTD because they put the work in and set them up and get them all ready for general practice and after six months they have to set them up for someone else.

On the basis of perceived skills deficits some practices have reportedly been reluctant to take RLRP doctors on - despite underlying medical shortages and the perceived 'commitment to Australia' of this permanent resident group. In a number of cases RWAV reported having to 'entice practices to even consider meeting with' RLRP doctors, let alone negotiating for provision of adequate mentoring time, contract terms and conditions etc. While practices eagerly compete for UK or South African qualified doctors ('They're on a different planet in terms of their ability… I've never had a bad experience with a [West] European or UK doctor'), those qualified in more 'alien' systems risk being stereotyped as innately problematic. Adequate vetting of OTDs (including reference checking) demanded time.

Four additional perceived deficits were also often mentioned:

1. OTDs lacking vocational registration received significantly lower Medicare rebates (c$17 cf c$24), a fact impacting on the earning capacity of the whole practice. ('Practices have a lot of difficulty with whether they actually drop the rate for a patient to see a non-VR GP in a practice, which could mean that the perception of the service is less.')
2. Doctors from less familiar cultural backgrounds could be viewed as culturally difficult to absorb. ('They may come from a system where they are extremely subservient in their junior roles, or where nursing staff or other staff are not even spoken to because they are so inconsequential. Even in places where there are lots of them they still suffer because they have people behaving towards them in ways they are not used to, they've got a family that's not with them, perhaps young children who are in another city, they are at high risk of depression and anxiety in their early days.')
3. Practices might be unwilling to provide support for OTDs if they have had negative experience in the past, including with doctors who have left precipitately. ('Some of them have got burnt when practices have paid the full relocation cost, and then six months later the OTD is gone!').
4. Small practices might feel daunted by the transitional level of support required, including later time off to support OTDs' training or exam preparation.

Within this context, practices face significant responsibilities:

> *We are particularly seeing a heavy concentration of OTDs in smaller more remote towns. In my area we have a large number of them up through the Wimmera and the Mallee in all the small towns and now even getting into the larger centre like Horsham and Mildura. For nearly all of these small locations they perform VMO functions as well so they are working with their local hospital. I guess our experience has led us now to really emphasise very heavily with practice managers and principals just how large and important the task of orientation is. It is probably one which some practices have not been good at it in the past and they have just put them in, given them a room, started booking patients and then wondered why they didn't settle or things went wrong. We have a checklist we are able to give practices of all the issues they should consider when they get a doctor started.*

A range of additional clinical training adjustments have also reportedly been required:

1. Knowledge about the nature of Australian general practice ('Almost all of them are experiencing this for the first time, so they have to quickly orientate themselves to Medicare and the PBS. They have to quickly pick up on the Australian style of general practice ie that is a private setting, consulting in 10-15 minutes blocks depending on whether it is a bulk-billing or a private billing practice. They have to contend with whatever the internal management structure is of the practice, and they also have to quickly pick up on the referral networks for any given location. They have to know where the specialists are, who does what, establish the contacts and start receiving some of the feedback for their patients.')
2. Adjustment to effective communication in English, if it is not their first language ('A lot of them would say that Australian expressions may not ring a bell with them, and [they may not have understood] some of the nuances of questions'.)
3. Preparation to deal appropriately with drug use/ abuse and domestic violence issues ('We had a number of cultural issues around females to start off with. Especially around rape victims who got pregnant, who were basically told [by OTDs] to grin and bear it. There were a few… people ringing us up quite a bit to start with.')
4. Training related to sexual health issues and geriatric care, ensuring that these were addressed within a comparable cultural framework to that governing Australian service provision norms ('Issues around [homosexuality], a lot of women's issues; men's impotency have not been dealt with particularly appropriately. Aged care issues, the use of palliative care especially in nursing homes.').
5. Knowledge related to class and gender equity issues ('In the Middle East, no female is superior to a male. And the difficulty that comes is that we will have an Australian female registrar and say an Iraqi or Egyptian HMO who's male - they can have great difficulty.')

6. Catering to Australian patient expectations for adequate information provision ('I think it is fair to say Australia is a fairly egalitarian society, and patients have a fair expectation for knowledge and do not wish to be treated with disdain.')
7. Understanding the importance of protocols related to privacy issues ('There needs to be a bit more training around the Privacy legislation. We've had to intercept a number of things - OTDs wanting to publicize broadly people's names and backgrounds, eg related to doctor shopping and drug seeking which does not fit within the Privacy legislation.')

Within this medical practice environment, the potential for OTDs to feel uncomfortable and disadvantaged was clear – a process at risk of being exacerbated by any local presumptions of the medical superiority of VORRS cf RLRP doctors. in one informant's view,

> *I know that a number of them feel like they think they are perceived as second-class in the system and there are plenty of Australian doctors that will talk with them in those terms. I think that is a sad thing and we are going to end up with a very fragmented profession out there. Some of the doctors who have come to Australia have been specialists from where they have come from and have academic work behind them and would have to have been highly regarded in their country of origin, very established. I can think of people who have done a lot of academic work in South Africa and come here and are treated as if they would barely rate to qualify for the profession. I know that for a number of them that is a very difficult thing and they really resent the number of hurdles put in front of them. It insults their intelligence and their pride. The fact that they have to go back and prove themselves so much and even when they do still not be accepted, that is a major factor that we see quite a bit. They come back at me and say, 'Why do we need to do this?' Some of them accept it and some don't. It is a difficulty for them, yet if you are a UK trained graduate you will be accepted straight in as if you were on an equal basis.*

In a range of instances, RLRP doctors have chosen to establish solo practices – a potentially problematic issue in terms of support, especially if supervision had originally been 'mandated' ('You've got a group who in general need to have more resourcing of the cultural idiosyncracies of the Australian way of life, who being solo practitioners don't necessarily have a peer group as most of them have started a new practice from scratch').

Despite such concerns, a range of informants cited positive practice outcomes based on very straightforward RLRP as well as VORRS medical transitions:

> *We've got some excellent examples of rural docs here who probably took up to nine months to build up to a good patient base, but patients love them. And one of them has become the (patients') doctor of first choice…*
> *It takes a while for the community to suss out the new doctor. Some people will go and see what they are like and others will hang back, and their word of mouth will make them or break them in terms of popularity…*
> *We had a doctor from (the Middle East), and whatever culture he worked in, he would be a success. So you've got him on one side, and this fellow we had earlier in the week on the other, who was very arrogant, thought he was a lot better than he was.*

C. Level of Remuneration (Expectations cf Reality)

Additional concerns were raised by key informants related to overseas trained doctors' employment locations – some with significant ramifications for level of pay. These are summarised briefly below:

1. As previously stated, substantial numbers of OTDs enter rural practice with unrealistic expectations of financial reward, including understanding of the time likely to be required to build up patient demand – a problem exacerbated for RLRP doctors bypassing the RWAV counselling process.

2. For doctors lacking vocational registration, payment per patient is significantly less until VR is gained – as we have seen at the start of this report, for many OTDs an inordinately long process.
3. For OTDs based in Rural, Remote and Metropolitan Areas classification 3[39] (ie regional city locations such as Wodonga or Bendigo), Medicare rebates are also substantially less, leading to a constant outflow of initially attracted doctors. ('If you're an Australian qualified GP and have the status you will get the rebate of $25.10. If you're an OTD then you will only get $17.63, whereas if you're an OTD in any of the rural areas except RRMA 3, and this includes people hard up against Melbourne so to speak, people will get the full Medicare rebate. So people who are on a lower socio-economic income, if they are accessing OTDs, the chances of them getting bulk billed are minimal because the GP is actually getting $7 less rebate per patient, which makes it very hard for us to attract them.')
4. For doctors reaching Australia with minimal financial reserves, start-up costs could also represent a serious burden – one exacerbated by slow patient takeup, the percentage of income required by practices, and the level of RACGP exam preparation costs. ('Finances can be an early driver of unhappiness in the placements. The financial return very early on is a real driver in the decision to go there in the first place and the level of happiness when they first start off. A new doctor coming into a town will be concerned about the cost of relocating whether it is from locally or overseas, setting up the house, setting up the family. They are more worried about what they will earn in the first two to three weeks than the first two, three years. They need to get through the initial period so we talk to hospitals and practices about making sure that they look at some income guarantee in the initial period.')
5. Initial disappointments aside, long-term expectations could be entirely unrealistic, given the level of demand in select country towns. ('One thing I have learnt is that they not only have an aspiration to come to a new country but that as new immigrants they aspire to a very good way of life. They are working for the long-haul to establish themselves, not just in Australia but they want to build wealth, they are very driven by wealth, they want to build high-income lifestyles, that is the driver to come from wherever they have come from.')
6. Where disappointment re income expectations is bracketed with other disappointments, OTDs could feel little incentive to stay. ('Often OTDs are coming hoping to make a lot of money, because they think the grass is very green here and they need to build themselves up quicker than (is feasible). And that becomes an issue of retention. I certainly know that one doctor has relocated after 6 months. I know that one doctor has had three moves.')

Within this fragile settlement context, doctors' vocational registration status could impose further financial burdens, as detailed in the following excerpt:

> *Just going back to the OTDs and the Medicare rebate, being here puts a lot of pressure on GPs to get their vocational registration. They seem to think they can sit the College exams, get their skills assessed (because they've) got 5 years general practice experience in their country of origin. But the failure rate is quite high for these OTDs. They have just moved to the area, often they got a family to consider. They have bought a house, they are trying to build up a practice, there's no way they could take some study leave, or even have the finance to purchase some of these packages that are put together to get them up to the exam preparation.*

D. Examination Preparation Support

RWAV's charter specifically precludes it from providing OTDs with vocational training leading to passes in the RACGP vocational registration exam, though it may support them with exam preparation courses – an issue of mounting concern to the organisation in a context where Victoria's reliance on OTDs is assuming a semi-permanent basis.

Our position has changed quite dramatically. We have been arguing extremely hard for the last two years for the Federal Government and the state Government to provide support to OTDs to pass their exams… (At the) national level all the Workforce Rural Agencies and the rural Divisions believe this is a critical issue. It is also a critical community safety issue, since it is untenable to continue to place doctors in rural areas who have not met the standards expected of our own doctors. We're still not getting support. And we say, well it's part of our core business to provide professional development to doctors in rural areas, and it's certainly part of our business to support their retention, and that's very much at risk if they don't pass these exams. In terms of recruitment it makes a big difference to these people if we can say, look, we give you all this support.

