15 March 2023

Primary Care Business Council Submission to the Joint Standing Committee on Migration Inquiry: *Migration, Pathway to Nation Building*

The Primary Care Business Council (PCBC) welcomes the opportunity to comment on the Joint Standing Committee on Migration's inquiry into Australia's migration system. This submission focuses on the urgent need to strengthen policy settings to attract and retain International Medical Graduates (IMGs) to ensure Australians can continue to access timely and equitable primary care.

Primary care is universally acknowledged as a critical element of successful health systems and key to ensuring health care is equitable, efficient and effective. As acknowledged by the OECD, effective primary health care decreases the number of avoidable hospital admissions and unnecessary presentations at emergency departments[1]. Rural and remote areas are especially dependent on primary care and reduced access translates into higher expenditure on hospital care[2].

However, Australia's primary care system is experiencing widespread workforce shortages and a declining rate of graduates choosing General Practice as a career. Research from the Australian Medical Association suggests that Australia is facing a shortage of more than 10,600 GPs by 2031–32, with the supply of new graduates not keeping pace with growing community demand.[3] Deloitte Access Economics similarly predicts a 30% shortfall in the GP workforce by 2030, attributing this increase in demand to a growing and ageing population and a focus on preventative health[4].

While broad reform is needed to address this shortfall and encourage more locally trained medical graduates to pursue a career in General Practice, increasing the supply of IMGs in Australia must form part of the short to medium-term policy response. For Australia's primary care network to function effectively, reforms to address the lengthy processing times and significant cost of recruiting IMGs must be prioritised.

About the Primary Care Business Council

The Primary Care Business Council (PCBC) represents ten of the largest General Practice (GP) providers in Australia. It was formed in response to the crisis currently facing the sector. PCBC's members operate more than 630 General Practices in both inner city and metropolitan areas as well as rural and remote locations. Engaging with more than 5,700 GPs and 3,000 nurses, our members facilitate 24 million patient visits each year.

[1] Organisation of Economic Co-operation and Development, "Realising the Potential of Primary Health Care", OECD Health.
[2] Standing Council on Health, "National Primary Health Care Strategic Framework", April 2013.
[3] The general practice workforce: why the neglect must end, Australian Medical Association 2022
[4] General Practitioner workforce report 2022, Deloitte 2022

Given the breadth, the PCBC has unique insights into the primary care system, how it operates and the challenges facing General Practice in relation to its workforce, clinical and patient issues and ongoing matters of sustainability and viability.

Recommendations

1) Prioritise International Medical Graduates for the development of migrant workforce attraction and retention strategies.

2) Reduce the cost, time and red tape associated with employing International Medical Graduates.

3) Deliver a more coordinated, streamlined system for International Medical Graduates engaging with regulators and accreditation authorities mirroring the New Zealand model which takes 3 months to process and costs up to $5k.

The critical role of IMGs in addressing service gaps

The PCBC welcomes the emphasis in the Inquiry's Terms of Reference on immigration as a strategic enabler of socially sustainable communities in our cities and regions. The primary care network supports this by providing communities with care that ranges from treatment of acute conditions, management of chronic conditions, early intervention and health promotion and prevention.

We note that due to the difficulties of attracting medical practitioners to work outside of the major cities, IMGs are particularly critical to Australians' ability to access primary care services in the most difficult-to-serve areas, particularly vulnerable lower socio-economic regional and outer metro areas.

Within the PBCB network, approximately 50% of primary care providers in these areas are IMGs. Importantly, IMGs are also more skewed to providing after hours care and therefore provide a significant community benefit in terms of accessibility of health care and reduced hospital admissions.

Through this lens, it is clear that the IMGs should be prioritised for the development of migrant workforce attraction and retention strategies.

Barriers to attracting International Medical Graduates

The following barriers exist in attracting IMGs to work in Australia:

- **Limitations in the Distribution Priority Area (DPA) classification system:** The number of DPA locations where IMGs must work to be eligible for Medicare has been systematically reduced since 2017. PCBC acknowledges that the Department of Health and the Government made changes to this program in July 2022, but with the long lead times for IMGs this change has not resolved the Doctor shortages in outer metro and regional areas.

