HUNGER STRIKES AND THE ACCREDITATION OF OVERSEAS TRAINED DOCTORS IN AUSTRALIA

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Following a recent hunger strike of overseas-trained doctors, the Australian Government announced some significant concessions regarding their accreditation to practise medicine here. The justification for these concessions is critically explored and some future problems on their implementation are canvassed.

There are at least three thousand overseas-trained doctors (OTDs) who hold permanent residence status in Australia, who have begun the process of gaining accreditation to practise medicine, but have not so far succeeded in being accredited. To be registered to practise medicine, anyone with a degree in medicine from overseas must first lodge a formal application with the Australian Medical Council (AMC) to initiate the accreditation process, then pass an English test if from a Non-English-Speaking-Background (NESB) country, and then a test of medical knowledge in the form of a multiple choice question (MCQ) examination. Finally, they must pass a clinical test. Some 2,000, or about half the OTDs who have began MCQ phase since the early 1980s, have eventually gained accreditation. Nevertheless, large numbers still remain to complete the process. By 1996, 1,492 had taken the MCQ test one or more times but had not passed, and another 786 had passed the MCQ test but not yet passed the clinical test.[1]

Meanwhile OTDs continue to migrate to Australia as settlers holding permanent residence in large numbers. There were 480 such settlers in 1992-93, 445 in 1993-94, 548 in 1994-95, 626 in 1995-96, and 500 in 1996-97. As a consequence the build up in potential new candidates for accreditation continues. The AMC has just released the results of its 1997 MCQ tests. A record 1,081 OTDs sat, including 399 who took the test for the first time. Of the 363 who passed, only 152 were sitting the test for the first time.[2]

The frustration of OTDs who are permanent residents and who are caught up in the accreditation process is understandable. A substantial minority (nearly half) of those who have got beyond the English test have eventually succeeded, but often only after a long and difficult process. Meanwhile those who are caught up in trying to pass know that rural areas are crying out for more doctors, and that the gap is being filled at least in part by a large and rapidly increasing number of Temporary Resident Doctors (TRDs). These doctors are specifically visaed to practise medicine in pre-arranged positions for up to four years, yet have not been required to obtain AMC accreditation. In 1996-97 there were 1,209 temporary resident visas issued to OTDs, up from 894 in 1995-96 and 728 in 1994-95. As of September 1997, 818 of these OTDs were present in Australia and presumably practising medicine.[3] Most of these doctors are being recruited for positions in Queensland. In principal, these positions could be filled by non-AMC-accredited OTDs already in Australia who hold permanent residence or who have Australian-citizen status. But, in practice, few have been offered such work. Employers prefer doctors trained in Britain, South Africa or the USA. The great majority of TRDs are being recruited from the UK.

In these circumstances some permanent resident OTDs are easily mobilised around

campaigns built on the alleged injustice of their position. Ethnic community leaders, humanitarian advocates and OTD interest group leaders have all asserted that the accreditation system is unfair, even racist in its structure. The Australian Doctors Trained Overseas Association (ADTOA) has recently lodged allegations of racial discrimination with the United Nations.[4] They argue that organised medicine is behind their 'exclusion'. The Australian Medical Association (AMA) is allegedly hiding its real agenda, which is to maintain its local monopoly on medical practice in Australia, behind a facade of concern about the low standards of the medical training of OTDs. No wonder some OTDs have been willing to put their bodies on the line in a hunger strike, the latest and most extreme step in their campaign for the right to practise in Australia.

In order to assess whether their protests were justified we first need to examine how the OTDs came to be in Australia. Were they recruited as skilled workers with implicit promises of professional work? Did they know, or should they have known before arrival, about the accreditation conditions in Australia?

THE CIRCUMSTANCES OF OTD MIGRATION TO AUSTRALIA

During the 1980s large numbers of OTDs came to Australia, particularly from the UK and Malaysia, (the latter often originally trained in Australia). But, towards the end of the decade, the flow was increasingly from non-Commonwealth countries, including Egypt, the subcontinent of India, and from East and South-East Asia. A high proportion entered under the skilled-migration categories. The British-trained doctors were immediately permitted to practise by the State Medical Registration Boards. But most of the others had to take the AMC accreditation exams. During this period there was no effort to dissuade OTDs from coming to Australia.

