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Lost in the Labyrinth

Report on the inquiry into registration processes and support for overseas trained doctors

House of Representatives
Standing Committee on Health and Ageing

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Canberra

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Foreword

Australia has one of the best health systems in the world, delivering high quality health care to the community. This, along with our high standard of living, makes Australia an attractive destination for international medical graduates (IMGs). In turn, Australia has long been reliant on IMGs to address medical practitioner workforce shortages, particularly in regional, rural and remote communities, where they make up over 40% of the medical workforce. Local communities highly value their IMGs and throughout the inquiry the Committee heard many examples of the way in which rural and remote communities in particular have embraced IMGs as one of their own. However, it is clear that whilst IMGs generally have very strong community support, they do not always receive the same level of support from the institutions and agencies that accredit and register them.

IMGs working in Australia are required to meet a number of accreditation standards in order to gain registration allowing them to practise medicine in this country. Importantly, the Committee does not support any reduction in the high clinical standards they are required to meet. Rather, in formulating the report's 45 recommendations the fundamental aim has been to reduce red tape, duplication and administrative hurdles faced by IMGs whilst ensuring that the Australian standard continues to be rigorously applied. The number of recommendations in the report reflects the complex nature of the accreditation and registration processes, and the breadth of issues faced by IMGs across their personal and professional lives as they seek to navigate these systems. These issues were canvassed in the 216 submissions (including supplementary submissions) which were received during the inquiry. Of the 216 submissions, 109 were from IMGs, 91 from organisations with involvement in accreditation, registration or recruitment of IMGs and the remaining 16 were from others interested parties including academics, co-workers, community members and patients. The Committee also conducted an extensive program of public hearings visiting in every state and territory in Australia, and hearing evidence directly from 145 witnesses during 22 public hearings in 12 different cities.

In addition to the range and complexity of issues canvassed, the Committee also had to contend with issues of a sensitive nature which had evidently resulted in high levels of angst and personal distress for some IMGs. Nearly one third of the IMGs who made submissions requested anonymity, citing fears that their chances of progressing through accreditation to registration would be compromised if it became known that they had commented publicly. The Committee also receive approaches from a number of IMGs, who while keen to air their concerns informally, refused to make formal submission to the inquiry fearing negative consequences.

Key themes emerged as the inquiry progressed, with a significant proportion of witnesses describing a system lacking in efficiency and accountability, and importantly, one in which IMGs themselves often had little confidence. Many IMGs also felt that they had been the subject of discrimination, and anti-competitive practices and that this had in some cases adversely affected their success in registering for medical practice in their chosen speciality. One particularly illustrative example of the type of problems faced by IMGs was a specialist who despite being highly regarded overseas was forced to sit a basic exam for his field. There was a textbook listed as a study guide – he was the author!

The context of the inquiry was the implementation in 2010 of the National Registration and Accreditation Scheme (the National Scheme). The National Scheme replaced varying schemes operated by state and territory governments. The Medical Board of Australia (MBA) was established as the national registration body for medical practitioners, with its administrative functions provided by the Australian Health Practitioners Regulation Agency (AHPRA). The fundamental aim of the National Scheme was to provide a more efficient and uniform system of accreditation and registration for health professionals, including IMGs.

Although the premise for implementing the National Scheme is laudable, managing the transition from state and territory based systems proved to be a significant undertaking. As such it is not surprising that its introduction was accompanied by a number of teething problems, particularly for AHPRA as administrative processes were developed, implemented and refined. Without doubt the introduction of new accreditation processes and national registration standards for IMGs resulted in confusion and frustration for many as they tried to navigate what is still a complex system in order to comply with new requirements. As noted earlier, a perceived lack of transparency and clarity in relation to aspects of the National Scheme left some IMGs feeling as if they had been significantly disadvantaged, and in some cases even deliberately discriminated against.

During the inquiry the Committee heard from many IMGs, some of whom had already practised medicine in Australia for a number of years under state and territory based schemes but were unable to continue practising under the National Scheme. Experiences ranged from those who had difficulties meeting new mandatory registration standards, particularly standards pertaining to English language proficiency, to those who felt that they were adversely affected by more stringent requirements to progress from limited registration to full registration.

Furthermore, many IMGs, medical recruitment agencies and employers of IMGs provided insights into systemic inefficiencies and inconsistencies, highlighting poor communication and coordination between key accreditation and registration authorities. Far from streamlining administrative processes, under the National Scheme many IMGs have been required to submit the same documents on multiple occasions but to different accreditation and registration authorities, a situation which I and other members of the Committee have found puzzling. In addition, many IMGs necessarily find themselves grappling with other complex requirements associated with immigration, employment and access to a Medicare provider number. In the more extreme cases, a number of frustrated IMGs have reconsidered their prospects in Australia and a few who have considered walking away from their lifelong careers in medicine.

In seeking to address these issues a significant number of the report's recommendations have been developed to increase the transparency of the National Scheme's accreditation and registration processes for IMGs, and to reduce the administrative burden on IMGs by improving efficiency. To achieve these outcomes IMGs must be able access to clear, concise and detailed information on the relevant processes and have access to advice; responsible authorities need to improve their communication and coordination.

In the context of Australia's aim to achieve self-sufficiency in medical practitioners by increasing the number of domestically trained graduates, the Committee considered the longer term utility of policy that requires IMGs to work for up to 10 years in a district of workforce shortage in order to qualify for a Medicare provider number – the so called 10 year moratorium. As Australia's reliance on IMGs decreases, it is understood that more will need to be done to encourage Australian trained medical practitioners to work in communities which have routinely experienced medical practitioner shortages in the past. In view of anticipated changes in the composition of the medical practitioner workforce the Committee concludes that a review of the 10 year moratorium would be appropriate and timely.

Last, but by no mean least, the Committee considered the importance of professional and personal supports for IMGs and their families, noting that access to these types of support is not only crucial to the initial recruitment of IMGs but also to rates of retention. The Committee's recommendations seek to enhance and strengthen existing systems of support, including pre- and post-arrival orientation, access to professional development opportunities and peer support networks for IMGs, and access support networks for spouses and children. With the 2010 establishment of Health Workforce Australia and its focus, among other things, on facilitating the immigration, recruitment and retention of overseas trained health professionals, I am confident that significant progress will be made to enhance support systems for IMGs and their families.

As Chair of the Committee, I would like to thank all of those who participated in the inquiry process and who have assisted with the provision of information. The knowledge and insight of those that have highlighted key issues, in many instances also providing suggestions for workable solutions, has been impressive. Likewise, those IMGs who have openly shared their difficult experiences with the hope of seeing an improvement for others in the future should be commended. I also thank the other members of the Committee for their participation, contribution and commitment to the inquiry.

In concluding, I emphasise that throughout the inquiry the Committee has been aware that improvements in registration processes for IMGs must be achieved without compromising the high standards that Australians expect from medical practitioners. In that context however, it is my sincere hope that the report's recommendations will help to resolve the administrative difficulties faced by many IMGs, and ensure that those wishing to practise medicine and call Australia home in future may do so with certainty and clarity of what is expected of them. To provide reassurance that this is the case, the Committee intends to review progress made towards implementing its recommendations at a future date.

Steve Georganas MP
Chair



Membership of the Committee

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Deputy Chair Mr Steve Irons MP

Members Mr Mark Coulton MP
 Ms Jill Hall MP
 Ms Deborah O'Neill MP
 Mr Geoff Lyons MP
 Mr Ken Wyatt MP

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Terms of reference

Recognising the vital role of colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs), the Committee will:

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



List of acronyms

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
ACRRM	Australian College of Rural and Remote Medicine
ADTOA	Australian Doctors Trained Overseas Association
AGPT	Australian General Practice Training
AHMC	Australian Health Ministers' Conference
AHPRA	Australian Health Practitioner Regulation Agency
AHWAC	Australian Health Workforce Advisory Council
AHWOC	Australian Health Workforce Officials Committee
AMA	Australian Medical Association
AMC	Australian Medical Council
ANZCA	Australian and New Zealand College of Anaesthesia
AOA	Australian Orthopaedic Association
AoN	Area of Need
ASGC-RA	Australian Standard Geographical Classification – Remoteness Areas
BEO	Branch Education Officer

CA	Competent Authority
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CPMC	Committee of Presidents of Medical Colleges
CSSP	Clinical Supervision Support Program
CV	Curriculum Vitae
DIAC	Australian Government Department of Immigration and Citizenship
DoHA	Australian Government Department of Health and Ageing
DWS	District of Workforce Shortage
ECFMG	Education Commission for Foreign Medical Graduates
EICS	ECFMG International Credentials Service
ENS	Employer Nomination Scheme
FGAMS	Foreign Graduates of an Accredited Medical School
FRACGP	Fellow of the Royal Australian College of General Practitioners
FTE	Full-time Equivalent
GPET	General Practitioner Education and Training
GPRIP	General Practice Rural Incentive Program
GSM	General Skilled Migration
HWA	Health Workforce Australia
HWPC	Health Workforce Principle Committee
IELTS	International English Language Testing System
IMG	International Medical Graduate
IMS	International Medical Specialist

JSCOTS	Joint Standing Committee on Overseas Trained Specialists
MBA	Medical Board of Australia
MCQ	Multiple Choice Question
MCQ CAT	Multiple Choice Question Computer Adaptive Testing
NHP	National Health Practitioner
NHWT	National Health Workforce Taskforce
NRAS	National Registration and Accreditation Scheme
NRHA	National Rural Health Alliance
NSWRDN	New South Wales Rural Doctors Network
OET	Occupational English Test
OTDs	Overseas Trained Doctors
OTS	Overseas Trained Specialist
OTSAN	Overseas Trained Specialist Anaesthetist' Network
PESCI	Pre-Employment Structured Clinical Interview
PGPPP	Prevocational General Practice Placements Program
PII	Professional Indemnity Insurance
RACGP	Royal Australian College of General Practitioners
RACS	Royal Australasian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCR	Royal Australian and New Zealand College of Radiologists
RAPTS	Recruitment, Assessment, Placement, Training and Support
RDAA	Rural Doctors Association of Australia

RDWA	Rural Doctors Workforce Agency
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RSMS	Regional Sponsored Migration Scheme
RTP	Regional Training Providers
RVTS	Rural Vocational Training Scheme
RWAs	Rural Workforce Agencies
RWAV	Rural Workforce Agency Victoria
SCE	Structured Clinical Examination
SCI	Structured Clinical Interview
SIMG	Specialist International Medical Graduate
STP	Specialist Training Program
TMT	Tropical Medical Training
TRD	Temporary Resident Doctor
VR	Vocational Recognition
WBA	Workplace-based Assessment
WHO	World Health Organisation



List of recommendations

Recommendation 1

The Committee recommends that the Australian Medical Council (AMC), in consultation with the Medical Board of Australia and international medical graduates (IMGs), take steps to assist IMGs experiencing difficulties and delays with primary source verification, including but not limited to:

- continuing to assist IMGs who have passed all requirements of a pathway towards registration as a medical practitioner, excepting primary source verification;
- liaising with the Educational Commission for Foreign Medical Graduates to ascertain and address any barriers to achieving timely primary source verification; and
- providing IMGs with up-to-date information relevant to their application, including the anticipated timeframe for response based on their application, or options on how they might hasten the process, such as contacting the institution directly. (*para 4.21*)

Recommendation 2

The Committee recommends that the Australian Medical Council take action to increase the availability of the Australian Medical Council Structured Clinical Examination (SCE) so that those making a first attempt at the examination be accommodated within six months of their initial application. (*para 4.53*)

Recommendation 3

The Committee recommends that the Australian Medical Council publish detailed information on its website outlining the processes for determining the allocation of places for the Structured Clinical Examination (SCE). The information should

explain prioritisation, the purpose and operation of the standby list and provide up-to-date information on waiting times for undertaking the SCE. (*para 4.55*)

Recommendation 4

The Committee recommends that the Australian Medical Council provides a detailed level of constructive written feedback for candidates who have undertaken the Australian Medical Council's Structured Clinical Examination. (*para 4.61*)

Recommendation 5

The Committee recommends that the Council of Australian Governments include workplace-based assessment (WBA) pathway for international medical graduates on its health workforce agenda in order to extend endorsement from state and territory governments and increase the availability of host sites nationally. (*para 4.81*)

Recommendation 6

The Committee recommends that the Medical Board of Australia in conjunction with the Australian Medical Council, commission an independent evaluation of the workplace-based assessment (WBA) model. The evaluation should incorporate a cost benefit analysis of WBA, and encompass the views of all stakeholders, including international medical graduates, clinical assessors and host institution administrators. The outcomes of the evaluation should be made public. (*para 4.83*)

Recommendation 7

The Committee recommends that the Australian Government Department of Health and Ageing and Australian Medical Council, in consultation with the Joint Standing Committee on Overseas Trained Specialists and the specialist medical colleges:

- publish agreed definitions of levels of comparability on their websites, for the information of international medical graduates (IMGs) applying for specialist registration;
- develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are used to determine level of comparability;
- develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are taken into account when

determining the length of time an IMG needs to spend under peer review; and

- develop and maintain a public dataset detailing the country of origin of specialist pathway IMGs' professional qualifications and rates of success. (*para 4.109*)

Recommendation 8

The Committee recommends that specialist medical colleges adopt the practise of using workplace-based assessment (WBA) during the period of peer review to assess the clinical competence of specialist international medical graduates (IMGs) in cases where applicants can demonstrate that they have accumulated substantial prior specialist experience overseas. As part of the WBA process the specialist medical colleges should make available the criteria used to select WBA assessors.

Specialist medical college examinations should only be used as an assessment tool where specialist IMGs are recent graduates, or where deficiencies or concerns have been identified during WBA. (*para 4.120*)

Recommendation 9

The Committee recommends that all specialist medical colleges consult with the Australian Medical Council to ensure each college undertakes a consistent three-stage appeals process, incorporating the following:

- an automatic right for an international medical graduate (IMG) to undertake the next stage of appeal, following completion of each preceding appeal;
- the option for the IMG to retain an advocate for the duration of any appeal process to an Appeals Committee, including permission for that advocate to appear on the IMG's behalf at the appeal itself; and
- the capacity to expand membership of the Appeals Committee to include an IMG who holds full membership of the relevant specialist college, but has no involvement with the decision under review. (*para 4.134*)

Recommendation 10

The Committee recommends that the specialist medical colleges undertake the following steps to ensure international medical graduates (IMGs) are aware of their right of appeal regarding their application for specialisation:

- publish information regarding their appeals process in a prominent place on their website, including information regarding each stage of the appeals process, timelines for lodging appeals and the composition of Appeals Committee membership; and
- ensure that IMGs are informed of their right to appeal when any decision is made regarding their application, with information regarding their right to appeal a particular decision provided in writing on the same document advising the IMG of the decision made regarding their application. (*para 4.136*)

Recommendation 11

The Committee recommends that the Australian Health Ministers Advisory Council, in conjunction with the Australian Government Department of Health and Ageing and the National Health Practitioner Ombudsman, develop and institute an overarching, independent appeals mechanism to review decisions relating to the assessment of clinical competence to be constituted following an unsuccessful appeal by an international medical graduate to the Appeals Committee of a specialist medical college. (*para 4.139*)

Recommendation 12

The Committee recommends that Health Workforce Australia, in consultation with state and territory health departments, the Medical Board of Australia, specialist medical colleges and other key stakeholders, investigate options to ensure equitable and fair access to clinical supervision places for international medical graduates. Consideration should include establishing designated supervised placements for international medical graduates in teaching hospitals or similar settings. (*para 5.23*)

Recommendation 13

The Committee recommends that the Australian Medical Council, the Medical Board of Australia and specialist medical colleges collaborate to develop a process which will allow semi or recently retired medical practitioners and specialist practitioners to maintain a category of registration which will enable them to work in the role of a clinical supervisor. (*para 5.25*)

Recommendation 14

The Committee recommends that Health Workforce Australia provide support under the Clinical Supervision Support Program to promote the innovative use of new technologies to increase clinical supervision capacity, particularly for medical practitioners who are employed in situations where they have little or no access to direct supervision. (*para 5.27*)

Recommendation 15

The Committee recommends that prior to undertaking practise in an area of need position or regional, rural, remote position with indirect or limited access to clinical supervision, international medical graduates (IMGs) be placed in a teaching hospital, base hospital or similar setting. Within this setting IMGs could be provided appropriate supervision for a defined period to further establish their clinical competency and assist with their orientation to the Australian health care system. (*para 5.31*)

Recommendation 16

The Committee recommends that Health Workforce Australia ensure aspects of cross cultural awareness and communication issues are key components in any guidelines, educational materials or training programs that are developed to support enhanced competency of clinical supervisors. (*para 5.40*)

Recommendation 17

The Committee recommends that the Medical Board of Australia/Australian Health Practitioners Registration Agency (MBA/AHPRA) provide more information on the Pre-Employment Structured Clinical Interview (PESCI).

At a minimum this information should outline:

- the criteria used to determine the need for an IMG to undertake a PESCI assessment; and
- criteria for accreditation of PESCI providers.
- details of the PESCI assessment process including:
 - ⇒ the composition of the interview panel, the criteria used for selecting panel members and their roles and responsibilities;
 - ⇒ the format of the interview and the aspects of skills, knowledge and experience that will be assessed;

- ⇒ criteria for assessment and mechanisms for receiving feedback; and
- ⇒ the process for lodging and determining an appeal against the findings of a PESCI assessment.

This information should be easily located on the MBA/ AHPRA website and provide links to relevant information on PESCI that is available on the websites of Australian Medical Council accredited PESCI providers. (*para 5.59*)

Recommendation 18

The Committee recommends that all Pre-Employment Structured Clinical Interview (PESCI) assessments be video-recorded and a copy of the video-recording be provided to the applicant for the purpose of providing appropriate feedback on the assessment and as a record should an international medical graduate wish to appeal the outcome of a PESCI. (*para 5.61*)

Recommendation 19

The Committee recommends that the Medical Board of Australia, as part of its current review of the utility and portability of Pre-Employment Structured Clinical Interview, include broader consideration of its utility as an assessment tool, particularly its application to international medical graduates who have already practised in Australia for a significant period of time under Limited Registration. (*para 5.65*)

Recommendation 20

The Committee recommends that the Medical Board of Australia provide an opportunity for interested parties, including international medical graduates, to provide input into its current review of the utility and portability of Pre-Employment Structured Clinical Interviews.

To promote transparency, the Medical Board of Australia should also provide regular updates on the review on its website, and at the conclusion of the review publish its findings. (*para 5.66*)

Recommendation 21

The Committee recommends that the Medical Board of Australia review whether the current English Language Skills Registration Standard is appropriate for international medical graduates.

The review should include consideration of:

- whether the International English Language Testing System and Occupational English Test scores required to meet the English Language Skills Registration Standard is appropriate; and
- the basis for requiring a pass in all four components in a single sitting. (*para 5.85*)

Recommendation 22

The Committee recommends that the Medical Board of Australia negotiate with providers of the International English Language Testing System and Occupational English Test with a view to requiring that detailed, qualitative written feedback on each component of the English Language test be provided in writing to international medical graduates to enable identification of areas of deficiency which may be rectified. (*para 5.87*)

Recommendation 23

The Committee recommends that the Medical Board of Australia extend the period of validity for English language proficiency test results as prescribed by the English Language Skills Registration Standard to a minimum period of four years. (*para 5.102*)

Recommendation 24

The Committee recommends that the Medical Board of Australia/Australian Health Practitioners Registration Agency provide the Australian Government Department of Immigration and Citizenship with direct access to information on its registration database as necessary to determine granting of a visa for employment purposes. (*para 5.113*)

Recommendation 25

The Committee recommends that the Australian Government Department of Health and Ageing produce and publish on its website a comprehensive guide detailing how District of Workforce Shortage (DWS) status is determined and how it operates to address issues of medical practitioner workforce shortages. The guide should include detailed information on the following:

- the methodology of DWS determination;
 - frequency of DWS status review; and
 - criteria for benchmarking of appropriate workforce levels.
- (*para 5.140*)

Recommendation 26

The Committee recommends that the Australian Government Department of Health and Ageing consult with state and territory government departments of health to agree on nationally consistent and transparent approach to determining Area of Need (AoN) status based on agreed criteria. Consideration should also be given to improving the alignment between the AoN and Districts of Workforce Shortage. (*para 5.145*)

Recommendation 27

The Committee recommends that the Department of Health and Ageing, in association with Health Workforce Australia, examine options for a planned, scaled reduction in the length of the 10 year moratorium so that it is consistent with the average duration of return of service obligations that apply to Australian graduates of Bonded Medical Places. Workforce modelling should be used to determine the implications for workforce preparation, transition, training and distribution. The outcomes should be made publicly available. (*para 5.160*)

Recommendation 28

The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, Australian Medical Council and specialist medical colleges, publish data against established benchmarks on their websites and in their annual reports, on the average length of time taken for international medical graduates to progress through key milestones of the accreditation and registration processes. Information published on websites should be updated on a quarterly basis. (*para 6.15*)

Recommendation 29

The Committee recommends that AHPRA's annual report, with respect to the functions carried out by the MBA must also include a number of other key performance indicators providing further information to IMGs. In the Committee's view, these indicators must include (but should not be limited to):

- the country of initial qualification for each IMG applying for Limited Registration;
- the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and specialist medical colleges; and

- the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for:
 - ⇒ Australian Medical Council Multiple Choice Question Examination;
 - ⇒ Australian Medical Council Structured Clinical Examination;
 - ⇒ AHPRA's Pre-Employment Structured Clinical Interview (PESCI);
 - ⇒ the MBA's English Language Skills Registration Standard;
 - ⇒ other MBA Registration Standards including Criminal History Registration Standard; and
 - ⇒ processes of specialist medical colleges including college interviews, examinations and peer review assessments. (*para 6.18*)

Recommendation 30

The Committee recommends that where an international medical graduate considers that the processes prescribed under the National Registration and Accreditation System have placed them at a significant disadvantage compared to their circumstances under the processes of former state and territory medical boards, that the Medical Board of Australia investigate the circumstances, and if necessary rectify any registration requirements to reduce disadvantage. The process and procedure for review should be clearly outlined. Any review should be conducted in a timely and transparent manner. (*para 6.38*)

Recommendation 31

The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency ensure that computer-based information management systems contain up-to-date information regarding requirements and progress of individual international medical graduate's assessment, accreditation and registration status to enable timely provision of advice. (*para 6.46*)

Recommendation 32

The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency implement appropriate induction and ongoing training for all employees responsible for

dealing with inquiries. This training should include among other things, an understanding of the overall system of accreditation and registration so that referrals to other organisations can be made where necessary. (*para 6.48*)

Recommendation 33

The Committee recommends that the Medical Board of Australia, in conjunction with the Australian Medical Council and specialist medical colleges, develop a centralised repository of documentation supplied by international medical graduates (IMGs) for the purposes of medical accreditation and registration.

The central document repository should have the capacity to:

- be accessed by relevant organisations to view certified copies of documentation provided by IMGs;
- be accessed by relevant organisations to fulfil any future documentary needs for IMGs without the need for them to resubmit non time-limited documentation multiple times;
- form a permanent record of supporting documentation provided by IMGs; and
- comply with the Australian Government's Information Privacy Principles and *Privacy Act 1988* (Cth). (*para 6.62*)

Recommendation 34

The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, the Australian Medical Council, and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible. These requirements should be developed with a view to further reducing duplication by preventing the need for international medical graduates (IMGs) to lodge the information more than once and in different forms and formats.

This documentation should form part of an IMG's permanent record on a central document repository. (*para 6.71*)

Recommendation 35

The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Registration Agency amend requirements so that Certificates of Good Standing provided by past employers remain valid for a period of 12 months, noting the following:

- where there is a period of greater than three months since the last Certificate was issued, applicants must certify that they have not been employed in medical practice during that period; or
- where applicants have been employed in medical practice since issuing of the last Certificate, additional Certificate(s) of Good Standing must be provided.

Certificates of Good Standing should also be available on a central document repository. (*para 6.82*)

Recommendation 36

The Committee recommends that specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to international medical graduates (IMGs) seeking specialist accreditation in Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the Australian Medical Council and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should be informed about possible penalties which may be applied throughout the assessment process. (*para 6.99*)

Recommendation 37

The Committee recommends that the Medical Board of Australia/ Australian Health Practitioner Registration Agency, the Australian Medical Council and specialist medical colleges review the administrative fees and penalties applied throughout the accreditation and assessment processes to ensure that these fees can be fully justified in a cost recovery based system. (*para 6.100*)

Recommendation 38

The Committee recommends that the Australian Medical Council and the Medical Board of Australia/ Australian Health Practitioner Regulation Agency increase awareness of administrative complaints handling and appeal processes available to international medical graduates (IMGs) by:

- prominently displaying on their websites information on complaints handling policies, appeals processes and associated costs; and
- ensuring when IMGs are advised of adverse outcomes of any review, that the advice contains information on the next step in the appeal process. (*para 6.120*)

Recommendation 39

The Committee recommends that the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies. (*para 6.141*)

Recommendation 40

The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop and implement a program of orientation to be made available to all international medical graduates (IMGs) and their families to assist them with adjusting to living and working in Australia. In addition to detailed information on immigration, accreditation and registration processes, the program should include:

- accommodation options, education options for accompanying family members, health and lifestyle information, access to social/welfare benefits and services, and information about ongoing support programs for IMGs and their families;
- information on Australia's social, cultural, political and religious diversity; and
- an introduction to the Australian healthcare system including accreditation and registration processes for IMGs, state and territory health departments and systems along with Medicare.

An integral part of the orientation program should be the development of a comprehensive package of information which can be accessed by IMGs and their families prior to their arrival in Australia. (*para 7.31*)

Recommendation 41

The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop a nationally consistent and streamlined system of education and training supports for international medical graduates.

The consultation should include specific consideration of the following:

- strategies for facilitating access for IMGs working in regional, remote and rural locations, including:
 - ⇒ the potential for the innovative use of new technologies including tele/video-conferencing and internet;

- ⇒ the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and
- ⇒ the adequacy of financial assistance for IMGs who need to travel to access educational and training supports.
- strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and
- the financial and resource implications associated with providing wider access to educational and training supports. (*para 7.71*)

Recommendation 42

The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop a cohesive and comprehensive system of ongoing support options for IMGs and their families as an integral part of its National Strategy for International Recruitment. Such a system should include at a minimum, a particular emphasis on the educational needs of children, along with support and employment prospects for spouses. (*para 7.89*)

Recommendation 43

The Committee recommends that Health Workforce Australia (HWA), as part of its National Strategy for International Recruitment program, examine options for establishing a one-stop shop for international medical graduates (IMGs) seeking registration in Australia. Serious consideration should be given to the feasibility of providing an individualised case management service for IMGs.

In developing the most suitable model for such a service, HWA should consider the proposed scope of this service and the range of assistance provided, having regard to available resourcing. (*para 7.109*)

Recommendation 44

The Committee recommends that the Australian Government Department of Health and Ageing expand the DoctorConnect website to include a register of support services available to IMGs in the various agencies around Australia, including information on:

- details of location;
- eligibility;
- duration and timing;

- cost; and
- whether the program is available electronically/remotely.
(*para 7.118*)

Recommendation 45

The Committee recommends that the Australian Government Department of Health and Ageing provide a telephone help line to answers questions and provide clarification on information provided on the DoctorConnect website.
(*para 7.120*)

Conduct and context of the inquiry

Referral

- 1.1 Australia has one of the best healthcare systems in the world, delivering consistently high quality of care. A qualified, trained and skilled workforce is a key component to the success of the healthcare system, including an adequate number of medical practitioners. The vital contribution that international medical graduates (IMGs)¹ make to this system is widely recognised and valued. Although Australia's reliance on medical practitioners who have qualified and trained overseas has varied over time, it is estimated that IMGs currently represent an estimated 39% of registered medical practitioners. It also seems that Australia will continue to need IMGs to maintain its medical practitioner workforce.
- 1.2 In view of this continued reliance on IMGs, the challenge is to establish a system which enables suitably qualified and experienced medical practitioners to work in Australia, while also protecting the health and wellbeing of the Australian public. With the latter in mind, it is important that IMGs undergo a thorough screening process to ensure that they meet the professional standards needed to practise medicine in Australia.
- 1.3 The Inquiry into Registration Processes and Support for Overseas Trained Doctors (the Inquiry) was referred to the House of Representatives Standing Committee on Health and Ageing (the Committee) on 23

1 Various terms have been applied to describe internationally trained medical practitioners. Although the terms of reference refer to overseas trained doctors (OTD), this appears to have been superseded by the term international medical graduate (IMG). Other terms that have appeared in evidence to the inquiry include overseas trained specialist (OTS) and international medical specialist (IMS).

November 2010. The impetus for the referral was a private Member's motion proposed by The Hon Bruce Scott MP. By way of background on 28 September 2010, Mr Scott gave notice of the following private Member's motion:

MR SCOTT: To move – That this House calls for:

(1) an inquiry into the role of Australia's medical and surgical colleges in the registration process of medical graduates and overseas trained doctors; and

(2) the Minister for Immigration and Citizenship to delay the revocation of 457 visas for those doctors who have been deregistered due to failure of the Pre Employment Structured Clinical Interview, to allow adequate time for a review of their case and reassessment of their competency.²

1.4 On 18 October 2010, Mr Scott's motion was one of the items of private Member's business which was debated in the Main Committee. In addition to Mr Scott, the following Members contributed to the debate: Mr Shayne Neumann MP; Mr Geoff Lyons MP; Mr Warren Entsch MP; Mr Bob Katter MP; Ms Jill Hall MP; Dr Andrew Laming MP; Mr Tony Zappia MP; Mr Luke Simpkins MP; and Mr Steve Georganas MP.

1.5 On 16 November 2010, the House of Representatives Selection Committee identified Mr Scott's private Member's motion as an item of business to be voted in the House on 25 November 2010. However, on 23 November 2010 the Minister for Health and Ageing, The Hon Nicola Roxon MP, referred the inquiry into registration processes and support for overseas trained doctors with the following terms of reference:

Recognising the vital role of colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs), the Committee will:

- explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges' assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions;
- report on the support programs available through the Commonwealth and State and Territory governments, professional organisations and colleges to assist OTDs to meet

2 The Hon Mr Bruce Scott, Member for Maranoa, *House of Representatives Official Hansard*, 28 September 2010, p 68.

registration requirements, and provide suggestions for the enhancement and integration of these programs; and

- 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.

1.6 On 25 November 2010, the anticipated vote on the motion did not proceed. Instead the Leader of the House, The Hon Anthony Albanese MP, made the following statement in the House:

MR ALBANESE: For the benefit of the House, I also table a letter from the federal member for Maranoa, along the lines of the following:

Dear Minister – addressed to me as Leader of the House –

Regarding the planned vote tomorrow on my Private Member's Motion of 18 October 2010, I believe that the substance of the Motion has been addressed by the Health Minister's request for the House Standing Committee on Health and Ageing to conduct an inquiry into Registration Processes and Support for Overseas Trained Doctors. As such I do not believe a vote in the House is necessary.

I table the letter from Mr Scott, the member for Maranoa, for the information of the House as to why that vote is not proceeding today.³

Conduct of the inquiry

1.7 Immediately after referral on 23 November 2010, details of the inquiry were made available on the Parliament of Australia website, and on 1 December 2010 an advertisement was placed in *The Australian* calling for written submissions. The inquiry was also advertised through an extensive mail out to interested parties, including peak bodies and organisations, health services and hospitals and the relevant government departments inviting submissions.

1.8 Over the course of the inquiry the Committee received 184 submissions from organisations, government authorities and from individuals. A list of submissions is at Appendix A. A range of publications, documents and

3 The Hon Mr Anthony Albanese, Leader of the House, *House of Representatives Official Hansard*, 25 November 2010, p 3761.

supplementary material tendered during the inquiry was received as exhibits. A list of exhibits is at Appendix B. In addition a significant volume of supplementary evidentiary material was also submitted to the inquiry. A number of submissions from individuals, particularly IMGs who have sought accreditation and registration in Australia, were accompanied by range of supporting documentation (eg certificates relating to qualifications, work history and professional training/experience, CVs, application forms and correspondence to/from accreditation/registration authorities etc). This material was received as additional documentary evidence. Information on this material is at Appendix C.

- 1.9 In addition, the Committee undertook an extensive program of public hearings. Twenty two public hearings, including 12 interstate public hearings were held between February 2011 and January 2012. The Committee took verbal evidence from a range of stakeholders including: representatives of the key organisations responsible for various aspects of the assessment, accreditation and registration of medical practitioners; peak bodies representing medical practitioners; representatives of public and private healthcare facilities seeking to meet their workforce needs; representatives of medical recruitment agencies; representatives of government departments involved; and from individual medical practitioners and IMGs. Details of the public hearings including a list of witnesses, is at Appendix D.

Scope of the inquiry

- 1.10 The scope of the inquiry is largely defined by the terms of reference. Although the terms of reference might be read to indicate a particular focus on the role of specialist medical colleges in the assessment, accreditation and registration of IMGs, a comprehensive review of these issues necessarily requires consideration of the accreditation and registration system more broadly. Whilst not explicit in the terms of reference, any inquiry into accreditation and registration needs to consider linkages with other processes, including those associated with immigration, and initiatives to encourage medical practitioners to work in regional, rural and remote locations.

