

# The Baby, the Bath Water And The Future of IMGs

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## ABSTRACT

Migration has significantly accelerated over in the past few decades, with the migration of doctors and other health professionals from developed countries forming a large part of the globalisation of health care. As such, migrant labour has been observed as a means of meeting job shortages within developed countries, from low-skilled to highly-skilled professional occupations, such as International Medical Graduates (IMG). Australia, like many other developed countries, has trained insufficient doctors in the past. This has led to the immigration of IMGs to fill this gap, particularly in rural and remote areas. As countries, such as Australia has developed an ongoing need for IMGs, so too the policies and regulations have developed over the decades to meet those needs. However, as Australia now begins to train more local medical graduates, the future for IMGs remains less conceivable. The aim of this paper is to discuss the increased use of IMGs and the development of legislation and policy to regulate this cohort of migrant labour in Australia while examining what the future may be for IMGs.

**Keywords:** Australia, future directions, history, International Medical Graduates, legislation, policy development

## INTRODUCTION

Migration has accelerated over in the past few decades, with the migration of doctors and other health professionals from developed countries forming a large part of the globalisation of health care (Brown & Connell, 2004; Oman, Moulds, & Usher, 2009). As such migrant labour has been observed as a means of meeting job shortages within developed countries, from low-skilled to professional occupations, such as IMGs (Lindgren & Gordon, 2011; MacKenzie & Forde, 2009). Migrant workers, including IMGs, have also been observed to be a cheaper alternative to training within the country and to fill positions which many of the local population are unwilling to fill themselves (Birrell & Hawthorne, 2004; Kyriakides & Virdee, 2003).

As such, worldwide recruitment of International Medical Graduates (IMGs), also known as overseas trained doctors (OTDs) continues to be central to health workforce planning particularly among developed countries. This includes Australia, which has the highest number of IMGs per capita in the world (Han, 2010; Iredale, 2009; Lim, 2010; Spike, 2006). Australia's effort to increase IMG numbers was due to a necessity to redress restrictions placed on Medical student enrolments and IMG registrations in the 1990s (Australian Medical Workforce Advisory Committee, 1996). This was triggered by a

speculative high doctor-to-population ratio, ongoing rural health disparity and doctor maldistribution (Elkin & Studdert, 2010; Harding, Parajuli, Johnston, & Pilotto, 2010). Nevertheless, due to recent changes in local graduate numbers, the ongoing role IMGs will take in Australia is relatively unknown.

## **BACKGROUND**

The restrictions placed on medical student enrolments occurred in 1992 when “the Medical Workforce Supply Working Party documented concern at Australia’s ‘persistent over-supply of doctors’, with doctor/patient ratios rising by around 67 per cent over a 20 year period” (Hawthorne & Birrell, 2002, p. 55). In that same year, the Commonwealth Government conducted an inquiry into a national competition policy for Australia. This produced the *Hilmer Report 1993*, a National Competition Policy Review. This led to the enactment of the *Commonwealth Competition Policy Reform Act 1995*. This reform had implications for industries nationwide, including health (National Competition Policy Review, 1993).

Under agreement, each Australian state and territory had enacted competition codes which mirror part IV of the *Trade Practices Act 1974*, which outlined the anti-competitive restrictions. This then allowed the “Australian Competition and Consumer Commission (ACCC), an independent, statutory authority responsible for monitoring compliance with, and enforcement of the [*Trade Practices Act 1974*]... to sanction anti-competitive behaviour provided that a clear public benefit can be shown” (Department of Health and Aged Care, 2001, p. 59).

Thus, a restriction on the number of Medical practitioners able to practise in Australia was allowed to occur. Subsequently, medical school graduates were restricted from 1,200 to 1,000 per year with only 200 IMGs allowed to register per year. It was anticipated these restrictions would reduce Medical practitioners in Australia by 7,500 by 2025, thus reduce an oversupply, yet meet the growing need of medical practitioner into the future (Australian Medical Workforce Advisory Committee, 1996).