However, since the early 1990s, successive Australian Governments have sought to curb the OTD inflow. Since 1992, all OTDs (except those trained in New Zealand but including those trained in the UK), have had to pass the AMC accreditation examinations before being allowed to practise. Also, in 1992, a quota of 200 was placed on the annual number permitted to move from the MCQ to the clinical examination. Finally, in order to deter OTDs from entering through the points-tested skilled categories of the immigration program, a ten-point penalty was applied to applicants who were doctors.

The reason for measures was that, by the early 1990s, the Australian Government had concluded that there were too many doctors in Australia. This concern was not driven by AMA lobbying, but by Commonwealth budget constraints. By international standards the doctor-patient ratio in Australia was quite favourable. Yet the number of doctors gaining registration was growing at an alarming rate and, with it, the number of services they provided to patients. The problem for the Commonwealth was that it was paying the bill via Medicare.

The stop sign was ignored by OTDs. As noted, they continued to migrate at around 500 a year after 1992. But over the last few years very few have come under the points-tested migration categories. To succeed under these categories normally required that they first passed the MCQ test overseas. Instead the great majority have arrived under the Preferential Family program as spouses or parents sponsored by Australian residents, or as accompanying spouses of principal applicants selected under another visa category. When, after 1992, entry via the skilled categories was effectively closed down, the number of OTDs arriving via the Preferential Family escalated, from 137 in 1992-93 to 379 in 1995-96. There is a strong implication here that some doctors, upon discovering that entry via the skilled categories was blocked, have somehow managed to gain entry as sponsored spouses or parents.

In December 1996, the Australian Government succeeded in legislating a major package of reforms designed, in part, to reduce the motive to migrate. The legislation stipulated that henceforth all doctors entering Australia (including those trained in New Zealand) would not be allowed to bill on the Medicare system until ten years after they had gained accreditation. This means that for those who managed to pass their AMC exams, the only medical employment option for ten years was salaried employment in the hospital system. But, so far, even this drastic measure has not stemmed the migrant inflow. Exactly 500 settlers declared themselves to be doctors when they arrived in Australia in 1996-97. Most entered by the Preferential Family categories. Some 182 were sponsored spouses or fiancé(e)s and another 85 were sponsored parents. A further 80 came as accompanying spouses of Independent or Concessional principals and 45 were New Zealanders. The dominant source country was China, with 121 of the 500 settlers born in China, 41 in the UK, 28 in India, 27 in Hong Kong and 26 in New Zealand.

AWARENESS OF, AND FAIRNESS OF, AUSTRALIAN ACCREDITATION STANDARDS

Since the great majority of OTDs arriving in Australia as settlers in the 1990s were not recruited as skilled migrants they cannot argue that they were attracted to Australia by any misleading imputation that their skills were in demand or that accreditation was not a problem. For those coming as family members the responsibility rests with the migrant doctor to find out what the qualification recognition situation is. Pamphlets on Skills Recognition generally, and on particular professions are available at all overseas posts. These specifically advise that examinations are required before practice is permitted in the health professions. As the hunger strike indicates, many migrant doctors are desperate to practise medicine. It is therefore difficult to believe that they would not have been aware that Australia, like all other western nations, enforces strict accreditation rules for foreign-trained doctors.

There is no doubt that some form of accreditation test is required. The great diversity of backgrounds of recently arrived OTDs is illustrated by the listing of countries of training for the OTDs who took the MCQ examination in 1997 (see Table 1). Most received their training in non-Commonwealth country medical schools little known to Australian Registration Boards. Since there was no evaluation of their skills before they entered Australia, the Registration Boards would have been derelict in their duty to the Australian public if they had allowed such persons to practise without first carefully assessing their medical skills.

But is the AMC system a fair one? It is a demanding test, especially for doctors whose English is weak and who have not looked at a medical textbook for years. However, when one considers that the MCQ test represents the sole assessment of OTD's medical knowledge it seems, if anything, to be a minimal requirement. It involves two three-hour exams divided into five components of medical knowledge. Candidates must provide correct answers for at least 45 per cent of the questions in each component and 50 per cent of all questions.