The 15 key informants interviewed for this project considered provision of effective exam preparation support to be critical to OTDs' satisfaction, and hence retention in rural Victoria.

The system obliges them to work towards the Fellowship eventually, and a number of them have had real difficulties over the years doing that. (Some) were avoiding it and we were going out giving gentle pushes to say you need to keep moving, otherwise we can't keep you registered. (They were) preparing in the way that they thought was right and having no comprehension of what they were preparing for, and falling over one, two and even three times in the exams. Linked to that is I have had a doctor who perhaps failed the second time ringing me up in absolute desperation wanting to know, 'Can I stay in this country? It means everything for us to stay here.' They know full well that the Fellowship is linked to a lot of other things in terms of being able to get permanent residency and convincing the Medical Registration Board that they are genuinely trying to get there. There would have been occasions when the Board has written back to somebody and said we are not prepared to give you any more than six months registration on a provisional basis because we are not satisfied that you are making adequate efforts to work through to either General registration or your Fellowship, and so having failed they go into a high state of anxiety, really desperate people wanting to know will it all be okay. It puts us in a situation of saying, 'Listen, if you devote yourself to Fellowship preparation you need to access all of the education, all of the GP educators and supervisors that you can. Try and find the resources and get to know what the exam is.' But it was just that sort of advice with nothing behind it. I didn't have the resources and there weren't many people around who wanted to help them.

The case for providing effective exam preparation support was summarised by Australian key informants as follows:

1. Overseas trained doctors desperately need such assistance – not merely to prepare for the RACGP exam, but in the case of select doctors as an essential strategy to ensure they possess the requisite skills for safe practice. ('Obviously the United Kingdom is not an issue. We would accept UK, Canada, America. When you get to the Middle East, the sub- continent and Europe you can't make blanket statements. Basically you check case by case. When you get to the Eastern European countries, the variety is particularly significant. We've had some fantastic doctors from Poland. We've had some very ordinary ones. In the Middle East I would say exactly the same. In India I would say there are some phenomenal medical schools, 50 or 60 or maybe more, but the variance is huge.')
2. Under the current Victorian schemes, OTDs are required to secure full vocational registration within five years, or theoretically two years in the case of VORRS doctors (though this timeframe is yet to be tested). Doctors lacking essential support are likely to be highly motivated to move wherever it can be acquired. ('Here in Victoria there is some elasticity in the 5 years but I personally would not be too happy about too much more. It just goes on for ever. And generally speaking, they've signed up with definite knowledge of what they need to do. If they haven't completed it or even attempted in some instances until after their 5 years is up, that may not necessarily mean that they are a good practitioner. It may also mean that they are working too hard. I think we do need to have support for these people, because it is hard to study and work full time, but having said that, many of us have done post-graduate courses whilst working full time.')

3. OTDs have strong expectations of the GP Divisions and RWAV providing such support – regarded as 'core business' given these bodies' attempts to minimise OTDs' practice disadvantage.
4. Traditionally the College has provided minimal support. ('Bloody hopeless, they were a disgrace. What they did for OTDs was take their money and that was it. [Only advice was] you need to come to us in Melbourne and we will see what we can do with you and a number of doctors have then taken the long trip down from [small townships] and got just more general advice!')
5. The recent commercialisation of RACGP exam preparation course by College-affiliates such as GPEA (General Practice Education Australia) imposes exceptional cost burdens on OTDs struggling to establish practices, in addition to high exam candidature costs. ('The Department of Human Services have recently funded on a 50-50 basis any OTDs who are experiencing some trouble after two years on the scheme, paying 50% of the GPREP course, which is offered by GPEA. The Fellowship preparation course they came up with is a package of support mechanisms priced at about $9,500. Well most of the OTDs said, 'I will be right thanks, and I will give it a couple of tries before I get that desperate'. The course really replicated the best of what the Divisions were doing and the initial 12 months have shown again that they can't necessarily deliver what they promised. A number of the OTDs are very disappointed in what they have received for what they have paid for.')
6. Within this context the majority of OTDs rely on what is described as 'patchworky' GP Division support. ('In the last twelve to eighteen months they have been running telephone conferences, doing case studies at night with a mentor, getting them in for a Saturday or a weekend and running MCQ preparation or Clinical component preparation. The Division is extremely frustrated with the College. The College will try and send somebody out, but are very reluctant for any one to leave Melbourne to do even a day's work. It is a major favour, they charge through the nose to do it, it has been very difficult and they are still not doing it well. [The local Division by contrast] has most of the OTDs linked into small case study preparation groups doing the teleconferences and getting some access to resource material, getting a bit better feedback on what the exam is. The pass rate this year has really picked up. A number of people who have been stuck have now gone through, so there is a cohort there who has finally made it and they ring up so happy!')

Provision of Effective Support: Catch 22

As affirmed by the comments above, provision of effective exam preparation support is viewed as a linchpin in rural support for the OTD workforce. At the same time, it is essential to note, such support is viewed by informants as creating a catch-22 situation – many convinced RLRP doctors *leave* rural locations as soon as they have passed exams, a pattern likely to be replicated by VORRS doctors on completion of their mandatory rural service periods.

One informant stated 'They're only leaving when they have got their Fellowship. They are choosing to be here (to practise) because we are offering a really good supportive network. Once they are free to go anywhere they do.' The Director of a regional hospital recalled:

> *For the first few years I had a very comprehensive and aggressively policed teaching program for OTDs which was very successful in getting them through their exams. Doctors were forced to comply, we had sessions at 7 in the morning or 8 in the morning. If people did not turn up they were rung up, put on speaker phone to explain to the whole room where they were, why they had not attended and it meant that the absentee rate was almost zero. And I think it was close to 30 that sat during the first few years that I was there, and all passed. The process after that became less stringent because one of the problems was that when they passed they left, and we were faced with new OTDs who had limited skills who needed to be trained again. In the end it was a question of my energy that was flagging because the end result was a doctor who left. You certainly got gratitude, and that gratitude will probably be life long as far as some of those doctors were concerned. And it was nice for them that they managed to get into the Australian system and got to go and do some of the things they wanted to do. But from the hospital point of view the rewards were pretty low. You need to balance, how do you train them so*

that they are safer and at the same time how do you retain them when they get safer and pass their exams and go away?

This appears to pose an intractable problem. To one informant at least it must be judged as a social justice issue:

> *We have the Rolls-Royce public funded system producing general practitioners who basically to this point in time have not gone anywhere near rural. On the other hand the people who are doing the job in rural are coming mainly because they are obliged to, and get no support. I was at the General Practice Training Conference last week and in two days of very professional (discussion) OTDs didn't rate a mention. I was disappointed about that, but I am also starting to get a little bit of feedback from some of the young Australian GP registrars themselves - a bit of an attitude. We had communication from one of them that he thought the OTDs had a far too easy path through to Fellowship, and I simply hit the roof when I heard that, because if you have actually worked with them you would know that for many of them it has been a ten year struggle. Whereas he has had it all funded and handed to him in a very accessible manner. .. So there is a little bit of an 'us and them' atmosphere: that they are second class or they are getting it easy or they are pushing us out of jobs. Well that is not the case at all! If (local registrars) would like to come and work, we will soon find the work for them.*

E. Family and Personal Issues Impacting on Retention

The final issue raised by local informants concerned OTDs' need for cultural comfort – a factor (in line with the survey findings) conceded to be more critical to the rural retention of some ethnic groups than others, and to families rather than doctors. In attempting to address this issue RWAV, in addition to select GP Divisions, has evolved informal processes to facilitate co-location:

> *We try and get enclaves of the nationalities in an area where there is mutual support. I have recently started bringing a group of Bangladeshi born people, most of them have come via South Africa but they are Bangladeshi by origin and I have got three doctors in this region now and they all feed off one another if you like…*
>
> *What I found was if they developed their own enclave, for example at Eastern Victoria the initial enclave was the Iraqi group, you'd get a couple who were friends, and eventually before you know it you've got seven or eight of them. They socialize together, their wives who don't speak much English tend to socialize together, and support themselves. They stayed in some cases I think for four or five years. Those who didn't have those enclaves tended to stay a shorter time, but it did depend on how quickly they passed the exam. Over a couple of years, the Iraqi enclave parcel moved on, and the next enclave we had was a Filipino enclave. At least half of them have moved into general practice, and will stay there I would think until they have retired. They moved with their entire family and there was enough of them that they could socialize together.*

Regardless of the effectiveness of such creative strategies, informants described the issue as unresolved:

1. Socio-cultural isolation remains a chronic problem for select OTDs, particularly affecting wives and (at times) children. ('I think it's difficult, particularly with the Middle Eastern doctors' wives. They won't go anywhere without their husband. So they're basically hanging around waiting for him until they can get in the car and drive to [the city] and go shopping. We've certainly talked to them about getting together during the week. But they won't, they don't drive.')
2. While a range of family support structures are in place and currently being diversified, these are typically insufficient to offset the attraction of compatriot or multicultural hubs, eg Melbourne, Shepparton or Cobram. ('You are generally moving a foreigner into what is a pretty conservative town that would like to see a white-Australian doctor and you are not going to see that anymore, that is the reality... I think our retention rate [in Shepparton] over the last three or fours years has been pretty good. Our OTDs I don't think are just here for the short term. You get the sense they are

establishing themselves, having families, putting kids through school. And I think their retention rate will be as good as an Australian trained doctor up here. They definitely are attracted by the fact that there is a community of people from their own countries up here, their religious needs are met, they have access to the mosque and their culture.')

3. In addition to these overall trends, retention is also clearly mediated by individual family and interpersonal preferences. ('Well the first one that came here, from England, has been here 4 to 5 years. He's bought property, an acreage out of town, and seems committed with his wife and children. The second one is a bit more unsettled, I believe. I think her partner is struggling to find a position. I think their eldest child finishes year 12 this year, and once that is completed they will seriously look at what options are presented for the family unit.')