These policies largely limited medical school places and led to the sustained under production of medical graduates in Australia (Elkin & Studdert, 2010; Harding, et al., 2010). This strengthened the basis for the Australian government’s *Medical Practitioners Registration Act 1996*. This Act required all future medical graduates who wished to practise as general practitioners to complete postgraduate study, thus limiting enrolment in these courses to 400 places a year Australia wide (Birrell & Schwartz, 2006; Birrell, 2004; Hawthorne & Birrell, 2002).

The shortages, which now exist, are due to this decrease in Australian medical graduates, an ageing medical workforce and the growth of the population. This has led to

a number of policy responses from the Australian Government including... a greater reliance on [International Medical Graduates].... However, while gains have been made, a maldistribution of health workers remains, and access to medical professionals by the population in regional and remote areas continues to be below the access in major cities (Deloitte Access Economics, 2011, p. 2).

These key policies which were later introduced include a relaxation of skilled migration for IMGs, which allowed temporary resident IMGs to enter and work in Australia in greater numbers (Birrell, 2004; Harding, et al., 2010; Hawthorne & Birrell, 2002; Hawthorne, Hawthorne, & Crotty, 2007; Laurence, 2008). To control the increase in number and distribution of IMGs, regulatory immigration rules and a restriction on Medicare provider number was introduced. In addition, an increase in the medical self-sufficiency within Australia has commenced (Elkin & Studdert, 2010; Rodgers, 2010). It was projected a 60 - 85% increase in medical school graduates would occur by 2012 (Elkin & Studdert, 2010; Joyce,

McNeil, & Stoelwinder, 2006). This significant increase brings with it a whole spectrum of issues that will inevitably impact on the future recruitment and placement of IMGs in Australia (Elkin & Studdert, 2010; Joyce, et al., 2006).

## **AUSTRALIA'S IMG POLICIES AND REGULATION**

To enable an understanding of contemporary issues concerning IMGs within Australia today, an appreciation and perspective of the expansion of IMG policies and regulations which have been developed is provided.

### **Policy and Regulation (1970s – 1990s)**

Many of the policies and legislation regarding IMGs were implemented in the 1930s -1950s and were not changed until the 1970s (Kamien, 2007; Kunz, 1975; Terry, Woodroffe, Lê, & Ogden, 2012). However, more contemporary legislation commenced in 1973, when *The Health Insurance Act 1973* was passed and remains a key piece of legislation, which regulates IMGs practicing in Australia today. Although enacted in 1973, this legislation was not used specifically for IMG regulation until the late 1990s.

Also at this time, the abolition of the *Immigration Restriction Act 1901* also known as the 'White Australia' policy occurred in 1974. This change in legislation eased migration processes and favoured many individuals including medical graduates across the globe to immigrate to Australia (Kamien, 2007). To counterbalance this increase in IMGs in Australia, the government continued to maintain a quota of IMGs practicing in Australia with the AMA proposing a restriction of 130 IMGs per annum (Birrell & Hawthorne, 2004; Kamien, 2007).

Lastly, in 1984, the Australian Medical Council (AMC), was established for medical education and training (Australian Medical Council, 2009a, 2012; Birrell & Schwartz, 2007; Medical Board of Australia, 2010; Spike, 2006). It was organised to develop "accreditation standards, policies and procedures for medical programs of study... and for assessment of International Medical Graduates for registration in Australia" (Australian Medical Council, 2012).

### **Policy and Regulation (1990s – present)**

In the 1990s, one of the greatest changes to occur in Australia was the 'source' countries IMGs were immigrating from. Prior to 1990, the majority of IMGs were from English speaking countries such as the UK, Ireland and New Zealand. By the mid-1990s IMGs were migrating from Africa, Asian, Eastern Europe and the Americas, with a dwindling number of IMGs from New Zealand and UK. This was due to an undersupply of doctors in rural areas which saw changes to the general skills migration program.

