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(Overseas Trained Doctors)
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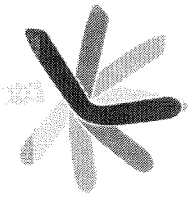

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Submission to the

Standing Committee on Health and Ageing Inquiry

Registration Processes and Support for Overseas Trained Doctors

16 February 2011

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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NRHA submission to the Standing Committee on Health and Ageing Inquiry into Registration Processes and Support for Overseas Trained Doctors

About the National Rural Health Alliance (NRHA)

The Alliance comprises 31 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers, educators and researchers (see Appendix A). The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, with the specific goal of equal health for all Australians by 2020.

Executive Summary

Issues relating to the registration and support of Overseas Trained Doctors are of great importance to Australia as a whole and, in particular, to the people of rural, regional and remote areas who depend so heavily on their services.

Perhaps surprisingly, there is no clear or simple answer to the question of how many doctors Australia has or needs. The number it in effect *has* depends in part on the hours worked by individual doctors, the type of general practice in which they work, the accessibility of that practice to new and existing patients, and the match between what a particular GP can do and what local patients require. The number of doctors Australia *needs* is in part a value judgement, in part a clinical or technical matter.

What can be said unequivocally is that there is a maldistribution of GPs in Australia across its various regions, with the shortage of GPs becoming worse with increasing remoteness. If it were not for overseas trained doctors (OTDs), many rural communities would not be served by general practice at all. They represent 29 per cent of the general practitioner workforce in Australia as a whole and 41 per cent of the medical workforce in rural and remote areas.

The story of the past twenty years has shown that medical workforce planning is not an easy or exact science. Education and training cycles in health care are long and supply and demand signals are unclear. Like other developed nations, Australia competes in the global market for doctors and, much to its shame, now finds itself drawing on the medical reserves of countries much poorer than itself.

Most of the slight net growth from 2000-01 to 2008-09 in the number of doctors working in Australia is attributable to substantial increases in the number of overseas trained doctors, and the Australian public has a high degree of satisfaction with the care they receive from OTDs. There is a multitude of reasons for increasing numbers of OTDs working in Australia, and they include the success of the so-called 'ten year moratorium'. Nevertheless, both the place and the value of the moratorium have now become contested issues, due to concerns about the fairness of such a scheme (seen by some as 'conscription') and concerns about the most effective balance that can be struck between 'sticks' and 'carrots'.

This submission canvasses the arguments for and against the moratorium – an argument worth resolving if it is true that perceptions of the set of administrative arrangements in place

for OTDs (of which the moratorium is a centrepiece) do much to determine the success of Australia's efforts to recruit and retain OTDs.

This submission is concerned mainly with the role played by OTDs in rural and remote areas. Difficulties in attracting medical professionals to non-urban areas are experienced around the world because they are perceived to be less attractive places in which to live and work. Australia is no exception to this, despite the efforts of the Alliance and others to promote the many benefits of rural and remote life for a GP.

This submission considers matters relating to both doctors wishing to migrate to Australia and OTDs already working here. It is clear that both groups would be encouraged and supported if there was simplification and greater transparency in the arrangements relating to their long and often arduous voyage from doctors from overseas wanting to work here, to contented, effective and well-supported medical practitioners working in rural and remote areas.

Many of our recommendations therefore deal with simplification and streamlining of an administrative system that everyone accepts is necessary to maintain safe and high quality health services in the rural and remote parts of this lucky country.

Recommendations

1. Clear and transparent information should be provided to assist OTDs in understanding the requirements for assessment by specialist colleges.

2. There should be better coordination of assessment procedures between agencies to improve understanding of those procedures and to simplify the overall process.

3. Government should encourage the Colleges to develop broader tests - other than comparability alone – for assessing the capabilities of OTDs.

4. Additional resources should be invested in providing general information to assist OTDs to navigate the pathways to registration.

5. The specialty colleges should establish and publish uniform appeal mechanisms.

6. A central agency (perhaps AHPRA) should work with the colleges to collate and publish data on the outcomes of applications for registration.

7. The colleges should publish data on the outcomes of applications for registration.

8. Governments and professional associations should provide financial support for OTDs to undertake vocational registration, to be provided with appropriate supervision in rural and remote Australia, and to work effectively within the Australian health system.

9. Support systems should be established to provide effective integration of OTDs and their families into their local community. This should include support for cultural training for work with Aboriginal peoples, ongoing peer support, and assistance to access health, education and other community services taken for granted by others in the community.

10. Additional supervised placements in general practice should be provided for OTDs.

11. Authorities should provide greater flexibility in the application of 3GA programs.

12. Government should commission independent research on the impact of the moratorium on OTDs and regional, rural and remote communities.

13. 19AB exemptions should be based on ASGC- RA rather than Districts of Workforce Shortage (DWS).

14. If DWS arrangements are to be maintained, information on DWS calculations should be provided to the communities they affect.

15. The Commonwealth Government should, in consultation with all states and territories, develop a substantial support program to provide a pathway of vocational training, professional development, peer support and attractive working and living conditions for Australian medical graduates to work in rural and remote practice.

16. Government should commission research and evaluation of overseas and domestic measures that are effective in attracting and retaining doctors in rural areas, especially new Australian medical graduates.

    In relation to recommendation 15, consideration should be given to:
    - an evaluation of medical recruitment and retention measures;
    - what options could be made available to encourage rural medical practitioners to extend their rural practice eg through opportunities for part-time mentoring;
    - the range of barriers to taking up vocational training in rural and remote areas;
    - the perspectives of new graduates on desired career progression opportunities; and
    - the range of supports and incentives that graduates are looking for in considering rural practice.

Introduction

The National Rural Health Alliance is pleased to make this submission to the House of Representatives Standing Committee on issues relating to the registration and support of Overseas Trained Doctors. We recognise the vital role that OTDs play in ensuring that there are sufficient doctors available to care for the medical and wider health needs of Australians – particularly those who live in rural and remote areas.

Medical workforce numbers are affected by a complex array of factors – many of which lie outside the control of policy makers and planners. Further complexity is added by the reality that it takes approximately 13 years to train a fully qualified medical practitioner. As a result, medical workforce planning will never be an exact science. As stated by the CEO of Rural Health Workforce Australia in a recent interview[1]:

> "Health workforce is a bit of an immature science... We don't know how many is enough, and we as country don't have a target or we've never published 'this is what you should expect'... the problem is that if you set the target people expect you to meet the target and I think that might frighten governments off. So, we don't actually know what we're aiming for."

These sentiments are echoed by a major study conducted by McKinsey Consulting which concludes that workforce planning is an 'inexact' science "because education and training cycles in health care are often quite long and traditional supply/demand signals are frequently muffled or ineffective. The consequences of planning decisions can take many years to become clear. Furthermore, the evidence base required for good planning is difficult to gather and codify"[2].

Clearly the solutions are complex but, as pointed out in the same study, flexibility and the capacity to respond quickly to changes in the labour market are critical. Increased flexibility "can also be achieved either by importing clinicians from abroad or by not guaranteeing employment to all locally trained clinicians"[3]. A nation's ability to draw on a global workforce may therefore be a key part of its capacity to meet its own current requirements, with the corollaries of this including the possibility that, in a global market, it may be the most impoverished nations that miss out.

Doctors trained overseas are a valuable resource which is available to Australia, as to other nations in the world. Workforce trends over the past ten years show that all of the net growth in GP numbers in Australian cities, and almost all the growth in regional areas, is attributable to overseas trained doctors (Table 1).

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[1] http://www.brisbanetimes.com.au/opinion/society-and-culture/full-transcript-kim-webber-enters-the-zone-20110128-1a7te.html accessed 30 January 2011.

[2] Nina Bhatia, David Meredith, and Farhad Riahi, McKinsey Quarterly, December 2009 accessed at www.mckinseyquarterly.com/Health_Care/Strategy_Analysis/Managing_the_clinical_workforce_2467#1

[3] ibid

Table 1: Australian GP workforce headcount by regional grouping and location of training (Australia/overseas)

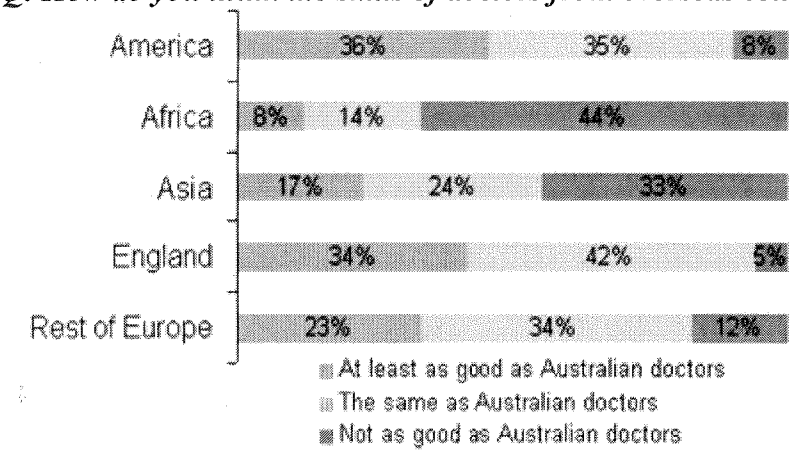
Headcount	Major Cities		Regional Centres		Remote Centres	
	Australia	Overseas	Australia	Overseas	Australia	Overseas
2000-01	12,902	4,300	3,933	1,534	238	178
2008-09	12,649	5,742	4,048	2,670	379	238
Change	**- 253**	**1,442**	**115**	**1,136**	**141**	**60**
Percentage change	-2.0%	33.5%	2.9%	74.1%	59.2%	33.7%

Source: www.health.gov.au[4]

There is evidence to show that the Australian public has a reasonably high degree of satisfaction when asked about their experiences when receiving care from an OTD[5].

Figure 1: Australian perceptions of overseas trained doctors

Q: How do you think the skills of doctors from overseas compare to Australian doctors?



The Alliance recognises the direct link between the overall supply of doctors throughout Australia and the ability to attract sufficient numbers of doctors to rural and remote areas. If there is a nationwide shortage of doctors, it will always be more difficult to attract doctors to locations that are perceived to be less attractive. Because OTDs are so important to ensuring the overall supply of doctors to Australia, they are also critical to the supply to rural and remote regions. Difficulties in attracting medical professionals to non-urban areas are experienced around the world[6], and Australia is no exception. "Supply of the medical workforce, when considered as the number of doctors in comparison to the population of the area in which those doctors practise, is low to very poor in many rural and regional areas of Australia"[7].

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[4] http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table15.csv

[5] Chris Byrne, "Australians divided over OS-trained doctor", TNS website, accessed 28 April 2010. Also: Comparing patient's perceptions of IMGs and local Australian graduates in rural general practice, by Catherine Harding et.al. Published in the Australian Family Physician, April 2010

[6] World Health Organisation, 2010, *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations,* Geneva, Switzerland, p i.

[7] Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra, p 3.

Achieving a more even distribution of medical practitioners across the nation as a whole is a vital part of what needs to be done to ensure that Australians living in rural and remote areas have equivalent access to services and equal health.

The Alliance's goal for equal health for all Australians by 2020 is consistent with the principles that the World Health Organisation (WHO) promotes to guide the formulation of national rural retention strategies. "Adhering to the principle of health equity will help in allocating available resources in a way that contributes to the reduction of avoidable inequalities in health"[8].

The terms of reference of this Committee of Inquiry recognise two groups of OTDs who have the capacity to assist our community in reaching the fundamental goal of health equity for rural and remote Australians. The first consists of those wishing to migrate to Australia; the second comprises those already working in rural and remote communities in Australia.

A key focus of this submission is the first of these groups and the systems for assessing their suitability for practice in Australia and for assisting them to gain registration. We are mindful that Australian assessment processes exist within a quality assurance process and a broader international policy framework for the ethical recruitment of OTDs.

The NRHA supports the World Health Assembly resolution in May 2010 which adopted the voluntary World Health Organisation global code of practice on the international recruitment of health professionals. The code takes into account the responsibilities and rights of source and destination countries, other stakeholders, and those of the migrant health professionals themselves.[9] Specifically, the NRHA believes that policy frameworks should be designed to encourage the recruitment of OTDs from countries with a surplus in their medical workforce and discourage, but not restrict the recruitment of OTDs from developing countries that are in desperate need of medical practitioners.

We also recognise that it is equally important to provide supports to ensure that OTDs already working in rural and remote communities in Australia are adequately supported. They represent 29 per cent of the general practitioner workforce in Australia[10] and 41 per cent of the workforce in rural and remote areas [11].

The World Health Organisation (WHO) has released global policy recommendations regarding increasing access to health workers in remote and rural areas through improved retention.[12] The Alliance acknowledges the fact that retention is improved when there are good support structures in place for those working in rural and remote communities.

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[8] World Health Organisation, 2010, *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations,* Geneva, Switzerland, p 4.