In conclusion, the majority of key informants shared the conviction that OTDs respond to identical factors dictating the practice choices of Australia-born doctors. To these are layered pressures in relation to the perceived value of practices, the need to secure examination and training support, and families' degree of comfort/discomfort in potentially isolating professional and/or cultural milieus. Some OTDs commit to rural Victoria, integrate superbly and stay as long as they can: the ultimate determinant of relocation to cities typically being the educational needs of children, as in the following quote:

> *I would say I know probably 10 OTDs who are working in the country whose families live in Dandenong or Melbourne, and they are doing it in order to support their families and get their registration so they can move back to the city. Now you're never going to get around that. No matter what support you give them they are never going to remain - or it's unlikely that they are going to remain unless you physically restrain them with legislation. On the other hand, there are others who have absolutely (committed). Their wives, their husbands, their families have come along and they have become integral to the community. And they have a real chance of staying around, except to say they have the same pressures as Australian graduates. I put my hand up here and say I did it as well, in that when my children got to high school age, given that my daughter and son both want to do medicine and law, a small country high school didn't have the opportunities for them and so we moved.*

Overall, informants viewed it as essential for rural communities to shift from long-term to short-term expectations in relation to doctor retention, with constant replacement being the norm. In the view of a final key informant:

> *From our point of view if they have been out rural for five to ten years, or have been in any given town for three to five years, that is a good long-term stint. We are not looking at any class of doctor now that we are going to attract at the start of their career, (thinking) this is where they will finish in 30 years time. A big part of my role is to go to towns and talk to them about the fact that this is changing - that they are not replacing old Dr Smith who was here for 50 years. If you can keep your doctor for three to five years, you have done very well. (Rural populations) need to expect that doctors will be coming and going, and they will need to have structures to match that. Anyone who has come rural for five years we would realistically say has met their commitment and done their time as it were. They have rendered that degree of service, they have made a great contribution, and we don't expect necessarily that they will stay forever. (They are entitled to) freedom of choice.*

5. Executive Summary and Recommendations

The reform measures placed on the supply of doctors in Australia during the 1990s, particularly those flowing from the 1996 Coalition legislation, have severely constricted the number of doctors eligible to practice as GPs. These measures, plus the enforcement of a stable quota on places for medical students enrolled in Australian universities, have contributed to the current supply crisis in Australia. It has been evident for several years that in the absence of Government intervention to ensure that local graduates or OTDs who gain full registration serve in areas where there are shortages, this supply crisis would impact severely on regional Australia, and even on low income outer metropolitan locations. That situation has now come to pass – as indicated by relatively low and declining bulk billing rates in these locations[40].

The Australian government is having to carry the political consequences of these earlier policy decisions. The result has been a raft of reform measures, including an increase in the number of medical school enrolments and the liberalisation of provisions allowing OTDs without full registration to practise in Australia in 'areas of need'.

The situation that RWAV faces in the immediate future is that:

- There is no possibility that the underlying shortage of Australian trained GPs will be alleviated. It will take several years before the supply of fully accredited local doctors increases. Nor has the Government shown any inclination (other than by marginal measures such as tying some medical training scholarships to regional location) to implement measures to oblige doctors to serve in areas of need.
- The resulting political crisis means that the Commonwealth and state governments will continue to have to deal with this shortage problem by facilitating the recruitment of OTDs.
- Our analysis shows this to be a 'viable' solution, in that there is a substantial pool of OTDs in Australia anxious to work as doctors, this pool is increasing by several hundred each year, and Victoria is a relatively attractive employment option. Because such doctors lack full vocational registration they can be tied to 'areas of need' while they gain accreditation and serve out the mandatory five or ten years required before they are free to bill on the Medicare system wherever they wish to practise.

The problem for RWAV is that most of this pool of OTDs come from Asian and Middle Eastern countries associated with concerns about variability of medical training, including the relevance of past training to Australian expectations (as mirrored by relatively low Australian Medical Council pass rates for select country of origin groups). In addition, such doctors and particularly their families may have difficulty adjusting to rural social environments where they are at risk of being regarded as culturally alien. Past studies have shown that the great majority of doctors from NESB backgrounds who have gained full registration ultimately relocate in Australian capital cities. At the outset of this study it was expected that the OTDs currently appointed by RWAV would move from regional locations once they had completed their accreditation process, as has indeed been the case in recent years. The current shortages of GPs, even in metropolitan areas, mean that there are no medical employment constraints for RLRP doctors inhibiting such a move.

Within this complex employment environment the study has examined the experience and attitudes of OTDs employed under both the RLRP and VORRS schemes, and from select regions of origin. Key findings from the surveys and individual interviews are as follows:

1. Overseas trained doctors in Victoria are characterised by an entrenched hyper-mobility: 66 per cent of all survey respondents reporting 5 major geographical moves prior to their current position (migrating to one or more countries and then additionally within Australia), 30 per cent making 3 to 4 moves, and 5 per cent reporting an extraordinary 6 to 8. A substantial number of such doctors have worked in a second country for 2-7 years prior to migration to Australia, with Asian-origin VORRS doctors significantly more likely to have experienced a high degree of global mobility. Within this context it would be rare for a random Victorian rural appointment to result in a commitment to permanent stay. For many OTDs, Victorian country posts are inevitably no more than an additional step along the way to doctors' goal of

maximizing family lifestyle, income level, and personal security. It is unlikely RWAV has any capacity to intervene in this process, except through the introduction of service restriction clauses and appropriate financial incentives (see Recommendations below).

2. Improved lifestyle and opportunities for children were stated to be the primary reasons overseas trained doctors elected to come to Australia (40 per cent), their comments making it clear that such motivations were inextricably linked. The point to note here is that career opportunity was relatively unimportant in determining Australia as a destination choice for OTDs – an issue indicating the extent to which doctors might let non-career factors determine their future practice locations. No significant differences between doctors in terms of motivation to migrate were found by RLRP cf VORRS status. In terms of region of origin, OTDs from the UK/Ireland were found to be over 4 times more likely to report coming to Australia for family/lifestyle reasons than other survey respondents. No other region of origin differences proved significant.

3. In contrast to choice of country, career opportunity was the primary reason overseas trained doctors reported that they came to the state of Victoria (39 per cent), followed by access to family/friends (38 per cent), the intrinsic attractiveness of Victoria as a state (14 per cent), and RWAV's rural GP recruitment scheme (4 per cent). A high 61 per cent of OTDs stated that job-related reasons had been the critical determinant in coming to their current rural location - suggesting if positions proved disappointing they might have minimal incentive to stay. Importantly a substantial number of doctors stated that they saw this site as their 'only' current medical option (in other words a highly constrained choice). It is essential to recall here that many such OTDs were indeed 'captive'. Sixty-nine per cent of all respondents had achieved only conditional medical registration by the time of the survey in April 2003. The majority of RLRP permanent residents had attempted without success to pass the 'mandatory' AMC pre-registration exams, resulting in them being eligible to work as general practitioners only in 'areas of need' or comparable sites. Those with full registration were seeking to reduce their period of exemption that allows them to bill on Medicare, from 10 to 5 years. Visa conditions for temporary resident OTDs were similarly constrained in terms of GP location.

4. OTDs reported having secured their first medical registration in a range of states, confirming the willingness of those established in Australia to shift to improve career or lifestyle options. While 27 per cent of all respondents had been placed in their current position immediately on arrival in Australia (including all selected through the VORRS scheme), 22 per cent had been without work for 4-12 months post-migration, 10 per cent for 1-2 years, and 30 per cent for 2 or more years (including some for very extensive periods). Within this interval RLRP doctors had become desperate to secure medical work, with years spent trying to pass AMC exams in relative isolation, convinced that clinical exposure would assist them to do this while they earned. For all OTDs, whether permanent or temporary origin, work in alternative Australian locations and other countries remained a viable option. While access to the RACGP pre-accreditation pathway was a welcome prospect for most - an opportunity to leave the failure associated with repeat AMC attempts behind them – it was only presumed *in advance* to be more benign. The majority at the point of the survey had not actually tried it.

5. Thirteen per cent of all OTDs stated that they had been in their current location for 4-5 years by April 2003, 56 per cent for 2-3 years, with the balance being far more recent arrivals (2002-3). Encouragingly, 40 per cent of respondents reported being very satisfied with the nature of their GP work, compared to 56 per cent who were only reasonably satisfied and 4 per cent who were dissatisfied. When level of satisfaction was examined, no statistical differences were found by region of origin or by VORRS/RLRP status. The great majority of OTDs expressed a high degree of satisfaction with general practice employment (95 per cent), viewing the work as extremely relevant to their skills, and supported by good access to specialist services.

6. Despite the overall positive nature of these survey responses, it is essential to note that significant differences in terms of level of satisfaction were found between doctors by region of origin. When complex statistical analysis was undertaken, doctors from Asia, Africa and the Middle East proved 3 times more likely to be only reasonably satisfied or to be actively

dissatisfied with the nature of their work when compared to survey respondents from the UK/Ireland or Europe.

7. While 76 per cent of survey respondents indicated that they had established positive relations with peers, this process had often been difficult, including for a number of British-origin South African doctors (suggesting the issue was not wholly culturally based). When statistical analysis of response patterns was undertaken, doctors coming from a UK/Ireland, Asian or European background were found to be three times more likely to be satisfied with their professional colleagues when compared with doctors from the Middle East or Africa. Four key themes in relation to colleagues' attitudes repeatedly recurred in the interviews:
   - Peer wariness or distrust of medical outsiders;
   - Lack of respect for the overseas-trained doctor's skills, including his/her ability to deal with a range of cases without vetting;
   - Reluctance of other doctors to refer on an adequate flow of patients; and
   - Unwillingness to allocate the OTD sufficient remuneration.

   These issues were viewed as particularly difficult to accept given the relative seniority of Victorian OTDs (56 per cent aged 40-49 years, and 20 per cent aged over 50), plus their level of qualifications (58 per cent of survey respondents having 2 medical qualifications, and 34 per cent stating 3-4).

8. Overseas trained doctors also had serious concerns about their level of remuneration in country Victoria – in some cases an issue improving over time, but in others leading them to consider precipitately leaving practices. By the time of the survey only two-thirds (62 per cent) of all survey respondents reported being satisfied or very satisfied in terms of remuneration, despite many having spent substantial periods already in their current location. When complex statistical analysis was undertaken, no significant differences were found related to this in terms of doctors' region of origin, or VORRS cf RLRP status.

