The challenge of retaining overseas-trained doctors in rural practice in Victoria: a case study in the globalisation of the medical workforce

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INTRODUCTION

In recent times a workforce crisis in health care has arisen in the developed world. The numbers of Australian medical graduates have failed to meet the demand for doctors, particularly in rural areas. Recruiting doctors from other countries is seen as one solution to this undersupply.¹

Australia has become increasingly dependent on temporary and permanent resident overseas-trained doctors (OTDs)¹ to meet shortages in the rural doctor workforce.

Despite the clear initial attraction of rural general practice, problems have emerged in the long-term retention of OTDs in rural areas, particularly for permanent resident overseas-trained doctors. While willing to move to country Victoria, OTDs and their families are characterised by a high degree of geographical and employment mobility. These doctors move between general practice, rural or urban hospital environments, overseas, within Victoria and Australia.

Using Victoria as a case study, this paper outlines medical labour market demand, an overview of the Victoria rural OTD general practitioner workforce, discusses issues that impact on the retention of OTDs and recommendations that support the retention of OTDs.

METHODS

This paper draws on Rural Workforce Agency Victoria (RWAV) experience gained in supporting the recruitment and retention of rural doctors and workforce data collected for workforce planning purposes and the national Rural General Practice Minimum Dataset. In particular it draws on two key research studies conducted in Victoria in 2003:

- OTD Retention research: RWAV commissioned Assoc Prof Lesleyanne Hawthorne and Professor Doris Young from the Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne and Dr Bob Birrell, Monash University to conduct a study into the retention of OTDs in rural Victoria. Key findings are presented in the report “The Retention of Overseas Trained Doctors in General Practice in Regional Victoria”.³

The study results were based on survey responses from 84 OTDs and 56 spouses (38 per cent response rate), in-depth 30 to 90 minute interviews with 37 OTDs and 15 key informants and analysis of secondary data including Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) arrivals and departure data for 1998–03, Census data, Australian Medical Council, Occupational English Test and RWAV data.

¹ Overseas-trained doctors are also known as international medical graduates.
Monash University OTD Community Integration study was conducted by Dr Gil-Soo Han and Prof John Humphreys, School of Rural Health, Monash University. This study involved interviews with 57 OTDs from around Victoria to identify the factors that influence OTDs community integration and their intention to stay in rural communities. A range of factors such as personal, professional and family integration and interaction with the community were considered. The study also identified the main characteristics of those OTDs who better integrate into rural communities and those who do so to a lesser degree. This study developed a four level typology of OTDs in relation to the level of integration into the rural communities.

RESULTS

1. Australia is increasingly reliant on OTDs for its workforce supply, in a competitive global medical market

Western developed countries including United Kingdom and Ireland, USA, Canada, New Zealand and Australia are experiencing substantial medical practitioner workforce shortages and are attracting OTDs to meet workforce gaps. A British government plan to have 15,000 more GPs and consultants working in the National Health Service by 2008 is likely to fall short of its target by around 3,000 GPs. British Government ministers say they will fill the gap with doctors recruited from overseas. In Canada and the USA, nearly one-quarter of licensed physicians are overseas-trained doctors. In Canada, it is estimated that by 2011, one hundred per cent of net growth in professions will depend on migration.

In Australia, GP shortages that were confined to rural and remote areas have extended into capital cities and the urban fringe as well as a wide range of medical specialities, hospitals and across the health workforce.

Health professions in short supply listed on the national “Migrant Occupations in Demand” list (September 2004) include general practitioners, anaesthetists, dermatologists, emergency medicine specialists, obstetricians and gynaecologists, ophthalmologists, paediatricians, pathologists, specialist physicians, psychiatrists, radiologists, surgeons, nurses, midwives, physiotherapists; pharmacists, occupational therapists and radiographers. These occupations now earn the highest points for immigration consideration for visa applications to Australia.