Doctors were added to the Skilled occupations list and greater number of temporary residency IMGs were permitted to enter and work in Australia (Birrell, 2004; Harding, et al., 2010; Hawthorne & Birrell, 2002; Hawthorne, et al., 2007; Laurence, 2008). These changes were also influenced by what was occurring elsewhere in the world, such as an influx of eastern European migrants due to social change and conflict, such as the fall of the Berlin wall and increased refugee outflows from the breakup of the former Yugoslav Republic (Colic-Peisker, 2009; Hawthorne, et al., 2007).

To curb an influx and redistribute a large number of IMGs, the function of section 19AB of *The Health Insurance Act 1973* in Australia, also known as the *10-Year moratorium* was implemented on 1 January 1997. The 10-Year moratorium is a scheme which restricts IMGs access to Medicare provider numbers,

subsequent cash rebates and therefore the ability to practise independently until a 10 year compulsory rural placement has been fulfilled. This measure was introduced after failed attempts by the Howard government (1996 - 2007) to set quotas and restrict the number of IMGs practicing in Australia and to control Medicare costs (Han, 2010). Setting quotas was deemed discriminatory by the Human Rights and Equal Opportunity Commission (Han, 2010). The Federal Court overruled the decision but the quota system was not reintroduced by the government (Han, 2010; Laurence, 2008).

The 10-Year moratorium was also enacted to ensure International Medical Graduates worked in area where there are underserved populations who undergo maldistribution of medical practitioners and services (Rural Health Workforce Australia, 2011a) However, this strategy has been noted to be anti-competitive and to safeguard local doctors from foreign competition, which had been one of the many issues from the 1940's (Kunz, 1975; Metherell, 2009). These types of compulsory service (CS) schemes have also been condemned in the past as breaching an individual's human right to choose the location of employment, however these allegation are refuted as participants of the scheme remain fully cognizant of the obligations of participating in such schemes (Frehywot, Mullan, Payne, & Ross, 2010; Lim, 2010).

The 10-Year moratorium, and other related programs such as the Rural Locum Relief Program (RLRP), the strengthening Medicare package and Medicare Plus program have increased and allowed IMGs to work in various capacities in Australia (Birrell & Hawthorne, 2004; Van Der Weyden & Chew, 2004). For example, the RLRP is designed to aid permanent resident IMG to work under supervision in rural general practice while they are working towards their GP Fellowship (Rural Health Workforce Australia, 2011b). These opportunities provide greater access of medical practitioners to rural communities (Birrell & Hawthorne, 2004; Van Der Weyden & Chew, 2004). In addition, these compulsory service programs are viewed as:

Instruments of social justice, an exercise in health equity, in that they enable governments to direct or augment health services to geographical areas that are not well served and in communities that are not favoured by market forces and health worker preference. (Frehywot, et al., 2010, p. 368).

When introduced, the moratorium and the new accreditation and registration system was highly complex and discriminatory as in most cases an "IMGs ability to work [in Australia] was largely determined by their visa status rather than their qualifications" (Douglas, 2008, p. 30). This led to a 21-day hunger strike in New South Wales (NSW) with similar hunger strikes being held by IMGs in 1997 in front of the Victorian and Federal parliaments. The aim of the hunger strikes was to lobby governments for changes to the current system. This was followed later in 1999 by a 19 day hunger strike by 40 IMGs (Han, 2010; Iredale, 2009; Kamien, 2007).

These strikes prompted the NSW government to commission a research report into the employment concerns raised by IMGs in the state (Australian Doctors Trained Overseas Association, 1998; Douglas, 2008). The report "The Race to Qualify, issued 32 recommendations and confirmed that the differential treatment of IMGs holding temporary visas from those on permanent visas could be considered unlawful discrimination" (Douglas, 2008, p. 30).