9. Provision of examination preparation support (AMC and/or FRACGP) proved to be a further critical issue, with an extremely low 31 per cent of doctors reporting satisfaction on this score. Sixty-six per cent of doctors had attempted the MCQ exam: 37 per cent once, 19 per cent twice, and 15 per cent on 3-5 occasions (with 83 per cent of attempters finally passing). Fifty-three per cent of all respondents had attempted the Clinical exam: 20 per cent once, 16 per cent twice and 13 per cent on three occasions (acute frustration being associated with these years of attempts/failures, in addition to career gaps, income loss etc). By the time of the survey 60 per cent of OTDs attempting the Clinical had passed it. When analysed by region of origin, no significant differences in MCQ or Clinical pass rates were found between survey doctors. Four major issues were raised in the interviews:
   - The appropriacy of being required to take Australian pre-registration exams (typically by UK/Ireland informants);
   - The need to receive appropriate preparatory mentor and training support (with a range of excellent models being cited);
   - The need to access training programs in convenient sites – offsetting the disadvantage experienced by OTDs in remote cf less decentralised locations; and
   - The need to secure some form of funding support in order to prepare for RACGP or other exams.

10. Within this complex pre-accreditation context, the RACGP Fellowship pathway represented an important alternative option for RLRP doctors as well as the standard requirement for VORRS doctors. Forty-eight per cent of all respondents were planning to sit the RACGP exam: 36 per cent of these attempting it once to date but some reportedly already up to 3 times. A mere 37 per cent of survey respondents reported that they had satisfied the FRACGP requirement - virtually all since 2000. The ultimate impact of FRACGP passes on rural retention (including for VORRS doctors) is therefore unknown.

11. A cluster of additional factors were associated with medium to very low OTD satisfaction ratings, including the quality of local schools (attracting 63 per cent approval rates), access to training/supervision (62 per cent), access to a partner's job (46 per cent), nearness to family/friends (41 per cent), level of support/time available to help pass pre-registration exams

(31 per cent), and access to ethnic communities (27 per cent). The quality of rural schools for children was revealed in the interviews to be absolutely critical to doctors' long-term retention.

12. Fifty-two per cent of all survey respondents reported that they expected to stay in their current location long-term (6-10 years more), compared to 24 per cent who planned to stay for 4-5 years, 8 per cent for 1-12 months more, 5 per cent for 2 more years, and 6 per cent for 3 more years. These projections may well be overly optimistic however, given that the research suggests far more ambivalence among spouses on this score. Overall the following factors appeared fundamental to determining the future retention of OTDs in rural general practice:
    - Family issues were paramount, with access to good education for children cited by 97 per cent of all OTD respondents as determining long-term location, followed by access to a good/well paid medical job (ranked as very important or important by 95 per cent), a higher salary (89 per cent), improved medical facilities (88 per cent), and better collegial support (87 per cent).
    - Access to examination preparation training courses was considered to be very important or important by 77 per cent of all OTDs, an issue closely followed by access to better medical training (76 per cent), shorter working hours (76 per cent), provision of a formal contract (75 per cent), location near family/friends (73 per cent), metropolitan location (70 per cent), better supervision/mentoring (62 per cent), and access to religious facilities (62 per cent).
    - Proximity to ethnic community was cited by just 35 per cent of OTDs - a far less important determinant of future retention than initially thought.

13. In terms of differences by region of origin, a number of significant findings were noted:
    - Doctors from Asia, Africa and the Middle East were 3 times more likely to be only reasonably satisfied or to be actively dissatisfied with the nature of their work when compared to survey respondents from the UK/Ireland/Europe group.
    - As we have seen, doctors coming from a UK/Ireland, Asian or European background were found to be three times more likely to be satisfied with their professional colleagues when compared with doctors from the Middle East or Africa.
    - Middle Eastern, Asian and European OTDs rated socio-cultural support more highly than did UK/Ireland or African OTDs as a factor likely to contribute to decisions re long-term retention.
    - Middle Eastern OTDs were also significantly more likely than others to plan for future employment locations close to their ethnic community, whereas UK/Ireland and African-origin doctors viewed this issue as of negligible importance.
    - Consistent with this, access to metropolitan locations was shown to be unimportant to African OTDs and minimally important to doctors of UK/Irish origin. It was however of significant importance to most other region of origin groups.

14. In terms of differences by VORRS cf RLRP scheme status, a number of additional important findings were noted:
    - VORRS doctors were significantly more likely to have moved to Australia for family and lifestyle reasons, to be highly sought by medical employers, to be offered long-term rather than short-term contracts, and to secure immediate post-arrival work.
    - RLRP doctors by contrast were significantly more likely to be of non-English speaking background origin, to have reached Australia with relatively poor English, to have experienced career gaps, and to have been offered short-term GP employment contracts.
    - Access to socio-cultural support was revealed as more important for RLRP doctors, with VORRS doctors appearing less likely to leave rural Victoria to co-locate in Melbourne or other regional sites with compatriots.
    - VORRS OTDs were significantly less motivated than RLRP doctors to seek access to better medical training – a factor that may become far more important with RACGP exam attempts in the future.
    - For all the above reasons, the temporary resident VORRS doctors seem more likely to choose to remain in Victorian rural general practice locations than RLRP doctors – or at least for the requisite 5 year period.

15. Overseas trained doctors most likely to remain in their current jobs for shorter periods of time were found to be those who had:
    - Gained unconditional medical registration recently;
    - Passed the RACGP Fellowship examination;
    - Reported lower satisfaction with the nature of their work; or
    - Were of non-Christian origin or with 'no religion'.

    Overall however the findings demonstrated that doctors who were *satisfied* intended to stay longer - regardless of RLRP or VORRS status, region of origin, or any other variable in the dataset. Within this context it makes sense to give overseas trained doctors highly effective support.

16. It should be noted in relation to the overall analysis that a substantial number of OTDs had been obliged to accept long-term family separation as 'the cost' of rural GP employment. As both the interviews and spouse surveys demonstrated, partners and children had frequently established themselves permanently in Melbourne to secure what were deemed essential employment and education opportunities - the burden of commuting typically falling on OTDs. The stresses associated with family separation seem certain to influence doctors' ultimate level of rural retention.

Recommendations

On the basis of the above findings, we propose seven recommendations for RWAV's consideration:

1. RWAV should focus its recruitment policy on the VORRS scheme, since this scheme attracts:
    - Doctors on temporary entry visas who cannot readily move to other Australian locations;
    - Doctors who appear to be highly regarded by practice employers;
    - Substantially higher proportions of doctors who feel culturally at ease in rural Australia (UK/Ireland and African origin) rather than desiring to co-locate in capital or other cities with compatriot groups; and
    - Medical practitioners who were attracted to migrate to Australia/rural practice in the first place for lifestyle reasons.

2. Given that OTDs appointed under the VORRS scheme are generally satisfied with the circumstances of their appointments, RWAV's second priority should be to help them to attain registration. The goodwill flowing from additional assistance should contribute to VORRS doctors' sense of satisfaction with their Australian experience, and thus with the medical settings in which they are currently serving. A range of pro-active measures will be required, including:
    - Securing policy approval and funding to extend RWAV OTD services to examination preparation support;
    - Provision of subsidised assistance to doctors in order to offset the current disadvantage experienced by those serving in decentralised sites; and
    - Increased advocacy to/ liaison with institutions with a capacity to provide expert examination preparation support, to ensure this is delivered in a timely, affordable and effective mode to VORRS doctors in need of it.

3. These exam support initiatives should not be restricted to VORRS doctors, given their numbers are limited in terms of supply, and they will have ample opportunity to move to metropolitan locations or regional settings not designated as 'areas of need' in the future.

4. There will need to be continued reliance on OTDs recruited by RWAV under the RLRP program - doctors who have already committed to Australia, and are potentially tied to the RLRP for the years required to complete their AMC examinations, in addition to ten years further service before they can bill on Medicare without locational restrictions. This study (like others examining doctors who have not completed the MCQ or Clinical components of the AMC) has shown such doctors are highly motivated to secure vocational registration, yet

often face disproportionate difficulties. The fact that many accept appointments in remote locations and/or small towns exacerbates the problem of gaining access to the tuition and study resources they need in order to successfully pass exams, as well as to maximise safe practice. The problem for RWAV is that RLRP doctors, being permanent residents, can move to other appointments even though they do not hold full medical registration. Such appointments may be interstate, in another country (like New Zealand) or another 'area of need' position (perhaps as a Hospital Medical Officer). Despite this, we recommend that RWAV provide fully equitable assistance to RLRP appointees in terms of exam preparation support. Realistically, this should be linked to guarantees from OTDs that they will stay in their initial place of appointment for a defined period of years (as is the requirement for VORRS doctors).

5. The many additional professional and social services reported in this study as provided by RWAV and GP Divisions to OTDs and their families are clearly valued. These should be elaborated in the period ahead, particularly those related to the provision of individual case management services in the preliminary appointment period, and social initiatives designed to ease the integration of families who desire these. Within this process, a more equitable level of post-appointment support should be directed to RLRP doctors.

6. At the political level, sustained lobbying should be undertaken to redress current policy anomalies which negatively impact on the retention of OTDs in select regional locations, most notably related to Rural, Remote and Metropolitan Areas classification 3.

7. Given the critical importance of OTDs securing adequate 'start up' finance within the preliminary settlement period, together with reasonable levels of financial reward during establishment in general practice, a number of additional initiatives should be undertaken by RWAV (or alternative designated body), in order to remove current income anomalies:
   - Standard Victorian baseline remuneration rates should be established and contractually enforced for all OTDs during their first year of practice, based on consensual agreement with key state stakeholders, and overseen by RWAV.
   - Access to loans to support car purchase and/or preliminary accommodation costs by OTDs should be provided by practices (as required), removing existing barriers for doctors lacking initial capital and/or Australian credit histories. (To ensure practices are not disadvantaged should select OTDs move on, appropriate terms and conditions related to repayment of these loans will be required.)
   - The payment of lower Medicare rebates to OTDs based in Rural, Remote and Metropolitan Areas classification 3 should be abolished (in line with 6. above), ensuring these OTDs receive an equitable level of remuneration.
   - Written information concerning both long and short-term remuneration prospects should be provided to all prospective Victorian RLRP and VORRS OTDs at point of initial enquiry and at point of appointment, in order to ensure appointees possess realistic expectations.
   - Wherever possible, practice principals should be encouraged to assist OTDs to supplement their incomes in the first year of practice, for example through securing some level of salary-based employment.