Nevertheless some OTD spokespersons have claimed that the test is not fair relative to what is required of Australian medical students. While the 200 quota was in place between 1992 and 1995 it meant that some who passed were not allowed to proceed to the clinical test. However, as a result of OTD protests, and successive hearings before the Human Rights and Equal Opportunity Commission and the Federal Court the AMC abolished the quota provision for the 1996, and subsequent MCQ tests. But unlike students in the university medical faculties, AMC candidates have hitherto been able to make multiple attempts to

pass. This provision has recently been sharply tightened. From 1998, new candidates will be allowed only two attempts for either the MCQ or the clinical test.

Table 1: Candidates sitting and passing the AMC MCQ examinations in 1997 by country of training

Country of training	Number sitting	Number passing
Afghanistan	29	5
Bangladesh	51	11
Bosnia-Herzegovina	27	5
China	106	43
Egypt	75	20
Fiji	8	7
India	104	41
Iraq	13	4
Ireland	65	27
Myanmar	33	6
Pakistan	55	9
Phillipines	64	23
Poland	21	5
Russua	24	9
Slvak Republic	23	5
South Africa	19	17
Sri Lanka	32	20
Syria	20	2
UK	51	41
USSR	41	6
Vietnam	36	4
Yugoslavia	41	6
Other	143	47
Total	1,081	363

Source: Australian Medical Council, unpublished

On the issue of comparative standards, there never was any substance to the claim that OTDs faced a tougher test of medical knowledge than Australia's medical students and therefore they had to perform better than locals. The Australian university test of medical knowledge is very similar to that used in the AMC accreditation process. As far as comparative performance levels in medical knowledge are concerned they were recently put to the test. In 1995 the AMC asked final-year medical students from Monash and Sydney Universities to take the MCQ test set for OTDs. Some 200 responded, voluntarily giving up their Saturday to do so. According to the Monash sub-dean of medicine who arranged the test at Monash, most students finished the exams within a couple of hours of the six hours allotted and were away. Despite this, the AMC later reported that 205 of the 214 who sat the exam passed, far above the pass rate registered by OTDs. When it comes to exams on medical knowledge, Australian medical students are clearly better performers than their OTD counterparts.

THE OUTCOME OF THE HUNGER STRIKE

'Notwithstanding the validity of the AMC accreditation process, on 8 December 1997 the Minister for Health and Family Services, Dr Wooldridge, capitulated to the hunger strikers. After a meeting with representatives of the ADTOA he agreed to create an extra 100 places on a one-off basis in Australia's medical schools for OTDs in 1998. These places were to begin at year four, five and six (presumably depending on the knowledge base of the OTD). According to the Minister's statement, if the OTDs successfully pass their medical course and complete their intern year they will be required to 'become a part of the rural medical workforce' by taking up a clinical assistantship in an 'area of need' and then working 'for a further five years as a medical practitioner'.[5]

The details of the package are still to be sorted out with the medical schools and the various medical training colleges. The package can only be understood in the context of the Government's attempts to get more doctors into undersupplied rural areas. The dilemma for the Government is that the priority it has placed on reducing the supply of doctors billing on Medicare will, in time, accentuate the shortage of rural doctors. As explained in an earlier analysis, the Government has chosen to slow the rate of doctors eligible to bill on Medicare as General Practitioners by requiring all future GPs to first undertake the Royal Australian College of General Practitioner (RACGP) training program. Only after completing this program can a doctor obtain a Medicare provider number to practise as a General Practitioner. The numbers holding this privilege will also be further limited by a parallel restriction on those allowed to enter the training program to 400 per year.[6] Short of despatching accredited GPs to the bush (as by requiring periods of compulsory service in areas of need) the rural crisis may well worsen, because the 400 limit will lower the numbers entering the ranks of accredited GPs (relative to the recent past) thus reducing the competition for patients and relieving the financial pressures on doctors to move to underserviced areas.