The recommendations from the inquiry, the Race to qualify, subsequently led to the introduction of the Five-Year Overseas Trained Doctor Scheme in 1999. This allows participating permanent resident IMGs to shorten the ten year restriction of Medicare provider number access to five years or less (Rural Health Workforce Australia, 2011a). The length of time remains dependent upon the remoteness classification of the employment an IMG chooses to work and "where recruitment and retention is found to be particularly problematic" (Rural Health Workforce Australia, 2011a, p. 12).

The Rural Health Workforce Strategy revamped the 5 year scheme and on 1st July 2010 it introduced a number of measures to respond to rural and remote workforce shortages (Deloitte Access Economics, 2011). One of these was the scaling of workforce incentives, which reduces the time an IMG is ineligible to access a Medicare provider number, by electing to live and work over a predetermined amount of time in more remote areas. This “remoteness” is defined by one of a number of remoteness classification measures, the Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA), as shown in

Table 1 (Department of Health and Ageing, 2010).

*Table 1 Scaling incentives - Rural Health Workforce Strategy*

<b>RA Classification</b>	<b>RA Category</b>	<b>Scaling % discount</b>	<b>Reduction of restriction</b>
Remoteness Area 1	Major City	Nil	10 years
Remoteness Area 2	Inner Regional	10%	9 years
Remoteness Area 3	Outer Regional	30%	7 years
Remoteness Area 4	Remote	40%	6 years
Remoteness Area 5	Very Remote	50%	5 years

*Note* RA = Remoteness Area. From Australian Institute of Health and Welfare (2011).

An additional inquiry was conducted by the Australian Competition and Consumer Commission’s (ACCC) and the Health Workforce Official Committee who submitted a research report in 2005 on the role of the specialist’s medical colleges in the assessment of IMG qualifications and their accreditation (Douglas, 2008). The report outline a “lack of procedural fairness, lack of transparency, unreasonably restricted entry to College Fellowship, and rigid assessment processes based on similarities of programs rather than competency-based assessment”. As such, “the ACCC accused the RACS of being a ‘closed shop’ and too strict over who can enter the College” (Han, 2010, p. 247). Twenty recommendations were provided with the findings, which included the development of competency-based criteria for assessing IMG qualifications to improve accreditation processes and to the current processes used to qualify IMGs to work in Australia. However, the recommendations are unable to be enforced as each specialist body is self-regulatory and there are no external processes to guarantee recommendations are implemented (Douglas, 2008).

In addition, a number of other changes occurred within this time period as well. This included the *Health Practitioner Regulation National Law Act 2009*, which was to establish a national registration and accreditation scheme to regulate health practitioners. One of the main objectives is to protect the public and simplify the mobility of the workforce within Australia. It was enacted to also expedite a rigorous and responsive assessment of overseas trained health practitioners, including IMGs (Queensland Government, 2009).

## **THE NEW NATIONAL PROCESS FOR IMGs**

Also occurring across the globe, was the Commonwealth Code of Practice for the International Recruitment of Health Workers outlined by *The Durban Declaration 1997*. The declaration recommended the advancement of the health and the reduction of inequities of the world’s rural population. Part of this recommended was to enhance and sustain health professionals in these rural

areas of developing countries (World Organisation of Family Doctors, 1997). *The Durban Declaration 1997* introduced the general concepts of the ethical recruitment of IMGs. However was later united by and is largely underpinned by *The Melbourne Manifesto 2002*, a code of practice for the international recruitment of health care professionals (World Organization of Family Doctors, 2002).

These two documents state a country must maintain adequate numbers of medical graduates to meet health needs of current and future domestic market. In addition medical recruitment should not actively or selectively seek doctors from developing countries. *The Melbourne Manifesto* does however; recognise individual freedoms and the self-determination of the health care professionals (Iredale, 2009). It also emphasises that assistance should be provided to support IMGs from developing countries, who without coercion, seek employment in developed countries (World Organization of Family Doctors, 2002).