- 1.11 National accreditation and registration processes apply to health practitioners intending to practise in various disciplines.⁴ However, in accordance with the terms of reference the Committee's considerations are confined to issues faced by internationally educated and trained medical practitioners.
- 1.12 In this context, a significant number of submissions were received from individuals outlining personal experiences regarding accreditation and/or registration processes. The Committee found these submissions to be valuable, using them to form a better understanding of the issues facing IMGs seeking to practice in Australia, and of the practical implications for IMGs and their families. However, the Committee emphasises that it is unable to investigate individual cases or recommend remedies for any particular person. Rather, the aim of the inquiry is to identify systemic problems, and where possible to make recommendations for reform to address these.
- 1.13 As part of the inquiry process the Committee intends to review progress made in relation to the report's recommendations at a later date.

Context of the inquiry

- 1.14 All medical practitioners, regardless of where they have qualified, must meet certain requirements before they are permitted to practise in Australia. As noted in the submission from the Australian Government Department of Health and Ageing:
- These requirements are designed to ensure minimum standards of quality and safety, and in some cases, will result in practitioners operating under a range of conditions, including under supervision and restrictions on area and/or scope of practice.⁵
- 1.15 Medical practitioners, including IMGs, must demonstrate to the Medical Board of Australia (MBA) that they meet these standards before they are registered to practise. Although there is clearly a need for a robust system of accreditation and registration with sufficient checks to ensure public

4 The regulated health professions presently include medicine, nursing and midwifery, pharmacy, physiotherapy, psychology, osteopathy, chiropractic, optometry, dental and podiatry. From 1 July 2012, Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupation therapy will also be included.

5 Australian Government Department of Health and Ageing (DoHA), *Submission No 84*, pp 4-5.

safety, some have argued that the regulatory frameworks to be navigated by IMGs are overly complex and their administration is flawed.⁶

- 1.16 Evidence to the inquiry has included various flowcharts from submitters which have sought to show how the system operates.⁷ However, one witness candidly described the system as resembling 'spaghetti'.⁸ This view was shared by some other submitters, who noted that while individual stakeholders considered their own processes to be straightforward, once all of these interactions were combined, the system was far more complex and potentially confusing than it may at first appear.⁹
- 1.17 For IMGs seeking to practise medicine in Australia, dealing with accreditation and registration is often only part of the wider process. Many IMGs, particularly those applying from overseas, need to engage with numerous organisations to arrange for their relocation to Australia. These may include the Australian Government Department of Immigration and Citizenship (DIAC), the Australian Government Department of Health and Ageing (DoHA), state and territory governments, recruitment agencies and potential employers. Understanding and navigating multiple processes, and attempting to coordinate disparate timeframes exacerbate the challenges faced by many IMGs.

A complex system

- 1.18 Prior to 2010, registration of medical practitioners was the responsibility of medical boards in each state and territory and was administered separately by each. In its submission to the inquiry, DoHA informed the Committee that prior to the establishment of the National Registration and Accreditation Scheme (NRAS) that:

6 See for example: Australian Medical Council (AMC), *Submission No 42*, p 20; Medical Board of Australia (MBA), *Submission No 51*, p 3; Government of Western Australia (WA), Department of Health, *Submission No 82*, pp 6-8; Australian College of Rural and Remote Medicine (ACCRM), *Submission No 103*, p 9-11; Western District Health Service, *Submission No 184*, p 2.

7 See for example: NSW Rural Doctors Network, *Submission No 172*, p 3.

8 Ms Claire Austin, Rural Workforce Agency, Victoria, *Official Committee Hansard*, Melbourne, 18 March 2011, p 28.

9 Mrs Martina Stanley, Alecto Australia, *Official Committee Hansard*, Melbourne, 18 March 2011, p 30.

... registration arrangements for health practitioners, including the medical profession, were separately administered by state and territory governments. This meant that requirements for registration differed from state to state and that practitioners were required to reregister every time they wanted to practise in another state or territory. It also enabled some practitioners to move interstate in order to avoid scrutiny.¹⁰

- 1.19 In late 2005, the Productivity Commission published a research report titled *Australia's Health Workforce*.¹¹ The research report, commissioned by the Council of Australian Governments (COAG), reviewed a range of workforce issues, including:
- factors affecting the future supply of, and demand for, health workers;
 - the efficiency and effectiveness with which the available workforce is deployed; and
 - what reforms to health workforce arrangements might be undertaken to improve access across the community to quality and safe health care.¹²
- 1.20 The report found that Australia's health workforce arrangements were 'extraordinarily complex and interdependent' and identified the following as contributing factors:
- The Australian, State and Territory Governments are involved in all of the key parts of the health workforce system, and often at several levels.
 - There are more than 20 bodies involved in accrediting health workforce education and training, and over 90 registration boards.
 - A host of professional bodies administer codes of conduct which complement formal regulation, or provide for self-regulation.¹³
- 1.21 In the report, the Productivity Commission proposed an integrated and coherent reform plan, making 20 recommendations to promote a more efficient, effective and responsive health workforce. Key recommendations were for there to be a single national registration board for health practitioners working in the regulated health professions¹⁴, as well as a

10 DoHA, *Submission No 84*, p 5.

11 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005.

12 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, p xv.

13 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, p xix.

14 Refer to footnote 4.

single national accreditation board for health professional education and training.

The National Registration and Accreditation Scheme

1.22 In July 2006, COAG agreed to establish a single national registration scheme for health professionals and a national accreditation scheme for health education and training.¹⁵ In 2008, COAG signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for Health Professionals (the Agreement). According to the COAG Communiqué of 26 March 2008:

The new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce.¹⁶

1.23 The Agreement set out a plan for progressive implementation during 2010, comprising the enactment of appropriate legislation by states and territories. In accordance with the Agreement, Queensland took the lead with primary legislation to implement a national scheme, enacting the *Health Practitioner Regulation National Law Act 2009* (Qld) (the National Law). During 2009 and 2010, similar bills were enacted in each state and territory, providing for the implementation and operation of the National Registration and Accreditation Scheme (NRAS).¹⁷ The NRAS aims to:

- improve the mobility of the health workforce;
- stop health professionals from having to re-register every time they cross a state border to practice medicine; and
- save time and money and to reduce inconvenience.¹⁸

15 Council of Australian Governments (COAG) Communiqué, 14 July 2006, p 4.

16 COAG Communiqué, 26 March 2008, p 5.

17 Legislation comprises: *Health Practitioner Regulation National Law Act 2009* (Qld); *Health Practitioner Regulation Act 2009* (NSW); *Health Practitioner Regulation National Law Act 2009* (Vic); *Health Practitioner Regulation National Law Act 2010* (ACT); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law Act 2010* (Tas); *Health Practitioner Regulation National Law Act 2010* (SA); *Health Practitioner Regulation National Law Act 2010* (WA). For a detailed explanation of the Scheme including Commonwealth and state and territory legislation changes that enacted the Scheme see the *Health Practitioner Regulation (Consequential Amendments) Bill 2010*, Bills Digest.

18 The Hon Ms Nicola Roxon, Minister for Health and Ageing, *House of Representatives Official Hansard*, 24 February 2010, p 1643.

- 1.24 It is important to note that throughout this report, where there is reference to provisions of the National Law, these references have been extracted from the Queensland legislation, as it was the first state to enact the legislation implementing the NRAS. Accordingly, these provisions may not correlate directly with the corresponding provisions of each piece of legislation enacted by other states and territories.
- 1.25 Under the National Law, a single national medical board, the MBA, is now responsible for all matters relating to the registration of medical practitioners. Section 35 of the National Law outlines National Board functions, which include responsibility for setting the standards, codes and guidelines for the profession, including the requirements relating to specialist assessment. The Australian Health Practitioner Regulation Agency (AHPRA) was established to provide administrative support for these functions and advice on associated matters to the MBA (and national boards for the other nine regulated health professions), giving effect to the NRAS.
- 1.26 The National Law also allows for considerable delegation of functions,¹⁹ enabling the MBA/AHPRA to externalise assessment and accreditation functions.²⁰ Specifically, s 43 of the National Law enables the appointment of the Australian Medical Council (AMC) as the independent entity responsible for the accreditation of the medical profession in Australia. The AMC is also responsible for managing the assessment and examination processes of the specialist medical colleges.
- 1.27 As the NRAS has now been operational for almost two years, the conclusion of the inquiry provides a timely opportunity for review.

Previous inquiries

- 1.28 As noted previously the complexity of the accreditation and registration processes has been a cause of concern both for Australian trained medical practitioners and for IMGs wishing to work in Australia. Not surprisingly therefore, these processes have been subject to earlier inquiries.
- 1.29 In 2004, the Australian Competition and Consumer Commission (ACCC), jointly with the Australian Health Workforce Officials Committee (AHWOC), conducted a review of selection, training and accreditation

¹⁹ See *Health Practitioner Regulation National Law Act 2009* (Qld), ss 43, 44, 59, pp 66, 77.

²⁰ MBA, *Submission No 42.1*, p 3.

arrangements of all specialist medical colleges. The review included consideration of how these processes applied to IMGs. The aim of the review was to:

... explore the extent to which specialist medical colleges are operating according to the general principles of transparency, accountability, stakeholder participation and procedural fairness ...²¹

- 1.30 The resulting report released in 2005 made a total of 20 recommendations to improve college assessment and accreditation processes. In relation to overseas trained specialists specifically, the report recommended:
- further consideration to the recognition of prior overseas training;
 - increased opportunities for competency-based assessment and training;
 - greater transparency of college assessment criteria for overseas trained specialists; and
 - improved access to continuing professional development for overseas trained specialists working towards specialist registration.²²
- 1.31 In 2011, almost a year after the commencement of the NRAS, the Senate Finance and Public Administration Reference Committee inquired into its operation and its administration through AHPRA. While acknowledging that the implementation of the NRAS was a huge undertaking, the report noted that there were some 'teething' problems associated with the transition.²³
- 1.32 The report noted that AHPRA's poor administration of the registration process had effected recruitment of overseas trained health practitioners.²⁴ Issues frequently raised by overseas trained practitioners seeking registration through AHPRA processes related to prolonged timeframes, provision of inaccurate advice and lost documentation. Concerns were also raised in relation to English language testing and the use of specific

21 Australian Competition and Consumer Commission (ACCC) and Australian Health Workforce Officials Committee (AHWOC), *Review of Australian specialist medical colleges*, 2005, p vi.

22 ACCC and AHWOC, *Review of Australian specialist medical colleges*, 2005, pp 33-34.

23 Parliament of Australia, Senate Finance and Public Administration References Committee, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, June 2011.

24 The term 'overseas trained health practitioners' here includes all health practitioners as would be registered with AHPRA, including medicine, nursing and midwifery, pharmacy, physiotherapy, psychology, osteopathy, chiropractic, optometry, dental and podiatry.

clinical assessment tools.²⁵ The Senate Finance and Public Administration References Committee concluded that there was scope for significant improvement in registrations processes for overseas trained health practitioners, recommending:

- regular review of registration processes for overseas trained practitioners; and
- increased transparency in relation to registration timeframes for overseas trained health practitioners through the annual publication of key performance indicators to include data on this issue.²⁶

1.33 In an accompanying minority report, while also acknowledging that transitional issues had led to frustration for some health professionals seeking registration, Government Senators concluded that AHPRA was already aware of many of the issues raised during the inquiry and that appropriate remedial action had been undertaken. As a result Government Senators expressed the view that the benefits of the new national registration system would become increasingly evident.²⁷

Structure of the report

1.34 Following the introductory material and context presented in Chapter 1, Chapter 2 examines workforce issues. Specifically, Chapter 2 examines what is known about Australia's medical practitioner workforce and how IMGs have contributed to meeting workforce shortages. It also considers issues associated with medical practitioner workforce planning.

1.35 Chapter 3 reviews the current system of accreditation and registration and the various pathways available to IMGs wishing to practise in Australia. It also considers departments and/or agencies that IMGs may need to interact with over and above those directly involved with accreditation and registration (eg DIAC, DoHA, state and territory government authorities, recruitment agencies etc).

25 Namely the Pre-Employment Structured Clinical Interview (PESCI).

26 Parliament of Australia, Senate Finance and Public Administration References Committee, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, June 2011.

27 Parliament of Australia, Senate Finance and Public Administration References Committee, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, June 2011, p 137.

- 1.36 Chapters 4 and 5 consider issues that have been raised in evidence with regard specifically to accreditation and registration of IMGs. The focus of Chapter 4 is on the AMC's assessment and accreditation processes for IMGs. It also includes consideration of issues relating the role of specialist medical colleges in assessment and accreditation of specialist IMGs. Chapter 5 considers registration processes for IMGs administered by AHPRA on behalf of the MBA, and other processes which IMGs have to engage with in order to practise medicine in Australia.
- 1.37 Chapter 6 considers system wide issues that have been raised in evidence, primarily those associated with the transition to a national system of accreditation and registration, an apparent lack of coordination between agencies and the practical implications for IMGs of systemic inefficiencies.
- 1.38 Chapter 7 examines issues associated with access for IMGs and their families to support mechanisms and programs across jurisdictions. The Chapter includes consideration of access to supports for IMGs working in regional, rural and remote areas and the implications of residency status on eligibility for support.

Australia's medical workforce

- 2.1 A health workforce with an adequate supply of well-trained practitioners, including medical practitioners, underpins the delivery of high quality health care in Australia. Governments at national and state levels are instrumental in determining the community's needs for health care, and what constitutes an adequate medical workforce to meet these needs. The supply of medical practitioners (both general practitioners and specialists), and where and how they can practise is heavily influenced by government policies.
- 2.2 This Chapter presents an overview of what is known about Australia's demand for, and supply of medical practitioners, and examines some of the issues surrounding the future stability and reliability of that workforce. In that broader context, the Chapter considers Australia's past and current reliance on international medical graduates (IMGs) to fulfil the health needs of the community. The Chapter presents a brief overview of current government workforce initiatives intended to achieve equilibrium between demand and supply of medical practitioners, and address issues of geographical mal-distribution. This Chapter concludes by considering issues associated with medical workforce planning.

Medical practitioner supply

- 2.3 Assessing the adequacy of Australia's medical practitioner workforce is not straightforward, relying on estimates of underlying demand for services and judgement in relation to an appropriate level of response. Concerns regarding the supply of medical practitioners in Australia have changed over time. As noted by the Australian Medical Council (AMC):

In the last two decades, the national policy on medical workforce has swung between concerns of significant oversupply (1992), resulting in quotas on the AMC examination and points penalties on migration applications for medical practitioners, to concerns of undersupply resulting in active recruitment of overseas trained health professionals and considerations of task substitution and regulatory reform (2005).¹

2.4 As noted above, concerns about the adequacy of Australia's medical practitioner workforce emerged in the mid to late 1990s. Initially there was concern regarding an apparent mal-distribution of medical practitioners, with shortages evident in rural and remote areas of Australia. Despite measures introduced to encourage more medical practitioners to work in rural and remote locations, these shortages persisted. Furthermore, by the early 2000s evidence was emerging of medical practitioner shortages in some outer-metropolitan locations.²

2.5 Currently, although there are some suggestions that there are no shortages of medical practitioners in Australia, and that there may in fact be a surplus³, the more widely held view is that there are still too few medical practitioners to meet Australia's needs.⁴ According to a 2005 Productivity Commission report on Australia's health workforce:

Though precise quantification is difficult, there are evident shortages in workforce supply – particularly in general practice, various medical specialty areas, dentistry, nursing and some key allied health areas.

These shortages persist despite the fact that the workforce has been growing at nearly double the rate of the population – though reductions in average hours worked in response to such factors as workforce ageing and greater feminisation of some professions, have partly offset this increase in numbers. Medical

1 Australian Medical Council (AMC), *Submission No 42*, p 19.

2 Parliament of Australia, Parliamentary Library, 'Medical practitioners: education and training in Australia', *Background Note*, July 2009, <<http://www.aph.gov.au/Library/pubs/BN/2009-10/MedicalPractitioners.pdf>> viewed 25 January 2012.

3 A Kamalakanthan & S Jackson, *The Supply of Doctors in Australia: Is There A Shortage?* Discussion Paper No 341, School of Economics, The University of Queensland, May 2006; Professor B Birrell, *Australia's New Health Crisis - Too Many Doctors*, Centre for Population and Urban Research, Monash University, September 2011, <<http://arts.monash.edu.au/cpur/--downloads/australias-new-health-crisis.pdf>> viewed 25 January 2012.

4 Australian Government Department of Health and Ageing (DoHA), *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008, p 35. See also: Australian and New Zealand College of Anaesthetists (ANZCA), *Submission No 87*, p 20; Rural Workforce Agency, Victoria, *Submission No 91*, p 10; Government of South Australia, *Submission No 96*, p 3.

shortages also remain despite an increasing reliance on overseas trained doctors, who now make up 25 per cent of that workforce compared with 19 per cent a decade ago.⁵

2.6 In 2008, a Australian Government Department of Health and Ageing (DoHA) report on the health workforce in regional, rural and remote locations made the following observations:

- Rural and remote Australia has experienced medical workforce shortages for a considerable period, particularly in terms of general practice services and some specialist services, such as obstetrics and gynaecology.
- Numbers of GPs in proportion to the population decrease significantly with greater remoteness, with the lowest supply to 'very remote' areas, particularly in New South Wales and Western Australia.
- There is also considerable variation across jurisdictions. Northern Territory and Western Australia, as well as the Australian Capital Territory, have lower number of GPs proportional to the population.
- In recent years, the medical workforce in rural and remote Australia has increased modestly, mostly due to restrictions on Medicare provider numbers for overseas trained doctors to encourage them to work in rural and remote areas of workforce shortage.
- One-third of doctors currently working in Australia were trained overseas.
- The proportion of overseas trained doctors is significantly higher in rural and remote areas where 41% of all doctors have trained overseas.
- Although the number of GPs continues to grow, this growth does not indicate increased availability of GPs over time, as the growth in the medical workforce has not kept pace with the rate of population growth.⁶

2.7 The Australian Institute of Health and Welfare Medical Labour Force 2009 survey (published in 2011) highlighted the gulf between cities and rural areas with regard to the availability of doctors and specialists:

The supply of employed medical practitioners was highest in major cities (392 full-time equivalent medical practitioners per 100,000 population) (based on a 40-hour working week). The rate

5 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, pp xvi-xvii, <http://www.pc.gov.au/_data/assets/pdf_file/0003/9480/healthworkforce.pdf> viewed 25 January 2012.

6 DoHA, *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008, p 35.

of employed medical practitioners per head of population was significantly lower in other remoteness areas, with outer regional having the lowest rate (206 full-time equivalent [FTE] medical practitioners per 100,000 population). The number of clinical medical specialists decreased with increasing remoteness (142 FTE per 100,000 for major cities; 24 FTE per 100,000 for remote/very remote areas).⁷

- 2.8 Furthermore, the Overseas Trained Specialist Anaesthetists Network noted that specialist shortfalls were part of a global trend as populations in developed countries continued to age:

... the [Australian] medical sector will more than ever be dependent on Overseas Trained Doctors. This is even more important in the light of an ageing 'baby-boom-generation'. This does not affect Australia alone - the shortfall in the medical workforce can be seen worldwide with a subsequent overall migration of medical practitioners and specialists. Thus Australia competes over medical specialists on a highly competitive market with medically highly developed areas (Canada, United States, Scandinavia, Central Europe etc) with most of them conducting active recruitment and integration programs.⁸

- 2.9 Over the years Commonwealth, state and territory governments have invested in various strategies to address medical workforce shortages. Arrangements that support IMGs to live and work in Australia, is one strategy that has been used to address medical workforce shortages in the short to medium term. In the longer term Australia seeks to become 'self-sufficient' with regard to its medical practitioner workforce by providing more support for education of medical practitioners (such as university places and scholarships) and by providing more training places for general practitioners.

International medical graduates or self sufficiency

- 2.10 As medical workforce shortages became apparent in the mid to late 1990s, Australia began to introduce policies to encourage IMGs to come to Australia to live and work. Since then, Australia has increasingly relied on IMGs to supplement its locally trained workforce, and IMGs make up a

7 Australian Institute of Health and Welfare (AIHW), *Medical labour force 2009*, Bulletin 89, August 2011, p 5, <<http://aihw.gov.au/publication-detail/?id=10737419680&tab=2>> viewed 25 January 2012.

8 Overseas Trained Specialist Anaesthetists Network, *Submission No 38*, p 1.

significant part of Australia's medical workforce, particularly in rural and remote Australia.⁹

2.11 While it is difficult to determine exact numbers, the submission from DoHA indicates that IMGs currently comprise approximately 39% of the medical workforce in Australia and 46% of general practitioners in rural and remote locations.¹⁰ As observed by Rural Health West, which reported that 52% of Western Australia's rural and remote workforces are IMGs, in some areas the proportion of IMGs is significantly higher.¹¹

2.12 Ideally Australia, as an economically developed nation, should have the capacity to become self-sufficient in meeting its medical practitioner workforce needs. Indeed, the World Health Organisation (WHO) global code of practice states that Member States should meet their own health human resources needs as much as possible.¹²

2.13 The Australian Doctors Trained Overseas Association explained the rationale behind the goal for WHO Member States like Australia to aim for self-sufficiency in the development of medical practitioners:

There is a moral responsibility on them to do that because, when it does not happen, the workforce from Third World countries is denuded and they come to Australia.¹³

2.14 Furthermore, as submitted by the Rural Doctors Association of Australia and others, self-sufficiency is also likely to create a far more sustainable system for the recruitment of doctors to rural and regional Australia.¹⁴

2.15 While acknowledging an expected increase in Australian medical graduates, DoHA observed that IMGs were still an integral part of Australia's health workforce, advising the Committee:

We expect that by 2013 we will have almost doubled the number of medical graduates coming on stream through our system. So,

9 See for example: DoHA, *Report on the Audit of Health Workforce in Rural and Regional Australia*, 2008, p 3; Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, p 11.

10 DoHA, *Submission No 84*, p 4.

11 Rural Health West, *Submission No 75*, p 1.

12 World Health Organisation (WHO), *The WHO Global Code of Practice on the International Recruitment of Health Personnel*, para 5.4, p 7, <http://www.who.int/hrh/migration/code/code_en.pdf> viewed 25 January 2012.

13 Dr Jonathan Levy, *Official Committee Hansard*, Canberra, 25 February 2011, p 47. See also: Rural Doctors Association of Australia, *Submission No 80*, p 6; Dr Andrew Pesce, Australian Medical Association (AMA), *Official Committee Hansard*, Canberra, 25 February 2011, p 29; Dr Alasdair MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 17.

14 Rural Doctors Association of Australia, *Submission No 80*, p 2. See also: AMA, *Submission No 55*, p 3.

over the medium-to-longer term, we will have many more Australian graduates, but in the meantime overseas doctors are a very important part of our workforce.¹⁵

- 2.16 However, Dr Rajendra Moodley noted that even with the anticipated increase in domestic medical graduates, it would still take time for them to develop the necessary level of skill and experience and therefore a continued reliance on IMGs is likely for a period of time. As Dr Moodley observed in relation to recent medical graduates:

How is an intern going to do the job of a registrar or of a GP who has been there for many years or of a specialist?¹⁶

- 2.17 Also, while agreeing with this ultimate goal of self-sufficiency, the AMA acknowledged that it would take some time to achieve, saying:

The doctors we are training have not yet emerged to take part in looking after patients and the public and it will be some time before they do. But there is a general recognition in Australia that Australia should be walking [working] towards self-sufficiency so that we are training our own medical workforce.¹⁷

Committee comment

- 2.18 The Committee notes that views on whether Australia's medical workforce has sufficient numbers of appropriately trained and skilled practitioners have varied over the last two decades. Over that period views have changed from an understanding of oversupply, to an understanding of mal-distribution with shortages in some geographical areas or in specific medical specialties, to the current generally held view of universal medical workforce shortages.
- 2.19 Notwithstanding the initiatives promoted by all levels of government, including the provision of additional education and training places to grow the domestically trained workforce, the Committee received a range of comments in relation to the extent of the shortfall. Two key medical workforce issues were raised again and again. These were an inadequate supply of medical practitioners generally, and an uneven geographical distribution of medical practitioners, with workforce shortages remaining acute in some regional areas and particularly in rural and remote locations. Based on the weight of evidence received, the Committee

15 Ms Kerry Flanagan, DoHA, *Official Committee Hansard*, Canberra, 25 February 2011, p 2.

16 Dr Rajendra Moodley, *Official Committee Hansard*, Brisbane, 10 March 2011, p 29.

17 Dr Andrew Pesce, AMA, *Official Committee Hansard*, Canberra, 25 February 2011, p 29.

understands that IMGs are needed to address current workforce shortages and are an integral part of Australia's medical workforce. It appears that IMGs will continue to fulfil this role at least in the short to medium term.

- 2.20 While acknowledging the valuable contribution of IMGs, especially in the provision of medical services to rural and remote communities, the Committee agrees that the development of self sufficiency in producing domestically trained medical personnel should be the target that Australia works towards. Importantly, consideration should encompass the potential for foreign born doctors who have trained in Australia to contribute to meeting domestic workforce needs by providing options which facilitates their working and practising in Australia when they have graduated. In addition, maintaining a sufficiently experienced cohort of IMGs will be critical to ensure that domestically trained medical graduates receive the clinical oversight they need for continued professional development. As observed by Associate Professor Michael Steyn:

Our foreign doctors are our current teachers, let alone our current providers of care. They teach our local students, our local health workers and our local specialist trainees. So it is more than just the provision of health care.¹⁸

- 2.21 Notwithstanding the observations above, the Committee believes that self sufficiency is an achievable goal for Australia, which will need to be facilitated by appropriate medical workforce policy developed in the context of robust workforce planning models. Information on Australia's current medical workforce policy and issues associated with medical workforce planning is presented below.

Australia's medical workforce policy

- 2.22 As noted earlier, governments at national, and state and territory levels have enacted a number of measures to address shortages and uneven distribution of the medical workforce in Australia. In broad terms these measures:

- seek to grow Australia's domestically trained medical practitioner workforce;
- target recruitment of IMGs to live and work in Australia;

18 Associate Professor Michael Steyn, *Official Committee Hansard*, 10 March 2011, p 41.

- encourage medical practitioners (domestically trained and/or IMGs) to work in areas that are difficult to recruit to, either by providing incentives or by placing restrictions on where some practitioners are able to work.¹⁹

2.23 DoHA identifies its role regarding the medical workforce:

... to maximise the possibility that there is an adequate number of health professionals to meet population need, both now and into the future; that the workforce is appropriately distributed and retained to meet the community's needs; and that adequate training and education arrangements are in place to support the continued development of the workforce.²⁰

2.24 In undertaking this role, DoHA administers a range of initiatives to support development of the medical workforce. As regional, rural and remote locations are more likely to experience medical workforce shortages, many of these initiatives form part of DoHA's Rural Health Workforce Strategy. While not a comprehensive review of all programs available under DoHA's Rural Health Workforce Strategy, the following section provides an overview of those programs which specifically target recruitment and retention of IMGs or which may be accessible to IMGs.²¹

Targeted programs

2.25 DoHA's target programs include the International Recruitment Strategy which was established to increase the supply of appropriately qualified IMGs to districts of workforce shortage (DWS) throughout Australia. Under this program funding is provided to Rural Workforce Agencies (RWAs) which assist prospective IMGs to work their way through various aspects necessary for working in Australian general practice, such as visa enquiries, pathways to medical registration, medical registration and skills recognition.²²

19 DoHA, *Submission No 84*, p 3; Parliament of Australia, Parliamentary Library, 'Medical practitioners: education and training in Australia', *Background Note*, July 2009, pp 2-3, <<http://www.aph.gov.au/Library/pubs/BN/2009-10/MedicalPractitioners.pdf>> viewed 25 January 2012.

20 DoHA, *Submission No 84*, p 3.

21 More information on the programs available under DoHA's Rural Health Workforce Strategy is available on the DoctorConnect website <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/RHWS>> viewed 25 January 2012.

22 DoHA, *Submission No 84*, p 3.

- 2.26 Other targeted initiatives that aim to encourage IMGs to work in DWS locations include non-cash incentive schemes which reduce the usual 10 year period of restricted access to a Medicare provider number that applies to IMGs in Australia.²³ Specifically, Overseas Trained Doctor (OTD) scaling reduces the restriction by up to five years for IMGs who choose to work in a DWS. Alternatively, IMGs may be eligible to participate in the Five Year OTD Scheme, which also reduces the period of restricted access to a Medicare provider number for IMGs who choose to practise in areas that are difficult to recruit to.
- 2.27 The Specialist International Medical Graduate (SIMG) element of the Specialist Training Program (STP) offers training and support for IMGs seeking Fellowship with a specialist medical college. To be classified as a SIMG, IMGs must be assessed by a specialist college as partially or substantially comparable to an Australian trained specialist. The aims of the SIMG element of the STP are to provide training for SIMGs seeking to achieve Fellowship of a specialist medical college in Australia; and support the permanent entry and retention of SIMGs in Australia, in the areas they are most needed, so they can contribute on a long-term basis to the community and the medical workforce.²⁴
- 2.28 DoHA also supports the DoctorConnect website. DoctorConnect provides a range of information about incentives available to work in regional, rural and remote Australia. It also provides a starting point for IMGs and potential employers, assisting them to work their way through the various approval processes leading to entry to the Australian medical workforce.²⁵

Non-targeted programs

- 2.29 IMGs who are permanent residents of Australia may be eligible to access support through the Additional Assistance Scheme. This Additional Assistance Scheme is administered by the RWAs, and was introduced to support increased access to general practitioners for people living in regional, rural and remote communities. The Scheme assists participants by addressing any medical knowledge/clinical deficits to support their efforts in achieving Fellowship with the Royal Australian College of General Practitioners (RACGP) or Australian College of Rural and Remote Medicine (ACRRM).

23 Restriction on access to Medicare provider numbers is legislated under the *Health Insurance Act 1973*. More information on the legislative basis of the restricted access is outlined in Chapter 3 of the report, and issues of concern with these restrictions are considered in Chapter 5.

24 DoHA, *Submission No 84*, p 13.

25 DoHA, *Submission No 84*, pp 11-14.

- 2.30 The General Practice Rural Incentive Program (GPRIP) was established in 2010 to increase the number of rural medical practitioners, GPs and specialists. It does this through the provision of financial incentives grants. While IMGs may be eligible to access some components of the available incentives, eligibility may be limited for IMGs who are not permanent residents or who are still subject to the 10 year period of restricted access to a Medicare provider number.²⁶
- 2.31 IMGs may also be able to access support through distance education and intensive training through the Rural Vocational Training Scheme (RVTS). The RVTS is a vocational education and training program in general practice that provides a pathway to Fellowship of RACGP or ACRRM. Unlike the Additional Assistance Scheme, the RVTS is open to IMGs who are temporary residents, though priority is given to permanent residents.
- 2.32 The Rural Locum Relief Program is also available to IMGs who are permanent residents and is designed to provide access to Medicare benefits for temporary placements in rural general practice or Aboriginal medical services.²⁷

Other initiatives

- 2.33 In addition to the programs described above, DoHA also funds Rural Health Workforce Australia (RHWA). RHWA is responsible for managing national programs to address the shortage of doctors and other health workers in rural and remote communities, including the recruitment of IMGs.²⁸ RHWA is also the peak body for the seven Rural Workforce Agencies (RWAs) which are not-for-profit organisations funded by DoHA, as well as their respective state governments.²⁹ The RWAs are primarily responsible for recruitment and provision of professional support services for medical practitioners in their jurisdictions, with an aim to increase the number of doctors in rural and remote communities across Australia.³⁰ RHWA, through the RWAs, is responsible for implementing programs including:
- the International Recruitment Strategy;

26 Health Workforce Queensland, *Submission No 44*, p 5.

27 DoHA, *Submission No 84*, pp 11-14.

28 Rural Health Workforce Australia (RHWA), *Submission No 107*, p 2.

29 The seven Rural Workforce Agencies are: General Practice Network NT Ltd; Health Workforce Queensland; NSW Rural Doctors Network Australia; Rural Workforce Agency, Victoria; Health Recruitment Plus Tasmania; Rural Doctors Workforce Agency; and Rural Health West.

30 RHWA, *Submission No 107*, p 6.

- the five year OTD scaling scheme;
 - the Rural Vocational Training Scheme; and
 - the Rural Locum Relief Program.³¹
- 2.34 Another significant initiative is the establishment in 2001 by the then Minister for Health and Aging of General Practice Education and Training Limited (GPET). GPET, a wholly owned Commonwealth company, was established to oversee and fund regionally based vocational education and training in general practice for medical graduates. GPET operates a system of general practice education and training, delivered through 17 regional training providers (RTPs) across Australia.³² GPET manages the Australian General Practice Training (AGPT) program and the Prevocational General Practice Placements Program (PGPPP) programs.³³
- 2.35 Under the AGPT program, registrars (including IMGs who have permanent Australian residency) may undertake vocational training in accordance with the curriculum and standards relevant to their chosen college vocational training pathway. The PGPPP (also accessible to IMGs who have permanent Australian residency) is a prevocational training program that enhances junior doctors' understanding of primary health care and encourages them to take up general practice as a career.³⁴

State and territory governments

- 2.36 While it is beyond the scope of this report to provide a comprehensive overview, state and territory governments also support a range of initiatives to address medical practitioner workforce shortages by recruiting IMGs. As noted previously, state and territory governments contribute to the funding of RWAs which provide recruitment and professional support for medical practitioners, including IMGs seeking employment and registration in Australia.
- 2.37 State and territory governments are also responsible for identifying Areas of Need (AoN). Although methods of defining them vary between

31 RHWa, Rural Locum Relief Program, <<http://www.rhwa.org.au/site/index.cfm?display=163785>> viewed 25 January 2012.

32 For a complete list of programs see: General Practice Education and Training, Training Providers, <<http://www.gpet.com.au/TrainingProviders/TrainingProviderLinks/>> viewed 2 February 2012.

