TALKING POINT

Few jobs in Australia

GEORGE REPIN

The Australian Government has recently tightened the requirements for the immigration of doctors—a move that has been applauded by the Australian Medical Association, which has been concerned about the oversupply of medical manpower. Doctors who apply for entry now need an employment nomination lodged either by an Australian health authority or by a private doctor. An acceptable employment nomination requires evidence that a suitable local doctor cannot be found to fill the vacancy. The Australian Department of Immigration and Ethnic Affairs has approved only 30 nominations for entry since this requirement was introduced in March 1979.

Australian medical manpower planning has not been notably successful. In 1973 the Committee on Medical Schools to the Australian Universities Commission, the Karmel Committee, estimated that the overall doctor-population ratio was 1 to 721 at 30 June 1972 and said that there was no gross overall deficiency of medical manpower in Australia at that time. But it decided that increasing demands for medical services created by growing affluence and other factors would call for a one-third improvement in the 1972 ratio in the next 20 years. Its recommendations, which were accepted by the Commonwealth Government, aimed at achieving a doctor-population ratio of 1 to 543 by 1991.

The committee and the Government did not know that soon afterwards another official committee would revise estimates of Australia's population growth sharply downwards, that graduation rates would improve, that world events would lead to a four-fold increase in the flow of medical migrants to Australia, and that economic recession would rouse a clamour for restraint in health care spending. In May 1978, 13 years ahead of the Karmel Committee's target, a survey by the Division of Health Services Research of the Health Commission of NSW showed that there was one active doctor in New South Wales for every 521 potential patients. On the Commission's estimate of community needs, this ratio represented an excess of 1778 doctors in the state. Similar figures have been published for other states.

It is now almost universally agreed in the medical profession and by most responsible health authorities that if there are not too many doctors already there soon will be. At 30 June 1977 Australia was producing medical graduates at the rate of 8·6 a year for every 100 000 of population compared with 6·5 in New Zealand and the United States and 5·4 in the United Kingdom. The task of the Australian Medical Association has been to recognise the problem sooner than most, to create a widespread awareness of the problem, and to try to influence those in authority to do something about it.

Several factors have made this job difficult. Firstly, there has been the lack of detailed information about medical manpower. There are eight medical registration boards in the states and territories and many doctors are registered with more than one. Many foreign doctors have registered in Australia but do not live here. Some doctors work part-time and others are registered but retired. Various registers of specialists are kept for different purposes and do not tally. Surveys have been carried out but all have limitations and tend to use different data bases. Secondly, there is no right answer to the question: "How many doctors are enough?" It is a matter of judgment based on many variables such as need, demand, population growth, growth in the economy, scientific advances, and social trends. Thirdly, there is the complexity of the government machinery which is concerned with and might be persuaded to take action on the number of doctors.

Some maintain that nothing should be done about manpower at present because of these uncertainties. The same people tend to argue that doctors have no right to expect special protection against the threat of unemployment and must take their chances like the rest. Furthermore, they claim that if some doctors are unemployed it will be for the community's good because the added competition will reduce the price of medical services and fill what vacancies remain for doctors in the less attractive jobs.

No special privileges

While not pleading for special privileges for doctors, the AMA argues strongly that training doctors who are not needed is an extremely wasteful exercise. Creating a surplus is also a wasteful way of filling vacancies in the dwindling number of specialties and remote areas that may still be undermanned—with no certainty that it would achieve this. In addition, the AMA claims that, far from reducing the cost of medical services, a surplus of doctors will greatly increase spending on health care.

The 1978 Australian Hospitals and Health Services Commission discussion paper, *Paying for Health Care*, stated:

> The doctor is the key decision maker. After the patient has made initial contact with the system, the doctor allocates health services by recommending revisits, referrals to specialists, ordering laboratory and x-ray investigations, recommending hospital admission, operations, and length of stay in hospital, and prescribing medication.
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> The doctor can exert direct influence on the demand function of the patient by altering his perception of his needs and of the capacity of medical technology to satisfy them. Thus, an increase in the total number of doctors, if they have discretionary powers over demand, may lead to increases in both output and prices. An increase in the number of doctors at a given volume of demand and price will lead to a fall in each one's income; he can respond to this change by expanding his effort on demand generation and then either working more or raising prices, or both. This could not be interpreted as the deliberate provision of unnecessary care.
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> The Canadian Government has recently decided to restrict the immigration of foreign doctors, not only because the nation is well-supplied (there are regional shortages), but because of an estimate that each new doctor admitted costs the Canadian population $150 000 a year.

Threat to standards

If this figure is correct and were applicable to Australia an excess of 2000 doctors would add $300m a year to health costs. Apart from the effects on health care costs, too many doctors would represent a grave threat to the ethical basis of medical practice and to standards of practice, from which the community would suffer. A surplus of doctors would also tend to lower the competence of individual doctors. At least a quarter of

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existing specialists in medicine, surgery, and obstetrics and gynaecology in Australia are not receiving sufficient continuing clinical work to maintain high standards of competence and skill.

