By Paul Worley
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Why Australia's medical system is discriminatory

In our attempts to provide adequate health care across the continent, could Australia be party to racially discriminatory policies?

Why do we support fair trade for coffee, but actively support the opposite for health care. Are there alternatives that can meet our needs and provide international leadership in the fair trade of doctors and nurses around the world?

Health Workforce Australia's recent report predicts a continuing crisis in health care delivery and describes four main reasons: workforce shortages for both doctors and nurses; a maldistribution of doctors that disadvantages rural and remote areas; bottlenecks, inefficiency and lack of capacity for medical training, and continued reliance, higher than most OECD countries, of recruiting doctors from overseas.

The evidence in this report is an admission that Australia is not meeting the requirements of the Melbourne Manifesto, a code of practice for international recruitment developed and endorsed in 2002. This manifesto states that, "It is the responsibility of each country to ensure that it is producing sufficient health care professionals for its own current and future needs; is retaining them; and is planning for both rural and urban areas."

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It supports the movement of doctors between countries of similar socioeconomic standing, but recommends that the flow of doctors should actually be from the developed to the developing world, not the other way round.

A recent report on the ABC provided further evidence there remains an unethical and policy driven poaching of doctors from countries that have higher mortality and morbidity and vastly lower numbers of doctors per population.

It's not a criticism of individual clinicians who make decisions to relocate but individual decisions are profoundly guided by government policy. Internationally it is recognised there are three requirements necessary to solve this crisis – selection, training, and working conditions.

Clearly, policies that determine who gets into medical and nursing training determine who will be our future clinicians and influence the natural affinities and priorities these people will have. There is clear evidence that students from a particular social or geographical group are more likely to return to practice in that group. Current university admission policies result in under-representation of students from disadvantaged groups. But our experience at Flinders is that it is one thing to recruit such students – it is another to provide the support required to enable them to succeed.

Government support that helps cover the increased costs of providing supportive tuition and provides such students with a living wage would be a starting point. Similar to the funding of PhD students, there could be an additional payment to the university when the student completes their

study. Some universities might not get on board, but evidence suggests medical schools can change admission and support policies in response to financial incentives.

And why is it that with acknowledged shortages in the medical workforce, medicine remains the only university course with a cap on it? There has been a significant increase in the number of medical and nursing student places over the last decade. However, Health Workforce Australia demonstrates that, in order to even get close to self-sufficiency and not rely on migration, we require a 50 per cent increase in student places and 100 per cent more nursing places per year.

Why not have uncapped places? Capping left rural, regional and remote Australia underserved and directly pulled doctors from sub-Saharan Africa, South Asia and Eastern Europe to make up the gap. Each time a doctor is lured to Australia from one of these regions, there is a net cost of more lives lost in certain ethnic groups than others.

Our policies are in effect say that saving a small number of Australian lives is worth the resultant death of many more Africans. This is abhorrent.

A reason given for sticking with the limit on places is our inability to provide enough internships. But the solution is simple – don't have an intern year. It is a blockage we no longer need and can no longer morally afford. .

The Australian Medical Council could instead require each medical school to graduate doctors who are eligible for full registration immediately and can therefore enter postgraduate training through the medical colleges. Standards could be monitored by the AMC in its usual rigorous way. It is interesting that our graduates are recognised as fully registerable in the US and Canada, but not in Australia. The Health Workforce 2025 says enough positions already exist to absorb this approach and a 50 per cent increase in medical student numbers is just enough to fill our present and anticipated future positions. These positions are currently being filled by doctors from overseas who are often being treated differently and paid less than Australian graduates.

There is also the problem of the medical benefits schedule (MBS).

Like our policy of capping medical student places, the MBS schedule may also be thought of as having built into it, unintentionally, elements that result in ethnic and geographic discrimination. How? First, the MBS pays an ophthalmologist the same amount to perform an eye operation in Double Bay as in Alice Springs. In fact, the surgeon can earn even more with gaps and fees in Double Bay. This discriminates against populations and health services with the highest proportion of Aboriginal patients by creating a reverse incentive for ophthalmologists to work in these areas. Because of the unequal proportions of different races and ethnic groups living in different geographic areas, policies which discriminate and disadvantage on the basis of geography often end up discriminating and disadvantaging on the basis of race and ethnicity also.

Second, the MBS rewards procedures at a far higher rate per minute than it does public health and preventive and consultative work in chronic diseases. This again discriminates against those population groups which are in the most need of this preventative work, which also happen to also have clear racial and ethnic delimiters.

Instead, the MBS could show affirmative action. The Rural Doctors Association of Australia's call for a simple rural and remote subsidy is important but is not sensitive enough and ignores the needs of inner city populations like Redfern. With the information available now, the MBS could have an SES/morbidity/mortality multiplier attached by the postcode of each practice so that patients seeing

doctors in a low SES, high morbidity postcode would be able to secure higher Medicare rebates for the services they need to be able to close the health outcome gap.

The multiplier could also be larger for consultative work compared to procedural. It could be very sensitive to health outcomes and service need and, if large enough, would encourage doctors to move their practice to areas of SES disadvantage.

Health Workforce 2025 also advocates for changing work practices with teams and role substitution. Yes, these do have some part to play, but it is likely that these new disciplines will have similar distribution problems to medical practitioners. This is certainly the case in the US for physician assistants and nurse practitioners. And we do not want to create two classes of health service in Australia – one based on medical practice for high SES areas and one based on other practitioners for low SES, those areas that have an even higher need for medical care.

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