



Muru Marri

School of Public Health and Community Medicine



Cooperative Research Centre for

Aboriginal Health

OVERSEAS TRAINED DOCTORS IN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICES: A LITERATURE REVIEW

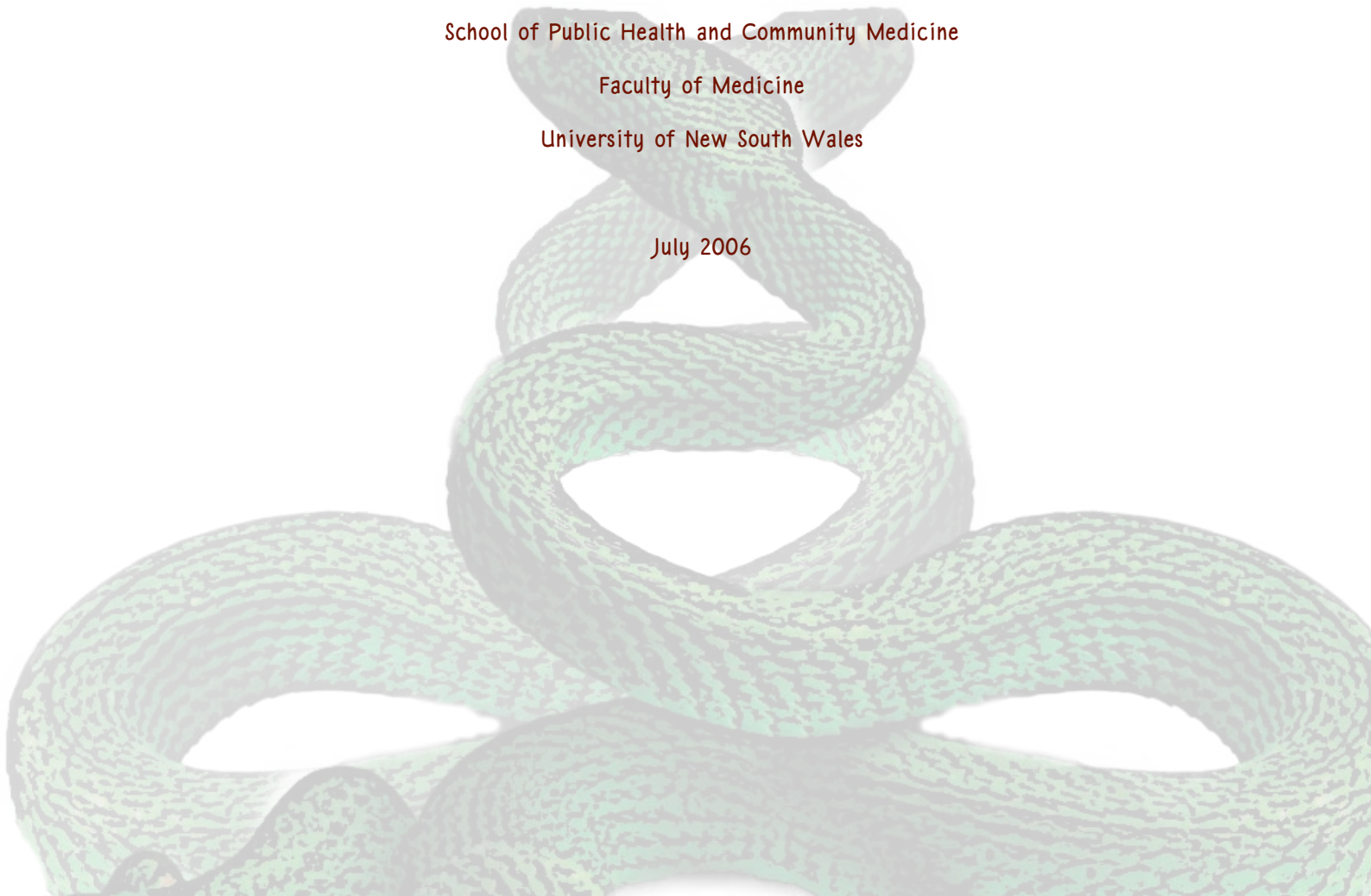
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OUR NAME, OUR LOGO, OUR PLACE

*Muru Marri*¹, the Indigenous Health Unit within the School of Public Health and Community Medicine at UNSW, is committed to enhancing Aboriginal and Torres Strait Islander health throughout Australia, yet acknowledges that it is based in a specific Aboriginal country, Gadigal land, part of the Eora nation of the greater Sydney area.

Our name indicates not only the breadth and diversity of the unit's work, but also our grounding, as an organisation, in our local community. *Muru*², in the Eora language, means 'road' or 'path', while *Marri*³ means 'many, great, large, very'. Thus *Muru Marri*, broadly translated as 'many paths / many ways', reflects, as well as the diversity within Indigenous Australian cultures and experiences, the critical necessity to base our work - even where problems are held in common - in the specific needs and wishes of local communities.

Our logo, and its accompanying artwork, reflects *Muru Marri* and our attitude to our place here at the University. The original artwork was created to show, in a visual way, the meaning of health and education. The hand, itself, represents many stories, including the journey of health and wellness, history, learning and togetherness. It is a story of all of us and of our roles in the story of caring for each other. It reflects two styles of art traditionally connected with this region: the motifs found on the walls of caves around the Sydney Basin and the clear lines of rock carvings, still to be seen on flat cliff-tops, not far from this campus. The larger artwork represents the many countries that Aboriginal people belong to, and how those people come together, here, for many reasons. It shows how the whole is greater than the parts, and how what happens in one place affects all the others through profound and sacred connections. It shows that health is a bigger story than illness and that the past affects the future as much as it does the present.

Finally, our name and our art show that there is no *one* way to improve Indigenous health. The physical health of individual Indigenous Australians cannot be separated from the social, spiritual and emotional well being of Indigenous Australia. We need to draw from traditional knowledge, enhance existing cultural resilience, examine international Indigenous experience and constantly innovate, building on a growing, national evidence base to work in fresh ways across professions and across sectors. Comprehensive inter-sectoral collaborations - based on respectful, transparent partnerships: where *all* partners have the capacity to work competently across cultural divides - offer the best hope of developing the 'many paths' necessary to improve multifaceted Aboriginal and Torres Strait Islander health. Our name and our art remind us that gains will only occur through the combined efforts of Indigenous and Gubba Australians.

1 The 'u' is pronounced as a vowel lying between the English 'put' and a shorter version of the vowel sound in 'boot': the 'r', 'a' and 'i' sounds are similarly short - the last-mentioned, for example, said as in 'bit' - they should not be pronounced as long sounds.

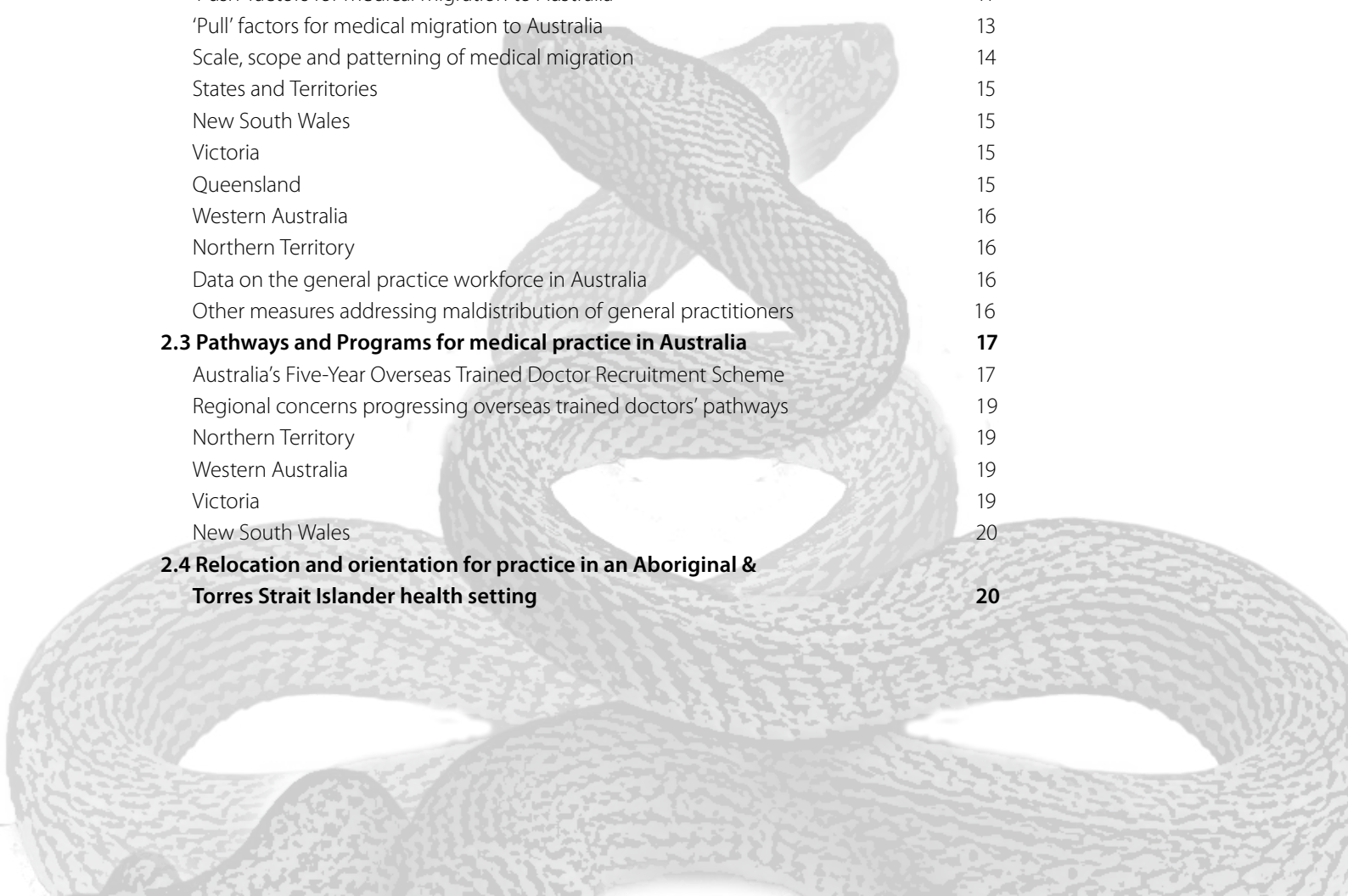
2 Troy, Jakelin, 'The Sydney Language', *Macquarie Aboriginal Words*, Macquarie Library Pty. Ltd., Macquarie University, 1995, p.68

3 Ibid, p.73



TABLE OF CONTENTS

Acknowledgements	vii
List of abbreviations	viii
Introduction	1
Aim	1
Scope	1
Methods	1
Identifying the relevant literature	2
Inclusion/exclusion criteria	2
Summary of findings of the review	3
Section 1: The literature review in context	5
Demographic trends in the developed world	5
Demographic trends in the medical workforce	5
The Migration Program	5
‘Brain Drain’ and migration	6
Section 2: Findings of the literature review	9
2.1 The Aboriginal and Torres Strait Islander medical workforce	9
Demographics of the Torres Strait Islander medical workforce	9
Medical maldistribution	10
The policy environment in Aboriginal and Torres Strait Islander health service provision	10
2.2 Medical migration to Australia: ‘push’ and ‘pull’ factors	11
‘Push’ factors for medical migration to Australia	11
‘Pull’ factors for medical migration to Australia	13
Scale, scope and patterning of medical migration	14
States and Territories	15
New South Wales	15
Victoria	15
Queensland	15
Western Australia	16
Northern Territory	16
Data on the general practice workforce in Australia	16
Other measures addressing maldistribution of general practitioners	16
2.3 Pathways and Programs for medical practice in Australia	17
Australia’s Five-Year Overseas Trained Doctor Recruitment Scheme	17
Regional concerns progressing overseas trained doctors’ pathways	19
Northern Territory	19
Western Australia	19
Victoria	19
New South Wales	20
2.4 Relocation and orientation for practice in an Aboriginal & Torres Strait Islander health setting	20



2.5 Professional integration of overseas trained doctors into Aboriginal and Torres Strait Islander Health practice	21
National concerns	21
State and Territory approaches to professional integration	23
Northern Territory	23
Queensland	23
Victoria	23
2.6 Social integration of overseas trained doctors into Aboriginal and Torres Strait Islander communities	24
2.7 Interaction with Aboriginal and Torres Strait Islander communities	24
2.8 Developing cultural awareness for practice in Aboriginal and Torres Strait Islander health	26
2.9 Retention of Overseas Trained Doctors in Aboriginal and Torres Strait Islander health	27
State and Territory concerns around retention	28
Northern Territory	28
Queensland	29
Victoria	29
Western Australia	29
Conclusion	29
References	31

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LIST OF ABBREVIATIONS

ABS	The Australian Bureau of Statistics
ACRRM	The Australian College of Rural and Remote Medicine
ACCHO	Aboriginal Community Controlled Health Organisation
AHW	Aboriginal Health Worker
AIATSIS	The Australian Institute of Aboriginal and Torres Strait Islander Studies
AIDA	Australian Indigenous Doctors' Association
AIHW	The Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMC	Australian Medical Council
AMWAC	Australian Medical Workforce Advisory Committee
AoN	Area of Need
ARRWAG	The Australian Rural and Remote Workforce Agencies' Group
CPMEC	Confederation of Postgraduate Medical Education Councils
DHAC	Department of Health and Aged Care
DIMIA	Department of Immigration and Multiculturalism and Indigenous Affairs
DoH	Department of Health (State)
DOHA	The Australian Government Department of Health and Ageing
EQUINET	The Regional Network on Equity in Health in Southern Africa
FRACGP	Fellow of the Royal Australian College of General Practitioners
GP	General Practitioner
GPET	General Practice Education and Training
GPPHCNT	General Practice and Primary Health Care Northern Territory
MDG	Millennium Development Goals
MJA	Medical Journal of Australia
MTRP	Medical Training Review Panel
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHA	The National Rural Health Alliance
OECD	Organisation for Economic Co-operation and Development
OMP	Other Medical Practitioner
OTD	Overseas Trained Doctor
PHR	Physicians for Human Rights
PROTD	Permanent Resident Overseas Trained Doctor
QRMSA	Queensland Rural Medical Support Agency
RACGP	The Royal Australian College of General Practitioners
RLRP	Rural Locum Relief Program
RWA	Rural Workforce Agency
RWAV	Rural Workforce Agency Victoria
The Scheme	The Federal Government's Five Year Employment Program
The Taskforce	The OTD Taskforce within the DOHA
TRD	Temporary Resident Doctor
VORRS	Victorian Overseas Trained Doctor Rural Recruitment Scheme
VRGP	Vocationally Registered General Practitioner
WACRRM	Western Australian Centre for Remote and Rural Medicine
WHA	World Health Assembly
WHO	World Health Organization

INTRODUCTION

The recruitment of medical practitioners to rural and remote areas as well as to other underserved communities is an international problem. In the Australian context, the burden of health professional shortages is most acutely felt in Indigenous communities, a constituency with profound economic, social, demographic and health disadvantage by comparison with the general population (Armstrong and Van der Weyden 2005; Turrell and Oldenburg 2004), and by contrast to other Indigenous groups in comparable countries (Lavoie 2004; AMA 2004). This has implications for the provision of both government and community-controlled health services to Aboriginal communities.

The demographics and dynamics of the Indigenous medical workforce in Australia, as in countries like Canada and New Zealand, can be understood in terms of the Indigenous experience of colonization and dispossession, and importantly, empowerment through the development of Indigenous community controlled health services, often tied to an Indigenous governance structure – what has been described as ‘a fourth sector’ in health system delivery (Lavoie 2004; Bartlett and Boffa 2001).

Increasingly, the majority of doctors being recruited to address critical shortages in health system delivery are overseas trained. Despite this, there is little information addressing the extent to which overseas trained doctors are employed in providing services to Aboriginal and Torres Strait Islander people, their professional and social experiences within these practice environments, and the experiences and impact of their employment on health services to Indigenous Australians.

