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Health professionals in multicultural Australia

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Abstract

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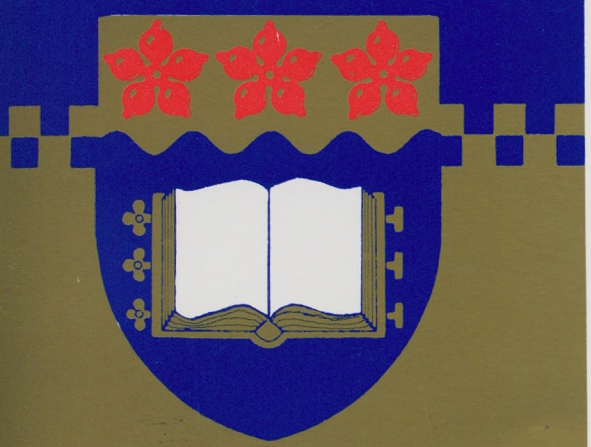

THE CENTRE FOR
MULTICULTURAL STUDIES

UNIVERSITY OF WOLLONGONG

Health Professionals in Multicultural Australia

Robyn Iredale, with Marion Gluck

Occasional Paper No. 29

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Bicultural/Bilingual Health Professionals

by Robyn Iredale

The Situation

> *'There is a coherent pattern of underutilisation of inpatient and community mental health services for NESB immigrants'* (Minas, 1993)
>
> *'Almost nothing is known about the quality of treatment outcomes for NESB immigrants' - in relation to mental health* (Minas, 1992)
>
> *'We have had contact with women who, ten years after they had a hysterectomy, still did not understand what had happened'* (quoted in Alcorso and Schofield, 1992)

Abstract

Targeted recruitment in the health systems to meet the special needs of patients has never been a high priority. The assumption has normally been that any health professional, working in conjunction with a trained interpreter, can adequately service a patient of non-English speaking background with or without low proficiency in English.

Many articles and submissions have alerted governments to the need for more sensitive and targeted recruitment and workforce planning and more effective human resource development and management. But evaluations of migrant health services carried out in 1993 highlighted again the inadequacies in these areas.

The options are to train workers in Australia, recruit or recognise appropriate bicultural/bilingual health workers from overseas or a combination of all of these.

At the 1991 census, 3,756,467 people or 22.3 per cent of the total Australian population registered as having been born overseas. For NSW, 1,306,692 of the 1991 population of 5,731,906 or 22.8 per cent were overseas-born and 854,851 (14.9 per cent) were of non-English speaking background.

The 1991 census also showed that there was a total of 2,448,909 people in Australia, or 14.5 per cent of the population, who spoke a language other than English at home. Of these, 22 per cent responded that they spoke no English at all or they did not speak it well.

For NSW, 922,326 or 16.5 per cent of the NSW population spoke a language other than English (LOTE) at home. Among these there is very great diversity in languages and ethnicity. The largest language groups in NSW were Chinese languages (which accounted for 13 per cent of LOTE speakers), Italian (12 per cent), Arabic/Lebanese (11.5 per cent) and Greek (10.3 per cent). Table 1 shows the data from the 1986 and 1991 censuses as well as the intercensal change. The most rapid increase has been in Chinese languages which increased by 90 per cent over this five year period.

Table 1: Languages other than English spoken at home at the 1986 and 1991 census, number and percentage change

Language	*1986*	*1991*	*% of 1991*	*Change 1981-91*	*% Change 1981-91*
Arabic/Lebanese	78 459	106 414	11.5	27 955	35.8
Chinese languages	82 832	119 551	13.0	56 719	90.3
Dutch	15 878	11 485	1.2	-4 191	26.7
French	18 684	17 155	1.9	-2 529	12.8
German	34 680	34 609	3.8	71	0.2
Greek	92 879	94 814	10.3	1 935	2.1
Italian	109 925	110 817	12.0	892	0.8
Maltese	23 469	20 410	2.2	-3 059	13.0
Polish	20 612	19 124	2.1	-1 488	7.2
Serbian, Croatian	27 088	34 052	3.7	6 965	25.7
Spanish	40 505	45 994	5.0	5 489	13.6
Vietnamese	23 091	39 401	4.3	16 310	70.6
Other	199 387	268 500	29.1	69 113	34.7
Total LOTE speakers	748 285	922 326	100.0	174 041	23.3
Total NSW population	5 318 260	5 585 509	16.5	525 315	10.1

Source: Table compiled by Census Applications, 1993 from ABS 1981, 1986 and 1991 census data.

In the past, the inability of many Australian institutions to adequately service all sectors of the Australian community was a major reason behind the move from 'less tolerant ethnic affairs policies' to multiculturalism, according to Alcorso and Schofield (1992, p. 96). It was not until the 1970s that welfare and health workers began to identify the need for specialist health interpreters and culturally sensitive servicing.

Needs or rights

Then, in the 1970s, migrants were often identified as a group with *problems* where the problems were 'attributed to their ethnicity or culture, rather than to economic or gender inequalities' (Bottomley and de Lepervanche, 1990). This focus freed mainstream organisations from bearing any responsibility for producing these 'problems'. That is, the way that they delivered their services was not at issue.

In the 1980s there was a move towards access and equity and more of a concept of *rights* rather than needs. Adequate and appropriate servicing came to be seen as a matter of right.

In order for these rights to be fulfilled, services need to be made more *accessible to people of NESB* and the services provided need to be more sensitive or *appropriate*, to their needs. 'Appropriate primary health service provision is, among other things, contingent upon the provider's capacity to adequately interpret and understand what the patient or client is saying about their complaint or condition, and the circumstances in which it occurs' (Alcorso and Schofield, 1992, p. 102).

In the National NESB Women's Health Strategy (1992), the Commonwealth-State Council on Non-English Speaking Background Women's Issues identified three key areas of service delivery that required reform:

- communication
- the culture of health services
- the structure of service delivery.

The first two of these areas will be discussed here.

Overcoming communication problems

One of the major ways of overcoming poor communication is by utilising specialist health care interpreters. But the health care interpreter service is far from adequate. Some of the major problems are:

- a specialist health interpreter service is lacking outside of NSW, Victoria and the ACT and is far from adequate in these three areas;

- the limited hours of the services;
- health care providers often lack skill in the use of interpreters or awareness of the need for interpreters;
- inadequate professional standards amongst interpreters;
- lack of availability of an appropriate interpreter in terms of gender, dialect and age.

Even if the difficulties with current health interpreting arrangements were eliminated, however, there are shortcomings with relying on interpreters, especially in sensitive areas such as mental health care, obstetrics and gynaecological care, drug and alcohol counselling, aged care and torture and trauma services. An interpreted consultation may be:

- too time-consuming,
- too insensitive or
- too imprecise.

Overcoming problems associated with ethnospecific service cultures

Parsons (1990, p. 108-53) provides a very good explanation of 'cross-cultural issues in health care'. She explains how notions of the body and mind, ways of communicating body, mind and illness and the concept of medical systems are all culturally based. But people of the one ethnic group do not all display the same views and behaviours.