[9] Sixty-third World Health Assembly unanimously adopts the WHO global Code of practice on the international recruitment of health personnel. Alliance members and partners applaud Member States., see http://www.who.int/workforcealliance/media/news/2010/codestatementwha/en/index.html

[10] Britt H, Miller GC, Charles J, Henderson J, Bayram C, Valenti L, Pan Y, Harrison C, O'Halloran J, Fahridin S, Chambers T 2010. General practice activity in Australia 2000–01 to 2009–10: 10 year data tables. General practice series no. 28. Cat. no. GEP 28. Canberra: AIHW, p 24.

[11] Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra, p3.

[12] World Health Organisation, 2010, Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations, Geneva, Switzerland.

The WHO suggests that "an abundance of evidence and experience shows that political commitment and policy interventions are central to more equitable health workforce distribution"[13]. The Alliance notes and supports the initiatives and commitments of Australian Governments in this regard, and considers that the work of this Committee of Inquiry can add to the effectiveness of current workforce policies and measures.

Detailed responses to the terms of reference

The three terms of reference provided by the Hon Nicola Roxon MP, Minister for Health and Ageing, for the Parliamentary Committee will be addressed in turn in the sections below. In providing various comments and recommendations, the NRHA is mindful of ensuring that there is no compromise to the quality or assessment processes for OTDs, and that the ultimate aim of this Inquiry is to work towards improved access to medical care for all Australians.

Term of Reference No.1

Explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand College assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions.

1.1 An overview of the administrative processes and accountability measures

Introduction

The key objectives in administrative processes should be the maintenance of quality standards and minimisation of uncertainty around obtaining the required workforce numbers.

In the Alliance's view, OTDs face a demanding array of requirements and steps on a complex pathway which has uncertain outcomes. The assessment process is vitally important to their ability to practise in their field of specialty in Australia. In fact, being able to practise in Australia can involve at least eight discrete processes (depending on the specialty type) with a number of separate organisations, whose processes are mostly independent of each other but very interdependent from the perspective of the OTD.

Typically, an OTD would need to navigate the processes of the Australian Medical Council, the relevant Specialist College, the Australian Health Practitioner Regulation Agency, the state health department in the employing jurisdiction (for Area of Need), Medicare (especially for GPs), the Australian Department of Health and Ageing (for GPs), the Australian Department of Immigration and Citizenship and the employing organisation (see Figure 2).

Each of these organisations would require the doctor to complete a wide range of forms, statutory requirements, assessments and examinations. In some cases two or more organisations may require the same information but require the doctor to submit it separately. There is no central point at which the doctor can receive support in navigating these systems other than Rural Workforce Agencies which are specific to individual jurisdictions and focus primarily on GPs wanting to work in rural and remote Australia. In some cases, assistance is also provided by recruiters but it is not possible to ensure that they provide the correct information and act in the interests of OTDs.

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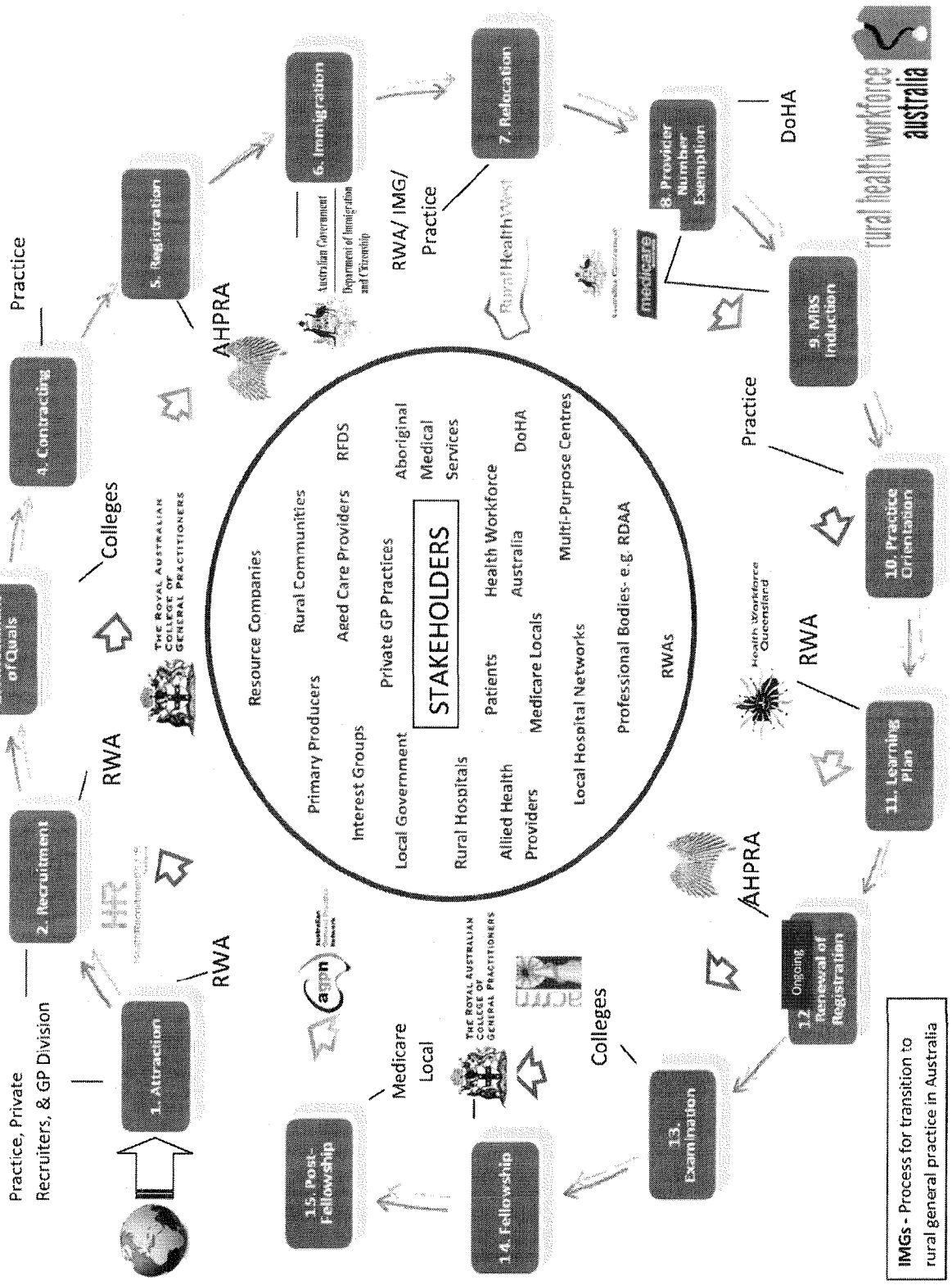
[13] Ibid, p 7.

Figure 2: Organisations involved in transition to practice by OTDS (supplied by RHWA)



As the diagram clearly illustrates, there are too many steps involving too many organisations and often there is duplication where many organisations require much of the same information. This makes it difficult for OTDs to know the best order in which to proceed in dealing with these various agencies and organisations. The order depends on a range of individual circumstances and there is little guidance available other than through Rural Workforce Agencies to ensure that OTDs know which way to proceed so as to avoid wasting time and resources by making costly errors. It is generally not possible for the applications to various organisations to run in parallel, so a delay in the processes for one of these organisations can lead to substantial delays for the whole process.

A summary of the first part of the process as it applies to specialists is provided in Appendix B. If an applicant is successful in meeting all of the requirements of each of the relevant organisations, including the different processes involved in finding the appropriate position, the process is likely to take between 12 and 24 months. Needless to say, some of the doctors who commence the process become discouraged along the way and give up on trying to register in Australia.

> *Dr G is an Irish born and qualified GP with the appropriate qualifications to be categorised as eligible for mutual recognition by the RACGP. She therefore represents those OTDs with the easiest pathway to registration as she is substantially comparable to an Australian GP specialist. In early 2010 she moved to Australia with her husband who has a clinical fellowship in a large teaching hospital. She recently decided to start working as a GP, and was able to find a position in an outer metropolitan practice with District of Workforce Shortage (DWS) status. Although she already had the relevant visas to allow her to work in Australia, she was required to complete over twenty different forms, pay approximately $3,500 in various fees and comply with a variety of additional requirements. It has been five months since she first applied for the specialist pathway with the AMC and she is still not registered to practise. She says she will be discouraging her friends and colleagues in Ireland from seeking work in Australia.*

1.1.1 Applying to the Australian Medical Council

All OTDs need to commence the process of registration by applying to the Australian Medical Council under one of the following pathways, as illustrated in Appendix C:

1. Standard Pathway
2. Competent Authority Pathway
3. Specialist pathway
4. Area Of Need (AON) Specialist pathway

Each pathway has different requirements and the first hurdle for an OTD is to determine the appropriate pathway and the requirements associated with that pathway. The Australian Medical Council (AMC) is an independent national standards and examination body and is the starting point for the assessment processes and all applications.[14] In the case of specialists, it may be that practitioners are eligible to apply for more than one pathway and that these applications may run in parallel[15]. For GPs there are also multiple pathways for gaining specialist recognition or for becoming eligible to work in Australia.

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[14] Doctor Connect http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-SMC accessed on 29/12/2010

[15] 2010 Medical Training Review Panel, p67

Typically this initial step includes:

- ensuring that all relevant documentation has been translated by a certified interpreter;
- having documents verified, which generally requires travelling to an Australian Embassy or hiring a notary public (all documents must be verified by the same person);
- sitting the English language proficiency exam;
- sourcing two sets of certificates of good standing - which need to be different for AMC and AHPRA;
- preparing a very detailed CV (often from 20 to 25 pages);
- completing a number of forms relevant to their selected pathway in the exact prescribed format; and
- paying the relevant application fees.

Failure to complete any of these steps adequately will result in extra costs and the application being held up. If there is a document needing verification that is missing, the OTD will need to ensure that additional documents are signed by the same individual as previously. The complexity of the processes for the application to the AMC is illustrated by the fact that the 'Quick Guide' runs to 72 pages and an additional guide for specialists covers 42 pages.

For the OTD, all of these steps can be associated with considerable effort and costs. For example, the verification of documents can only be carried out by a notary public or by the Australian embassy in the relevant country. Engaging a notary public is associated with considerable costs and therefore is not easily accessible. In some countries there is no Australian embassy and in those countries where there is an embassy, doctors may need to travel considerable distances to have their documents verified and will still need to pay a fee for the service.

> *Dr M has lived and practised in the United States for more than ten years, but currently works in Germany where she grew up and completed her basic medical degree. In order to complete the first part of her AMC application recently, she took Friday off work at her busy medical practice to travel to Berlin to the Australian Embassy to have her documents certified. She then stayed overnight and took her IELTS exam on Saturday. If for any reason, there is a document missing from the certified copies she sends to the AMC, she will need to return to Berlin and find the same embassy official to sign her documents. If she is unable to find the same person, she potentially will need to have all documents re-certified as they need to be signed by the same person.*

1.1.2 Applying to the specialist colleges

Once the AMC has completed its processes and ensured that the paperwork for the specialist college is complete, the AMC will pass on the paperwork for each doctor to the relevant Specialist Medical College. Most colleges assess the OTD's application on the basis of comparability to the standard of an Australian Trained Specialist.

> "There are three possible outcomes of assessment: substantially comparable; partially comparable (requiring up to 2 years of specified requirements to reach comparability); and not comparable. The majority of medical colleges will allow applicants who are

considered 'substantially comparable' to Australian trained specialists to gain Fellowship without requiring an additional examination"[16].

Each College has its own assessment processes and its own interpretation of what they consider to be 'comparable' to the standard of an Australian Trained Specialist. However, some may set further requirements for Fellowship purposes.[17] The way in which Specialist Colleges assess Area of Need applications differs; some provide a 'dual pathway' (i.e. assess the doctor for the AoN position and specialist assessment), while others assess for the AoN position only. To date some five colleges (RANZCOG, RACP, RCPA, ACD and RACS) have agreed to undertake the combined assessments of overseas trained specialists[18]. However, in all instances the AoN pathway requires a number of additional requirements of the OTD and the employing organisation.

Most applicants (except those previously assessed as 'not comparable') will need to attend an interview in person in Australia. Interestingly, one recent development has seen the Australian College of Rural and Remote Medicine (ACRRM) provide for interview via international teleconference.

Fees payable to the specialist colleges range up to $8,000.

1.1.3 Applying to AHPRA

Once the relevant specialist college has finalised their assessment, OTDs must apply to AHPRA to gain registration. AHPRA requires an outcome of assessment from the relevant Australian Specialist Medical College before registering a doctor for practice in their field of specialisation and what, if any, conditions should be applied to their registration[19] . Hence the assessment outcome by the Specialist College will determine the eligibility or type of registration available to the OTD. This means that the Specialist College Assessment processes and the assessment outcome are crucial to enabling OTDs to practise in their field of speciality in Australia. With the exception of General Practice, each specialty only has one recognised professional college - making the influence of colleges on the future of OTDs very considerable. All of the processes for applying to AHPRA are totally separate from the other application processes, meaning that additional requirements will need to be met.

1.1.4 Applying for Certificates of Good Standing

As outlined above, OTDs coming to Australia will need to provide Certificates of Good Standing from every jurisdiction where they have recently worked. For the AMC the requirement is to provide evidence for the past two years, whereas the AHPRA requirement covers ten years.