Aim

The aim of the literature review was to identify the current and recent body of knowledge in the public domain relevant to the experiences of overseas trained doctors (OTDs) working in government and community controlled Aboriginal health services. The literature was reviewed in relation to the key objectives of the research. In reviewing the current literature, the

gaps in our knowledge about overseas trained doctors working in an Aboriginal and Torres Strait Islander practice environment have become evident.

Scope

The Review considered all relevant research and policy published in both the peer-reviewed and non-peer reviewed literature. This was restricted to literature published from 1994, so as to capture the critical policy initiatives impacting on the recruitment and employment of overseas trained doctors introduced from the mid-to late nineties. Judgements about the quality of the research and associated methodologies were not undertaken as part of this review. Given that the topic encompassed several broad subject areas, it was necessary to draw only on information that related to the key objectives of the research, and drew on reviews already conducted, in order to synthesize large subject areas. This is presented in a thematic format.

Methods

The following research themes were used to guide the literature searches:

- Demographics of the Aboriginal and Torres Strait Islander health workforce
- ‘Push’ and ‘pull’ factors for medical migration to Australia
- ‘Pathways’ to employment for overseas trained doctors in Australia
- Experience of relocation to practice in an Aboriginal and Torres Strait Islander health setting
- Experience of professional integration in an Aboriginal and Torres Strait Islander health setting
- Experience of social integration in an Aboriginal and Torres Strait Islander health setting
- Interaction between overseas trained doctors and Indigenous communities

- Cultural awareness by overseas trained doctors of the local community and practice environment
- Retention of overseas trained doctors in Aboriginal and Torres Strait Islander health practice settings

Identifying the relevant literature

a. The peer-reviewed literature was identified through MEDLINE and CINAHL database searches using combinations of the following MESH and free text terms. The following MESH terms and combinations were used: International/Foreign Medical Graduates, Physicians-Family, Australia, Oceanic Ancestry Group, Health Services - Indigenous, Medically Underserved Area, Emigration and Immigration. The following free terms were used: Overseas Trained Doctor, Aboriginal Medical Services, Culturally Appropriate, Cultural Safety, Brain Drain, Indigenous and Torres Strait Islander Health.

b. Government departments, professional organisations and non-government organisation websites were searched for publications and relevant policy documentation. These included: the Commonwealth Department of Health and Ageing (DOHA), the Australian Medical Workforce Advisory Committee (AMWAC), the OTD Taskforce within the DOHA (The Taskforce); State Health Departments; the Royal Australian College of General Practitioners (RACGP); the Rural Workforce Agencies (RWAs); the Australian Rural and Remote Workforce Agencies Group (ARRWAG), the National Rural Health Alliance (NRHA), The National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliate State organisations, the Australian College of Rural and Remote Medicine (ACRRM) and the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS).

The APAIS database was searched using the following term combinations: (overseas or foreign) and (doctor* or medic*) and (aborig* or indigen*).

The Australian Indigenous HealthInfoNet Website was searched for relevant research and publications.

Key stakeholders advised the inclusion of relevant reviews and reports.

c. A Google search using multiple search terms was undertaken.

Inclusion/Exclusion criteria

- Search was restricted to material published between 1994–2005 inclusive
- Medical practitioners in the study were limited to general practitioners
- Review focused on the Australian experience
- Review excluded evaluations of methodology or quality of research
- Review excluded all web-based material below the level of State based material, for example, local employer websites

SUMMARY OF FINDINGS OF THE REVIEW

There is no body of literature articulating the specific experiences of Overseas Trained Doctors working in Aboriginal medical settings, nor the experiences of Aboriginal Medical Services with doctors trained overseas. There are however, related subject areas of considerable relevance to the research topic. These include research and policy driven reports about overseas trained doctors in Australian service provision; a growing body of literature on medical migration, on recruitment and retention of doctors (including those who are overseas trained) in Australia's rural and remote areas; information on Aboriginal and Torres Strait Islander health and the supporting medical workforce; and a body of work addressing issues of 'cultural safety' and culturally appropriate health service provision for Aboriginal and Torres Strait Islander and other 'marginalised' communities.

The review highlighted the following issues:

- Much of the core literature in this area is policy driven but lacks the depth of research to inform and refine it
- Much of what we know is drawn from particular methodologies. These include the use of survey questionnaires, stakeholder consultations and focus group interviews
- Ethnographic and other qualitative methodologies have been used to research patient-doctor communication in the Aboriginal health setting. The specific experiences of overseas trained doctors, as another layer of the health professional experience, have not been studied
- The use of in-depth qualitative research techniques, such as a grounded theory or ethnographic approach, would be valuable methods for exploring the 'cultural spaces' and the dynamic interactions within a team or community environment
- Longitudinally linked data collection is also an underutilised research methodology given its suitability to studies of transient or mobile populations. These include populations with uncertain residency and practice outcomes, such as conditionally registered overseas trained doctors
- Much of the literature into overseas trained doctors addresses recruitment and employment in rural and remote areas, or in selected hospital environments. There is little, if any information in the public domain about overseas trained doctors working in urban or outer metropolitan Aboriginal medical settings. This is unsatisfactory given that the urban areas have the greatest number (as opposed to proportions) of Aboriginal people residing there, and, that outer metropolitan areas have been included in policy addressing emerging workforce shortages. It is very likely therefore, that significant numbers of overseas trained doctors would be working in these environments. Their perspectives, and the perspectives of the health services utilising OTDs in these areas, needs to be made known.
- The 'Google' search utilising multiple search terms was highly effective in identifying relevant literature. The MEDLINE and CINAHL database searches were not as comprehensive in the amount of information that was identified. This is likely an indication, as stated earlier, that much of the core literature in this area is policy driven and not based on peer-reviewed or evidence-based research. It also indicates the limited research in this specific field.



The lack of a specific focus on the experiences of overseas trained doctors in Aboriginal and Torres Strait Islander health settings leaves open a number of interesting research avenues. These include the following:

- Are the experiences of overseas trained doctors essentially the same or similar to those of Australian trained doctors working in an Aboriginal and Torres Strait Islander health environment?
- Do overseas trained doctors have to negotiate multiple 'cultural domains' when practicing in an Aboriginal and Torres Strait Islander workplace or community setting, or are all non-Aboriginal doctors, whether overseas trained or Australian trained, considered 'outsiders' in an Aboriginal health setting?
- Are the perceptions in Aboriginal Medical Services or Aboriginal and Torres Strait Islander communities, in relation to the worth of overseas trained doctors, mediated in any way by experiences of their 'foreign-ness'?
- How might the experiences of overseas trained doctors working in urban and outer-metropolitan Aboriginal and Torres Strait Islander settings compare with their counterparts in rural and remote areas?
- How might the past employment and lived experiences of doctors, whether trained overseas or locally, have a bearing on the specific skills, attributes and characteristics required to function effectively in the socio-cultural environment of Aboriginal and Torres Strait Islander health practice in all settings, but particularly those in remote environments?
- Further, how might good qualitative research, grounded in the local practice environment, contribute to the development of vocational assessment criteria of doctors' suitability for practice in an Aboriginal and Torres Strait Islander and/or remote area environment?

SECTION 1: THE LITERATURE REVIEW IN CONTEXT

Australia is part of the global market place for health professionals. While overseas trained doctors have always been a feature of Australia's medical workforce, more recent global, demographic, economic and political pressures have signalled some important shifts in the scope, scale, characteristics and patterning of this migration. This section will briefly identify some of the key dimensions that inform our understanding of these global flows.

Demographic trends in the developed world

Two phenomena mark current demographic trends in most industrialised countries. Low fertility and increasing longevity mean that population growth rates are slowing down. These demographic developments impact on current and future projections of labour supply, creating shortages in many key professions in the developed world (OECD 2003). For countries like Australia, New Zealand and Canada, the inflow of migrants constitutes a significant replacement of any losses of working age population, with immigration projections preventing an absolute decline, for example, in the numbers of Australians of labour force age (DIMIA 2003). However, the vagaries of supply and demand in specific professions are often manipulated by professional and political interests (Groutsis 2003). Recent and current crises in the supply and distribution of medical professionals in Australia have been debated in relation to this argument (Birrell 1997).

Demographic Trends in the Medical Workforce

Demographic trends underpinning changes in the supply of doctors and other health professionals in Australia, as in many other industrialised nations, are increasing the international recruitment and migration of health professionals. These general trends in the medical workforces of countries like Australia, Canada, the United States and the United Kingdom have been well documented (AIHW 2004; AMWAC 1999, 2000, 2002, 2003, 2004; DHAC 2005). They include:

- Inadequate numbers of locally trained medical students

- Ageing of the workforce
- Greater consumer demand for medical services
- 'Feminisation' of the workforce with reduction in full-time working hours to balance work and family life - apparent for both female and male doctors
- Undersupply of health professionals in certain specialties and in socially and geographically deprived areas
- Maldistribution of the health workforce both within and between countries
- Increasing reliance on overseas trained doctors to address deficits in country health systems and,
- Marked changes in general practice since the beginning of the 21st century with technological innovations, workforce and demographic changes

More detailed studies elaborate on these trends. Changes in the profile of the general practice workforce in Australia show the proportion of Australian graduates falling between 1991 and 2003 from 81.4 percent to 72.2 percent; the proportion of GPs who graduated in Asia increasing significantly between 1991 (5.8%) and 2003 (9.8%), and, the proportion of African graduates trebling, from 1.4 percent to 4.2 percent between 1999 and 2003 (Charles et al 2004: 87). Other studies highlight the reliance of the public hospital medical workforce in Australia on doctors who have come from an increasingly diverse range of countries (AMWAC Aug 2004).

The Migration Program

Australia's migration program has always played a central role in its population growth. Australian Bureau of Statistics (ABS) figures show 52 percent of Australia's population growth from net overseas migration (ABS 2004:6). Stocks of foreign-born labour force are particularly high for Australia compared with other OECD countries, which show Australia in 2002 with almost a quarter of its total labour force foreign-born (OECD 2003).

Within the general migration pattern of Australia's Migration Program, there has been a significant change in the source countries of permanent arrivals since the mid-1990s, with settlers arriving from more diverse areas of the world compared with the early 1980s. The percentage of immigrants to Australia from developing countries has risen from 20 in 1970-1974 to 53 in 2000-2002 (IOM 2005). The growing diversity in source country migration to Australia is reflective of variations in the numbers and types of visas issued. In the six years from 1999 to 2000, the proportion of settlers arriving under the skilled migration category ranged from 23 percent in 1994-95 to 35 percent in 1999-2000 (ABS 2002). Of skilled migrants arriving in 1999-2000, 24 percent came from Europe (mostly from the UK and Ireland), while South East Asia and Africa (excluding North Africa) contributed 18 percent each (ABS 2002).

In 1999-2000, 22 percent of settlers came as part of the family component of Australia's immigration program. The birthplaces of these immigrants partly reflect past migration patterns with about 24 percent born in Europe and the former USSR, 23 percent born in South-East Asia and a further 18 percent born in North-East Asia (ABS 2002).

A substantial intake of overseas trained doctors occurred mainly via the family reunion program and from New Zealand from the mid-1990s. Closer scrutiny of the New Zealand data however, revealed a mere 29 percent of New Zealand doctors being New Zealand born (Hawthorne et al 2003). Their primary birth countries (and probably country of qualification) were listed as Bangladesh (15%), India (8%), Sri Lanka (7%), China, UK/Ireland (6%) and Iraq (5%) out of a total of 47 countries listed (Hawthorne et al 2003: 8).

Overseas trained doctors enter Australia via the major visa categories. These include the Refugee and Humanitarian, the Family Entry for Permanent Migrants, the Skilled Entry, and the Temporary Migration Entry categories. The success or failure to address shortages in skilled health personnel lies in targeted recruiting to fill 'Area of Need' positions. Thus, from a policy point of view, temporary migration (via visa categories 442 and 422 for example) as well as more recent initiatives outlined under the Medicare Plus legislation (see section 2.2 'pull' factors for medical migration), constitute a targeted response to health professional recruitment and deployment. These immigration initiatives work in tandem with other jurisdictions, such as Health, to provide access to Medicare provider numbers for doctors exempted from restrictions

introduced in 1996. Under the Medicare provider number legislation, Australian citizens or permanent resident doctors (those who were first recognised as medical practitioners after 1 November 1996 and who have not achieved fellowship from a recognised medical college) are prevented from accessing Medicare, except where they are participating in approved training or workforce programs (DOHA 2003).

'Brain Drain' and migration: changing patterns in the international flows of medical professionals and their implication

Doctors and nurses have been migrating between developed countries, and between a few developing countries to the developed world for decades.

The landmark Meija study (initially published in 1978) reported global physician flows mainly from Canada, Germany, Ireland, the UK, India, Iran, Pakistan, Sri Lanka, the Philippines, Korea and Latin America to the USA and the UK (Meija 2004). Since the 1970s however, the patterns of migration and source countries have changed globally with new source regions for doctors in the Caribbean, Egypt, sub-Saharan Africa, Cuba and the Soviet Union (Whelan et al 2004). Since the 1990s there has been increasing diversification of supplier countries for medical migration, a decline in permanent migration and a concomitant rise in temporary migration (Chanda 2003). Current Australian data however, indicates an upward trend in permanent migration (cf. 'pull' factors for medical migration), but more work is needed to track these workforce flows.

The last two decades have seen Australia, Canada and New Zealand emerge as newer destination countries for health professionals. The scale of the recruitment effort, the particular patterning of developing country migration and the size of medical 'diasporas' in Australia differ from those found in the USA (Hagopian et al 2004) and the UK (Mensah et al 2005). However, high levels of physician migration and increasing reliance on physicians from developing and resource poor countries are characteristics that Australia's medical workforce shares with countries like the USA, the UK and Canada (Mullan 2004).

The scale and scope of this cumulative recruitment by developed countries of health professionals from developing countries, as well as the methods of recruitment employed (the growth of private recruiting companies) has injected urgency into the current debate on global health equity and inequity. Severe



shortages of health professionals in resource poor countries are implicated in the undermining of global health initiatives such as achievement of the United Nations Millennium Development Goals (MDG) by 2015 (UNDP 2003). The HIV/AIDS pandemic has magnified the health human resource crisis in Sub-Saharan Africa (PHR 2004).

A sizeable body of literature has emerged which documents, analyses and formulates policy around the phenomenon of 'brain drain', described as a conveyor belt-like movement from poorer to richer regions, countries and areas of the health sector. (Padarath et al, undated). Concerns over medical migration have percolated into the international medical literature (Dovlo 2005; Scott et al 2004; Ioannidis 2004, Levy 2003). There is now considerable interest in measuring the extent of these global health professional flows, including their impact on the capacity of poorer countries to deliver even basic health services and the capacity for managing them at international, regional, national and local levels (WHO 2003; WHA 2005).

Ethical frameworks governing international recruitment have been developed (DoH UK 2001; NRHA 2004). A Code of Practice for the International Recruitment of Health Care Professionals (the Melbourne Manifesto) was adopted in Melbourne in May 2002¹. The National Rural Health Alliance (NRHA) has also articulated a position around an ethical approach to the training and supply of health care professionals in support of the Melbourne Manifesto (NRHA 2004). The Melbourne Manifesto has been a landmark document in Australia's efforts to encourage ethical recruitment and employment of medical migrants to Australia. The Manifesto supports and endorses the principles of the Alma-Ata Declaration, adopted in 1978. The significance of this document is that it declared its commitment to reducing the gap between the health status of the populations of developing and developed countries, as well as providing community based and community driven primary health care as the central strategy to reducing inequalities in health status - both between and within countries².

1 Information about the Melbourne Manifesto can be accessed at the following web address (Accessed July 2006). http://www.globalfamilydoctor.com/about/Wonca/working_groups/rural_training/melbourne_manifesto.htm

2 Information on the Alma-Ata Declaration can be accessed on the Peoples Health Movement Website: <http://www.phmovement.org/charter/almaata.html>.