Service providers and practitioners who do not recognise the many different ways of approaching health and illness cannot possibly service all clients satisfactorily. This emerged in a review of *Drug and Alcohol Intervention in a Multi-Ethnic Society* by the Centre for Multicultural Studies at the University of Wollongong (Morrissey et al., 1991, p. 162). In relation to treatment methods, the authors argued that:

> ...the use of interpreters in this process *in itself* represents the provision of a second-class service compared to that available to people whose therapy is conducted in their own language. In fact we would apply this stricture even to cases where the supply of well-trained interpreters is unlimited ...

In relation to providing appropriate services for drug and alcohol abuse it was stated (Morrissey et al., 1991, p. 184):

> ...that attitudes to substance usage, levels of substance usage, and even the *meaning* of substance usage varies from ethnic group to ethnic group. One might, in fact, say the same thing about any aspect of belief and practice about health, illness and healing. ... we should see the problem as one of structuring service delivery so that services are forced to respond to the fact of cultural diversity because of this very structure.
>
> The starting point for this is to increase the linguistic availability of the services and we argue strongly that the only way to do this is to increase the linguistic resources available.

It is clear that the lack of bilingual health professionals, and particularly female bilingual doctors, counsellors, nurses and specialists, is a major stumbling block to the provision of adequate and appropriate services for NESB clients. Given that most health care is provided by the private sector it is these services that need to be changed markedly. This issue was repeatedly raised in community consultations for the NESB women's health strategy.

Numerous other articles and submissions have alerted governments to the need for more sensitive and targeted recruitment and workforce planning and more effective human resource development and management. But targeted recruitment in the health systems to meet the special needs of patients has never been a high priority. The assumption has normally been that any health professional, working in conjunction with a trained interpreter, can adequately service a patient of non-English speaking background who has low proficiency in English.

Overall, there is still little priority given to hiring people with bilingual or bicultural skills. A survey of the two pages of health and medical advertisements in the Sydney Morning Herald on Saturday 9 October 1993 (pages 28A-29A) revealed only three advertisements where language or cultural skills were specifically mentioned as being essential, desirable or beneficial. The first ad was seeking a Mandarin-speaking nurse for Burwood and Liverpool, the second wanted a Thai-speaking Multicultural Health Promotion Officer (Sexual Health) for Sydney Hospital and Barnardos sought a Child Sexual Assault Counsellor where 'experience of working within a multicultural community would be beneficial'.

In contrast, the Northern Sydney Area Health Service advertisements were all silent on these aspects in spite of the fact that northern Sydney is the region of Sydney with

one of the most rapid rates of influx of NESB immigrants. The 1991 census data show while the NESB proportion of the population is still lower (12.8 per cent) than in other regions, 78 per cent of the increase in the region's population between 1986 and 1991 consisted of people of non-English speaking background.

The question must be asked as to why targeted recruitment has not been an active policy. The outcome is a situation, for example, where the majority of medical practitioners are male and of English-speaking background. Only approximately 9 per cent of general practitioners acquired their qualifications in NES countries (Alcorso and Schofield, 1992, p. 100). For specialists the percentage is lower at 2.5 per cent; and lower still for other health professions.

Solution

The first issue is to continue to try and convince health service providers that these aspects are important. Looking back at the *Proceedings and Workshop Recommendations* of the Adelaide April 1988 conference, the report (1989, p. 47) stressed the need for bilingual and bicultural health professionals.

Once this need is re-affirmed, the options are to recruit appropriate bilingual health workers from overseas, to recognise the overseas qualifications of bilingual and bi-cultural immigrant health professionals already in Australia and enable them to gain employment in their field of training, to train bilingual workers in Australia or provide adequate cross-cultural training for all health professionals. Each of these options will be considered separately though some mix of the four is probably the most likely outcome.

(1) The recruitment of professionals from overseas has varied. On the whole, it has not been aimed at meeting specific needs. Overseas recruitment has been more geared to filling general vacancies, for example in the medical and nursing areas. Some of this has been of a temporary nature (such as the recruitment of general practitioners in the UK, Ireland, Hong Kong, Malaysia and South Africa for a period of up to two years to meet shortages in country and outer areas of capital cities), while some has been permanent (such as the recruitment of nurses from the UK, Ireland, Canada, etc in the late 1980s when there was a general shortage). Most of this general recruitment has now stopped due to a perceived oversupply in nursing and in medicine and to pressure from the respective unions.

Some targeted recruitment has occurred, for example of psychiatrists to Victoria in the 1980s. Four psychiatrists were brought from overseas to service ethnic communities that were in need, such as the Turkish and Serbian communities. Unfortunately the scheme did not work and was disbanded.

In the past, the number of health professionals who have arrived from overseas as immigrants has been relatively independent of the need for such people. Independent and Concessional applicants qualify through the points system while family reunion migrants and refugees are not points-tested. The former two categories are now required to have their qualifications recognised before they are able to acquire the necessary number of points to be selected for entry. In addition, from 1992, a potential immigrant who is a medical practitioner has ten points deducted from their score - thereby lessening their chances of qualifying for entry to Australia.

Alcorso and Schofield (1992, p. 109) described 'the strong resistance on the part of the medical professional associations to the provision of incentives to recruit bilingual practitioners, or to possible schemes to *fast-track* registration processes for overseas trained doctors'. Bodies such as the Australian Medical Association (AMA) have lobbied governments to prevent the continuation of offshore recruitment as well as actively seeking to get a cut in immigration. In addition, representatives of the AMA sit on all state medical registration boards. These boards are renown for failing to use their discretionary powers to enable overseas trained doctors, especially specialists, to be granted provisional registration so that they can take up employment that has been offered to them. The imposition of a quota on the number of people who could be admitted into medical practice each year in Australia, by the Federal and State health Ministers, is the most extreme example.

(2) The recognition of the overseas qualifications of immigrant health professionals has been an intractable problem in Australia. Once in Australia many people have faced the situation of their qualifications not being recognised. The situation first occurred on a significant scale with Jewish refugee doctors in the 1930s but since then a progressive tightening of assessment procedures, the elimination of work experience opportunities (in medicine and nursing) and the introduction of other requirements has occurred.

In 1989, there was optimism that the establishment of the National Office on Overseas Skills Recognition (NOOSR) and the establishment of the NSW Migrant Employment and Qualifications Board (MEQB) and similar offices in other states would lead to positive change.

Some things have improved, such as the provision of bridging courses, but overall the situation has actually worsened. The nature of assessment procedures has received little attention - either from National Office of Overseas Skills Recognition (NOOSR), the State Boards/Units, the Industry Commission (IC) in the *Exports of Health Services* or the Vocational Education, Employment and Training Advisory Committee's (VEETAC) inquiries into panels and councils for overseas trained people in nursing, dentistry, physiotherapy, dietetics, occupational therapy, pharmacy, podiatry and radiography.