33 General Practice Education and Training Limited, *Submission No 119*, p 2.

34 DoHA, General Practitioners, Prevocational General Practice Placements Program, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-pgppp>> viewed 25 January 2012.

jurisdictions, essentially AoN is a location in which there is a lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. Importantly, AoNs are not confined to regional, rural or remote locations but also encompass metropolitan and outer metropolitan locales. To address workforce shortages, eligible IMGs are offered options to accelerate their accreditation and apply for Limited Registration to enable them to practice in AoN locations or positions while working concurrently to obtain full Australian medical registration. More information on the options and processes available to IMGs pursuing AoN position is provided in Chapter 3 of the report.

Medical Workforce Planning

2.38 As noted earlier, assessing medical workforce needs is complex. Over the last 30 years views of the adequacy of the medical workforce have ranged from concerns of over-supply to concerns of mal-distribution and finally workforce shortages. It appears that actions taken in the past to restrict the flow of doctors into Australia had the unintended consequence of creating a larger shortfall than desirable, which has led to the need to recruit large numbers of IMGs to meet demand. Dr Paul Mara, President of the Rural Doctors Association of Australia told the Committee:

My understanding of the workforce over the past 28 years is that you do tend to reach a flip-flop scenario so that changes occur very rapidly and the systems do not catch up with that for a period of time after it. So for many years we were seen as having an oversupply of doctors and a misdistribution in the country and then very rapidly we all of a sudden have an undersupply in both the city and the country.³⁵

2.39 Robust workforce planning models are crucial if Australia is to meet its current and future medical workforce needs. Effective workforce planning needs to take into account a number of factors which will influence population demands for medical services and the supply of medical practitioners to deliver these services. Factors which will influence demand for medical services and the supply of medical practitioners to deliver them include:

35 Dr Paul Mara, Rural Doctors Association of Australia, *Official Committee Hansard*, Canberra, 31 May 2011, p 2.

- demographic trends and changing population distributions;
- changes in the burden of disease, including an increased prevalence of chronic diseases associated with an ageing population;
- technological and medical advances, coupled with higher health care expectations from consumer;
- the number of Australian medical graduates and IMGs entering the workforce;
- the availability of supervised placements Australian medical graduates and IMGs;
- retirement of current medical practitioners associated with an ageing workforce; and
- changes to working patterns, including a trend to lower average weekly working hours.³⁶

2.40 Clearly medical workforce planning is a complex undertaking. As observed by the National Rural Health Alliance (NRHA):

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.³⁷

2.41 The difficulty associated with developing robust models and assessment tools for workforce planning is amplified by substantial gaps and inconsistencies in national medical workforce data. As observed by Mrs Martina Stanley, Director of Alecto Australia:

The other issue is around [workforce] research and data. ... When you start looking at the little bit of data that we have it is actually highly unreliable because of the way that it is collected. Different bits of data, whether it is AIHW, Medicare or whatever, all use different criteria for collecting the data, so you cannot put it back together again and then use it for anything useful because basically you are comparing apples with oranges.³⁸

36 Productivity Commission, *Australia's Health Workforce*, Research Report, 2005, pp10-11.

37 National Rural Health Alliance (NRHA), *Submission No 113*, p 6.

38 Mrs Martina Stanley, Alecto Australia, *Official Committee Hansard*, Melbourne, 18 March 2011, p 34.

COAG and medical workforce planning

- 2.42 Responsibility for Australia's health workforce is shared by the Commonwealth, state and territory governments. In brief, the Australian Government is principally responsible for policy relating to, and funding of, university education for medical students. State and territory governments are largely responsible for the delivery of health services and are major employers and trainers of medical practitioners, primarily through the public hospital system. In view of this shared responsibility for health workforce planning, the Council of Australian Governments (COAG) has played a key role.
- 2.43 In 2004, COAG's Australian Health Ministers' Conference (AHMC) developed its National Health Workforce Strategic Framework.³⁹ The Framework established a 10 year plan to address Australia's health workforce needs based on the following seven principles:
- achieving and sustaining self-sufficiency in health workforce supply;
 - workforce distribution that optimises access to health care and meets the health needs of all Australians;
 - health environments being places in which people want to work;
 - ensuring the health workforce is always skilled and competent;
 - optimal use of skills and workforce adaptability;
 - recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system; and
 - recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in this framework.⁴⁰
- 2.44 In 2006 COAG established the National Health Workforce Taskforce (NHWT) to undertake projects to inform the development of practical solutions on workforce innovation and reform. Specifically the NHWT was to develop health workforce strategies encompassing:

39 Australian Health Ministers' Conference, *National Health Workforce Strategic Framework*, April 2004, <<http://www.ahwo.gov.au/documents/National%20Health%20Workforce%20Strategic%20Framework/AHMC%20National%20Workforce%20Strategic%20Framework%20004.pdf>> viewed 25 January 2012.

40 Australian Health Ministers' Conference (AHMC), *National Health Workforce Strategic Framework*, April 2004, p 14. See also: Tropical Medical Training, *Submission No 114*, p 6.

- planning, research and data;
- education and training; and
- innovation and reform.⁴¹

2.45 The work of the NHWT was overseen by the Health Workforce Principal Committee (HWPC), the Australian Health Ministers' Advisory Council's principal advisor on national health workforce policy and strategic priorities. The NHWT was a time limited, project based entity which ceased operation with the establishment of Health Workforce Australia (HWA). HWA is in the process of assuming NHWT activities as part of its broader work program.

Health Workforce Australia

2.46 In late 2008, under the National Partnership Agreement on Hospital and Health Workforce Reform, COAG announced that it would establish HWA to manage and oversee major reforms to the Australian health workforce.⁴² In 2010 HWA commenced operation as a statutory authority reporting to the Australian Health Ministers' Conference (AHMC).⁴³ According to its mission statement HWA's organisational objective is:

To facilitate more effective and integrated clinical training for health professionals, provide effective and accurate information and advice to guide health workforce policy and planning, and promote, support and evaluate health workforce reform.⁴⁴

2.47 In addition to assuming the work of the former NHWT, COAG announced the following major reforms which HWA will manage and oversee:

Increasing Supply

- Improving the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places.
- Facilitating immigration of overseas trained health professionals and continuing to develop recruitment and retention strategies.

Reforming the Workforce

41 Australia's Health Workforce Online, National Health Workforce Taskforce, <<http://www.ahwo.gov.au/nhwt.asp>> viewed 25 January 2012.

42 Health Workforce Australia (HWA), <<http://www.hwa.gov.au/>> viewed 25 January 2012.

43 See *Health Workforce Australia Act 2009*.

44 HWA, <<https://www.hwa.gov.au/about/mission-statement>> viewed 25 January 2012.

- System, funding and payment mechanisms to support new models of care and new and expanded roles.
- Redesigning roles and creating evidence based alternative scopes of practice.
- Developing strategies for aligned incentives surrounding productivity and performance of health professionals and multi-disciplinary teams.⁴⁵

2.48 Since commencing operation HWA has developed a work plan for 2011-12. In general terms, activities being undertaken as part of HWA's 2011-12 work plan are aimed at improving Australia's ability to more effectively manage medical workforce issues. The work plan identifies a number of projects to be progressed under the following four priority areas:

- information, analysis and planning - including analysis of supply and demand trends to inform decision making on a range of workforce policy and program matters;
- clinical training reform - improving and expanding access to quality clinical training for health professionals in training across the public, private and non-government sectors;
- workforce innovation and reform - encouraging the development of health workforce models which will support new models of healthcare delivery and equip health professionals and employers to meet emerging healthcare demands; and
- international health professionals - developing a coordinated national approach to the recruitment and retention of international health professionals to work in Australia's public and non-government health sectors.⁴⁶

2.49 Projects being progressed under the information, analysis and planning work program include:

- a national training plan which aims to provide a set of planning objectives for training of health professionals, including doctors, to achieve self sufficiency by 2025; and
- a national statistical resource which aims to develop a national health workforce dataset, including registration and workforce survey data from the Australian Health Practitioners Registration Authority (AHPRA). The dataset will be used to develop an improved

45 Australia's Health Workforce Online, Recent COAG Reforms, <<http://www.ahwo.gov.au/coag.asp>> viewed 25 January 2012.

46 HWA, *Annual Report 2010-11*, pp 20-32.

understanding of the health workforce. Access to more robust data will also contribute to the development and application of a National Health Workforce Planning Tool.

- 2.50 Action to address health workforce shortages under the clinical training reform work program is being progressed through:
- the Clinical Training Funding Subsidy program which aims to address health workforce shortages by providing subsidies to increase the number of clinical training places for health professional students, including medical students; and
 - the Clinical Supervision Support program which aims to enhance post-graduate supervision capacity for a number of health professions, including doctors, by offering measures to support and develop a competent clinical supervision workforce.
- 2.51 The workforce innovation and reforms work program has been informed by HWA's National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015 (the Framework). The Framework, which was developed on the basis of research and consultation is intended to:
- ... provide an overarching, national platform that will guide future health workforce policy and planning in Australia. It sets out key priority areas and five essential domains that create the foundation for an integrated, high performing workforce fit to meet Australia's health care needs.⁴⁷
- 2.52 The five domains for action under the Framework are:
- health workforce reform for more effective, efficient and accessible service delivery;
 - health workforce capacity and skills development;
 - leadership for the sustainability of the health system;
 - health workforce planning; and
 - health workforce policy, funding and regulation.⁴⁸
- 2.53 The Regional, Rural and Remote Health Workforce Innovation and Reform Strategy complements the Framework. This strategy aims to
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47 HWA, *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*, p 1.

48 HWA, *National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015*, p 14.

promote better use of the existing workforce and will also work to build workforce capacity to respond and adapt to the changing demands of rural and remote communities.⁴⁹

- 2.54 HWA completed an initial consultation process in late 2010 to inform the development of a National Strategy for International Recruitment (the National Strategy). The aim of the National Strategy is to provide a nationally consistent approach to the recruitment and retention of international health professionals, including doctors.
- 2.55 To complement the National Strategy's aim of developing a consistent and coordinated approach to international recruitment of health professionals, the HWA's work plan also supports a project to establish a single website portal under its International Health Professionals Website Development Project.

Committee comment

- 2.56 It is clear to the Committee that health workforce planning is crucial if governments are to implement health workforce policies which ensure that the supply and distribution of medical practitioners is appropriate to meet community healthcare needs and expectations. Current workforce policies have been influenced by the continuing need for IMGs to supplement the domestically trained medical practitioner workforce.
- 2.57 Evidence to the inquiry suggests that current workforce planning assessment tools have failed to adequately account for the range of dynamic factors which can influence supply and demand. Limitations on workforce planning models have been exacerbated by significant deficiencies in national workforce data. While the Committee acknowledges the complexities of health workforce planning, particularly in a dynamic environment, the Committee considers that there is definite scope for improvement.
- 2.58 The Committee is pleased to note that the Australian Government, through COAG, in association with its state and territory counterparts, has already taken steps to address the deficiencies in workforce planning with the establishment of HWA. Although HWA has only been in operation since 2010, the Committee is encouraged by progress made to date in relation to HWA's work plan. In particular, the Committee notes the progress on projects to improve the access to robust national health

49 HWA, *Annual Report 2010-11*, p 27.

workforce data and to develop more sophisticated workforce planning models.

- 2.59 The Committee notes that there are a number of HWA programs which aim to address medical workforce shortages by increasing education and training opportunities, with the ultimate goal of achieving health workforce self sufficiency in Australia by 2025. Although supportive of this goal in principle, the Committee has already observed that in the short to medium term Australia needs to rely on IMGs to address current medical workforce shortages. In view of this the Committee supports a national approach to recruitment and retention of IMGs currently being considered under HWA's National Strategy for International Recruitment.

Accreditation, registration and other processes

- 3.1 To practice medicine in Australia IMGs need to have their medical qualifications accredited and their medical knowledge and skills assessed. These processes are designed to assess eligibility for IMGs to work towards full registration, allowing them to practise in Australia either as a general practitioner or specialist. The Australian Medical Council (AMC) and the Medical Board of Australia (MBA) through the Australian Health Practitioners Registration Authority (AHPRA) are primarily responsible for accreditation and registration.
- 3.2 In addition to navigating the AMC and MBA/AHPRA processes, IMGs seeking to practise in Australia also usually need to interact with a range of other government and non-government organisations to formalise their residency and employment arrangements.
- 3.3 This Chapter provides a detailed description of the accreditation and registration processes that are available to IMGs and briefly outlines other inter-related processes that an IMG may have to pursue to practise in Australia and progress toward full medical registration.

Overview

- 3.4 When an IMG seeks to work as a medical practitioner in Australia they have to engage with a number of organisations, including, but not limited to:
 - the Australian Medical Council (AMC) for recognition of academic qualifications and the certification of documents;

- a specialist medical college for assessment of equivalence of qualifications and experience if seeking Specialist Registration;
- the Medical Board of Australia (MBA) through the Australian Health Practitioner Regulation Agency (AHPRA) to gain registration as a medical practitioner;
- the Australian Government Department of Immigration and Citizenship (DIAC) to arrange permanent or temporary migration to Australia;
- the Australian Government Department of Health and Ageing (DoHA) for information on Districts of Workforce Shortage (DWS) if they are seeking to work in a DWS;
- Medicare Australia to acquire a Medicare Provider Number;
- state governments for advice on Area of Need (AoN) if seeking an AoN position;
- employment and recruitment agencies; and
- employers (depending on visa class and the type of registration).

3.5 The sequence in which an IMG needs to engage with each of these organisations depends on a range of individual circumstances. Typically, an IMG commences the process of attaining full Australian medical registration with the following initial steps:

- sourcing all of the documentation required for immigration, accreditation and registration purposes;
- if not in English, ensuring that all relevant documentation has been translated by a certified interpreter;
- having all the necessary documents verified in accordance with the requirements of the relevant organisation or agency;
- passing prescribed English language proficiency exams;
- completing a number of forms relevant to their selected immigration, accreditation and registration pathway in the exact prescribed format; and
- paying the relevant application fees.¹

3.6 Failure to complete any of these steps adequately can result in an increase in costs associated with the program, as well as increasing the total

1 National Rural Health Alliance Inc (NRHA), *Submission No 113*, p 12.

amount of time expended applying to work in Australia and gaining registration.

- 3.7 This Chapter outlines the accreditation and registration processes that an IMG must follow when seeking employment in Australia. This Chapter does not provide an analysis of the issues arising from these processes. Consideration of issues presented in submissions and raised by witnesses in relation these processes can be found in later Chapters of the report.

Accreditation

- 3.8 Under the National Registration and Accreditation Scheme (NRAS) the AMC is the national authority responsible for the accreditation of medical professionals. It is also responsible for the accreditation of university medical schools and the specialist colleges that deliver medical training.²

- 3.9 The functions of the AMC are to:

- develop accreditation standards, policies and procedures for medical programs of study based predominantly in Australia and New Zealand and for assessment of international medical graduates for registration in Australia.
- assess, using the approved accreditation standards, undergraduate medical programs (the specialist medical colleges assess postgraduate programs) and the institutions that provide them – both those leading to General Registration and those leading to Specialist Registration of the graduates to practise medicine in Australia.
- assess other countries' examining and accrediting authorities to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by those authorities have the knowledge, clinical skills and professional attributes necessary to practise medicine in Australia.
- assess the knowledge, clinical skills and professional attributes of overseas qualified medical practitioners seeking registration to practise medicine in Australia.³

- 3.10 Depending on individual circumstances and the type of registration sought, there are a number of pathways which IMGs can follow.

2 Australian Medical Council (AMC), *Submission No 42*, p 2.

3 AMC, <<http://www.amc.org.au/index.php/about>> viewed 25 January 2012.

Regardless of the pathway selected however, the AMC requires all IMGs to undergo the process of primary source verification of qualifications and provide proof of identity.

Primary source verification of qualifications and proof of identity

3.11 The Medical Board of Australia (MBA) has established a national policy for all IMGs for the assessment of qualifications by the International Credentials Service of the Educational Commission for Foreign Medical Graduates (ECFMG) of the United States. The AMC administers the process for primary source verification (also known as EICS) which involves:

... the medical qualifications documents of all IMGs being electronically scanned and sent to the Educational Commission for Foreign Medical Graduates of the United States (ECFMG) for verification. The ECFMG forwards the documents on to the original issuing authorities for confirmation that they were issued to the IMG concerned. The ECFMG maintain an annually updated list of designated officials who are authorised to verify qualifications.⁴

3.12 In addition to primary source verification, IMGs are also required to fulfil proof of identity requirements to verify that they are in fact the person they claim to be. This requires an applicant to supply a certified copy of his/her passport, plus one other certified copy of identification from a list provided, which includes drivers licence, credit card or current registration.⁵ At least one of the submitted documents must include both a recent photograph and the applicant's signature.

3.13 As noted below, the AMC's proof of identity process which is an integral part of the accreditation process, is separate and distinct from the MBA/AHPRA proof of identity process which is needed for registration:

All applicants for medical registration will be required to satisfy the Proof of Identity Framework and Requirements of the Medical Board of Australia, which is separate to the AMC's requirements, in order to obtain medical registration.

Please note that some of the identification requirements set out by the Medical Board of Australia cannot be met by applicants

4 AMC, *Submission No 42*, p 9.

5 AMC, Proof of identity, <<http://www.amc.org.au/index.php/ass/apps/id-proof>> viewed 25 January 2012.

applying from overseas. The AMC has therefore developed its own proof of identity requirements that can be met by doctors applying from overseas for assessment through the AMC.⁶

AMC pathways to registration

3.14 All IMGs need to commence the process of registration by applying to the AMC to have their medical training accredited. There are a number of pathways available including the following:

- Competent Authority Pathway
 - ⇒ Advanced Standing; and
 - ⇒ Workplace performance assessment (minimum of 12 months).
- Standard Pathway
 - ⇒ AMC Examination; and
 - ⇒ Workplace-based Assessment.
- Specialist Pathway
 - ⇒ Specialist IMGs seeking registration for independent practice; and
 - ⇒ Area of Need (AON) Specialist Pathway.⁷

3.15 It is at the IMG's discretion which pathway they apply for. The outcome of the AMC process is the provision of the AMC certificate which enables an IMG to apply for either Provisional or Limited Registration⁸ depending of the pathway chosen, and to commence work in the Australian medical system.⁹

3.16 It is also important to note that once an IMG's medical training has been accredited by the AMC, they must also satisfy all of the MBA's registration requirements in order to be eligible for registration. The registration requirements are outlined later in this Chapter.

6 AMC, Proof of identity, <<http://www.amc.org.au/index.php/ass/apps/id-proof>> viewed 25 January 2012.

7 AMC, *Submission No 42*, p 8.

8 Provisional and Limited Registration are two distinct registration categories which allow IMGs to practise within parameters and under supervision as specified by the Medical Board of Australia (MBA)/ Australian Health Practitioner Regulation Agency (AHPRA). More information on registration categories is provided later in this Chapter.

9 AMC, *Submission No 42*, p 10.

The Competent Authority Pathway

- 3.17 The Competent Authority Pathway is for non-specialist IMGs who have obtained their medical qualifications in a country that is considered to have a comparable medical education system to Australia and is listed by the AMC as an approved competent authority. At present, competent authorities that are recognised are:
- United Kingdom (General Medical Council);
 - Canada (Medical Council of Canada);
 - United States (United States Education Commission for Foreign Graduates, the Accreditation Council of Graduate Medical Education);
 - New Zealand (Medical Council of New Zealand); and
 - Republic of Ireland (Medical Council of Ireland).¹⁰
- 3.18 In addition to the five countries listed above, the AMC has indicated that it is actively considering extending competent authority status to other countries with substantially comparable systems of medical education and training. Extending the list of competent authorities is considered by the Committee in more detail in Chapter 4.
- 3.19 In being assessed through the Competent Authority Pathway an IMG is eligible for 'advanced standing' towards the AMC Certificate. An IMG with 'advanced standing' may apply for Provisional or Limited Registration through the MBA/AHPRA. The IMG is generally then required to undertake a minimum of twelve months workplace performance assessment in a designated position prior to being eligible to receive the AMC Certificate.¹¹
- 3.20 Upon successful completion of this pathway the IMG is awarded an AMC Certificate and is eligible to apply for General Registration through the MBA/AHPRA.¹²

The Standard Pathway (2-part assessment)

- 3.21 IMGs that completed their medical training at institutions not presently on the AMC Competent Authority List are required to undertake screening and examination of their medical knowledge and skills. IMGs who are not
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10 AMC, Competent Authority Pathway, <<http://www.amc.org.au/index.php/ass/apo/cap>> viewed on 26 January 2011.

11 AMC, *Submission No 42*, p 10.

12 AMC, *Submission No 42*, p 10.

- seeking Specialist Registration may be eligible to gain registration through the Standard Pathway.¹³
- 3.22 To gain the AMC Certificate through the Standard Pathway an IMG must successfully complete the following sequential components:
- the AMC Multiple Choice Question (MCQ) Examination; and
 - the AMC Structured Clinical Examination (SCE).¹⁴
- 3.23 The AMC Examinations are designed to assess the medical knowledge and clinical skills of IMGs whose basic medical qualifications are not recognised by the MBA; that is, doctors trained in medical schools that have not been formally reviewed and accredited by the AMC.
- 3.24 The AMC MCQ Examination was a computer-administered multiple choice question examination that was used at the commencement of the inquiry. It contained 300 items (240 of which were scored) and was available on secure computer sites both in Australia and offshore.¹⁵
- 3.25 In 2011 the AMC MCQ Examination was replaced by the AMC Computer Adaptive Testing Multiple Choice Question (AMC CAT MCQ) Examination, a computer-administered fully integrated examination delivered in one (3 ½ hour) session that consists of:
- 150 multiple choice questions (where there is one correct response from five options); and
 - 120 scored multiple choice questions and 30 pilot (non-scored) multiple choice questions.¹⁶
- 3.26 The AMC CAT MCQ Examinations are conducted in examination centres in Australia and worldwide.
- 3.27 The SCE¹⁷ assesses clinical skills and is conducted in teaching hospitals in Australia. The SCE is a multi-station 16 component test including three obstetrics/gynaecology stations and three paediatrics stations.¹⁸

13 AMC, *Submission No 42*, p 8.

14 AMC, *Submission No 42*, pp 10-14.

15 AMC, *Submission No 42*, p 10.

16 AMC, *Submission No 42*, p 10.

17 The Structured Clinical Examination is distinct from the Pre-Employment Structured Clinical Interview (the PESCI). The PESCI is not run by the AMC. How the PESCI is used differs between jurisdictions. The PESCI is explained further in Chapter 5.

18 AMC, *Submission No 42*, p 10.

- 3.28 Once these examinations have been passed the IMG is issued with an AMC Certificate and is eligible to apply to the MBA/AHPRA for Provisional or Limited Registration. To achieve General Registration, the IMG is usually also required to complete 52 weeks of supervised practice. During these 52 weeks IMGs are generally expected undertake the following hospital based components:
- 10 weeks of surgery;
 - 10 weeks of medicine; and
 - 8 weeks of Emergency Medicine.¹⁹
- 3.29 Applicants for General Registration who have not completed any part of the core rotations in Australia must be able to demonstrate to MBA/AHPRA that they have achieved the learning outcomes expected in the rotation/s they have not undertaken.²⁰

The Standard Pathway (Workplace-based Assessment)

- 3.30 The Standard Pathway (Workplace-based Assessment) has been established as an alternative pathway to the AMC Clinical Examination and tests clinical skills in the actual environment of doctors' everyday practice.
- 3.31 According to AMC guidelines, an IMG must pass the AMC CAT MCQ to be eligible for the Standard Pathway Workplace-based Assessment, and must:
- provide evidence of English Language Proficiency;
 - provide evidence of Primary Source Verification (this does not need to be completed prior to commencing the pathway, but is needed to obtain the AMC Certificate); and
 - have obtained Limited Registration through MBA/AHPRA; and

19 New South Wales Government Department of Health, *Submission No 124*, p 6. See also: MBA, *Granting general registration to medical practitioners in the standard pathway who hold an AMC certificate*,

<<http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2f4691&dbid=AP&checksum=kgA7KR4HJI1ugAz%2bjlcFg%3d%3d>> viewed 26 January 2012.

20 MBA, *Granting general registration to medical practitioners in the standard pathway who hold an AMC certificate*,

<<http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2f4691&dbid=AP&checksum=kgA7KR4HJI1ugAz%2bjlcFg%3d%3d>> viewed 26 January 2012.

- be currently employed in a clinical position with an AMC-accredited authority.²¹
- 3.32 The AMC advised the Committee that although this pathway was included in the original 2007 COAG IMG Assessment Initiative proposals, it was not endorsed and signed off by all Australian jurisdictions at that time. As a result, implementation of this pathway has been delayed. Presently this pathway is not available nationwide and is currently being trialled in four state (NSW, Vic, Tas and WA).²² IMGs that successfully complete this pathway are entitled to apply for General Registration.²³
- 3.33 The Committee comments further on the value of the workplace-based assessment pathway and its availability in Chapter 4 of the report.

Specialist assessment

- 3.34 IMGs who are deemed to be specialists or who have trained as a specialist in their country of origin may pursue one of the pathways towards registration as a specialist medical practitioner in Australia.²⁴
- 3.35 Assessment of an IMG's claims for Specialist Registration is conducted by one of Australia's sixteen specialist medical colleges. Once an IMG's qualifications are verified through primary source verification, the AMC refers the IMG to the relevant specialist medical college to receive specialist assessment of their qualifications. The AMC is responsible for the accreditation of specialist medical colleges.
- 3.36 There are two pathways an IMG may follow to achieve specialist accreditation:
- Specialist Pathway (Full recognition); and
 - Specialist Pathway (Area of Need).

The Specialist Pathway (Full Recognition)

- 3.37 This section provides an overview of what 'generally' occurs when a specialist IMG uses the Specialist Pathway to seek Specialist Registration

21 AMC, Workplace-based assessment (Standard Pathway) FAQs, <<http://www.amc.org.au/index.php/ass/ass-faqs/wba-faqs>> viewed 26 January 2012.

22 AMC, *Submission No 42*, pp 12-13.

23 MBA, Standard Pathway (AMC Examination), <<http://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Standard-Pathway.aspx>> viewed 26 January 2012.

24 Royal College of Pathologists of Australasia (RCPA), *Submission No 72*, p 2.

in Australia. However, it should be noted that each specialist medical college has its own assessment process.

3.38 The AMC noted the challenges faced in reviewing overseas specialist training, noting that it presented:

... an even more complex challenge for recognition and registration than basic or primary medical training. There are substantial differences in the format and content of specialist training and practice between countries. Some adopt a formal postgraduate training program administered on completion of a primary (or undergraduate) medical course. Other countries integrate specialisation into the primary (or undergraduate) training with a shorter period of postgraduate specialist training than would be considered generally appropriate in Australia or other countries with developed specialist training schemes. In other countries again, there may be no formal postgraduate specialist training as such, but relevant work experience may lead to licensure to provide 'specialist' medical services.²⁵

3.39 As with the Competent Authority Pathway and the Standard Pathways, the AMC has a significant role in administering the process. Essentially, specialist medical colleges assess IMGs by comparing each applicant to an Australian-trained specialist. In assessing the applicants, specialist medical colleges make an initial assessment that the applicant is either:

- substantially comparable with an Australian-trained practitioner, in which case the applicant is considered suitable for recognition as a specialist. The applicant is eligible to apply for admission to Fellowship of the relevant specialist medical college, subject to up to 12 months work under oversight to confirm the initial assessment, and to ensure the practitioner's satisfactory integration into the Australian health system (this is sometimes termed 'peer review'); or
- partially comparable with an Australian-trained practitioner, where the applicant requires up to two years further up-skilling in aspects of the discipline to reach the standard of an Australian-trained practitioner; or
- not comparable with an Australian-trained practitioner, in which case it is necessary for the applicant to enter the relevant specialist college training program on a competitive basis with Australian-trained

25 AMC, *Submission No 42*, p 18.

graduates, possibly with some recognition of previous specialist training undertaken overseas or pursue another pathway.²⁶

- 3.40 Table 1.1 presents the 11 step Specialist Pathway to registration as a specialist medical. It details actions undertaken by the AMC, the applicant, the MBA and the relevant specialist college.

26 Committee of Presidents of Medical Colleges, *Submission No 28*, p 2.

Table 3.1 Eleven step specialist pathway to registration as a specialist medical

Step	Process
1	The AMC receives forms and documentation from applicant
2	The application is assessed through AMC Primary Source Verification
3	Referral is sent to the relevant college and the applicant is advised that this has happened
4	The applicant completes and sends Form SC ²⁷ and initial assessment fee to specialist college
5	The college assesses the application against college standards to determine compatibility to an Australian-trained specialist
6	The AMC receives a report from the specialist medical college advising of applicant's level of comparability. The report forwarded to applicant. Note: at this stage in the specialist assessment process <ul style="list-style-type: none"> • an applicant who has been determined to be substantially comparable to an Australian trained specialist proceed to step 9. • an applicant who has been determined to be partially comparable to an Australian-trained specialist and to require additional components of the assessment procedure proceed to step 7. • an applicant who has been determined to be not comparable to an Australian-trained specialist has their application for specialist assessment discontinued.
7	The applicant advises the AMC in writing of their intentions to comply with the requirements set out in the specialist medical college's initial assessment (termed Report 1) ²⁸
8	The AMC then advises the specialist medical college of the applicant's intention to comply with the requirements set out in Report 1, for example undergo 24 months of peer review.
9	Following the applicant's completion of Report 1 requirements the Specialist Medical College advise the AMC of final assessment decision via the second assessment by the specialist medical college (termed Report 2) ²⁹
10	The AMC receives Report 2 from the college and forwards a copy to the applicant. Note: at this stage in the specialist assessment process: <ul style="list-style-type: none"> • an applicant who has been determined to be substantially comparable to an Australian trained specialist proceeds to step 11 • an applicant who has been determined not to be comparable to an Australian trained specialist has their application for specialist assessment discontinued.
11	The AMC advise the relevant medical board of the applicant's eligibility to present for registration as a specialist.

Source: Australian Medical Council, Submission No 42, p 15.

27 Form SC is the application for assessment by Specialist Medical College. These forms are available at AMC offices or the website, <<http://www.amc.org.au/index.php/ass/forms>>.

28 AMC Report 1 is the initial assessment report completed by a Specialist Medical College advising the applicant's level of comparability to an Australian trained specialist. If Report 1 indicates that training and experience is not comparable to an Australian Specialist, the college will set out the necessary steps an IMG must complete to gain Fellowship to the specialist college and therefore gain unrestricted Specialist Registration. Report 1 is completed by the specialist college and sent to the AMC (the AMC will send a copy to the applicant).

29 AMC Report 2 is a report indicating that a specialist IMG has obtained Fellowship to the College. The specialist college completes AMC Report 2 and sends it to AMC who in turn informs the medical board. This means that the specialist IMG may be registered to have unrestricted practice as a specialist in Australia.

The Specialist Pathway (Area of Need)

- 3.41 Specialist IMGs who wish to practice their specialty in a position that has been designated as an Area of Need (AoN) position are able to apply to the AMC through the Specialist AoN Pathway.
- 3.42 AoNs are declared by the relevant state and territory governments. Although methods of defining them vary between jurisdictions, essentially an AoN is any location in which there is a lack of specific medical practitioners, or where medical positions have remained unfilled following various recruitment efforts. AoNs may apply to specialist positions in both public and private sector.³⁰
- 3.43 Because of the identified need, the accreditation process is fast-tracked by all parties involved in this pathway. The AMC website details the application process for those seeking to work in an AoN as follows:
- The documentation requirements and arrangements for processing 'Area of Need' Specialist Applications are similar to those for applications through the standard Australian Medical Council (AMC) Specialist Pathway for overseas-trained specialists.
- However, there are some differences because the AMC and the assessing college process area of need applications in parallel to save time.³¹
- 3.44 To pursue the Specialist AoN Pathway, an IMG must have already been selected by an employer and deemed suitable for an AoN specialist position. The AMC verifies documentation related to the specific job requirements and at the same time, the relevant specialist medical college assesses the applicant against the detailed position description provided by the jurisdiction, rather than the standards required of an Australian-trained specialist in that discipline.³² If the outcomes of the AMC and special college assessment processes are satisfactory, the specialist college advises the MBA and the employer that the IMG is suitable to fill the AoN. The assessing college also proposes any limitations it deems necessary in relation to the extent and nature of the IMG's practice. On the basis of this information the MBA/AHPRA proceeds with an AoN Limited

30 Australian Government Department of Health and Ageing (DoHA), DoctorConnect, Restrictions, <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/restrictions>> viewed 26 January 2012.

31 AMC, Assessment as an Area of Need Specialist, <http://www.amc.org.au/index.php?option=com_content&task=view&id=141&Itemid=160> viewed 26 January 2012.

32 Committee of Presidents of Medical Colleges, *Submission No 28*, p 2.

Registration. This registration is linked to ongoing monitoring and assessment undertaken by the college over a defined period. Reports are provided to the employer and the MBA, with continued registration being depended on satisfactory performance.

- 3.45 It should be noted that specialist IMGs assessed as suitable to work in a specific AoN may not be assessed as substantially comparable to an Australian-trained specialist and suitable for independent practice. This can drastically reduce the mobility of specialist IMGs employed under the AoN scheme. It is expected that IMGs working in AoN positions should be working towards qualifying for General or Specialist Registration, or planning to return to their country of origin after gaining experience in Australia.³³

Registration

- 3.46 The purpose of registration of IMGs is to ensure that all doctors practising medicine in Australia meet a minimum standard equivalent to their Australian counterparts. This ensures that the Australian health system maintains its high standard of quality and safety.
- 3.47 The Medical Board of Australia (MBA) is responsible for the registration and regulation of medical practitioners. Once medical practitioners are registered they are able to practise medicine in Australia.