This has resonance for populations in rural and remote areas, and in particular, for health inequalities experienced by Indigenous people in Australia and elsewhere. The moral imperative to avoid active recruitment of medical practitioners from developing countries raises issues of having to compete with a limited pool of suitably trained doctors globally to address maldistribution of health professionals. It also raises issues around individual autonomy versus distributive justice (Boffa 2002) and the importance of addressing the local-global relationship in finding solutions to combating health disadvantage (NRHA 2004; Whelan et al 2004). Despite efforts to avoid active recruitment from developing countries, increasing numbers of developing country medical professionals continue to migrate to wealthier countries like Australia. This reality illustrates the complexities of controlling recruitment. The story is further complicated by who initiates the recruitment and the lack of linear flows from country A to country B (Whelan et al 2004; Marchal et al 2003).

Australia's diversified medical workforce underscores the need for an increasingly complex environment of support to address language, cultural and institutional differences. Differential experiences of professional and social integration into medical practice by country of origin have already been identified, although these require further research and ongoing monitoring and evaluation to determine the impact of current and recent policy initiatives (Hawthorne et al 2003). These concerns raise important issues about the use of Overseas Trained Doctors in Aboriginal and Torres Strait Islander health services. These include:

1. The extent to which doctors trained overseas are prepared for the clinical and cultural challenges of working with Aboriginal and Torres Strait Islander people, and in Aboriginal and Torres Strait Islander health services;
2. The extent to which language, class, culture, ethnicity and gender mediate the relationships between medical practitioners, their colleagues and communities being served;
3. The nature and extent of workplace support in Aboriginal and Torres Strait Islander medical settings for integrating overseas trained doctors both professionally and socially and,

4. The relationship between overseas trained doctors' experiences within an Aboriginal and Torres Strait Islander setting and their longer-term practice and migration intentions.

SECTION 2: FINDINGS OF THE LITERATURE REVIEW

2.1 The Aboriginal and Torres Strait Islander Medical Workforce

The Aboriginal and Torres Strait Islander Health Workforce is defined differently in different settings. It is used *inter alia* to denote health professionals who are themselves of the Indigenous community; who are located within institutions servicing either exclusively or largely Indigenous communities, such as the community controlled health services; or to denote a workforce providing services to Indigenous Australians regardless of the point of access, that is, whether through mainstream service provision or Indigenous health services such as the Aboriginal Medical Services (AMA 2004a) This review uses the latter definition as defined by the Australian Medical Association (AMA), although the focus of this research is on overseas trained doctors in Aboriginal medical services.

The central problem is recruiting and retaining sufficient professionals with the skills and attributes necessary to work effectively in the socio-cultural environment of Aboriginal and Torres Strait Islander communities. Currently, Indigenous doctors account for 0.18 percent of the medical profession, despite 2.4 percent of the Australian population being Indigenous, while Indigenous medical students still only make up 1.1 percent of the medical student population (AIDA 2005:17).

Health services for Aboriginal and Torres Strait Islander populations are provided through a range of sources. These include the Aboriginal Community Controlled Health Services funded by the Commonwealth; State funded and operated public hospitals and community health clinics and programs; private general practitioners covered by Medicare, and the Royal Flying Doctor Service (Hill et al 2001). The development of Aboriginal community-controlled health organizations – around 120 since the first AMS was established in Redfern in 1971 - has been documented in *General Practice in Australia 2000* (DHAC 2000:74-103). The key features of Indigenous Primary Health Services include increased responsiveness to local Indigenous needs, increased opportunities for employment of Indigenous peoples, and increased cultural expression

in health care delivery (Lavoie 2004). The recent *Review of General Practice in Australia: 2004* (DHAC 2005) includes chapters on both Aboriginal and Torres Strait Islander primary health care and general practice and Aboriginal Community Controlled Health Services. These provide current data, policy and programs relevant to the provision of general practice services to the Aboriginal and Torres Strait Islander population.

Demographics of the Aboriginal and Torres Strait Islander workforce

The Review acknowledges that meeting the goals of Indigenous health goes beyond simply the 'right numbers' of medical and health professionals, but includes sufficient support services, appropriate health and community infrastructure and less tangible resources relating to community capacity, self-determination and empowerment. However, calculations of the shortfall in the numbers of medical professionals meeting Indigenous health needs give an indication of the relative disadvantage experienced by Indigenous populations in relation to the general population. The Australian Medical Association has estimated the shortfall of medical professionals providing services to Aboriginal and Torres Strait Islander people at 430 FTE medical practitioners, with the shortfall in access to primary health care at 250 FTE medical practitioners (AMA 2004b:16). Further, a gap of 928 doctors has been estimated as necessary to increase the proportion of Aboriginal and Torres Strait Islander people working as health professionals to non-Indigenous levels, with an additional 2000 Aboriginal Health Workers also required (AMA 2004a: 2).

The review of Aboriginal and Torres Strait Islander primary health care and general practice reports the resident Aboriginal and Torres Strait Islander population of Australia to be 2.4 percent of the total estimated resident population of Australia (an increase of 16 percent from that estimated for the 1996 census and a 33 percent increase from the 1991 census) (DHAC 2005: 305). In 2001, the State with the largest Aboriginal and Torres Strait Islander population was New South Wales, followed by Queensland (registering over half of the Torres Strait Islander population) and Western Australia, with 14 percent of the total Indigenous

population. The Northern Territory had the highest jurisdictional population proportion (28.8 percent). In all other jurisdictions this proportion was less than 4 percent (DHAC 2005: 305; ABS 2005: 4).

However, health service provision based on simplistic population based formulae is not an appropriate benchmark for determining health needs, given the scale, scope and complexity of Australian Indigenous health disadvantage (QRMSA 2004). Further, there is a need to disaggregate data at the local area level to capture variations in morbidity and mortality within the national picture. Understanding the interactions between Aboriginal families and health workers in the context of differing socio-economic and cultural environments is important in order to acknowledge the diversity of the Indigenous experience¹.

Medical maldistribution

Medical maldistribution is a feature of health workforces both within and between countries. The burden of health professional shortages is concentrated in certain populations, particularly in remote rural areas, but also in outer metropolitan areas (new growth areas) and poorer inner city areas. Aboriginal and Torres Strait Islander populations in Australia experience under-servicing in relation to medical care on three main accounts (Wells 2000). These include geographic isolation, coupled with the barriers to accessing appropriate services as a result of insufficient practitioners per population, as well as the distances required to travel to services. Secondly, unaffordable health services, given that the supply of general practice is largely market driven; and finally, under-servicing due to socially or culturally inappropriate services (Wells 2000: 289).

While most Indigenous Australians live in urban areas, the Indigenous proportion of the total population increases with remoteness. As in the case globally, the supply of health professionals decreases with increasing remoteness. In 2001, the number of medical practitioners per 100,000 population in the major cities was 296. This fell to 166 in inner regional areas, to 131 in outer regional areas, to 108 in remote areas and to 73 per 100,000 population in very remote areas (AIHW 2004: 263).

¹ A report on Indigenous data developments and information governance arrangements will be available in late 2005 from the ABS website (www.abs.gov.au) and the AIHW website (www.aihw.gov.au) (ABS, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Commonwealth of Australia, 2005)

Data drawn from the ARRWAG Minimum Data Set Report show the following proportions of general practitioners providing 'Aboriginal health services by State': NT (63.9%), WA (40.9%), QLD (31.4%), NSW (18%), TAS (14%), SA (13.1%) and VIC (9.2%) (ARRWAG 2003:10). The same data by RRMA show the following proportions for general practitioners in 'Aboriginal health services': RRMA 4 (16.5%), RRMA 5 (18.4%), RRMA 6 (56.6%), RRMA 7 (54.2%) (Ibid).

Government programs and policies to redistribute the medical workforce to high need areas have encompassed numerous policy directions. These include regulatory mechanisms (legislating 'conditions' of practice for Australian graduates and temporary and permanent resident overseas trained doctors), educational and training initiatives (increasing the supply of Australian-trained and rural-origin medical graduates as well as initiatives in medical education) and financial incentives (bulk-billing, after-hours payments) for servicing disadvantaged populations.

A major policy plank addressing maldistribution of medical practitioners in Australia, and other Western countries, has been the recruitment and employment of doctors trained overseas. In the 12 months to June 2004, 1,895 overseas trained doctors were granted Medicare provider numbers that included geographic restrictions on practice (Gavel 2004). This represents an increase of 26.6 percent in numbers over the previous financial year (*ibid*). Overseas trained doctors, it is argued, are 'keeping Australia's rural and remote workforce afloat' and the Central Australian Aboriginal Congress and other Aboriginal Health Services in Central Australia rely heavily on OTDs to maintain their general practice workforce (Boffa 2002).

The policy environment in Aboriginal and Torres Strait Islander health service provision

Overseas trained general practitioners (as with any general practitioner) provide medical services to Aboriginal and Torres Strait Islander communities in a particular policy environment. The implementation of the Primary Health Care Access Program (PHCAP) in 1989 was a major Aboriginal health policy reform addressing access to comprehensive primary health care services. Central to this model of health care is community control. The case studies in the May 2005 *Indigenous Health* edition of the *Medical Journal of Australia*, illustrate that carefully designed primary health care systems, community based collaborative approaches, and importantly, partnerships based



on *hearing and understanding each others' stories*, are essential elements of a successful primary health care initiative (Armstrong and Van der Weyden 2005: 499).

The relationship of general practitioners to the outside community within Aboriginal Community Controlled Health Services (ACCHSs) is different from that experienced by GPs working in private practice settings. This is because in ACCHSs, GPs are ultimately responsible to the community. This, it is argued, is a role that requires specific skills and attributes and does not suit all doctors (Anderson 2002). Doctors in community controlled Aboriginal Medical Service environments require advocacy skills (Gruen and Yee 2005), need to cope with power differentials, such as equality for all members of the health care team (Hill et al 2001) and value differentials, such as different cultural 'knowledges' embodied in bio-medical models of health, 'non-Western' models of health and Aboriginal knowledge about illness and well-being (Lowell 1998; Maher 1999).

Anderson and Wakerman, in the review of *General Practice in Australia* (DHAC 2005) point to the lack of general practice service availability in more remote regions for Aboriginal and Torres Strait Islander populations. They argue, '*Poor access in rural and particularly in remote areas is caused by poor availability of health services rather than poor acceptability, which is a more significant factor in urban and some regional settings*' (DHAC 2005: 315). The reason put forward is that urban centres consist largely of what they describe as *non-Aboriginal 'spaces'*, and Aboriginal people have demanded their own spaces for the delivery of health and other services. By contrast, remote Aboriginal communities are, by and large, '*Aboriginal spaces*'. Research drawing on the 1999 Community Housing and Infrastructure Needs Survey (CHINS) data, found limited or no access to a registered doctor or nurse in discrete Indigenous communities, where almost 90 percent of the Indigenous population of the Northern Territory live, with corresponding figures for Queensland, South Australia and Western Australia around 25 percent, New South Wales, 8 percent and Victoria, 1 percent respectively (Carson and Bailie 2004). Rural and Remote Statistical Local Area (SLA) data, after adjustment for Indigenous status and GP availability, show 25.3 percent less general practitioner use than for that in the most advantaged tertile, illustrating the lack of economic and geographic accessibility of health services (Turrell and Oldenburg 2004).

In the case of Aboriginal Community Controlled Health Services, the biomedical clinical paradigm has had to integrate with other more holistic models of health. The globalisation of the practice of medicine has also meant increased integration of the 'Western model' of biomedicine with other non-Western cultural traditions. However, the effectiveness of different practice styles and approaches to health care for Aboriginal and Torres Strait Islander patients has not been directly evaluated (DHAC 2005: 318).

Issues of 'place' in different cultural domains, and the power relationships between them, have been analysed in relation to the study of Aboriginal managers and their negotiation of different cultural domains (Hill et al 2001).

The extent to which overseas trained doctors draw on their own cultural traditions in their approach to medical practice, and the extent to which their immersion in other cultural 'spaces' provides a transformative experience, remains unexplored in the Aboriginal and Torres Strait Islander practice setting.

Further, given that the majority of overseas trained doctors, particularly those in rural and remote settings, are compelled to work in specific 'Areas of Need' - as a condition of their medical registration - the question arises as to how the element of compulsion impacts on their relationship to the service and the outside community, as well as on the successful completion of their vocational pathway.

2.2 Medical Migration to Australia: 'Push' and 'pull' factors

'Push' factors for medical migration to Australia

Specific conditions precipitating the outflow of medical practitioners from their home countries vary in nature, scope and purpose. However, the 'push' factors for medical migration from developing countries have been well documented and are summarised below (Whelan et al 2004:102).

These include:

- Dissatisfaction with conditions of work encompassing, poor remuneration, inflexible working conditions, lack of prospects for career advancement, limited training and educational opportunities for professional development, lack of supplies and equipment and poor work environments;
- Social pressures such as, family and friends abroad and the needs and expectations of extended family and kin for remittances from greater earnings;
- Impact of HIV/AIDS on the attrition of health professionals and their morale;
- Concerns about personal security and violence as well as political instability and conflict; and,
- Economic instability and stagnation

There is an emerging literature relating to the reasons why doctors migrate to Australia. Much less is known however, about the future practice and migration intentions of overseas trained doctors. While some overseas trained doctors come to Australia with the intention of a short-term stay only, others hope to become long term or permanent residents of Australia.

Research into health professional migration from Pacific Island Countries to Australia and New Zealand has shown that international migration and return are linked to extended family and residence of kin as much as to individual financial and career aspirations and goals (Brown and Connell 2004). Other motivations such as improving lifestyle and opportunities for children appear to be the driver for the migration of doctors from a range of countries to Australia. Research into overseas trained doctors in regional Victoria found that doctors from the United Kingdom and Ireland were over four times more likely to report coming to Australia for family or lifestyle reasons. Doctors of Asian origin in the Victorian study, *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* (Hawthorne et al 2003: 29). These variations in motivation illustrate the importance of understanding factors in source countries influencing decisions around migration and return, and their relationship to the success of targeted migration initiatives aimed at acquiring doctors to practice in areas of high workforce need. We know little, however, of the professional

and social linkages between overseas trained doctors in Australia with networks in their home countries as well as here in Australia, or of the relationship of these factors to subsequent career and migration decisions.

The findings of the Victorian study suggest strongly that the reasons for coming to Australia may differ from the motivations for overseas trained doctors to move to a particular State (ibid: 30). In that research, career opportunities and job-related reasons were the critical determinants in coming to their current rural location. A substantial number of the respondents in the Victorian study saw their current practice location as their 'only option' to practice. This depicts the situation of many overseas trained doctors with conditional registration.

Health professional migration from Sub-Saharan Africa to Australia has increased dramatically in a relatively short period. Two substantial information resources on the flows of doctors and other health professionals out of Sub-Saharan Africa are the body of work collected by the Regional Network for Equity in Health in Southern Africa (EQUINET), and, Physicians for Human Rights (PHR), which released a Report, An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa, in July 2004 (PHR 2004)². Both provide a comprehensive source of data on the extent of health professional migration out of Sub-Saharan Africa, the factors influencing migration - described as a 'push-pull-stick-stay' matrix - and the costs of such migration for supplier countries in financial, institutional, human and health terms.