The 'autonomy' of the professions to set their own standards and then to decide who meets those standards continues. NOOSR opted for the strategy of working with the professions and trying to encourage them to be fair and equitable in their operation. But the IC found in 1992 that tight controls in the health professions appeared to go well beyond patient protection. The report stated that there was evidence that the regulations had been used as a device to restrict competition.

The NSW Minister for Ethnic Affairs set up a Taskforce in 1993 to report on the recognition of overseas qualifications and the hiring of people of non-English speaking background in the NSW public sector. The terms of reference are similar to the 1988-89 NSW Fry Committee of Inquiry into the same area which suggests that there has been little change.

(3) The training of bilingual health professionals in Australia. This method of obtaining bilingual medical practitioners has been the one recommended by the medical fraternity. Passmore, Secretary General of the AMA, in a letter to the editor of the Sydney Morning Herald (SMH, 13/4/92) argues that:

> Migrants and the children of migrants are proportionally much better represented among medical students than one would expect from their representation in the population as a whole. It is they who will provide medical services relevant to the migrant community, rather than overseas-trained doctors.

Whether the situation that Passmore envisages will prevail is unclear at the moment. The probability that students will retain their cultural and linguistic heritage is minimal and the heavy concentration of Asian students in Australian medical schools is not proportionate to the composition of first and second generation ethnic communities in Australia. The Committee of Inquiry into Medical Education and the Medical Workforce (1988, p. 532) found that 'both students and parents of students of non-English speaking background were predominantly from Asia, whereas nationally

the majority of migrants from non-English speaking countries are from Southern Europe.

Actively seeking the enrolment of NESB students in courses or positive discrimination in training opportunities in favour of people with pre-existing linguistic ability would both be options that could be pursued. Unfortunately there are limitations on these mechanisms, such as the requirement of a certain Tertiary Entrance Result for entry to most professional health courses.

Some Universities, such as the University of Newcastle and the Victorian University of Technology, have sought to overcome this problem by selecting medical students by interview and on the basis of a range of criteria, including non-English speaking background. The numbers are small, however, and unlikely to impact greatly on the system.

All universities have access and equity policies and EEO strategies which should enable the greater participation of NESB students in all courses, including health courses. But the DEET higher education statistics for 1989 and 1992 show a decline in the proportion of NESB students enrolled in these courses in the last three years. Table 2 shows that the number of NESB students in health studies increased slightly from 4,263 in 1989 to 4,684 in 1992. But the proportion of all students undertaking health courses was 24 per cent in 1989 and 20 per cent in 1992. Nevertheless, the NESB component was higher than the 14.5 per cent of the overall 1991 census population.

Clearly, training bilingual students in Australia is a possibility but there is no guarantee of getting the supply of professionals that is needed or of them possessing the bilingual and bicultural skills that are required. Access to universities is determined by entrance scores and students' choice rather than by labour market need. The Department of Employment Education & Training (DEET) data show that amongst the major language groups, Greek-speaking students have a lower than average propensity to participate in health courses (less than 10 per cent), as do Arabic-speakers. On the other hand, the proportion of Vietnamese-speaking students engaged in health studies was 20 per cent in 1992 compared with 14 per cent for English-speaking students.

Table 2: NSW higher education enrolments by home language and field of study, 1989 and 1992

Field of Study	*English*	*Arabic*	*Chinese**	*Greek*	*Viet-Namese*	*Total non-English*	*Total*
1989							
Non award course	824	7	41	11	2	387	1 211
Agriculture, animal husbandry	2 781	4	26	1	2	231	3 012
Architecture, building	2 492	31	343	72	18	1 068	3 560
Arts, humanities, social sciences	25 802	168	472	697	62	5 696	31 498
Business, administration, economics	20 121	148	1 770	525	85	6 026	26 147
Education	17 744	61	87	179	21	3 474	21 218
Engineering, surveying	6 343	192	1 230	283	283	4 320	10 663
Health	13 704	100	851	228	262	4 263	17 967
Law, legal studies	4 194	21	189	112	23	861	5 055
Science	13 146	174	1 317	452	529	5 402	18 548
Veterinary science	447	2	12	3	0	40	487
Total	107 598	908	6 338	2 563	1 287	31 768	139 366
1992							
Non award course	1 813	17	90	36	5	483	2 296
Agriculture, animal husbandry	3 411	8	24	5	2	260	3 671
Architecture, building	3 085	38	469	114	34	1 321	4 406
Arts, humanities, social sciences	32 542	248	1 024	735	138	5 978	38 520
Business, administration, economics	23 279	259	3 873	610	250	9 429	32 708
Education	20 663	147	244	446	48	2 574	23 237
Engineering, surveying	7 706	363	1 748	299	422	5 713	13 419
Health	18 245	193	1 642	250	406	4 684	22 929
Law, legal studies	5 165	32	318	142	32	1 182	6 347
Science	17 487	304	2 457	491	666	7 862	25 349
Veterinary science	505	1	14	3	2	63	568
Total	133 901	1 610	11 903	3 131	2 005	39 549	173 450

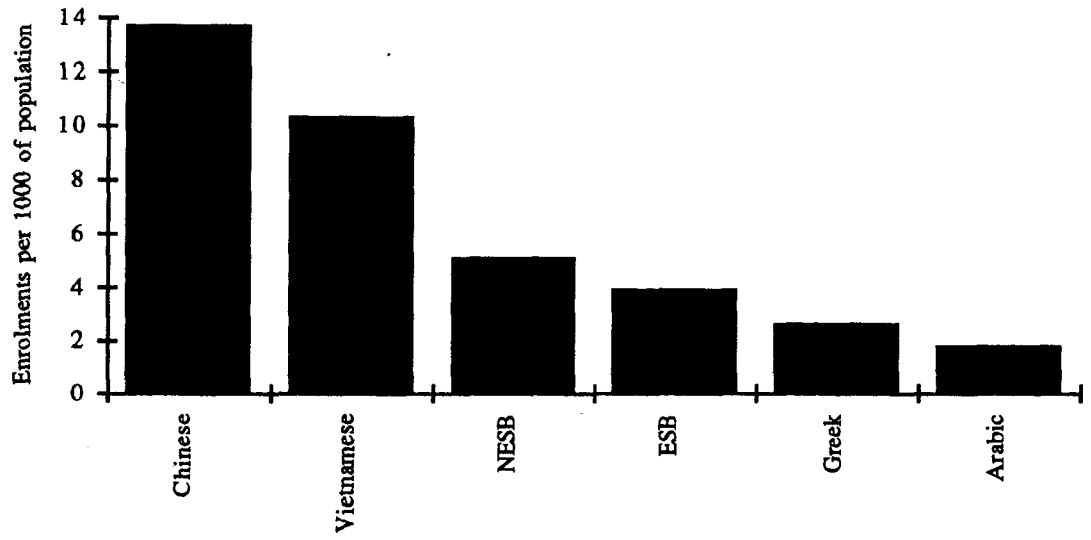
* Chinese=Cantonese+Mandarin+Chinese NEI

Source: DEET higher education data, 1993.