Categories of registration

- 3.48 The MBA can register medical practitioners including IMGs (provided they meet the registration requirements) under several categories. These categories include:
- General Registration;
 - Provisional Registration;
 - Limited Registration; and
 - Specialist Registration.

General Registration

- 3.49 General Registration allows medical practitioners to practice independently in all fields of medicine.³⁴ Most medical practitioners in Australia practice under General Registration.³⁵ General registration (s 52 of the National Law) is available to medical practitioners:
- who have completed a medical degree and an approved internship in Australia or New Zealand; or
 - who have had their eligibility assessed through the Competent Authority Pathway and have completed a period of supervised training in accordance with the MBA/AHPRA registration standard; or
 - who have qualified outside of Australia or New Zealand, and demonstrated equivalence by obtaining the AMC certificate via the AMC examination process and completed a period of supervised practice.³⁶

Provisional Registration

- 3.50 Provisional Registration is granted to Australian or New Zealand graduates who are applying to undertake an approved intern position. Intern positions are approved by the MBA and are of usually 12 months duration. After successful completion of the intern year, practitioners working under Provisional Registration may apply for General Registration.³⁷
- 3.51 IMGs who have obtained the AMC certificate through the AMC Standard Pathway are also eligible for Provisional Registration. As noted in the preceding section, IMGs applying for General Registration are generally expected to have undertaken a period of supervised practice.³⁸

Limited Registration

- 3.52 Limited Registration is available to medical practitioners whose medical qualifications are from a medical school outside of Australia or New

34 AMC, *Submission No 42.1*, p 1.

35 MBA, General Registration, <<http://www.medicalboard.gov.au/Registration/Types/General-Registration.aspx>> viewed 26 January 2012.

36 MBA, Types of Medical Registration, <<http://www.medicalboard.gov.au/Registration/Types.aspx>> viewed 26 January 2012.

37 DoHA, *Submission No 84*, p 7.

38 DoHA, *Submission No 84*, p 7.

Zealand.³⁹ Limited Registration is available for both specialists and non-specialists. It allows a medical practitioner to practise under supervision. Practise under this form of registration may be limited in scope, duration or by location.⁴⁰

3.53 The purpose of providing Limited Registration is to ensure that IMGs work within a framework that ensures public safety and which encourages them to reach the Australian standard.⁴¹

3.54 The MBA reported in its submission that Limited Registration is always granted for a specific purpose, namely:

- to allow for work in a designated AoN position;
- for postgraduate training or supervised practice;
- to allow practise in the public interest; and
- for non-practising registration for teaching or research.⁴²

Limited Registration for Area of Need

3.55 IMGs who are working under Limited Registration to work in an AoN position (s 67 of the National Law) are usually working under supervision in an area of medical workforce shortage. As noted earlier, while definitions for AoN differ between state and territory jurisdictions, IMGs practising medicine under this category must comply with the relevant MBA Registration Standards which include:

- compliance with a supervision plan;
- compliance with a professional development plan;
- authorising and facilitating regular reports from their supervisors about their safety and competence to practise; and
- continued satisfactory performance.⁴³

39 MBA, Limited Registration, <<http://www.medicalboard.gov.au/Medical-Registration/Limited-Registration.aspx>> viewed 26 January 2012.

40 AMC, *Submission No 42.1*, p 1.

41 Dr Joanna Flynn, MBA, *Official Committee Hansard*, Canberra, 25 February 2011, p 14.

42 MBA, *Submission No 51*, p 2.

43 MBA, Area of Need, <<http://www.medicalboard.gov.au/Medical-Registration/Limited-Registration/Area-of-Need.aspx>> viewed 26 January 2012.

Limited Registration for Postgraduate Training or Supervised Practice

- 3.56 Limited Registration for Postgraduate Training or Supervised Practice (s 66 of the National Law) is for IMGs who are undertaking supervised medical training in Australia. IMGs practising medicine under this category of registration must comply with relevant MBA Registration Standards which include:
- compliance with a supervision plan;
 - compliance with a training plan;
 - authorising and facilitating regular reports from their supervisors about their safety and competence to practice; and
 - continued satisfactory performance.⁴⁴
- 3.57 IMGs with Limited Registration wishing to practise medicine in Australia in the longer term are expected to make progress towards gaining full General or Specialist Registration.⁴⁵

Other types of Limited Registration

- 3.58 While the MBA allows for Limited Registration to be granted for other purposes (eg for the public interest or for teaching and research) these are not examined as the focus of the inquiry is on IMGs wishing to practise and qualify for full Australian registration (either General or Specialist Registration).

Specialist Registration

- 3.59 Specialist Registration allows independent practise in an approved area of medical specialty.⁴⁶ When registering specialist IMGs, the MBA/AHPRA takes advice from the AMC and specialist medical colleges on the qualifications and comparability of individual IMGs.
- 3.60 As noted in the submission from DoHA:

Specialist registration is available to medical practitioners that are assessed by AMC accredited specialist colleges as being eligible for

44 MBA, Postgraduate Training or Supervised Practice, <<http://www.medicalboard.gov.au/Medical-Registration/Limited-Registration/Postgrad-Training.aspx>> viewed 26 January 2012.

45 MBA, *Submission No 51*, p 38. See also: MBA, Area of Need, <<http://www.medicalboard.gov.au/Medical-Registration/Limited-Registration/Area-of-Need.aspx>> viewed 26 January 2012.

46 AMC, *Submission No 42.1*, p 1.

Fellowship. AMC accredited Specialist Medical Colleges in Australia are responsible for setting and administering programs relating to specialist medical training and examinations including the assessment of IMGs. Where components of the college examination and assessment procedures are applied, they are the same as, or derived from, those that apply to local specialist trainees. The colleges provide the AMC and the MBA with advice on the outcome of assessments.⁴⁷

Registration requirements

- 3.61 All medical practitioners must meet certain requirements before they are registered and permitted to provide medical services in Australia. This applies to medical practitioners trained in Australia, as well as to IMGs, who must also meet some additional requirements.⁴⁸
- 3.62 In addition to fulfilling the necessary AMC accreditation requirements as outlined earlier, IMGs must also fulfil a number of MBA registration requirements. According to the MBA's submission:

The National Law requires that applicants for registration are eligible, qualified and suitable for the particular type of registration being applied for. The requirements help the Board to ensure that an IMG applying to practise medicine in Australia:

- is the person they are claiming to be - Proof of identity and all supporting documentation is that of the same person applying for registration;
- is medically qualified - holds a primary medical qualification from a recognised medical school.
- is able to communicate effectively in English to a standard expected of medical practitioners practising in Australia.
- meets the recency of practice standard as required by the National Law which identifies whether the IMG's skills and knowledge are up-to-date with current medical practice in the area the IMG intends to practise medicine.
- is a suitable person to practise as a medical practitioner. That is, the IMG has no previous or on-going criminal history or disciplinary action taken by another registering authority which may impact on the ability of the individual to provide competent, safe and ethical care to the public.

47 DoHA, *Submission No 84*, p 7.

48 DoHA, *Submission No 84*, p 4.

- does not have a mental or physical impairment that may impact their ability to practise medicine safely.
 - will be employed in a position that is suitable for his or her level of knowledge, skills and experience and that the appropriate supervision and support mechanisms will be provided.⁴⁹
- 3.63 Specific registration requirements and processes will vary depending on the registration pathway selected by the applicant, and the category of registration sought. However, there are mandatory registration requirements which apply to all applications for medical registration and to registered medical practitioners, with the exception of students and non-practicing registrants. Registration Standards which have been approved by the Australian Health Workforce Ministerial Council, define the requirements that applicants need to meet.⁵⁰
- 3.64 In brief, before registering any medical practitioner the MBA must:
- verify the applicant's identity;
 - verify the applicant's qualifications;
 - ensure that the applicant has undertaken an internship or period of supervised practise;
 - ensure that the applicant is a suitable person to practise medicine in Australia; and
 - confirm that the applicant complies with registration standards for:
 - ⇒ English language
 - ⇒ criminal history check
 - ⇒ recency of practice
 - ⇒ continuing professional development (CPD)
 - ⇒ professional indemnity insurance (PII)
- 3.65 As noted earlier in this report, AHPRA was established under the National Law to administer these processes on behalf of the MBA. AHPRA commenced operating in July 2010.

49 MBA, *Submission No 51*, p 47.

50 For a full list of registration standards see MBA, Registration Standards, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 2 February 2012.

Proof of identity

- 3.66 Proof of identity is required for any new application for registration. The MBA/AHPRA provides detailed information on what documentation need to be provided as proof of identity, noting that the documents provided must meet the following criteria:
- All documents must be true certified or notarized copies of the original.
 - At least ONE document must include a recent photograph ...
 - At least ONE document must be in the applicant's current name.
 - All documents must be officially translated in English.
 - All documents must be current / valid at the date of submission.⁵¹
- 3.67 The requirement includes special provisions for applicants seeking registration from overseas or who have recently (less than 6 weeks previously) arrived in Australia and who may have difficulty in supplying some documents.⁵² As noted earlier, the MBA/AHPRA proof of identity process is separate to that required by the AMC.

Evidence of qualifications

- 3.68 IMGs are required to provide information of medical qualifications and evidence of having undertaken an internship (or equivalent). Documentary evidence (certified copies of original documents) must be provided in accordance with AHPRA's guidelines. Applicants must also demonstrate that they have had primary source verification from the AMC.⁵³

Registration and work history

- 3.69 In addition to evidence of their qualifications, IMGs also need to provide information relating to their registration history. Specifically the MBA/AHPRA requires a Certificate of Registration Status or Certificate of Good Standing from every jurisdiction where the applicant has been

51 AHPRA, *Proof of Identity Requirements*, pp 2-3, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f1973&dbid=AP&checksum=H7xVC2W%2bm57CqcCbJbUOrg%3d%3d>> viewed 26 January 2012.

52 AHPRA, *Proof of Identity Requirements*, p 3, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f1973&dbid=AP&checksum=H7xVC2W%2bm57CqcCbJbUOrg%3d%3d>> viewed 26 January 2012.

53 AHPRA, *Certifying Documents*, <<http://www.ahpra.gov.au/Registration/Registration-Process/Certifying-Documents.aspx>> viewed 26 January 2012.

registered (including overseas registrations) during the last 10 years. According to the AHPRA guidelines original certificates must be forwarded directly from the licensing or registration authority to the relevant state office of the MBA. Certificates submitted must be dated within three months of the application being lodged.

- 3.70 Applicants are also required to provide a comprehensive curriculum vitae (CV) detailing their work practice history, including information on any gaps in practice history of more than three months. MBA/AHPRA provides guidance on standard format that the CV should take.⁵⁴

Employment information

- 3.71 Applicants for Limited Registration are also required to provide written confirmation of an offer of employment. The sponsoring employer is required to provide a statement including a detailed position description, information on proposed clinical supervisors and a detailed supervision and training plan for the applicant.⁵⁵

Other registration requirements

- 3.72 In addition to the information above, IMGs also need to meet a number of suitability requirement standards including:
- English language skills need to be demonstrated by all medical practitioners who have qualified overseas or received their secondary education overseas. All applicants must be able to demonstrate English language skills at IELTS academic level 7 or equivalent. Test results will generally need to be obtained less than two years prior to applying for registration. Exceptions are made for IMGs who obtained their qualifications in the following countries: Canada; New Zealand; Republic of Ireland; South Africa, United States of America; and United Kingdom.⁵⁶
 - criminal history is checked for all new applicants for registration and applicants seeking registration renewal. Specific factors are considered

54 AHPRA, Standard Format for Curriculum Vitae, <<http://www.ahpra.gov.au/Registration/Registration-Process/Standard-Format-for-Curriculum-Vitae.aspx>> viewed 26 January 2012.

55 MBA, Registration Standards, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 26 January 2012.

56 MBA, *English language skills registration standard*, p 1, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f103&dbid=AP&chksum=nrU04kzBXoRQUWoQD7jP2A%3d%3d>> viewed 26 January 2012.

to determine whether the criminal history of health practitioners is relevant to the practice of their profession.⁵⁷

- recency of practice standards requires that all practitioners must have undertaken a certain number of hours of practice, as specified by the MBA, within preceding years of registration. This ensures that medical practitioners have recent practice in the fields in which they intend to work during the period of registration for which they are applying.⁵⁸
- continuing professional development (CPD) is required for all registered medical practitioners, including all applicants for initial registration who are not new graduates. According to the CPD standards the purpose is to maintain, develop, update and enhance their knowledge, skills and performance to ensure that they deliver appropriate and safe care.⁵⁹
- professional indemnity insurance (PII) standard applies to all medical practitioners who seek to undertake any form of practice. It requires all medical practitioners to have PII which covers all aspects of their intended practice and for the whole period of the registration.⁶⁰

3.73 In assessing suitability for registration applicants are also requested to provide information on any disqualifications from practice, suspensions or cancellations of registration. Information on any physical or mental impairment which may detrimentally affect an individual's capacity to practise is also required.

Pathway specific requirements

3.74 In addition to these general requirements, there are additional requirements for Provisional or Limited Registration depending on the pathway through which they seek to qualify for General or Specialist Registration.

57 MBA, *Criminal history registration standard*, p 1, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f102&dbid=AP&chksum=2Udhuw6cqfGw%2boDhSqpoHQ%3d%3d>> viewed 26 January 2012.

58 MBA, *Recency of practice registration standards*, p 1, <http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f108&dbid=AP&chksum=ePw%2fM61E57VzMD27KPKV0w%3d%3d> viewed 26 January 2012.

59 MBA, *Continuing professional developmental registration standards*, p 1, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f101&dbid=AP&chksum=Nx18OyXfwajDAfAm%2fQQNNQ%3d%3d>> viewed 26 January 2012.

60 MBA, *Submission No 51*, p 2. See also: MBA, *Professional Indemnity insurance registration standards*, p 1, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f107&dbid=AP&chksum=oD3TxQ2nxbPyCEfwz4EL8Q%3d%3d>> viewed 26 January 2012.

- 3.75 For example, IMGs on the Competent Authority Pathways are required to provide the AMC's Certificate of Advanced Standing and may also be required to satisfactorily complete a Pre-employment Structured Clinical Interview (PESCI).
- 3.76 IMGs on the Standard Pathway are required to have passed the AMC CAT MCQ, the SCE (or workplace-based assessment) and may also be required to satisfactorily complete a PESCI. This will qualify the applicant for Provisional or Limited Registration for postgraduate or supervised training. An additional period of approximately 12 months supervised practice is usually required before the applicant can apply for General Registration.
- 3.77 Applicants for Limited Registration pursuing the Specialist Pathway are required to provide confirmation of the specialist college assessment (co-ordinated by the AMC) identifying them as substantially or partially comparable. Where possible, the college should also provide recommendations about additional training needed for specialist recognition. Applicants require the specialist college to confirm that additional training has been satisfactorily completed to qualify for college Fellowship and Specialist Registration.
- 3.78 Applicants for Limited Registration AoN are also required to provide evidence of an area of need declaration for the geographical area and/or type of health service for which there is a need. This declaration is issued from the relevant state or territory Minister for Health or delegate for the jurisdiction in which the designated area of need position is located.⁶¹
- 3.79 IMGs working under Limited Registration for postgraduate training or supervised practice, or for those working in AoN positions, are expected to work towards General or Specialist Registration if they intend to continue to practise in Australia.

Registration renewal

- 3.80 The MBA is also responsible for registration renewals. Under the National Law, initial registration as a medical practitioner is granted for a period of up to 12 months and is then renewed annually.⁶² The registration renewal

61 MBA, *Limited registration for area of need registration standard*, p 2, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f104&dbid=AP&chksum=SA4kRfNqUsUoPJ040ocw1w%3d%3d>> viewed 26 January 2012.

62 For General Registration see: s 56 of the *Health Practitioner Regulation National Law Act 2009* (Qld) (the Act); for Specialist Registration see: s 61 of the Act; and for Limited Registration see: s 72 of the Act.

date for medical practitioners with General or Specialist Registration is 30 September.

- 3.81 The registration renewal date for practitioners with Provisional or Limited Registration is determined on a case by case basis. This is generally on the anniversary of 12 months but may be at an earlier expiry date as determined by the delegate.

Registration renewal for Limited Registration

- 3.82 Until such time as they qualify for General or Specialist Registration, IMGs generally qualify for Limited Registration. When considering an IMG's application for renewal of registration, the MBA considers whether the IMG is safe to continue to practise and whether they meet the requirements for registration. Specifically the MBA takes into account:
- work reports from supervisors;
 - evidence of progress towards qualifying for General or Specialist Registration;
 - whether all other registration standards have been met (CPD, PII etc); and
 - mandatory declarations regarding impairment, criminal activity etc.⁶³
- 3.83 The requirement for IMGs to renew Limited Registration allows the MBA to identify any potential risks to public health and safety which may result from an IMG continuing to practise. The MBA may refuse to renew Limited Registration if the practitioner's employment ceases or is terminated; if the practitioner fails to comply with supervision requirements; or if significant deficiencies are identified in the practitioner's practise.
- 3.84 Alternatively, the MBA may decide to impose additional conditions on the applicant's Limited Registration. Additional conditions which may be imposed on the IMG include modified levels of supervision, amended training and professional development requirements, or additional requirements to undergo additional assessment or examination.
- 3.85 Under s 72(3) of the National Law, 12 month Limited Registration cannot be renewed more than three times. After this time the IMG needs to reapply for new Limited Registration.⁶⁴

63 MBA, *Submission No 51*, p 6.

64 See s 72, *Health Practitioner Regulation National Law Act 2009* (Qld).

Other processes

3.86 As noted earlier, in addition to accreditation and registration processes, most IMGs wishing to practise in Australia are also required to interact with a series of other organisations and agencies. The following section briefly outlines some of the additional processes that IMGs may need to undertake.

Obtaining a visa

3.87 The Department of Immigration and Citizenship (DIAC) manages the entry and stay of people in Australia. According to information on the DIAC website a key objective is to promote a society which values Australian citizenship, appreciates cultural diversity, and enables migrants to participate equitably.⁶⁵

Visa options

3.88 IMGs who wish to migrate for the purpose of employment are required to make contact with DIAC for a visa to enter Australia and for the right to seek paid employment. For many IMGs, as with other skilled workers, this will require seeking entry under the auspices of Australia's skilled migration program. As outlined by DIAC:

The Department's skilled migration program provides a number of temporary and permanent pathways for OTDs including;

- General Skilled Migration (GSM) (permanent)
- Regional Sponsored Migration Scheme (RSMS) (permanent)
- Employer Nomination Scheme (ENS) (permanent)
- Temporary Business (Long Stay) – Subclass 457.⁶⁶

Permanent residency options

3.89 Permanent residency options are available for doctors who have achieved full medical registration in Australia.⁶⁷ The General Skilled Migration (GSM) pathway allows medical practitioners with full Australian registration to live permanently in Australia and work in independent

65 Australian Government Department of Immigration and Citizenship (DIAC), <<http://www.immi.gov.au/about/department/who-we-are.htm>> viewed 26 January 2012.

66 DIAC, *Submission No 138*, p 1. See also: DIAC, <<http://www.immi.gov.au>> viewed 26 January 2012.

67 DIAC, *Permanent Visa Options for Doctors*, <<http://www.immi.gov.au/skilled/medical-practitioners/permanent-visas.htm>> viewed 26 January 2012.

practice. The Regional Sponsored Migration Scheme (RSMS) and Employer Nomination Scheme (ENS) also provide options for permanent residency for highly skilled workers on the basis of employer sponsorship.

Temporary residency options

3.90 The vast majority of IMGs are initially eligible for temporary residency only, generally through the Temporary Business (Long Stay) Visa (the 457 visa). As outlined by DIAC:

Australian organisations (businesses, communities or government agencies) can sponsor overseas doctors to work in Australia for up to 4 years.

Temporary visas are the usual pathway to permanent residence for doctors who do not yet hold full medical registration in Australia. Overseas trained doctors can commence a period of supervised practice and formal assessment in Australia to meet the requirements for full medical registration.⁶⁸

3.91 To be eligible for a 457 visas applicants must:

- be sponsored by an employer to fill a nominated position
- have skills, qualifications, experience and an employment background which match those required for the position
- demonstrated English language proficiency
- be eligible for any relevant licences or registration required for the nominated position.⁶⁹

3.92 Mr Kruno Kukoc, First Assistant Secretary, Migration and Visa Policy Division, DIAC, informed the Committee that in the 2010–11 financial year, Australia's skilled migration program delivered approximately 4 000 doctors to Australia, with close to 3 000 of these doctors granted temporary skilled worker visas.⁷⁰

3.93 As with all temporary visa categories, there are obligations associated with the 457 visa. Notably, if an IMG ceases employment, he or she is obliged to:

- find another employer who is willing to nominate you
- apply for another type of substantive visa

68 DIAC, Temporary Visa Options for Doctors, <<http://www.immi.gov.au/skilled/medical-practitioners/temporary-visas.htm>> viewed 26 January 2012.

69 DIAC, Employer Sponsored Workers, <<http://www.immi.gov.au/skilled/skilled-workers/sbs/eligibility-employee.htm>> viewed 26 January 2012.

70 Mr Kruno Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 4.

- leave Australia within 28 days unless your visa expires before that time, in which case you must leave Australia prior to visa expiry.⁷¹
- 3.94 IMGs who are unsuccessful in obtaining full Australian registration in the required period, or who have been deregistered for whatever reason, have to leave Australia within 28 days or earlier, if their visa expires before that time.

Accessing Medicare practitioner benefits

- 3.95 To work as a medical practitioner in Australia, IMGs may need access to a Medicare provider number. The Medicare provider number is a unique identifier linked to the individual medical practitioner and the location from which they practise. The Medicare provider number is used by medical practitioners to:
- raise referrals for specialist services; and
 - make requests for pathology or diagnostic imaging services.
- 3.96 A Medicare provider number may also be used to claim Medicare rebates for professional services rendered – that is, to treat private patients.⁷²

Section 19AB of the *Health Insurance Act 1973*

- 3.97 However, under the *Health Insurance Act 1973* (the Act), many IMGs are subject to restrictions which limit the circumstances under which they can apply for a Medicare provider number. For IMGs who are not permanent residents or Australian citizens, including most IMGs with Limited Registration, the following restriction applies:

Section 19AB of the Act applies to overseas trained doctors (OTDs) and foreign graduates of an accredited medical school (FGAMS) who gained their first medical registration on or after 1 January 1997. Section 19AB of the Act restricts their access to Medicare benefits and requires them to work in a 'district of workforce

71 DIAC, Employer Sponsored Workers, <<http://www.immi.gov.au/skilled/skilled-workers/sbs/obligations-employee.htm>> viewed 26 January 2012.

72 DoHA, DoctorsConnect, Restrictions, <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/restrictions>> viewed 26 January 2012. Medicare provider number does not automatically allow you to attract Medicare rebates for your services. You should ask your Australian employer which level of Medicare access for a provider number you need.

shortage¹ (DWS) for a minimum period of ten years from the date of their first medical registration.⁷³

3.98 This legislative provision, often referred to as the s 19AB restriction or the 10 year moratorium, is intended to ensure equitable distribution of medical services across Australia, including services in outer-metropolitan, regional, rural and remote locations. The incentive to attract IMGs to work in districts of workforce shortage (DWS)⁷⁴ locations is to offer access to Medicare professional benefits by exempting them from the s 19AB restriction if they choose to work in a DWS.⁷⁵

3.99 DWS are determined by DoHA and are geographical areas in Australia where the population's needs for healthcare have not been met.⁷⁶ The process for determining DWS is described by DoHA as follows:

Districts of Workforce Shortage (DWS) are areas where the general population has less access to GPs when compared to the national average. The Department uses the latest Medicare billing statistics, which account for all active Medicare billing, and Australian Bureau of Statistics (ABS) population to determine which areas are a DWS. This information is used to create a doctor to population ratio which is used as the basis for calculating DWS. If an area has a lower doctor to population ratio (i.e. less full time equivalent doctors) than the national average, the area is a DWS.⁷⁷

3.100 DoHA provides a locator map which can be used by those intending to work in general practice to check whether a potential job is located in a DWS.⁷⁸ Information on DWS status of an area with respect to specialist positions is obtained by contacting DoHA's Workforce Regulation Section.

73 DoHA, DoctorConnect, *Section 19AB of the Health Insurance Act 1973: Factsheet*, <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/section19AA>> viewed 26 January 2012.

74 Districts of Workforce Shortage re determined by the DoHA, and should not be confused with Areas of Need, which are determined by state and territory governments. DWS relate specifically to the Section 19AB provisions while the AoN system has been implemented to fill vacant medical positions.

75 DoHA, Health Practitioners, *District of Workforce Shortage Factsheet*, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-dws-fact>> viewed 26 January 2012.

76 DoHA, *Submission No 84*, p 11.

77 DoHA, *Submission No 84.1*, p 1.

78 DoHA, DoctorsConnect, *Factsheet: District of workforce shortage*, <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/dwsFactsheet>> viewed 26 January 2012.

- 3.101 To obtain a Medicare provider number an IMG working in a DWS needs to complete a standard application form and lodge it with Medicare Australia. Medicare Australia provides the information to DoHA which determines whether a s 19AB exemption is approved, and then notifies Medicare Australia accordingly. The Committee heard from Medicare Australia about the process of obtaining a Medicare provider number for IMGs practising in a DWS. Once an exemption has been approved, Medicare Australia provides the applicant with a Medicare provider number and the information they need to make claims for professional services.⁷⁹ According to Medicare Australia:
- Much of that process, although it does involve the two departments, is seamless to the doctor.⁸⁰
- 3.102 There are options for IMGs to reduce the period of their obligation to work in DWS under the s 19AB restriction. One option is to complete the requirements of the Five Year Overseas Trained Doctor Scheme run by DoHA. Eligible locations are usually those where recruitment and retention of medical practitioners has been particularly problematic.
- 3.103 The scheme requires IMGs to complete a period of service within an eligible rural or remote area of between three and five years. It also requires IMGs to obtain permanent Australian residency and Fellowship with either the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine.⁸¹
- 3.104 Alternatively, reductions on the period of the 10 year moratorium can be obtained through a ‘scaling mechanism’ available to IMGs who establish private practice in eligible regional, rural and remote areas as defined under the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA). In addition to working in an eligible location, the practice must meet a Medicare billing threshold of \$5 000 per month. Table 1.2 shows the moratorium reductions available under this arrangement.

79 Ms Sheila Bird, Australian Government Department of Human Services (DHS), *Official Committee Hansard*, Canberra, 1 November 2011, p 6.

80 Ms Bird, DHS, *Official Committee Hansard*, Canberra, 1 November 2011, p 6.

81 DoHA, *Submission No 84.1*, p 5.

Table 1.2 Scaling of period of 19AB restriction according to location

ASGC-RA Classification	ASGC RA 1 Major Cities	ASGC-RA 2 Inner Regional	ASGC-RA 3 Outer Regional	ASGC-RA 4 Remote	ASGC-RA 5 Very Remote
Period of restriction	10 years	9 years	7 years	6 years	5 years

Source: Department of Health and Ageing, Submission No 84.1, p 6.

Section 19AA of the *Health Insurance Act 1973*

3.105 Australian medical graduates and IMGs who are permanent residents or Australian citizens and who do not hold continued recognition by the Royal Australian College of General Practitioners, or the Australian College of Rural and Remote Medicine, or by a recognised specialist college, are subject to restrictions s 19AA of the *Health Insurance Act 1973* (the Act). According to information on DoHA's website:

Section 19AA of the Health Insurance Act 1973 (the Act) was introduced to recognise and support general practice as a vocational specialty, as well as to provide a framework for achieving long term improvements in the quality of doctors working in Australia.⁸²

3.106 All medical practitioners restricted by s 19AA are unable to access Medicare benefits unless they participate on an approved training or workforce program under s 3GA of the Act. Programs approved under s 3GA are:

- Rural Locum Relief Program;
- Queensland Country Relieving Program;
- Approved Medical Deputising Service Program;
- Prevocational General Practice Placements Program;
- Australian General Practice Training Program;
- Approved Private Emergency Department Program;
- Special Approved Placements Program;
- Temporary Resident Other Medical Practitioners Program; and

82 DoHA, Health Practitioners, *Section 19AA of the Health Insurance Act 1973*, p 1, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/C8CE54F77A1B9763CA25744000057C9F/\\$File/19aa.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/C8CE54F77A1B9763CA25744000057C9F/$File/19aa.pdf)> viewed 26 January 2012.

- Specialist Medical Colleges in Australia.⁸³
- 3.107 Alternatively, the doctor can be placed in a workforce program where workforce shortages have occurred.
- 3.108 IMGs that have completed their commitment to s 19AB are subject to the restrictions under s 19AA of the Act. This means that if a doctor completes their 10 year moratorium but has not gained Fellowship or specialist recognition, they will still be subject to the restrictions.⁸⁴

Finding employment

- 3.109 Once again, although the specifics will vary depending on the individual circumstances of IMGs (eg visa type, selected registration pathway etc), finding a suitable employment opportunity is often a prerequisite to initiating accreditation and registration processes.
- 3.110 There are many sources of information on employment opportunities that IMGs seeking to practise in Australia might access. These include:
- newspapers and some Australian medical journals (many of which are available online);
 - some specialist medical college websites;
 - state and territory government websites which list medical vacancies in public health sector organisations, including hospitals;
 - medical recruitment agencies representing public and private employers, which actively seek appropriately qualified medical practitioners, including IMGs, to fill vacancies all around Australia; and
 - state and territory based Rural Workforce Agencies (RWA) which focus on recruitment and retention of general practitioners in rural and remote areas of Australia.⁸⁵
- 3.111 Although the process of locating potential employment opportunities may be relatively straight forward, for many IMGs ascertaining the suitability

83 DoHA, Health Practitioners, *Section 19AA of the Health Insurance Act 1973*, p 1, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/C8CE54F77A1B9763CA25744000057C9F/\\$File/19aa.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/C8CE54F77A1B9763CA25744000057C9F/$File/19aa.pdf)> viewed 26 January 2012.

84 DoHA, Health Practitioners, *Section 19AA of the Health Insurance Act 1973*, p 1, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/C8CE54F77A1B9763CA25744000057C9F/\\$File/19aa.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/C8CE54F77A1B9763CA25744000057C9F/$File/19aa.pdf)> viewed 26 January 2012.

85 DoHA, DoctorConnect , Finding a job, <<http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/findingAJob>> viewed 26 January 2012.

of a specific position not only requires a good understanding of the myriad of processes outlined above, but also a holistic understanding of how these processes can interact and impact on one another.

- 3.112 For example, in addition to considering the professional merits of a specific medical position, an IMG may also need to consider whether the position has an AoN classification if he or she intends to pursue an AoN registration pathway, and whether it is located in a DWS if seeking access to a Medicare provider number. In turn, the scope of employment opportunities will be influenced the applicant's visa type, residency status and selected registration pathway. Personal considerations such as access to social networks, to services and other supports for IMGs and their family members are also important factors.
- 3.113 As outlined at the beginning of this Chapter, IMGs wanting to practise in Australia are faced with a complex array of processes. While some IMGs may seek assistance with navigating these processes, others may attempt to 'go it alone'. The remaining Chapters of this report examine issues that have been raised in evidence, based on the experiences of IMGs who have attempted to navigate the various processes, as well as other stakeholders involved with accreditation and registration of medical practitioners, or involved in medical workforce recruitment.

Issues with accreditation and assessment

- 4.1 The Australian Medical Council (AMC) is responsible for the assessment of international medical graduates (IMGs) qualifications, skills and experience, leading to various categories of registration provided through the Medical Board of Australia (MBA).
- 4.2 Accreditation and assessment processes for IMGs can follow a number of pathways. In broad terms, the AMC administers a range of accreditation requirements and assessment processes for non-specialist registration. Where Specialist Registration is sought, the relevant specialist medical college applies its own model of assessment, though accreditation remains the responsibility of the AMC.
- 4.3 This Chapter outlines evidence received from IMGs and from a range of entities assisting IMGs relating to particular elements of the AMC's assessment and accreditation processes. The Committee will also consider elements of the specialist medical colleges' models of assessment in this Chapter. Issues covered include concerns relating to lengthy timeframes and waiting periods associated with some elements of the assessment and accreditation processes. Issues relating to the assessments themselves, including concerns regarding the means and processes for assessing clinical competency of IMGs are also considered. The Chapter concludes by considering issues associated with perceptions of assessment and accreditation entities.

AMC accreditation and assessment

- 4.4 In accordance with provisions under the *Health Practitioner Regulation National Law Act 2009* (Qld) (the "National Law"), the AMC is authorised as the external accreditation entity to carry out the qualification

accreditation function on behalf of the MBA.¹ The AMC is also responsible for conducting the assessment of non-specialist IMGs leading to General Registration, as well as liaising with the specialist medical colleges to facilitate the assessment of IMGs who wish to become specialists.² Further detail in relation to the AMC's functions and assessment processes may be found at Chapter 3.

Primary source verification

4.5 The first step in the accreditation process for IMGs is verification of their international qualifications. The AMC is responsible for overseeing primary source verification, although the primary medical qualifications are actually verified by the Educational Commission for Foreign Medical Graduates (ECFMG) International Credentials Services (EICS) of the United States.