A number of studies have been undertaken outlining the nature, scope and impact of the migration of skilled health personnel in Pacific Island Countries. This migration is of increasing concern due to the widespread regional loss of skilled health professionals over the past two decades through emigration, mainly to Australia and New Zealand. The significance of out-migration from the Pacific Island Countries centres on their unique demographic and geographic characteristics as relatively small and dispersed island states. In these situations, even relatively small numbers of people out-migrating may have a disproportionate effect on the country and its health services, and, the capacity for replacing health personnel - particularly in the smaller and more marginalised islands - is extremely limited and

2 Cf. The EQUINET Website: <http://www.equinet africa.org/>; The Physician's for Human Right's Website: <http://www.phrusa.org/> (both accessed on January 31 2006)



problematic in cultural and resource terms. Other significant factors relating to the flows of skilled health personnel have been identified in work commissioned by the World Health Organisation (WHO) (2004) and the research conducted by Brown and Connell (2004). Their concerns over the out-migration of doctors and other health personnel from this region include:

- *The lack of information and databases on the distribution of the health workforce, attritions and migration flows;*
- *The impact of emigration leading to a shrinking workforce, a costly 'skills drain', loss of morale, unmet or poorly met health needs, concern over cost and quality of workforce replacements;*
- *The particularly acute health human resource situation regarding young doctors seeking career advancement and stimulation, and, the situation in the smaller states;*
- *The fact that migration is not an 'overspill' but a definite loss with negative outcomes for health status and financial viability of health systems*
- *The existence of substantial 'trans-national communities of kin' through which migration of skilled health personnel is facilitated; and,*
- *The significant flows of remittances to PICs where economic growth has been limited;*

Research surveying the migration of health professionals from India reported the following main findings (Chanda 2003; Khadria 2004):

- *Australia ranked as the third preferred destination country for doctors after the USA and UK because of, 'its climate and newly emerging employment opportunities';*
- *Prospective emigrant doctors were young (average age 25 yrs) and single;*
- *Most respondents felt that socio-cultural problems and racial bias could be the most severe problems overseas which they might have to face. Many respondents voiced the fear of becoming second-class citizens in their host country. This echoes the findings of Hawthorne et al's research (2003) which points to the difficulties faced by many doctors of Indian origin integrating into the medical labour market;*
- *Career growth is the main motivating factor for health professional migration from India;*

- *Doctors expressed satisfaction with their education and training in India – a scenario quite different from many other developing countries from which health professionals migrate.*

'Pull' factors for medical migration to Australia

Information on health professional flows into Australia has been sourced from a number of available data sets as well as from recent and current research into health human resource flows to Australia. These include data from the following sources:

- Australian Bureau of Statistics (ABS) Migration Statistics – This data provides statistics on overseas arrivals and departures and describes those arriving and departing from Australia holding health professional qualifications. These are not precise indicators of employment in the health labour force. The data also excludes short-term arrivals (less than 12 months duration), a sizeable proportion of whom would be temporarily employed in the health labour force
- Commonwealth Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) – This data provides estimates of medical and health personnel entering and leaving Australia as collected on passenger cards. More detailed information on the specific visa subclass - within the raft of skilled migration initiatives targeting employment in the medical sector - provides the best measure for determining the use of overseas trained doctors and trends in their use over time (Birrell and colleagues, cited in this review, have drawn extensively on this use of data)
- State Medical Registration Boards – This data provides a good indication of the number of medical practitioners who are registered to practice annually. It also provides information on the conditions of their registration to practice in the relevant States, including the differential categories for conditional registration. The limitations in the use of this data nationally is that differing definitions and criteria are used across the State and Territory registration Boards
- The Australian Medical Workforce Advisory Committee (AMWAC) provides profiles of the Medical Labour Workforce. These provide quantitative data covering current supply and projected requirements for the medical and health

workforces. Data capturing qualitative questions and exploring the dynamics of the medical workforce are not routinely collected in national data collections. However, qualitative information is collected from responses to annual Rural Workforce Agency surveys conducted by the individual States and Territory (ARRWAG 2003: 8)

- State and Territory Rural Workforce Agencies – The Rural Workforce Agencies hold databases of the rural and remote medical workforce in their State or Territory. This data provides a valuable source of information about the general practitioner medical workforce at the State level, including information about doctors trained overseas and their use. The limitation in this data is that regional and state level data are not drawn from compatible minimum data sets. As noted by ARRWAG, *'the data usually reflect the more stable elements of the workforce and do not always include the more transient, short term service providers, such as locums'* (ARRWAG 2003:9)
- The Australian Rural and Remote Workforce Agencies Group (ARRWAG) draws on the data of the Rural Workforce Agencies. It notes the potential of the minimum data sets to improve their capacity for collecting information on the movement of transitory doctors (see the Report, *Reality Bites*, October 2003). It argues that 'unique doctor identifiers' could be used to document the movement of doctors into and out of rural and remote practice (ARRWAG 2003: 33).
- General Practice Statistics – data on general practitioner demographics provides a further source of information on the supply and distribution of general practitioners in Australia. General practice statistics for this Review were accessed on the Australian Government Department of Health and Ageing website at <http://www.health.gov.au/internet/wcms/publishing.nsf> (1 July 2005)

Scale, scope and patterning of medical migration

Birrell (2004), Birrell and Hawthorne (2004) and Hawthorne et al (2003) have reviewed extensively the scale and sources of Australian Government initiatives to recruit overseas trained doctors. These exert a 'pull' factor for migration to Australia as they provide opportunities for employment in the medical workforce. As a result of additional measures under

the Medicare Plus legislation, there are now incentives for staying in Australia for longer periods of time, and for changing residency status from temporary to permanent. It is argued that as a result of these policy measures the medical workforce in Australia has been transformed, *'towards a high level of dependence on doctors resident in Australia on a temporary basis and, within the permanent workforce, on doctors trained overseas'* (Birrell and Hawthorne 2004: 83).

Medical professionals born overseas have increased by 7 percent between 1991 and 2001 (Hawthorne et al 2003: 8). Changes in source countries are reflected over this period. The most important change in medical migration at the beginning of the 21st century is that the UK and Ireland no longer dominate medical migration flows to Australia. The significance of this is that language and educational equivalency can no longer be assumed. This has created the need for an increasingly complex environment of support to ensure the successful integration of doctors trained in diverse countries.

A second notable trend in the data on medical migration to Australia shows a marked decline in the numbers of persons holding medical qualifications permanently migrating to Australia. The numbers in this category declined from 639 in 1991-92 to 292 in the years 1999-00 (AIHW 2003). In the permanent migration category since the mid 1990s, there has been a substantial intake of overseas trained doctors mainly via the family reunion program and from New Zealand. Birrell and Hawthorne have estimated that as of census date 2001, there was a stock of about 3,142 overseas born doctors who arrived between 1991 and 2001 and who were not employed as doctors (2004: 94). This illustrates the difficulties experienced by many permanent resident overseas trained doctors achieving a successful outcome in the process of medical assessment, that is, their requirements for 'fitness to practice' in Australia.

By contrast, temporary migration for medical practitioners has been on the increase. Data pertaining to visa category of temporary resident overseas trained doctors reflect the impact of government policy initiatives introduced to increase the numbers of OTDs in 'Areas of Need'. The number of visas issued to OTDs for the temporary entry visa category (422) increased from 664 in 1993-94 to 1,419 in 1999-00 to 2,496 in 2002-03 (Birrell and Hawthorne 2004: 88).



Temporary residents practice in Australia under conditional medical registration. The total number of conditional registrations in WA is estimated at 10.5 percent of the total number of medical registrations; 10.1 percent in Queensland; 6.6 percent in Victoria and 4.7 percent in New South Wales (Joyce 2004).

Despite the trend toward temporary medical migration, there are indications that permanent medical migration is currently on the increase. Preliminary data reflecting the impact of the federal Government's increased efforts to keep OTDs in Australia on a permanent basis show the following: In 2001-02, 54 category 422 visa holders were sponsored under the permanent residence employer nomination program; in 2002-03, this increased to 225. The numbers sponsored under the Regional Sponsored Migration Scheme increased from 26 in 2001-02 to 176 in 2002-03 (Birrell and Hawthorne 2004: 91).

Other initiatives encouraging permanent migration include the completion of a five-year placement in a designated District of Workforce Shortage under the Federal government's Five Year Employment Program (cf. Section 4: Pathways and Programs for medical practice in Australia) and the achievement of an unrestricted provider number, subject to the successful completion of a fellowship of the RACGP.

● States and Territories

There is considerable variation in the use of temporary medical migrants across the States and Territories with the greatest use of visa subclass 422 being in Queensland, Western Australia and Victoria, while for visa subclass 442 (occupational trainees) the greatest use is in New South Wales (Birrell R 2004). Increases in visa subclass 422 in the majority of States from 2000 to 2003 can be seen in the Table below.

Table 1: Visa subclass 422 by State, 2000-01 to 2002-03³.

State	2000-01	2001-02	2002-03
QLD	899	716	1016
WA	456	472	597
VIC	406	508	581
TAS	94	82	89
NT	84	98	97
NSW	58	89	176
SA	60	68	133
ACT	7	12	50
TOTAL	2062	2045	2739

³ This data is drawn from Table 2: Number of visa subclass 422 nominations by State, 2000-01 to 2002-03, Birrell R 2004: 636

New South Wales

The NSW Medical Board notes the continued increase in the numbers of practitioners registered to work in Area of Need (AoN) positions. AoN registrations increased from 192 in 2003 to 217 in 2004, with increases in postgraduate trainees from 889 to 1 082, and overseas trained specialists from 426 to 511 over the one year period (NSW Medical Board Annual Report 2004:13). The four top source countries for currently registered AoN doctors in NSW are India, South Africa, Egypt and the UK (Hawthorne et al 2003)

Victoria

Since 1998, the Rural Workforce Agency of Victoria has recruited approximately 500 overseas trained doctors to work in general practices in rural Victoria (Hawthorne et al 2003). In Victoria, the top source countries for registrations outside of Australia include India, the UK, New Zealand, Sri Lanka, South Africa, Iraq, China and Ireland. According to the Rural Workforce Agency of Victoria, approximately 26 percent of the rural GP workforce in Victoria were trained overseas and come from more than 57 different countries. Supplier country diversity in the public hospital medical workforce is particularly marked (DHS VIC 2002).

Queensland

Data from the Queensland Rural Medical Support Agency (QRMSA 2003) show 41.7 percent of the current rural and remote medical workforce in QLD obtained their basic medical qualification overseas. According to their Report, the largest proportions of OTDs are from the UK (10.3%) followed by South Africa (7.2%) and India (4.9%). Other substantial source countries include Pakistan, China, Bangladesh, Fiji, New Zealand, Egypt, Nigeria and Ireland.

Of the OTD workforce in RRMA 4-7, 54.4 percent are overseas trained and permanent residents or Australian citizens, while 45.6 percent are overseas trained and temporary residents. The reliance of overseas trained doctors in the primary care workforce in Queensland increases with remoteness and is particularly characterised by the use of temporary resident doctors. This, it is argued, 'creates a very fragile environment in rural and remote areas reflected in the relatively high mobility of the workforce (greater than 25% turnover in a 6 month period in RRMA 7) having serious implications for continuity of care and development of preventative

healthy care, particularly impacting on remote indigenous communities ...' (QRMSA, 2004: 5).

Western Australia

Data on the rural and remote general practice workforce in Western Australia is collected by the Western Australian Centre for Remote and Rural Medicine (WACRRM). The WACRRM Program Report for 1992-2002 indicated 68 doctors on their database and that the majority of these were from South Africa (26), the UK (13) and Nigeria (9) (Roach 2002). The Report also notes the high turnover of rural doctors in WA each year (estimated at around 60). To counteract the attrition of doctors, WACRRM aims to recruit an additional 20 OTDs a year to the program. In its analysis of the rural general practice workforce in WA, it is estimated that 38 percent of the current rural and remote medical workforce in WA obtained their primary medical qualifications overseas. The largest proportions of overseas trained doctors are from the UK (36%), followed by South Africa (22%) (Downs 2003).

Northern Territory

As at June 2004, OTDs make up 30 percent of the General Practitioner workforce in the rural and remote areas of the NT, and the proportion of new GPs being recruited to the Territory who are OTDs has risen significantly (NT Remote Workforce Agency, 2004a).

Data on the general practice workforce in Australia

Data on the general practice workforce in Australia illustrates the impact of measures taken to increase the numbers of general practitioners in rural and remote Australia. These measures include the 'pull' factors related to migration initiatives for temporary resident OTDs, registration initiatives for permanent resident overseas trained doctors without general registration and other non-migration related initiatives. These include financial incentives to increase the numbers of GPs working in areas of district workforce shortage.

Data drawn from the Department of Health and Ageing General Practice Statistical Website show that during the period 1995-96 to 2003-04, the percentage of Australian trained (basic qualification) GPs fell by 9.7 percent and those trained overseas by 1.8 percent in urban areas. By contrast, the same period saw an increase of Australian trained GPs by 8.8 percent for rural and regional areas and 80 percent for overseas

trained GPs⁴. This illustrates the success of the supply-side measures taken to address the problem of medical maldistribution in Australia's rural and remote areas.

These supply side measures are particularly evident when looked at in relation to the degree of remoteness for medical practice. The GP headcount by type and broad RRMA for the years 1995-96 to 2003-04 are provided below⁵.

Table 2: GP headcount by type and broad RRMA, 1995-96 to 2003-04

Urban GP registrars	Urban non VRGP	Urban VRGP	Rural and remote GP registrars	Rural and remote non VRGP	Rural and Remote VRGP
- 42.6 %	-56.4%	16.6%	53.1%	55.6%	15.5%

● Note: VR stands for Vocationally Registered

Changes in percentage terms in the number of GPs over the period, 1995-96 to 2003-04, are reflected in the following table⁶.

Table 3: GP headcount by RRMA, 1995-96 to 2003-04

	1. Capital City	2. Other Metro	3. Large Rural	4. Small Rural	5. Other Rural	6. Remote Centre	7. Other Remote	Total
2003-04	-8.7	1.3	10.6	24.2	27.9	36.5	82.8	-0.2

The following table shows the variations across States and Territories in 2003-04 since 1995-96 in the numbers of full-time equivalent (FTE) GP's employed. Changes in percentages for the same period for full-time workload equivalent (FWE) are shown in bold⁷.

4 This data is drawn from the Australian Government Department of Health and Ageing Website under, *General Practice Statistics*, April 2005, Table 18 (Accessed in July 2005)

5 This data is drawn from the Australian Government Department of Health and Ageing Website under, *General Practice Statistics*, April 2005, Table 12: GP headcount by type and broad RRMA, 1995-96 to 2003-04 (accessed in July 2005)

6 This data is drawn from Table 6: GP headcount by RRMA, 1995-96 to 2003-04, accessed on the Australian Government Department of Health and Ageing Website, April 2005 (accessed in July 2005)

7 These data are drawn from Table 3:FTE GPs by State, 1995-96 to 2003-04 and Table 4: FWE GPs by State, 1995-96 to 2003-04 respectively, in the Australian Government's Department of Health and Ageing Website, April 2005 (accessed in July 2005). The explanatory notes for these General Practice Statistics are drawn from the following webaddress: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-gpstats-explan.htm>



Table 4: FTE and FWE⁸ GPs by State, 1995-96 to 2003-04

	Year	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	TOT
FTE ⁸	2003-04	2.4%	4.8%	13.6%	2.2%	5.9%	2.5%	17.4%	-8.0%	5.2%
FWE	2003-04	3.9%	3.3%	12.0%	4.5%	4.6%	1.3%	12.1%	-11.1%	5.1

These figures give a snapshot of changes in GP supply for the previous decade. The supply of general practitioners has increased substantially over this period in rural, and particularly remote, medical settings. We know little, however, of the 'qualitative component' behind these figures, namely, how well prepared GPs are for practice in these settings, the adequacy of this supply to meet growing demand or the longer-term practice intentions of the current GP workforce. The lack of longitudinally linked data precludes analysis of the retention of such practitioners.

Other measures addressing maldistribution of general practitioners

Other measures targeting supply and retention of general practitioners to areas where they are needed include initiatives granting access to Medicare Provider Numbers and to full Medicare rebates. A number of workforce programs have been introduced allowing for access by general practitioners (graduates and overseas trained doctors) to practice in certain settings. These exemptions follow the major changes to Medicare provider number access for new medical practitioners introduced in 1996 by the Australian Government.

The impact of the Operation of the Medicare Provider Number Legislation upon the quality, supply and distribution of the medical workforce has been reviewed in the Biennial Review of the Medicare Provider Number Legislation and a number of anomalies within the system have been highlighted (DOHA 2003). The Review noted the success of the implementation of measures under section 3GA of the Act to address shortages in both rural and after-hours workforces. As the Review stated, 'The workforce programs under 3GA accounted for 1081 doctor placements in 2002-03. The vast majority of these placements were in rural and remote areas' (DOHA 2003:25).

The proportion of vocationally registered general practitioners billing Medicare, whose country of initial medical training was overseas, increased to 24 percent in 2000 from 22 percent in 1998. The number of Other Medical Practitioners (OMPs) who received their initial medical qualification overseas, increased from 33 percent in 1998 to 40 percent in 2000 (DHAC 2005:109). Rural OMPs, whose work under a new program from January 2001 attracts Medicare benefits at VRGP rates in defined rural areas, illustrates the role of workforce support programs in increasing supply. The 2004 Review of general practice in Australia showed an 86 percent increase in the overall number of TRDs in the period from 1997-98 to 2001-02 (DHAC 2005:110).