Figure 1 shows the number of students for various languages enrolled in health fields in higher education relative to the 1991 census count for each language group in NSW. For example, there were 13.7 students who spoke Chinese languages studying in various health fields in NSW in 1991 for every 1000 Chinese speaking people in NSW.

The figure shows over representation in the health fields of Chinese and Vietnamese speaking students relative to all English speaking and NESB students. On the other hand the Greek and Arabic-speaking communities are under-represented in the student population in the health fields. These disparities indicate that relying on Australian training as the major source of supply of bilingual/bicultural health professionals will see some communities under-serviced.

Figure 1: Higher education student enrolments in health fields in NSW, by language, 1992



Source: DEET higher education data, 1993.

(4) Provision of cross-cultural training for all health professionals. Of all four options, this is the least desirable but probably the one that has been the most favoured in Australia. The reason is that it has been seen as the simplest and the most expedient.

In fact most cross-cultural training, where it has existed, has been inadequate and often faulty. In the 1970s, attempt were made to teach people about different cultures - 'what a Greek was like', etc. In the 1980s, training became somewhat more sophisticated and talked about processes and with much less attempt to homogenise

clients. Attempts were made by the Office of Multicultural Affairs in the 1980s to integrate cross-cultural awareness training into all professional health courses but with relatively little success.

Garrett and Lin in 'Ethnic health policy and service development' (1990, p. 361) concluded that:

> As an ill-defined strategy standing alone and lacking direction, cultural awareness education must remain controversial.
>
> Cultural sensitivity education ideally should aim to improve not only knowledge and awareness but also skills for working in a multicultural health system - skills for dealing with the day-to-day issues experienced by people of non-English speaking background and acquiring an understanding of the culture of health-care systems, medicine and the institutions of health-care provision.

Reliance on such training to enable health professionals to properly service mentally-ill, aged or tortured and traumatised immigrants would be extremely unsatisfactory.

Conclusion

In the past we have had a minimalist approach to health care for ethnic groups. Institutional change is needed. From this analysis, it appears that in terms of NESB clients the provision of bilingual health professionals is required. This could be most expeditiously achieved by the recognition of more overseas qualifications and the employment of immigrant professionals. But the tension remains as the continued autonomy of the professional associations enables them to exert significant control over entry to their professions.

This issue has not been resolved by NOOSR in the DEET. NOOSR's basic modus operandi has been to try to work with the professions and encourage them to be 'less restrictive'. Unfortunately this approach has brought few positive outcomes and the move to assessing people on the basis of competencies could be just as discriminatory as the 'paper' assessment method (Iredale, 1992).

At the same time DEET has funded more bridging training places for overseas trained general practitioners, in particular, prior to the AMC examination. This has facilitated recognition for some people but often not necessarily in the communities where they are most needed. For example, the Kurdish community in Sydney which consists predominantly of refugees is very under serviced, in spite of the fact that doctors are

well represented amongst them. Bridging courses often have an examination as the means of entry and without any local experience some NESB doctors find it very hard to qualify for the course. Some form of positive assistance is required.

The situation with specialists is much worse with recognition being a matter for the Specialist Colleges. If the needs of clients were really taken seriously, the state medical registration boards would offer more conditional registration to specialists in psychiatry, geriatrics and obstetrics and gynaecology already in Australia. This is not happening, due to the power of the professional bodies.

Therefore, some overseas trained professionals will continue to trickle into the system but not as a result of overt action or a specific strategy. The training of bicultural/bilingual health professionals in Australia is likely to be the major source in the future. How sensitive they will be to the demands placed on them will be a matter for future research.

One can only conclude that the rights of clients are of secondary importance. The interest groups control the quality of service provision for NESB immigrants and the consequence of this is a much higher cost in the long run for medical services and health care. Efficient and appropriate prevention and primary care would often alleviate the development of further problems but the denial of migrants' access to such services often compounds into massive health costs for both the government and the consumer.

As Minas (1992, p. 19) concluded in his study of mental heath services, communication difficulties and cultural differences:

> may lead to inappropriate treatment and very unsatisfactory treatment outcomes for NESB patients. ... If health agencies were businesses dependent on the satisfaction of their customers, many of them would be in severe financial difficulties.

Not only is it costing the Australian community money to not service immigrant clients properly but the knowledge and skills of people trained overseas is not being tapped. It is a well documented fact that most birthplace groups in Australia experience lower mortality over the 15 to 74 age range than occurs for the total population of Australia. As Young (1992: 49) concludes:

> The denial of the health and survival advantages experienced by ethnic groups, and the failure to learn from their lifestyle and means of coping with illness, is a

waste of the opportunities provided by a diverse ethnic population for improving the wellbeing and survival of all Australians.

Employing more health professionals from overseas would provide all Australians with a wider range of options in relation to health care services so that we could be more open to other forms of health care.

Clients and their representatives should put more pressure on governments to free up the labour market and loosen restrictions on entry imposed by professional bodies and at the same time more overseas trained health professionals should challenge procedures barring entry to their occupations. South Australia, for example, has a 1991 amendment to its *Equal Opportunity Act 1984* relating to overseas qualifications which to date has not been tested. This should be tested and a similar amendment should be introduced into other relevant State and Commonwealth legislation.

It is interesting that 'productive diversity' is the government slogan in relation to industry/trade but not in relation to health. It is also interesting that professional associations want the market to operate more freely in relation to fees, but do not want the same in relation to numbers.

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The Medical Quota

by **Robyn Iredale and Marion Gluck**

In 1992 the Commonwealth Government introduced a quota on the number of overseas trained medical practitioners who could become eligible for registration each year. This paper examines the economic, equity and human rights aspects of this decision.

Introduction

This paper has come about as a result of the recently introduced quota system for overseas trained medical practitioners in Australia. The paper will discuss quota systems in general as well as analysing the effects of the medical quota.

The concept of a quota is not new in Australia. Quotas on the number of overseas trained medical practitioners eligible for registration applied in NSW from the 1930s. The NSW Medical Practitioners Act (1938) stated that foreign graduates successfully completing the last three years at Sydney University could be included in the medical register, provided that no more than eight such doctors would be registered in any one year.

The Second World War led to an influx of Jewish refugee doctors and in 1949 13 foreign doctors were eligible for registration under this section of the Act. Consequently a ballot was held to decide who should be registered after completing their medical studies. The section restricting the number to eight was subsequently omitted from the Act in October 1950.

Background

The procedures for eligibility for registration for overseas medical practitioners have changed significantly since the 1950s. Until 1978, a system was in place whereby overseas trained general practitioners could gain temporary registration and undergo three years of supervised training or work experience within a public hospital.