- **Overly burdensome process across multiple agencies:** IMGs are subject to unnecessary testing and documentation requirements (e.g. comparability assessment, Health Workforce Certificate, in-person ID checks). This process requirements the candidate to engage with the Department of Health, Australian Health Practitioner Regulation Agency (AHPRA), the Department of Home Affairs and the Royal Australia College of General Practitioners (RACGP) and the Australian Medical Council. The current time it takes to process an IMG in Australia is around 14 months and costs around $23k – in a lot of cases we see IMGs dropping off from when they started the process due to their circumstances changing which then adds another layer to the process.

- **High registration fees:** IMGs are required to pay $9,000 registration fee.

- **Limited recruitment pool:** In practice, the current IMG program is only attracting workers from the UK, Republic of Ireland and Malaysia and this needs to be expanded to include other countries like Canada, Singapore, and South Africa for example.

- **Prohibitive supervision requirements:** IMGs with provisional or limited registration must be supervised by a supervisor with three years post-Fellowship. This is a significant barrier because there is a limited pool of supervisors and there are no incentives for supervision to make this attractive.

Practical improvements to IMG recruitment processes

PCBC recommends a more appropriate balance between ensuring safe IMG clinical practice and facilitating the attraction and retention of primary health care medical practitioners, including in rural and remote areas.

Practical ways this could be achieved include:

- **Increase the recruitment pool by including more eligible countries in the 'substantially comparable' or 'partially comparable' classification:** PCBC recommends including the United States and South Africa to the list of eligible countries. This would increase the international GP workforce pool of substantially comparable countries from 3% to 8% of global workforce. RACGP should also reinstate its program that recognises the overseas fellowship of 'substantially comparable' countries (UK and Ireland).

- **Increase the number of IMGs on the Australian General Practice Training program:** Allow IMGs from comparable countries onto the AGPT Training Program to fill places not already taken by Australian medical graduates.

- **Introduce a more modern approach to ID checks:** AHPRA should conduct ID Checks virtually through facial recognition software or in the country of origin. Requiring IMGs to travel to Australia for in-person ID checks early in the 14 month process adds unnecessary cost, time, and complexity to the process.

- **Remove the need for Labour Market Testing**: Noting that designated DPA locations already have established workforce shortages, there is no need for additional labour market testing. This would save 28 days and the cost of advertising on three different websites to meet the requirements for an IMG visa.

- **Coordinate and streamline RACGP and AHPRA processes:** PCBC acknowledges that both organisations need to independently assess IMGs. However, he current sequential double handling of each application adds an approximately three-month delay to the process. There is also a need to expedite RACGP lodgement of Medicare Provider Numbers. IMGs should be allowed to apply for Provider Numbers directly rather than through the RACGP as this adds a 4-6 weeks delay, often when the IMG is already in Australia and ready to commence work.

- **Reduce supervision for 'substantially comparable' GPs and enable more GPs to become IMG supervisors:** A key restriction in the ability to recruit IMGs is the supervision requirements, which are particularly onerous in rural and remote communities where doctor shortages, and therefore supervisor shortages, are widespread. We recommend reducing the supervision requirements for GPs from 'substantially comparable' countries, reconsidering the current 3-year time requirement to become a supervisor and allowing retired GPs to supervise IMGs if they have been registered within the last 5 years.

- **Provide a financial incentive for GPs to become IMG supervisors:** Reduced remuneration is a key barrier to GPs becoming supervisors for IMGs. It is financially prohibitive for potential supervisors to reduce their personal direct service provision in order to support an incoming IMG.

- **Introduce a Parents Visa (sub class 103) for rurally placed IMGs in priority locations:** This will increase the attractiveness of rural and remote locations, particularly for GPs with young families who may need the assistance with young children.

Contact

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