More than half of the primary care workforce in remote areas is made up of Other Medical Practitioners (OMPs) and Temporary Resident Doctors (TRDs), who sought work in defined areas of doctor shortage in order to qualify to treat Medicare-subsidized patients. There have been reductions in the numbers of Medicare primary care providers occurring between 1995-96 and 2000-01 in capital cities (-7%) and other metropolitan centres (-2%), while the same period saw increases of between 22 percent and 28 percent or more in rural and remote zones (DHAC 2005:115). The 2004 Review into General Practice (DOHA 2005) notes that the figures for remote zones are distorted by the introduction of the ability to bill Medicare in Aboriginal Medical Services, creating apparent increased Medicare activity.

2.3 Pathways & Programs for Medical Practice in Australia

Overseas trained doctors are not a homogenous group. The Report by the Medical Training Review Panel into Overseas Trained Doctors identified the different pathways used by overseas trained doctors to enter the Australian workforce (MTRP 2004). These differ depending on:

- Residency status and visa class (such as,

⁸ FTE denotes Full-Time Equivalent; FWE denotes Full-Time Workload Equivalent. FTE is a modified count of doctors that takes into account the partial contribution of doctors who work less than full-time. FWE is a measure of medical workforce supply that takes into account the differing working patterns of doctors.

permanent/temporary resident and occupational trainee/Area of Need)

- Registration status (conditional vs general registration)
- Vocational status (general practitioner, specialist)

The MTRP Report noted the complexity of recruitment pathways, in that they may encompass a number of different organisations from government and or the private sector. Inconsistencies across States and Territories in pre-employment assessment of overseas trained doctors as well as gaps in the assessment of their skills prior to employment were also noted in the Report. A lack of flexibility in practice conditions was noted in light of the additional hurdles faced by 'conditionally registered' overseas trained doctors required to complete either the AMC pathway or the Fellowship pathway.

Australia's Five-Year Overseas Trained Doctor Recruitment Scheme

One of the most significant programs providing a pathway to employment and residency in Australia was the introduction in 1999 of the joint Australian-State & Territory 5 Year Overseas Trained Doctor Recruitment Scheme. This Scheme provides for conditional registration for doctors to work in rural areas for a period of 5 years with each State scheme aimed at those areas most in need. The main incentive for eligible overseas trained doctors who complete the 5 years in approved districts of workforce shortage and obtain the FRACGP, is a reduction in the 10 year moratorium on provider numbers under section 19ab of the Health Insurance Act 1973. The establishment of the State based Rural Workforce Agencies (RWAs) in 1998 have been critical to the implementation of the workforce programs.

The Scheme to-date has attracted approximately 250 OTDs with equivalent qualifications and/or experience to Australia (ARRWAG 2004: 3). A survey of respondents in the Five Year Scheme reported Western Australia with the largest numbers on the Scheme (34.5%), followed by Victoria (20.7%), NSW (15.2%), SA (10.3%), QLD (9.6%), TAS (8.9%) and the NT (3.4%) (AMWAC 2004: 4-5). Almost 63 percent of survey respondents had achieved permanent resident visa status while 37 percent held temporary residence status.

Workforce and Training Programs under Section 3GA of the Health Insurance Act 1973 have also been major factors in improving doctor numbers in rural and regional Australia (DOHA 2003) The major workforce schemes include:

- The Rural Locum Relief Program
- The Queensland Country Relieving Doctors Program
- The Approved Medical Deputising Service Program
- The Rural and Remote Area Placement Program and,
- The Temporary Resident Other Medical Practitioners Program (TROMP)

Doctor numbers in rural and remote areas over the period from 1995-96 to 2002-03 have increased by 9.3 percent in areas designated as 'Large Rural', 15.7 percent in 'Small Rural', 8.1 percent in 'Other Rural', 11.5 percent in 'Remote Centre', 32.5 percent in 'Other Remote', with a 15.5 percentage change for the category 'Total Rural and Remote' (Ibid: 30)⁹.

Training programs introduced over this period include the Royal Australian College of General Practice (RACGP) Training Program, and more recently, the Australian General Practice Training Program under the auspices of General Practice Education and Training (GPET). Key principles underpinning education and training in the Aboriginal and Torres Strait Islander Health sector include (GPET 2004a; GPET 2004b):

- Partnerships with Aboriginal people
- Cross-cultural training of educators
- Localised learning experience to address the diversity between communities
- Understanding holistic health care of communities
- Working as a team member and,
- Competency in a range of relevant clinical and public health skills

⁹ Information drawn from Table 1: Growth in General Practice Full-Time Workload Equivalent in Rural and Remote Areas, 1995-96 to 2002-03 (DOHA Dec 2003). Data on the specific placements for 2002-03 can be found in Appendix 0: Approved 3GA Workforce Program Placements in the Biennial Review of the Medicare Provider Number Legislation (Ibid).



Regional concerns progressing overseas trained doctors' pathways

Rural Workforce Agencies report various difficulties in relation to overseas trained doctors progressing their pathways. While some relate to the unique conditions within a given State or Territory, similarities of experience occur nationally as documented by the Confederation of Postgraduate Medical Education Councils (CPMEC) national scoping study (CPMEC 2004). The following is an overview of State based perspectives.

Northern Territory

Northern Territory's Rural Workforce Agency, General Practice and Primary Health Care NT, notes the 'limited preparation for living in the Territory' received by overseas trained doctors recruited to and practicing in rural areas, including remote practice and Indigenous health (GPPHCNT 2004a: 6). As the Agency notes, 'understanding the specific vocational pathway that the overseas trained doctor is on is critical to the provision of appropriate training, integration and support'. Given that the overseas trained doctor workforce is an essentially mobile and dynamic workforce, '*evidence based attraction and retention strategies*' need to be developed, as with the general workforce (Ibid). The GPPHCNT Report notes the significant cultural dislocation and social isolation of overseas trained doctors in the remote environment of the Northern Territory. Other difficulties experienced by overseas trained doctors include the duration and cost of travel to remote locations, limited specialist GP trainers, minimal provision of training outside urban centres and limited opportunities for pre-exam experience in mainstream General Practice (Ibid: 7). The training requirements in the NT include not only those of the FRACGP, but also of rural and remote practice, including primary health care, cross-cultural and language skills and multidisciplinary practice. Rural Workforce advocates note that the requirement of those on temporary resident visas such as the subclass visa 422 for full-time employment of 35 hours per week, does not provide a conducive environment for the training and study required to obtain the FRACGP (Ibid: 8). Further, '*families may be restricted from accessing Medicare and social security benefits, free school education, credit arrangements, property and investment – all significant investments to practicing in Australia*' (Ibid).

Western Australia

Western Australia is another state heavily reliant on overseas trained doctors to service unmet areas of need. The Rural Workforce Agency, WACRRM, has noted a lack of sufficient supervisors impacting on the support provided to overseas trained doctors to assist their professional integration. Further, research into the needs of overseas trained doctors in Western Australia reports that prior to coming to the State, many overseas trained doctors are unaware of assessment expectations and unsure how their qualifications and experience might meet those requirements (Roach 2005). WACRRM's analysis of the general practitioner workforce in rural and remote WA noted a 7 percent attrition rate of doctors per annum since the Five Year Scheme started in 1999 (Downs 2003: 50). The Report also noted several doctors had been 'conditionally registered' for ten years or more, illustrating the difficulties some overseas trained doctors experience with progressing their vocational pathways.

Victoria

The Rural Workforce Agency of Victoria has noted the following issues of relevance in relation to overseas trained doctors on the Rural Locum Relief Program (RLRP) and the Five-Year OTD Scheme:

- That undergraduate training has an important impact on whether the doctor has a patient-centred focus
- That cultural attitudes and religious beliefs can seriously impact on a doctor's attitude to Indigenous people or women
- That the reasons for leaving their country of origin can have an impact on how well they settle into a community and,
- That refugees who have experienced human rights abuses may not seek help and may suffer severe post-traumatic stress disorder (Greacen undated: 7).

Victoria's rural retention study found the provision of examination preparation support (for both the AMC and/or FRACGP) to be a critical issue, with only 31 percent of overseas trained doctors reporting satisfaction on this score (Hawthorne et al 2003: 75). Their study also reported differences between those on the Victorian Overseas Trained Doctor Rural Recruitment Scheme (VORRS) and the Rural Locum Relief Program (RLRP). The profile of VORRS doctors

indicated that they were highly sought after by medical employers, were offered longer term contracts and work immediately following arrival; whereas RLRRP doctors were more likely to be of non-English speaking background, to have relatively poor English, to have experienced career gaps, and to have been offered short-term work (Hawthorne et al 2003:76). The implications of this for rural retention were that temporary resident VORRS doctors were more likely to remain in Victorian rural general practice.

New South Wales

An audit of Area of Need doctors in December 2002 in New South Wales, found 64 percent of permanent resident doctors had passed the Multiple Choice Question (MCQ), the clinical or the College exams, with only 15 percent of temporary resident doctors completing these exams (NSW Health 2003). Half of the permanent resident doctors expressed 'gratitude' at being able to work in the health care system and resume their medical careers through the Area of Need (AoN) program. This masks the significant amount of deskilling and 'brain waste' of permanent resident doctors in Australia who have been unable to progress their career pathway. Temporary resident doctors under the AoN program were less satisfied with their experiences, with only 24 percent expressing satisfaction (Ibid 2003: 9). Their frustrations related to a lack of coordination and synchronization of the recruitment and employment process in relation to obtaining visas, being granted access to Medicare for their own family's health needs, their assessment and their registration. A number of the temporary resident doctors surveyed were critical of the role of the recruiting agencies in not providing accurate information about the job and feeling misled about the expectations for the job - prompting decisions to return to their countries of origin. The Report also found that many staff were unfamiliar with requirements and processes involved in the Area of Need program.

Recent and current initiatives under Medicare Plus, however, are addressing the increased resources required by organizations like the RACGP and the Divisions to support orientation and induction programs to ease the pathway, to provide guidelines about the job and its expectations and to increase mechanisms for promoting awareness of support and assistance.

2.4 Relocation and Orientation for practice in an Aboriginal and Torres Strait Islander health setting

The national scoping study into education and training for overseas trained doctors in Australia (CPMEC 2004) found that many overseas trained doctors face significant professional and personal difficulties in seeking to practice medicine in Australia and other comparable Western countries. Their review identified recurring themes in the national and international literature including, differing levels of English proficiency, communication and cross-cultural competencies as well as differing levels of medical knowledge and skills. The scoping study also noted the significant life stressors involved in the adjustment to migration. These ranged from loss of networks of support and self-esteem to the additional financial responsibilities tied up in the relocation experience (CPMEC 2004: 39). Further, research into the needs of GPs and GP registrars working in Aboriginal and Torres Strait Islander health noted an 'unrealism of expectation' for many acclimatizing to their new practice role (Death et al 2002: 3).

The survey of doctors working in rural and remote locations under Australia's five-year overseas trained doctor recruitment scheme, provides insight into the types of problems doctors experience with relocation to a new country and to how these problems impact on the employment experience (AMWAC 2004). These problems were particularly evident for temporary resident doctors and those with 'conditional registration'¹⁰. They include:

- *Substantial costs incurred in the relocation process*
- *Difficulties obtaining bank loans and credit*
- *Expenses such as boarding schools and child-care*
- *High costs of premiums for vehicle insurance*
- *Lack of medical coverage for the family*
- *Lack of permission for spouse to work*
- *Poor quality accommodation*

¹⁰ The specific comments of the overseas trained doctors reported in the AMWAC Survey are available at Appendix B of the Report (AMWAC 2004.3 August 2004).



- *Lack of orientation to the local practice and local community*
- *Lack of information about Medicare and the Pharmaceutical Benefits Scheme*
- *Travel costs incurred in the remote location*
- *'Culture shock'*
- *Lack of acceptance for some by local general practitioners*
- *Costs of reapplication for temporary visas*
- *Difficulties passing assessments*
- *The 'coercive' element of the Scheme (being tied to a placement for 5 years)*
- *A feeling that life was 'on hold' for temporary resident doctors until permanent residency was obtained*

Problems reported in the context of medical practice in remote locations - most likely in practice with Aboriginal and Torres Strait Islander communities - include:

- *Remoteness of the geographic environment*
- *Degree of morbidity and mortality encountered*
- *Problems experienced with the 'culture of the service'*
- *Difficulties with colleagues*

In light of the unique stressors of medical practice in the remote area context the Report suggests increased program flexibility with the ability to change States within the 5-Year Contract and differentiating the length of the contract period across RRMA areas (AMWAC 2004: 9). These recommendations have been made elsewhere (Boffa 2002).

The problem of orientation to a new environment was noted in the NSW audit of Area of Need (AoN) positions (NSW Health 2003). Twenty eight percent of respondents indicated some form of orientation. This emerged as a problem for practitioners in private practice in particular, with only 16 percent participating in an orientation program compared with 51 percent of doctors employed in public sector positions (Ibid: 6). Elsewhere, overseas trained doctors have reported the limitations of initial orientation if not continued over

the first 6 months of working in a new position (Roach 2005).

Wolfe (quoted in QRMSA 2004:5) has identified key attributes relating to selection criteria for successful international relocation. These include:

- Cultural adaptability, including cross-cultural fluidity, previous overseas experience, cultural sensitivity and tolerance of ambiguity
- Maturity, stability and ability to adapt behavioural style
- Realistic identification of the needs of the family and involving the spouse/family in the selection process from the start and
- Clinical competencies

The success (or otherwise) of the relocation experience raises the need for an expanded repertoire of competencies to inform assessment in a globalised medical labour market.

2.5 Professional Integration of Overseas Trained Doctors into Aboriginal and Torres Strait Islander Health Environments

National concerns

Numerous reviews and research to-date highlight conceptual and operational anomalies with the system designed to address recruitment and integration of overseas trained doctors (MTRP 2004; CPMEC 2004; Hawthorne et al 2003). It is argued that these problems have their roots in the role the medical profession has historically played in manipulating supply and demand conditions, including in strictly directing the registration and labour market access of overseas-trained doctors (Groutsis 2003). Further, policies and processes evolved in a fragmented and inequitable manner, designed up until the nineties at keeping overseas trained doctors out of the medical system, and from the mid-nineties onwards, intensifying initiatives to recruit temporary resident doctors as an interim workforce. Tensions in the system, both in Australia and elsewhere, have been identified at a number of levels (DOHA 2003; Dauphinee 2003). These tensions include:

- Lack of congruence between the needs of the system and the needs of many overseas trained doctors
- Differential requirements for practice between permanent resident and temporary resident overseas trained doctors
- Employers' service provision obligations and public concerns over standards of practice
- Concerns that supply pressures will compromise standards of training and preparation for local practice environments
- Concerns related to clinical, linguistic and cultural competencies

McGrath (2004) points to the lack of a national approach supporting the integration of OTDs into the workforce. He summarises the areas needing urgent policy attention as:

- Information access
- Orientation to Australian health care systems and specific workplaces
- Communication between patients and healthcare professionals
- Nationally consistent standards for skills assessment and education and training support
- The capacity of the system to support ongoing initiatives

The mid-term review of the *Medicare Provider Number* legislation identifies workforce pressures leading to increasing exemptions under section 3GA of the Act, prompting concerns that the intention of section 19AA of the Act to maintain the quality of the workforce may in fact be compromised (DOHA 2003). The Review calls for steps to ensure quality of the general practice workforce, particularly in relation to workforce programs in which overseas trained doctors are employed. Increased supervision and educational support for overseas trained doctors are identified as areas needing specific attention.

In their review of Aboriginal and Torres Strait Islander primary health care and general practice, Anderson and Wakerman note the '*different style and quality of practice*' inherent in addressing the health needs of

Aboriginal and Torres Strait Islander peoples (DHAC 2005: 312). They relate this to the complexity of the consultations, the socio-economic disadvantages impacting on the community, the extent of co-morbidity, and, in the Aboriginal and Community Controlled Health Services, the use of Aboriginal health workers as a first point of contact.