Satisfactory completion of this period was followed by full registration. At the end of the 1970s this avenue to registration for general practitioners was discontinued.

Some specialists had to use this avenue as a means of gaining registration, as entry to the Specialist Colleges was restricted to people with qualifications from a small number of (mainly British) institutions. The National Specialist Qualification Advisory Committee of Australia (NSQAC) had developed a list of acceptable qualifications in an ad hoc way and on the basis of institutions about which it had detailed personal knowledge. Institutions that were unknown to its members were simply not on the list.

From 1978, successful completion of an examination became the major means of gaining registration for the majority of doctors. Individual State Registration Boards continued to maintain lists of 'automatically acceptable qualifications' which included qualifications from up to 20 countries, including the major English speaking countries as well as places such as Pakistan, Puerto Rico, Lebanon, Uganda and India (Iredale, 1987: 124). NSW had the longest list of 19 countries in 1970 but by 1983 this list had been reduced to three countries (UK, Ireland and New Zealand).

Gradually these lists were whittled away so that New Zealand is now the only country whose medical qualifications are automatically recognisable on a national basis and accredited by the Australian Medical Council (AMC). In addition, South Australia and Western Australia still continue to recognise British and Irish qualifications, although these states are expected to follow the other states and only recognise the accredited New Zealand qualifications.

Medical practitioners who gained their training in all countries but New Zealand and the British Isles in WA must now sit the AMC examination. The Industry Commission (1992) in its report on *Exports of Medical Services* noted that in moving towards a national system ... the most restrictive state system—NSW—has been adopted as the benchmark.

From 1978 to 1985 the examination was administered by the Australian Medical Examining Council (AMEC), an independent Expert Panel associated with the Committee (later the Council) on Overseas Professional Qualifications (COPQ) which was located in Canberra as part of the Department of Immigration.

In 1986 the AMC was formed as an independent standards and examination body incorporated under the Associations Incorporation Ordinance of the Australian Capital Territory. The AMC is a non-statutory body which reports to the Commonwealth, State and Territory Ministers of Health and to each of the state and

territory medical boards. The AMC's three major functions are the accreditation of Australian medical schools, a role that it assumed from its fore-runner the British Medical Council, the assessment of overseas qualified medical practitioners and the promotion of uniform approaches to medical registration throughout Australia.

The AMC examination basically adopted the format of the AMEC examination. There are two components: a 150 multiple choice question (MCQ) paper and a clinical examination in the disciplines of Medicine, Surgery and Obstetrics/ Gynaecology. Table 1 provides details of the number of people sitting and passing the AMC examination each year from 1978-79 to 1992-93.

According to the AMC's figures, 345 new candidates attempted the MCQ examination in 1992-93 but there were a total of 812 attempts at the MCQ. This figure of 812 is not the number of people who sat the examination as some people may have made two attempts in 1992-93. Column 4 refers to people and shows that 208 people are identified as having passed the MCQ examination in 1992-93 - in line with the newly imposed quota. This compares with 298 for the previous year and a peak of 455 who passed the MCQ in 1990-91.

Columns 5 and 6 of the table show the number of people newly presenting for the clinical examination and the number of overall attempts at the clinical examination, respectively. The last column of the table shows the number of overseas trained medical practitioners qualifying for registration each year through the AMC examination from 1978-79 to 1992-93. The total number over this period is 1,383 with the maximum number being 246 in 1991-92.

Between 1986 to 1992, the AMC introduced a number of changes to the examination conditions, fees, eligible number of attempts etc. In response to widespread criticism, mainly from overseas-trained doctors, ethnic community groups and various government inquiries (the Commonwealth Fry Committee of Inquiry, 1982; the Doherty Report on Medical Education and the Medical Workforce, 1988; the Committee to Advise on Australia's Immigration Policies, 1988, and the NSW Fry Committee of Inquiry, 1989), the AMC commenced a full scale review of its examination in June 1989. The AMC's Working Party released an Interim Report in July 1990 and a Final Report in July 1991.

Table 1: Summary of number of candidates and attempts at examinations conducted for overseas trained medical practitioners by the AMC, 1978-79 to 1992-93

Year	*Total no. of new candidates*	*MCQ Total no. of attempts*	*No. of people passing*	*No. of new candidates sitting*	*Clinical Total no. of attempts*	*No. qualifying for registration*
78-79	174	198	117	96	103	35
79-80	125	170	104	73	100	28
80-81	92	155	91	51	85	26
81-82	91	148	77	47	78	30
82-83	118	191	76	59	107	55
83-84	111	191	74	73	150	68
84-85	122	219	85	82	149	75
85-86	143	264	111	111	214	79
86-87	253	447	69	65	190	83
87-88	193	424	88	64	137	64
88-89	282	501	122	93	168	85
89-90	392	653	326	187	281	(a) 131
90-91	538	915	455	278	391	194
91-92	523	921	298	344	587	246
92-93	345	812	(b) 208	192	434	184
Total	3 503	6 209	2 301	1 815	3 174	1 383

Source: AMC statistics supplied by the Executive Officer, 1993

Notes

(a) In 1990, with a change in the standard of the AMC examination, a provision for AMC candidates to complete 12 months supervised practice was introduced. Medical boards retain the discretion to waive this provision.

(b) Includes 8 non-permanent residents who have fallen into the MCQ quota requirements but are not eligible to receive the AMC certificate. They will be able to proceed to the clinical examination as 'provisional candidates' and will be granted and AMC certificate after passing that examination and when their permanent residence status has been confirmation. They will be counted in the quota of the year that they enter the permanent workforce in Australia.

The major recommendations of the report were for considerable revision to the examination (changing it from a pass/fail examination to a screening or qualifying examination), a change to a system of separate dual pathways for general practitioners and specialists, and improved counselling, bridging course and appeal services. The major features of the new assessment procedures were to be implemented by the beginning of 1993 but the announcement of the quota system introduced a new element for the AMC. Consequently the AMC decided not to change the format or content of the AMC examination for 1992-93.

The re-introduction of a medical quota system in 1992

Medicine is the only profession to date which has had an explicit quota system, though in many occupations there have been fears of unofficial quotas being in operation for many years.

A Task Force to examine the medical workforce was set up by the Commonwealth Government in 1991 with membership from the Departments of Health, Housing & Community Services, Immigration, Employment, Education and Training, and Prime Minister and Cabinet (Office of Multicultural Affairs). In April 1992 the Health Ministers' Conference voted for the implementation of three strategies to restrict the supply of overseas trained medical practitioners entering the temporary or permanent labour market in Australia. The strategies are:

(1) a quota system to restrict the number of overseas trained medical practitioners eligible to proceed to registration each year. The quota system was first introduced by the AMC in July 1992 in response to it being formally outlined i by the former Minister for Health, Brian Howe, in April 1992. The report calls for limiting the entry of overseas trained doctors into local practice to 10 per cent of the annual output of Australian medical schools. The quota does not apply to specialists who under the new arrangements recommended by the Australian Medical Council are expected to apply directly to the Specialist Colleges for assessment, rather than sitting the AMC examination.