While all applicants will appreciate the need to provide evidence of good practice, the way in which the system is currently applied represents a series of challenges as a result of administrative processes. These may include:

- confusion because there are two requests for Certificates to be provided with no apparent reason for the duplication. This confusion extends to the relevant overseas

[16] 2010 Medical Training Review Panel, p66
[17] Doctor Connect http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-fullregistration accessed 20/01/11
[18] 2010 Medical Training Review Panel, p66 and http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-fullregistration
[19] Doctor Connect http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/work-SMC accessed on 29/12/2010

Medical Boards that may be confused with the instruction to send the documents to two different agencies. As a result, there can be errors and subsequent delays to the process as documents have to be re-sent.

- the Certificates are only valid for six months but the processes which occur between the time when a doctor first applies to the AMC and AHPRA can often take much more than six months, so that the two applications to the relevant overseas Medical Boards have to be made at different times.
- providing Certificates for multiple jurisdictions over a period of ten years is a very difficult process for a mobile, international workforce. There is no doubt that there may be cases where the AHPRA may choose to investigate a particular doctor in more detail and may need to request additional documentation. But a 'default' requirement which applies to every doctor represents a very high administrative burden.
- all of the Certificates have to be sent directly to the AMC and AHPRA. While there is a need to ensure that documents are not falsified, this creates a significant burden for OTDs. The OTD typically sends requests to all the relevant medical registration bodies and then has no ability to monitor which documents have arrived and which need to be followed up. This means the OTD needs to regularly phone the AMC and AHPRA to check which documents have been received and then follow up. There is also no way that the OTD can track whether a document has been mislaid by the issuing medical registration body or by the AMC or AHPRA. If the OTD has to request documents to be re-issued, there are additional time delays and costs.

Dr R is a female GP from Ireland who is a graduate of ICGP and holds MICGP membership meaning that her qualifications are fully recognised in Australia. (Cat 1 Faeg). Dr R recently applied to the AMC through the specialist pathway. As required, she contacted the registration authority in Ireland for a certificate of good standing to be sent directly to both the AMC and AHPRA. The registration authority mistakenly sent both certificates to AHPRA. The AMC advised the applicant that the Irish registration authority needed to send out another certificate (when it could have had it faxed over from AHPRA). This caused delays to the AMC process which meant that the AMC could not forward her application to the RACGP. This caused a delay for the applicant on what is already a long drawn out process for a doctor who holds fully comparable qualifications. She had already booked places in a child care centre and had to continue to pay childcare fees in order to keep the places for the future. This added to her expenses during a time when she was unable to earn an income. In the meantime she was unavailable to provide medical care to the community where she was contracted to work.

1.1.5 Applying for a Medicare Provider Number

All doctors require a Medicare Provider Number in order to be able to work in Australia. There are three types of provider numbers.

A Medicare Provider Number may allow a doctor to:

1. raise referrals for specialist services; and
2. make requests for pathology or diagnostic imaging services.

Where the doctor satisfies the legislative requirements, their Provider Number may also be used to:

3. attract Medicare rebates for professional services rendered (that is, treat private patients).

All overseas trained doctors (except those who received their primary degree in New Zealand) seeking to work in general practice (or in specialist services attracting a Medicare rebate) will need to be able to attract Medicare rebates and will therefore also require an exemption from Section 19AB of the *Health Insurance Act 1973*. These exemptions were introduced in 1997, which means that for the past fourteen years OTDs have been required to work in a District of Workforce Shortage for up to 10 years. This is commonly known as the 'ten year moratorium'.

OTDs who are permanent residents or Australian citizens will also be subject to the restrictions under Section 19AA, which means that they will be required to enrol in a training program towards Fellowship.

All OTDs who are subject to these restrictions will need to work in an area that is both a DWS and an AoN[20]. The DWS process is controlled by the Department of Health and Ageing and is a function of the Australian Government. The AoN process, on the other hand, is a state-based process and the application has to be approved by the Health Minister's office in the relevant jurisdiction. The criteria for AON applications vary between jurisdictions, but it is worth noting that the AON application is becoming increasingly complex and requires a separate process which generally takes several weeks to complete. There appears to be duplication in these processes and it is unclear why both processes are required when either an AON or DWS classification should suffice to confirm that there is a workforce shortage.

Depending on the various restrictions that apply to individual OTDs, application for a Medicare Provider Number may involve applications to two or more of the following organisations:

- Medicare Australia
- Department of Health and Ageing
- Rural Workforce Agencies
- State Health Minister (AON application)
- Australia General Practice Training Program (AGPT) (applications have to be in person only)
- Other providers of programs legislated under Section 3GA of the *Health Insurance Act 1973*

1.1.5 Applying to the Department of Immigration and Citizenship

In addition to fulfilling all the requirements to gain medical registration in Australia, OTDs need a visa to enable them to work in Australia. There are frequent changes to the requirements for visas and many OTDs will require the services of a registered migration agent in order to obtain the appropriate visa. These services may cost up to $4,000.[21]

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[20] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/employ-medicare-tempres accessed 27 January 2011.

[21] https://www.mara.gov.au/Consumer-Information/What-does-it-cost-to-use-an-Agent-/What-does-it-cost-to-use-an-Agent-/default.aspx

1.2 Supporting OTDs' understanding of college assessment processes

The section below provides a number of suggestions on ways in which OTDs could be supported to understand the assessment processes that will determine whether they will be able to work in Australia. Ultimately, improved processes should also enable OTDs to navigate the system more easily and will remove some of the impediments to practising in Australia.

The provision of information available to OTDs and the wider community could be improved in a number of ways. A number of suggestions are provided in the section below.

Clear information on assessment criteria

The NRHA believes that substantial improvements could be achieved if colleges were to make their assessment processes publicly available and state what criteria apply to determine whether a doctor is 'substantially', 'partially', or 'not' comparable. Currently the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) both make comprehensive information available on their website, which makes it clear to intending applicants whether they are likely to be eligible for specialist recognition on the basis of their specialist qualification. Thus specialists could make an initial self assessment as to where they might fit on the scale of comparability (expressed as Category 1, 2 or 3) and then make a decision about whether they would like to proceed. Such a process would also provide transparency to the wider community and may reduce the level of frustration with the current processes.

At present most colleges do not provide any indication of the likelihood of a particular specialist qualification being recognised in Australia. The most common response from a college is that 'anyone is eligible to apply' through a formal application via the AMC specialist pathway. This process requires numerous forms, certified documents and detailed descriptions of previous training. This represents a large investment of time, effort and money (generally $4,000-$9,000) on behalf of the applicant and also draws heavily on the time of senior specialists involved in the process.

"In 2008, 1,760 applicants were assessed through the Specialist pathway. Of these applicants 212 (12%) overseas trained specialists were approved to practise. Two-fifths of all OTDS (90 or 42.5%), who had their applications approved, were trained in the United Kingdom and Ireland"[22].

If doctors were able to better determine their eligibility, the approval rate would be higher, with intending applicants self-assessing and deciding whether they should proceed with the application. This could save the applicants, their future employers, the AMC and colleges a lot of money, time, energy and stress.

Currently there is a major cost to the community of having senior specialists (ie current Fellows of specialist colleges) tied up in assessing a large number of unsuccessful applicants. Assuming that the assessment of each applicant (including interviews) takes 8 hours and recognising that in 2008, for example, there were 1,670 applicants who were not considered 'substantially comparable', this process could have taken up 13,360 hours of clinician time without a positive outcome. This equates to just over 7 years of clinician time to assess the unsuccessful applicants in a single year.

[22] 2010 Medical Training Review Panel, p xxi

Development of online self-assessment tools

If each college were to provide greater detail of their comparability criteria and assessment processes, then the AMC or 'DoctorConnect' website could be funded to develop online self assessment tools[23]. These tools would not replace formal, individualised advice, but would give applicants a general idea of which pathway they should apply for and the time/training investment that would be required if they continued down the path of applying for registration in Australia. Ideally a self-assessment tool should cover the process from end to end – taking an OTD through all the processes required to achieve registration. The RACGP has a simple self-assessment tool that provides an example of how one part of the process is currently covered for GPs.

Change requirements for providing a position description

The OTD assessment process would become more streamlined if colleges were able to reconsider the requirement (of some colleges) for applicants to provide a position description. While it is perfectly reasonable that specialist colleges require position descriptions from a prospective employer for applicants on the Area of Need pathway (as they are assessed against the position), it is unclear why this is required of other doctors on the specialist pathway (e.g GPs). Because the process of gaining registration can take up to 24 months, some employers will not consider applications until the OTD has been assessed by the relevant college. It is too difficult for employers to keep positions open for lengthy periods of time while they wait for an OTD to be ready to practise. Similarly, OTDs would be unwise to give up their current position and finalise arrangements for moving to Australia before it is clear that they will eligible to practise here. These factors combine to make it difficult for OTDs to provide a position description as part of application for the specialist pathway.

Provide a telephone service about requirements of Sections 19AA and 19AB

It is difficult for GPs and specialists that are potentially subject to Section 19AA and/or Section 19AB of the *Health Insurance Act 1973* to determine whether they are subject to those provisions. Currently the Department of Health and Ageing only answers enquiries by email, and does not provide the opportunity to discuss individual details or questions. As the criteria or guidelines for granting an exemption are not publically available it is not possible for a doctor to pre-assess the probability of gaining an exemption.

Recommendation 1
Clear and transparent information should be provided to assist OTDs in understanding the requirements for assessment by specialist colleges.

There is considerable confusion about the differences in the roles of the AMC and AHPRHA in the current system. Much of the information required by AHPRA on their registration forms is also required by the AMC. For example, they both require certificates of good

[23] the New Zealand Medical Council has developed such a tool see www.mcnz.org.ns/Registration/SelfAssessmentforRegistration/tabid/70/Default.aspx

standing and certified copies of all medical degrees and specialist qualifications. (AHPRA requires ten years for a certificate of good standing, compared with two years for the AMC.) As outlined above, this duplication leads to considerable delays in the application process.

Significant savings in time, effort and money could be achieved if the AMC was responsible for ensuring that all of the documentation for doctors was complete and accurate. AHPRA should then be able to use this information and work on the assumption that the AMC has carried out its functions rather than duplicating them. This approach is already in place for the processes between the AMC and the specialist colleges. A similar approach should be applied to AHPRA so that information can be passed on seamlessly.

Similarly, it should be possible to streamline processes so that AHPRA does not request the same information as the AMC. This would alleviate a lot of duplication of process for the applicant.

The current system is also very lengthy and applicants have to wait for the outcome of the college assessment before being able to make an application to AHPRA. While there is a certain logic to this approach, it should be possible to make exemptions for those qualifications (such as Fellowship of the Irish College of GPs) that have been listed as being fully recognised in Australia. The ability to have some of the processes operate in parallel would assist in speeding up the task of preparing an OTD for practice in Australia.

Furthermore, the fact that there is limited coordination between the agencies at the moment can result in unnecessary delays. It should be possible to develop mechanisms that allow for the flow of information between agencies involved in the process.

Recommendation 2
There should be better coordination of assessment procedures between agencies to improve understanding of those procedures and to simplify the overall process.

Members of the public sometimes struggle to understand why specialists from countries such as Belgium, Germany, the US or Scandinavia are unable to gain ready recognition in Australia. It is difficult for them to understand that while there is wide agreement that the quality of a practitioner is paramount, the basis of the assessment is only comparability with Australian training. In practice, this means that colleges assess whether the training of the specialist has been comparable to the Australian specialist training program and are assessed as 'substantially', 'partially' or 'not' comparable. This system means that Australia effectively places barriers to entry for any doctor that has been trained outside a small number of Commonwealth countries.

There is no question that those doctors who have been trained in similar training programs will be of a similar quality to Australian trained doctors, but this should not necessarily exclude other competent clinicians who have gained their skills and knowledge in a different system.

In almost all other areas of vocational training, the Australian Government requires providers to allow for formal 'recognition of prior learning' – regardless of the way in which the trainee has gained that knowledge. The same principle should apply to medical specialist assessment. For example, from a rural perspective, a medical specialist whose training may not be comparable but who has had several years of experience overseas in a rural setting could well have entirely comparable skills. Overall, the test should be one of comparable

quality in capacity. Colleges could be asked, as a matter of priority, to develop broader approaches to assessing the standard of capability of potential applicants.

Recommendation 3
Government should encourage the Colleges to develop broader tests – other than comparability alone – for assessing the capabilities of OTDs.
The Alliance supports the Australian Government's recent initiatives towards national coordination of assessment processes through AHPRA. When the AHPRA registration standards become national, registration standards will ensure consistency in registration requirements for all OTDs. At present AHPRA still operates as a collection of jurisdictionally based registration bodies so that nationally consistency has not yet been achieved. However, as pointed out in the introductory sections of this submission, there are many different agencies involved in the pathways to registration for an OTD. This makes it difficult for OTDs and the community at large to understand what a doctor needs to do to successfully navigate the system as there are too many steps, too many organisations and too many potential failure points.

The complexity of the system is further increased by the frequency of changes that occur across the various participating agencies. Even the new standards and processes established by the Medical Board of Australia are only valid for three years and it is difficult to anticipate changes. Many of the agencies that provide advice to OTDs and the community are themselves struggling to keep abreast of the changes.