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7. Appendix A

Mailout Survey (Overseas Trained Doctors)

A. BACKGROUND

Please tick the correct answer or write your answer in the space provided.

1. Are you male or female?
   i) Male
   ii) Female

2. What is your age group?
   i) 20-29
   ii) 30-39
   iii) 40-49
   iv) 50-59
   v) 60+

3. In which country were you born?_____

4. Which language(s) do you currently speak at home
   i) _____
   ii) _____

5. What is your current marital status?
   i) Never married
   ii) Married / de facto
   iii) Separated / divorced / widowed

6. Do you have any children?
   i) Yes
   ii) No

7. If yes, how many dependant children do you have living with you?
   _____

8. What is your religion?
   i) Christian
   ii) Islam
   iii) Buddhist
   iv) Hindu
   v) No religion
   vi) Other_____

B. LOCATION

9. Where are you currently employed?
   i) Melbourne
   ii) Regional city (eg Ballarat, Bendigo, Shepparton, Wodonga)
   iii) Small town (eg Charlton)
   iv) Other (please describe or name): _____

10. In which year did you first arrive in Australia?
    19 _____

11. What immigration category did you migrate under at this time?

Permanent migration:
- i) Independent (skilled)
- ii) Employer nomination scheme
- iii) Family
- iv) Humanitarian/ refugee

Temporary migration:
- v) Temporary medical doctor (422 visa)
- vi) Occupational trainee
- vii) Student
- viii) Other: _____

12. Were you the Principal Applicant at the time you first migrated?
- i) Yes
- ii) No
- iii) Don't know

13. How good did you feel your English was at the time you first migrated?
- i) Native speaker
- ii) Excellent
- iii) Very good
- iv) Good
- v) Poor or nil

14. What is your current residential status?
- i) Permanent resident status, gained 19____
- ii) Citizen status, gained 19____
- iii) Still temporary resident

15. Many overseas trained doctors have lived and worked in a range of international and Australian locations. Please tick the statement that best describes your relocation from your place of birth to Australia:
- i) Moved directly from my country to live in Australia
- ii) Moved from my country to live in one other country, then to Australia
- iii) Moved from my country to live in two other countries, then to Australia
- iv) Other (please describe):
  _____
  _____

16. Please fill in the gaps (as in the example below) to show the sequence of all your international and Australian re-locations:
(eg UK→ Gulf States→ New Zealand→ Melbourne→ Shepparton)
_____→_____→_____→_____→_____→_____→_____→___

17. We would appreciate your comments in the spaces below on the most important reason/s for the following migration decisions:
- i) Why you came to Australia?
  _____
- ii) Why you came to Victoria?
  _____
- iii) Why you came to your current 'area of need' location?
  _____

18. When you first came to Australia, did you intend to live in this country:
- i) Permanently
- ii) Temporarily
- iii) Unsure

19. Please tick your 3 most important reasons for coming to Australia:

i) To accept current GP position
ii) To gain better (or better paid) medical employment
iii) To gain a safer / more secure environment
iv) To gain a better standard of living for self/ family
v) To join family/friends/spouse
vi) To gain a first medical qualification
vii) To gain postgraduate training
viii) Other (please specify):

_____

20. If you migrated directly to Victoria, please tick your 3 most important reasons for coming to this state:

i) Offer of current medical job
ii) Given support/ invited to come
iii) Offer of other medical job (eg in public hospital)
iv) Family or friends in Victoria
v) Good economy
vi) Good environment
vii) Training/ education opportunities
viii) Other (please specify):

_____

ix) Not applicable

21. If you migrated to Victoria after living in another state in Australia, please tick your 3 most important reasons for choosing to relocate here:

i) Current medical job offered
ii) Other medical job offered (eg public hospital)
iii) Family or friends in Victoria
iv) Good economy
v) Good environment
vi) Other (please specify):

_____

vii) Not applicable

C. QUALIFICATIONS & REGISTRATION

22. What are your overseas medical and related qualifications? In which country and in which year did you obtain these?

Qualification A: _____ Country:_____ Year: 19____
Qualification B: _____ Country:_____ Year: 19____
Qualification C: _____ Country:_____ Year: 19____
Qualification D: _____ Country:_____ Year: 19____

23. If you have studied here, what are your Australian medical qualifications?

Qualification A: _____ Year: 19____
Qualification B: _____ Year: 19____
Qualification C: _____ Year: 19____

24. What type of medical registration do you currently have?

i) Conditional
ii) Unconditional

25. In which year did you first get registration as a doctor in Australia? 19____

26. In which state did you first get registration as a doctor in Australia? _____

27. In which states of Australia have you worked in medicine so far (please list)?

_____

28. Did you take any courses in order to get conditional (or other) registration?
    i) Yes
    ii) No

29. If yes, please show how many of each type of course you took to assist you get medical registration in Australia:
    i) Number of English course/s:____
    ii) Number of Pre-MCQ course/s:____
    iii) Number of Pre-clinical course/s:____
    iv) Occupational traineeship/s:_____
    v) Other course/s (please specify):_____

30. Did you need to sit for the Occupational English Test in Australia?
    i) Yes
    ii) No

31. If yes, how many times did you sit for the test before passing it? _____

32. Have you attempted the AMC Multiple Choice Question Test yet in Australia?
    i) Yes
    ii) No

33. If yes, how many times have you sat for the test? _____

34. Have you passed it at this stage?
    i) Yes (Year: 19___)
    ii) No

35. What are your views about the MCQ test?
_____

36. What kind of assistance do you feel overseas trained doctors need to prepare for the MCQ test and pass it?
_____

37. Have you attempted the AMC Clinical examination yet in Australia?
    i) Yes
    ii) No

38. If yes, how many times have you sat for the Clinical? _____

39. Have you passed the Clinical at this stage?
    i) Yes (Year: 19___)
    ii) No

40. What are your views about the Clinical examination?
_____

41. What kind of assistance do you feel overseas trained doctors need to prepare for the Clinical test and pass it?
_____

42. Have you attempted the RACGP Fellowship examination yet in Australia?
    i) Yes (Year: 19___)
    ii) No

43. If yes, how many times have you sat for it? _____

44. Which educational programs have you chosen to prepare for the FRACGP Fellowship?
   i) GPREP course
   ii) University-based modules
   iii) Formal GPEA training program

45. Have you passed the RACGP Fellowship requirements at this stage?
   i) Yes (Year: 19___)
   ii) No

46. If yes, what pathway did you choose?
   i) Traditional exam
   ii) Performance based assessment

47. What are your views about the RACGP Fellowship examination?
_____

48. What kind of assistance do you feel overseas trained doctors need to prepare for the RACGP Fellowship examination and pass it?
_____

49. Do you have any other comments you would like to make on the Australian medical registration process?
_____
_____

D. MEDICAL EMPLOYMENT

50. How many years experience did you have working as a registered doctor before you migrated to Australia?_____ years

51. In which countries had you worked as a doctor and in which years?
   i) Country:_____
      Dates: _____
   ii) Country:_____
      Dates: _____
   iii) Country:_____
      Dates: _____

52. What was your most senior medical position before arriving in Australia:
   _____

53. How quickly did you find medical employment after arriving in Australia?
   i) Immediately: recruited for current 'area of need' position
   ii) Immediately: recruited to fill other 'area of need' position
   iii) Immediately: recruited to fill other medical position (please specify): _____
   iv) 1-3 months post-arrival
   v) 4-6 months post-arrival
   vi) 7-12 months post-arrival
   vii) 12-24 months post-arrival
   viii) 25 months or more post-arrival

54. Please describe the medical position you currently hold:
   i) Type of medical work: _____
   ii) Hours per week worked : _____
   iii) Period of appointment: _____

55. Many overseas trained doctors struggle to get suitable work. Please show the sequence of all jobs you have held in Australia from your arrival to the current time (eg Non-medical job →HMO (Melbourne hospital) → HMO (Tasmania psychiatry) → GP (Victorian 'area of need'):

_____→ _____→ _____ → _____→ _____ →
_____→ _____→ _____ → _____→ _____ →

56. How satisfied are you with your current position?

i) Very satisfied
ii) Reasonably satisfied
iii) Dissatisfied

57. Could you please comment below on the reasons for your current level of satisfaction?

_____
_____
_____

58. Can you rate please your level of satisfaction with the following aspects of your current position in the chart below:

		Very Satisfactory	Satisfactory	Fair	Very Unsatisfactory
I	Type of work	1	2	3	4
Ii	Medical location	1	2	3	4
Iii	Relevance to your skills/ past experience	1	2	3	4
Iv	Good/ supportive colleagues	1	2	3	4
V	Salary level	1	2	3	4
Vi	Level of professional support	1	2	3	4
Vii	Access to training/ supervision	1	2	3	4
Viii	Opportunity to prepare for AMC examination/s	1	2	3	4
Ix	Medical resources	1	2	3	4
X	Access to specialist services	1	2	3	4
Xi	Other:……	1	2	3	4

59. In the same way, please rate the following non-professional aspects of your current lifestyle:

		Very Satisfactory	Satisfactory	Fair	Very Unsatisfactory
I	Attractiveness of location	1	2	3	4
Ii	Size of city/ town	1	2	3	4
Iii	Friendliness of people	1	2	3	4
Iv	Quality of facilities (transport, shops etc)	1	2	3	4
V	Access to good schools	1	2	3	4
Vi	Access to employment for partner	1	2	3	4
Vii	Access to religious facilities	1	2	3	4
Viii	Access to friends/ family members	1	2	3	4
Ix	Access to ethnic community and resources (eg specialist shops)	1	2	3	4
X	Other: ……..	1	2	3	4

60. How long have you been living in this location now? ___months

61. How much longer do you think you will work here in this job? ___(months)

62. How much longer would your partner and/or children like to stay? ___ (months)

63. Can you please tell us the most important issue for you in deciding whether you will stay in this job or leave?

_____

64. As you know, RWAV wants to encourage overseas trained doctors to continue GP employment in regional and rural Victoria. To what extent are the following aspects of residential location likely to influence where you work in the future?