(2) a review of the selection points system in relation to overseas trained doctors. The outcome has been a decision by the Department of Immigration, Local Government and Ethnic Affairs to deduct 10 points from the score achieved by a person applying to migrate to Australia in the Independent and Concessional categories where that person is a medical practitioner.

Points are accrued for education, training, work experience, recognition of qualifications, English language proficiency, age, etc and are then subjected to a loss of 10 points. Overseas medical practitioners who wish to migrate as Concessional or Independent migrants must commence the assessment of their qualifications before they are processed for migration purposes. The MCQ may be attempted at overseas locations but the clinical examination can only be undertaken in Australia. This means that an intending migrant must travel to Australia for the purposes of the second part of the AMC examination and be successful at that part before they can complete the immigration process.

Even then, they may not accrue the requisite number of points because of the 10 point deduction at the end and because of the floating mark for entry to the pool of potential migrants.

(3) abolition of the recruitment of temporary work visas for doctors from overseas. Over the last decade, doctors have been actively recruited in the UK, Ireland, South Africa, Hong Kong and Malaysia, to fill vacancies in public hospitals. These countries were selected on the basis of previous scores at the Australian Medical Council's examination of candidates from these countries. Overseas trained doctors already in Australia had been arguing that they should be eligible to fill such vacancies on a provisional registration basis. Though State Medical Registration boards were able to grant provisional registration to overseas trained doctors to fill vacancies in areas of demonstrated need, on the whole there was no use made of this mechanism. Abolition of temporary entry now seems to have been replaced by a proposal to phase out temporary overseas recruitment over the next five years.

The mechanics of the quota system

The provisions that will apply to the AMC examination as a result of the Ministers' decision are:

a) A limit of 200 places in any one year has been set on access to the AMC clinical examination. This quota will be determined on merit order performance in the MCQ examination. The quota will be subject to review by the Health Ministers.

b) Those overseas trained doctors who have already passed the AMC MCQ examination or have commenced but not yet passed the clinical examination will be permitted to continue with the clinical examination outside the quota but subject to the normal requirements of the AMC examination.

There will be no limit on the number of attempts that can be made at the MCQ examination but three unsuccessful attempts will lead to counselling and advice regarding future options and the need for further training. The fact that the MCQ examination is to be offered only once, rather than twice a year as it has been in the past, will slow down peoples' attempts at recognition.

There is a limit of three attempts at the clinical examination and then candidates will be required to resit the MCQ examination and compete for one of the quota places. Where there are more candidates for the clinical examination than there are places, candidates will be ranked according to their score at the MCQ and the number of attempts that they have already made at the clinical examination. New candidates will be given priority.

Arguments for the medical quota system

The basis for the medical quota seems to be twofold. First, the former Minister for Health, Brian Howe, in a letter to the President of the Overseas Trained Doctors' Association argued that:

> Australia has a larger medical workforce than it needs and this surplus has generated substantial costs for the community and contributed little to overcoming structural and distributional problems.
>
> With the doctor surplus projected to worsen significantly, steps are necessary to reduce the growth of the medical workforce from all sources. A coordinated strategy that was agreed to by the Australian Health Ministers in April is being developed to reduce doctor supply from around 1 doctor per 430 people to one doctor per 500 people. (Letter to Dr M. Gluck, 24/7/92)

In a later letter to Sir William Keys, Chair of the National Advisory Committee on Skills Recognition (NACSR), Brian Howe expanded on the reasons why the increasing costs were justifiable reason for a quota. He said (12/10/92):

> ... no other profession enjoys automatic access to an open-ended Government funded payment system upon registration, and while the Government is committed to helping migrants obtain recognition for their skills, entry to the medical workforce, from any source, cannot be unlimited.

Another letter from J. Whalan, Assistant Secretary, Workforce Policy Branch, Dept. of HH&CS, to Dr Gluck (20/6/92) pointed out that:

> ... although the total number of candidates who have passed the Australian Medical Council examination is relatively small, it is growing rapidly. Over 200 candidates passed in 1991 and around 300 are expected to pass in 1992 (compared with 76 in 1988) which will represent one quarter of the annual output of Australia's medical schools. These figures reflect the rapid growth in

> the number of overseas trained doctors who have entered Australia in recent years (to a level that Australia cannot afford to sustain) as well as the benefits of the range of measures the Government has introduced to help migrants enter the occupations for which they have trained.

Second, the Australian Medical Association (AMA) has applied continuous pressure about the alleged oversupply of doctors in Australia, especially regarding the contribution by the number of overseas trained medical practitioners. The AMA's opposition to overseas trained doctors has a long history in Australia. Its predecessor, the British Medical Association (BMA) which existed in Australia up till 1962, opposed doctors qualified in other than British universities when Jewish refugee doctors arrived before and after World War II. According to Kunz in his book *Displaced Persons Calwell's New Australians* (1988: 191):

> The AMA used the same tactics of power politics and misinformation when confronted with the arrival of about 330 male and 70 female DP [Displaced Persons] doctors, amongst whom Hungarian men and Latvian women predominated. Through the registration boards in each state, which were *de facto* controlled by the AMA Council, and through AMA influence over medical faculties, they were able to ensure that universities forced foreign-qualified doctors to study for at least three years at local medical schools. ...
>
> Though labelled incompetent, unethical and dangerous, the DP doctors were allowed to work in areas where work was arduous and financial rewards were meagre. There were no AMA objections against a handful of outback appointments. They were also allowed to serve as medical officers at the Australian Antarctic Stations and in Papua New Guinea—places where Australian doctors were seldom keen to go.

In the 1990s the AMA voiced its views as follows:

> There is broad agreement between the Government and the medical profession that there are already too many doctors. The growing oversupply can only be solved either by reducing the output of medical schools, or the registration of foreign trained doctors, or both.
>
> The AMA strongly believes that an attempt must be made to deal with the problem by restricting overseas trained doctors, first, before there is any reduction in medical school student numbers.

At the same time, the Deans of Australian Faculties of Medicine in a letter to the Sydney Morning Herald (Glover, 13/4/92) said:

> ... while the intake of students has been reduced the number of overseas-trained doctors (OTDs) entering the workforce has continued to rise. Should this trend continue, the number will equal the output of all 10 medical schools by 1994. If, as proposed in your editorial (*Herald,* April 8), there should be a cutback in the training of Australian students rather than a limit on the number of OTDs, it would be necessary to close most of our medical schools to solve the problem of oversupply.
>
> However, depriving young Australians the opportunity to become doctors is not the most serious consequence of this ludicrous proposal. Your editorial fails to recognise the high quality of the graduates produced by our medical schools and the relevance of their training for practice in Australia.

The annual output of Australian medical schools is between 1200 to 1400. Table 1 above shows that in 1990-91 and 1991-92 the number of overseas trained doctors passing the AMC examination was 194 and 246, respectively. Clearly Glover et al. exaggerated the numbers in their letter to the Sydney Morning Herald.

