IMGs and their role as part of the NZ workforce

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Kate Baddock

NZMA GP COUNCIL

The place of international medical graduates in the workforce needs to be addressed, suggests NZMA GP Council chair Kate Baddock

International medical graduates are doctors who have obtained their medical qualifications overseas and then come to work as doctors in New Zealand.

Primary medical qualifications from Australia are accepted, but many doctors from other countries are required (or exempted for various reasons) to sit written and clinical examinations as part of NZREX (New Zealand registration examination).

Since 2008, the number of international medical graduates (IMGs) in the New Zealand workforce has gradually but steadily increased.

In 2008, 1096 IMGs were registered in New Zealand, of whom 626 were retained 12 months later (57 per cent).

In 2011, 1254 IMGs were registered in New Zealand, of whom 774 were still here 12 months later (nearly 62 per cent).

More than 40 per cent of IMGs who had held their primary qualification for 11–20 years before arriving in New Zealand are still here and working as doctors nine years following their registration.

Not only has the total number of IMGs increased over the past four or five years, so has their percentage in the workforce. In 2008, there were just over 303 doctors per 100,000 population, of whom 118 were IMGs. By 2012, the number of doctors per 100,000 population was 328.7 and the number of IMGs 136.1.1 This is the highest percentage of IMGs of all countries with Luxembourg at 26 per cent the next closest!

So, IMGs have been coming to New Zealand in increasing numbers and staying, and represent an increasing percentage of our medical workforce. And now the IMG tap is being turned down, if not off. The Medical Council reduced the number of clinical examinations in 2014 to three (which are now full) and has no plans for any in 2015 at this stage.2 The rationale is apparently that this will ease the bottle neck problem we have had with PGY1 placements this year. This is because, like New Zealand graduates, all IMGs are required to do specific hospital runs in order to acquire general registration.

Stopping the flow of IMGs into New Zealand may help with the problem of placement of our medical graduates in the short term. But what about after that? IMGs represent a significant proportion of our medical workforce (you only need to look at the statistics), and turning off that tap may have unintended consequences.
For instance, the proportion of IMGs in general practice is over 40 per cent of the total,3 and the proportion of all currently practising medical graduates from New Zealand universities who are GPs dropped from just under 50 per cent in the late 1970s to around 25 per cent by the late 1990s.4

Without a steady source of IMGs coming into general practice and other disciplines, there will be an even greater gap between what is required and what we are producing. If the IMG tap continues to be turned off, the issue of the under-representation of medical graduates who choose general practice will need to be addressed.

Some initiatives are already under way to increase the percentage of graduates choosing general practice. This includes looking at basing prevocational graduates in primary care instead of hospitals. In Flinders, South Australia, they have extended this to placing undergraduates in primary care for an entire year at a time.

There is also the feasibility of compulsory bonding, which happens in some Australian states – the Compulsory Rural Bonding Scheme has places in medical schools in return for spending time in rural areas after qualification.

We need to be looking at the entire workforce training system from undergraduate to vocational registration; initiatives must span undergraduates, graduates and prevocational trainees.

The role of IMGs in this needs also needs to be addressed. Is turning off the tap the best solution? Should IMGs be required to work in hard-to-staff areas or disciplines? Should the Medical Council be more directive in its selection of IMGs? Should they be compulsorily bonded to meet New Zealand requirements?

Unless these issues are addressed as part of a whole-of-system approach to workforce planning, we will continue to have bottlenecks in training and no doctors where we need them most.

References