	Very	Not Very

		Important	Important	Important	Unimportant
I	Good well-paid medical job	1	2	3	4
Ii	Improved medical facilities	1	2	3	4
Iii	Higher salary	1	2	3	4
Iv	Shorter working hours (less after-hours on call)	1	2	3	4
V	Better attitude from colleagues in practice, hospital, and/or other health practitioners (please circle which)	1	2	3	4
Vi	Access to formal contract	1	2	3	4
Vii	Access to better medical training facilities	1	2	3	4
Viii	Access to better supervision/ mentoring	1	2	3	4
Ix	Access to pre-AMC training courses	1	2	3	4
X	Access to RACGP training courses	1	2	3	4
Xi	Access to ongoing medical education	1	2	3	4
Xii	Access to metropolitan location	1	2	3	4
Xiii	Settlement near ethnic community	1	2	3	4
Xiv	Settlement near family and friends	1	2	3	4
Xv	Access to good education for children				
Xvi	Access to religious facilities	1	2	3	4
Xvii	Other: ……..	1	2	3	4

65. Please add any comments you feel are appropriate in relation to this:

_____

_____

66. Do you feel you have experienced any disadvantages in practicing medicine in your current position, as a result of being an overseas qualified doctor?

i) Yes
ii) No

67. If yes, what kinds of difficulties have you encountered?

_____

_____

68. Have you been able to progress as much as you would like to in your career in Australia so far?

i) Yes
ii) No

69. If no, which of these barriers have affected you?

i) Lack of recognition of qualifications
ii) Lack of respect for past experience
iii) Problems with English language
iv) Cultural differences with colleagues
v) Prejudice against overseas trained doctors
vi) Lack of suitable positions
vii) Personal problems (eg family needs)
viii) Other _____

70. Victoria has introduced a number of professional development services to help overseas trained doctors in regional/rural Victoria. How useful have you found these services

		Very Useful	Satisfactory	Fair	Not Useful	Didn't Use
I	Individual Clinical Skills Training Grants	1	2	3	4	5
Ii	Overseas Trained Doctor Orientation	1	2	3	4	5
Iii	Rural Emergency Skills Training Course	1	2	3	4	5
Iv	Mentoring or supervision (RWAV or Division)	1	2	3	4	5
V	FRACGP examination support (GPEA or Division)	1	2	3	4	5
Vi	VMPF bridging program	1	2	3	4	5

71. Do you have any other comments about these services?

_____
_____

72. Thinking over your experience in regional/rural general practice in Victoria, are there any other suggestions you would like to make, which might increase the retention of overseas trained doctors in these locations?

_____
_____
_____

73. Finally, what are your own future plans at this stage?

i) Stay in current position for the foreseeable future
ii) Change GP positions in regional/rural Victoria
iii) Seek medical position in Melbourne (public hospital)
iv) Seek medical position in Melbourne (other) _____
v) Change states (eg_____)
vi) Change countries (eg_____)
vii) Other _____

Thank you most sincerely for taking time to complete this survey. The results will make an important contribution to medical workforce planning in regional and rural Victoria.

7. Appendix B

Mailout Survey (Spouses of Overseas Trained Doctors)

Introduction

We recognise that the views of doctors' spouses are very important in determining ultimate family location. We would therefore very much appreciate your completion and return of this brief survey. Your participation is entirely voluntary. No identifying information is required, and the results will be treated confidentially. The survey should take around 10 minutes of your time to complete. Thank you very much for your assistance with this part of the study.

Please tick the correct answer or write your answer in the space provided.

A. BACKGROUND

1. Are you male or female?
   - i) Male
   - ii) Female

2. What is your age group?
   - i) 20-29
   - ii) 30-39
   - iii) 40-49
   - iv) 50-59
   - v) 60+

3. In which country were you born?_____

4. Which language(s) do you currently speak at home?
   - i) _____
   - ii) _____

5. What is your current marital status?
   - i) Never married
   - ii) Married / de facto
   - iii) Separated / divorced / widowed

6. Do you have any children?
   - i) Yes
   - ii) No

7. If yes, how many dependant children do you have living with you?

   _____

8. What is your religion?
   - i) Christian
   - ii) Islam
   - iii) Buddhist
   - iv) Hindu
   - v) No religion
   - vi) Other_____

B. LOCATION

9. Where are you currently living?
   - i) Melbourne
   - ii) Regional city (eg Ballarat, Bendigo, Shepparton, Wodonga)

iii) Small town (eg Charlton)
iv) Other type of location (please briefly describe): _____

10. In which year did you first arrive in Australia?
19 _____

11. What immigration category did you migrate under at this time?
Permanent migration:
i) Independent (skilled)
ii) Employer nomination scheme
iii) Family
iv) Humanitarian/ refugee
Temporary migration:
v) Temporary medical doctor (422 visa)
vi) Occupational trainee
vii) Student
viii) Other: _____

12. Were you the Principal Applicant at the time you first migrated?
i) Yes
ii) No
iii) Don't know

13. How good did you feel your English was at the time you first migrated?
i) Native speaker
ii) Excellent
iii) Very good
iv) Good
v) Poor or nil

14. What is your current residential status?
i) Permanent resident status, gained 19____
ii) Citizen status, gained 19____
iii) Still temporary resident

15. Many migrants have lived and worked in a range of international and Australian locations. Please tick the statement that best describes your relocation from your place of birth to Australia:
i) Moved directly from my country to live in Australia
ii) Moved from my country to live in one other country, then to Australia
iii) Moved from my country to live in two other countries, then to Australia
iv) Other (please describe):
_____
_____

16. We would appreciate your comments in the spaces below on the most important reason/s for the following migration decisions:
i) Why you came to Australia?
_____
ii) Why you came to Victoria?
_____
iii) Why you came to the current 'area of need' location?
_____

17. When you first came to Australia, did you intend to live in this country:
i) Permanently
ii) Temporarily
iii) Unsure

18. Please tick your 3 most important reasons for coming to Australia:
i) For spouse to accept current GP position

ii) For spouse to gain better (or better paid) medical employment
iii) For myself to accept a position
iv) To gain a safer / more secure environment
v) To gain a better standard of living for self/ family
vi) To join family/friends/spouse
vii) To gain a first medical qualification
viii) To gain postgraduate training
ix) Other (please specify):
_____

19. If you migrated directly to Victoria, please tick your 3 most important reasons for coming to this state:
i) Offer of current medical job to spouse
ii) Offer of other medical job to spouse (eg in public hospital)
iii) Offer of medical or other job to myself
iv) Given support/ invited to come
v) Family or friends in Victoria
vi) Good economy
vii) Good environment
viii) Training/ education opportunities
ix) Other (please specify):
_____
x) Not applicable

20. If you migrated to Victoria after living in another state in Australia, please tick your 3 most important reasons for choosing to relocate here:
i) Current medical job offered to spouse
ii) Other medical job offered to spouse (eg public hospital)
iii) Medical or other job offered to self
iv) Family or friends in Victoria
v) Good economy
vi) Good environment
vii) Other (please specify):
_____
viii) Not applicable

C. QUALIFICATIONS & EMPLOYMENT

21. What are your school or university qualifications? And in which country and year did you obtain these?
School: _____ Country:_____ Year: 19____
Qualification A: _____ Country:_____ Year: 19____
Qualification B: _____ Country:_____ Year: 19____
Qualification C: _____ Country:_____ Year: 19____

22. If you worked in your country of origin, what was your occupation?
Occupation: _____ Years worked: 19____

23. If you have worked in Australia, what was your occupation?
Occupation A: _____ Years worked: 19____
Occupation B: _____ Years worked: 19____
Occupation C: _____ Years worked: 19____

24. Are you working at the moment?
i) Yes
ii) No

25. If yes, what are you currently doing?

_____
_____

26. How satisfactory is your current occupation?

i) Very satisfactory
ii) Reasonably satisfactory
iii) Not satisfactory

27. If you are working, can you please rate your level of satisfaction with the following aspects of your current position in the chart below:

		Very Satisfactory	Satisfactory	Fair	Unsatisfactory
I	Type of work	1	2	3	4
Ii	Location	1	2	3	4
Iii	Relevance to your skills/ past experience	1	2	3	4
Iv	Good/ supportive colleagues	1	2	3	4
V	Salary level	1	2	3	4
Vi	Level of professional support	1	2	3	4
Vii	Access to training/ supervision	1	2	3	4
Ix	Resources	1	2	3	4
Xi	Other:……	1	2	3	4

28. In the same way, please rate your level of satisfaction with the following non-professional aspects of your current lifestyle:

		Very Satisfactory	Satisfactory	Fair	Unsatisfactory
I	Attractiveness of location	1	2	3	4
Ii	Size of city/ town	1	2	3	4
Iii	Friendliness of people	1	2	3	4
Iv	Quality of facilities (transport, shops etc)	1	2	3	4
V	Access to good schools	1	2	3	4
Vi	Access to employment for partner	1	2	3	4
Vii	Access to religious facilities	1	2	3	4
Viii	Access to friends/ family members	1	2	3	4
Ix	Access to ethnic community and resources (eg specialist shops)	1	2	3	4
X	Other: ……..	1	2	3	4

29. How long have you been living in this location now? ___months

30. How much longer would your family like to stay? ___ (months or years)

31. Can you please tell us the most important issue for you in deciding whether you will stay or leave?

_____

32. Thinking over your experience living in regional/rural Victoria, are there any suggestions you would like to make, which might increase the retention of overseas trained doctors and their families in these locations?