A study into the support and training needs of general practitioners (GPs) and general practitioner registrars working in Aboriginal and Torres Strait Islander Health, found thirty seven percent of GPs and eighteen percent of GP supervisors had received no formal training in Aboriginal and Torres Strait Islander health prior to working in that area (Death et al 2002:18). Although respondents in this study indicated a high level of interest in Aboriginal and Torres Strait Islander health, overall response rates were low. The experiences of the non-responders in the study may tell an interesting story but there is no indication as to whether the profile of respondents in the study correlates to the profile of general practitioners who work in Aboriginal and Torres Strait Islander health. Respondents were not asked to indicate whether they were overseas or locally trained, or whether they were temporary or permanent resident overseas practitioners. Therefore, any differences in the professional experiences of general practitioners working in an Aboriginal and Torres Strait Islander setting could not be teased out according to country of training, occupational visa category or language or cultural 'distance'.

Respondents in the RACGP study expressed the great benefits of working with and learning from elders, community members, and Aboriginal health workers (Death et al 2002). As the Report noted, '*partnerships between general practitioners and members of the ATSI community offered a different approach to health and ownership of health services*' (Ibid: 2). The provision of local level cultural awareness training was identified as most beneficial given the differences between communities. This also applied to the provision of in-depth community based cultural awareness training over and above that provided by a vocational training curriculum. The most highly rated training methods were visits to Aboriginal and Torres Strait Islander community centres, workshops and cross-cultural camps (Ibid: 21). This 'immersion' in Aboriginal and Torres Strait Islander communities was regarded as most helpful as in the case of the Aboriginal community controlled health organisations. General



practitioners valued small group discussions and the use of general practitioner mentors as the best methods of support in Aboriginal and Torres Strait Islander health. In addition to practice specific training needs are the support needs in common with all general practitioners working in a rural and remote environment. These include, access to time off for continuing medical education, and for overseas trained doctors, supervisory and educational support necessary to progress specific vocational pathways.

The RACGP study raised the issue of the *'right personality and temperament'* for working in an Aboriginal and Torres Strait Islander environment (Death et al 2002:31). Gruen and Yee's article in the MJA (2005) also illustrates the types of skills and attributes that might be needed to function effectively in this environment. This begs the question of what type of skills and experiences do overseas trained doctors bring with them that may have a bearing on the Aboriginal and Torres Strait Islander environment, and further, what is the transforming effect of the experience of partnership between themselves and the community in which they practice.

The Confederation of Postgraduate Medical Education Councils (CPMEC) National Scoping Study noted that the knowledge, skills and experience of overseas trained doctors and the collective diversity of their experience are not always acknowledged (CPMEC 2004:53). The importance of *'learning from each others' stories'* (cf. *editorial, MJA, Indigenous Health, 2005*), suggests strongly the importance of documenting these narratives.

Suggested attributes for overseas trained doctors working in Aboriginal and Torres Strait Islander health

- Prior knowledge and interest in Indigenous and remote area health in countries of origin
- Sensitivity to different cultural groups
- Openness to alternative healing practices and health beliefs
- Capacity to be transformed by different experiences
- Openness to different styles of learning
- Ability to adapt to resource poor environments

- Adjusting expectations in remote or high need contexts

These issues have a bearing on the selection process. However, as noted earlier in this Review, it is not clear how the element of 'coercion' to practice in a particular workforce program for a specified number of years – a common experience amongst overseas trained practitioners in rural and remote locations – impacts on their professional and social integration.

State and Territory approaches to professional integration of overseas trained doctors

State and Territory initiatives to enhance and support the training and professional development of overseas trained doctors in their clinical capacity have been collated by the Confederation of Postgraduate Medical Education Councils (CPMEC). Reporting by the Rural Workforce Agencies to the CPMEC's national scoping study (2004) has identified problems with the implementation of some of these initiatives. The following is a snapshot of some of these difficulties.

Northern Territory

- Lack of suitably trained and resourced staff to ensure appropriate supervision of conditionally registered medical practitioners
- Lack of introduction to the Australian health care system
- Need for individual clinical evaluation of prior clinical experience
- Need for competency assessment as well as general support mechanisms

Queensland

- Lack of standardised assessment procedures for the majority of OTDs
- Over-reliance on temporary resident doctors
- On-going public concerns about clinical safety

Victoria

- Assistance needed with registration and preparation for examinations
- Variation in the quality of doctors joining the Rural Locum Relief Program (RLRP) and lack of a clear pathway for RLRP doctors to obtain Fellowship while they are on the Program.

2.6 Social Integration of overseas trained doctors practicing in Aboriginal and Torres Strait Islander health environments

While professional considerations are mostly at the forefront of what attracts doctors to a particular job, it is often factors associated with the family's social integration that results in doctors leaving their placement. A national survey of doctors working in rural and remote locations under Australia's five-year overseas trained doctor recruitment scheme found acceptance by the local community, educational opportunities for children and access to essential goods and services key factors associated with satisfaction with practice location (AMWAC 2004:10). About half of those surveyed (50.7%) expressed satisfaction with access to social, cultural and recreational activities. Fifty eight percent of those surveyed expressed satisfaction with opportunities to engage in spiritual and religious activities. Overseas trained doctors were least satisfied with work opportunities for their spouse (42.7%) and with educational opportunities for their spouse (32.4%).

A study of overseas trained doctors' community integration and retention intentions in rural communities throughout Victoria found maintaining cultural and religious values as well as relationships to their respective ethnic communities to be important (Han and Humphreys 2005). Overseas trained doctors in this study expressed their appreciation of communities that could 'embrace differences' and which provided some form of welcoming such as, introductions in the local paper and the provision of temporary accommodation. The study noted the role of local community support in facilitating integration of overseas trained doctors and their families into the community as well as the converse, that discrimination and indifference caused anxiety and discomfort and resulted in families leaving as soon as possible. As the authors noted, *'issues of discrimination (both overt and covert), the importance of meeting ethnic, cultural and religious needs, and the need to facilitate appropriate educational and spouse requirements are fundamental issues that partially differentiate OTDs and Australian-trained graduates'* (Han and Humphreys 2005: 239).

Supportive community integration arrangements in remote area settings are particularly important to address the unique problems of geographic, social and 'cultural' isolation. In the context of the Northern

Territory, Boffa has outlined some of the supportive arrangements for general practitioners and their families (Boffa 2002:302). In particular, those facilitating social integration include:

- Site visits - to visit the community and facilitate the interviewing process
- Orientation and Training Grants – two to three weeks orientation on full-pay including, cross-cultural as well as clinical orientation
- The Family Support Program – regular funded trips for remote GPs and their families to visit Darwin or Alice Springs for networking and relaxation
- Grants for doctors' children to attend sporting and other events in regional centres
- Spouse re-training grants

Rural Workforce Agencies have been pivotal in providing support to overseas trained doctors and their families in rural placements.

A collation of 'best practice' in the area of community support and integration would be a valuable addition to the literature on overseas trained doctors in localised practice environments. A similar exercise by the Aboriginal Community Controlled Health Organisations (ACCHOs) would also be instructive.

2.7 Interaction with Aboriginal and Torres Strait Islander communities

A sizeable body of literature addressing doctor-patient communication exists. This literature highlights the correlation between effective communication and improved health outcomes, including physiological criteria. Conversely, professional, language and cultural barriers can impede communication. However, few investigators have studied the extent and consequences of miscommunication in Australian Aboriginal health care (Cass et al 2002). A study researching the interactions between renal staff and Yolngu patients in a satellite dialysis unit in Darwin, revealed the following recurring themes (Ibid: 466-470). These included:



- *Lack of patient control over the language, timing, content and circumstances of interactions*
- *Differing modes of discourse with the dominance of the biomedical model and marginalisation of Indigenous (in this case Yolngu) knowledge*
- *Lack of shared knowledge and understanding of key concepts resulting in cultural and linguistic distance*
- *Lack of staff training in intercultural communication and lack of involvement of trained interpreters*
- *Miscommunications often going unrecognised and a lack of tools or guidelines for assessing the extent of miscommunication*
- *Absence of resources to construct a body of shared understanding*

McDonald's research supports the view that Western health professionals and their Indigenous clients lack insight into each other's 'cultural knowledge' (McDonald 2004). In her research she noted that, 'while Indigenous people may use Western disease labels, they interpret these disease processes in Indigenous cultural terms' (Ibid: 2). Her observations of information exchange in the provider-client relationship show a two way process with both the knowledgeable person and the questioning person contributing to the information. She observes that, '*White people in positions of power frequently ask direct questions in ways which are highly inappropriate to Indigenous ways of interacting*' (Ibid: 5).

The political and cultural orientation of Aboriginal Community Controlled Health Organisations leads to distinctive organisational features (Taylor et al 2001). This has implications for interactions between the staff employed by the service, and, between staff and the communities they serve. The negotiation of different '*cultural domains*' has been explored in relation to Aboriginal and Torres Strait Islander Health Managers in Aboriginal Community Controlled Health Organisations (Hill et al 2001). Little, if any, information exists however, on how overseas trained doctors negotiate the different '*cultural domains*' they find themselves in.

Within the medical literature are numerous personal perspectives of general practitioners working within an Aboriginal and Torres Strait Islander environment. These experiential accounts illustrate the '*cultural distance*' that doctors must negotiate. These include accounts of learning who to converse with in a community, which may sometimes be the patient, their family, or other community members, such as

traditional healers or elders from the church; and the lack of competition between these different members in offering knowledge about the patient's condition or their treatment plan (Abrahams 2005). Gruen and Yee's (2005) personal perspectives of working in remote area Aboriginal health as 'transient non-Aboriginals' suggest the types of skills and attributes that might be needed to function effectively in a remote Aboriginal context. Their narrative account illustrates the experience of transformation gained by the partnership with an Aboriginal community, one in which 'humility' is experienced. The sense of forbearance by the community in the face of undiagnosed and untreated illness raises the need for advocating preventative and early treatment health programs as well as the provision of health education, 'which involve more than just the standard doctor-patient relationship' (Gruen and Yee 2005).

In their editorial, Armstrong and Van Der Weyden (2005: 499) talk about the importance of partnerships based on hearing and understanding each other's stories as the basis for working together. Being an overseas trained doctor is yet another layer of the health professional experience. The lack of any research into their interactions within diverse health care settings in the Aboriginal and Torres Strait Islander context does raise some pertinent questions. These include:

- Are the experiences of overseas trained doctors essentially the same or similar to those of Australian trained doctors working in the Aboriginal and Torres Strait Islander setting?
- Do overseas trained doctors have to negotiate multiple '*cultural domains*' when practicing in an Aboriginal and Torres Strait Islander workplace or community setting, or are all non-Aboriginal doctors, whether overseas trained or Australian trained, '*outsiders*' in an Aboriginal medical setting?
- Are the perceptions in Aboriginal Medical Services or Aboriginal and Torres Strait Islander communities, in relation to the worth of overseas trained doctors, mediated in any way by experiences of their '*foreign-ness*'?
- How might the past employment and lived experiences of doctors, whether trained overseas or locally, have a bearing on the specific skills, attributes and characteristics required to function effectively in the socio-cultural environment of Aboriginal and Torres Strait Islander medical practice, particularly, in remote environments?

2.8 Developing Cultural Awareness for practice in Aboriginal and Torres Strait Islander health

The development of 'culture' as a competency has arisen not only in response to recognising diversity and the needs of more marginalised cultures in the population but in recognition of the diversity within the medical workforce itself (MCNZ 2005). In their discussion document, the Medical Council of New Zealand (2005: 2) notes how common cross-cultural doctor-patient interactions are and therefore, the importance of doctors acquiring cross-cultural competencies. In New Zealand, a statutory obligation exists for the Medical Council to ensure the cultural competence of practitioners, with the introduction of the Health Practitioners Competence Assurance Act in September 2004. In practise, this means that the doctor has the attitudes, skills and knowledge needed to achieve cultural competence. As the Medical Council of New Zealand's discussion document on cultural competence asserts (2005: 4), *'In the New Zealand context, a culturally competent doctor will acknowledge the status of Maori and the Treaty of Waitangi in the New Zealand health sector; that NZ has a culturally diverse population; that a doctor's culture and belief systems influence his or her interactions with patients and accept that this may impact on the doctor-patient relationship, and that a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding'*.

The Australian Health Ministers' Advisory Council prepared a 'Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009' (AHMAC 2004). The framework was developed in recognition of the urgent need to improve the health outcomes of the Aboriginal and Torres Strait Islander populations in Australia and the growing recognition that health and health care is culturally constructed. The report acknowledges that social interactions at the service interface will be influenced by the following factors: (Ibid 2004: 6):

- The attitudes of the individual to their own health status
- When and why Aboriginal communities access services

- Their acceptance or rejection of treatment
- The likelihood of compliance with treatment recommendations
- The likely success of preventative and health promotion strategies
- The assessment of quality of care
- Perceptions of health care providers and personnel

In Australia, assessments of competence of communication skills (as distinct from linguistic proficiency) and cultural awareness are not included in current assessments of overseas trained doctors (Van der Weyden and Chew 2004). The Review of Cultural Training for GPs working in Aboriginal and Torres Strait Islander Health found that cultural training is limited for GPs working in Aboriginal and Torres Strait Islander health (RACGP 2004:6). Only fourteen percent of respondents in the RACGP survey indicated they delivered training during the period from 2002. This meant that 122 responding training organisations were not involved in cultural training for GPs at that time, despite a need being acknowledged by them. Most rural workforce agencies were involved in training and worked with State affiliates of NACCHO to deliver training for general practitioners working in Aboriginal and Torres Strait Islander Health. This training was mostly targeted at locums and overseas trained doctors and was delivered in rural and metropolitan centres in all States and the Northern Territory. Eighty percent of this training was accessible to GPs in private practice, 41% to doctors in Aboriginal Community Controlled Health Services (ACCHSs) and 32% to doctors in other clinical settings (Ibid: 6). Some important issues have emerged as a result of the RACGP review. These include:

- The need for more Aboriginal and Torres Strait Islander involvement in cultural training, particularly in the area of training evaluation
- The need for improved prior assessment of participant's learning needs to ensure program relevance, and importantly,
- The lack of flexibility in program delivery, which is currently aimed at giving access to knowledge, but not at changing attitudes and behaviours facilitating changes in participants' work practices towards the provision of 'culturally safe' services



McDonald's (2004) ethnographic research highlights the limitations of many cultural education programs for Western health professionals. She argues the need to go beyond cultural awareness and competency training to develop the capacity to engage in ongoing intercultural dialogue with Indigenous staff and patients, and, the ability to switch between Western Indigenous modes of knowledge and practice (McDonald 2004:1). Understanding for example, that consultations with traditional healers can be a priority in facilitating treatment options is also an important part of creating a flexible and cultural environment for Indigenous patients (Westmore 2004).

A Quantitative Evaluation of Aboriginal Cultural Awareness Training in an Urban Health Service (Mooney et al 2005) shows that one-off interventions, or brief cultural awareness training programs have little impact on perceptions or beliefs of health care staff towards Aboriginal People. The evaluation however, did find that the areas where the cultural awareness training intervention had a positive effect were on familiarity or friendships with Aboriginal people, and, increased understanding of the complexity of Aboriginal health problems. Developing the competencies to facilitate changes in medical work practices and interactions, appear to involve a different process and type of skill development from awareness of culture per se.

The Rural Workforce Agency of Victoria has identified as a requirement of general practitioners, and particularly those trained overseas, that they gain an understanding of Aboriginal culture through Koori cross-cultural training. This training is delivered by the local Aboriginal Community Controlled Health Organisation in Victoria, VACCHO (cf MOU between RWAV and VACCHO).

In the dialogue between general practitioners and Aboriginal and Torres Strait Islander communities the issue arises as to the telling of their *respective stories* (cf. *Indigenous Health: partners in healing*, MJA 182 (10), 2005). The emphasis in improving access to general practitioner's services requires that doctors are capable of practicing in a culturally safe way. However, what is often overlooked is the community's understanding of the background, experiences and cultural perspectives of the doctor.