In addition to the *Durban Declaration 1997* and the *Melbourne Manifesto 2002*, a number of significant changes within Australia were brought about in 2005. These were largely prompted by Dr. Jayant Patel, an IMG who was implicated with 87 deaths occurring at the Bundaberg Base Hospital in Queensland between 2003 and 2005 (Birrell & Schwartz, 2006, 2007; Dunbar, Reddy, & May, 2011; Harvey & Faunce, 2005; Moynihan, 2010). In 2010, Patel was found guilty of criminal negligence resulting in 3 deaths and one case of grievous bodily harm, and sentenced to seven years in jail (Flatley, 2010). Subsequently, Dr. Patel appealed his conviction, which was upheld in the Australian High Court on August 24, 2012, but is facing a retrial in November 2012 ("Patel to face new trial after manslaughter conviction quashed," 2012; Remeikis, 2012).

As a result of the Dr. Patel case, a single National Registration and Accreditation Scheme (NRAS) was as announced in July 2006, at the Council of Australia Governments (COAG). This scheme was first enacted in Queensland as the *Health Practitioner Regulation National Law Act 2009 (Qld)* with other states and territories enacting similar bills between 2009 and 2010. The new registration was to decrease bureaucracy, increase the ease in movement of health professionals and protect the public. In addition, the national accreditation process focusses on the education and training of health professionals, including IMGs (House of Representatives Standing Committee on Health and Ageing, 2012a; Queensland Government, 2009). This process is administered by the AMC who assesses IMGs seeking to practise medicine in Australia (Birrell & Schwartz, 2006, 2007). The assessment has a number of pathways and is dependent on where the IMG has obtained training and will follow one of several alternate pathways for registration.

As part of the process, the AMC rigorously verifies an IMGs credentials, the country of origin's examining and accrediting processes and administers a multiple choice question (MCQ) exam. In a submission to the recent Parliamentary inquiry, *Lost in the labyrinth*, the AMC stated the demand to sit the MCQ exam had increased over the past five years from 1,509 candidates sitting the exam in 2005-2006 to 4,466 in 2009-2010. In addition most (84.54%) IMGs who attempt the MCQ exam pass within the first two attempts with 66.77% of participants passing on the first attempt while 19.69% passed on their second attempt (House of Representatives Standing Committee on Health and Ageing, 2012a).

Following the MCQ and provisional medical registration, either a clinical interview, workplace based assessment or a clinical examination is conducted (Australian Medical Council, 2009b, 2012). In most cases IMG need to travel to a hospital in a major centre, such as Melbourne to undertake a clinical examination. However, a National Examination Centre in Melbourne was recent announcement to open in April 2013 by the Rural Workforce Agency (RWA) (Austin, 2013). The dedicated centre is to redress the current bottle neck in IMGs awaiting to sit an AMC clinical examination; ensure there are timely AMC examinations in the future; to meet the future capacity of 2,500 AMC clinical examinations in 2013;



and to provide a centre where other professionals, part of the NRAS, can undertake examinations (Austin, 2013).

The AMC assessment pathways allow an IMG to apply for full registration once competency has been demonstrated and established (Australian Medical Council, 2009a, 2012; Medical Board of Australia, 2010). However Iredale (2009) argues competency must be judged against a universal set of standards, rather than national or state benchmarks. In addition, it has been argued the new assessment procedures may have been causing unfair deregistration of a number of IMGs with bias against a number of IMGs being well documented (Louis, Lalonde, & Esses, 2010; Moynihan, 2010).

Once full registration has been achieved then an IMG with temporary, permanent resident visa status or citizenship has other restrictions placed upon them (Han, 2010). For example, there are restrictions on where an IMG with a temporary visa can be employed (Australian Institute of Health and Welfare, 2008). Often they are employed in short stay opportunities which are focused on identified gaps in the local workforce. These are called Area of Need (AoN) positions and District of Workforce Shortage (DWS) positions (Australian Institute of Health and Welfare, 2008; Birrell & Hawthorne, 2004; Department of Immigration and Citizenship, 2012; Laurence, 2008). DWS are determined by the Department of Health and Ageing, whereas AoN are determined by the State and Territory Governments and allow an IMG to receive exemption on Medicare provider number restrictions (Laurence, 2008; Rural Health Workforce Australia, 2011a).