4.6 Primary source verification is authorised under the National Law, which states:

The National Board [MBA in the case of medical practitioners] may ask an entity that issued qualifications that the applicant believes qualifies the applicant for registration for confirmation that the qualification was issued to the applicant.³

4.7 Mr Ian Frank, Chief Executive Officer of the AMC, informed the Committee of the value of primary source verification observing:

It needs to be understood too that [primary source verification] is not just purely a barrier. We have had cases, for example, of people coming out of China where there have been problems with their documents. Because we have access to the verification services, we were able to pursue it back into China and get verification from other sources in China that this person was a legitimate medical practitioner. So it is not just something that sort of stops people going forward; it can actually be used to verify or

1 Australian Medical Council (AMC), *Submission No 42*, p 2. The *Health Practitioner Regulation National Law Act 2009*, originally enacted in Queensland, implemented an agreement reached by COAG to construct a national accreditation scheme for medical practitioners. Similar legislation has been enacted in all states and territories of Australia, under varying names.

2 AMC, *Submission No 42*, p 2. For further information on the AMC assessment process, see Chapter 3 of this report.

3 Section 80(1)(ii), *Health Practitioner Regulation National Law Act 2009* (Qld).

confirm something that might not be readily available to, say, the regulatory authorities in Australia. So it is a very positive process.⁴

4.8 A range of submissions to the Committee, often from IMGs themselves, outlined concerns relating to primary source verification. Largely, these relate to the amount of time taken by the AMC to verify documents, the lack of updates provided to IMGs on the progress of their application, and the lack of assistance from the AMC in obtaining primary source verification.⁵

4.9 There is no published standard to inform IMGs of the length of time primary source verification may take. However, the AMC's booklet *Quick Guide to Applying to the Australian Medical Council* states:

EICS [ECFMG International Credentials Service] verification will continue via ECFMG until the candidate's medical school has verified their medical degree. This process may take several months to several years (this is largely determined by the medical school responding to the EICS request – the AMC is unable to contact medical schools to speed this process up).⁶

4.10 Dr Elwin Upton submitted to the Committee that 17 months had elapsed since the date of his applying to the AMC, without primary source verification being received. As at the date of making a submission to this inquiry (6 December 2010), Dr Upton's qualifications had still to be verified. Dr Upton cites an email received from the AMC on 10 February 2010, advising that a request for verification had been made to the institution and the processing time for receiving EICS notification would be approximately 'six to eight weeks'. However, Dr Upton contacted the overseas tertiary institution directly and was told there was no record of any request being received from the AMC.⁷

4.11 Dr Ponraja Thuryrajah highlighted a similar issue. Dr Thuryrajah practised medicine in Western Australia from 2004-2007 on Provisional Registration. In 2008, changes in registration procedures required the AMC to get primary source verification of Dr Thuryrajah's qualifications from the University of Kashmir. Dr Thuryrajah has encountered a number

4 Mr Ian Frank, Australian Medical C, *Official Committee Hansard*, Canberra, 19 August 2011, p 2.

5 Dr Elwin Upton, *Submission No 2*, p 2; Dr Ponraja Thuryrajah, *Submission No 102*, p 2; Dr Susan Douglas, *Submission No 111*, p 8.

6 AMC, *Quick Guide to Applying to the Australian Medical Council*, p 22, <<http://www.amc.org.au/images/publications/applying-to-the-amc.pdf>> viewed 26 January 2012.

7 Dr Elwin Upton, *Submission No 2*, p 2.

of difficulties in obtaining verification since that time.⁸ After some initial delays in the process, Dr Thuryrajah told the Committee:

I decided to focus my energies on expediting communication between the University of Kashmir and the AMC by contacting the University directly. I did contact the University via telephone, and was informed that the University had been subjected to an arson attack circa 1983, and all records of students graduating prior to that year had been destroyed.⁹

4.12 The University of Kashmir requested that Dr Thuryrajah post the original qualification to them so that it could be verified by the institution. However, Dr Thuryrajah was reluctant to post original documentation due to difficulties with the postal service. The offer to send a certified true copy was declined by the institution. Dr Thuryrajah argues that a lack of flexibility associated with the primary source verification requirement has led to three years passing without resolution of this issue. He has been unable to practice since that time.¹⁰

4.13 The AMC advised that of the 6 014 applications received for primary source verification in 2010, 5 642 sets of qualifications were sent to the ECFMG but only 2 862 verifications were received.¹¹ The AMC reported that:

The most common cause of delays in processing verification is the failure of the issuing University or institution to respond to the request for verification. In some instances it appears that additional payments or inducements are sought by officers of the institutions involved to complete the verification process.¹²

4.14 The AMC has developed a list of overseas institutions that have not responded to requests for primary source verification or that have been particularly slow to respond in the past. On the AMC's website, IMGs are encouraged to review the list to identify whether the institution where they received their qualifications is likely to delay or fail to respond to any requests to verify their qualifications.¹³ The AMC states:

8 Dr Ponraja Thuryrajah, *Submission No 102*, p 2.

9 Dr Ponraja Thuryrajah, *Submission No 102*, p 3.

10 Dr Ponraja Thuryrajah, *Submission No 102*, p 3.

11 AMC, *Submission No 42*, p 9.

12 AMC, *Submission No 42.2*, p 4.

13 AMC, Primary source verification, *Overseas institutions with a high percentage of outstanding EICS requests*, <<http://www.amc.org.au/images/info/institutions-with-high-percentage-of-outstanding-EICS-requests.pdf>> viewed 3 February 2013.

If an IMG is able to identify their overseas medical training institution in the list provided by the AMC, we recommend that they contact the institution to confirm that the institution will respond to the EICS verification request through the agreed processes between the AMC, the ECFMG and the relevant overseas institution.¹⁴

- 4.15 The AMC has also attempted to rectify some of the issues with respect to primary source verification, including assisting IMGs who have successfully completed all other stages of the registration pathway, excepting the primary source verification process. The AMC submitted that it has identified a group of candidates who have met all requirements for the award of the AMC Certificate but are still waiting for primary source verification. The AMC stated that at the commencement of 2011, 70 individuals were in this position, however this number had reduced to 47 individuals from 15 countries following additional efforts by the ECFMG to expedite the verification the outstanding qualifications.¹⁵
- 4.16 Mr Frank expanded further on the AMC's efforts to rectify delays occurring in the verification process for candidates who have completed the assessment process excepting primary source verification, saying:

We have had some discussions at the Medical Board of Australia to see whether there are ways in which we might be able to deal with those people without holding them up unnecessarily.¹⁶

Committee comment

- 4.17 The Committee understands that there is a range of factors that may prevent the timely processing of applications for primary source verification. These factors include whether the applicant's overseas medical school is recognised by the ECFMC, the completeness of the applicant's documentation (including whether correct witnessing requirements have been met) and whether the issuing institutions themselves respond to requests from the ECFMC.
- 4.18 The Committee notes the AMC's evidence that much of the delay in primary source verification may be sourced to the verification processes of the ECFMG. The Committee acknowledges that the AMC has made substantial efforts to assist candidates to have their qualifications verified through the ECFMG process. In particular, the Committee supports the

14 AMC, *Submission No 42.2*, pp 4-5.

15 AMC, *Submission No 42.2*, pp 4-5.

16 Mr Ian Frank, AMC, *Official Committee Hansard*, Canberra, 19 August 2011, pp 4-5.

AMC continuing efforts to assist IMGs who have passed all other components of the registration pathway but have been unable to achieve primary source verification.

- 4.19 It is evident to the Committee that a large source of frustration for IMGs is the lack of follow-up or communication from the AMC in relation to the progress of primary source verification, and their inability to take steps to rectify any difficulties. The Committee recommends that the AMC and MBA consider what further assistance might be provided to IMGs seeking to verify their qualifications, including the provision of regular updates on the progress of primary source verification, and an anticipated timeframe for the outcome of the process.
- 4.20 Further, the Committee proposes that the AMC and MBA in consultation with IMGs take steps to assist IMGs who have encountered obstacles to achieving verification which are beyond their control, such as circumstances regarding an institution's ability or willingness to provide primary source verification.

Recommendation 1

- 4.21 **The Committee recommends that the Australian Medical Council (AMC), in consultation with the Medical Board of Australia and international medical graduates (IMGs), take steps to assist IMGs experiencing difficulties and delays with primary source verification, including but not limited to:**
- **continuing to assist IMGs who have passed all requirements of a pathway towards registration as a medical practitioner, excepting primary source verification;**
 - **liaising with the Educational Commission for Foreign Medical Graduates to ascertain and address any barriers to achieving timely primary source verification; and**
 - **providing IMGs with up-to-date information relevant to their application, including the anticipated timeframe for response based on their application, or options on how they might hasten the process, such as contacting the institution directly.**

Competent Authority Pathway

4.22 IMGs seeking non-specialist registration who have completed examinations or accreditation in the UK, Canada, United States, New Zealand or Ireland may seek General Registration through the Competent Authority Pathway. To be eligible for this pathway, IMGs are required to have completed all licensing requirements of the relevant Competent Authority's accrediting body and a minimum specified period of post-examination practise in the relevant Competent Authority country.¹⁷ The AMC submitted to the Committee:

The CA (Competent Authority) model recognises that there are a number of established international screening examinations for the purposes of medical licensure that represent a 'competent' assessment of applied medical knowledge and basic clinical skills to a standard consistent with that of the AMC examination for non-specialist registration.¹⁸

4.23 Once recognition under this pathway is granted, IMGs are awarded 'advanced standing' towards the AMC Certificate. IMGs with advanced standing can apply for Provisional or Limited Registration and must undertake a 12 months period of peer reviewed supervision in a designated position prior to being eligible to apply for General Registration. The AMC told the Committee:

Despite getting some occasional bad press it has probably been one of the most successful things we have been able to implement in Australia and it certainly led to us attracting some fairly high quality people into this country.¹⁹

4.24 The main advantage of the Competent Authority pathway is that it provides candidates with the ability to expedite their journey towards General Registration.

Competent Authority recognition

4.25 Evidence provided to the inquiry notes that there are other countries (particularly those in Western Europe) in addition to those currently deemed to be Competent Authority countries, which also have very high standards of medical education and training.

17 See also: AMC, *Submission No 42*, pp 9-10.

18 AMC, *Submission No 42*, p 9.

19 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 7.

4.26 The Western NSW Local Health Network told the Committee that consideration should be given to extending the number of countries deemed to be Competent Authority countries, saying:

Several European countries, such as Germany and the Netherlands, appear to produce doctors who are as well-trained as the recognised competent authority nations, however, they enjoy no preference over countries whose training systems are viewed less favourably. It may be that blanket acceptance of medical practitioners from additional countries is not possible due to differences in the approach to some specialities. It could, however, be appropriate to recognise those specialities that do have equivalence to avoid unnecessary assessment and supervision requirements (all of which consume Health System resources and may deter suitable applicants).²⁰

4.27 Further, some submissions to the inquiry suggested that the Competent Authority model is discriminatory.²¹ For example, Dr Dennis Gonzaga notes:

The Competent Authority Pathway gave rise to a query of what[’s] so special about doctors trained in the USA, UK, Canada and NZ? Isn’t [it] that medical knowledge is a universal thing, regardless of language, colour, country status, the biochemical principles, human anatomical landmarks, mode of action of medications, types of bacteria and viruses, etc. are all the same wherever you are on Earth ... Therefore there shouldn’t have boundaries in categorising and assessing competency of an IMG regardless of country of origin.²²

4.28 Dr Johannes Wenzel also submitted:

For decades the medical system has maintained a two-tier culture where OTDs are treated inferiorly to their Australian trained counterparts ... This dilemma has not been helped by AMC introducing the ‘competent authority’ pathway, psychologically perceived by majority of OTDs from the other countries that they are INCOMPETENT!²³

4.29 In contrast to these arguments, the Committee also received evidence suggesting that increasing the number of Competent Authority countries

20 Western NSW Local Health Network, *Submission No 49*, p 7.

21 See for example: Dr Jonathan Levy, *Submission No 34*, p 7.

22 Dr Dennis Gonzaga, *Submission No 35*, p 2.

23 Dr Johannes Wenzel, *Submission No 68*, p 7.

is neither feasible nor appropriate. Outlining the reasons for limiting the number of Competent Authority countries, the AMC noted that the diversity of medical training conducted around the world has implications on an IMG's ability to integrate into the Australian health system:

There is considerable diversity in the format, content and methodology of medical training across these courses. Equally, there are significant variations in:

- The clinical context of medical practice, including the burden of disease, levels of technology and the delivery of health services.
- Professional ethics, including non-discriminatory treatment and the rights of all patients.
- The educational context, including principles, systems and delivery of medical education.²⁴

4.30 The AMC submitted further:

In the case of the Competent Authority applicants, the fact that they had already completed formally recognised licensing examinations, that were rigorous and detailed assessments of medical knowledge and clinical skills, meant that their entry to the medical workforce in Australia could be fast-tracked with confidence.²⁵

4.31 The AMC advised that it is reviewing international examinations and medical schools and courses that lead to registration for the purpose of accrediting those that meet set criteria as 'Competent Authorities'.²⁶

Committee comment

4.32 The Committee notes the AMC's comments that any reduction in rigour or completeness of assessment of IMGs would need to be balanced by a corresponding increase in the monitoring of IMGs in a clinical setting.²⁷ The Committee understands that entry into the Competent Authority list is based soundly on the similarity between the examination processes of Competent Authority countries to those in Australia, taking into account relevant factors such as the assessment of medical knowledge and basic clinical skills. The Committee is satisfied that the AMC is the appropriate agency to assess whether it is feasible to extend the list of countries that are deemed to be Competent Authorities.

24 AMC, *Submission No 42*, p 17.

25 AMC, *Submission No 42*, p 21.

26 AMC, *Submission No 42*, pp 33-34.

27 AMC, *Submission No 42*, p 21.

- 4.33 The Committee is of the view that the AMC has taken a cautious approach in limiting the ability of IMGs to 'fast-track' the assessment process to those IMGs who have qualifications from a country whose assessment process is comparable to Australia. Such caution ensures that IMGs being assessed under this pathway have the best opportunity possible to integrate into the Australian health system, while also ensuring that the high standards and rigour of assessment and registration as a medical practitioner in Australia is maintained.
- 4.34 Accordingly, the Committee supports the AMC's view that the list of Competent Authority countries should not be extended to include countries which do not have comparable assessment regime, as this has implications for the overall safety and standards of the health system in Australia.
- 4.35 Notwithstanding this view, the Committee is also supportive of the AMC undertaking a review of international examinations and assessment processes to determine whether any other countries should be added to the list of Competent Authorities, on the basis of comparability of medical education and assessment standards. The AMC should be proactive in undertaking visits to enquire into examination and assessment processes of selected countries in order to expedite the outcomes of this review.

Standard Pathway (2-part assessment)

- 4.36 IMGs who do not hold qualifications from a Competent Authority country and who are not seeking registration as a specialist must follow the Standard Pathway of assessment through the AMC. Assessment under the Standard Pathway consists of two components – the AMC Multiple Choice Question (AMC MCQ) examination and the AMC Structured Clinical Examination (SCE). If a candidate successfully completes both components of this process, the IMG will be awarded an AMC Certificate which enables the holder to apply for registration through the MBA.

Part 1 – Multiple Choice Question examination

- 4.37 The AMC advised that there has been a steady increase in demand for the AMC MCQ examination over the past 5 years, rising from 1,509 candidates in 2005/2006 to 4,466 in 2009/2010.²⁸ The AMC said of the MCQ examination:

28 AMC, *Submission No 42*, p 11.

The pattern of passing shows that there is a significant fall-off in the pass rates after two attempts at the MCQ examination with 66.77% of candidates who pass doing so at their first attempt, 19.69% at their second attempt, 7.2% at their third attempt and 6.2% at their fourth or subsequent attempt. The data for 2010, which is consistent with previous years, shows that the majority of candidates who will pass the MCQ examination (84.54%) will do so within two attempts and that the pass rates flatten out after two attempts.²⁹

Part 2 – Structured Clinical Examination (SCE)

- 4.38 The AMC SCE assesses clinical skills through the use of clinical stations. Concerns raised throughout this inquiry regarding the SCE include issues regarding demand for places, how the assessment is administered and concerns regarding the increasing demand for the examination.

Supply and demand

- 4.39 The AMC submitted to the Committee that the demand for SCE places now exceeds supply, increasing from 887 candidates in 2005/2006 to 1,258 in 2009/2010.³⁰ The increased number of IMGs successfully completing the MCQ has resulted in an increased demand for the SCE. According to the AMC, the challenge of meeting this increased demand is affected by the availability of appropriately qualified clinical assessors, venues and persons to act in either role playing or patient capacities.³¹
- 4.40 Commenting on waiting times to sit the SCE, Dr Wenzel noted:
- After passing the AMC MCQ examination, the average wait for a position in the clinical AMC examination is 18 (!) months which exacerbates doctors' 'time out of clinical work'. There are no explanations why some IMGs have to wait much longer than 18 months!!! It gets worse for OTDs who fail in their first attempt, they face a wait of about 22 months, in some cases even up to 3 years! The situation is compounded by the AMC conducting unlimited MCQ examinations locally and overseas at a time where they cannot provide AMC clinical examination positions within a reasonable time!³²

29 AMC, *Submission No 42*, p 11.

30 AMC, *Submission No 42*, pp 11-12.

31 AMC, *Submission No 42*, p 12.

32 Dr Johannes Wenzel, *Submission No 68*, p 2.

- 4.41 Similarly the Government of Western Australia Department of Health noted:

There is currently an 18-24 month delay for applicants seeking to sit this exam. There have been steady increases in the number of exam places and variety of sites these tests are held, but high rates of failure indicate IMGs are not well supported to pass this exam on the first attempt. Each attempt requires progressing through the 'wait' period and additional financial imposts.³³

- 4.42 The Committee has heard concerns regarding access to the SCE from a number of IMGs and organisations.³⁴ These concerns not only evidence delays in the SCE process, but also the personal consequences resulting from a failure to complete the process. For example, Dr Chaitanya Kotapati states:

The current delay for AMC clinical examination is not only causing delay in the progress of the training of the overseas doctors but also is contributing to tremendous stress in their personal lives as they are under constant pressure to meet the requirements of AHPRA (Australia Health Practitioners Regulatory Agency) in order to maintain conditional registration.³⁵

- 4.43 In relation to the AMC's capacity to address this demand Mr Frank of the AMC told the Committee:

We know for example that even now with our current clinical examination we are running 22 series of examinations a year. That is one set of clinical examinations every two-and-a-half weeks through the year. ... Now there are up to three venues, three cities, we are running it in. That is probably the maximum capacity of that system to be able to work.³⁶

- 4.44 In terms of addressing wait times for the SCE Mr Frank added:

... one of the things we are looking at is outsourcing part of the clinical examination to universities to see if we can use their facilities and their people outside of the weekends, because at the

33 Government of Western Australia (WA) Department of Health, *Submission No 82*, p 7.

34 See for example: Dr Sunayana Das, *Official Committee Hansard*, 10 March 2011, pp 23-24; Mr Kevin Gillespie, *Submission No 157*, p 2; Government of WA Department of Health, *Submission No 82*, p 4.

35 Dr Chaitanya Kotapati, *Submission No 21*, p 2.

36 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 9.

moment we can only use the weekend facilities because that is when the hospital facilities are available to us ...³⁷

4.45 In addition, in an attempt to balance supply and demand, the AMC advised that it had developed a system which determines a list of priority for SCE places. The priority list aims to distribute the number of available SCE places in an equitable way. Under the priority system first-time applicants are accorded priority over those who have previously attempted the examination.³⁸ However, the Committee was advised that one-third of all SCE places are reserved for repeat candidates, Mr Frank noting that if only first attempt candidates were selected, repeat candidates would not have the opportunity to re-attempt the examination.³⁹

4.46 Mr Frank told the Committee of the current waiting list for the SCE:

Ideally we like to get everybody into an exam within 12 months of qualifying for a clinical examination. In practical terms it is closer to 18 months, two years now. For repeat-attempt candidates we give priority to people with fewer attempts over people with more attempts. The reason for that ... the data shows that they just flatline out and do not get through.⁴⁰

4.47 The AMC also told the Committee about a 'standby list' that it has to ensure that all available SCE places are filled, explaining:

... we also have what is called a standby list and on merit order the next group of candidates down from the ones that have been allocated – so if you have got 250 places allocated – we take another 100 places and we contact the people and say, 'Do you wish to be placed on a standby list in the event that somebody declines one of the places that has been allocated?' If they say yes, we put them on that list and we treat them in merit order. So if a vacancy becomes available – often at the last minute – then we contact those people and say, 'There is a place available. Do you wish to take it?'⁴¹

4.48 However, Dr Paramban Rateesh made the following observation of his experience of being called from the standby list to take the SCE:

37 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 17.

38 AMC, Clinical examination scheduling process, <<http://www.amc.org.au/index.php/ass/clinex/clinex-sched>> viewed 3 February 2012.

39 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 15.

40 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 15.

41 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 13.

... all the times I have failed [the SCE] I have been called from the [standby] list when I was already told no because the last person has dropped out and they wanted that money to come back to them. I am getting a phone call on a Friday saying ... 'Are you ready to take up the exam for the coming Saturday?' The condition is that if I said no then I would go to the bottom of list, then I would have to climb a mountain to get back up.⁴²

Committee comment

- 4.49 The Committee notes statistics provided by the AMC show that a high percentage of candidates pass the AMC MCQ examination within two attempts, while candidates who attempt the examination on more than two occasions find it extremely difficult to pass. As the AMC MCQ is a computer based assessment, the Committee understands that it can be readily accessed by IMGs, and can be taken by applicants who are not based in Australia. The Committee understands that the AMC MCQ is an important screening tool, providing an initial assessment of IMGs clinical knowledge prior to successful applicants progressing to the next stage of the AMC assessment, the SCE.
- 4.50 In contrast, the Committee perceives that there is a need to increase the availability of places for the SCE. However, it also understands that the resources available to increase the capacity of the SCE are finite. In this circumstance, the Committee is pleased that the AMC is undertaking a number of initiatives to deal more effectively with the demand by establishing prioritisation mechanisms, including prioritisation and standby lists, to maximise the equitable allocation of places and ensure that the available capacity is utilised.
- 4.51 In addition, the Committee encourages the AMC to continue exploring the full range of options available to increase the availability of SCE places, such as outsourcing to universities. To this end, the Committee recommends that the AMC examine options for increasing the availability of the AMC SCE for the benefit of IMGs.
- 4.52 Amid concerns that many IMGs are required to wait for up to two years for the opportunity to undertake the AMC SCE, the Committee believes that additional examination places must ensure that IMGs can undertake examination within a reasonable timeframe. The Committee appreciates the AMC's contention that an ideal scenario for IMGs attempting the AMC SCE for the first time should be accommodated within 12 months.
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42 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 39.

However, the Committee considers that a six month period would be more appropriate. As foreshadowed in Chapter 1, the Committee intends to review progress made in relation to the report's recommendations at a later date. The adequacy and feasibility of this timeframe will be considered in consultation with the AMC and IMGs at that time.

Recommendation 2

4.53 **The Committee recommends that the Australian Medical Council take action to increase the availability of the Australian Medical Council Structured Clinical Examination (SCE) so that those making a first attempt at the examination be accommodated within six months of their initial application.**

4.54 It is evident to the Committee that the scheduling priorities and the standby list used to allocate places for the SCE are not well understood by IMGs, and as such causes confusion and frustration. This is particularly the case for IMGs who are repeat candidates with lower priority, who are likely therefore to experience even longer waiting times. The Committee is of the view that the AMC should alleviate this by publishing detailed information on its website in relation to the allocation of places, and the current anticipated waiting times for undertaking the SCE.

Recommendation 3

4.55 **The Committee recommends that the Australian Medical Council publish detailed information on its website outlining the processes for determining the allocation of places for the Structured Clinical Examination (SCE). The information should explain prioritisation, the purpose and operation of the standby list and provide up-to-date information on waiting times for undertaking the SCE.**

4.56 The Committee notes that the AMC is prioritising first-time candidates who attempt the SCE over those who are repeat candidates. The Committee is of the view that a further step towards reducing the demand for the SCE would be to identify the difficulties that repeat candidates

have encountered and consider whether further support might be offered to those candidates. This issue is considered in more detail below.

Provision of feedback

4.57 Another concern raised in evidence relates to feedback received in relation to the SCE. IMGs in particular have expressed their frustration to the Committee about the lack of feedback provided to them once they have been advised that they have failed a component or components of the SCE.

4.58 The AMC's website advises that the overall result for each of the 16 marked 'stations' of the SCE are recorded as a pass or fail mark only. Candidates are graded as a clear pass, marginal performance or clear fail.⁴³ In his submission to the inquiry, Dr Wenzel criticised the lack of SCE feedback, observing:

The AMC clinical examination does not entail constructive feedback for candidates who fail a station. No other university or college restricts examination results to a simple pass/fail and provides feedback in [the] form of a global tick box approach which does not relate to individual stations.⁴⁴

4.59 Having failed on three occasions to pass the SCE, Dr Rateesh noted that in the absence of constructive and specific feedback he was not able to determine precisely why he had failed and seek to improve on any deficiencies.⁴⁵

Committee comment

4.60 The Committee is concerned that feedback for candidates attempting the SCE is limited to whether the candidate passed or failed a particular station. This leaves candidates unaware of any shortcomings in their knowledge and unable to take steps to rectify these shortcomings. As the provision of constructive feedback is crucial to assisting IMGs to advance to registration the Committee believes this situation should be rectified.

43 AMC, Clinical examination performance requirements, <<http://www.amc.org.au/index.php/ass/clinex/clinex-perform>> viewed 3 February 2012.

44 Dr Johannes Wenzel, *Submission No 68*, p 2.

45 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 39.

Recommendation 4

- 4.61 **The Committee recommends that the Australian Medical Council provides a detailed level of constructive written feedback for candidates who have undertaken the Australian Medical Council's Structured Clinical Examination.**

Targeted level of AMC examinations

- 4.62 The Committee has heard that some IMGs are dissatisfied with the competence level targeted by the AMC through the MCQ and SCE examinations. The AMC's website states:
- 4.63 The examinations are set at the level of attainment of medical knowledge, clinical skills and attitudes required of newly qualified graduates of Australian medical schools who are about to begin intern training.⁴⁶
- 4.64 Dr Michael Cleary, giving evidence to the Committee on behalf of Queensland Health, compared the AMC examinations to the final examinations provided to medical students in Australia, saying:

The AMC exam is in two parts: a clinical component and a multi-choice component. In lay terms, the examinations are meant to be equivalent to a sixth-year medical student, so someone who has graduated from university in Australia who has the knowledge, skills and abilities to be able to practise medicine as a junior doctor.⁴⁷

- 4.65 Dr Cleary also told the Committee:

The clinical examination requires you to have an understanding of the healthcare system as well as an understanding of medical practice. It is very difficult—I would say it would be extraordinarily difficult—to pass that exam from overseas without having practised in Australia, so generally people come and practise in Australia.⁴⁸

46 AMC, AMC examinations (Standard Pathway), <http://www.amc.org.au/index.php/ass/apo/sp/exams>, viewed 3 February 2012.

47 Dr Michael Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 8.

48 Dr Michael Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 8.

- 4.66 Dr Susan Douglas, representing the Australian Doctors Trained Overseas Association (ADTOA), told the Committee:

The nature of that test is that it actually is a proxy for someone who is just getting out of medical school. The evidence clearly shows that the type of knowledge an experienced clinician has, like an IMG, is very different from an AMC entry test ...⁴⁹

- 4.67 Similarly, Dr Viney Joshi also representing ADTOA, told the Committee:

The AMC exam is by no means a test of an individual's ability to safely practise medicine. We are looking at people in their 40s ... It is well known among people who are involved in adult education that when people in their 40s or 50s have been in a particular stream of a profession for 15 or 20 years, they lose the academic ability. I think the assessments should be more pointed towards their safety in their chosen field of expertise. For example, for an ophthalmologist, there should be a peer review process to see whether he is safe as an ophthalmologist – not that he is asked to go and sit the AMC exam, which has directed questions on obstetrics and gynaecology, which this man may have studied 22 or 25 years ago. He will never pass that exam.⁵⁰

Committee comment

- 4.68 The Committee understands that the AMC examinations are targeted at the level of an Australian medical graduate and is aimed at testing an IMG's basic medical knowledge and knowledge of the Australian medical system. As the examinations do not seek to assess knowledge beyond that which is required of a new medical graduate, the Committee is of the view that the examination achieves its desired outcome and places IMGs seeking employment in Australia on an equal playing-field as Australian-trained graduates.
- 4.69 The Committee understands that there are a number of IMGs, particularly those who completed their basic medical education some time ago, who feel disadvantaged by this assessment mechanism. The alternative assessment process offered through workplace-based assessment (discussed below) should alleviate these concerns for some IMGs. The Committee considers, however, that the examinations should be retained in their current format, as the assessment appropriately establishes the

49 Dr Susan Douglas, *Official Committee Hansard*, Canberra, 25 February 2011, p 48.

50 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, pp 15-16.

foundation of medical knowledge which is expected of all practitioners seeking employment in Australia.

Standard Pathway (Workplace-based assessment)

- 4.70 IMGs choosing the Standard Pathway of assessment may choose an alternative to the SCE, this being the workplace-based assessment model (WBA). A candidate for WBA must pass the AMC MCQ and must also comply with a number of other conditions regarding their English language proficiency and employment.
- 4.71 Although the WBA alternative pathway was included in the 2007 COAG IMG Assessment Initiative proposals⁵¹, it was not endorsed by all Australian jurisdictions and is therefore limited to four sites nationally, being:
- Hunter New England Area Health Service (New South Wales);
 - Rural and Outer Metropolitan United Alliance (Victoria);
 - Launceston General Hospital (Tasmania);
 - Western Australia Health:
 - ⇒ Bunbury Hospital;
 - ⇒ Hollywood Private Hospital and Joondalup Health Campus.⁵²
- 4.72 The Committee has received evidence regarding the effectiveness of this program, as well as evidence advocating for this pathway to be expanded and made available on a national scale for the benefit of all IMGs.

Effectiveness of the workplace-based assessment model

- 4.73 Mr Frank, representing the AMC, told the Committee that the SCE is a valid form of testing as it provides a three-hour snapshot of an IMG's clinical performance across a range of disciplines.⁵³ However, Mr Frank noted that assessing somebody in a workplace setting over a longer period of time is the ideal, stating:

... being able to assess somebody over a period of time in a workplace setting ... is a far more effective way of testing people, and that is one of the reasons why the AMC was a strong advocate for getting workplace based assessment implemented.⁵⁴

51 AMC, *Submission No 42*, p 6.

52 AMC, *Submission No 42*, p 13.

53 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 8.

54 Mr Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 8.

4.74 The AMC submission includes the following observations on WBA:

This model offers a number of advantages over the AMC clinical examination pathway:

- The assessments are undertaken over time, providing a much more reliable and accurate evaluation of the clinical skills of the IMG.
- The IMG is assessed in terms of his or her 'performance' rather than 'competence' alone. In other words, they are assessed in relation to how they actually perform in a clinical setting rather than measuring their capabilities in an artificial examination setting.
- The assessment includes feedback on performance which assists in addressing performance problems and issues, a function that is not available in the AMC clinical examination, unless these can be linked to bridging programs.
- The IMGs are employed and are better able to offset the cost of their assessments.⁵⁵

4.75 Other evidence to the inquiry was generally supportive of WBA as a credible alternative assessment to the AMC SCE.⁵⁶ Ms Marita Cowie, Chief Executive Officer of the Australian College of Rural and Remote Medicine (ACRRM), told the Committee that ACRRM has received seed funding from the Australian Government Department of Health and Ageing (DoHA) to trial a new WBA program which will also provide an alternative to the AMC SCE for IMGs. Ms Cowie told the Committee that ACRRM is hoping that the WBA program will allow candidates working in general practice roles to obtain General Registration more efficiently than the current clinical examination system.⁵⁷

4.76 Concerns expressed in evidence primarily related to the limited availability of WBA places, issues associated with ensuring the quality and independence of WBA review, and the resource implications associated with implementing and participating in WBA.⁵⁸

55 AMC, *Submission No 42*, p 28.

56 See for example: Dr Chaitanya Kotapati, *Official Committee Hansard*, Brisbane, 10 March 2011, p 21; Professor Kichu Nair, *Submission No 162*, p 2; Dr David Thurley, General Practice Network Northern Territory, *Official Committee Hansard*, Darwin, 30 January 2012, p 8; Dr Helmut Schoengen, *Submission No 150*, p 2.

57 ACCRM, *Submission No 103*, p 14; Ms Marita Cowie, Australian College of Rural and Remote Medicine, *Official Committee Hansard*, Brisbane, 10 March 2011, p 55. See also: DoHA, *Submission No 84*, p 15.

58 See for example: AMC, *Submission No 42*, p 28; Government of WA Department of Health, *Submission No 82*, p 5, 11; Dr Alasdair MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 18.