There appears to have been a deliberate campaign by some sections of the medical profession to exaggerate the numbers and escalate fears amongst their colleagues. For example, in letters to the Sydney Morning Herald, Dr Summons, Acting Secretary General of the Committee of Presidents of Medical Colleges, said on 17 January 1992 that 'about 800 overseas-trained doctors entered Australia each year, most into general practice' while on 28 April 1992 Dr Buhagiar, President, Royal Australian College of General Practitioners, said that in 'both 1990 and 1991, over 1,200 overseas-trained doctors qualified to practice here'.

The principles of quota systems

The introduction of a medical quota raises important issues of both principle and practical outcomes. The issues of principle will be dealt with first.

Positive side of a quota system

1) Curtails supply

The overall effect is to limit the supply from overseas of people in a particular occupation. This has dual effects. First, it lessens competition within an occupation and ensures higher employment of local graduates, along with presumably higher income levels. The recent report that was commissioned by the Federal Government, *National Competition Policy Report* (Hilma 1993), would not condone such an approach.

2) Guarantees more training places for Australians

Second, it guarantees places of training in Australian institutions for Australian residents, without pressure to reduce the number of places on account of supplies coming in from overseas.

3) Effect on over-servicing

The argument is frequently put that the supposed excess of doctors in Australia leads to over-servicing with the logical conclusion that a reduction in the number of doctors will automatically lead to a reduction in over-servicing. There is no conclusive evidence that this would occur. Any system of fee-for-service payment is open to abuse and it is not clear that a possible reduction in over-servicing is a positive argument in favour of a quota.

Negative side of a quota system

1) Denial of basic human rights

People have been admitted to Australia as permanent residents and therefore are entitled to appropriate employment and equality of treatment. Australia is a signatory to various international agreements, as well as having enacted laws to give effect to these agreements, which protect the rights of all residents of Australia. Quota systems that discriminate against people trained overseas contravene these instruments and laws.

In a media release issued when the concept of a quota was being discussed, Sir William Keys stated (20/2/92) that:

> In principle, the very nature of any quota system is unfair, unequitable, and discriminatory. ... At the same time, such a practice could be seen as discriminatory against one particular group of migrants and as such would not be in accordance with the principles of equal employment opportunity.

2) Wastage of skills

Skills embodied in migrants and gained at the expense of foreign taxpayers arrive as a gift to Australia. There is no compensation to the country that loses its skilled personnel. When these skills go unutilised or underutilised in Australia the loss is magnified.

According to Kirk (SMH, 6/4/92) it is 'extremely uneconomic for Australia'. Sir William Keys is quoted in the same editorial as saying:

> We are prepared to take someone from high school, put them through a skilled course and spend perhaps $200,000 training them when we already have qualified people here, on whom that money has been spent, waiting in the shadows.

3) Mixing recognition and labour market issues

Another major argument against a quota is that it confuses 'issues of recognition' with labour market supply and demand. It has repeatedly been stated in Australia that the recognition of overseas qualifications should be independent of the situation in the labour market. For example, the Fry Committee of Inquiry into the Recognition of Overseas Qualifications in Australia (1982: 36-7) referred to a confusion of human resources and assessment issues and stated that:

> recognition has sometimes been withheld because an occupation was perceived as being, or likely to be in the near future, in a situation of over supply.
>
> ...Finally, the Committee is of the strong opinion that accreditation and manpower [sic] or employment issues are, and should be kept, distinct.

In 1988, *The Discussion Paper: Towards a National Agenda for a Multicultural Australia* (1988:77) stated that the recognition of overseas qualifications mechanisms:

> ... is a system tailor-made for closed shops and one entirely at odds with the strategy of increasing Australia's exposure to international competition.

> Certainly Australian standards need to be preserved, but skills must not be lost because of a mixture of bureaucratic red tape and protectionist sentiment.

Consequences of the medical quota system

1) Denial of natural justice as outlined in Migrant Skills Reform Strategy

People may now pass the MCQ but not be eligible to sit the clinical as they are not in the top 200 in a given year. Their only option is to re-sit the MCQ and hope to be in the top 200 at the following examination session. This is a type of lottery similar to the ballot system of 1949. That is, candidates possess the skills required to pass the MCQ but regulation of the numbers prohibits them from demonstrating their clinical skills.

The AMC has countered this criticism by saying that the MCQ examination is no longer of the pass/fail variety but is now a screening or qualifying examination. Therefore, it is legitimate to select the top candidates.

The Overseas Medical Graduates Association (OMGA) of Victoria (1992) has stated that in making the decision about the quota the Health Ministers have breached the Government's own Migrant Skills Reform Strategy. The Association says:

> ...the strategy stipulates that each person with professional or para-professional skills gained overseas should be entitled to have those skills recognised for employment purposes in Australia subject to demonstrating his or her ability to meet Australian national competency standards for that profession or para-profession. A significant level of inconsistency and confusion at the government level is confirmed further by the fact that the Quota Decision directly contradicted the earlier resolution of the Australian Health Ministers' Conference (supported by the AMA) that 'the standard of the AMC examinations conducted after 1st January 1991 should be the level of attainment of medical knowledge and clinical skills corresponding to that of newly qualified graduates of Australian Medical Schools who are about to commence intern training'. The Ministers' decision stipulated that only the 100 best applicants passing the MCQ examination (ie. not all who pass it at the national standard expected from local graduates) will be allowed to take the clinical part of the examination. In effect the legislation expects a higher medical knowledge from Australians who were trained overseas than from

those trained in Australia for the purpose of being eligible to practice medicine in this country.

This discrimination is compounded by the fact that the affected group of people already resident in Australia has no alternative recourse for proving themselves eligible for professional recognition and employment. Accordingly the decision:

> ...is in breach of Australian constitutional guarantee of the equality of all citizens. It also appears to be in breach of the Human Rights and Equal Opportunity Commission laws of Australia and therefore should be fully investigated ...

2) Two sets of criteria for entry to the profession apply

As noted above, the AMC examination has become a sifting or qualifying examination where a maximum of 200 overseas trained medical practitioners per year can proceed to the clinical examination. This compares with the situation for Australian trained doctors where all medical students who satisfy university requirements can proceed to the next level of training. All Australian medical students who satisfy the requirements of the AMC are eligible for registration after one year of internship.

3) Indirect discrimination towards non-English speaking background (NESB) candidates

Flowing from the above two points is the fact that it is a well established fact that English-speaking background candidates achieve higher scores at the MCQ than NESB candidates. The reasons are different models of training, patterns of patient care, drugs and examination types. The discrimination is indirect because it is built into the system for selecting the quota.

On the other hand and completely ignoring this point, the former Minister for Health, Brian Howe, argued in a letter (12/10/92) to Sir William Keys that the new arrangements are not discriminatory since 'doctors from the United Kingdom, Ireland and South Africa will no longer be exempt from the AMC process...'.