The limitations on the rights of Australian-trained doctors to practise as GPs created a furore amongst local medical students. They were fearful that the restriction on training places would cut out some of their number from access to post-graduate training, perhaps condemning them to a life as salaried hospital doctor without access to Medicare billing rights. In response to these fears, the Government has created a new post-graduate training category called Clinical Assistantships. These begin in 1998. They give doctors unable to get into a post-graduate training program another option, but one which in effect requires them to serve in undersupplied areas. A doctor taking up a Clinical Assistantship will have to serve in an 'area of need' for four years. During this time the Government will ensure that there is access to post-graduate training relevant to one or other of the medical college

training programs.[7] The bait at the end of line is that those completing the four years will be guaranteed access to the RACGP training program or to some other specialist training program, thus eventually securing Medicare provider status.

It remains to be seen how many Australian graduates or OTDs who receive AMC accreditation opt for the clinical assistantship program. In the unlikely event that many do, then from the Government's point of view the program will have satisfied both junior doctors' anxiety about entry to training programs which allow them to practise private medicine and the Government's concern to get more doctors into rural hospitals, rural General Practices and Aboriginal Medical Services.

THE OTD HUNGER STRIKE DEAL

Why would an OTD who had failed the MCQ or clinical test, or not yet begun the accreditation process, choose to take up the option of one of the medical school places offered by the Government? To do so would be to give up the relatively easy one off MCQ and clinical test option. It would require full-time attendance at university, a substantial HECS debt and the risk of failure. That is, they might well fail the similar MCQ test of medical knowledge given to medical students. The only OTDs likely to see any gain in the medical school option are those with the poorest prospects of passing the AMC test. They may feel that intensive university teaching will get them over the line. The resource implications for the medical schools who offer to provide the extra government-funded places are severe, as they will have to cope with the problems presented by these weaker students.

Since the details of the deal are yet to be worked out we can only speculate how many OTDs are likely to take up the offer. If the package is implemented as specified in the Government's media release, I doubt that many will. As noted, the statement indicates that on satisfactory completion of their medical course and clincal assistantship (presumably involving four years) the OTD will have to work a further five years in the bush. But no such requirement is specified for other medical graduates who take up a clinical assistantship. An OTD would have to be feeling very pessimistic about the chances of passing the AMC exams to take up such an offer. Some may take it up anyway in the hope that such an arduous requirement would never be enforced. It will surely be subject to challenges about alleged discrimination on the grounds that migrant doctors who had added local qualifications to those gained overseas nevertheless faced tougher rules than Australian graduates.

CONCLUSION

Dr Wooldridge should have kept his nerve. His decision will probably come back to haunt him or one of his successors — given the possiblility of future challenge in the courts. Having successfully pushed though the restrictive legislation described above which was designed to reduce the incentive for medical migration, Dr Wooldridge has now sent out a different signal. It says to OTDs, 'Don't be deterred from coming to Australia'. The Government will eventually crumble in the face of ethnic community and organised OTD pressure to allow you to practise here. This would not be a problem if Australia needed more doctors and if there was no doubt about the skill levels of the OTDs offering themselves. But neither is the case.

References

1 B. Birrell, ‘Implications of controls on access to Medicare billing for GPS’, *People and Place*, vol. 5, no. 1, 1997, p. 69

2 Figures courtesy of Mr Ian Frank, Executive Officer, AMC

3 These data derive from an unpublished Department of Immigration and Multicultural Affairs analysis. For further details see the accompanying article, this issue of *People and Place* on ‘Globalisation and Temporary Entry’, by B. Birrell and E. Healy.

4 ‘Foreign doctors allege racism’, *Australian Doctor*, 7 November 1997

5 Hon. Dr Michael Wooldridge, Minister for Health and Family Services, Media Release, 8 December 1997

6 ‘Implications of controls on access to Medicare billing for GPs’, *People and Place*, vol. 5, no. 1, 1997

7 *Review of General Practice Training*, Memorandum of Understanding between Department of Health and Family Services, the AMA and other interested parties, in relation to ‘The "training safety net" for Australian medical graduates and the Clinical Assistantship program’, unpublished, 29/30 August, 1997

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