The AMA has been pressing these arguments vigorously and frequently on federal and state government politicians and officials at all levels since 1977, encouraging other medical bodies to do the same. In the main, the arguments have been supported by the Government's own health advisers. But health departments are not the only departments concerned. At federal level there is the Department of Education and the Tertiary Education Commission. In addition, there is the Department of Immigration and Ethnic Affairs, which in turn is advised by the Department of Employment and Youth Affairs. A similar diffusion of responsibility exists at state level.

Plans for a new medical school in North Queensland were deferred some time ago but as recently as April 1978 the Tertiary Education Commission, while conceding that there was no justification for expanding the intake to medical schools, recommended against any variation in the intake of existing medical schools in the 1979-81 triennium.

Until recently all the existing figures on medical immigration have shown an accelerating intake. The Opposition spokesman for Immigration and Ethnic Affairs, Dr Moss Cass, said in September 1978 that 668 doctors had migrated to Australia in 1976, but that in 1977 the figure was 810—over two-thirds of the number of Australian medical graduates produced that year. The 1977 Federal Assembly of the Australian Medical Association urged federal authorities to undertake an urgent review of the intake to medical schools. In August 1978 the Federal Council of the AMA came down firmly in favour of a 20% cut in the number of students admitted to medical schools.

The government review of medical manpower, which the AMA has been demanding for so long, has at last been undertaken. In September 1978 the Minister for Health formed a Committee of Officials on Medical Manpower, chaired by Dr Sidney Sax, head of the Prime Minister's Social Welfare Policy Secretariat. It included officers of the Departments of Health, Education, Immigration and Ethnics Affairs, and of Employment and Youth Affairs. The committee's report, tabled in Parliament in March 1979, was disappointing in that it seemed to be an interim report. It exposed substantial divisions of opinion among officers of the departments represented, avoided firm recommendations, and did little to allay the fears of those who believe, like the AMA, that there is an impending surplus of doctors in Australia.

(*Accepted 26 September 1979*)

Abortion (Amendment) Bill, continued from page 1164

Clauses

Clause 10: Interpretation

This clause provides that the tests referred to in clause 7 means investigations the results of which are not conclusive until after 20 weeks of pregnancy.

BMA comments

We would question the meaning of the phrase "medical reasons" as the diagnosis of fetal abnormality following investigation may be made after the 20th week for several reasons. The pregnant woman may not attend for antenatal care until after that time, postal delays or other communication problems of a non-medical nature may prevent results reaching the gynaecologist before the 20th week. Any investigation which gave conclusive evidence that the fetus was severely handicapped should be acceptable under clause 7.

Clause 11: Commencement

This clause provides for the licensing provisions in clause 4 to come into force six months after the passing of the Act. The rest of the Act would take effect on the day Royal Assent is given.

Since doctors have no way of finding out the day on which a Bill receives the Royal Assent, this clause should be amended to provide that the Bill will come into force on a stated date. In our opinion, the earliest acceptable date would be 1 January 1981.

From the Scottish Council, continued from page 1162

access to specialised diagnostic and therapeutic facilities, which were unlikely to be available on a wide scale in the private sector.

Abortion (Amendment) Bill

The council approved the comments which Dr Davidson had submitted to the SHHD on its behalf on the Abortion (Amendment) Bill. Dr Davidson had told the Department that in the Council's view the 1967 Abortion Act was being administered tolerably well and was in the medical interests of the mother, the unborn child, and the family unit. No evidence was available to the BMA in Scotland that any change was necessary.

According to Dr G H Swapp, the Bill would make abortion more difficult on three counts—it introduced the terms "grave" and "substantial" risk to the mother; it attempted to reduce the upper time limit for abortions; and it extended the Infant Life Preservation Act to Scotland. The Bill also wanted to licence premises where patients were seen. It should be opposed. Dr A G R Law (SGMSC chairman) was concerned that the BMA was not issuing a definite policy on the matter and was simply hiding behind the ARM, which had said that the 1967 Act should not be changed. The council was told that the BMA's comments on the Bill had been circulated to the members of the House of Commons standing committee on the bill (see p 1163).

Oil industry

It was reported to the council that the Institute of Environmental and Offshore Medicine at Aberdeen University would take on responsibility for NHS (onshore) and non-NHS (offshore) specialist services. It will do this in conjunction with Offshore Medical Support Ltd—set up by Aberdeen University and three oil companies. The NHS has agreed to fund one post at senior lecturer level. This doctor will be responsible for treating divers working in pressurised conditions and training other doctors.

The chairman reported a meeting he had had with the CMO of Shell UK Ltd about the representation of the medical profession on the Health and Safety Commission's Oil Industry Advisory Committee. This committee, the members of which are determined in consultation with the CBI and TUC, represents employer and trade union sides of all the main sections taking part in offshore work except the medical profession. There is a medical advisory committee to give specifically medical advice on which the BMA, is represented by a member of the Association's Occupational Health Committee. Dr Davidson told the Scottish Council that he hoped arrangements would be made for a Scottish doctor to sit on this committee.

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