_____
_____

33. Finally, can we ask what are your own future plans at this stage?

i) Stay in current location for the foreseeable future
ii) Change locations in regional/rural Victoria
iii) Move to Melbourne
iv) Change states (eg_____)
v) Change countries (eg_____)
vi) Other _____

7. Appendix C

Semi-Structured Interview Format (OTD Informants)

Introduction by interviewer:

i) Explanation of the potential relevance of the study, including the importance of securing overseas trained doctors' personal experience and perspectives on select issues
ii) Provision of rationale for audiotaping the interview, to allow for full transcription and assignment of pseudonyms to tape transcripts
iii) Clarification of ethical procedures (as described in the Plain English Statement) as required, designed to preserve the anonymity of informants

Interview stages:

The following topic areas will be covered in sequence in a semi-structured interview format, allowing individuals to place their own hierarchy of importance on the issues:

A. BACKGROUND

1. The overseas-trained doctor's background, including:
- Country of birth
- Migration patterns (eg Syria→UK to study MBBS→South Africa→Sydney→Melbourne)
- Years of medical experience prior to current position
- Languages spoken, religion
- Family situation
- Date of arrival in Australia, in Victoria and in current position
- Permanent or temporary migration?
- Current qualifications status (AMC)
- Current RACGP status (including which pathway to Fellowship being pursued)

B. MEDICAL EMPLOYMENT

2. Medical employment locations, including:
- Prior to migration
- In Australia and NZ (dates)
- Length of time post-arrival to secure first medical position in Australia (what was it?)
- Degree of satisfaction with first position (if not current one)

3. Motivation for coming to Victoria, and in particular accepting current position.
- Was the doctor recruited under the VORRS or the RLRP schemes?

4. Current position:
- Length of appointment to date
- Scope of practice
- Positive factors associated with current position (probe range)
- Any negative factors (probe range)
- Degree of acceptance by peers?
- Degree of acceptance by patients?
- Other professional issues?

5. Sources of professional support:
- What types of support needed?
- What types of support actually received?
- How satisfactory?
- RWAV's role?

- Other professional bodies (eg RACGP)?

6. Sources of social support (for self and family):
   - What types of support needed?
   - What types of support actually received?
   - How satisfactory?
   - Particular problems related to spouse employment, children's education, access to cultural and/or religious support etc? (probe range)

C. FACTORS LIKELY TO INFLUENCE RETENTION

7. How likely to stay in current position in the immediate cf longer-term future?
   - Future plans (what are they?)

8. Key determinants of this decision
   - Professional cf social determinants
   - Probe in line with the individual's concerns/ prior comments

9. Potential positive interventions:
   - If planning to leave position, any factors that could influence decision to stay?
   - Potential RWAV role?
   - Other?

D. CONCLUSION

10. Other issues informant would like to raise?

11. Outcomes:
   - Report availability (September 2003 through RWAV)
   - Anonymity of interviews in line with ethics protocol (names, positions, locations)
   - Thanks

7. Appendix D

Semi-Structured Interview Format (Key Informants)

Introduction by interviewer:

i) Further explanation of the potential relevance of the study, including the importance of securing key informant perspectives on select issues
ii) Provision of rationale for audiotaping the interview, to allow for full transcription and assignment of pseudonyms to tape transcripts
iii) Further clarification of ethical procedures (as described in the Plain English Statement), designed to preserve the anonymity of informants

Interview stages:

The following topic areas will be addressed in sequence in a semi-structured interview format, allowing each key informant to respond in line with his/her expertise relative to the issues:

1. The interviewee's current position, including role/s and experience working in relation to overseas trained doctors in the specified location.
2. Perceived reasons for the degree of dependence on overseas trained doctors for provision of general practice services at this rural/regional site.
3. Perceived differences (if any) between OTDs recruited through the VORRS (Victorian Overseas Trained Doctor Rural Recruitment Scheme) and the RLRP (Rural Locum Relief Program) schemes.
4. Length of time overseas trained doctors typically stay in this region in general practice employment.
5. Type of medical work typically undertaken by OTDs, including hours worked and public hospital service.
6. Professional transition challenges typically faced by overseas-trained doctors in this location.
7. Type, level and adequacy of professional support services provided to overseas-trained doctors in this site.
8. Type, level and adequacy of social support services provided to overseas-trained doctors and their families in this site.
9. Factors perceived by the informant as likely to increase rural/regional retention of overseas-trained doctors in this area.
10. Factors perceived by the informant as likely to discourage rural/regional retention of overseas-trained doctors in this area.
11. Any additional comments of potential relevance to the study.

[1] For select international comparisons in terms of reliance on OTDs see Brotherton, S E, Simon F A & Tomany, S C (2000), 'US Graduate Medical Education, 1999-2000', Journal of American Medical Association, Sept 6, 284 (9), 1121-6; Mick, S, Lee S & Wodchis, W (2000), 'Variations in Geographical Distribution of Foreign and Domestically-Trained Physicians in the United States, Social Science Medicine, Jan, 50 (2): 185-202; Stinmel, B D (1996), 'Congress and the International Medical Graduate: The Need for Equity', Mt Sinai Journal of Medicine, Oct-Nov, 63 (5-6): 359-63; Square, D (1997), 'Storm of Protest Greets Motion to Restrict Specialty Exams', Canadian Medical Journal, Apr 15, 156 (8): 1188-9; Sheffield J, Hussain A & Coleshill P (1999), 'Organizational Barriers and Ethnicity in the Scottish NHS', Journal of Management Medicine, 13 (4-5): 263-4; Barnett, J R (1991), 'Where Have All the Doctors Gone? Changes in the Geographic Distribution of General Practitioners in New Zealand Since 1975', New Zealand Medical Journal, Aug 28, 104 (918): 358-60; Barnett, J R (1992), 'How Long Do General Practitioners Remain in Any One Location? Regional and Urban Size Variations in the Turnover of Foreign and New Zealand Doctors in General Practice, 1976-90', New Zealand Medical Journal, May 13, 105 (933): 169-71.

[2] See AMWAC (2002), *The General Practice Workforce in Australia. Supply and Requirements 1999-2010*, AMWAC Report 2000-2, August, Canberra; Birrell, B & Hawthorne, L (2001), 'Doctor Dilemmas: How GP Medicine is Practised in Australia', *People & Place*, Vol 9 No 3.

[3] See Hawthorne, L & Birrell, B (2002), Doctor Shortages and Their Impact on the Quality of Medical Care in Australia', *People & Place*, Vol 10 No 3.

[4] Australian Institute of Health and Welfare (2000), *Medical Labour Force*, Canberra.

[5] Australian Medical Workforce Advisory Committee (AMWAC) (2000*), Draft: The General Practice Workforce in Australia: Supply and Requirements 1999-2010*, AMWAC Report 2000.2, August; Australian Medical Workforce Advisory Committee (AMWAC) (1999*), Temporary Resident Doctors in Australia*, June; Australian Medical Workforce Advisory Committee (AMWAC) (1998), *Medical Workforce Supply and Demand in Australia - A Discussion Paper*, AMWAC Report 1998.8, October, Canberra.
Australian Medical Workforce Advisory Committee (AMWAC) (1996), *Australian Medical Workforce Benchmarks*, January

[6] See eg Strasser RP, Hays RB, Kamien M & Carson D (2000), 'Is Australian General Practice Changing? Findings from the National Rural General Practice Study', *Australian Journal of Rural Health* August, Vol 8 No 4; Wilkinson D (2001), 'Selected Demographic, Social and Work Characteristics of the Australian General Medical Practitioner Workforce: Comparison of Capital Cities with Regional Areas', *Australian J Rural Health* February, Vol 9 No 1; Humphreys J, Jones J, Hugo G, Bamford E & Taylor D (2001), 'A Critical Review of Rural Medical Workforce Retention in Australia', *Australian Health Review*, Vol 24 No. 4; Gorton SM & Buettner PG (2001), 'Why Paediatricians Rural Out Going to the Country but Support Opportunities for Change', *Journal of Paediatric Child Health* April, Vol 37 No 2; McMurray JE, Cohen M, Angus G, Harding J, Gavel P, Horvath J, Schmittdiel J & Grumbach K (2002), 'Women in Medicine: A Four-Nation Comparison', *Journal American Womens Association*, Fall, Vol 57 No 4; Simmons D, Bolitho LE, Phelps GJ, Ziffer R & Disher GJ (2002), 'Dispelling the Myths About Rural Consultant Physician Practitioners: Victorian Physicians Survey', *Medical Journal of Australia* May 20, Vol 176 No 10; Humphreys JS, Jones MP, Jones JA & Mara PR (2002), 'Workforce Retention in Rural and Remote Australia: Determining the Factors that Influence Length of Practice', *Medical Journal of Australia* May 20, Vol 176 No 10; Wilkinson D, Symon B, Newbury J & Marley JE (2001), 'Positive Impact of Rural Academic Family Practices on Rural Recruitment and Retention in South Australia', *Australian Journal of Rural Health* February, Vol 9 No 1.

[7] Hawthorne, L & Birrell, B (2002), Doctor Shortages and Their Impact on the Quality of Medical Care in Australia', *People & Place*, Vol 10 No 3.

[8] See eg Birrell, B, Hawthorne, L & Rapson, V (2003) 'The Outlook for Surgical Services in Australasia', Royal Australasian College of Surgeons, Australia; Barton, D, Hawthorne, L, Singh B & Little, J (2003), 'Victoria's Dependence on Overseas Trained Doctors in Psychiatry', *People & Place* Vol 11 No 1.

[9] Birrell, B. Hawthorne, L. and Rapson, V. (2003), *The Outlook for Surgical Services in Australasia*, Royal Australasian College of Surgeons, Melbourne.