The Australian Government has recognised these shortages and introduced a range of initiatives to attract OTDs to work in rural and remote Australia. These include the introduction of respective “Five Year Schemes” in the States and Northern Territory. These schemes offer a reduction of five years in the 10-year moratorium to overseas GPs with eligible postgraduate qualifications and experience to work in areas designated as Districts of Workforce Shortage. In 2004, the Australian Government agreed under Medicare reforms to

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i Victorian OTD Rural Recruitment Scheme aims to attract general practitioners with postgraduate general practice qualifications or recognised general practice experience to work in rural areas designated as Districts of Workforce Shortage by the Australian Department of Health and Ageing. Selected doctors receive a reduction of 5 years in the 10-year moratorium on provider numbers. Doctors who achieve their Fellowship of the Royal College of General Practitioners can gain permanent residency and can move anywhere within Australia after five years in the Scheme.

ii In December 1996, the Australian Government introduced the 10-year moratorium on access to Medicare Provider numbers for GPs. This restricted access to Medicare provider numbers to those who completed the RACGP Training program, and to permanent resident or temporary resident OTDs to practice in approved areas-of-need for ten years.
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aim to recruit an additional 725 full-time equivalent general practitioners and medical specialists by 2007.\textsuperscript{iv}

In the last decade, Australia has seen substantial growth in the number of OTDs entering the country with for example, the proportion of overseas-born medical practitioners working in Australia rising from 40 per cent in 1991 to 44 per cent in 1996 to 47 per cent in 2001.\textsuperscript{2} and the number of temporary entrant OTDs recruited each year in Australia increasing fourfold in a decade from 664 in 1993–94 to 2656 in 2001–02.\textsuperscript{7}

General Practice Education and Training report that in 2004 overseas born doctors represented 69.4 per cent of the 616 GP registrars entering the training program. Overseas-trained doctors represented 36.4 per cent of the GP registrars entering the training program in 2004, up from 35.1 per cent in 2003.\textsuperscript{12}

Analysis of 2001 and 2002 DIMIA migration data on medical practitioners entering and leaving Australia found that overall in those two years, there had been a net loss of 705 Australian doctors overseas with a net gain of 2781 medical practitioners from overseas arriving in Australia, making Australia a net importer of OTD medical migrants. 84 per cent were Temporary Resident Doctors (TRDs) arriving on visas to work in Australia for up to two years and 16 per cent arrived as permanent residents.\textsuperscript{2}

The largest groups of Temporary Resident Doctors (TRDs) are arriving under two major visa classes: Occupational Trainees (visa 442), a visa category originally intended to allow OTDs from third world countries to develop their skills in Australia, then return home and Visa 422 ‘Area of Need’ positions. TRDs entering on 422 visas, gain limited medical registration. These TRDs are exempted from sitting the Australian Medical Council (AMC) pre-accreditation examinations and the Occupational English test and require an employer sponsor. Under 2004 Medicare reforms, their visa stay has been extended from a maximum of two years to up to four years.

The number of TRDs arriving on 422 visas varies significantly among the States with Queensland, Western Australia and Victoria, attracting the largest numbers of TRDs.\textsuperscript{2} In Victoria, the vast majority of TRDs are working in Victorian hospitals, with a relatively small proportion (6 per cent in 2001–02) ending up in rural general practice.\textsuperscript{5}

Each year substantial numbers of OTDs also arrive as permanent residents mostly via the family reunion program or as spouses of other principal applicants. Relatively smaller numbers also arrive as refugees or on specific skilled migration programs. An important component of these permanent resident doctors are New Zealand citizens. These doctors have the right to move to Australia with most of the privileges of permanent residents. Hawthorne et al notes that a great majority of these New Zealand citizens however are in fact third country migrants. Of the New Zealand citizen arrivals in 2001 and 2002, only 29 per cent were New Zealand born.\textsuperscript{2}

Hawthorne et al examined OTD success in finding medical employment and found that many permanent residents have struggled to find work in Australia. For example, 80 per cent or more of doctors qualified in New Zealand, UK/Ireland and South Africa had found medical employment within 5 years of arrival whilst only a third of those from Middle Eastern, Eastern European or non-Commonwealth Asian countries had found medical employment.\textsuperscript{2}

\textsuperscript{iv} Strengthening Medicare seeks to recruit suitable OTDs to work in areas approved as Districts of Workforce Shortage across Australia. To be eligible, OTDs must not have worked in Australia in the last 12 months.
Key barriers identified were the Occupational English Test (OET) and the two stage Australian Medical Council examinations that involve a Multiple Choice Questionnaire (MCQ) and a clinical exam. Hawthorne et al reported that just 35 per cent of all candidates passes the MCQ on their first attempt between 1978 and 1993, with an additional 39 per cent passing on successive tries. Hawthorne et al concluded that high OET and AMC failure rates has led to large pool of work-hungry permanent resident OTDs whose only access to medical work is through conditional employment in areas of need such as rural areas. At the same time, there have been growing numbers of TRDs able to bypass the OET and AMC exams, a situation regarded as deeply inequitable by large numbers of OTDs.