Committee comment

- 4.77 Based on evidence to the inquiry the Committee understands that WBA model provides a useful and effective method of clinical assessment. As such it offers a credible alternative assessment pathway to the AMC SCE. The Committee is encouraged by the positive feedback in relation to WBA provided during the inquiry by representatives from a number of host sites that are currently offering this model of assessment. The Committee was impressed by the success of the award winning WBA program run by Hunter New England Health⁵⁹, noting that in a little over 12 months 49 IMGs had successfully progressed through the assessment and another 19 were expected to complete the program in the near future.⁶⁰ Similarly high rates of success were reported for IMGs undertaking WBA through Launceston General Hospital.⁶¹ The Committee considers that these programs provide good examples of WBA program best practice and is encouraged to note that with support from DoHA, ACRRM is in the process of implementing a pilot WBA to operate in general practice settings.
- 4.78 In view of the AMC's advocacy of WBA, and the positive feedback on the model from those sites currently supporting this type of assessment, it is unclear to the Committee why this model it is not offered more widely around Australia. In Chapter 3 the Committee has already noted information provided by the AMC indicating that although WBA was included in the original 2007 COAG IMG Assessment Initiative proposals, this form of assessment was not endorsed and signed off by all Australian jurisdictions at that time. According to the AMC this resulted in delays in implementing WBA at a national level.⁶²
- 4.79 The Committee concludes that the limited endorsement of WBA by jurisdictions as part of the 2007 COAG IMG Assessment Initiative proposals, combined with other constraints such as the availability of financial, human and administrative resources needed to support WBA may have contributed to the relatively small number of sites available to host this assessment pathway. Although understandable, concerns

59 Hunter New England Health received the following awards for its workplace-based assessment program: 2011 Premier's Public Sector Award for 'Innovation in front-line delivery'; 2011 Ministry of Health Award; 2011 NSW Ministry of Health Director Generals Innovation Award; 2011 Hunter New England Health Quality Award for 'Building the HealthWorkforce'.

60 Mrs Julie Wein, *Official Committee Hansard*, 27 September 2011, Newcastle, p 3.

61 Dr Beth Mulligan, Director of Clinical Training; Chair IMG Subcommittee, Department of Health and Human Services, *Official Committee Hansard*, 14 November 2011, Launceston, p 12.

62 AMC, *Submission No 42*, pp 12-13.

regarding the resource implications of hosting WBA may need to be balanced with consideration of the benefits deriving from the additional clinical services offered by the IMGs who are undertaking WBA.

- 4.80 Given the evident success of WBA and widespread support for this form of assessment, the Committee believes that action should be taken to increase access to WBA for IMGs seeking registration through the Standard Pathway. To achieve this aim, the Committee recommends that COAG's health workforce agenda include consideration of WBA to increase jurisdictional endorsement of this pathway and increase availability nationally.

Recommendation 5

- 4.81 **The Committee recommends that the Council of Australian Governments include workplace-based assessment (WBA) pathway for international medical graduates on its health workforce agenda in order to extend endorsement from state and territory governments and increase the availability of host sites nationally.**
- 4.82 Also, to gauge whether improvements could be made to the current WBA model, the Committee recommends that the AMC commission an independent evaluation of WBA. The evaluation should include a cost-benefit analysis of WBA and encompass the views of all stakeholders including IMGs, clinical assessors and host institution administrators. The outcomes of the evaluation should be made public.

Recommendation 6

- 4.83 **The Committee recommends that the Medical Board of Australia in conjunction with the Australian Medical Council, commission an independent evaluation of the workplace-based assessment (WBA) model. The evaluation should incorporate a cost benefit analysis of WBA, and encompass the views of all stakeholders, including international medical graduates, clinical assessors and host institution administrators. The outcomes of the evaluation should be made public.**

Specialist medical college processes

- 4.84 IMGs who are deemed to be specialists or who have trained as a specialist in their country of origin may pursue one of the pathways towards registration as a specialist medical practitioner in Australia. The AMC and specialist colleges are required to liaise in order to coordinate the assessment and accreditation processes for IMGs seeking specialist recognition.

Assessing level of comparability

- 4.85 Assessment of an IMG's claims for Specialist Registration is conducted by one of Australia's sixteen specialist medical colleges, and leads to a determination of the IMG's level of comparability as 'substantially comparable', 'partially comparable' or 'not comparable'. The outcome of this assessment will impact on the length of time an IMG is required to undergo supervised practise under peer review, and whether there are additional requirements to be met (e.g. college examinations).
- 4.86 Although the specifics of specialist medical college assessments vary, evidence concerning these processes identified common issues of general concern. These issues relate primarily to the transparency and fairness of specialist medical college assessment processes.
- 4.87 An overview of the specialist medical college assessment processes is provided in Chapter 3 of the report. In brief however, assessing the level of comparability usually involves the relevant college in the first instance reviewing documents as verified by the AMC which detail qualifications, skills and experience gained by overseas trained specialists.
- 4.88 Applicants are also required to submit an application for assessment to the relevant specialist college. Further assessment usually involves interview with applicants to determine an IMG's level of comparability to the standard expected of an Australian-trained medical specialist. Assessors for this process are generally chosen from the Fellowship of the relevant college.⁶³
- 4.89 The Royal Australian and New Zealand College of Radiologists (RANZCR) explained in its submission that:

The interview is a structured and thorough process that provides an opportunity for the panel to:

63 See for example: Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission No 45*, p 3.

- explain the assessment process;
- clarify the applicant's training and experience;
- determine the applicant's suitability for practice in Australia.

It is an opportunity for the applicant to:

- detail and explain previous training and working experience.
- ask any questions of the panel about the assessment process.⁶⁴

Distinctions between levels of comparability

4.90 The Committee has heard evidence suggesting that there is some confusion regarding the classification of IMGs level of comparability. Specifically, some members of the IMG community are unsure of the weight accorded to individual aspects of an IMG's prior skills, experience and training.

4.91 In highlighting this issue, the NSW Department of Health suggested that the specialist colleges should develop clear, evidence based criteria by which comparability of training programs can be assessed.⁶⁵ In this regard the Department noted:

The majority of specialist Colleges do not provide a list of qualifications, or guidance on evidence of experience, that they consider to be substantially comparable to Australian qualifications for the benefit of applicants and their potential employers ... This lack of clear information on the criteria to be met makes it difficult for an employer or applicant to easily determine if they will be assessed as partially or substantially comparable at the early stage in an assessment process.⁶⁶

4.92 Alecto Australia Medical Recruitment also noted that it is unclear what overseas qualifications are likely to be considered substantially comparable or otherwise, and submitted:

It would be helpful to provide a listing of the qualifications that are generally deemed to be 'substantially comparable'.⁶⁷

4.93 The submission from Queensland Health also raised concerns regarding criteria for determining comparability, noting:

64 Royal Australian and New Zealand College of Radiologists (RANZCR), *Submission No 43*, p 5.

65 NSW Department of Health, *Submission No 124*, p 3.

66 NSW Department of Health, *Submission No 124*, p 2.

67 Alecto Australia, *Submission No 85*, p 4. See also: South Eastern Local Health Network, *Submission No 16*, p 1.

The definitions of comparability are recognised by all colleges; however each college stipulates extra requirements beyond the comparability definition without clear explanation of the reasons.⁶⁸

- 4.94 The Western NSW Local Health Network raised the issue of consistency of college assessments within, and between colleges, saying:

The approaches to assessment also vary between colleges and some consistency would be useful. Greater transparency would improve the whole assessment system. It would allow health services to better understand college processes and improve recruitment decisions.⁶⁹

- 4.95 The AMC noted that the Joint Standing Committee on Overseas Trained Specialists (JSCOTS), formed by the AMC and Committee of Presidents of Medical Colleges, had examined the issue of assessment comparability with input and support from the colleges. While progress had been made toward achieving a common definitions and understandings of the different comparability levels, the AMC added:

... it appears that there are still some problems with the application of the terminology, including outcome reports of a 'substantially comparable' assessment, but with an additional 24 months oversight (the terminology for 'substantially comparable' makes it very clear that the maximum oversight is 12 months). Some outcome reports have confirmed 'substantially comparable' but with workplace based assessment (of summative nature). Again this is inconsistent with the agreed assessment outcomes. These examples illustrate the need to ensure that processes are monitored and continually updated and confirmed to ensure consistency. This has been a key role for JSCOTS.⁷⁰

Recognition of prior training and experience

- 4.96 Some evidence to the inquiry suggests that not enough weight is afforded to previous medical training and experience that IMGs have gained in their home country when applications for specialist recognition are assessed.
- 4.97 The Committee has been told that where an IMG's prior experience is not given adequate recognition, an IMG can spend significantly longer under peer reviewed supervision, and may be required to demonstrate basic

68 Queensland Health, *Submission No 126*, p 9.

69 Western NSW Local Health Network, *Submission No 49*, p 7.

70 AMC, *Submission No 42*, p 26.

skills and experience which they would argue they have previously gained in their home country. Drs David Wood and David Levitt submitted:

When an OTD has significant experience in a speciality and is actively and successfully progressing towards appropriate registration in that speciality they are required to do a requisite amount of general training at an intern level. This shows a lack of understanding of:

- The experience level of the OTD in this speciality; and
- The experience that this OTD will have had in the basic specialties by exposure in current training at a higher level.⁷¹

4.98 Dr Paramban Rateesh told the Committee that the Royal Australian College of General Practitioners (RACGP) requires that IMGs have a minimum of four years experience before sitting the RACGP exams:

For the Royal Australian College of General Practitioners, I need to be a general practitioner for a minimum of four years, but my 30 years of experience has been counted only as one year and nine months.⁷²

Peer review

4.99 IMGs who are deemed to be ‘substantially’ or ‘partially’ comparable to an Australian-trained specialist may also be required to undertake a period of supervision under peer review, before they are eligible to apply for Fellowship with the relevant specialist medical college. The Royal Australasian College of Physicians (RACP) provided the following evidence in relation to the peer review process:

The purpose of the period of peer review is two-fold. Firstly, it allows the overseas trained doctors the opportunity to be orientated to the Australian health care system and his/her workplace. It also allows practising specialists to interact with the overseas trained doctors in a clinical context to determine if he/she is performing at an appropriate level and to identify any areas of practice that might require improvement prior to fulfilling the requirements for specialist recognition.⁷³

4.100 IMGs assessed as substantially comparable may be required to undertake a period of peer review of up to 12 months, or up to two years for IMGs

71 Dr David Wood and Dr David Levitt, *Submission No 78*, p 1.

72 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 26.

73 Royal Australian College of Physicians (RACP), *Submission No 65*, p 22.

assessed as partially comparable. However the periods vary for individual IMGs as this is determined on a case-by-case basis. In the document *Assessment of Overseas Trained Specialists Guidance for Colleges*, prepared by the JSCOTS, the peer review process for an IMG assessed as substantially comparable is discussed as follows:

The applicant is eligible for registration as a recognised specialist and may apply for fellowship without further examination, but may be required to undertake a period of up to 12 months oversight or practice under peer review by a reviewer appointed through the college assessment unit. This is to ensure that the level of performance is similar to that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access continuing professional development. The length of peer review and nature of assessment is up to the individual college to determine on a case-by-case basis.⁷⁴

- 4.101 For IMGs assessed as partially comparable the same document provides the following guidance on the period of peer review:
- 4.102 In order for a partially comparable applicant to be considered substantially comparable the applicant will be required to undertake a period of up to 24 months of training and assessment' under a supervisor appointed through the college assessment unit, to ensure that the level of performance reaches that of an Australian trained specialist, and to assist with their transition to the Australian health system, provide professional support and help them to access continuing professional development.⁷⁵
- 4.103 The Western NSW Local Health Network submitted to the Committee that the 'probationary' period imposed on some IMGs seeking specialisation accreditation should be tailored to each individual to ensure the period is focussed on that individual's knowledge, experience and skills, stating:

Although there is a careful assessment of the qualifications and experience of overseas trained specialists, there appears to be a blanket approach to the question of probation. In many cases, two years is clearly unnecessary and has led to situations in rural areas

74 AMC, *Submission No 42*, Appendix K: Joint AMC/CPMC Standing Committee on Overseas Trained Specialists - Assessment of Overseas Trained Specialists Guidance for Colleges, p 65.

75 AMC, *Submission No 42*, Appendix K: Joint AMC/CPMC Standing Committee on Overseas Trained Specialists - Assessment of Overseas Trained Specialists Guidance for Colleges, p 68.

where 'probationary' specialists have been leaders in teaching and advising their colleagues.⁷⁶

- 4.104 The NSW Department of Health also noted that it is unclear what implications a period of peer review would have on an IMG's registration status:

Currently there is confusion for both employers and registrants on whether an overseas trained specialist, who is assessed as being substantially comparable but requiring 12 months peer review/ supervision, is eligible for specialist registration or only limited registration.⁷⁷

Committee comment

- 4.105 The Committee understands that college assessment interviews and peer review are vital elements of the assessment of an IMG's qualifications, skills and experience gained overseas for those seeking specialist recognition. However, the evidence provided during the course of the inquiry suggests that there are a number of elements which could be clarified and improved.
- 4.106 The Committee has observed that among IMGs there is confusion about the classification of comparability levels and how they are determined in the context of past skills and experience. To avoid this confusion the Committee encourages the specialist medical colleges to keep IMGs well informed on the definitions for each level of comparability. Specifically, guidelines outlining how particular qualifications might ordinarily be considered by a college determining comparability would be a helpful indicator for IMGs to digest prior to making their application for assessment. For ease of access the Committee recommends that the AMC and specialist medical colleges ensure that the clarified definitions and guidelines are made available on their websites.
- 4.107 The Committee notes the role of the Joint Standing Committee on Overseas Trained Specialists (JSCOTS), as outlined by the Australian Medical Council⁷⁸, in clarifying the definitions of each level of comparability. The Committee supports the continued role of JSCOTS,

76 Western NSW Local Health Network, *Submission No 49*, p 7.

77 NSW Department of Health, *Submission No 124*, p 4.

78 For further information on Joint Standing Committee on Overseas Trained Specialists (JSCOTS), see AMC, *Submission No 42*, pp 24-25.

seeing this as is an important step in ensuring consistency and transparency between colleges.⁷⁹

- 4.108 Another prevalent issue relates to the period of time an IMG is required to spend in supervised practice under peer review following an assessment as 'substantially' or 'partially' comparable. The Committee acknowledges that peer review by individual colleges is an integral component of the pathway towards specialisation. While noting that the period is determined on a case-by-case, it is apparent to the Committee that IMGs are frustrated by the lack of objective guidelines explaining how an individual's qualifications, skills and past experience are used to determine the duration of peer review. The current system of informing IMGs that the period of peer review is 'up to' one or two years is unhelpful and could be further detailed for clarity. The Committee is of the view that the colleges should seek to rectify this situation.

Recommendation 7

- 4.109 **The Committee recommends that the Australian Government Department of Health and Ageing and Australian Medical Council, in consultation with the Joint Standing Committee on Overseas Trained Specialists and the specialist medical colleges:**
- **publish agreed definitions of levels of comparability on their websites, for the information of international medical graduates (IMGs) applying for specialist registration;**
 - **develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are used to determine level of comparability;**
 - **develop and publish objective guidelines clarifying how overseas qualifications, skills and experience are taken into account when determining the length of time an IMG needs to spend under peer review; and**
 - **develop and maintain a public dataset detailing the country of origin of specialist pathway IMGs' professional qualifications and rates of success.**

⁷⁹ AMC, *Submission No 42*, p 26.

Specialist medical college examinations

- 4.110 In addition to interview and peer review, some specialist colleges may require an IMG to undertake the relevant college examinations for their chosen specialisation.⁸⁰ Evidence to the Committee has highlighted a range of issues regarding the requirement for IMGs to sit college examinations which require further investigation.

Competence level of college examinations

- 4.111 Evidence to the Committee suggests that college examinations generally assess IMGs at the level of competence expected of an Australian-trained medical graduate entering the relevant specialist medical college training program. Specifically, IMGs who have acquired significant specialist experience in their home countries have been frustrated by the target level of the college examinations.
- 4.112 Some IMGs have informed the Committee that they have been required to re-learn skills and basic specialist knowledge which they have not utilised in practise since their early training as a specialist overseas. These IMGs have argued that such examinations are inappropriate for overseas trained specialists with years of experience, and do not accurately reflect their level of competence as a specialist in their chosen field.⁸¹
- 4.113 In a joint submission to the inquiry, Associate Professors Michael Steyn and Kersi Taraporewalla, told the Committee:

The level of expertise examined is that of a trainee completing the training program rather than at someone with experience beyond this point.⁸²

- 4.114 Associate Professor Steyn expanded on this point during a public hearing, observing:

My insight to answering a question for an exam was that of a registrar – a trainee. When I answered it is like a trainee, I passed; when I answered it like a specialist, I failed.⁸³

⁸⁰ See for example: RANZCR, *Submission No 43*, p 6; Royal Australian College of Surgeons (RACS), *Submission No 74*, p 3.

⁸¹ Dr Christoph Ahrens, *Submission No 66*, p 2; Dr Michael Galak, *Submission No 31.1*, p 2.

⁸² Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 10.

⁸³ Associate Professor Michael Steyn, *Official Committee Hansard*, Brisbane, 10 March 2011, p 42.

- 4.115 Dr Christoph Ahrens told the Committee that a specialist's knowledge of a chosen field evolves and deepens over time. He noted that during this period, general knowledge which is not directly applicable to the specialist's practice may not be retained. He added:

I am supposed to sit the orthopaedic registrar's examination. This may seem fair at first sight, as all Australian Orthopaedic Surgeons have to sit this exam at the end of their training. It is however an inappropriate assessment tool to assess a senior surgeon. The exam is designed for the purpose to test the knowledge of trainees before they are allowed to work independently. It is unable to test surgical skills or ability of clinical judgement including the very vital judgement of surgeons own's limits.⁸⁴

- 4.116 A South African trained ophthalmologist with over 20 years specialist experience overseas, seeking Specialist Registration in Australia after several years working in an Area of Need (AoN) position, observed:

The college assessment is inappropriate for the age of the specialist: - no other Australian ophthalmologist at my age (50 years old) is required to write the exam, nor are they likely to pass if they did without studying.⁸⁵

- 4.117 The South Australian Government Department of Health also noted:

In some cases, highly qualified specialists from overseas have failed to gain specialist qualifications because of college requirements that they sit a fellowship exam, despite the fact that they work within a specific sub-speciality and will not realistically practice within the full scope of the fellowship.⁸⁶

Committee comment

- 4.118 The Committee understands why many specialist IMGs feel frustrated when they find they are required to complete a graduate-level assessment, particularly when they are practising a sub-specialty within their chosen field, sometimes for many years. The Committee is of the view that specialist medical colleges should consider taking a more targeted approach to the assessment of IMGs who have been deemed substantially

84 Dr Christoph Ahrens, *Submission No 66*, pp 2-3.

85 Name withheld, *Submission No 39*, p 4.

86 South Australian Government Department of Health, *Submission No 96*, p 5. See also: Overseas Trained Specialists Anaesthetists Network (OTSAN), *Submission No 38*, p 2; Dr Frank Quigley, *Submission No 14*, p 1.

or partially comparable to an Australian-trained specialist with an increased focus on WBA and reduced reliance on college examinations.

- 4.119 A more targeted approach should include the ability for IMGs with substantial experience in particular sub-specialities to be assessed on the basis of the skills and experience required for that sub-speciality rather than on facets of the speciality which the IMG is unlikely to utilise during the practise in their chosen sub-speciality. Consideration should be given to an IMG's qualifications, level of experience and skills accumulated during their overseas practise. In particular, it would appear that this type of assessment would be appropriate for IMGs who have attained significant specialist experience in niche sub-specialities.

Recommendation 8

- 4.120 **The Committee recommends that specialist medical colleges adopt the practise of using workplace-based assessment (WBA) during the period of peer review to assess the clinical competence of specialist international medical graduates (IMGs) in cases where applicants can demonstrate that they have accumulated substantial prior specialist experience overseas. As part of the WBA process the specialist medical colleges should make available the criteria used to select WBA assessors.**

Specialist medical college examinations should only be used as an assessment tool where specialist IMGs are recent graduates, or where deficiencies or concerns have been identified during WBA.

- 4.121 The Committee also understands that the Australian Health Workforce Advisory Council (AHWAC) has been commissioned by the Australian Health Workforce Ministerial Council (AHMC) to inquire into and report on the assessment requirements for Fellowship of each of the medical specialist colleges in relation to the recognition of qualifications and management of assessment processes for overseas trained doctors.⁸⁷ The Committee anticipates that this review will include further recommendations for improving specialist college assessment processes for overseas trained specialists seeking Specialist Registration in Australia.

87 IMG Inquiry Recommendation Working Group, *Submission No 168*, p 6.

Reconsideration, review and appeal of college decisions

- 4.122 An IMG seeking recourse following a specialist medical college's decision regarding their application is required to follow the review mechanisms stipulated by that college. From evidence provided to the Committee, it appears that a number of colleges employ a three stage process for appeals.⁸⁸ In the first instance, an IMG may seek review from the original decision makers, usually an internal committee or board of the college.⁸⁹ Where a decision is upheld, an IMG may then seek review from a higher-level committee of the college.⁹⁰ Where such a review is upheld, many specialist medical colleges have the ability to convene a formal Appeals Committee.⁹¹
- 4.123 Generally, an Appeals Committee may only be convened through a decision by the college's Chief Executive Officer, if an IMG has exhausted all other avenues of review.⁹² An Appeals Committee is usually convened with a majority of non-college members.⁹³ With the agreement of the Appeals Committee, an IMG may be entitled to have legal representation present during the appeal.⁹⁴
- 4.124 The Committee's inquiry has taken evidence which highlights a negative perception of the clinical dispute resolution mechanisms available to IMGs seeking specialist accreditation. Dr Chaitanya Kotapati, submitting in a private capacity, told the Committee that there is an urgent need to regulate the appeal processes of the AMC, MBA and specialist medical colleges to improve accountability and transparency.⁹⁵
- 4.125 Dr Anatole Kotlovsky told the Committee that based on unverified information, adverse findings were made by a specialist medical college in relation to his application and he was not aware of any right of appeal:

No opportunity to present my perspective regarding the subsequent adverse decisions against my professional recognition

88 See for example: Royal Australasian College of Physicians (RACP), *Submission No 65*, p 23; Royal Australian College of General Practitioners, <<http://www.racgp.org.au/Content/NavigationMenu/educationandtraining/Assessment/Assessmentpolicies/AppealsPolicy.pdf>> viewed 3 February 2012.

89 RACS, Policy, <http://www.surgeons.org/media/55600/pol_2011-06-02_appeals_mechanism_v3.pdf> viewed 3 February 2012.

90 RACP, *Submission No 65*, p 23.

91 Australian and New Zealand College of Anaesthetists (ANZCA), *Submission No 87*, p 11.

92 ANZCA, *Submission No 87*, p 11.

93 RANZCOG, *Submission No 45*, p 7.

94 RACP, *Submission No 65.1*, p 1.

95 Dr Chaitanya Kotapati, *Submission No 21.1*, p 4.

or advice of my right to appeal these decisions was ever provided to me.⁹⁶

4.126 Another IMG, who wished to remain anonymous, stated:

I submitted an appeal to RANZCO which was supposed to be heard within 3 months and surprisingly was allowed to be re-employed and re-registered until the date of the expiry of the appeal. Shortly afterwards RANZCO requested that the appeal should be held in abeyance whilst RANZCO re-assess my clinical, surgical and academic abilities over a further year. I had no choice but to accept this additional assessment, as my registration which had been coupled to the appeal period was about to expire. If registration expired I would have 28 days to leave the country.⁹⁷

4.127 Some contributors to the inquiry expressed concerns with the independence of the appeals process, with the Committee receiving evidence calling for a process entirely independent of college structures to conduct final determinations.⁹⁸ For example, Dr Viney Joshi told the Committee:

I feel it is time that the government stepped in and created some sort of an ombudsman which sat above the colleges and the regulatory bodies – that is, AHPRA, the medical board and all these organisations – where at least people could go and get a fair deal.⁹⁹

4.128 Dr Christopher Hughes from RANZCOG expressed some reservations about such a process:

... if it was for an external independent body to be making those decisions, I am not sure that the intimate professional expertise and knowledge to reverse or come up with an alternative decision is necessarily there, if it is going to involve people outside the specialty area. I guess you can take them from the specialty area but outside the college process.¹⁰⁰

4.129 Dr Jennie Kendrick, Fellow and Censor-in-Chief of Royal Australian College of General Practitioners (RACGP) told the Committee that

96 Dr Anatole Kotlovsky, *Submission No 47*, p 3.

97 Name withheld, *Submission No 39*, p 3.

98 IMG Inquiry Working Group, *Submission No 168*, p 6.

99 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, p 13.

100 Dr Christopher Hughes, RANZCOG, *Official Committee Hansard*, Melbourne, 18 March 2011, p 58.

determining whether an IMG has reached the appropriate clinical standard should be assessed by appropriate clinical experts.¹⁰¹

Committee comment

- 4.130 It is apparent that the nature of many specialist medical college assessment grievances could be deemed as subjective, as often it is one clinician assessing another in a supervisory capacity. An example of this might be an IMG not receiving a favourable report during the peer review period. Despite a large number of submissions being received with respect to appeals, the Committee has received evidence that the number of reviews subject to a formalised appeals process by an Appeals Committee is relatively small.¹⁰²
- 4.131 The Committee understands that specialist medical college Appeals Committees fulfil the function of providing a final process for the determination of decisions made by colleges. However, that there are aspects of college Appeals Committees which could be improved in the interests of transparency. The first of these is the discretion of the Chief Executive Officer of a relevant college to determine whether an Appeals Committee should be convened. The Committee is of the view that following the completion of the second-stage of appeal regarding a decision of a college, IMGs should have automatic grounds to appeal to the college's Appeals Committee. The Committee is also of the view that IMGs should have the option to retain an advocate to represent them in an appeal to the relevant specialist medical college's Appeals Committee.
- 4.132 The final aspect the Committee has considered in relation to the specialist medical colleges Appeals Committee is its membership. The Committee understands that Appeal's Committee's constitute a majority of independent members. However, the Committee is concerned about the perception of many IMGs who have made submissions to this Committee regarding their belief that the appeals processes of the specialist medical colleges are not independent, impartial or transparent.
- 4.133 The Committee is of the view that the colleges should provide clear and detailed information on the Appeals Committee and its membership on its website, including profile information on each member of the Committee to inform IMGs of each member's impartiality. The Committee also

101 Dr Jennie Kendrick, RACGP, *Official Committee Hansard*, Melbourne, 18 March 2011, p 59.

102 See for example: Mr Ivan Thompson, RACS, *Official Committee Hansard*, Melbourne, 18 March 2011, p 59; Dr Jennifer Alexander, RACP, *Official Committee Hansard*, Canberra, 25 February 2011, p 54; Dr Richard Willis, Australian and New Zealand College of Anaesthetists, *Official Committee Hansard*, Melbourne, 18 March 2011, p 57.

recommends that the Appeals Committee of each college should also comprise of an additional member who is an IMG and member of the college's international medical graduate committee.

Recommendation 9

4.134 The Committee recommends that all specialist medical colleges consult with the Australian Medical Council to ensure each college undertakes a consistent three-stage appeals process, incorporating the following:

- **an automatic right for an international medical graduate (IMG) to undertake the next stage of appeal, following completion of each preceding appeal;**
- **the option for the IMG to retain an advocate for the duration of any appeal process to an Appeals Committee, including permission for that advocate to appear on the IMG's behalf at the appeal itself; and**
- **the capacity to expand membership of the Appeals Committee to include an IMG who holds full membership of the relevant specialist college, but has no involvement with the decision under review.**

4.135 The Committee is also concerned about submissions to the inquiry from IMGs who advised that were not informed regarding the relevant college's appeals process and therefore did not avail themselves of the process. To rectify this issue, the Committee suggests that the colleges provide a two-pronged approach to ensure IMGs are informed about their right to appeal a decision made by the college, during their assessment process:

- **by providing clear and detailed information on the relevant college website regarding the appeals process, including timeframes for lodging an appeal, the stages of appeal and how the appeals operate; and**
- **by providing relevant information on the next stage of appeal, including deadlines for submitting an appeal, in writing to all IMGs, in the same document advising the IMG of the decision the college has made in respect of their application for specialisation.**

Recommendation 10

4.136 **The Committee recommends that the specialist medical colleges undertake the following steps to ensure international medical graduates (IMGs) are aware of their right of appeal regarding their application for specialisation:**

- **publish information regarding their appeals process in a prominent place on their website, including information regarding each stage of the appeals process, timelines for lodging appeals and the composition of Appeals Committee membership; and**
- **ensure that IMGs are informed of their right to appeal when any decision is made regarding their application, with information regarding their right to appeal a particular decision provided in writing on the same document advising the IMG of the decision made regarding their application.**

4.137 During the inquiry, the Committee also canvassed the concept of developing an overarching independent appeals mechanism with respect to decisions of clinical competence made by specialist medical colleges. Although independent appeals processes are available for administrative decisions made by the MBA/AHPRA (through the National Health Practitioner Ombudsman as outlined in Chapter 6), where matters of clinical judgement arise no independent mechanism exists beyond the Appeals Committee process discussed above. The Committee believes that such a mechanism, discharging its functions independently, is paramount to providing reassurance in relation to the integrity of clinical competence assessments.

4.138 While evidence to the Committee was in general terms supportive of an overarching independent appeals mechanism to review decisions relating to clinical competence, there was a paucity of detail on the composition and functioning of an independent review mechanism. However, the Committee proposes that an overarching independent appeals mechanism for the review of clinical competence decision should comprise an appropriately selected panel. Composition of the panel will need to allow for the necessary perception of independence, in particular independence from the specialist college subject to review. Importantly, composition of the panel also needs to preserve the integrity clinical decision making through the involvement of medical practitioners with the requisite

knowledge and expertise to review college decisions relating to clinical competence. While not wishing to impose a structure, the Committee proposes that necessary balance between independence and clinical expertise could be achieved by a panel comprising:

- an independent Chair familiar with either administrative or clinical matters (eg National Health Practitioner Ombudsman or Commonwealth Medical Officer or their independent nominee);
- medical practitioners familiar with the particular speciality, with an equal representation of nominees made by the IMG and by specialist medical college subject to review; and
- medical practitioners from specialist medical colleges other than that subject to the review, with familiarity in clinical assessment. It might be that these panellists could be drawn from a pool of nominations made by specialist medical colleges, selected at the discretion of the independent Chair.

Recommendation 11

4.139 The Committee recommends that the Australian Health Ministers Advisory Council, in conjunction with the Australian Government Department of Health and Ageing and the National Health Practitioner Ombudsman, develop and institute an overarching, independent appeals mechanism to review decisions relating to the assessment of clinical competence to be constituted following an unsuccessful appeal by an international medical graduate to the Appeals Committee of a specialist medical college.

4.140 In making its recommendations to improve the transparency and independence of appeals processes relating to assessments of clinical competence, the Committee recognises the need for colleges to ensure that specialist IMGs are appropriately qualified, skilled and experienced. Ensuring that the community continues to receive health care that is safe and high quality remains paramount.

Perceptions of assessment and accreditation authorities

4.141 Evidence has been provided to the Committee suggesting that specialist medical colleges are often not held accountable for their decisions, with a

perception that some specialist colleges are ‘boys clubs’ with a ‘closed shop’ mentality which discriminate against IMGs. Dr Joshi told the Committee of his concern regarding the specialist medical colleges, saying:

I am going to make a very controversial statement here, but colleges are degenerating into old boys’ clubs sadly enough. Instead of becoming centres of quality education they are becoming bastions of power and absolutely like an exclusive club, whether you are part of that club or not. Even when you become a part of the club through getting your fellowship whether you can pervade into the inner sanctum sanctorum depends on how good your manipulative skills are. If you are not slick enough then you get left out.¹⁰³

4.142 Dr Michael Galak submitted to the Committee:

The registering bodies or a body now, are not answerable to anyone with the political clout to change their decisions. The hypothetical possibility of going to the Administrative Appeals Tribunal or Human Rights Commission is useless because these organisations, having tackled Medical Boards before, learned the awesome power of the legal protection these registering bodies enjoy. Who would wish to squander the limited resources on a hopeless quest? In the end OTDs are left unprotected.¹⁰⁴

4.143 Dr Jonathan Levy of the Australian Doctors Trained Overseas Association (ADTOA) told the Committee that many IMGs were scared to contribute to the Committee’s inquiry as a result of their perceptions:

... they are all scared of the taskmaster on the ground and will not raise their heads above the parapet ... If everybody who wanted to put a submission in had put a submission in, you would have had two, three, four or five times the number that you received.¹⁰⁵

4.144 The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) submitted to the Committee that it should be made clear that registration decisions are the responsibility of the Medical Board of Australia on advice from the AMC, and not by the College itself. RANZCO noted that there was a tendency to demonise the College and

103 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, p 15. See also: Dr Michael Galak, *Submission No 31*, p 1.

104 Dr Michael Galak, *Submission No 31*, p 2.

105 Dr Jonathan Levy, *Official Committee Hansard*, Canberra, 25 February 2011, p 44.

accuse them of restricting entry of doctors to their speciality.¹⁰⁶ RANZCO also stated in this regard that:

The College takes pride in the fairness and transparency of its decisions made in good faith, and feels that the MBA and the AMC should be public in defending such processes undertaken at their request.¹⁰⁷

- 4.145 Chair of the MBA, Dr Joanna Flynn responding to a question about whether the accreditation processes were susceptible to being manipulated to deliberately restrict IMG entry, observed:

The way that it is dealt with structurally is to make sure that the standards that the colleges are using to assess are published, that they are clear, that there are appropriate reports written of the basis on which decisions were made and that there are appropriate appeals processes. I also believe that most people working as a doctor, which I do, recognise that there is a significant workforce shortage across the whole medical workforce – that there is more than enough work for everyone. So whereas 20 years ago the issue was about, ‘Don’t stay on my patch; there’s not enough work for both of us,’ I really do not believe there is anyone who believes that now.¹⁰⁸

Committee comment

- 4.146 The Committee has heard evidence, particularly from IMGs themselves, suggesting that the AMC and specialist medical colleges lack transparency and fairness when performing their roles of assessing and accrediting IMGs qualifications, prior skills and experience for the purposes of registration.
- 4.147 The Committee is particularly concerned that some IMGs assert that these entities have acted with a degree of bias and/or discrimination. The Committee trusts that the AMC and specialist medical colleges aim to carry out their functions in an impartial, fair and transparent way, as affirmed by their representatives who gave evidence before the Committee during the course of this inquiry.