The most common is an Area of Need (AoN) positions which comes under section 21(2) (g) (Area of Need) of the *Medical Practitioners Registration Act 1996*. This states a medical practitioner is conditionally registered and can be placed in positions, where a need exists. This is not related to geographical location, but rather an AoN in public or private services. It can include positions such as general practitioner, non-specialist and specialist position within hospitals (Harvey & Faunce, 2005). There were also occupational trainee temporary resident IMGs who entered on occupational trainee visa (Visa 442) for up to 12 months, however this scheme is also now obsolete (Australian Institute of Health and Welfare, 2008; Birrell & Hawthorne, 2004; Department of Immigration and Citizenship, 2012; Laurence, 2008)

The Temporary Business (Long Stay) - Standard Business Sponsorship (Subclass 457) Visa program, has recently replaced Visa 422 (Area of Need). As such, it allows an IMG:

to enter Australia for temporary employment or training purposes. To obtain the relevant visa requires employment sponsorship and conditional registration by the state or territory medical registration board...[and]...excludes overseas-trained and Australian-trained medical practitioners with permanent resident or Australian citizenship status (Australian Institute of Health and Welfare, 2008, p. 32).

In addition to the Temporary Business (Long Stay) (Subclass 457) Visa, there are also three additional options for IMGs to enter Australia outlined by the Department of Immigration and Citizenship (DIAC). These include General Skilled Migration (GSM) (permanent); Regional Sponsored Migration Scheme (RSMS) (permanent); and Employer Nomination Scheme (ENS) (permanent). These are commonly used to obtain permanent residency for highly skilled workers (House of Representatives Standing Committee on Health and Ageing, 2012a).

Unlike the AoN positions, DWS positions are in rural and remote Australia that are considered difficult to fill. DWS are in locations where the population's health care needs are not being met and where less access to medical services than the national average is occurring (Department of Health and Ageing, 2010). In addition, section 19AA of *The Health Insurance Act 1973* also allows IMGs with permanent

residency or Australian citizenship to access to Medicare benefits through the RLRP. This is on the provision the IMG is not subject to or has sought a 3GA exemption of 10-year moratorium from section 19AB of *The Health Insurance Act 1973*. If all requirements are fulfilled then an IMG can provide locum services in rural and remote areas while they work towards their GP Fellowship (Laurence, 2008; Rural Health Workforce Australia, 2011b).

Lastly, 'Lost in the labyrinth', an extensively detailed Parliamentary inquiry on IMGs was published in March 2012 (House of Representatives Standing Committee on Health and Ageing, 2012a). The inquiry was conducted by the Standing Committee on Health and Ageing between December 2010 and March 2012, where 184 submissions were received from key informants, peak bodies, stakeholder organisations, government bodies and individuals across Australia. In addition, twenty two public hearings were held between February 2011 and January 2012 to gather further verbal evidence. The objective of the inquiry was

to explore the registration process and support available for those [IMGs]... and to explore ways to remove impediments and promote pathways for [these] doctors to achieve their full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies. (House of Representatives Standing Committee on Health and Ageing, 2012b, p. 1)

From the inquiry there were 45 recommendations made to improve IMGs experiences and aid IMGs achieve Australian qualification.

## **THE FUTURE OF IMGs IN AUSTRALIA**

Despite the development of contemporary policy and regulation, the future of the IMG labour force in Australia remains unknown. In March 2010, the then Australian Prime Minister, Kevin Rudd, announced \$632 million in funding over 10 years to train more than 5,000 new doctors and to train a greater number of specialists in general surgery, pathology, radiology, obstetrics and gynaecology. The funding was announced to also assist more than 5,400 junior doctors to participate in general practise placements. The announcement was said to maintain current levels of medical practitioners needed for the next 10 years (Rodgers, 2010). Since this announcement, medical school entrants increased 25.8% from 2007 to 2011, while domestic medical graduates completing university rose 69.2% from 2006 to 2010 (Australian Institute of Health and Welfare, 2013).