A Post-Graduate Medical Council Victoria Study of AMC candidates in the Victorian hospital system found that key issues identified by stakeholders included OTDs’ variability in medical knowledge, clinical skills and communication skills supporting the need for standardisation of processes for OTDs, particularly at entry into Australia.

Regardless of the pathways to employment, it is clear that there is a growing cohort of overseas born and overseas-trained medical practitioners at all levels of the medical workforce including postgraduate GP trainees.

2. Characteristics of OTDs working in Victorian rural general practice

In Victoria, OTDs have always been an important supply of doctors over many decades for rural Victorian communities, with many OTDs now long-term well-established Australian residents. RWAV data indicates that in November 2003, 30 per cent of the 1101 GPs in regional, rural and remote Victoria gained their basic medical degree outside Australia. These doctors gained their qualifications from 55 different countries with the major source regions being UK and Ireland (10.2 per cent), Asia (8.4 per cent), Eastern Europe (3.9 per cent) and Africa (3.5 per cent).

Whilst earlier periods of migration to Victoria were particularly characterised by UK and Irish migration, data on the most recent arrivals indicate that the source regions of supply are changing with a trend to greater Asian migration and a broader diversity of source countries. RWAV data indicates that of those OTDs who have commenced in Victorian rural general practice since 1998 the major source regions in order of size include Asia, UK and Ireland, Africa, Eastern Europe and the Middle East.

Whilst the proportion of OTDs entering Australia in 2001 and 2002 indicate a ratio of about four TRDs to every one permanent resident, this ratio is reversed in rural Victoria.

RWAV recruitment data indicates that for every one Temporary Resident Doctor recruited and placed from overseas, approximately three Permanent Resident Doctors with conditional registration are seeking approval to work in rural Victoria under the Rural Locum Relief Program.

Victorian rural practice is therefore a culturally and professionally diverse workforce, with a significant proportion of doctors working with conditional registration only (69 per cent of the Hawthorne et al. study).

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A standard assessment process is currently under consideration by various State Medical Boards and the Australian Medical Council. The AMC is developing a standard MCQ test, which is proposed to be available offshore for temporary and permanent resident applicants.

Asia includes Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka and Vietnam
RWAV conducts the assessment of OTDs under the Five Year Scheme and for the Rural Locum Relief Program (RLRP)\textsuperscript{vii} and is an approved recruitment agency under Strengthening Medicare. Interview panels routinely recommend a range of support for these doctors to assist in their placement and to support their retention. These include up-skilling in emergency medicine, additional clinical skills training often including women’s health and cross-cultural training, orientation to Australian health system and their practices and communities and family support to assist their integration into communities. For those doctors who do not have AMC or Fellowship of Royal College of General Practitioners, these doctors also seek additional assistance to prepare for their examinations, which is a major priority for many doctors and a requirement of the Five Year Scheme.

Consistent with the various program guidelines that target areas of need or districts of workforce shortage, the proportion of OTDs increases with remoteness. OTDs are 20 per cent of GPs in regional centres, 32 per cent in large rural centres, 33 per cent in small rural centres and 43 per cent of GPs in remote locations in Victoria.\textsuperscript{9}

3. OTDs are characterised by extreme hyper-mobility in search of better opportunity for themselves and their families

A key finding from the OTD retention research was the level of entrenched and global hyper-mobility of OTDs. Sixty-six per cent of all survey respondents reporting five major geographical moves prior to their current position in Victorian rural general practice (migrating to one or more countries and then additionally within Australia), with some reporting up to eight major country or interstate moves involving travel around the world and/or extensively within Australia.