[10] B. Birrell & V. Rapson, 'New Zealanders in Australia: the end of an era', *People and Place*, vol. 9, no. 1, 2001, pp. 61-74

[11] Inglis, C & Stahl, C (1993), Global Population Movements and Their Implications for Australia, AGPS, Canberra.
[12] Bureau of Labour Market Research (1986), Migrants in the Australian Labour Market: Research Report No. 10, AGPS, Canberra, p 6.
[13] Niland, C & Champion, R (1990), EEO Programs for Immigrants: The Experience of Thirteen Organisations, AGPS, Canberra.
[14] Bureau of Labour Market Research (1986), Migrants in the Australian Labour Market: Research Report No. 10, AGPS, Canberra, pp 6-7.
[15] Bureau of Labour Market Research (1986), Migrants in the Australian Labour Market: Research Report No. 10, AGPS, Canberra, p 115.
[16] Birrell B & Hawthorne L (1999), 'Australia's Skilled Migration Program Outcomes as of 1996', commissioned research for the *Review of the Independent and Skilled-Australian Linked Categories*, Department of Immigration and Multicultural Affairs, Canberra; Birrell B & Hawthorne L (1997), *Immigrants and the Professions in Australia*, Monash University, Melbourne
[17] Hawthorne, L & Toth, J (1996), 'The Impact of Language Testing on the Registration of Overseas Trained Doctors', *People and Place*, Vol 4 No 3
[18] See eg Kunz E. (1975) *The Intruders: Refugee octors in Australia*. Canberra: Australian National University Press; Hawthorne L. (1997) The Question of Discrimination: Skilled Migrants' Access to Australian Employment, in *International Migration Review*, Volume XXXV, No 3, Geneva; Iredale R. (1987) *Wasted Skills: Barriers to Migrant Entry to Occupations in Australia*. Sydney: Ethnic Affairs Commission of NSW; Human Rights and Equal Opportunity Commission (HREOC) (1995), 'The Experience of Overseas Medical Practitioners in Australia: An Analysis in the Light of the Racial Discrimination Act 1975', Human Rights and Equal Opportunity Commission, Sydney, 1992; Kidd, M. & Braun, F. (1992): *Problems Encountered by Overseas-Trained Doctors Migrating to Australia*, Australian Government Publishing Service, Canberra.
[19] Human Rights and Equal Opportunity Commission (HREOC) (1995), 'The Experience of Overseas Medical Practitioners in Australia: An Analysis in the Light of the Racial Discrimination Act 1975', Human Rights and Equal Opportunity Commission, Sydney; Human Rights and Equal Opportunity Commission (1992).
[20] Hawthorne L (1997) The Question of Discrimination: Skilled Migrants' Access to Australian Employment, in *International Migration Review*, Volume XXXV, No 3, Geneva. The Australian Medical Council justified its imposition of a quota for overseas qualified doctors by stating that in the early 1990s 'a very large increase over any similar previous period' had been eligible to sit for the Clinical - in part due to additional examinations being held in outer metropolitan hospitals in Sydney and Melbourne. The overall rate of candidates passing both registration tests, moreover, had risen from 34 per cent (1978-79) to 47 per cent (1992-93) - a trend seen as risking not only a substantial Medicare cost blowout but the increasing displacement from tertiary courses of Australia-born medical students.
[21] Australian Medical Council Incorporated (1995), *Annual Report 1993-1994*, Australian Medical Council Incorporated, Canberra.
[22] See Hawthorne, L & Toth, J (1996), 'The Impact of Language Testing on the Registration of Overseas Trained Doctors', *People and Place*, Vol 4 No 3; Hawthorne, L. (1997) The Question of Discrimination: Skilled Migrants' Access to Australian Employment, in *International Migration Review*, Volume XXXV, No 3, Geneva.
[23] Human Rights and Equal Opportunity Commission (HREOC) (1995), 'The Experience of Overseas Medical Practitioners in Australia: An Analysis in the Light of the Racial Discrimination Act 1975', Human Rights and Equal Opportunity Commission, Sydney; Human Rights and Equal Opportunity Commission (1992), *The Experience of Overseas Medical Practitioners in Australia: An Analysis in the Light of the Racial Discrimination Act 1975*, HREOC, Sydney.
[24] When one of the authors, L Hawthorne, presented a paper on this issue at the premier world conference on migration issues (*the Sixth Annual Metropolis Conference*: Oslo September 2002), researchers and policy makers from a range of these nations could not credit the ease of employment access being described. Two weeks later the author was contacted by the OECD headquarters in Paris, seeking to affirm whether this was indeed the case. Data from the current study showed the major reason for OTDs relocating from New Zealand to Australia was to access medical employment, from which they had been barred in New Zealand prior to meeting pre-registration requirements.
[25] Postgraduate Medical Council of Victoria (PMCV) (2002), 'AMC Candidates in the Victorian Public Hospital System', PMCV, Melbourne; Birrell, B. & Hourigan, C. (2002), 'The Postgraduate

Medical Council of Victoria Survey of AMC Candidates in the Victorian Hospital System', Centre for Population & Urban Research, Monash University, 26 February.

[26] The extracts represent abbreviated sections from the following published reports: Birrell, B, Hawthorne, L & Rapson, V (2003) 'The Outlook for Surgical Services in Australasia', Royal Australasian College of Surgeons, Australia, pp 15-23; and Barton, D, Hawthorne, L, Singh B & Little, J (2003), 'Victoria's Dependence on Overseas Trained Doctors in Psychiatry', *People & Place* Vol 11 No 1, pp 56-58.

[27] Surgical training in many countries of origin may differ significantly to that prevailing in Australasia. As a result, RACS may exempt overseas trained surgeons from Basic Surgical Training, but require them to compete with local applicants for Advanced Surgical Training places. The necessity to do so presents permanent resident surgeons with a serious challenge. While many can secure a short-term supernumerary position, typically in locations characterised by surgical shortages, according to a range of informants it is virtually impossible for overseas-trained surgeons to compete for AST places.

[28] For discussion re the potential importance of bridging courses for overseas qualified professionals in Australia see Hawthorne, L (2001), 'The Globalisation of the Nursing Workforce: Barriers Confronting Overseas-Qualified Nurses in Australia', *Nursing Inquiry*, Vol 8 Issue 4, Blackwell Science; Hawthorne, L (2002), 'Qualifications Recognition Reform for Skilled Migrants in Australia: Applying Competency-Based Assessment to Overseas-Qualified Nurses', *International Migration Review*, 40 (6), Geneva; Barton, D, Hawthorne, L, Singh B & Little, J (2003), 'Victoria's Dependence on Overseas Trained Doctors in Psychiatry', *People & Place* Vol 11 No 1, pp 56-58; Hawthorne, L (1994), *Labour Market Barriers for Immigrant Engineers in Australia*, Australian Government Publishing Service, Canberra.

[29] See Kish, L, *Survey Sampling*, New York: John Wiley & Sons (1965).

[30] This would probably have been an Australia-born doctor who returned and trained to a source country overseas, ultimately coming back to Australia.

[31] SPSS (2003), *SPSS for Windows. Version 11.5*. Chicago, SPSS Inc; Dean A, Dean J, Coulombier D, Brendel K, Smith D, Burton A, Dicker R, Sullivan K, Fagan R & Arner T (1994), *EpiInfo Version 6: A Word Processing, Database and Statistics Program for Epidemiology on Microcomputers*, Atlanta, Centers for Disease Control and Prevention; Graphpad (2000), *InStat*, San Diego, GraphPad Software.

[32] In some cases such relocations involved substantial periods of study rather than work. Eg a Commonwealth-Asian doctor might report periods of undergraduate and/or postgraduate study in the UK, Europe. Canada or Australia. A range of doctors from African and Asian countries had studied in other locations, eg a Sudanese doctor studying in Egypt.

[33] Cummins R (1995), 'On the trail of the gold standard for subjective wellbeing', *Social Indicators Research*. 35: 179-200.

[34] One of the authors, L Hawthorne, has previously completed a major study of Australia's growing dependence on overseas qualified nurses See eg Hawthorne, L (2001), 'The Globalisation of the Nursing Workforce: Barriers Confronting Overseas-Qualified Nurses in Australia', *Nursing Inquiry*, Vol 8 Issue 4, Blackwell Science; Hawthorne, L (2002), 'Qualifications Recognition Reform for Skilled Migrants in Australia: Applying Competency-Based Assessment to Overseas-Qualified Nurses', International Migration Review, Volume 40 (6), Geneva;

[35] Ineson, S. (2003), 'Education and Training for Permanent Resident Overseas Trained Doctors', Medical Council of New Zealand Conference, June, Wellington

[36] See Hawthorne, L & Toth, J (1996), 'The Impact of Language Testing on the Registration of Overseas Trained Doctors', *People and Place*, Vol 4 No 3.

[37] This would probably have been an Australia-born doctor who returned and trained to a source country overseas, ultimately coming back to Australia.

[38] Cortina J (1993), 'What is Coefficient Alpha? Examination of Theory and Applications', *Journal of Applied Psychology*. 78 (1): 98-104; Nunally J (1967), *Psychometric Theory*, New York: McGraw Hill.

[39] A range of interviews were conducted with RRMA 3 informants, who held deep concerns about a bureaucratic process of definition which reportedly led to a constant process of appointing and losing overseas trained doctors – people who typically moved to other RRMA areas to secure greater monetary rewards. The following quote illustrates something of this issue: 'The RRMA 3 group are excluded from the VORRS scheme. (The definition is based on a) population of 100,000 people which invariably makes them regional centres. There's four in Victoria, Ballarat, Bendigo, Shepparton and Albury Wodonga. RRMA 3 fall outside a lot of the Federal Government

initiatives which are basically for RRMA 4 to 7, even though in many people's eyes they're seen as rural. Not just OTDs (who miss out on benefits in RRMA 3), but all doctors here. If they were in the rural area and they were in solo general practice, they would receive $1000 for two weeks per year to assist them in affording a locum. There are particular allowances, depending on the RRMA location, for living in a rural small town. There are particular assistance packages for families of rural practitioners to support them getting a job and kids to get into school and that sort of thing. In RRMA 3, if you're an Australian qualified GP and have the status you will get the rebate of $25.10, if you're an OTD then you will only get $17.63, where if you're an OTD in any of the rural areas except RRMA 3, and this includes Sunbury, Melton you know, Riddle's Creek, people hard up against Melbourne so to speak, people will get the full Medicare rebate. There's an additional ROMPS payment, however that doesn't occur for GPs in the Bendigo area. We recently presented to AMWAC, which is the Australian Medical Workforce Advisory Committee, who report directly to the Minister. And they told us very unofficially I believe, that RRMA 3 areas are not a priority. Recently the RRMA 3s in Victoria and Wagga Wagga have put in a joint submission. I don't know if there is even an awareness in Canberra that there is a problem with this. It's further exacerbated last year by the Federal Government addressing the need for more doctors in the outer metropolitan area and they have put an incentive for metropolitan doctors to move to the outer fringe of $20,000 to $30,000 if they either move to a practice there or open a new practice, so this further disadvantages us, because why move to Bendigo if you can go to the Dandenongs and get an extra $30,000.' The consequence is reportedly a constant leeching of OTDs from RRMA 3 areas.

[40] See Birrell, R & Hawthorne, L (2001), 'Doctor Dilemmas: How GP Medicine is Practised in Australia', *People and Place*, Vol 9 No 3.