Submission No. 115
(Overseas Trained Doctors)
Date: 25/02/2011

OTD Registration & Supports

FRIENDLY SOCIETY PRIVATE HOSPITAL

BACKGROUND:

The Friendly Society Private hospital runs the only After Hours Medical Practice in Bundaberg. We recruit General Practitioners to staff the clinic.

Bundaberg is a rural city in Queensland with a resident population in Bundaberg Regional Council District of 89,814 and a known growth rate of 2.2% leading to an estimated population between 100,910-107,060 by 2016. The median age in the district is 47yrs (a projected increase of 6yrs by 2031).

The service we run is specifically an After Hours Medical Service that has been developed to support the community and allows access to medical services during times that the patients own GP practices are closed. It is the **only** after hours medical practice in Bundaberg. We know that this service decreases the load onto the Bundaberg Base Hospital as we regularly see between 800-1000 patients per month. During week nights we may only have 10-15 patients present to the practice – this is problematic as it is not financially viable for the community based GP's to work as there is limited financial reward attached and the item numbers/fees charged are the same as during the day.

OTD REGISTRATION AND SUPPORTS

A. RECRUITMENT PROCESSES

The process is complicated and involves multiple bodies. The submission directly addresses each of these processes to describe our experience, where things work well and where there are significant barriers and hurdles. We have also added situational and constructive comment for your review and consideration.

1. **Application** – as an afterhours medical practice we have serious problems in getting any applicants to our practice at all. We continually advertise in Australia, but have only ever received one applicant to work as our employee. This doctor is semi-retired and only works one day per week.

Issues here:

a. Community based GP's will only work when they want, they do participate on the weekend roster but they limit their shifts to 1shift every 8 weeks and have extended leave breaks. They will also NOT work weeknights making rostering the shifts extremely difficult so we have to employ doctors to work these times.

b. There are no condition/s or onus for any Australian graduates to work in an after hours environment – it is considered antisocial and not a desired position at all. Additionally the income generated is not as much as they can make through the day in a day-time GP practice, - consequently no Australian trained/qualified applicants have ever applied for permanent full time work.

c. Similarly we have had no applicants from Australian Registered or Vocationally Registered OTD's to undertake the role as again there are no conditions on their registration for mandatory work in an After Hours roster as they consider it anti-social and undesirable

d. We have had applications from experienced doctors who are permanent residents in Australia who are still working towards their Full and Vocational Registration. We would be happy to accept these applicants as we would welcome their experience and knowledge, however when we have applied for Provider numbers they have been refused as they fall under the 19AA Exemption classifications. We have then gone to the bodies that support programs attached to the 19AA and tried to get placement and been told there were no positions, that there is a waiting list for these positions and that we should not even bother to apply due to the high demand and acceptance criteria (ie, we would not be successful, and that it would not meet our needs as it would take to long to even get an applicant into the program). Hence we know that education programs are scarce, and that the doctors have little access to these supports.

e. The anti-social hours make it very difficult to even find an OTD applicant who will reach the standards now set by AHPRA. The conditions associated with their level of clinical practice add to the increase in costs and subsequently the decrease in available funds for an employment package - making this an even less desirable position. Hence we have not ever been able to recruit form any of the preferred streams (eg, England, New Zealand).

2. **OTD's Pre-Employment**
   a. PESCI – All the doctors who apply to us now need to undertake this. There are limited positions for them to do this overseas and their lack of exposure to the Australian Health Care System and practice standards make it difficult for them to successfully undertake this in their own environment. We have committed to bringing them to Australia for a period of time prior to the PESCI, placing them in an Australia General Practice. We then have to negotiate with one of the General Practices in town to place them for the period in an observer position. These costs are borne by the practice, again adding to costs and decreasing available funds for their employment.

3. **Employment**
   a. **Preliminary Assessment of a District of Workforce Shortage (PADWS)** – (Commonwealth) the After hours has automatic access to a PADWS even though we are in a RAMA 3 area. We would like to see this same exemption applied to any OTD doctors with permanent residency who apply to work in an After Hours practice. Tis will have a dual result, supporting after hours medicine and giving added employment opportunities (see point 1 (d)) while they work towards their full registration/VR status.

   b. **Area of Need (AON)** – (State) we continually advertise due to the difficulties in even getting a doctor, let alone trying to cope with the fast turn-over of doctors that we experience. The practice is seen very much as a stepping stone for the wider Australian market and we have been very successful in getting our doctors to their registration and high standards of clinical practice. We take pride in our results and have invested considerable amount of time and funds into this program.

   We have never had an Australian apply for fulltime work and will not in the foreseeable future unless there are significant changes in terms of their registration and practice conditions, consequently we know we will continue to recruit from the overseas market. Due to the issues we experience in recruitment and retention we would also like to see

the AON requirement for after hours medical practices as a much simpler/automatic process.

Unable to find contacts for anyone from the AON department – no website, no published contact details, no access to the formal structures we need to comply with and no communication by them/state government regarding changes or issues – you have to know someone who knows someone. Then you are not sure you have completed the right form – fearful of delays if asked to redo and resubmit. This delay and lack of knowledge has led to some of our doctors being fearful of registration refusals and incurs a level of anxiety.

c. IELTs & Criminal checks – nil issues, must continue.

d. AHPRA – process for registration is slow (understanding that they are new and still working through their teething problems), however this is too extended, leaving a lot of uncertainty for both newly registered doctors and those renewing registration. Capacity to talk to staff and find out paths or forms required again difficult – phone calls divert and responses vary according to the staff member you speak to – little consistency.