4) Inhibiting access and equity

In 1986, the Commonwealth Government introduced its Access and Equity (A&E) Strategy to ensure equitable access to government services for the whole population. Access to medical services, including public hospitals, community health centres, government sponsored medical practitioners and so on, is incorporated under the

A&E Strategy. Indirect discrimination against certain NESB groups of doctors denies their communities access to culturally and linguistically appropriate medical services. Passmore, Secretary General of the AMA, in a letter to the editor (SMH, 13/4/92) argues that:

> Migrants and the children of migrants are proportionally much better represented among medical students than one would expect from their representation in the population as a whole. It is they who will provide medical services relevant to the migrant community, rather than overseas-trained doctors.

That the situation that Passmore envisages will prevail is unclear at the moment. The probability that medical students will retain their cultural and linguistic heritage is minimal and the heavy concentration of Asian students in Australian medical schools is not proportionate to the composition of first and second generation ethnic communities in Australia.

Table 2 shows the number of new settlers to Australia each year from 1978-79 to 1992-93, together with the ratio of new settlers to overseas-trained doctors qualified for registration through the AMC examination each year.

Table 2: New settler arrivals and ratio of new settlers to migrant doctors qualifying to practice in Australia, 1978-79 to 1992-93

Year	*No. of new settlers in Australia*	*No. of new settlers to no. of o/s trained doctors passing AMC*
78/79	67 192	1 920
79/80	80 748	2 884
80/81	110 689	4 257
81/82	118 031	3 934
82/83	93 011	1 691
83/84	68 810	1 012
84/85	77 508	1 033
85/86	92 590	1 172
86/87	113 541	1 368
87/88	114 466	1 789
88/89	145 316	1 710
89/90	121 227	925
90/91	121 688	627
91/92	107 391	437
92/93	76 000	435
Total	1 512 208	1 093

Source: Department of Immigration statistics, 1993.

The table shows that the ratio of new arrivals to the number of overseas trained doctors qualifying to practice through the AMC examination has changed significantly. In 1980-81 the ratio was 4,257 new settlers to every one doctor qualifying and since then the ratio has declined to 437 and 435 settlers to each doctor qualifying in 1991-92 and 1992-93 respectively.

The figures suggest that just when the ratio of new patients to new overseas trained doctors approximated the Australian patient/doctor ratio and when their was a chance of greater access and equity for migrants the rules were changed.

5) Labour market control

The quota to sit the clinical exam is set at 200/year whereas Table 1 shows that in 1991-92, 298 people were eligible to proceed to the clinical examination. For general practitioners from all but New Zealand and UK/Ireland in WA, this is the only avenue for registration.

This figure of 200 does not include people who are not permanent residents of Australia. People who are in the process of applying to migrate to Australia are awarded 'provisional candidate' status if they qualify within the quota to proceed to the clinical examination. They will not be counted as part of the quota till they actually qualify for permanent residence status, after having satisfactorily negotiated the Department of Immigration and Ethnic Affairs' points system. People with Australian permanent residence status who for whatever reason sit the MCQ overseas are considered as part of the quota.

In 1992-93, eight non-permanent resident candidates still outside of Australia were granted 'provisional candidate' status to come to Australia to proceed to the clinical examination. They will be counted in the quota system in the year that they ultimately migrate to Australia and become part of the permanent medical workforce.

The AMC has worked out this system so that non-permanent resident candidates do not take up some of the quota until they are actually granted a permanent residence visa and proceed to Australia. This is not fully understood by overseas-trained doctors already resident in Australia, some of whom would still wish to exclude all but permanent residents from the quota.

6) The quota applies after the MCQ and before the clinical examination

Only three attempts are permitted at the clinical examination. Failure at the clinical requires re-sitting the MCQ and re-qualifying for the clinical examinations. In the

past 70 per cent of people, on average, have eventually passed the clinical. One would expect this proportion to rise after the quota, given the creaming off process that is being applied, but the number actually passing would still be expected to be less than 200.

If the labour market absorption capacity (as decided by the 1992 Health Ministers Conference) was 200 doctors per year, the question remains as to why the quota was not imposed after the clinical examination. In all probability this would have led to even more criticism of the quota by fully successful AMC candidates. At the moment, it can be argued that successful MCQ candidates are only partially assessed and that only the best candidates are selected to progress to the clinical examinations. The placement of the quota at this point is probably aimed to reduce the amount of political backlash.

7) Reduction in medical immigration

The stated purpose of the quota decision was to 'immediately decrease medical immigration'. This means that potential migrants to Australia who are medical practitioners are discriminated against both by the quota system and the deduction of 10 points from their points score. Instead of overt discrimination on the basis race, discrimination now occurs on the basis of occupation.

Conclusion

The only desirable outcome is for the quota system to be totally abolished and for a situation of fair and open competition in the medical profession to be instituted. This would involve major changes in the whole system of assessing overseas qualifications. These have been canvassed elsewhere and stress the importance of equity and the provision of adequate assistance (see for example, National Population Council, 1988; Iredale, 1988).

Australian medical practitioners have a long history of trying to restrict competition from overseas-trained doctors but it is time to move to a new era whereby the free flow of labour is encouraged and the wastage of skills is eliminated. 'The Government needs to take a lead on this issue and demonstrate a real commitment to a more open policy rather than giving out signals of wanting to continue to protect Australian workers' (Iredale, 1992: 49).

In the past, Australian governments have shown an unusually high level of acquiescence when it comes to the wishes of powerful interest groups. It may be part of a trade-off but in this particular situation it results in a blatant denial of human rights. Immigrants have a right to equal treatment and placing an absolute limit on the number who can get their qualifications fully assessed, and therefore denying them the opportunity to work in their chosen field, is discriminatory.

In particular, the quota should not apply to people who enter Australia in the Preferential Family or Refugee/Special Humanitarian categories. The first group are exercising a basic right to family reunification and in many instances are coming to join people who earlier migrated as refugees. The latter group have not come here by choice. They have been uprooted and forced to move to a place where their safety and that of their family can be guaranteed. Our international obligations require us to assist such people.

These two groups of people, therefore, need special assistance and support. They may, in some instances, require considerable retraining but they deserve to be treated with dignity. To be told that you do not 'fall into the quota', assuming of course that you have got as far as passing the MCQ paper, must be the final blow. They have already qualified for the refugee or family reunion quota only to be told that they do no qualify for the medical quota.

To date there has been little evidence of real commitment to increasing Australia's international perspective in the labour market area, especially in respect of Asia. We have heard a lot of rhetoric. But until we begin to demonstrate that we no longer see ourselves as the 'white [superior] tribe of Asia' but as willing to accept and assist people with skills that may be slightly different to our own we will not become integrated into the Asian region. Protecting the living standards of one group of Australians, the medical practitioners, while the whole country bears the cost is no longer acceptable.

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