It is also our understanding that clear documentation of requirements for registration is not available. Clear and public documentation would assist both potential OTD enquirers as well as AHPRA itself. Furthermore, the registration application forms that OTDs must use from AHPRA are not clearly defined and doctors often apply using incorrect forms. It would be beneficial if each form for medical registration in Australia could have some clear guidance material so that doctors are using the correct forms when applying for registration.

As part of a solution to these challenges, the Alliance supports better coordination of centralised information to OTDs coming to Australia as well as those who are already in the system and who may be affected by changes to the requirements. For example, many specialists assessed as 'partially comparable' will be told that they have 60 months to achieve vocational registration. At the same time they probably hold a limited registration that is only valid for three years. Similarly there has been considerable media coverage of doctors being subjected to additional testing after being well established in Australia and being de-registered as a result. There are many other changes that could occur when the current three year cycle of AHPRA standards expires. Doctors need to be kept informed about the impact this could have on their ability to practise in Australia in the future.

As a starting point, the 'Doctor Connect' website could improve the way it outlines the entire process for OTDs, as each individual organisation listed above provides advice specific to their individual processes, without always knowing how that impacts on all the other parts of the process. If the information on 'Doctor Connect' was improved and was linked to a telephone helpline, this would be a significant improvement. The previous 'Doctor Connect' helpline was closed in May 2008[24]. If such a service was re-established, OTDs would be able to get advice on all aspects of the process of being able to practise in their field of speciality in Australia.

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[24] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/employ-medicare-tempres accessed 27 January 2011

International Health Professionals Victoria is a model which could be adapted and expanded to provide practical information sources for doctors or their agents wanting to make general enquiries. The IHPV has also designed some very useful flow charts which provide an overview of pathways (see Appendix C). Similar resources could be used nationally to help doctors gain an overview of processes and pathways.

Recommendation 4
Additional resources should be invested in providing general information to assist OTDs to navigate the pathways to registration.

1.3 Helping OTDs and the wider community understand college appeal mechanisms

All specialist colleges have appeal mechanisms for OTDs seeking a review of an adverse college assessment[25]. Generally speaking, most of the colleges outline the grounds for appeal, their internal processes, and the time period 'post decision' to apply for an appeal. Some colleges publicly list any appeals made to the college in their annual report. Most of the colleges have members of the board and Fellows of the College sit on their appeal board/committee. Colleges seldom publish the fee that the appellant must pay for the appeals process, but do note that they will reimburse half, if not all, of the fees if the appeal is successful. For example, the Royal Australasian College of Surgeons notes that before it will convene "an Appeals Committee, the appellant shall pay a fee of such amount as the Council determines. If the appeal is successful, 50% of the fee will be refunded"[26].

It is encouraging that there is the opportunity for appeals following an unfavourable outcome. It is also understandable that the colleges would have fees to discourage frivolous applications.

However the NRHA believes the system would be fairer and easier for OTDs if there were a number of changes to the current appeal processes that were applied consistently across the colleges. This could include:

- clearly published criteria for decision making;
- clear feedback to applicants on reasons for initial decision (already in place for many committees);
- a publicly available fees schedule;
- the practice of having at least 50 per cent non-College panel members (e.g AMC, AHPRA, DoHA, State Government representatives); and
- an intercollegiate appeals committee that functions as an ombudsman.

These types of processes would facilitate more transparency and better understanding by the community at large. Some greater uniformity, consistency and commonality of appeal procedures would significantly improve transparency. Furthermore, more transparency would provide OTDs with a better understanding of their prospects in the appeals process.

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[25] For example:
http://www.cicm.org.au/cmsfiles/IC1%20Assessment%20of%20Overseas%20Trained%20Intensive%20Care%20Specialists.pdf,
http://www.ranzco.edu/advice/overseas-trained-specialists-ots-assessment/OTS%20Information%20WEB.pdf,
http://www.surgeons.org/media/16725/REL_LEA_6006_P_Appeals_Mechanism_Policy_and_Procedure.pdf,
http://www.dermcoll.asn.au/downloads/AppealsProcess-July2010.pdf, http://www.acem.org.au/media/training/TE_Handbook_-_4_Nov_10.pdf,

[26] http://www.surgeons.org/media/16725/REL_LEA_6006_P_Appeals_Mechanism_Policy_and_Procedure.pdf

Recommendation 5
The specialty colleges should establish and publish uniform appeal mechanisms.

1.4 Ways to promote community acceptance of registration decisions

At present, the various bodies that are involved with the pathways that enable a doctor to practise in Australia have no standard for reporting on applications by OTDs. More openness and standardisation of reporting about decision making processes and outcomes would enhance transparency and public understanding.

Reporting on basic data would also help the community at large to understand registration decisions. The creation of the Australian Health Practitioner Regulation Agency (AHPRA) provides a unique opportunity to address at least some of the issues that have contributed to difficulties in data collection in the past. A nationally coordinated registration process and the opportunity to disseminate and analyse surveys from a central point would reduce some levels of inaccuracy. If, in addition to taking a national approach, AHPRA was to introduce a small number of additional questions, data quality would improve. Unlike the previous state-based systems, AHPRA provides the means for information to be verified with respondents as the data collection body has a direct communication link with doctors.

In addition to this, specialist colleges generally report on data that include:

- the number of applications for assessment received each year;
- assessment outcomes (substantially, partially or non-comparable);
- the average time taken for assessment;
- aggregated data on categories of grounds on which applications were assessed as unsuccessful; and
- the number of appeals and the number of resulting changes to assessment.

The Alliance would support AHPRA centralising information reported by the colleges, instead of having to locate it in the individual annual reports for example, the Royal Australian and New Zealand College of Ophthalmologists.[27]. A summary of key data items, across the colleges, could be published by AHPRA.

Recommendation 6
A central agency (perhaps AHPRA) should work with the colleges to collate and publish data on the outcomes of applications for registration.

Term of Reference No.2

Report on the support programs available through the Commonwealth and State and Territory governments, professional organisations and colleges to assist OTDs to meet registration requirements, and provide suggestions for the enhancement and integration of these programs.

There are many good reasons to support the notion that greater assistance should be provided to OTDs working in rural and remote Australia. As pointed out in other sections of this submission, OTDs provide vitally important services to many communities across Australia.

[27] http://www.ransco.edu/aboutus/college-annual-reports/RANSCO_WEB.09.pdf p 19-20.

In an internationally competitive market, the attractiveness of Australia and especially of rural and remote areas to overseas doctors contemplating taking up positions will be greatly enhanced if they are provided with appropriate support measures. Some of these needs are general in nature eg support for gaining the appropriate registration, while others vary by location and by individual doctor and their family composition.

In addition to attracting the best OTDs, a package of supports will aid in integration of doctors into the medical profession and into the community, contributing to the relevance, quality and safety of their practice and to the prospects for continuity both within and beyond the moratorium periods.

Australian taxpayers have not provided funding to support the training of these doctors during their undergraduate and postgraduate training programs. It is therefore reasonable to provide supports in recognition of the benefits that come from their services once they are eligible to work. Ultimately, rural and remote communities will reap the benefits of having doctors who are appropriately assisted towards gaining general and/or vocational registration in Australia.

Given the Commonwealth's responsibilities for the provision of primary care, especially through general practice, and for equity of access to general practice for rural and remote Australia, the Commonwealth should contribute substantially to a broad range of supports to attract, support and retain OTDs in rural and remote areas.

Ultimately the Australian community has an obligation to support and care for doctors who come to this country to provide vitally important services. Conceptually, this can be seen as a long-term program of supports similar to those provided by the Australian Defence Force to its personnel.[28] This would require a national approach to supports rather than the fragmented approach that applies at present.

This section will outline the principles we believe should guide the development of supports for OTDs in rural and remote Australia and consider the following three topic areas:

- current supports to assist OTDs to meet registration requirements;
- supports to assist newly-arrived OTDs working towards full registration; and
- supports to aid the retention of OTDs already working in rural and remote Australia.

Suggestions to improve the support for doctors seeking initial registration in Australia are also provided in Sections 1 and 3 of this submission.

2.1 Current Supports to assist OTDs to meet registration requirements

There are a number of programs available to doctors working in rural and remote Australia. Some of these are designed to assist OTDs in gaining vocational registration (eg 'the five year scheme'). The most significant of these is the provision of Rural Workforce Agencies (RWAs) which are funded by the Commonwealth to provide a range of supports to OTDs applying to come to Australia. RWAs also provide some supports to those who already work in rural and remote locations and through the Additional Assistance Scheme to help support OTDs to complete fellowship training

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[28] See Kim Webber in http://www.brisbanetimes.com.au/opinion/society-and-culture/full-transcript-kim-webber-enters-the-zone-20110128-1a7te.html accessed 30 January 2011.

There is a wide range of programs provided to OTDs by the bodies listed in the Terms of Reference and there is no single centralised source of information on them. However, the Alliance believes that the available supports designed to assist OTDs with meeting registration requirements do not match the needs of many OTDs currently working in Australia. More importantly, the supports are not adequate to compensate for the complexity of processes described in other sections of this submission.

One Commonwealth Government initiative to provide support for the recruitment of OTDs is the International Recruitment Strategy. This Scheme is managed by Rural Health Workforce Australia This program has been in place for many years and provides a cash payment for each OTDs recruited from overseas (to ameloriate the recruitment costs) but is only paid for doctors who take up employment in rural and remote areas. The Scheme does not include specific support for assisting with registration requirements but as successful recruitment is contingent on assisting doctors to become registered in Australia, it is an example of a relevant support.

A summary of incentives provided in Queensland and nationally is provided in a specialised website maintained by Health Workforce Queensland, *Rural and Remote Incentives Programs Assistance (RRIPA),* at www.rripa.com.au . However, as this website illustrates, there is an array of programs with differing criteria and some OTDs may find it difficult to identify the appropriate supports if they are not in touch with one of the RWAs.

2.2 Supports to assist newly-arrived OTDs

The Alliance believes there is significant opportunity to improve the ways in which OTDs are supported and provided with orientation when they first start work in Australia. The requirement to provide this information rests with the employer (as specified by the Australian Medical Council) but there is no standard set and the AMC is not checking whether this occurs. A number of programs for virtual support (such as the 'Tasmanian GP Atlas') and other programs of intensive supervised training workshops have been suggested in recent years, but many are still to be implemented. Further work is required to develop detailed and effective programs and the Alliance would be pleased to assist.

Table 2: Key topics areas required to provide support to newly arrived OTDs

Orientation to the Australian Health System	Professional Orientation	Key organisations and supports
• Pharmaceutical Benefits Scheme • MBS billing • Specialist referral • Private and public health services • Indigenous health • Key software platforms • Pathology and imaging	• Professional ethics • Medical indemnity and litigation • Contract negations • Cultural diversity • Cultural appropriateness • Psychological support services	• Rural Workforce Agencies • GP Network • Specialist colleges • AGPT • Cultural support networks
Living in Australia	**Teaching and training**	**Virtual supports**
• Education systems and qualifications • Purchasing or renting a home • Access to medical care • Public facilities (sporting complexes, libraries etc) • Community relationships • Australian family traditions and conventions	• Preparation for AMC Part 1 &2 • Preparation for specialist college exams • Prevalent chronic illnesses (i.e. mental health, diabetes, heart disease, cancer) • Team membership skills • Working in multi-disciplinary teams	• Comprehensive 'web atlas' to provide ongoing information updates • Information support phone services • Updates on changes to registration requirements and implications for OTDs

Orientation of OTDs to the Australian healthcare system is one crucial element. People want health services that are well integrated in rural Australia across primary, community-based, hospital and aged care. It is extremely valuable for an OTD to have knowledge and understanding of these various domains.

Recommendation 7
Governments and professional associations should provide financial support for OTDs to undertake vocational registration, to be provided with appropriate supervision in rural and remote Australia, and to work effectively within the Australian health system.

2.3 Supports to aid retention of OTDs

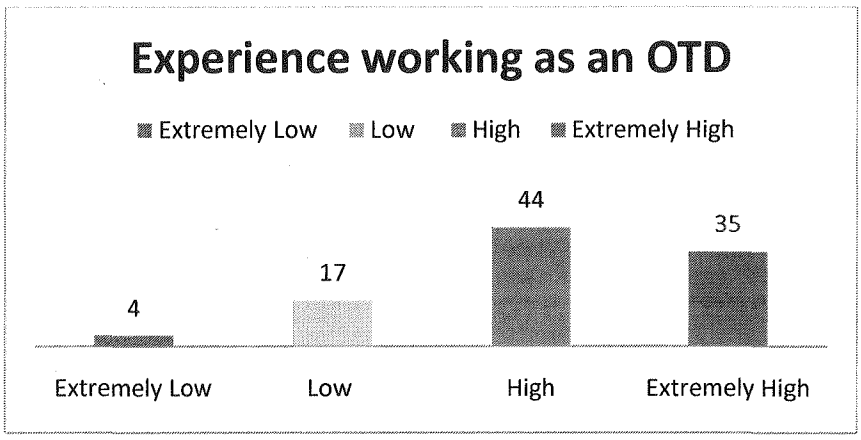
One of the most effective ways of improving workforce numbers in rural and remote communities and in improving continuity of service for communities is by increasing the retention of the doctors already working there. The following section provides a summary of suggestions based on two published research reports that arrive at similar conclusions and policy recommendations:

- A report commissioned by the Victorian Department of Health: *Barriers to employment of international medical graduates within the Victorian public health system*, 2008
- A report published in the Australian Health Review (2008): *If it wasn't for OTDs there would be no AMS: overseas trained doctors working in rural and remote aboriginal health settings.*

In the *Barriers* report doctors were surveyed about their satisfaction with being an IMG. While the IMGs surveyed were all from Victoria, the information is likely to be indicative of broader trends. The survey specifically asked whether the IMG's "overall experience in coming to Victoria to work as a doctor" was either extremely low, low, high or extremely high. Most respondents answered high (44 per cent) or extremely high (35 per cent),

suggesting that three-quarters of the respondents were happy with their choice of working in Victoria. It should be noted that 29 per cent of respondents were working in regional/rural areas and 71 per cent in metropolitan areas[29].