OTDs are coming to Australia for improved lifestyle and opportunities for their children, although pre-existing family links, security and safety, career opportunity and a chance for adventure or a sea change were other factors. Career opportunity was the primary reason OTDs chose Victoria, followed by access to family and friends and the intrinsic attractiveness of Victoria as a State. Once in Victoria, job related reasons was a prime determinant in selecting a rural location, although many doctors saw rural locations as their only medical option.\textsuperscript{2}

The moratorium on provider numbers is a strong incentive for OTDs to enter rural general practice. For many OTDs, Victorian country posts are inevitably no more than an additional step along the way to doctors’ goals of maximising family lifestyle, income level, and personal security.\textsuperscript{2}

4. Satisfied OTDs stay longer

On average, RWAV data indicates that Victorian rural GPs stay in their current general practice position for 10 years. However when comparing Australian-trained doctors and overseas-trained doctors, significant differences emerge. Australian-trained doctors remain an average 12.3 years and OTDs remaining 7.1 years. Younger OTDs are clearly more mobile, with Australian-trained doctors aged under 45 years remaining an average of seven years, with OTDs aged under 45 years remaining 3.5 years.\textsuperscript{14}

\textsuperscript{vii} The Rural Locum Relief Program is a national program that assists permanent resident or Australian citizens with relevant clinical skills and experience to work in rural general practice. RWAV assesses applicants and makes recommendations to the Health Insurance Commission on provider numbers for specific locations under the RLRP. Eligibility is defined by the criteria designated in sections 19AA and 19AB of the Health Insurance Act.
Hawthorne et al research found that encouragingly 40 per cent were satisfied with the nature of their GP work and 56 per cent reasonably satisfied, viewing the work as extremely relevant to their skills, and supported by good access to specialist services. 2.

High, medium and low satisfaction factors were identified in the Hawthorne et al. research, with ‘high satisfaction’ factors being the nature of GP work, relevance of the position to their medical skills, friendliness of the town, the medical location and access to specialist services2.

The ‘reasonably satisfying’ factors involved relationships with colleagues, level of local professional support, access to other medical resources, the location and size of the town and range of town facilities.

Importantly ‘low satisfaction’ factors included quality of schools, salary level, access to partners job, nearness to family and friends and the level of support to help pass exams.2 All of these factors were also rated extremely high as factors influencing the OTDs decision to remain in rural general practice.

Significant differences in level of satisfaction were also identified between doctors of region of origin. Doctors from Asia, Africa and the Middle East proved three times more likely to be only reasonably satisfied or actively dissatisfied with the nature of their work when compared to survey respondents from the UK/Ireland or Europe.2 This cohort represents an increasing proportion of doctors moving into rural Victoria.

Whilst most respondents had established positive peer relations (76 per cent) respondents indicated that the process had often been difficult, with doctors coming from a UK/Ireland, Asian or European background found to be three times more likely to be satisfied with their professional colleagues than doctors from the Middle East or Africa.2

Four key themes in relation to colleagues’ attitudes repeatedly recurred in the interviews. These were:

- peer wariness or distrust of medical outsiders;
- lack of respect for the overseas-trained doctor’s skills, including his/her ability to deal with a range of cases without vetting;
- reluctance of other doctors to refer on an adequate flow of patients; and
- unwillingness to allocate the OTD sufficient remuneration.

These issues were viewed as particularly difficult to accept given the relative seniority of Victorian OTDs and their level of qualifications (58 per cent of Hawthorne et al. survey respondents having 2 medical qualifications, and 34 per cent stating 3–4). 2

OTDs had serious concerns about their level of remuneration that in some cases improved over time, but in other cases, led them to consider leaving practices. OTDs could enter rural practice with unrealistic expectations of financial reward and the time required to build up patient demand.

OTDs lacking vocational registration and working in regional cities of Bendigo, Ballarat, Shepparton and Wodonga cannot be paid at vocational registration rates unlike OTDs in other rural and remote areas. As a result payment per patient is significantly less in these locations. Consequently, these regional cities have had extreme difficulty in attracting and keeping doctors. For doctors reaching Australia with minimum financial reserves, start-up costs represented a serious burden. 2
5. The importance of community integration to long-term retention

Monash University community integration study highlighted the critical importance of community integration to long-term retention, identifying four typologies of rural community integration.