106 Royal Australian and New Zealand College of Ophthalmologists (RANZCO), *Submission No 73*, p 3.

107 RANZCO, *Submission No 73*, p 3.

108 Dr Joanna Flynn, Medical Board of Australia, *Official Committee Hansard*, Canberra, 25 February 2011, p 22. See also: Dr Andrew Pesce, Australian Medical Association, *Official Committee Hansard*, Canberra, 25 February 2011, pp 33-34; and RANZCOG, *Submission No 45*, p 6.

- 4.148 With regard to the specialist medical colleges, the Committee has already referred to the outcomes of the 2004-5 Review of Australian specialist medical colleges conducted by the Australian Competition and Consumer Commission (ACCC) in conjunction with the Australian Health Workforce Officials Committee (AHWOC). The review focused on four principles - transparency, accountability, stakeholder participation and procedural fairness - making 20 recommendations to improve college assessment and accreditation process. The Committee understands that since 2005 the colleges have made considerable progress in implementing many of the recommendations.¹⁰⁹
- 4.149 Nevertheless, noting continuing concerns raised and perceptions held by IMGs and associated health stakeholders throughout Australia, the Committee encourages the AMC and specialist medical colleges to continue to take further steps towards achieving a high level of transparency and accountability in its dealings with IMG candidates seeking accreditation and/or registration as specialists in Australia.
- 4.150 As recommended by the Committee earlier in this Chapter, transparency should include the dissemination of clear and concise information regarding assessment processes, including explanatory information on how assessment processes are undertaken and the criteria used to determine levels of comparability.
- 4.151 IMGs should also be afforded access to appropriate independent and efficient appeals processes when they object to a decision made regarding the assessment their clinical competence. The Committee notes that there is further discussion on MBA/ AHPRA appeals processes in Chapter 6 which deals with IMG registration processes.

109 Mr Scott Gregson, Australian Competition and Consumer Commission, *Official Committee Hansard*, Canberra, 20 September 2011, p 2.

Issues with registration and associated processes

- 5.1 All medical practitioners, including international medical graduates (IMGs), must be registered with the Medical Board of Australia (MBA) to practise medicine in Australia. Under the *Health Practitioner Regulation National Law Act 2009* (Qld) (the National Law)¹, the MBA was established as Australia's national medical registration authority. Also under the National Law, the Australian Health Practitioner Regulation Agency (AHPRA) was established to undertake the administrative functions of the MBA in relation to implementation of a national registration and accreditation scheme (NRAS). The Committee's inquiry has highlighted a range of issues relating to poor communication and systemic inefficiencies resulting from the transition to the NRAS. These are considered in more detail in Chapter 6.
- 5.2 This Chapter considers those elements of the registration requirements that have been prominent features in evidence, and are obvious causes for concern by many IMGs holding Limited Registration and working towards achieving full General or Specialist Registration in Australia. Issues examined in this Chapter relate to:
- processes for demonstrating clinical competency including concerns about:
 - ⇒ peer review and supervision;
 - ⇒ the utility of the Pre-Employment Structured Clinical Interview (PESCI); and

1 As noted in Chapter 1 where there is reference to provisions of the National Law, these references have been extracted from the Queensland legislation, as it was the first state to enact the legislation.

- the process of demonstrating English language proficiency.
- 5.3 While not related directly to registration, this Chapter also examines issues relating to processes adjacent to registration which IMGs must address if they are to be able to live and practise medicine in Australia. Issues considered include those associated with establishing and maintaining residency status, and restrictions on gaining access to Medicare provider benefits associated with provisions of the *Health Insurance Act 1973* (Cth).

Demonstrating clinical competency

- 5.4 Regardless of which registration pathway is pursued, each IMG must undertake a period of supervised practise, in some cases with specified additional training or requirements to pass examinations, to establish clinical competency and gain an understanding of the Australian health care system.
- 5.5 The Committee took a range of evidence in relation to the processes associated with demonstrating clinical competency from IMGs holding Limited Registration following the Competent Authority, Standard or Specialist Pathways. These issues related primarily to supervision/peer review and the utility of the PESCI.

Peer review and clinical supervision

- 5.6 As noted above, IMGs seeking full registration in Australia undergo a variable period of supervised practise. Clinical supervision involves the oversight (either direct or indirect)² by a clinical supervisor of professional procedures and/or processes for the purpose of assessing clinical competency and providing opportunities for professional development to ensure delivery of high quality patient care. Where IMGs are seeking registration in a specialist capacity, the term 'peer review' is used for this period.

2 **Direct supervision:** the clinical supervisor is present, observes, works with and directs the person who is being supervised. **Indirect supervision:** the clinical supervisor is readily contactable but does not directly observe the activities.

Availability of clinical supervisors

5.7 Evidence suggests that it is difficult to find suitably qualified supervisors for IMGs, particularly for IMGs working in regional, rural or remote locations. This shortage may be heightened in the case of specialists, where the number of potential supervisors is even more limited.³ With regard to supervision, the Australian Government Department of Health and Ageing (DoHA) notes that:

... with the ageing of the medical workforce overall, the availability of supervisors for OTDs (as well as for Australian educated and trained doctors) needs close monitoring, and options to ensure there is enough supervision capacity in the system.⁴

5.8 Also commenting on the shortage of clinical supervisors, the Rural Doctors Workforce Agency (RDWA) observed:

There is enormous pressure for medical practitioners to become supervisors of OTDs however there is little or no training for supervisors. Supervisors are not paid to take on the extra responsibility.⁵

5.9 In his submission Mr Ian Shaw, contributing in a private capacity, noted:

Many OTDs in rural and regional areas are employed at a private practice where, because of a practitioner shortage or high patient ratio, no or inadequate supervision and mentoring is available.⁶

5.10 Associate Professors Michael Steyn and Kersi Taraporewalla also noted the shortage of supervision available to IMGs working in specialist AoN positions:

The AoN process requires supervision by an [Australian and New Zealand College of Anaesthesia] (ANZCA) fellow. ... AoN positions in remote areas may not be able to provide a suitable ANZCA fellow for supervision.⁷

3 See for example: Australian and New Zealand College of Anaesthetists, *Submission No 87*, p 17; Rural Workforce Agency, Victoria, *Submission No 91*, p 10; Confederation of Postgraduate Medical Education Councils (CPMEC), *Submission No 93*, pp 1-3.

4 Australian Government Department of Health and Ageing (DoHA), *Submission No 84*, p 10.

5 Rural Doctors Workforce Agency (RDWA), *Submission No 83*, p 5.

6 Mr Ian Shaw, *Submission No 56*, p 2.

7 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 7.

- 5.11 Noting that IMGs are required to find their own supervised positions, which are then subject to approval, the Royal Australasian College of Surgeons (RACS) told the Committee:

Often the only positions available to IMGs are in hospitals that are not traditional teaching hospitals and which have a predominant service requirement. Often the Fellows located at these hospitals have limited involvement in the training and education process and are not experienced in clinical assessment processes. As they are often smaller hospitals, the IMG is deprived of a support network of a wide range of surgical colleagues.⁸

- 5.12 The Royal Australasian College of Pathologists (RACP) considered that finding suitable placements for IMGs in remote areas is difficult:

We are very mindful of the difficulties in providing adequate supervision in remote areas. Current workforce constraints mean that proper supervision for peer-review pathways to [college fellowship] in remote areas is not feasible at this stage.⁹

- 5.13 Noting that in 2005 an estimated 2,669 people from the medical workforce retired, the National Rural Health Alliance (NRHA) proposed making use of semi or recently retired general practitioners to increase the availability of clinical supervisors for IMGs working in regional, rural or remote locations. To implement this, the NRHA observed:

The GPs would need to be identified and offered training and financial support for supervision. 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.¹⁰

- 5.14 For IMGs intending to practise in rural or remote locations, including those on the AoN pathway, a number of inquiry participants suggested that an initial placement in a teaching hospital might be appropriate. One contributor to the inquiry observed:

Areas of need are not best placed to adequately supervise overseas trained doctors. By allowing OTDs to go directly into areas of need, and expect the doctors in these areas to find the time to supervise them adequately, or even at all, is ludicrous and patently unfair. They are, by definition, in need. Most often these

8 Royal Australasian College of Surgeons (RACS), *Submission No 74*, p 4.

9 Royal Australasian College of Pathologists (RACP), *Submission No 72*, p 5.

10 National Rural Health Alliance Inc (NRHA), *Submission No 113*, p 29.

doctors are burned out. At best they are extremely time-poor. Expecting them to take on supervisory roles just adds to the load of people who are already hanging by their fingernails. It is too much to ask, even if things go well. When things go wrong, these people are subjected to extreme stress and are stretched to breaking point. Overseas trained doctors should only be sent to areas of need after the 12 month supervisory, assessment and orientation/training process is completed.¹¹

5.15 Similarly, Dr Diane Mohen told the Committee:

One measure which would help ensure that practitioners destined to work in rural areas are well oriented to the Australian health care system, well assessed with respect to clinical assessment, communication and procedural skills and well supported by professional peers is to insist that all doctors have the opportunity, and are expected, to undertake a period of closely supervised work in a major metropolitan centre.¹²

5.16 RACS also submitted that a period of initial supervised practise and assessment in a teaching hospital, would better equip IMGs to work in non-urban settings, saying:

If appropriately funded and structured assessment posts were created in teaching hospitals it would be preferable for IMGs to commence assessment in these posts for approximately 6 months before rotating out to other posts.

By commencing in these posts IMGs, in conjunction with their clinical assessors, would be able to establish their assessment plan and establish support networks to assist them when they then move to rural and remote locations.¹³

5.17 While supporting the concept of initial supervised practice in a teaching hospital, the Australian Orthopaedic Association (AOA) acknowledged that this would have workforce implications, noting:

... supervision of OTDs in regional areas is often less than ideal. It is for these reasons that the AOA strongly support the creation of specific positions for OTDs in the main teaching hospitals prior to them taking up regional posts. This can put pressure on workforce numbers in certain areas if it delays the taking up of posts. It

11 Name withheld, *Submission No 158*, p 1.

12 Dr Diane Mohen, *Submission No 79*, p 1.

13 RACS, *Submission No 74*, p 4.

would however give the best form of assessment of the OTDs and allow processes to be put in place if issues were identified.¹⁴

- 5.18 Similarly, while acknowledging implications for addressing workforce shortages in regional, rural and remote locations Dr Joanna Flynn of the Medical Board of Australia (MBA) told the Committee:

Again, in an ideal situation all IMGs would do a period in a teaching hospital for three months and be supervised before they went out any further. They would go and work in a group setting where there were people on site to supervise them.¹⁵

Committee comment

- 5.19 The Committee understands that it may be difficult to find clinical supervisors for IMGs for a variety of reasons. Medical workforce shortages, coupled with workload pressures and resource constraints can impact on the capacity and willingness of clinicians to take on supervisory roles. The Committee recognises however that the ability of IMGs to undergo a specified period of clinical supervision is paramount in their progression to achieving full Australian registration.
- 5.20 The need to expand Australia's clinical supervision capacity has long been acknowledged, and is a key component of the 2008 National Partnership Agreement on Hospital and Health Workforce Reform.¹⁶ Health Workforce Australia (HWA), under its clinical training reform program, has provided \$28 million for its Clinical Supervision Support Program (CSSP). The intent of the CSSP is to support projects and activities aimed at expanding clinical supervision capacity and competence. The Committee anticipates that this process will examine a range of options to increase the supply for clinical training places and supervision, including consideration of incentives such as remuneration, and support for supervisor training and skills development.
- 5.21 However, with the anticipated increase in the number of Australian trained medical graduates coming through the system, demand for clinical supervision places is likely to increase. In this context, the Committee believes that specific consideration should be given to the supervision

14 Australian Orthopaedic Association (AOA), *Submission No 69*, p 3.

15 Dr Joanna Flynn, Medical Board of Australia (MBA), *Official Committee Hansard*, Canberra, 19 August 2011, p 20.

16 Council of Australian Governments (COAG), <http://www.ahwo.gov.au/documents/COAG/National%20Partnership%20Agreement%20on%20Hospital%20and%20Health%20Workforce%20Reform.pdf> viewed 3 February 2012.

needs of IMGs, who are already struggling in some cases to find suitable clinical supervision, and may be disadvantaged when competing for places with an expanded cohort of Australian trained graduates.¹⁷

- 5.22 The Committee recommends that HWA, in consultation with state and territory health departments, the MBA, specialist medical colleges and other key stakeholders, investigate options to ensure equitable and fair access to clinical supervision places for IMGs. Consideration should include establishing designated supervision placements for IMGs.

Recommendation 12

- 5.23 **The Committee recommends that Health Workforce Australia, in consultation with state and territory health departments, the Medical Board of Australia, specialist medical colleges and other key stakeholders, investigate options to ensure equitable and fair access to clinical supervision places for international medical graduates. Consideration should include establishing designated supervised placements for international medical graduates in teaching hospitals or similar settings.**
- 5.24 The Committee also believes that shortages of clinical supervisors could be partially alleviated through the use of semi or recently retired medical practitioners who may wish to maintain clinical currency, but who may not necessarily wish to practise full. Options for semi or recently retired medical practitioners to provide clinical supervision on a locum basis would allow those that may usually reside in areas where there medical workforce shortages are not an issue, to provide short to medium term clinical supervision for IMGs practising in regional, rural or remote locations and there are limited number of practitioners able to provide clinical supervision. Understandably, potential supervisors who have retired and whose medical registration has lapsed would need to undergo some professional development and training to ensure that their clinical skills and expertise accords with current clinical best practice. However, the Committee believes that the AMC, specialist medical colleges and MBA should work together to determine an appropriate pathway to support this process.

17 See for example: CPMEC, *Submission No 93*, p 2; Australian General Practice Network, *Submission No 61*, p 6.

Recommendation 13

- 5.25 **The Committee recommends that the Australian Medical Council, the Medical Board of Australia and specialist medical colleges collaborate to develop a process which will allow semi or recently retired medical practitioners and specialist practitioners to maintain a category of registration which will enable them to work in the role of a clinical supervisor.**
- 5.26 The Committee also suggests that shortages of clinical supervisors could be further alleviated by the innovative use of new technology to assist in the supervisory process. The increasing availability of broadband internet services in rural and remote locations throughout Australia should increase options to enhance the use of new technology to better support clinical supervision for IMGs in situations where direct access to their clinical supervisor is limited. The Committee recommends that HWA provide support under the CSSP to promote the innovative use of new technologies to increase clinical supervision capacity.

Recommendation 14

- 5.27 **The Committee recommends that Health Workforce Australia provide support under the Clinical Supervision Support Program to promote the innovative use of new technologies to increase clinical supervision capacity, particularly for medical practitioners who are employed in situations where they have little or no access to direct supervision.**
- 5.28 The Committee is particularly attuned to the difficulties associated with providing appropriate levels of supervision for IMGs intending to practice in regional, rural or remote locations. The Committee is concerned that many of these IMGs are placed in vulnerable situations, often with indirect or very limited access to their clinical supervisors, despite great levels of responsibility. The Committee has also taken evidence to suggest that some professional bodies do not feel that current processes for IMG clinical assessment are adequate to demonstrate the level of clinical competency needed to practice with this limited level of clinical supervision. The Committee is concerned that placements without

adequate clinical assessment, particularly in cases where IMGs are the sole practitioner in a particular location, could be seen as significantly risky in terms of safety and competency.

- 5.29 To address this concern the Committee believes that IMGs intending to practise in settings with indirect or limited access to clinical supervision should have an initial placement in a teaching hospital, base hospital or similar setting to allow for clinical competency to be more thoroughly assessed in the workplace prior to being assigned to a position. This not only enables a fully registered practitioner to assess the skills and competency of an IMG over a period of time (rather than at a brief clinical interview) and for any perceived deficiencies to be addressed, but also allows the IMG to develop a better understanding of the Australian health care system, Australian culture and to develop professional and peer support networks.
- 5.30 The Committee concedes that this would place further demands on already limited clinical supervision places and also would mean that some communities would have delayed access to much needed medical services. However, the Committee is of the view that this approach is necessary to ensure that high standards of care are maintained in regional, rural and remote Australia.

Recommendation 15

- 5.31 **The Committee recommends that prior to undertaking practise in an area of need position or regional, rural, remote position with indirect or limited access to clinical supervision, international medical graduates (IMGs) be placed in a teaching hospital, base hospital or similar setting. Within this setting IMGs could be provided appropriate supervision for a defined period to further establish their clinical competency and assist with their orientation to the Australian health care system.**
- 5.32 Of course the Committee understands that the feasibility of this recommendation is contingent on the availability of sufficient supervised clinical placements for IMGs as per Recommendation 12.

Skills and training of clinical supervisors

- 5.33 Some evidence to the Committee suggests that prior to appointing clinical supervisors, the MBA and specialist medical colleges should ensure that

supervisors have an additional set of skills to complement their clinical expertise. In particular, this would include the ability to objectively assess clinical performance, provide professional guidance and feedback and to modify behaviour if necessary.

- 5.34 The Australian College of Rural and Remote Medicine (ACRRM) told the Committee that the college:

... would support the introduction of mandatory accreditation for all doctors supervising OTDs. Colleges should set the standards, provide training and accreditation if there is to be improved supervision provided and increased accountability for supervisors. Government should be providing incentives such as support for training and accreditation of training posts and remuneration to the supervisor for time spent in teaching and reporting.¹⁸

- 5.35 To enhance clinical supervision of IMGs specifically, a number of inquiry participants suggested that there is also a need for cross-cultural awareness training.¹⁹ For example, Dr Wenzell suggested that there is a need to:

Fund dedicated supervisor positions with improved training for supervisors concentrating on cross-cultural and communication skills training.²⁰

- 5.36 Associate Professors Michael Steyn and Kersi Taraporewalla noting that 'there is no training of the supervisors towards assessment of cultural differences', observed:

Other areas of development include appropriate training for the supervisors into assessment of behaviours and ways to modify behaviour. Supervisors in the vocational training scheme aim to generate behaviours and often have trouble with this element. For the OTD where behaviours have already been established based on cultural norms in a variety of settings in their basic training, changing to the Australian culture requires key understandings on the part of the supervisors so as to achieve the outcome of integration, rather than claim that the OTD is not performing as to expected. Supervisors of the OTD also need to understand the processes and changes that the OTD has to go through. This is not

18 Australian College of Rural and Remote Medicine (ACRRM), *Submission No 103*, p 17.

19 See for example: Dr Johannes Wenzell, *Submission No 68*, p 6; Rural Doctors Workforce Agency, *Submission No 83*, p 6.

20 Dr Johannes Wenzell, *Submission No 68*, p 6.

easily understood as it is difficult to find out about the perspective of the OTD ...²¹

Committee comment

- 5.37 The Committee believes that one way to ensure that IMGs who are required to undergo supervision have a successful and positive experience is by pairing them with clinical supervisors who will help them to develop and also assist in rectifying gaps in knowledge and clinical competence. In particular, the Committee considers that development of clinical supervisors skills in provision of objective assessment, feedback and mentoring would be of benefit. Although the suggestion for mandatory accreditation of clinical supervisors is not without merit in the longer term, given the chronic shortage of clinical supervisors at the current time, the Committee is concerned that this approach would unnecessarily restrict access further.
- 5.38 As noted earlier, the Committee is aware that HWA is undertaking a range of activities and projects to enhance Australia's medical supervision capacity under the CSSP. These include activities to better define the roles, responsibilities and accountabilities of clinical supervisors, and to improve the quality of supervision through the provision of training.²² The Committee is also aware that the MBA/AHPRA also provides Guidelines for Supervised Practise for Limited Registration.²³ This document sets out the principles for supervision and outlines the responsibilities of the IMG under supervision and of the clinical supervisor.
- 5.39 For clinical supervisors of IMGs, the Committee understands cultural awareness and communication may be an important contributor to effective clinical supervision. Improved cultural awareness and communication may assist supervisors to establish a professional relationship with their IMG, and deliver guidance and constructive feedback on their clinical skills and proficiency. Ideally, the clinical supervisor should also be the first person to whom an IMG turns to for advice on clinical issues, career development, issues of interaction with other staff and with patients. Therefore, the Committee recommends that HWA include information on cross cultural awareness and communication in its guidance on the roles and responsibilities of clinical

21 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 16.

22 Health Workforce Australia (HWA), *Annual Report 2010-11*, p 24.

23 MBA, Recruitment Standards, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 16 January 2012.

supervisors, and that these elements should be components of clinical supervisor training.

Recommendation 16

- 5.40 **The Committee recommends that Health Workforce Australia ensure aspects of cross cultural awareness and communication issues are key components in any guidelines, educational materials or training programs that are developed to support enhanced competency of clinical supervisors.**

Pre-Employment Structured Clinical Interview (PESCI)

- 5.41 One of the more contentious issues raised during the inquiry was that of the Pre-Employment Structural Clinical Interview (PESCI). For IMGs pursuing registration via the Competent Authority or Standard Pathways, the requirements for registration may include:
- ... satisfactory results of a pre-employment structured clinical interview (PESCI) required for any non specialist position if the Board determines the PESCI is necessary. The Board will base its decision on the nature of the position and level of risk.²⁴
- 5.42 In brief, a PESCI is used to assess an IMG's suitability for a particular role based on the assessed risks of the particular position. It requires the IMG to undergo a structured interview based on clinical scenarios to demonstrate that they have the knowledge, skills and experience to work in a particular position. The PESCI is conducted under the auspices of AMC accredited providers by a panel of at least three members, two of whom need to be familiar with the clinical and professional demands of the type of position involved.²⁵
- 5.43 The Committee has taken evidence of the concerns held by IMGs in regards to PESCI assessments. Primarily these concerns relate to:
- the application and utility of PESCI, and the feedback received following assessment; and

24 MBA, Limited Registration for Area of Need Registration Standard, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 3 February 2012.

25 Australian Medical Council (AMC), *Submission No 42.2*, p 3; See also: MBA, Communiqué, Meeting of the MBA, 24 August 2011, pp 2-3.

- the consistency and portability of PESCI across jurisdictions.

Application, utility and feedback

5.44 The submission from the Australian Doctors Trained Overseas Association (ADTOA) listed a number of concerns regarding the PESCI based on experiences related by 35 IMGs. These include:

- Many believed that the PESCI exam was an inadequate, unfair and invalid measure of their clinical skills and knowledge;
- A number complained about the lack of fair due process with regards to the PESCI in that they were not recorded and/or transcribed;
- A number complained about the lack of validation of the PESCI tool ; [and]
- Some reported serious mistakes made by the PESCI panellists. (i.e. panellists not the IMG were in error).²⁶

5.45 While some evidence to the inquiry reported on the limited opportunities for IMGs to take the PESCI and long waiting lists with delays of up to 12 months²⁷, there were more fundamental concerns regarding the utility of the PESCI. A number of submitters expressed frustration that some IMGs were required to undertake PESCI without fully understanding the basis of this requirement.²⁸ This seemed to be a particular issue for a number of IMGs who have been practising in Australia for various periods of time (sometimes for many years) under Limited Registration, who now under the National Registration and Accreditation Scheme (NRAS) may find that they are required to undertake a PESCI to continue practising.²⁹ With regard to using the PESCI to assess IMGs finding themselves in this position, the Australian Medical Association (AMA) note:

While the PESCI is used for initial pre-employment assessment of a doctor for a particular job, prior to initial registration, as an assessment after that time it may not be the most appropriate tool to use. A PESCI test is a pre-employment evaluation, looking at

26 Australian Doctors Trained Overseas Association (ADTOA), *Submission No 101*, p 8. See also: Name withheld, *Submission No 15*, p 2; IMG Inquiry Working Group, *Submission No 168*, p 7.

27 See for example: NSW Rural Doctors Network, *Submission No 37*, p 10; Victorian Medical Postgraduate Foundation Inc, *Submission No 105*, p 8; Mayo Private Hospital, *Submission No 106*, p 2; Friendly Society Private Hospital, *Submission No 115*, p 2; Australian Locum Medical Service Pty Ltd, *Submission No 117*, p 1.

28 See for example: Dr David Thurley, General Practice Network Northern Territory, *Official Committee Hansard*, Darwin, 30 January 2012, p 1.

29 See for example: Dr Chaitanya Kotapati, *Submission No 21*, p 3; Australian Medical Association (AMA), *Submission No 55*, p 10; Dr Sudheer Duggirala, *Official Committee Hansard*, Brisbane, 10 March 2011, p 24.

whether the applicant is able to do a particular job. It is not a detailed performance assessment of the medical aptitude and performance of the doctor.³⁰

- 5.46 The Committee also received evidence outlining concerns relating to the subjectivity of PESCI assessments and suggesting that feedback following PESCI is inadequate. Some IMGs were surprised to receive feedback on elements of their performance which they were unaware would form part of the assessment. Dr Paramban Rateesh told the Committee of his experience with the PESCI, stating:

Although it is called a structured clinical interview, it did not have much structure to it. There were things like clinical assessment, procedural skills, which were commented on, which cannot really be tested in an interview. The disturbing things – people can have their opinions – that came out of it were that I have poor communication skills. I have poor understanding of Australian culture and idioms. I worked in a rural area for six years. I can write a book about it. If those two aspects alone are ridiculous, the rest of it is a sham. There was no video recording of it. I cannot go back and say, ‘I didn’t say that’ or ‘I know what crook means’ or whatever.³¹

- 5.47 Dr Rajendra Moodley strongly advocated that such assessments should be recorded because he failed his PESCI on the basis that the assessors believed that he had ‘poor understanding of Australian culture and idioms and poor communication’.³²

- 5.48 Dr Emil Penev noted in relating to feedback received following his PESCI:

I was shocked to see that I even failed components like not understanding the Australian culture, without being asked a single question about it. I was marked down on not having communication skills and understanding of Australian idioms. I was never assessed in those areas in the SCI at all, but I was marked down!³³

- 5.49 The Australian College of Rural and Remote Medicine (ACCRM), one of the AMC’s accredited PESCI providers advised the Committee that in terms of feedback:

30 AMA, *Submission No 55*, p 10.

31 Dr Paramban Rateesh, *Official Committee Hansard*, Brisbane, 10 March 2011, p 27.

32 Dr Rajendra Moodley, *Submission No 100*, p 2.

33 Dr Emil Penev, *Submission No 3*, p 1.

Certainly, it is advertised quite broadly that we are available to provide feedback. The feedback is recorded and a file note is made of the areas covered in the conversation. We have had a couple of incidents where doctors who have been unsuccessful in a PESCI, after speaking to a member of the panel who has gone through with them at quite a personal, one-to-one level, have developed a learning plan and got assistance.³⁴

Consistency and portability

- 5.50 Another issue of concern in relation to PESCI is the lack of national consistency and recognition across jurisdictions. The fact that some jurisdictions have differing requirements for how a PESCI is used does not provide an IMG with certainty, particularly where an IMG needs to find employment in another jurisdiction. For example, the Rural Doctors Workforce Agency South Australia stated:

... in Victoria, the Royal Australian College of General Practitioners (RACGP) Pre-Employment Structured Clinical Interview (PESCI) is conducted against a generic job description for general practice, and then based on the PESCI recommendations; the applicant is matched to a suitable position. In South Australia, the RACGP requires that the applicant be assessed against a particular position.³⁵

- 5.51 The General Practice Network Northern Territory also commented that the inconsistent application of PESCI assessments causes confusion for IMGs:

It is still unclear that if a doctor passes a Pre-Employment Structured Clinical Interview (PESCI) in one jurisdiction, it will be accepted prima facie in another.³⁶

- 5.52 As noted by Rural Health Workforce Australia (RHWA):

Currently you can pass an assessment (using a Pre-Employment Structured Clinical Interview (PESCI)) by an agency in Victoria which is accredited by the Australian Medical Council. However, this will not be accepted by a Medical Board in all States. How can this be when the process is supposed to be national? This goes

34 Ms Dianne Wyatt, *Official Committee Hansard*, Brisbane, 10 March 2011, p 58.

35 Rural Doctors Workforce Agency South Australia, *Submission No 83*, p 2.

36 General Practice Network Northern Territory, *Submission No 81*, p 1. See also: Dr David Thurley, General Practice Network Northern Territory, *Official Committee Hansard*, Darwin, 30 January 2012, pp 1-2.

some way to explain why it is so difficult to explain the national process - we don't have one!³⁷

- 5.53 Explaining how these inconsistencies have arisen the AMC told the Committee:

The PESCI process was developed prior to the implementation of the national accreditation and registration scheme. Since it is designed to assess an individual IMG for fitness to work in a designated position with specific clinical responsibilities and levels of supervision, the assessment is not a 'generic' assessment (as in the case of the AMC MCQ examination) and is not, therefore, readily portable to another position or state. As an example an individual IMG might be assessed through a PESCI to be suitable for registration in an area of need position in a regional hospital, but may not have the necessary skills or expertise to satisfy a PESCI assessment for an area of need position in a rural or remote location.³⁸

- 5.54 However, the AMC proceeded to note:

The Medical Board of Australia recently initiated a review of the PESCI process in conjunction with the Australian Medical Council, to evaluate the effectiveness of the assessment outcomes and to explore options to streamline the process, including the possibility of developing a more portable or 'generic' assessment. The AMC is working with the MBA to conduct a workshop on the PESCI later this year as part of this review.³⁹

- 5.55 The AMA also told the Committee:

We are pleased that the Medical Board of Australia has agreed to review these in consultation with the Australian Medical Council, and we look forward to substantial improvements from that review and this inquiry.⁴⁰

- 5.56 The excerpt below from the MBA Communiqué in August 2011, confirms that the MBA review is considering issues associated with national consistency and portability across jurisdictions of the PESCI:

With the transition to the National Registration and Accreditation Scheme, there is an opportunity to review the conduct and

37 Rural Health Workforce Australia (RHWA), *Submission No 107*, p 3.

38 AMC, *Submission No 42.2*, p 3.

39 AMC, *Submission No 42.2*, p 3.

40 Dr Andrew Pesce, AMA, *Official Committee Hansard*, Canberra, 25 February 2011, p 31.

reporting of PESCI to establish more consistent processes and reporting across jurisdictions and to consider whether PESCI results are transferable across similar risk positions.⁴¹

Committee comment

- 5.57 It is clear to the Committee that the application and utility of PESCI under the NRAS is a source of confusion and concern for IMGs and for some organisations. Based on information provided by the MBA/AHPRA on standards for IMGs seeking Limited Registration through the Competent Authority or Standard Pathways, it is evident that MBA retains discretion as to when PESCI are required. However, other than the noting that the MBA will base this determination on the 'nature of the position and level of risk'⁴², there is no further information on criteria used to make this determination.
- 5.58 The Committee is also concerned by the limited information provided by the MBA/AHPRA on more general aspects of PESCI. While noting that this type of information is available from some of the AMC accredited PESCI providers, the Committee considers that the MBA/AHPRA - as the national registration body - also has a responsibility to provide information outlining PESCI processes. Thus information should explain how PESCI are conducted, the nature of the assessment and level of feedback. It is probable that the lack of readily accessible information on the PESCI has contributed to the confusion and stress experienced by some IMGs. In order to rectify this situation, the Committee believes that information on the PESCI should be made readily available on the MBA/AHPRA website.

41 MBA, Communiqué, Meeting of the MBA, 24 August 2011, pp 2-3

42 MBA, *Submission No 51*, p 28.

Recommendation 17

5.59 **The Committee recommends that the Medical Board of Australia/Australian Health Practitioners Registration Agency (MBA/AHPRA) provide more information on the Pre-Employment Structured Clinical Interview (PESCI).**

At a minimum this information should outline:

- **the criteria used to determine the need for an IMG to undertake a PESCI assessment; and**
- **criteria for accreditation of PESCI providers.**
- **details of the PESCI assessment process including:**
 - ⇒ **the composition of the interview panel, the criteria used for selecting panel members and their roles and responsibilities;**
 - ⇒ **the format of the interview and the aspects of skills, knowledge and experience that will be assessed;**
 - ⇒ **criteria for assessment and mechanisms for receiving feedback; and**
 - ⇒ **the process for lodging and determining an appeal against the findings of a PESCI assessment.**

This information should be easily located on the MBA/AHPRA website and provide links to relevant information on PESCI that is available on the websites of Australian Medical Council accredited PESCI providers.

5.60 In addition, to alleviate concerns about the assessment process itself and also to avoid perceptions of subjectivity in PESCI, the Committee proposes that all such assessments be video-recorded. A copy of the video-recording should be provided to the applicant. This will not only enable the provision of appropriate feedback on assessments but ensure that a record is maintained should an IMG wish to challenge the findings of a PESCI.

Recommendation 18

- 5.61 **The Committee recommends that all Pre-Employment Structured Clinical Interview (PESCI) assessments be video-recorded and a copy of the video-recording be provided to the applicant for the purpose of providing appropriate feedback on the assessment and as a record should an international medical graduate wish to appeal the outcome of a PESCI.**
- 5.62 While differences in PESCI processes between states and territories is concerning in the context of a 'national system of registration', the situation is exacerbated by the fact that an IMG can undertake a PESCI in one jurisdiction and risk not having the result recognised in another, even when relocation involves employment in a substantially similar role. Given the level of angst expressed during the inquiry in relation to the PESCI, it is reassuring to note that the MBA, in consultation with the AMC, is conducting a review into the portability of PESCI assessments.
- 5.63 What is unclear to the Committee is what other aspects of the PESCI, if any, will be considered as part of the review. In particular, the Committee is keen for the MBA and AMC to include broader consideration of the utility of the PESCI, particularly as a tool to assess the clinical competence of IMGs who have been practising in Australia for a number of years under Limited Registration prior to the implementation of the NRAS.
- 5.64 In the interests of supporting a consultative review process, the Committee is also of the view that the MBA should provide opportunities for all interested parties, including IMGs, to provide input. The Committee also believes that the MBA should provide regular updates on progress of the review and in due course provide information on the findings.