Figure 3: Satisfaction of OTDs working in Victoria



The *Barriers* report suggested that the most important driver of "overall experience of coming to Victoria" was found to be the ease of registering as a doctor. This suggests that the improvements suggested in Section 1 of this submission are key factors in attracting and retaining OTDs.

The *Barriers* report concludes that the key drivers of satisfaction (in ranked order) for OTDs are[30]:

1. ease of registering as a doctor in Victoria;
2. being accepted as a member of the local community;
3. the level of support;
4. ability to attain a desirable lifestyle for the doctor and their family;
5. recognition of the doctor's experience; and
6. the ease of applying to migrate to Australia.

A number of these factors may relate to geographic and/or demographic factors which are unique to Victoria, but many of them would apply more broadly.

In terms of acceptance as a member of the local community and other supports, it is incongruous that IMGs and their families do not have access to Medicare funded services and to free access to public education. While we acknowledge that such restrictions apply broadly to other workforce categories working under temporary residence, if Australia is serious about competing at a global level in attracting high quality health professionals, these restrictions on inclusion into community should be squarely addressed. This is particularly the case as OTDs are the only profession to be subject to the moratorium arrangements, discussed in the next section.

The *Barriers* report[31] also discusses some of the challenges IMGs experienced while practising in Victoria. The biggest challenges were:

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[29] 2008, M Reed et. al 2008). Barriers to employment of international medical graduates within the Victorian public health system research report

[30] M Reed et. al (2008), Barriers to employment of international medical graduates within the Victorian public health system research report prepared for Service and Workforce Planning Branch Department of Human services in Melbourne, Victoria, p. vii.

- discrimination – treated differently to other doctors/apartheid/discrimination from peers/patients/bullied (17%);
- many exams to pass/AMC exams/issues with exams/college exams (16%);
- lack of recognition of prior qualifications/skills/training/work at a lower level (15%);
- Medicare moratorium/provider number issues/10 yr moratorium (13%);
- others such as "restrictions on where we can work/AON/DWS" and "state-based registration/lack of coordinated national system/too much bureaucracy in the process/duplication/paperwork".

The report, *If it wasn't for OTDs there would be no AMS*[32] is based on in-depth case studies of ten OTDs and includes interviews with spouses, colleagues, co-workers and Indigenous community members accessing the health service. All the OTDs examined in the case studies worked in areas where a substantial proportion of their practice population were Aboriginal and/or Torres Strait Islander people.

The case studies reflected a number of observations from the Victorian *Barriers* report by emphasising the importance of caring for personal, social and cultural needs as well as the level of frustration resulting from the complex maze of registration and institutional requirements. The report concludes that:

> *"During the recruitment process, all OTDs communicated with multiple private and public agencies and professional groups, often resulting in no clear pathway, inconsistent advice and 'too much confusion'"*
>
> *"OTDs were usually recruited to a specific rural town, though no identified strategies matched location to social needs such as religious amenities, ethnic group, spouse employment or children's education. This adversely affected retention in a rural AHS."*
>
> *"Institutional barriers featured prominently in the integration process. Medical registration was sometimes problematic. Some medical organisations were criticised for not recognizing prior medical experience, often leaving OTDs feeling undervalued. Annual renewal of provisional registration and the need to prove their competence exacerbated these feelings and generated uncertainty about the future."*
>
> *"Some experiences with similar to those of OTDs in Australia generally. OTDs wanted to better understand the Australian healthcare system, were confused at the plethora of agencies relating to their immigration, recruitment and registration, and articulated the importance of spouse employment and education for children."*

The report also found that professional integration was also hampered by a lack of collegiate support in longer-term career planning.

The report findings highlight the importance of providing appropriate supports and considering the needs of OTDs and their families when matching them with a particular

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[31] M Reed et. al (2008). Barriers to employment of international medical graduates within the Victorian public health system research report. prepared for Service and Workforce Planning Branch Department of Human services in Melbourne, Victoria.

[32] 2008, M Gilles, J Wakerman and A Durey, "If it wasn't for OTDs there would be no AMS": overseas trained doctors working in rural and remote aboriginal health settings". Published in Australian Health Review November 2008.

location. It further highlights the importance of simplifying registration and integration requirements for OTDs coming to Australia.

In summary the key policy recommendations included[33]:

- systematic cultural, historical and political orientation at the local level;
- dedicated resources for mentoring and training;
- better matching of OTDs, their spouses and children to locations; (evidence from the United States demonstrates that if this occurs, retention of doctors increases);
- consistent information to potential immigrants including on integration and registration processes and Australian Medical Council examination requirements etc.;
- support for OTDs to complete fellowship training; and
- reducing our over-reliance on OTDs.

Recommendation 8
Support systems should be established to provide effective integration of OTDs and their families into their local community. This should include support for cultural training for work with Aboriginal peoples, ongoing peer support, and assistance to access health, education and other community services taken for granted by others in the community.

Term of Reference No.3

Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies.

This section will look at the main impediments and suggest recommendations that seek to promote the pathways for OTDs to achieve full Australian qualifications, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies. These will be dealt with in separate sections covering the key topic areas:

- difficulties in accessing an initial period of supervised practice;
- Section 19AA restrictions; and
- Section 19AB restrictions - the 'ten year moratorium'.

3.1 Access to an initial period of supervised practice

One impediment for OTDs to achieve full qualifications is the requirement to complete 12 months of supervised practice. The Alliance supports this requirement in principle as it provides the opportunity to assist OTDs in becoming fully orientated to the Australian health system and local conditions and health requirements. However, it does mean that new OTDs cannot work in remote practice, even those highly experienced doctors from countries like South Africa for example. This means that the services that need to most help are unable to get it in many cases. There are also no guidelines available which establish criteria for supervision and, as a result, it is often not possible to develop creative approaches to providing supervision.

At the same time, the Alliance is aware that finding suitable supervised placements is becoming increasingly difficult for OTDs.

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[33] M Gilles, J Wakerman and A Durey (2008), If it wasn't for OTDs there would be no AMS: overseas trained doctors working in rural and remote aboriginal health settings. Published in Australian Health Review, November 2008.

Hospitals already provide supervised practice for Australian and New Zealand trained interns and there is a limit to the supervision capacity of hospitals. This is particularly true of rural hospitals that often lack senior staff to provide supervision. As a result, in 2009 there were only 137 AMC graduate supervised training positions in hospitals across Australia, representing 6.1 per cent of the total pool of commencing postgraduate year 1 trainees or supervised training positions.[34] This problem will be exacerbated by 2014 when it is estimated that the shortfall of intern training positions for graduates could be in the vicinity of 2,250[35]. The University of Sydney is so concerned about the issue they are investigating the possibility of sending their Australian graduates to developing countries to undertake their intern year.[36] As a result of government commitments in 2009, Australian and New Zealand doctors in Commonwealth-supported places will have priority for access to intern positions and it is possible that many full fee paying domestic students and foreign graduates of Australian medical schools will miss out[37]. This will place OTDs even further back in the 'queue' for supervised hospital placement. This is particularly difficult for OTDs who are already in Australia and unable to work.

In any case the hospital environment is not necessarily the most appropriate location for supervised practice for GPs. Postgraduate years in hospitals for medical school graduates are suitable to consolidate the clinical skills developed during university training and the intern year, and to equip junior doctors with the prerequisite experience and procedural skills for entry into general practice training programs. But for experienced general practitioners who were trained overseas, supervised hospital practice may not provide the most appropriate environment to prepare for work in general practice - particularly in a rural and remote setting. In Australia, this is not only an issue because of the need to understand clinical practice in a primary care setting, but also because the ability for practices and doctors to generate an income depends on a solid understanding of MBS and PBS billing systems. The Alliance believes that, wherever possible, OTD General Practitioners would benefit from a supervised general practice experience for at least half of the required supervised practice.

Recommendation 9
Additional supervised placements in general practice should be provided for OTDs.

The Alliance applauds changes to the Standard Pathway which provide additional opportunities for doctors to work in supervised positions within General Practice if they are able to pass the Pre-Employment Structured Clinical Interview (PESCI). This appears to be addressing some of the 'bottlenecks' caused by a shortage of hospital-based positions. At the same time, we recognise that such systems may place a significant burden on rural and remote general practices needing to provide supervision. Many rural general practices already take on undergraduate students and provide supervision for registrars. While practices receive support for providing training, many practitioners believe that they are out of pocket for the experience - especially in relation to the time commitment required by the practice manager in managing the paperwork. In smaller rural practices, there may not be the support of a practice manager available. Providing additional supervised placements for OTDs in rural and remote general practice will further increase supervision commitments for rural and remote GPs who are already at their limits. This may particularly disadvantage

[34] MTRP 2010, p 18.
[35] Corderoy, A., 19/1/2011, Intern rules leave medical students on the outer, Sydney Morning Herald.
[36] Corderoy, A., 12/1/2011, Overseas internships proposed, Sydney Morning Herald.
[37] Healy, G & Hare, J., 29/9/2010, Medical internship shortage forces AMA crisis summit, The Australian. & Corderoy, A., 19/1/2011, Intern rules leave medical students on the outer, Sydney Morning Herald.

smaller and more remote practices that would potentially be able to use the supervised training places as a way of attracting new GPs.

There are currently very few data available to indicate the overall effectiveness of the new opportunities provided as a result of these changes. There are also significant concerns raised in various forums about some aspects of the implementation of these changes. We would therefore support further monitoring and gathering of data – including qualitative data on the experiences of OTDs who have used the system.

It may also be possible to establish a rural mentoring system that enables OTDs arriving in the community to work under the supervision of local, retired or retiring GPs who are willing and able to supervise and/or mentor. This could include clinical supervision but also assistance with helping doctors from overseas to become integrated into the community. In 2005, there were an estimated 2,669 people in the medical labour force who were retired[38]. The GPs would need to be identified and offered training and financial support for supervision.[39] Many of these retired professionals may enjoy the stimulation of providing support to newly arrived doctors while helping their local communities to access medical care. This approach would be particularly useful in more remote areas where it would otherwise be impossible to provide supervision and support to OTDs and the proposal has the support of some stakeholder organisations[40].

We note that ACRRM have received Commonwealth government funding to develop a pilot program for workplace based assessment of OTDs, in the GP setting, that would potentially short-circuit the up to 2 year wait for OTDs who are waiting to sit the AMC clinical exam. This process should provide longer term benefits for rural communities, both in terms of getting doctors into communities earlier, and reducing the likelihood of them being drawn away by settling their families into cities in close proximity to large hospitals.

A further option would be to relax moratorium restrictions for OTDs who commit to working in remote general practice (eg RA 4 and 5) but who need supervision before working independently. In this situation, their 12 months of supervised practice could be undertaken in general practices in genuinely rural RA2 or preferably RA3 locations that can properly expose them to the primary care needs of rural and remote areas. These practices are often short of doctors and may see this as providing a useful workforce solution. The OTDs involved in such programs would need to understand that provision of their Provider Number would be contingent on them working in more remote areas after the specified supervision period. The practices investing in the supervision of these doctors (who would have reduced ability to generate an income for the practice) would need to be compensated for income lost. This may not be restricted to cash payments but could include the ability to employ a doctor working under a 19AB exemption for a further 12 months.

3.2 Section 19AA restrictions

A second impediment for OTDs to achieve full qualifications is Section 19AA of the *Health Insurance Act 1996* which requires Australian citizens and permanent residents to have Fellowship of either the RACGP or ACRRM to access Medicare benefits and work in

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[38] 2008 Health Workforce Audit, p 26.

[39] RHWA (formerly ARRWAG), Recruitment, Recognition and Retention of Overseas Trained Doctors for the Rural and Remote Medical Workforce in Australia, Policy Position Paper, October 2005, p 6.

[40] See http://www.medicalobserver.com.au/news/solve-the-workforce-shortage-by-coaxing-retirees-back-study for an example of previous discussions

General Practice[41]. No doubt the provisions of Section 19AA are based on the assumption that most doctors will have achieved vocational registration by the time they become citizens or permanent residents. In other words, the legislation appears to assume that OTDs arrive in the country as temporary residents and achieve Fellowship before they become permanent residents. This is clearly applicable to the majority of cases, but there are a significant number of exceptions or 'unintended consequences'. OTDs who are citizens or permanent residents should not have more restrictions on their ability to practise than those who are not or not yet citizens of Australia.