e. Practice conditions – the need for limited registration involving conditions of group practice progressing through to independent practice is accepted. Our after hours medical practice has been put to considerable financial expenditure in an effort to meet the initial need for Group Practice. Our own doctors leave as soon as they have full registration meaning we only have a VR doctor on roster one week day night. The community based GPs who work on the 1:8 weekend program will not work on roster week nights without considerable financial incentive. We therefore have to pay these doctors to be on-site in the practice for this period of time and they will agree to only supervise the doctor, not see patients themselves, therefore they do not generate income during this time unless they perceive problems and then see the patients personally.

f. Additionally, because we have limited VR doctors in the practice we have had to establish an alliance and a business relationship with one of the General Practices on campus to undertake the role of Supervisor. This again has been at considerable cost to the practice.

g. Progression through the requirements for registration renewal becomes critical to our doctors – if partially or fully independent practice status is not granted then we have problems. We have had one Dr sit his AMC Clinical and pass 70% of the questions during his first year here – his upgrade to partially independent practice was refused even he has shown satisfactory progress and supervisors reports. We believe that the pass/fail issue should be addressed and given due consideration of the three years available under the renewal system.

h. Changes to registration and renewal conditions (for example the above scenario) are not communicated and we are left wondering why the renewal upgrade was not approved – what then makes up the term "satisfactory progress"? The doctors are left with a strong sense of failure in spite of the exceptional achievements that they have actually made.

i. The requirement of three years available to obtain full registration may well also be problematic due to workloads and transition issues with such a drastic change in their lives and cultures.

j. We have also had to further our relationship with the General Practice who undertakes the supervision to place our doctors in his practice for a period of time to obtain the Group Practice requirement – this has been very difficult as we cannot get PADWS for the aligned General Practice without extreme difficulty. We ask that there be changes to legislation to support these doctors in our type of environment to meet their supervision requirements.

4. Provider Numbers/Medicare Rebates

a. Access to provider numbers is limited to the PADWS and the 19AA & 19AB Exemptions. There is an exemption for the 19AA for those doctors who work in a Deputizing Service – we would like this to be applied to After Hours Medical Practices. This would enable experienced IMG doctors who are Permanent Residents access to a supported work place until they achieved full registration or VR status – whichever comes first. This would then give further employment choices to these doctors. Time limits could apply to this application and linked to their progress through AHPRA registrations.

b. Medicare/Item Numbers and payments for after hours medical practices remain at the same scale as during the day, and are graded according to the level of GP you are. Nil financial recognition for services delivered in times that automatically incur penalty payment – higher costs, nil rewards – a plumber earns more in an after hours call out than a doctor.

c. PIP payments for the doctors are dependent on the practice being accredited, however the Government/Medicare only recognizes simple Australian Accreditation program for GP practices – eg., QIP. We completed an internationally recognized accreditation program (ISO) and are fully accredited, however not eligible for funding as we do not have accreditation through this limited agency. The doctors are therefore not entitled to the flow-on effects of the PIP payments, further limiting their access to income. We know that we are accredited at a far higher level than QIP and are not prepared to spend further funds to undertake a secondary accreditation process at a lower level. We would like consideration of alternative accredited accreditation programs to be considered as acceptable for this process so the doctors can access their earned payments.

B. SUPPORT FOR IMG's

AHPRA have a strong expectation of registration as a full registrant within the three years. They expect full support for the GPs in their practice. Difficulties also exist in rural areas where support is further limited. There are insufficient vacancies for IMG's in training programs in Australia and there is a continuing pressure for success first time. I believe we have set high (but necessary) standards, but have failed to deliver on placements in education programs.

Access issues also require consideration. The IMG's are usually in rural areas with limited teleconferencing capacity or additional peer support. Capacity to undertake programs through colleges is limited to computer and what few opportunities they have to get to the

cities for education. The After hours is not eligible for access to Locums as we are in a RAMA 2 area and therefore not eligible for Health Workforce initiatives. We request that consideration be given to extend this program to the After Hours Medical Practices (Deputising Services already qualify – the only difference we have is that our patients come to us and we do not do home visits). We cannot get locums to work at an affordable rate and because we are a RAMA 2 are not eligible for the Locum funding program through Health Workforce Queensland – this initiative would allow increased relief for study and leave to better ensure their physical and mental health.

The AHPRA registration functions on clinical standards– and does not give substance to the doctors legal responsibilities and programs – i.e., PBS approvals, Workcover responsibilities, registration requirements, medico-legal issues. Can the program include some consideration of non-clinical requirements to verify knowledge and understanding of these requirements.

Consideration of the changes in culture and family dynamics are also important – the transition between countries cannot be under-estimated. The additional stress of trying to complete the AMC Clinical quickly places extreme difficulty on both the IMG and their families.

Partial failures in the AMC Clinical should not be seen as that, but should be viewed as partial success – and while progress continues then consideration for the doctors efforts should be recognized and supported in a graded program for partial -> independent practice (on full registration).

Currently all the support falls to the clinics – we are in fact minimizing government expenditure for this – as such I believe that each practice should be on a performance based subsidy to assist these doctors to fill a role that the Australian System has failed in delivering. There has been no training and support impost to put these doctors through to full registration, yet there is an expectation that they pick-up all their learning and skill needs themselves. The same does not apply to Australian Medical Graduates.

The failure to deliver on medical officers into rural or socially unacceptable practices will not change with the additional funding initiatives that have been introduced. The problems that are at the core have not been addressed, so have no possibility of success.

CONCLUSION

The submission recounts our personal experiences, highlights only briefly the frustration and problems we experience in trying to register and support our IMG.s While AHPRA have developed systems, they remain incomplete and communication remains limited. We battle through each stage and the doctors feel threatened and under siege by the number and complexity of steps involved in this process. We would hope that this may change through his review and that our suggestions assist in this process. We would be happy to further clarify any of the comments made in this document.

Yvonne McChesney
ADON Compliance
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