2.9 Retention of Overseas Trained Doctors in Aboriginal and Torres Strait Islander Health

The success of policy initiatives in increasing the supply of doctors to areas of workforce need, and in providing incentives for permanent migration, have been outlined (MTRP 2004; Birrell 2004). While there has been increasing utilisation of primary health care services in Aboriginal communities (Bartlett and Boffa 2001), there remains a persistent problem in recruiting and retaining suitable general practitioners to work in Aboriginal health care in areas such as Central Australia (Boffa 2002).

There is increasing recognition that retention involves a different set of issues from recruitment, and further, that integration into a given community is positively related to retention (Veitch 2002). Issues impacting on overseas trained doctors' retention in rural areas share much in common with locally trained doctors, in particular, concerns over quality of children's education and work opportunities for spouses. Other factors such as lack of facilities in rural and remote areas, problems with availability and quality of housing, problems with transport and other expenses incurred in isolated living have also been documented (Death et al 2002).

Ability to retain links to cultural and religious communities has been shown to impact on the level of life satisfaction in rural communities (Han and Humphreys 2005). The need for socio-cultural support and proximity to ethnic community however, has been shown to vary in importance for doctors from different ethnic and cultural backgrounds (Hawthorne et al 2003). Acceptance by the local community is a key factor influencing a positive view of work location (AMWAC 2004). Many rural communities may have had little exposure to people from other cultures and may not initially welcome an OTD with different customs and beliefs. Communities may need assistance to recognise the benefits of an OTD and may benefit from an introduction to the 'culture' of the overseas trained doctor (ARRWAG 2004:14-5).

Case studies of successful community based initiatives welcoming overseas trained doctors and their families and assisting in their integration would make a very valuable contribution to the literature, both in identifying enablers of retention and in informing analysis of decision making around practice and migration intentions.

The ability to successfully resolve professional and social concerns is the key to longer-term retention (Kamiens 1998). Baseline data examining the practise and migration intentions of doctors is emerging. A review of the Five-Year Overseas Trained Doctor Recruitment Scheme indicated above average intentions to remain in rural locations longer term, and were associated with overall satisfaction with the location, working conditions and the medical education and training program provided (AMWAC 2004). The limitation in the research on rural retention remains the lack of any follow-up to determine outcomes over time and determinants of change in circumstances.

An evidence based review of the literature examining the recruitment and retention of general practitioners to rural areas has identified the predictors for recruitment and retention of doctors in rural practice (McDonald J et al 2002). The key predictors are associated with the doctor or spouse having a rural background, undergraduate and postgraduate experience in rural practice. This raises the issue of improved selection criteria for rural and remote recruitment and the need for longer-term follow-up to determine the relationship of recruitment selection and retention in rural and remote environments.

In addition to the general problems of retention in rural areas, there are problems retaining doctors practicing in Aboriginal community controlled services and in the remote Aboriginal communities. These include the problems of burn out due to inadequate locum relief, inadequate support for the family and the social and cultural isolation of practicing in these environments. A report into the needs of general practitioners and general practitioner registrars working in Aboriginal and Torres Strait Islander Health suggests that one of the key factors contributing to this situation are the inadequate funding arrangements for Aboriginal and community controlled health services, *'resulting in poor resourcing and remuneration for these posts and an unstable working environment, with continual turn over of staff'* (Death et al 2002: 32). The report also found that general practitioners often left practice in Aboriginal and Torres Strait Islander health because of their frustration at not being able to achieve more as a result of the difficult problems encountered and a lack of resources and support in dealing with these problems (Ibid). The RACGP Report (Death et al 2002) also raises the issue of 'unrealistic expectations', a theme that is echoed elsewhere (Anderson 2002).

The Australian Rural and Remote Workforce Agencies Group has made the recommendation that *'realistic professional and personal needs of both the employer and the overseas trained doctor (and their family) need to be considered in determining suitable placements'* (ARRWAG 2004). This illustrates the importance of transparency in pre-employment orientation and cultural awareness programs, the need to improve the criteria for recruitment to practice in an Aboriginal and Torres Strait Islander and remote area health setting, as well as more information provided to employers about the characteristics, needs and practice intentions of overseas trained doctors.

The lack of flexibility in workforce programs, requiring overseas trained doctors with conditional registration to practice in remote environments for a fixed period of years, has been identified as a further factor mitigating against recruitment and retention (Death et al 2002). It is argued that overseas trained doctors practicing in remote area health should be able to work in more than one State and local Area of Need while meeting the requirements of workforce programs. Attempts to compel overseas trained doctors to Areas of Need have met with mixed success and are the cause of resentment by some doctors (Hawthorne et al 2003; AMWAC 2004). Boffa (2002) has argued the need for the introduction of non-financial incentives that link voluntary years of service in areas of need (whether in urban, rural or remote areas) to preferential access to the career pathway of choice. Adequate incentives – both financial and non-financial - may open the way for a pathway specialising in Aboriginal and Torres Strait Islander health for overseas trained doctors and interest in this option is worthy of investigation. Financial incentives to support this option include the provision of geographic provider numbers and grant payments to bulk billing GPs in Areas of Need, and, extension of the 'concept' of the Remote Area Grants to apply in all areas of need. This argues Boffa would, *'address one of the major access barriers to GP's for poorer people - the lack of bulk billing'* (Boffa 2002:301).

State and Territory concerns around retention

Northern Territory

A study into GP remuneration found a high level of differentiation in the base salary (as well as other conditions and benefits) offered to general practitioners in Aboriginal health care in the Territory (GPPHCNT July 2004b).



Queensland

The Rural Workforce Agency in Queensland has noted a number of strategies used to facilitate retention including, financial incentives, locum support, professional support, and the establishment of mentoring and support networks. However, it is argued that *'perhaps the strongest retention strategies will be those that support changing work patterns, and provide flexible career paths, ensuring professional and family/ personal needs are met'* (QRMSA 2004:8).

Further, the reliance on temporary resident doctors in Queensland to fill areas of workforce shortage has created a, *'fragile service environment in rural and remote areas reflected in the relatively high mobility of the medical workforce (greater than 25% turnover in a 6 month period in RRMA7 with serious implications for continuity of care and development of preventative health care, particularly impacting on remote indigenous communities ...'* (QRMSA 2004:5). Specific consideration in the Queensland context therefore needs to be provided to temporary resident doctors. New models of support, specifically for remote practice, have been proposed and include culturally appropriate multidisciplinary service provision, whereby all health professionals participate in cultural awareness training, receive orientation to remote and Indigenous environments, and are linked to local community mentors (QRMSA 2004:16).

Victoria

Retention research in Victoria found extreme hyper-mobility of overseas trained doctors both internationally and within Australia. It was also found that access to good education for children was a key determinant of retention, resulting in moves to metropolitan areas once general registration was achieved (Hawthorne et al 2003). Other factors impacting on retention were access to examination preparation and training courses, access to well-paid medical jobs and improved collegiate support (RWAV November 2003).

Western Australia

In Western Australia, the Rural Workforce Agency (WACRRM) reported to the CPMEC national scoping study (2004) that of overseas trained doctors who initially come to work for periods of 6 months to 2 years, around 25 percent will decide to stay longer term. Further, over 60 percent of the doctors working on the OTD Five Year Scheme have obtained permanent residency (CPMEC 2004:61).

Challenges to retention have been identified in a national stock-take of rural health (Best 2000). These include social dislocation, professional isolation, community acceptance and succession planning. The ability to effectively monitor retention requires that data systems have the capacity to collect information that can be utilised for this purpose. In its review of the Australian Rural and Remote Workforce Agencies Group (ARRWAG) Minimum Data Sets (MDS) (ARRWAG 2003), it was noted that while temporary resident doctors make a significant contribution to the rural and remote workforce in Australia, this item was not included in the current version of the MDS which reports on the national picture. The issue of a standardised data collection system is currently on the agenda but a major challenge is to overcome discrepancies between State and Territory data collections. Secondly, there is concern that movement of health professionals into emerging areas of workforce shortage will impact on the rural and remote general practice workforce (ARRWAG 2005). There is, however, little knowledge of the translocation of workforce flows within and between States and Territories and more work is needed to compare the impact of various policy interventions on longer-term supply in rural areas. Finally, a further limitation noted in the area of workforce dynamics is the lack of information about the movement of doctors into and out of rural areas. The development of data systems capable of 'tracking' these groups of doctors would provide not only useful information on the dynamics of the workforce but would also enable us to gain a more comprehensive picture of the flows of medical practitioners from overseas to see what happens to them in practice (ARRWAG 2003).

Conclusion

Australia's diversified medical workforce, as well as cultural, social and economic diversity within the population, underscores the need for an increasingly complex environment of support to address language, cultural and institutional differences. Differential experiences of professional and social integration into medical practice by country of origin as well as by differences in registration, residency and vocational status have been noted, although these require further research in a range of diverse practice settings and ongoing monitoring and evaluation to determine the impact of current and recent policy initiatives. Further, it has been argued, that medical practice in an

Aboriginal and Torres Strait Islander context requires specific skills and attributes not suited to all doctors, and that these practice environments are further diversified by location and organisational 'culture' and setting.

There is yet to emerge a body of literature articulating the specific experiences of overseas trained doctors working in Aboriginal and Torres Strait Islander Health, and the experiences of these services with doctors trained overseas.

The literature review highlighted the following issues:

- Much of the core literature in this area is policy driven but lacks the depth of research to inform and refine it
- Much of what we know is drawn from particular methodologies. These include the use of survey questionnaires, stakeholder consultations and focus group interviews
- Ethnographic and other qualitative methodologies have been used to research patient-doctor communication in the Aboriginal health setting. The specific experiences of overseas trained doctors, as another layer of the health professional experience, have not been studied
- The use of in-depth qualitative research techniques, such as a grounded theory or ethnographic approach, would be valuable methods for exploring the 'cultural spaces' and the dynamic interactions within a team or community environment
- Longitudinally linked data collection is also an underutilised research methodology given its suitability to studies of transient or mobile populations. These include populations with uncertain residency and practice outcomes, such as conditionally registered overseas trained doctors
- Much of the literature into overseas trained doctors addresses recruitment and employment in rural and remote areas, or in selected hospital environments. There is little, if any information in the public domain about overseas trained doctors working in urban or outer metropolitan Aboriginal medical settings. Given that the urban areas have the greatest number (as opposed to proportions) of Aboriginal people residing there, and, that outer metropolitan areas have been included in policy

addressing emerging workforce shortages, this is a significant gap in our knowledge.

The lack of a specific focus on the experiences of overseas trained doctors in Aboriginal and Torres Strait Islander health settings leaves open a number of interesting research avenues. The following gaps in our knowledge constitute a good starting point for further research in this area.

1. Are the experiences of overseas trained doctors essentially the same or similar to those of Australian trained doctors working in an Aboriginal and Torres Strait Islander health environment?
2. Do overseas trained doctors have to negotiate multiple 'cultural domains' when practicing in an Aboriginal and Torres Strait Islander workplace or community setting, or, are all non-Aboriginal doctors, whether overseas trained or Australian trained, considered 'outsiders' in an Aboriginal health setting?
3. Are the perceptions in Aboriginal and Torres Strait Islander communities, in relation to the worth of overseas trained doctors, mediated in any way by experiences of their 'foreign-ness'?
4. How might the experiences of overseas trained doctors working in urban and outer-metropolitan Aboriginal and Torres Strait Islander settings compare with their counterparts in rural and remote areas?
5. How might the past employment and lived experiences of doctors, whether trained overseas or locally, have a bearing on the specific skills, attributes and characteristics required to function effectively in the socio-cultural environment of Aboriginal and Torres Strait Islander health practice in all settings, but particularly those in remote environments?
6. Further, how might good qualitative research, grounded in the local practice environment, contribute to the development of vocational assessment criteria of doctors' suitability for practice in an Aboriginal and Torres Strait Islander, and/or, remote area environment?

REFERENCES

ABS (Australian Bureau of Statistics) (2005). *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Cat. No. 4704.0 Australian Bureau of Statistics, Canberra

ABS (Australian Bureau of Statistics) (2004) *Migration 2002-3*. Cat. No. 3412.0 Australian Bureau of Statistics, Canberra

ABS (Australian Bureau of Statistics) (2002) *Year Book Australia 2002 Population International Migration*, Australian Bureau of Statistics, Canberra

AGPT (Australian General Practice and Training) (2004). *A Framework for General Practice Training in Aboriginal and Torres Strait Islander Health*. Canberra. Accessed on the following website: <http://www.agpt.com.au/pdf/A%20Framework%20for%20GP.pdf>

AHMAC (Australian Health Ministers Advisory Council) (2004). *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*. Published by the Department of Health, South Australia, March 2004. Accessed on the following website: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-crf.htm/\\$FILE/Cultural_Respect_Framework.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-crf.htm/$FILE/Cultural_Respect_Framework.pdf)

AIDA (Australian Indigenous Doctors Association) (Minniecon D & Kong K). (2005) *Healthy Futures Defining best practice in the recruitment and retention of Indigenous medical students*, September 2005

AMA (Australian Medical Association) (2004a). *Healing Hands – Aboriginal and Torres Strait Islander Workforce Requirements*. AMA Discussion Paper 2004. Canberra. Accessed on the following webaddress: [http://www.ama.com.au/web.nsf/doc/WEENPV34X/\\$file/Indigenous_Report_Card_2004.pdf](http://www.ama.com.au/web.nsf/doc/WEENPV34X/$file/Indigenous_Report_Card_2004.pdf)

AMA (Australian Medical Association) (2004b). *Indigenous Health Workforce Needs*

A Report by Access Economics PTY LTD for The Australian Medical Association. July 2004. Accessed at the following webaddress: [http://www.ama.com.au/web.nsf/doc/WEEN-6PV36B/\\$file/Access_Economics_Paper_Indigenous_Health_Workforce_Needs.pdf](http://www.ama.com.au/web.nsf/doc/WEEN-6PV36B/$file/Access_Economics_Paper_Indigenous_Health_Workforce_Needs.pdf)

AIHW (Australian Institute of Health and Welfare) (2004). *Australia's Health* 2004. Canberra: AIHW

AIHW (Australian Institute of Health and Welfare) (2003). *Medical Labour Force 2001* AIHW Cat. No. HWL 28. Canberra: AIHW (National Health Labour Force Series No. 28)

AMWAC (Australian Medical Workforce Advisory Committee). (1999, 2000, 2002, 2003, 2004). *International Medical Collaborative Workforce Conference Papers*, accessed at <http://www.healthworkforce.health.nsw.gov.au/amwac/amwac/8conf.html>

AMWAC (Australian Medical Workforce Advisory Committee) (Aug 2004). *The Public Hospital Medical Workforce in Australia*, AMWAC Report 2004.3, August 2004, Sydney

AMWAC (Australian Medical Workforce Advisory Committee) (Feb 2004). *Survey of Doctors Working in Rural and Remote Locations Under Australia's Five-Year Overseas Trained Doctor Recruitment Scheme*. Report to the National Review Steering Committee of the Five-Year Overseas Trained Doctor Scheme. AMWAC Report 2004.1 February 2004

ARRWAG (Australian Rural and Remote Workforce Agencies Group) (2003). *Reality Bites: Rural and Remote GP Workforce Information*. Commonwealth Department of Health and Ageing, October 2003

ARRWAG (Australian Rural and Remote Workforce Agencies Group) (2004). *Overseas Trained Doctors and the Rural and Remote Workforce*. ARRWAG Policy Position Paper No. 2 November 2004. Accessed on the ARRWAG Website