This legislation also affects Australian Trained Doctors who have worked overseas for the greater part of their careers (in 2005, there were an estimated 2,947 people in the medical labour force who were working overseas in medicine[42]) and wish to return to Australia.

> ***Case Study:*** *Dr T came to Australia in the early 1990s as a medical student on a student visa and completed his medical training as a full-fee paying student at a major Australian university. He subsequently completed his internship and worked in an Australian hospital for two years. During this time he became an Australian citizen but decided to return to his home country where he worked as a GP for more than ten years. He decided to return to Australia for family reasons in 2010 and found a position in a suburban bulk billing practice. However, because he was an Australian citizen, he could not receive an exemption from the provisions of Section 19AA. Had he been a temporary resident, he would have be able to work without restrictions as it had been more than ten years since he had been registered in Australia and he therefore was no longer subject to Section 19AB.*

In order to be granted a Medicare Provider Number, doctors such as Dr T need to be enrolled in one of the programs listed under Section 3GA of the *Health Insurance Act 1973.* While 3GA programs are a useful way of working towards Vocational Registration they raise a number of possible impediments for an OTD, or an Australian doctor returning to Australian general practice after a long period of practising as an expatriate overseas and wanting to start work in Australia as soon as possible.

Two examples of commonly accessed programs for GPs are the Rural Locum Relief Program and the Australian General Practice Training (AGPT) Program. The Rural Locum Relief program is administered by each Rural Workforce Agency and the General Practice Training Program is administered by twenty Rural Training Providers. The AGPT program has an intake only once per year with a six-week window during which doctors can apply. Typically, doctors are required to apply in mid May for a start in February of the following year[43]. This means that, depending on when an OTD becomes aware of the requirement to participate in the program, he or she may need to wait 8-11 months before starting the program and being allowed to practise. In addition, all applicants are required to attend a series of interviews and tests in person in Australia in July. This means that doctors will either need to be in Australia for several years awaiting the start of the program or travel to Australia in order to attend the screening exams.

Admission to the Rural Locum Relief Program (RLRP) is on a case by case basis and arrangements differ for each Rural Workforce Agency, but candidates will generally be required to have a Pre-Employment Structured Clinical Interview (PESCI) and their

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[41] http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/locator accessed 22 January 2011

[42] 2008 Health Workforce Audit, p 26.

[43] For further details see http://www.agpt.com.au/ApplyforAGPT/AGPTSelectionProcess2011/ accessed 27 January 2011.

application will be assessed at a monthly quality and assessment meeting of the relevant RWA. As a result, the timing of this program is more flexible.

> ***Case Study*** *- Dr. K came to Australia nine years ago from South Africa where she worked as a GP. Since arriving in Australia, she has been working in a metropolitan hospital where she is able to work without coming under the provisions of the 'ten year moratorium'. Dr. K recently decided that she, her husband and children would like to move to rural Australia for a 'tree change'. At the same time, Dr. K saw this as an opportunity to gain vocational registration as a GP through the practice eligible route of the RACGP. Dr K very quickly found a position in a private general practice in a regional town which was classified as a District of Workforce Shortage. The practice conducts satellite clinics in two remote communities which would have welcomed the services of an experienced female GP and Dr K had expressed willingness to work in those clinics.*
>
> *However, as Dr. K is now an Australian citizen, she is subject to both Section 19AA and 19AB of the Health Insurance Act. This means that she is required by law to work in a District of Workforce Shortage and be enrolled in an accredited 3GA training program to work towards vocational registration, in order to work in general practice. The next intake for the AGPT program was in six months, as these programs only have an intake once per year and she had missed the deadline for the application. Not understanding the nature of the Rural Locum Relief Program, as its title can be misleading, Dr K made the decision to reconsider her relocation to the regional town and to continue working in the metropolitan hospital because "it is all too hard". As a result, she will not pursue her career as a GP and will not work in a rural community in the near future.*

There needs to be greater flexibility in relation to 3GA programs. OTDs should be able to start practising as soon as they have met the standards required by colleges and regulatory bodies and have applied to participate in a 3GA approved program. As pointed out above, doctors subject to 19AA will not be able to practise until they are accepted onto a suitable 3GA program.

The Alliance would also support a review of eligible programs to extend the scope and number of 3GA eligible programs to provide more options for doctors who are potentially disadvantaged by this legislation.

Recommendation 10
Authorities should provide greater flexibility in the application of 3GA programs.

3.3 The 'ten year moratorium'

3.3.1 Background

A key component of the registration process for GPs wishing to work in Australia is gaining exemption from *19AB of the Health Insurance Act 1973*. Overseas trained doctors must separately apply for an exemption under section 19AB of the Act in order to access Medicare benefits for the services they provide[44]. Exemptions under the Act are generally only granted

[44] MTRP 2010, p 70.

if the medical practitioner works in a recognised district of workforce shortage, as defined by the Australian Government.[45]

These restrictions under Section 19AB are applied for ten years (now scaled down to five for practice in more remote areas) and are commonly referred to as the 'ten year moratorium'. (It was originally designed to limit OTDs from practising in Australia when there was a perceived oversupply of doctors in Australia.)

3.3.2 Changes to rural medical workforce supply

It is not at all surprising that many of the doctors who work in rural and remote areas do so - at least initially - because they are forced to in order to receive an exemption from Section 19AB. OTDs are now 41 per cent of the rural and remote workforce[46] although it is very difficult to access reliable statistics[47] on the exact figures. As shown in Figure 4, the ratio of GPs to population in regional and rural Australia has moved closer (and in remote areas at times has exceeded) the national average in recent years.

It is not possible to determine to what extent these changes are linked to the implementation of Section 19AB in 1997, but there is no doubt that an improvement has occurred since then.

However AIHW data suggest that the growth in medical practitioner numbers may be more attributable to hospital non-specialists and specialists in training (i.e registrars) than to growth in the GP workforce (Table 3). The increase in hospital non-specialist medical practitioner positions in regional and remote areas suggests that state/territory based attraction and retention programs are working well.

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[45] Ibid

[46] Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra, p9.

[47] See discussion paper *The dearth of data on rural and remote medical workforce issues* (Appendix D).

Figure 4: Changes in GP numbers in rural (RRMA 4) locations [48]

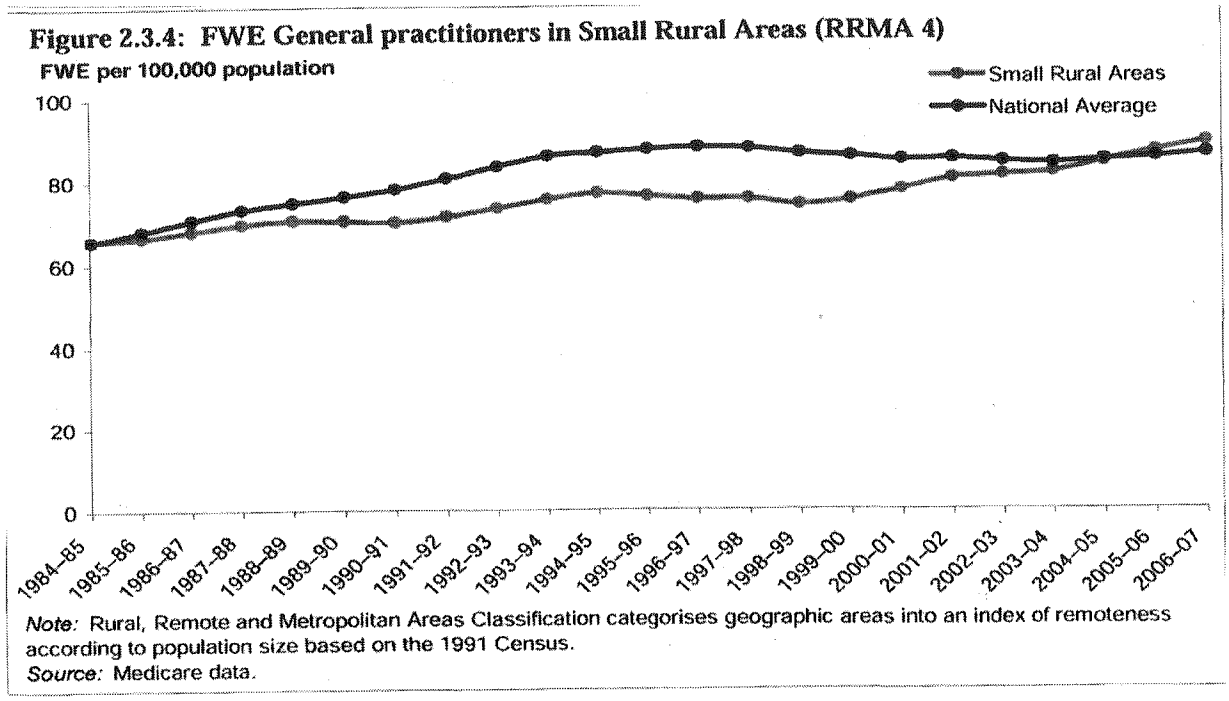


Table 3: Changes in FTE of Medical practitioners 2003-2007 per 100,000 population[49]

	Major Cities			Inner Regional			Outer Regional			Remote/Very Remote[50]		
	2003	2007	% Change	2003	2007	% Change	2003	2007	% Change	2003	2007	% Change
Total Number	285	310	8.77	181	178	-1.66	159	150	-5.66	153	192	25.49
PC Practitioner	99	95	-4.04	95	85	-10.53	91	84	-7.69	101	106	4.95
Hospital Non-Specialist	35	40	14.29	18	21	16.67	20	15	-25.00	27	45	66.67
Specialist	111	116	4.50	59	54	-8.47	38	38	0.00	20	29	45.00
Specialist in Training	41	56	36.59	10	17	70.00	11	12	9.09	5	12	140.00

Compiled from data in *Medical labour force 2007*

Additional data also confirm that while all parts of Australia have benefitted from increased numbers of medical practitioners from overseas, the increases have been greater in regional Australia (74 per cent) than in metropolitan areas (31 per cent)[51]. This trend is highlighted in

[48] Australian Government Department of Health and Ageing (2008). Report on the Audit of Health Workforce in Rural and Regional Australia, April 2008. Commonwealth of Australia, Canberra, p11.

[49] This table uses the FTE as the full time equivalent based on a full time working week of 45 hours and also per 100,000 population.

[50] Notations in the original source document indicate that the data for remote/very remote areas is highly inaccurate and not reliable and should be considered with caution. See Appendix D for more comments.

[51] http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table15.csv

the graphs below[52] and clearly signals that OTDs are vital to the overall supply of doctors in Australia and that there is a link between rural and metropolitan workforce supply.

Figure 5: major cities: Proportion of Australian and overseas trained doctors[53]

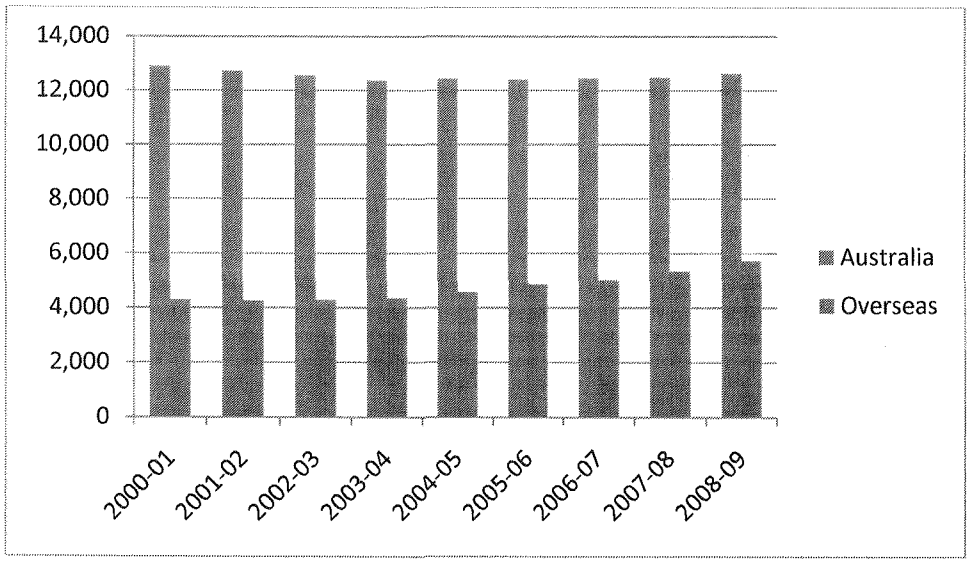
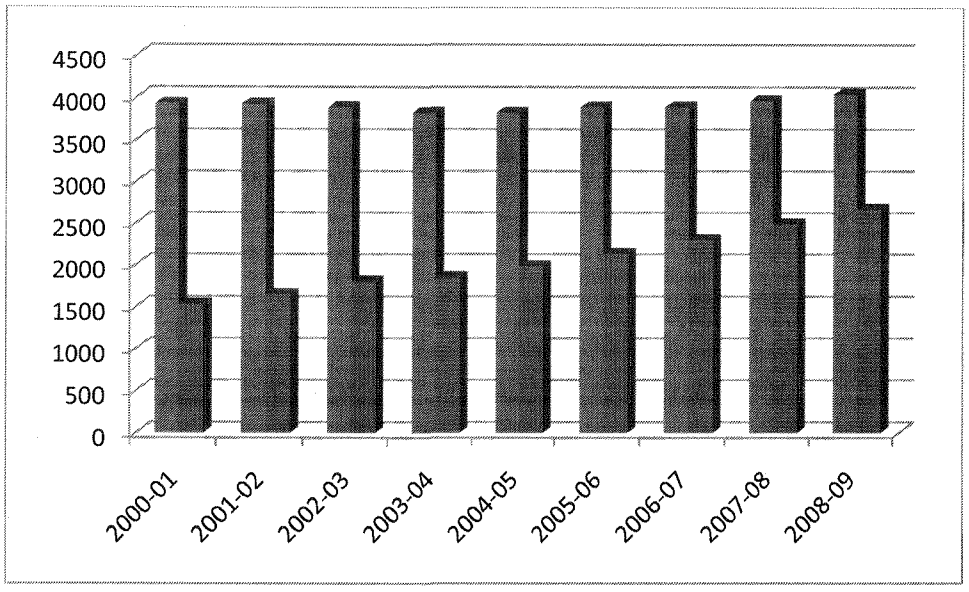