‘Integrated’ doctors were highly satisfied with their practice, had cultivated relationships with the locals and had developed a strong sense of belonging. Of the 57 doctors interviewed in the Monash study about half fell into this group. Participants who were clearly aware of the requirement to work in rural communities before they arrived tended to predominate among the integrated doctors, with better-integrated doctors coming from both rural and urban backgrounds.

‘Ambivalent’ OTDs were unsure about their future settlement place, but with persuasion might settle in the rural community for a longer term. These OTDs could easily leave for reasons such as children’s education, spouse employment or practice viability issues. They were highly satisfied with their rural practice and life but had considerable reservations about the future.

‘Fence sitter’ OTDs lived in the city fringe areas where they could enjoy both urban and rural practice and lifestyle. They are unable to think of life in a rural community more than 200kms away from the city. Their proximity to the city gives access to ethnic communities and city opportunities but they enjoy rural practice and lifestyle.

‘Satellite operators’ were OTDs who work in rural areas temporarily for the sake of required training and obtaining qualifications. Their families already live in Melbourne and the doctors commute to work either daily or weekly. These doctors may be integrated into their rural community, but are destined to head to the city when they can. They can be highly anxious about how their life and practice will unfold.

DISCUSSION

Recruiting doctors from other countries is a strategy employed by many major western countries including Australia to meet national workforce shortages and growth in demand for medical practitioners. There are many doctors in developing and developed countries that are undertaking strategic moves around the world in an effort to improve lifestyle, career and family opportunities. The relative attractiveness of Australia means that Australia is currently a net importer of OTDs.

However, OTDs are arriving with a vast range of cultural, professional and medical experiences, training, qualifications and English language skills. Many are arriving to work in identified practices on temporary visas and the number of temporary entrants has rapidly increased over the last decade. Others are arriving as permanent residents, mostly as part of family reunion programs or as spouses of principle applicants to live long term in Australia. For many, perhaps the majority, their medical practice experience has been gained in communities that are significantly different to the Australian medical environment.

Each OTD has a unique set of qualifications, experience, training, family circumstances and pathways to rural general practice in Victoria. However, the data seems to indicate some discernable differences between groups of OTDs.

There are those more typically recruited through schemes such as the Five Year Scheme who will have postgraduate qualifications or considerable relevant experience. These doctors are in demand by rural practices. However, TRDs in this category are by definition on limited visas.
For many practices, the hope is that the TRD who fits in well will apply for permanent residency and stay in that practice long term.

Whether the doctor stays or not is dependent on a range of factors that relate to the extent to which the doctor and family integrate into the community, the level of professional and family satisfaction with the practice and the community and the availability of options that meet the families’ needs including children’s schooling and spouse employment options.

However, for OTDs who do not have qualifications and experience assessed as equivalent to Australian standards or who have no or poor English language skills, then the pathways into medical practice can be characterised by substantial struggle and delays to practice in medicine in Australia. Many permanent resident doctors fall into this group and they can experience long career gaps, years of study to pass the Occupational English test, Australian Medical Council exams or postgraduate training to achieve Fellowship of RACGP. As permanent residents these doctors are more likely to have a long-term commitment to remain in Australia. For many however, rural practice may be their only option, with these OTDs therefore moving rural with some reluctance and who will move as soon as they are able into the next position that will advance their career goal of gaining unconditional medical registration.

The Victorian evidence also indicates that cultural backgrounds may play an important part in the integration and long-term retention of OTDs, with the Hawthorne et al. research finding that OTDs from Asia, Africa and the Middle East are significantly less likely to be satisfied with rural practice. There is a level of resentment by permanent resident doctors in particular, who believe that the skills they do have are undervalued or resent the inequities in the system that enables temporary entrants to bypass processes they are obliged to complete.

Rural communities and practices quite rightly seek security that the doctors working in their communities meet the practice standards required and are able to communicate with patients and respond to community needs. However, because practices in small rural or remote communities and in isolated environments have different and specific demands, OTDs placed in rural and remote areas may require additional skills and appropriate aptitude to meet the challenges of rural practice.