- ARRWAG (Australian Rural and Remote Workforce Agencies Group) (2005). Recruitment, Recognition and Retention of Overseas Trained Doctors for the Rural and Remote Medical Workforce in Australia. Policy Position Paper, October 2005
- Abrahams J (2005). Medicine in the Australian Desert, *Australian Journal of Rural Health*, 13 (2) April 2005
- Anderson P (2002). Interesting Times: Aboriginal Health, Education and Workforce Issues. Paper presented to the Australian Remote and Rural Workforce Agency Group (ARRWAG) Conference, Adelaide 24 April 2002
- Armstrong R, Van der Weyden, M (2005). Indigenous health: partners in healing. Editorial, *Med J Aust* 2005;182 (10); 16 May 2005: 498-499
- Bartlett B, Boffa J (2001). Aboriginal Community Controlled Comprehensive Primary Health Care: The Central Australian Aboriginal Congress. *Australian Journal of Primary Health*, 7 (3) 2001
- Best J (2000). Rural Health Stock-take. Commonwealth Department of Health and Aged Care, March 2000
- Boffa J (2002). Is there a doctor in the house? *Australian and New Zealand Journal of Public Health*, 2002; 26 (4)
- Birrell B (1997). Implications of controls on access to Medicare billing for GPs, *People and Place*, 1997 5 (1)
- Birrell B, Hawthorne L (2004). Medicare Plus and Overseas-Trained Medical Doctors. *People and Place*, 2004 12 (2)
- Birrell R (2004). Australian policy on overseas-trained doctors, *MJA* 2004 181 (11/12): 635-639
- Brown R, Connell J (2004). The Migration of doctors and nurses from South Pacific Island Nations. *Social Science and Medicine*, June 2004; 58 (11): 2193-2210
- Cass A, Lowell A, Christie, M, Snelling P, Flack M, Marrnganyin B, Brown I (2002). Sharing the true stories: improving communication between Aboriginal patients and healthcare workers. *MJA* 2002 176 (10): 466 - 470
- Carson, B, Bailie R (2004). National Health Workforce in Discrete Indigenous Communities. *Aust NZ J Public Health* 2004 28 (3): 235-45
- Chanda R (2003). *Trade in Services – Movement of national persons and human development (IT and Health) Country case study India*. Asia Pacific Regional Initiative
- on Trade, Economic Governance and Human Development. June 2003: OECD
- Charles J, Britt H, Valenti L (2004). The evolution of the general practice workforce in Australia, 1991-2003. *MJA*, 19 July 2004 81 (2)
- CPMEC (Confederation of Postgraduate Medical Education Councils) (2004). *Information and resources relating to education and training available to overseas trained doctors in Australia. A National Scoping Study*. Commissioned by the Australian Government Department of Health and Ageing. April 2004.
- Dauphinee D (2003). *Integrating International Medical Graduates into Health Care Delivery in Canada: Attempting to Resolve Years of Discontinuity between Immigration Policy and Implementation Strategies In the Field*. Paper presented at the 7th Annual Conference of the International Medical Workforce Collaborative Conference, September 2003, Oxford England. Available through the AMWAC website at the following web address: http://www.health.nsw.gov.au/amwac/amwac/pdf/IMGs_policies_Canada.pdf
- Death E, Reath J, Curtis P (2002). *The Needs of GP's and GP Registrars working in Aboriginal and Torres Strait Islander Health*. National Rural Faculty of the Royal Australian College of General Practitioners. August 2002.
- DOHA (Department of Health and Ageing) (2003). *Biennial Review of the Medicare Provider Number Legislation*. Commonwealth of Australia, 2003
- DOHA (Department of Health and Ageing) (April 2005). General Practice Statistics, Accessed on the following website: <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/General+Practice+Statistics-1>
- DHAC (Department of Health and Aged Care) (2000). *General Practice in Australia: 2000*. Canberra: Commonwealth of Australia, May 2000



- DHAC (Department of Health and Aged Care) (2005). *General Practice in Australia: 2004*. Canberra: Commonwealth Department of Health and Aged Care.
- DIMIA (Department of Immigration and Multiculturalism and Indigenous Affairs) (2003). *Annual Report 2002-03*. Commonwealth of Australia 2003
- DoH (Department of Health) (2001). *Code of Practice for NHS employers involved in the international recruitment of healthcare professionals*. London: Department of Health, England
- DHS (VIC) (Department of Human Services Victoria) (2002) Overseas Trained Doctors in the Victorian Public Hospital System. Report prepared by the Postgraduate Medical Council of Victoria for the Department of Human Services, Victoria. Accessed at:
- <http://www.health.vic.gov.au/publichospitals/otdreport.pdf>
- Dovlo, D. 'Taking More Than a Fair Share? The Migration of Health Professionals from Poor to Rich countries', *PloS Medicine*; May 2005; 2 (5). Accessed at <http://medicine.plosjournals.org>
- Downs G et al. 2003. Analysis: Rural General Practice Workforce in Western Australia. WACRRM, June 2003.
- EQUINET (The Regional Network on Equity in Health in Southern Africa). Information accessible at the following web-address: <http://www.equinet africa.org/>
- Gavel P (2004). Programs and Policies to Redistribute Physicians to High Need Areas – Australia. Paper presented to the 8th Medical Workforce Collaborative Conference, Washington 2004: 9 of 20. Accessed on the AMWAC website at the following:
- http://www.health.nsw.gov.au/amwac/amwac/pdf/8sess1_gavel.pdf
- GPPHCNT (General Practice and Primary Health Care Northern Territory) (2004a). *Overseas Trained Doctors*. Position Statement 7 October 2004
- GPPHCNT (General Practice and Primary Health Care NT) (2004b). *Final Report GP Remuneration project*, July 2004
- GPPHCNT (General Practice and Primary Health Care NT) (2004). *The Darwin Statement* on Sustainable General Practice in Aboriginal Primary Health Care in the Northern Territory. Accessible on the GPPHCNT Webaddress
- Greacen J (undated). Assessing the clinical competence and suitability of doctors trained overseas for recruitment to rural general practice. RWAV, Victoria.
- Greacen J (2003). Submission to Senate Select Committee Inquiry into the Governments Medicare Plus Package. RWAV: Dec 2003
- Groutsis D (2003). The State, Immigration Policy and Labour Market Practices: The Case of Overseas Trained Doctors, *The Journal of Industrial Relations*, March 2003 45 (1): 67-86
- Gruen R, Yee, T (2005) Dreamtime and awakenings: facing realities of remote area Aboriginal health, *Med J Aust* 2005; 182 (10) 538-540
- GPET (General Practice Education and Training) (2004a). *A Framework for General Practice Training in Aboriginal and Torres Strait Islander Health*, GPET Ltd., 2004.
- GPET (General Practice Education and Training) (2004b). *Good GPs for Aboriginal and Torres Strait Islander Communities*, GPET Ltd., 2004.
- Hagopian A, Thompson MJ, Fordyce M, Johnson KE, Hart LG (2004). The migration of physicians from Sub-Saharan Africa to the United States of America: measures of the African brain drain. *Human Resources for Health* 2004; 2:17 (14 Dec 2004)
- Han and Humphreys (2005). Overseas-trained doctors in Australia: Community integration and their intention to stay in a rural community. *Aust.J. Rural Health* 2005 13: 236-241
- Hawthorne L, Birrell B and Young D (2003). *The Retention of Overseas Trained Doctors in General Practice in Regional Victoria*, Nov 2003.
- Hill, P, Wakerman, J, Matthews, S, Gibson, O (2001). Tactics at the interface: Australian Aboriginal and Torres Strait Islander health managers, *Social Science and Medicine*, Feb 2001 52 (3): 467-480.

Ioannidis J (2004). Global estimates of brain drain and deficit, *The FASEB (Federation of American Societies for Experimental Biology) Journal* 2004 18: 936-939

Joyce C (2004). Uncovering an invisible workforce, *MJA* 181 (11/12) Dec 2004

Kamiens M (1998). Staying in or leaving rural practice: 1996 outcomes of rural doctors' 1986 intentions. *MJA* 1998; 169: 318-321

Khadria, B. Perspectives on Migration of Health Workers from India to Overseas Markets: Brain Drain or Export? Seminar on Health and Migration, 9-11 June 2004 International Organisation for Migration (IOM)

Lavoie, J (2004). 'Governed by Contracts: The Development of Indigenous Primary Health Services in Canada, Australia and New Zealand'. *Journal of Aboriginal Health*, January 2004; Canada

Levy L (2003). 'The first world's role in the third world brain drain'. *British Medical Journal* 2003; 327:170 (19 July). e-bmj accessed on 13 September 2005 <http://bmj.bmjournals.com/cgi/content/full/327/7407/170>

Lowell A (1998). Communication and Cultural Knowledge in Aboriginal Health Care: A Review of two subprograms of the Cooperative Research Centre for Aboriginal and Tropical Health's Indigenous health and education research program. Casuarina, NT; Cooperative Research Centre for Aboriginal and Tropical Health

McDonald H (2004) Factors which inhibit successful Indigenous participation in health service delivery in northern Australia. Paper presented at The National SARRAH Conference Alice Springs 26-28 August 2004 (accessed on 4 August on the following website: <http://www.sarrah.org.au/sarrah/Papers/McDonald.pdf>)

McDonald J, Bibby L, Carroll S (2002). *Recruiting and Retaining General Practitioners in Rural Areas: Improving Outcomes through Evidence-Based Research and Community Capacity-Building*. Centre for Health Research and Practice, University of Ballarat, Victorian Universities Rural Health Consortium (VURHC). Accessed at: http://www.cecc.com.au/programs/resource_manager/accounts/chrp/recruiting_and_retaining_GPs_summary.pdf

McGrath B. Integration of overseas-trained doctors into the Australian medical workforce. *Medical Journal of Australia* 2004 181 (11/12): 640-642

Maher P. A Review of 'Traditional' Aboriginal Health Beliefs. *Aust. J. Rural Health* 1999 (7): 229-236

Marchal B, Kegels, G (2003). Health workforce imbalances in times of globalization: brain drain or professional mobility? *Int J Health Plann and Mgmt*, 2003 18: s89-s101 Published online at: <http://www3.interscience.wiley.com/cgi-bin/fulltext/106561856/PDFSTART>

MCNZ (Medical Council of New Zealand) (2005). Assuring Medical Practitioners' Cultural Competence, A discussion document produced for the Medical Council of New Zealand by the Health Services Research Centre/Te Hikuwai Rangahau Hauora, School of Government, Victoria University of Wellington 5 January 2005.

Meija A (2004). Migration of Physicians and Nurses: a World Wide Picture. First published in the *International Journal of Epidemiology*, Oxford University Press 1978; 7 (3). Reproduced by permission of the international *Journal of Epidemiology* in the *Bulletin of the World Health Organization*, August 2004; 82 (8)

The Melbourne Manifesto, A Code of Practice for the International Recruitment of Health Care Professionals; Adopted at the 5th WONCA World Rural Health Conference, Melbourne, Australia, May 2002

MTRP (Medical Training Review Panel) (2004). Overseas Trained Doctor Subcommittee Report. Report submitted to the Medical Training Review Panel February 2004.

Mensah, K, Mackintosh, M & Henry, L. (2005). The 'Skills Drain' of Health Professionals from the Developing World: a Framework for Policy Formulation MEDACT, February 2005. This document can be downloaded from the MEDACT website: <http://www.medact.org/index.php>

Mooney, N et al. (2005). A Quantitative Evaluation of Aboriginal Cultural Awareness Training in an Urban Health Service, *Aboriginal and Islander Health Worker Journal*, July/August 2005, 29 (4)



Mullan F. *Filling the Gaps: International Medical Graduates in the United States, the United Kingdom, Canada and Australia*. Paper presented at the 8th International Medical Workforce Conference, Washington, DC October 6-9, 2004. Available on the following website: http://www.health.nsw.gov.au/amwac/amwac/pdf/8sess4_mullan.pdf

NSW Health (NSW Department of Health) (2003). Report on the audit of overseas trained doctors in Area of Need positions. Medical Training and Workforce Development Branch, June 2003. Available on the following website: http://www.health.nsw.gov.au/pubs/r/pdf/audit_report.pdf

NRHA (National Rural Health Alliance) (2004). An ethical approach to the training and supply of health care professionals: in support of the Melbourne Manifesto May 2004. National Rural Health Alliance Position Papers, 2003-04. Available at: <http://www.ruralhealth.org.au/nrhpublic/PublicDocs/PositionPapers/2004%20Position%20Papers.pdf>

New South Wales (NSW) Medical Board Annual Report 2004. Accessed on the following webaddress: http://www.nswmb.org.au/NSWMB_annual_report_2004.pdf

OECD (Organisation for Economic Co-operation and Development) (2003). *Trends in International Migration*. OECD Report Paris: 2003. Available at the following webaddress: <http://www1.oecd.org/publications/e-book/8103061E.PDF>

IOM (International Organisation for Migration) *World Migration Reports* 2005. Available from the following webaddress: http://www.cfr.org/publication/8987/world_migration_2005.html

Padarath A, Chamberlain C, McCoy D, Rowson M, Loewenson R (2003). Health Personnel in Southern Africa: Confronting maldistribution and brain drain. EQUINET Discussion Paper 3. Available from the EQUINET Website

PHR (Physicians for Human Rights) (2004). *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*. A Report by Physicians for Human Rights, Boston MA, June 2004

PMCV (Postgraduate Medical Council of Victoria) (May 2002). *Overseas Trained Doctors in the Victorian Public Hospital System*. Department of Human Services Victoria. This Report can be accessed on the following webaddress: <http://www.dhs.vic.gov.au/pdpd/pdfs/otdreport.pdf>

QRMSA (Queensland Rural Medical Support Agency) (2004). *Solutions for the Provision of Primary Care to Rural and Remote Communities in Queensland*, March 2004

QRMSA (Queensland Rural Medical Support Agency) (2003). *Minimum Data Set Report* as at 30 November 2003

Roach S (2002). *Overseas Trained Doctors. The WACRRM Program 1999-2002*. WACRRM

Roach S (2005). *The Needs of Overseas Trained Doctors in Western Australia* Forthcoming Publication DOH Perth, WA, July 2005

RWAV (Rural Workforce Agency Victoria) 2003. Victorian Rural General Practice Workforce Planning for 2002-12. Summary Report, November 2003

RACGP (Royal Australian College of General Practitioners) (Curtis P and Reath J) (2004). *Review of cultural training for GPs working in Aboriginal and Torres Strait Islander Health*, June 2004. Available at: http://www.racgp.org.au/downloads/pdf/CSTreport_summary.pdf

Scott M, Whelan A, Dewdney J, Zwi A (2004). 'Brain Drain' or ethical recruitment? *Med J Aust* 16 Feb 2004; 180 (4): 174-176

Taylor J, Dollard J, Weetra C, Wilkinson D (2001). Contemporary management issues for Aboriginal Community Controlled Health Services. *Aust Health Rev*. 2001; 24 (3):125-32

Turrell and Oldenburg (2004). Utilisation of general practitioner services by socio-economic disadvantage and geographic remoteness. *Aust NZ J Public Health* 2004 28:152-8

UNDP (United Nations Development Program) (2003). Millennium Development Goals: A compact among nations to end human poverty. Accessed on the following website: <http://hdr.undp.org/reports/global/2003/>

Veitch C, Crossland (2002). Exploring indicators of experiential place integration in a sample of Queensland rural practitioners: A research note, *Rural and Remote Health 2*, Accessed at: <http://rrh.deakin.edu.au>

Van der Weyden M, Chew M (2004). Arriving in Australia: overseas trained doctors, *Med J Aust* 2004; 181 (11/12): 633-634

Wells, R 2000. 'Underserved Communities – Australia'. Report prepared for Session 5: Medical Workforce Supply in Underserved Communities – Australia. Presented to the 5th International Medical Workforce Conference, Sydney 2000: **289-328**

Westmore, A. Cultural Shift Treating Indigenous People requires a deep understanding of their beliefs. *Australian Doctor*, 26 Nov 2004:17-18

WHA (World Health Assembly) (2005). WHA 57.19 International migration of health personnel: a challenge for health systems in developing countries. Accessed on the WHO Website at the following webaddress (July 2006). http://www.who.int/gb/ebwaha/pdf_files/WHA57/A57_R19-en.pdf

WHO (World Health Organisation) (2003). International Migration Health and Human rights. Health and human rights publication series, Dec 2003 (4)

WHO (World Health Organisation) (2004). The Migration of Skilled Health Personnel in the Pacific Region. World Health Organisation Western Pacific Region, 2004

Whelan, A, Arkles, R, Dewdney J, Zwi A. (2004). International Movements of Skilled Health Professionals: Ethical Policy Challenges for Developed Nations. *Harvard Health Policy Review*, Fall 2004 5 (2)

Worley P and Couper I. The ethics of international recruitment. *Rural and Remote Health 2* (online) no. 196 available from: <http://rrh.deakin.edu.au>