Figure 6: Regional areas: Proportion of Australian and overseas trained doctors



There is little research to indicate whether compulsory schemes are successful in addressing workforce mal-distribution, but Humphreys et al[54] suggest that:

> *Putting the ethical issues aside, the most compelling evidence available from studies examining the effectiveness of specific workforce retention measures, albeit limited, is for strategies incorporating some form of obligation. This may be in the form of either visa conditions restricting practice for International Medical Graduates (OTDs) or*

[52] Data about changes to the remote health workforce have not been included as research by the NRHA suggests that much of the data relating to remote workforce issues is not reliable and should be treated with caution. (see Appendix D)

[53] Ibid

[54] John Humphreys, John Wakerman, Dennis Pashen, Penny Buykx (2009) Retention Strategies and Incentives for Health Workers in Rural and Remote Areas: What Works? Australian Primary Healthcare Research Institute. Canberra. November 2009. p. 25

financial obligations such as loan repayment. Obligation to provide service in specific locations appears to be effective for the duration of the agreement, although retention beyond this period is less certain.

There are numerous accounts of small towns that have done exceptionally well at welcoming and integrating doctors and their families from other countries. Similarly there are accounts of doctors who have gone to a rural community only because they had to, but who then enjoy the experience so much that they choose to remain there.

Whereas Table 3 shows a decline in the number of GPs per 100,000 people in Inner and Outer Regional areas, Table 4 shows increases in GP headcount in rural and remote areas – particularly where OTDs are concerned. These two tables illustrate the great difficulty of making categorical statements about the availability of GPs, which requires detailed knowledge of the hours worked, the sort of practices in which they are employed, the distribution of those practices, bulk billing and new enrolment customs, visiting services and GP-type services provided by practice nurses and Nurse Practitioners.

However the raw numbers in Table 4 suggest that something has had a beneficial impact, with the growth in numbers of GPs in coming almost exclusively from IMGs – especially in rural and remote areas – and many believe it could only be the moratorium.

Table 4 GP Headcount by place of basic qualification and broad region

Year	Urban Australian	Urban OTDs	Rural/remote Australian	Rural/remote OTDs
1995-96	14,328	4,631	4,086	1,331
2006-2007	13,019	5,243	4,514	2,788
% change	-9.1%	+ 13.2%	+10.5	+109.5

(Source: paper at 10th National Rural Health Conference, Leveratt, M.)

Significant numbers of international students studying in Australia are undertaking GP vocational training on the rural pathway and are also restricted under the moratorium as to where they can practise.

3.3.3 Consideration of longer term outcomes

Australia needs a policy regime which makes medical practice in Australia attractive to the best candidates applying from overseas. As shown in the report prepared by Rural Health Workforce Australia[55], it is unlikely that rural and remote Australia will experience significant improvements in the supply of Australian-trained medical practitioners in the near future. So people there, and in the cities too, will continue to be at least partially dependent on the supply of doctors from overseas.

This Inquiry provides the opportunity to review implementation of Section 19AB and the 'ten year moratorium' to ensure that it has no unintended consequences.

3.3.4 Concerns with District of Workforce Shortage calculations

For hospitals, other employers, communities and OTDs themselves, many of the concerns relating to exemptions from Section 19AB are based on the way in which District of

[55] RHWA, 2008. Will more medical places result in more rural GPs? Rural Health Workforce Australia, Melbourne, October 2008.

Workforce Shortage (DWS) decisions are made. This section raises a number of issues and questions about that matter.

Lack of transparency

It is difficult to get specific details about how DWS is calculated. The Department of Health and Ageing states that "a District of Workforce Shortage (DWS) is an area in which the general population's need for healthcare has not been met ... [and] it falls below the national average for the provision of medical services"[56] The data used to calculate doctor to population ratios are based on quarterly active Medicare billing statistics for an area[57].

Improved transparency of the way in which calculations are made would help GP practices and health services to prepare applications for DWS status and, more importantly, to anticipate which factors may result in a change of their status in the future. If these factors were known, they may be better able to prevent loss of their DWS status or to implement alternative measures. More importantly, a more transparent approach to these calculations which have a significant impact on GP practices, hospitals, other health services and OTDs alike, and would assist in increasing community understanding and acceptance of ways in which the status of various regions and towns is calculated.

Frequency and complexity of changes to DWS status

The data used to calculate doctor-to-population ratios are based on quarterly active Medicare billing statistics for an area[58]. This means the workforce supply (or shortage) is re-assessed quarterly, with the result that there may be sudden and frequent changes in DWS status for particular communities. In fact, the official website which provides current information on the DWS location is updated on a daily basis and indicates that the information is valid for a period of three months from the date of publication.[59] It is not possible to anticipate these changes or prepare for them as there is no publicly available information about how the ratios are calculated or which factors may lead to changes.

It is often difficult for GP practices to monitor developments and ensure that they have recorded the status for their location before it changes and, in particular, that they note when it loses its status as a DWS. As pointed out in a recent *White Paper on workforce issues in Victoria::* "practices must re-apply for District of Workforce Shortage approval if they lose their doctor. Medical practices operate as small businesses, and they really struggle to survive when they lose their access to OTDs as the national average changes. They cannot effectively plan ahead."[60] If medical practices cannot plan ahead, they cannot provide assurances to OTDs about employment and this can create significant impediments for doctors and their families.

In addition, there is a range of complex factors which will ultimately determine whether an organisation can employ a doctor who needs an exemption from Section 19AB. Each and every application for a Medicare Provider Number for an OTD must include an application for preliminary assessment as a District of Workforce Shortage. A number of factors will

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[56] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/District+of+Workforce+Shortage accessed 22 January 2010.
[57] Communicated by email from DoHA workforce branch on 24 May 2010.
[58] Ibid
[59] http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/locator
[60] Ibid

determine whether the exemption will be granted. For example, practices may be able to recruit replacements for a doctor who was granted an exemption or if they have a valid Preliminary Assessment of District of Workforce Shortage (PADWS), but there are no circumstances under which a service will be guaranteed consideration as a DWS. This constant flux and change of status contributes to confusion in regard to a number of employment issues and creates an administrative burden for health service providers. OTDs working in Australia will experience various impediments as individual practices are impacted by changes to the DWS status.

Use of national averages as a benchmark for appropriate workforce levels

The use of the national average for doctor-to-population ratios for determining DWS raises a number of concerns.

1. It assumes that the national average is appropriate and adequate and that the current national workforce numbers can be used as a proxy for a quality benchmark.
2. It assumes that the same ratios are appropriate for all regions and communities, when it could be argued that areas of low population density or high levels of disadvantage may have additional needs.
3. The data reflect the past rather than the present. According to the recent *White Paper on workforce issues in Victoria,* DWS criteria use retrospective Medicare data to establish a national average for rural doctor-to-population ratio. The greater the national workforce shortage, the lower the doctor-to-population ratio and the more difficult for rural communities to fall beneath the national average and gain District of Workforce Shortage approval to recruit an OTD. This floating average further compounds the difficulties already experienced by rural practices in recruiting to their practices [61].

Consideration of additional factors contributing to demand for medical services

From available information it is unclear whether DWS calculations take into account key factors that potentially contribute to workforce shortages. For example, some towns may appear to have a reasonable doctor-to-population ratio but may provide medical care for a large catchment area and population. For example, a GP practice in Port Augusta will provide services for patients from Woomera and Roxby Downs because the transport networks make it the most convenient access point. Similarly, a place like Castlemaine in Victoria provides medical services for surrounding communities that may be classified as Districts of Workforce Shortage but, of itself, is not so classified.

There are many areas that are classified as DWS which are so sparsely populated that it would not be viable or practical for them to have a medical practice. If the nearest town is classified as being non-DWS, local practices are limited to employing Australian trained doctors (or those who have fulfilled their moratorium obligations) – reducing the available medical care for those in surrounding communities.

Getting the balance right in attracting locally trained and overseas trained doctors

The District of Workforce Shortage requirements may lead to unintended consequences which result in rural communities being increasingly dependent on overseas trained doctors.

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[61] White Paper, The Viability of Rural and Regional Communities. Resolving Victoria's Rural Medical Workforce Crisis. Version 1: March 2007. Pg 28

As an example, the areas classified as DWS in outer metropolitan Sydney and Melbourne were substantially reduced in mid January 2011. In Sydney the non-DWS areas now extend westward as far as Bathurst. In Melbourne, the only remaining DWS areas are in the Dandenongs and in the rural area to the north that borders the new growth areas. Until recently, most of the western suburbs and areas surrounding Dandenong (which experience significant levels of socio-economic disadvantage) were classified as having workforce shortages.

While some may see this as providing increased advantages to rural communities that are classified as DWS, the DWS restrictions mean that virtually all GP practices in Sydney and Melbourne are unable to employ OTDs (until they have completed moratorium requirements) and are therefore largely dependent on Australian trained GPs. Practices in these two metropolitan areas serve a population base of approximately 9-10 million people – many of whom have complex health needs (such as refugees and newly-arrived migrants). These practices will be able to offer multiple opportunities to Australian trained doctors, making it harder for rural and remote practices to attract them. While we recognise the very significant contribution of OTDs in rural and remote communities, it would be a pity if a permanent situation were to develop in which rural areas are served by OTDs and metropolitan areas by Australian trained doctors and those OTDs who have several years' experience working in Australia.

With a mix of Overseas and Australian trained doctors in rural communities, there is a wider range of support available for newly-arrived OTDs to become oriented to the Australian system and clinical practice. As the more experienced Australian doctors retire and are replaced with newly-arrived OTDs, there is less and less support available to those who need the most assistance. A more diverse medical workforce mix in rural and remote Australia is also likely to better reflect the cultural mix of the community. The proportion of Indigenous and traditional Anglo-Saxon Australians is generally higher in rural areas, whereas inner urban centres can be more racially diverse and more in line with the OTD population arriving in Australia.

> *An inner urban community health clinic has been providing medical care to the poorest and most disadvantaged communities in Melbourne for over fifty years. Increasingly, it is providing support to refugees and new migrants from the 'Horn of Africa' and Vietnam who live in the area. The clinic has had its books closed for almost four years as recruitment of doctors is increasingly difficult. They would like to employ OTDs from Sudan, Ethiopia and Vietnam who can provide culturally appropriate care to highly marginalised communities, but are only able to employ Australian trained doctors as they are not classified as having workforce shortages and are unable to employ OTDs.*

Such unintended consequences as these from the DWS system need to be considered by the Inquiry.

3.3.5 Unintended consequences

The Alliance acknowledges the significant improvements in workforce numbers in rural and remote Australia in recent years and many rural communities have benefitted from their status as Districts of Workforce Shortage and their ability to employ doctors who are unable to work in other regions. However, some issues in relation to the moratorium signal the

potential for unintended consequences or longer term problems which may ultimately disadvantage rural and remote communities.

International perspectives

There has been widespread discussion of whether the 10 year moratorium is discriminatory. International chat forums provide one vehicle for such debate and many different opinions are expressed. Some say the moratorium represents an abuse of human rights and that it shows that "racism is rife in Australia". Others say that if you come to Australia you have to live by Australian rules and mores, and respect the way things are. Some doctors currently working in Australia warn off doctors who are thinking of moving. Overall there is probably more negativity about the 10 year moratorium then the opposite and, in general, Australia appears to be building a negative reputation as a destination for OTDs.

It is also worth noting that while chat forums may not be scientific in their approach to developing an argument, they have a high degree of credibility with some readers who are wary of government 'spin' and general advertising. Many people view opinions expressed by their peers as more genuine than those generated by 'official sources'.