While it has been argued that the funding was needed, it has also been asserted that the conditions were short sighted. Many of the extra medical graduates who need to complete their year of internship would be unable to do so as the practical placements required for training would be unavailable (Griffiths, 2010; Kaye, 2012; Kirchner, 2010; Rodgers, 2010). This has meant those graduates who are Commonwealth-supported would be guaranteed an internship placement, while those who are Australian fee-paying medical students and international full fee-paying medical students do not have this same guarantee (Aizen, 2010; Caldwell, 2010).

This shortfall in practical placements was coming to fruition as early as 2012 and 2013 (Kaye, 2012). It was indicated in 2007, before 2010 Rudd announcement, an increase number of state medical schools were occurring (Hawthorne, et al., 2007). However, at this time Postgraduate Medical Education Councils (PMC) were already "concerned about the ability of state hospital systems to provide sufficient numbers of accredited intern positions to accommodate such numbers" (Hawthorne, et al., 2007, p. 99).

In small states such as Tasmania, it has been stated that due to this new announcement, a third of medical graduates would have to leave the state to complete their internship (Griffiths, 2010; Kirchner,



2010). To circumvent this occurring a commitment was made by the State Health Minister, Michelle O'Byrne in July 2010, to provide adequate training opportunities for the increased numbers of medical graduates in Tasmania (Griffiths, 2010; Kirchner, 2010). However, with this commitment there is the potential for a reduction in international full fee-paying medical students studying in Australia (Aizen, 2010).

The increase in Australian graduates is anticipated bring with it a spectrum of issues. Not only for the placement of many extra medical graduates, but it will inevitably impact on the future recruitment and placement of IMGs in Australia, where so much cost and effort has gone into removing barriers and promote retention (Elkin & Studdert, 2010; Joyce, et al., 2006). In addition, in a recent IMG study, a key informant also highlighted this concern when they said

*My greatest concern for IMGs is that we've have raped and pillaged their contribution in the past and we now are going to have a surfeit of our own doctors. We are likely to throw the baby out with the bath water and I think that is a very offensive, so one of the real challenges that I see is making sure that we exercise a duty of care to those people that we have taken on. (Informant 16)*

In addition, this new challenge potentially leaves the future health and wellbeing of rural and remote communities unknown. Historically recruiting and retaining local graduates in rural areas has been challenging (Durey, 2005; Han, 2010; Harding, et al., 2010; Liaw & Kilpatrick, 2008). Birrell & Hawthorne (2004, p. 83) state "Australian-trained doctors are not available for or are unwilling to undertake [non-metropolitan positions] because they do not find these location or working conditions attractive". Notwithstanding these recent increases in local graduates, the future medical workforce will remain dependent on the recruitment IMGs in the immediate and near future as the current solution, particularly in rural and remote areas (Han, 2010; Han & Humphreys, 2005; Lim, 2010; Van Der Weyden & Chew, 2004).

## **CONCLUSION**

Migration has significantly accelerated over in the past few decades with migrant labour viewed as a means of meeting job shortages, which includes IMGs. Australia, like many other developed countries, has trained insufficient doctors in the past. This has led to the immigration of IMGs to fill this gap; particularly in rural and remote areas. This has led to greater legislation, policy and regulation to meet those needs. As Australia has begun to meet the job shortages by increasing local medical graduates, the future for IMGs remains less predictable. This paper has discussed the development of legislation and policy to regulate IMGs and articulates the future of IMGs will remains in areas where ongoing recruitment and retention of local medical graduates may remain problematic. Nevertheless, rural retention of both IMGs and local medical graduates requires ongoing examination.

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