As a result, OTDs working in rural Victoria require significant levels of support to work and remain in rural practice. Commonly, the support required falls into a number of categories including:

- orientation to the practice, the community and the Australian medical system;
- training and upskilling in a substantial range of areas but most commonly emergency medicine and women’s health. In addition to clinical skills training, OTDs required greater support for study skills, communication and English language skills and Koori cultural sensitivity
- employment and case management support including contract assistance
- an active community program that welcomes the doctor and family and fosters the integration of the doctor and family where possible into the community;
- examination preparation support to achieve their AMC or Fellowship qualifications, which is a high priority for OTDs; and
- ongoing professional support and assistance.
Evidence indicates that many OTDs do remain in communities for longer periods of time and the average for Victorian OTDs is 7 years, which is a significant contribution by any standards. However, the retention decisions depend on many factors. Critical to the OTD are family factors such as children’s education and spouse employment, access to a good, well-paid medical job, orientation, practice and professional support.

Whilst communities, practices and agencies such as Rural Workforce Agencies and Divisions of General Practice actively work to support OTDs at a range of levels, there has been no systematic funding or structured programs of support that expressly address the broad retention and support needs of OTDs particularly for permanent resident OTDs. Agencies such as RWAV and the Divisions have done what they can to meet some of these needs such as orientation support, training grants, specific emergency medicine and other essential training, linking into exam preparation programs and family support systems where available. Funding is now available for some support for exam preparation. However resources are limited and there are insufficient funds available to meet the broad retention needs of OTDs.

As the global competition for medical resources continues and as opportunities open up for OTDs in metropolitan areas, across Australia and overseas, it is clear that OTDs are not fearful of moving in search of better opportunities. If Australia and rural Australia is to remain an attractive destination, more is required to effectively support the integration of OTDs into rural communities. A good first step would be greater recognition of the valuable contribution that OTDs do currently make to the rural medical workforce and will need to make for some considerable time into the future.

**RECOMMENDATIONS**

That the National Rural Health Alliance recommend to respective Australian and State and Territory Governments and other key stakeholders:

**Assessment**

1. That the proposal to develop a common national assessment tool that applies to all OTDs, permanent and temporary, be supported and that the medical registration boards give consideration to establishing nationally consistent criteria and processes for granting area of need registration, to ensure that all OTDs granted area of need registration have the skills and experience required for rural general practice in Australia.

**Orientation**

2. That permanent and temporary resident OTDs receive access to information and orientation programs to the Australian Medical System and work in Australia.

**Placement support**

3. That realistic professional and personal needs of the employer, the OTD and their family need to be considered in determining suitable placements.

4. That OTDs are provided with realistic advice on prospective incomes and access to employment and other contract advice and assistance.
5 That individual case management services are funded that support the retention of OTDs and consider additional family and spouse employment support needs.

6 That professional and personal orientation and welcome be provided locally by the practice and community. Community support networks should be used to help the OTD and his/her family settle in the community.

7 That the OTD is provided with an initial practice grant to support the start up costs whilst they build up a clientele.

### Examination preparation support

8 That funding assistance for exam preparation and support be available to all OTDs who require this assistance.

### Retention support

9 That community orientation programs that assist OTDs to integrate with their local communities are supported.

10 That ongoing professional development of OTDs including individual learning plans that will assist OTDs to develop appropriate medical and clinical, communication and cultural orientation skills, is supported.

11 That experienced rural GPs who are willing and able to supervise OTDs need to be identified and offered training and financial support to undertake supervision of OTDs.

12 That RWAs are resourced to establish a network of trained GP mentors within their states/territory who are then provided with funded communication and meeting opportunities to provide mentoring support to OTDs who require and/or desire it.

### Removal of inequalities

13 That the Australian Government consider access to vocational registration rates (ROMPS) for specific RRMA 3 regional locations that have demonstrated workforce shortages and assessed as District of Workforce Shortage.

14 That the Australian, state and territory governments be alerted to the fact that those OTDs on the five-year OTD scheme, with the FRACGP and Permanent Residency (PR) status could potentially move to any urban or outer urban district of workforce shortage anywhere in Australia. It would take very few such moves to have a significant impact on the rural/remote GP workforce, and effort is required to provide incentives to those doctors to remain in rural locations.
PRESENTER

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