Even some of the more credible information sources can contribute to negative perceptions about Australia. *Australia operates 'closed shop' to restrict doctors from overseas, say critics* appeared on the BMJ website[62]. If articles like this are appearing on respected sites such as the BMJ, Australia's reputation for its treatment of IMGs may be seriously tarnished.

It is obviously essential that Australia's regime in this regard does not infringe international conventions on human rights. A recent WHO code of practice includes the following:

> "4.6 Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.
>
> 4.7 Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis."[63]

Australia is part of a global market for OTDs. It is not the only OECD country that relies on OTDs to maintain the medical workforce and is therefore one of many destinations in the highly competitive medical workforce market. This means that every effort should be made to ensure that Australia is portrayed as a nation that looks after and respects OTDs.

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[62] 2009, Melissa Sweet, "Australia operates "closed shop" to restrict doctors from overseas, say critics", http://www.bmj.com/cgi/content/full/339/nov16_1/b4843, BMJ website, accessed 28/04/10.

[63] WHO Global Code of Practice on the International Recruitment of Health Personnel, Sixty-third World Health Assembly - WHA63.16, May 2010.

A complex system of regulation creating an administrative burden

The AON and DWS classifications mean that there is a large amount of paperwork to analyse and complete before an OTD can work in Australia. All OTDs who are temporary residents will not only be required to apply for an assessment for District of Workforce Shortage, but will also need to work in an Area of Need - which requires a further application by the employers[64]. Even experienced professionals and practice managers working in the health system in Australia are unable to sort through the maze of regulations without dedicating a significant amount of time and effort to research different aspects of OTD requirements. This is further complicated by the differences between jurisdictions and frequent changes to systems and processes.

The complexity of the system clearly creates a burden for OTDs themselves and for government departments, GP practices, hospitals and others involved in health services.

A simpler system would mean:

- less confusion and more choice - OTDs could work in any part of rural Australia where there was a vacancy that suited them and where the employer was willing to be a sponsor;
- there would be no need for DWS and AON classifications; (without this administrative burden, government departments and Rural Workforce Agencies would be able to focus their energy and resources on looking for other ways to encourage both overseas and Australian trained doctors to move to country areas);
- resources currently dedicated to administration of these complex systems could be re-deployed to provide supports and incentives to doctors working in rural and remote areas; and
- OTDs would be able to get their Medicare provider number more quickly, with no reduction in standards or safety.

Proportion of doctors from developing countries

Over the past ten years, there has been a significant change in the geographic distribution of country of graduation for doctors trained overseas[65]. Over time the number of doctors from developing countries in Asia, Africa and the Middle East has increased.[66] It is possible that these changes are due to political instability and the increasing numbers of doctors being trained in developing nations. However, as a signatory to the Melbourne Manifesto[67], the Alliance wishes to see the recruitment to Australia of OTDs from developing countries discouraged.

A report from the World Health Organisation states that "there is a dramatic imbalance in the global distribution of doctors, with countries in the African and South-East Asia Regions currently facing the largest disparities"[68]. Even more pressing for the African region is the fact that the WHO forecasts a dramatic shortage of doctors in the African Region by 2015.[69]

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[64] http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/employ-medicare-tempres

[65] Britt H, Miller GC, Charles J, Henderson J, Bayram C, Valenti L, Pan Y, Harrison C, O'Halloran J, Fahridin S, Chambers T 2010. General practice activity in Australia 2000–01 to 2009–10: 10 year data tables. General practice series no. 28. Cat. no. GEP 28. Canberra: AIHW, p 21.

[66] Ibid,p.24.

[68] Richard M Scheffler a, Jenny X Liu b, Yohannes Kinfu c, Mario R Dal Pos, Forecasting the global shortage of physicians: an economic- and needs-based approach, Volume 86, Number 7, July 2008.

[69] Ibid

It is problematic - if not unethical - that Australia is attracting and accepting greater numbers of GPs trained in such regions.

The ten year moratorium was introduced in 1997. At that time 70 per cent of OTDs came from the UK. By 2002-2003 the number of OTDs from the UK had fallen to 43 per cent[70]. For doctors in NSW who had received their basic medical qualification outside Australia, Southern Asia was the dominant region (29 per cent) in 2009; next was Western Europe with 21 per cent, followed by Africa with 15 per cent[71]. However, the data are inconsistent and it is difficult to gain a clear picture of trends.

These changes have occurred despite the fact that countries such as the UK, Belgium and Austria have had medical workforce surpluses at different times in recent years. While considerable analysis would be required to confidently identify the reason for these changes, it is possible that doctors from countries with a similar standard of living and with good political stability are not willing to go to the effort required to become registered in Australia, especially if it means they are required to participate in a compulsory service scheme. If they regard the Australian regulatory system as overly onerous, these doctors are likely to choose to stay in their own country or to work in places like Canada, the US and Britain. Those from politically unstable or economically disadvantaged countries stand to gain additional advantages by coming to Australia and will therefore not be deterred as easily by regulation and restrictions on their practice.

OTDs who come from countries with similar healthcare systems, disease patterns, levels of technology and workplace culture are often more effective in Australia – particularly if they work in relative isolation in a rural or remote community where there is limited support[72]. It therefore makes sense for Australia to try to attract as many doctors as possible who have a similar background and training as Australian doctors.

Impacts on the attractiveness of General Practice

It is possible that the moratorium contributes to making General Practice appear a less attractive career choice for OTDs looking for work in Australia. To work in General Practice, doctors need to be able to bill Medicare and so need to be in a rural area. To avoid this requirement OTDs can work as salaried medical officers in hospital, where a Medicare number is not needed - for instance in a large metropolitan hospital which is an AON - or practise in another specialty. The outcome is that OTDs are less likely to pursue a career in General Practice in Australia.

> ***Case study:*** *Dr W is a UK born and qualified specialist, and like many of his peers in England, achieved a 'dual' qualification in general practice and in General Medicine. He spent several years working as a GP in England. After deciding to come to Australia with his family, he was faced with the decision as to whether to apply for recognition as a specialist in general practice or as a General Physician. When Dr W heard about the moratorium, he considered the impact on his family and quickly decided that he would discontinue his general practice career and work as a*

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[70] Australian government Department of Health and Ageing, 2005, as quoted in *A critical analysis of OTD factors in the Bundaberg base hospital surgical inquiry*, by Harvey K and Faunce T, 2006.

[71] *NSW Rural Doctors Network, minimum data set report*, November 2009. Pg 74

[72] Harvey K and Faunce T "A Critical Analysis of Overseas-Trained Doctor (OTD) Factors in the Bundaberg Base Hospital Surgical Inquiry" in Freckelton I (ed) Regulating Health Practitioners, Law in Context Series Federation Press Sydney 2006; p. 74.

Physician. He now works as a Physician in a large teaching hospital in metropolitan Melbourne.

3.3.6 Suggestions for Improvements

The recommendations below propose a number of options for addressing some of the issues with the moratorium.

Recommendation 11
Government should commission independent research on the impact of the moratorium on OTDs and regional, rural and remote communities.

Research related to OTDs could include:

- the impact of the moratorium on the decision making of doctors currently practising in OECD countries and considering migration (why they would/would not move to Australia);
- changes in the global market for general practitioners;
- the impact of the current regulations on general practice as a specialty;
- an appraisal of the methodology currently used for determining DWS.

There were reviews of provider number legislation in 1999, 2003 and 2005 but they only considered Sections 19AA, 3GA and 3GC of the *Health Insurance Act* which are considered to underpin a range of quality and workforce programs[73]. Those reviews did not deal with Section 19AB which is a very significant 'workforce program'. The only known study commissioned by the government that actually reviewed Section 19AB was undertaken in 2006, but it appears that a report on that study has not been released.[74]

The potential risks associated with abandoning the Moratorium are significant. However in the absence of better evidence about how the Moratorium impacts on the decision making of doctors, it is important to consider ways in which it could be improved in the interim.

Recommendation 12
19AB exemptions should be based on ASGC- RA rather than Districts of Workforce Shortage (DWS).

It would be a significant improvement if decisions relating to DWS and AON were based on the same boundaries as apply for rural relocation incentives: ASGC-RA 2-5. At present there are different boundaries for different rural and remote workforce mechanisms and this adds to the complexity of the system. Most importantly, boundaries based on AGSC RA would be more predictable and would change less frequently.

This approach would have several advantages.

1) For OTDs, it would make it easier to navigate the processes for registration in Australia. There would be increased flexibility around the locations in which they can work, greater work opportunities for their spouses, less bureaucracy, fewer administrative fees, less perceived discrimination, less confusion and more predictability.
2) The Department of Health and Ageing and other agencies would be better able to focus resources on supporting the current regional, rural and remote workforce and on

[73] http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-provleg
[74] http://www.theaustralian.com.au/news/health-science/conscripted-to-the-country/story-e6frg8y6-1225848811924

looking for other ways to encourage Australian Trained Doctors and OTDs from OECD countries with a surplus to practise in regional, rural and remote areas. Also, having the same criteria for 'rurality' would promote better alignment of a range of departmental rural workforce measures.

3) It would put all regional, rural and remote communities on the same footing. There is currently concern in some rural and remote communities that feel they have been 'left out'. There would also be a reduction in administration burdens and rural communities not covered by DWS would avoid additional delays and expenses in applying for Preliminary Assessments of DWS (which are more often refused than accepted).

Recommendation 13
If DWS arrangements are to be maintained, information on DWS calculations should be provided to the communities they affect.

The moratorium is a mechanism to promote health equity in rural, remote and regional communities and DWS is the tool that applies that mechanism. If that system is to continue, communities in rural, regional and remote areas, as well as the broader community, should be able to have access to the data the government uses to act in their interests. Communities at the 'coal face' would be able to account for any anomalies in calculations that affect their ability to provide primary care. This may also assist in creating better community acceptance of the effects of the various policy regimes.

3.4 Attracting Australian Medical Graduates to Rural and Remote Australia

Workforce shortages generally result from a relatively complex mix of factors that impact on the attractiveness of individual workplaces. Regardless of moratorium conditions, workplaces perceived as being 'unattractive' will find it difficult to attract and retain staff. A narrow focus on doctors who have relatively few options can mask a range of more important issues that need to be addressed. This point has been made in arguments against the moratorium from the RDAA, RACGP and AMA.

Irrespective of the framework for the attraction and placement of international medical graduates, Australian trained medical graduates should be given every opportunity and encouragement to take up rurally relevant training and practice, as an element of their overall career. With the number of Australian trained medical graduates estimated to increase from 2392 in 2009 to 3786 in 2014, (Medical Training Review Panel 13th report), this opportunity must not be missed.

One fruitful policy approach is that of the 'rural generalist pathway'. In essence, the existing Queensland-based program provides a coordinated, supported and mentored career from before graduation and through vocational training. Its focus is on rural and generalist training across hospital and general practice, covering rural needs such as obstetrics, and with downstream remuneration arrangements that recognise the breadth of skills and responsibilities.

Another essential ingredient in the attraction of medical graduates is the provision of attractive infrastructure (accommodation, practice facilities and modern equipment) that supports the broad scope of practice and multi-disciplinary responses to patient need.

Taking urgent action along these lines is consistent with providing a range of vocational and family supports for OTDs as recommended previously in this paper.

At the same time, it is important to recognise and support the needs of the existing rural medical workforce, to promote the best practicable continuity of service for rural communities.

Recommendation 14
The Commonwealth Government should, in consultation with all states and territories, develop a substantial support program to provide a pathway of vocational training, professional development, peer support and attractive working and living conditions for Australian medical graduates to work in rural and remote practice.

Recommendation 15
Government should commission research and evaluation of overseas and domestic measures that are effective in attracting and retaining doctors in rural areas, especially new Australian medical graduates.

In relation to this last recommendation, consideration should be given to:

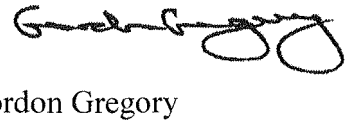
- an evaluation of medical recruitment and retention measures;
- what options could be made available to encourage rural medical practitioners to extend their rural practice eg through opportunities for part-time mentoring;
- the range of barriers to taking up vocational training in rural and remote areas;
- the perspectives of new graduates on desired career progression opportunities; and
- the range of supports and incentives that graduates are looking for in considering rural practice.

Conclusion

The administrative systems relating to Overseas Trained Doctors should be designed to filter for quality and safety – rather than to test for perseverance and persistence. The Australian public demands systems that provide for clinical safety and protection from unsafe doctors who may be looking to re-locate to Australia. However, currently there is an uncoordinated and complex system of requirements that represent a barrier to the best and most appropriate doctors interested in coming to Australia.

The Australian public would benefit considerably if improvements to the current systems and processes made it easier for highly qualified and expertly trained overseas doctors from OECD countries with strong health systems to come to Australia. Overseas trained doctors represent a very valuable resource that is vital to ensuring that good healthcare is provided to rural and remote communities in particular.

Doctors wishing to migrate to Australia and OTDs already working here would find it easier if there was simplification and greater transparency in the arrangements relating to their long and often arduous voyage from doctors from overseas wanting to work here, to contented, effective and well-supported medical practitioners working in rural and remote areas.



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