Recommendation 19

- 5.65 **The Committee recommends that the Medical Board of Australia, as part of its current review of the utility and portability of Pre-Employment Structured Clinical Interview, include broader consideration of its utility as an assessment tool, particularly its application to international medical graduates who have already practised in Australia for a significant period of time under Limited Registration.**

Recommendation 20

- 5.66 **The Committee recommends that the Medical Board of Australia provide an opportunity for interested parties, including international medical graduates, to provide input into its current review of the utility and portability of Pre-Employment Structured Clinical Interviews.**

To promote transparency, the Medical Board of Australia should also provide regular updates on the review on its website, and at the conclusion of the review publish its findings.

English language skills

- 5.67 The MBA's English Language Skills Registration Standard ('English Standard') has been the basis of much evidence during the inquiry, and has caused difficulty for some IMGs seeking registration.
- 5.68 The English Standard outlines that results from either the International English Language Testing System (IELTS) or from the Occupational English Test (OET) are acceptable as proof that a prospective candidate for registration has the appropriate level of English required by the MBA. The English Standard stipulates:

The following tests of English language skills are accepted by the Board for the purpose of meeting this standard:

- a) The IELTS examination (academic module) with a minimum score of 7 in each of the four components (listening, reading, writing and speaking); or

b) completion and an overall pass in the OET with grades A or B only in each of the four components.⁴³

5.69 IDP Australia Pty Ltd, a company which administers IELTS, describes IELTS Level 7 as demonstrating:

... [an] operational command of the language, though with occasional inaccuracies, inappropriacies and misunderstandings in some situations. Generally handles complex language well and understands detailed reasoning.⁴⁴

5.70 The inquiry attracted a significant volume of evidence which raised concerns relating to the English Standard. A review of the evidence indicates that concerns about the English Standard revolve around a small number of key themes, including:

- difficulties in achieving the English Standard at the level required;
- an inappropriate focus on academic English language skills rather than general communication; and
- the limited validity (2 years) of English language test results for the purposes of medical registration.

Difficulty in achieving the English Standard

5.71 The Committee received evidence that suggested that some IMGs were experiencing difficulty in achieving the English Standard at the level required by the MBA.⁴⁵ A number of contributors to the inquiry questioned the stringency of English Standard, specifically the need to achieve IELTS 7 or OET level B for all four components (listening, reading, writing and speaking) in a single sitting.⁴⁶

5.72 With regard to the MBA's English Standard, Dr Viney Joshi told the Committee:

The standard of English that they are expecting from IMGs is that of professorial English, which is absolutely crazy ... I can tell you there will be several people – Australian trained doctors as well – who would not be able to write one paragraph of

43 MBA, English Language Skills Registration Standard <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 3 February 2012.

44 IDP Australia Pty Ltd, *Submission No 155*, p 7.

45 See for example: Dr Nasir Baig, *Submission No 10*, p 1; Dr Mohammed Anarwala, *Submission No 18*, p 2; Dr Azhar Ahmad, *Submission No 140*, p 1.

46 See for example: Name withheld, *Submission No 89*, p 1; Association of Medical Recruiters Australia & New Zealand, *Submission No 139*, p 4; Mr Chris Johnson, *Submission 170*, p 1.

grammatically correct, punctuated English ...Why do you expect overseas people to meet a standard which people here do not meet?⁴⁷

- 5.73 Mr Christopher Butt, a former GP with a post-graduate qualification in Teaching English to Speakers of Other Languages observed:

There have been considerable levels of disquiet among candidates about the Occupational English Test (OET), and in particular about the speaking test, in which candidates are interviewed by interlocutors untrained in any English teaching skills. The statistical hurdle of obtaining a 'B' pass in all 4 skills at the one sitting (reading, writing, speaking and listening) is arguably unnecessarily difficult. Many candidates have sat the test on multiple occasions, each time getting 3 'B' and one 'C' mark, and so have to resit again and again (at a considerable cost in time and money).⁴⁸

- 5.74 The impact of difficulty in attaining the required English Standard was borne out by the experiences of some IMGs. For example, Dr Mohammed Anarwala, expressed his frustration as with the English Standards noting:

I have appeared in the same OET English exam for 11 times over the last 3 years and passed 3 skills several times but failed in 4th.⁴⁹

- 5.75 Similarly, Dr Nasir Baig indicated in his submission:

I have written the same OET English exam 19th time over the last 3 years and passed 3 skills several times but failed in 4th.⁵⁰

- 5.76 Mr David Lamb, an English language tutor with experience in teaching English as a second language, also made the following comment:

Candidates should not be required to pass all sub-tests (Listening, Reading, Writing, Speaking) simultaneously. There is no evidence of any benefit deriving from the requirement for simultaneity. Results should be cumulative to allow candidates time to improve on areas of language weakness (the opportunity for acquisition of language skills is more important than testing).⁵¹

47 Dr Viney Joshi, *Official Committee Hansard*, Brisbane, 10 March 2011, p 16.

48 Mr Christopher Butt, *Submission No 50*, p 1.

49 Dr Mohammed Anarwala, *Submission No 18*, p 2.

50 Dr Nasir Baig, *Submission No 10*, p 2.

51 Mr David Lamb, *Submission No 64.1*, p 1.

- 5.77 The lack of feedback explaining why candidates had not achieved the required standards was also another source of frustration for IMGs, who reported that this restricted their capacity to rectify any identified deficiencies.⁵²

Academic focus of the English Standard

- 5.78 Some evidence suggests that while the prescribed English Standard assessment instruments (IELTS and OET) are sufficient to assess the ability of a candidate to read, write and comprehend English, they do not sufficiently assess a candidate's ability to communicate in a clinical setting. For example, the Royal Australasia College of Surgeons (RACS) told the Committee that:

The College has previously indicated that it does not believe this standard reflects the language skills necessary for working in the Australian healthcare system ...⁵³

- 5.79 In its submission to the inquiry, Peninsula Health emphasised the difference between achieving the MBA's English Standard requirements and being able to communicate effectively in the clinical setting, noting:

It is Peninsula Health's experience that a number of OTDs (perhaps as high as 25%) who may have passed the English examination remain unable to practically engage with other staff and/or patients, particularly in moments of stress.⁵⁴

- 5.80 Acknowledging the influence of the diverse cultural backgrounds of IMGs on language and communication, Associate Professor Kersi Taraporewalla told the Committee:

It is not just English; it is actual communication as such. It is not just the words they use; it is also how they use them, what phrases, their tone of language and what sort of background they have. There is a difference between the level of English which the college examines them at, the IELTS 7 that they have to perform at, and what is required as true communication with the patient.⁵⁵

52 Australian Doctors Trained Overseas Association (ADTOA), *Submission No 101*, p 5; Mr Michael Suss, *Submission No 101*, pp 64-66.

53 Royal Australian College of Surgeons (RACS), *Submission No 74*, p 5.

54 Peninsula Health, *Submission No 27*, p 5.

55 Associate Professor Kersi Taraporewalla, *Official Committee Hansard*, Brisbane, 10 March 2011, p 45.

- 5.81 Asked to comment on survey results showing that 80% of IMGs do not believe that they have communication problem, Associate Professor Taraporewalla added:

They may have no trouble in speaking English, but they do have a problem addressing it to local conditions and to the local patient.⁵⁶

Committee comment

- 5.82 It is concerning that some IMGs, who may otherwise be competent medical practitioners, cannot meet the English Standard. However, the Committee understands that a standard is needed as a medical practitioner's ability to communicate effectively in English is a fundamental aspect of good quality and safe medical practice in Australia.
- 5.83 During the inquiry the Committee took some evidence questioning the validity and consistency of test results from the IELTS and the OET.⁵⁷ As the focus of this report is on issue of the English Standard as part of the process of medical registration, the Committee is not in position to analyse information on the IELTS or the OET as testing instruments. However, the Committee has been reassured that both tests have already been extensively validated by linguistic experts and accordingly the Committee does not propose to comment further on this issue.⁵⁸
- 5.84 However, the Committee believes that there is merit in reviewing the English Standard, in particular whether the IELTS and OET levels (Level 7 and Grade B respectively) set by the MBA are appropriate for IMGs, and whether the need to achieve this level across all four components of testing in a single setting is overly restrictive. While the Committee fully acknowledges the importance of ensuring that IMGs have the requisite English language skills to support their work in the clinical setting, at the same time it recognises that setting unnecessarily stringent standards is not in the interest of the Australian community.

56 Associate Professor Kersi Taraporewalla, *Official Committee Hansard*, Brisbane, 10 March 2011, p 46.

57 See for example: Mr Michael Suss, *Submission No 110*, p 51; Dr Susan Douglas, *Official Committee Hansard*, Canberra, 25 February 2011, p 45.

58 See for example: Professor Timothy MacNamara, *Official Committee Hansard*, Melbourne, 31 August 2011.

Recommendation 21

5.85 **The Committee recommends that the Medical Board of Australia review whether the current English Language Skills Registration Standard is appropriate for international medical graduates.**

The review should include consideration of:

- **whether the International English Language Testing System and Occupational English Test scores required to meet the English Language Skills Registration Standard is appropriate; and**
- **the basis for requiring a pass in all four components in a single sitting.**

5.86 Another area of concern for the Committee was that many IMGs noted the lack of qualitative feedback available from both the IELTS and OET in cases where they failed to achieve to required test scores under the MBA's English Standard. At present, the Committee understands that providers of both accepted English language tests provide test results in the form of graded scores only.⁵⁹ The Committee considers that the provision of qualitative feedback would be beneficial to IMGs to enable the rectification of any identified deficiencies. However, the Committee understands that the MBA does not hold jurisdictional authority over IELTS or OET test providers to mandate this type of feedback. The Committee is also aware that IELTS and OET providers test English language skills for a range of other health disciplines that are regulated by AHPRA which do not incorporate a qualitative feedback component. Nonetheless, the Committee believes that the MBA should negotiate with IELTS and OET providers with a view to requiring that detailed, qualitative feedback on each component of the test is provided to IMGs in writing to facilitate identification of areas of deficiency which may be rectified.

59 International English Language Testing System (IELTS), <http://www.ielts.org/test_takers_information/getting_my_results/my_test_score.aspx> viewed 20 February 2012 and Occupational English Test Centre (OET), <<http://www.occupationalenglishtest.org/Display.aspx?tabid=2571>> viewed 20 February 2012.

Recommendation 22

- 5.87 **The Committee recommends that the Medical Board of Australia negotiate with providers of the International English Language Testing System and Occupational English Test with a view to requiring that detailed, qualitative written feedback on each component of the English Language test be provided in writing to international medical graduates to enable identification of areas of deficiency which may be rectified.**
- 5.88 The Committee understands that communication in the health care setting goes beyond simply demonstrating academic levels of English language proficiency. Medical practitioners also need to fully comprehend what patients are telling them (which will require knowledge of colloquialism and idioms), answer questions and communicate medical information and results using language that is readily understandable and in a manner that shows empathy for a patient's situation. Working in a team environment or consulting with professional colleagues will also mean that IMGs need to be familiar with medical and professional terminology and communication styles.
- 5.89 Furthermore, the cultural context of communication is crucial. For example, in an Australian context it is not unusual for patients to want to discuss sensitive issues, such as mental health or sexual health issues, with their medical practitioner. It is conceivable that some IMGs may have concerns discussing such matters with their patients. Clearly the English Standard does not assess these aspects of an IMGs communication. Nevertheless the Committee considers it vitally important that this aspect of communication is developed and assessed during the IMGs period of clinical supervision. The Committee comments further in Chapter 7 on the importance of including cultural awareness and communication training for IMGs as an integral part of their orientation to the Australian health care setting.

Two year validity of test results

- 5.90 One of the key concerns about the English Standard is that the MBA mandates that English test results must be obtained in the two years prior

to applying for registration.⁶⁰ The MBA may allow exemptions to this period of validity for results if an IMG:

- (a) has actively maintained employment as a registered health practitioner using English as the primary language of practice in a country where English is the native or first language; or
- (b) is a registered student and has been continuously enrolled in an approved program of study.⁶¹

5.91 With respect to the two-year validity of English test results, Ms Joanna Flynn of the MBA told the Committee:

The reason that that requirement was introduced was that some people pass their English language test and are not working in Australia or in another English language place and are speaking their own native language and have not spoken English since they sat the test. It is a blanket rule. I can hear you saying that it sounds a bit harsh. The English language standards, like all the national registration standards, are to be reviewed in the three-year cycle. There have been some questions about whether it is the most appropriate regime for English language testing, so there will be an evaluation of that.⁶²

5.92 A number of submitters to the inquiry expressed concern at the two year validity of English language test results. IMGs particularly affected by the limited validity of English Language test results include:

- individuals whose registration has lapsed, requiring them to reapply for Limited Registration and repeat their English language test if existing results are more than 2 years old;
- IMGs who have been practising for varying periods of time in Australia transitioning from state based registration systems to the NRAS; and
- individuals who experienced delays in applying for Limited Registration during which time their English language test results expire.

5.93 The impact of the two year validity for English test results is illustrated by Dr Anarwala. Dr Anarwala successfully completed the AMC 2-part

60 MBA, English Language Skills Registration Standard, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 3 February 2012.

61 MBA, English Language Skills Registration Standard, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 3 February 2012.

62 Dr Joanna Flynn, Medical Board of Australia (MBA), *Official Committee Hansard*, Canberra, 25 February 2011, p 25.

assessment, and was asked to undertake another English language test as results from an earlier test were more than two years old. Despite repeated attempts Dr Anarwala has not been successful in attaining the OET English Standard required by the MBA. Dr Anarwala told the Committee:

After [previously] passing the English proficiency examination, I remained in Australia since. I do not think that the level of my English skills has lowered. I believe that the validity of English proficiency for two years is totally wrong especially if a medical professional remains in English speaking country.⁶³

5.94 Dr Sayed Hashemi also related his experience regarding English language testing as follows:

As of July 1st 2007, the NSW Medical Board required overseas trained doctors to pass the OET before progressing onto the AMC Clinical and MCQ examinations. Also, the OET would not be considered if it was achieved more than two years at the time of applying for placement. This is where I was severely disadvantaged as it meant that my OET success was now 'expired'. I had completed all exams in March 2007, before the change in policy was introduced.

I am an Australian citizen who has lived in Australia for several years (i.e. 19 years). Inevitably, living here I have adopted the Australian culture, interact daily with English speaking community and taking in English media. ... I believe my language skills, understanding and appreciation for the Australian culture and have deepened rather than gone backwards or 'expired'.⁶⁴

5.95 Dr Salahuddin Chowdhury related his experience of being required to resit the English language test despite having passed previously in 2003 and again in 2006. Dr Chowdhury told the Committee:

They have asked me to do English again. But I was continuously working as a general practitioner and, according to the website, those doctors who have worked continuously in general practice in Australia or anywhere in Australia are not required to do English again.⁶⁵

5.96 Another IMG, expressed his frustration at the two year validity of the English language test results, noting despite having lived and worked in

63 Dr Mohammed Anarwala, *Submission No 18*, p 2.

64 Dr Sayed Hashemi, *Submission No 104*, p 1.

65 Dr Salahuddin Chowdhury, *Official Committee Hansard*, Darwin, 30 January 2011, p 16.

Australia since 2005, under the NRAS he had been required to repeatedly undertake English language testing.⁶⁶

- 5.97 Also commenting on the period of validity for English language test results, Mr Lamb told the Committee:

Any limitation to the validity period of an English Test should be related to the period it would take to complete the entire registration process. The validity period should not be used if applicants are hindered by non-availability of Medical Tests (for example, MCQ, Clinical). There may be valid reasons for applying a limited validity period to language test results obtained outside Australia, but there is no evidence of much deterioration of language skills in people who are living and working in Australia. Any skill that is not used can become blunted, and this applies equally to Australian-educated people.⁶⁷

- 5.98 When asked by the Committee to comment about the two year validity, Mr Gerrard Neve of the OET Centre responded:

... there is a significant body of research into the area of second language acquisition or language loss, more specifically known as attrition, that suggests that the two-year period is quite conservative.⁶⁸

- 5.99 Noting further that the MBA's English Standards require candidates to attain a high level of English language proficiency, Mr Neve added:

There is a body of research that suggests that for candidates who have already demonstrated a performance at the higher end of that spectrum two years is very conservative and that we might be looking at something like four years as perhaps an appropriate period before we can start to confidently suggest that any language loss could occur.⁶⁹

Committee comment

- 5.100 The Committee understands the importance of establishing English language standards to ensure that IMGs can demonstrate competent English language skills, and that the requisite level of competency is

66 Name withheld, *Submission No 11*, p 2.

67 Mr David Lamb, *Submission No 64.1*, p 1.

68 Mr Gerrard Neve, The OET Centre, *Official Committee Hansard*, Melbourne, 31 August 2011, p 2.

69 Mr Neve, The OET Centre, *Official Committee Hansard*, Melbourne, 31 August 2011, p 2.

current. However, it is evident that the restricted validity period for English language test results is a source of frustration. This was particularly so for IMGs who, as a result of the transition to the NRAS find that they are required to undertake English language testing as earlier test results have expired. This appears to be the case even for some IMGs who ostensibly qualify for exemption from this requirement based on the fact that they have been continuously working in medical practice in Australia.

- 5.101 While the Committee understands the need to ensure the currency of English language skills, the English Standards should not impose an unreasonable burden on IMGs. In terms of finding an appropriate balance, the Committee considers that the two year period of validity for English language proficiency results is unreasonably short. Noting the four year period allowed for renewal of Limited Registration under the NRAS, and in view of evidence about second language attrition over time, the Committee recommends that the MBA extend the period of validity for English language proficiency test results as prescribed by the English Language Skills Registration Standard to a period of four years.

Recommendation 23

- 5.102 **The Committee recommends that the Medical Board of Australia extend the period of validity for English language proficiency test results as prescribed by the English Language Skills Registration Standard to a minimum period of four years.**

Processes adjacent to registration

- 5.103 In addition to complying with the requirements of the NRAS, IMGs are required to interact with a range of other organisations and agencies in order to remain in Australia and practise as the work toward either General or Specialist Registration. These include:
- the Australian Government Department of Immigration and Citizenship (DIAC); and
 - the Australian Government Department of Health and Ageing (DoHA) and Medicare Australia.
- 5.104 The remainder of this Chapter will examine the interrelationship between immigration, residency and registration. It will also examine issues related

to visa and residency status and the implications for accessing Medicare provider benefits.

Immigration and registration

- 5.105 Once an IMG (and their family) have made the decision to come to Australia with the intention of practising medicine, contact must be made with DIAC to determine the individual or family's immigration status. Broadly, there are two paths that can be followed; that by a temporary resident and that by a permanent resident.
- 5.106 The inquiry identified a number of issues affecting IMGs which relate to their interactions with DIAC or to their immigration status. These issues include the provision of registration information for the MBA/AHPRA to assist DIAC to make timely decisions in relation to granting of visas, the impact of changes to immigration status from temporary to permanent residency and deregistration of temporary resident IMGs, all of which are discussed below. Other issues relating to immigration status and access to various support for IMGs and their families are addressed in Chapter 7.

Provision of data for immigration decision making

- 5.107 Once an IMG is offered employment, the IMG must contact the MBA to apply for registration. At around the same time, IMGs who do not already have residency in Australia will need to commence the process of obtaining a suitable visa from DIAC. For the majority of IMGs this means applying for a Temporary Business (Long Stay) Visa (the 457 visa). Once an application has been lodged, DIAC assesses the applicant for visa eligibility based on a range of eligibility criteria. This assessment requires DIAC to obtain some information on the applicant's registration status from the MBA.
- 5.108 As explained by Mr Kruno Kukoc from the Migration and Visa Policy Division of DIAC:
- We do rely on the MBA to provide that registration and to provide the information to the visa applicant, who then brings this as part of the skills assessment criteria under the visa application process.⁷⁰
- 5.109 DIAC further advised in its submission:

70 Mr Kruno Kukoc, Australian Government Department of Immigration and Citizenship, (DIAC), *Official Committee Hansard*, Canberra, 11 October 2011, p 2.

At present, the outcome and process for the registration of OTDs is not easily accessible for departmental case officers making decisions on visa applications. The provision of reliable registration information in this area would result in a streamlining of the registration and immigration skills assessment processes, ensuring that OTDs are not inadvertently delayed by communication difficulties between government and professional bodies.⁷¹

- 5.110 In seeking to improve this circumstance, Mr Kukoc explained to the Committee how access to the MBA/AHPRA registration database would assist in streamlining the immigration decision-making process, noting:

With some other bodies ... we are able to interrogate the registration database of that body and that streamlines the process a lot. We believe that if MBA would consider such a proposal that would probably streamline the visa application process as we would be able to identify immediately and get the information off the registration database to support the visa application.⁷²

Committee comment

- 5.111 The inquiry has highlighted that there are processes which exist in the system of accreditation and registration that contribute to the inefficiencies and delays effecting IMGs. The Committee notes that one of the significant frustrations experienced by many IMGs relates to the complexity of the whole process of coming to Australia and seeking registration to practice medicine. IMGs who are dealing concurrently with multiple different entities have told the Committee that they are required to provide the same information time and time again to confirm that they meet the criteria of each separate entity. Poor communication between entities involved in immigration, registration and employment contributes to the levels of frustration that IMGs experience.
- 5.112 The Committee believes that streamlining communication between the MBA/AHPRA and DIAC would alleviate some of the concerns expressed by IMGs and those seeking to recruit them. Specifically, the Committee recommends that the MBA/ AHPRA should provide DIAC with access to the information on its registration database to expedite DIAC's decision making process on visa eligibility. Importantly, for privacy reasons, the

71 DIAC, *Submission No 138*, p 3.

72 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 2.

accessible information should be limited to that information that would be necessary for the granting of a visa for employment purposes.

Recommendation 24

5.113 The Committee recommends that the Medical Board of Australia/Australian Health Practitioners Registration Agency provide the Australian Government Department of Immigration and Citizenship with direct access to information on its registration database as necessary to determine granting of a visa for employment purposes.

5.114 In Chapter 6 of the report the Committee deals extensively with issues relating to systemic inefficiencies. One of the key recommendations relates to establishing a central document repository. If a central document repository is established, the Committee anticipates that DIAC could be granted an appropriate level of access in order to obtain the information it requires.

Deregistration of temporary resident international medical graduates

5.115 As noted above, temporary resident IMGs (typically holding 457 visas) make up a high proportion of IMGs in Australia. As a result, losing registration can lead to a range of difficulties for IMGs. In particular, holders of 457 visa risk deportation from Australia upon deregistration. As Mr Michael Willard of DIAC's Migration and Visa Policy Division told the Committee:

What typically will happen is that the doctor's employer will inform us that the doctor is no longer registered, and then we need to take cancellation action. That involves a letter that is called a Notice of Intention to Cancel that goes to the doctor. And that asks them to do one of three things: to make an application for another visa, to make arrangements to depart Australia, or to talk to us about their circumstances.⁷³

5.116 The Committee took evidence from a range of IMGs who outlined their circumstances with respect to their experiences of being deregistered and being faced with deportation.⁷⁴ In these circumstances, 457 visa conditions

73 Mr Michael Willard, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 3.

74 See for example: Dr Emil Penev, *Submission No 3*, p 2; Name withheld, *Submission No 39*, p 3; Dr Rajendra Moodley, *Official Committee Hansard*, Brisbane, 10 March 2011, p 27.

stipulated that IMGs have 28 days to try and reregister, find another sponsor or to leave the country. The potential impact of this on IMGs and their families is illustrated by Dr Rajendra Moodley who told the Committee:

... [you are given] 28 days to leave the country, whether you own an asset, you own a home, you have a car, you have children in school – no concept of how it is going to affect them. ... I did not know what I was going to do – put a shirt on and leave, tell my friends to take my keys, sell my house, tell my children, ‘You cannot go to school now.’⁷⁵

- 5.117 In circumstances where an IMG is in the process of appealing an MBA registration decision, Mr Willard advised the Committee that DIAC had discretion to extend the 28 day period if appropriate, or to offer a bridging visa.⁷⁶ However, Mr Kukoc observed:

We have some discretionary powers. ... The 457 visas are temporary visas. As such, the holders do not have access to any social security, community support or general government support. If that person is not able to practise in the occupation in which they work, there are legitimate questions about how that person will be self-supported in Australia. That is also an important question to be asked. Other avenues are available to that person. A person can go back to his home country. When the appeal process kicks in and the appeal hearing is set, we consider other visa options such as 456 [Business Short Stay] to facilitate that person appealing.⁷⁷

Committee comment

- 5.118 The Committee understands that once a temporary resident IMG on a 457 visa ceases to hold registration with the MBA, they will receive a Notice of Intention to Cancel, leaving them 28 days to investigate other options or leave the country. Given these circumstances, it is easy to see how IMGs, some of whom may have resided in Australia for a considerable period of time, may find it difficult to finalise all aspects of their lives in Australia within that short timeframe prior to departing. Clearly this is likely to be stressful and disruptive for IMGs and their families.

75 Dr Sudheer Duggirala, *Official Committee Hansard*, Brisbane, 10 March 2011, p 74. See also: Dr Emil Penev, *Submission No 3*, p 2.

76 Mr Willard, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 3.

77 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 4.

- 5.119 Notwithstanding this, the Committee understands that the 28 day period associated with the Notice of Intention to Cancel is a condition of the 457 visa, which applies to all holders of this visa class regardless of their profession. As this visa class requires the holder to be employer sponsored, an IMG who does not hold registration and so is unable to practise, cannot comply with the visa conditions. Individuals on this visa type should be fully aware of the visa conditions.
- 5.120 While the Committee understands that the 28 day period is a condition of being granted such a visa⁷⁸, it also appreciates that DIAC has some discretion to extend that period depending on individual circumstances. While recognising that this discretion is applied on a case by case basis, the Committee urges DIAC to give due consideration to IMGs who cease to hold registration and who are in the process of appealing an MBA decision regarding registration.

Classifying areas of workforce shortage

- 5.121 There are two systems operating to identify areas of medical practitioner workforce shortages in Australia, the so called Districts of Workforce Shortage (DWS) and Areas of Need (AoN).
- 5.122 DWS is a Commonwealth Government tool, administered by DoHA, which estimates population based doctor-to-patient ratios. Where ratios indicate that there is an insufficient number of medical practitioners in a geographical location to service a population, the location is assigned a DWS classification. AoN classifications are determined by state governments and are linked to particular job vacancies for medical practitioners which have been vacant for some time, despite attempts to fill the positions. The criteria used to determine AoN status vary between jurisdictions.
- 5.123 The operation of DWS is linked to provisions in the *Health Insurance Act 1973*, specifically s 19AB of the Act. As explained by DoHA, the provision:
- ... restricts access to Medicare benefits and generally requires OTDs to work in a district of workforce shortage (DWS) for a minimum period of 10 years from the date of their first medical registration in Australia in order the access the Medicare benefits arrangements.⁷⁹

78 DIAC, Booklet 9, *Temporary Business (Long Stay) (Subclass 457) Visa*, <<http://www.immi.gov.au/allforms/booklets/books9.htm>> viewed 3 February 2012.

79 DoHA, *Submission No 84*, p 4.

- 5.124 This restriction is commonly known as the 10 year moratorium. The 10 year period can be reduced by up to five years if IMGs work in eligible regional, rural and remote areas as defined by the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA).
- 5.125 AoN classifications operate by providing IMGs with opportunities to access an accelerated accreditation and registration pathway (Specialist AoN Pathway) if they agree to work in a state government approved AoN position or location.
- 5.126 The inquiry received a significant volume of evidence raising concerns about the DWS and AoN classifications, and their application. The main issues that have emerged relate to:
- confusion associated with DWS and AoN classifications; and
 - the equity and utility of the 10 year moratorium.

Districts of Workforce Shortage (DWS) and Areas of Need (AoN)

- 5.127 Although broadly speaking DWS and AoN are intended to address issues of medical practitioner workforce shortage and mal-distribution, in a supplementary submission to the inquiry, DoHA provided the following clarification regarding their implementation:

The DWS and Area of Need (AoN) systems have been established for different purposes.

DWS is a workforce distribution mechanism that is based on the Medicare billing statistics and applies to overseas trained doctors (OTDs) and foreign graduates of accredited medical schools (FGAMS) who are seeking to access the Medicare benefits arrangements for their professional medical services.

The AoN system has been implemented to fill vacant medical positions, in both the public and private health systems, with conditionally registered medical practitioners, both Australian and overseas trained.⁸⁰

- 5.128 The Committee took a range of evidence which suggested dissatisfaction, confusion and frustration with the application of the two classification systems. The National Rural Health Alliance (NHRA) dealt at length with concerns around the way in which DWS is estimated. The NHRA specifically noted a lack of transparency associated with the way in which DWS is determined and frequent review and changes in DWS status,
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80 DoHA, *Submission No 84.1*, p 3.

making it difficult for health service providers to effectively plan recruitment strategies.⁸¹ Advocating for more transparency, the NHRA commented further:

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.⁸²

5.129 The NHRA suggested that the DWS classification should be replaced by ASGC-RAs, arguing:

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.⁸³

5.130 A number of contributors to the inquiry expressed a range of concerns relating to AoN classified positions. For example, in a joint submission Associate Professors Steyn and Taraporewalla identified the following problem with AoN:

There is confusion as to what the result of the AoN process signifies to the applicant. If the applicant is considered as approved for the position, the process accepts them as suitable to work in a specialist capacity but denies them recognition as a specialist. This is anomalous, has no real function and perhaps constitutes abuse of the [overseas trained anaesthetist].⁸⁴

5.131 Confusion about the outcomes of the AoN process is well illustrated in the submission received from a South African trained ophthalmologist who observed:

I somehow had the impression that the hospital would sponsor my residency after 2 years of work and did not quite understand

81 National Rural Health Alliance Inc (NHRA), *Submission No 113*, pp 35-42.

82 NHRA, *Submission No 113*, pp 36.

83 NHRA, *Submission No 113*, p 42. See also: Ms Martina Stanley, Alecto Australia, *Official Committee Hansard*, Melbourne, 18 March 2011, p 40.

84 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 7. See also: Australia and New Zealand College of Anaesthetists, *Submission No 87*, p 9.

that my professional application for AoN and Specialist recognition was different - I thought my application documents were being sent to the same processing bodies - AMC, COLLEGE, MBQ etc.⁸⁵

- 5.132 Also commenting on the utility of AoN positions, Dr Diane Mohen, a consultant obstetrician and gynaecologist submitted:

AON positions were created to allow health services to fill gaps to which local graduates cannot be recruited. In reality they have created a level of second tier specialist services and which have allowed health services to avoid the issue of ensuring that the support, incentive and working conditions that should be provided to attract locally trained specialists. AON positions also create situations where OTDs can avoid pursuing the requirements and attaining the skill set and knowledge needed to meet permanent registration to work as a specialist in the Australian workforce.⁸⁶

- 5.133 Some submitters have called for the AoN pathway to be discontinued to encourage IMGs who are specialists to seek full recognition through the Specialist Registration pathway.⁸⁷

- 5.134 In addition, some contributors to the inquiry commented on the interaction between DWS and AoN. Noting that many IMGs subject to s 19AB restrictions requiring them to work in a DWS to access Medicare provider benefits, will also work in an AoN position, the NHRA submitted:

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.⁸⁸

- 5.135 Confirming that an overlap between DWS and AoN classification exists, DoHA submitted:

While there are no formal arrangements, the AoN units within each state and territory generally require that a vacant private practice position is located within a DWS area for the relevant

85 Name withheld, *Submission No 39*, p 1.

86 Dr Diane Mohen, *Submission No 79*, p 5.

87 Associate Professor Michael Steyn and Associate Professor Kersi Tararewalla, *Submission No 54*, p 3; Dr Carlos Zubaran, *Submission No 86*, p 9.

88 NRHA, *Submission No 113*, p 15.

specialty prior to granting an applicant employer approval to employ an AoN doctor.⁸⁹

- 5.136 The submission from the Association of Medical Recruiters of Australia and New Zealand made the following observation on the links between DWS and AoN:

Most States now insist on the DWS being part of the AON application process. Oddly enough we have gone for a standard nationwide registration process but still have the situation where every State/Territory determines its specific AON allocations and requirements. The system needs to be changed to improve transparency and to allow for a site with DWS to automatically be allocated AON status.⁹⁰

- 5.137 As a major recruiter of IMGs, Mr Kevin Gillespie of Health Link Family Medical Centres expressed his frustration with the DWS and AoN classifications, stating:

An IMG GP requires an Area of Need (AoN) certificate from the State Government Department of Health and a District of Workforce Shortage (DWS) approval from the Federal Government Department of Health and Ageing. These 2 approvals both aim to ensure that an IMG GP is only recruited and registered to work in an area of GP workforce shortage. This could be streamlined and improved by only requiring 1 approval, simplifying and shortening the registration process but still maintaining integrity.⁹¹

Committee comment

- 5.138 The Committee recognises that tools to identify locations where there are current shortages of medical practitioners, monitor changes in service needs and workforce distribution over time, are needed to assist with workforce planning and the implementation of measures to address workforce shortages. In relation to DWS, the Committee notes evidence questioning the validity of the criteria and methodology used in its determination. While acknowledging these concerns, the Committee makes no further comment here, as it later consideration on longer term utility of the 10 year moratorium may make comment on the DWS at this stage redundant.

89 DoHA, *Submission 84.1*, p 3.

90 Association of Medical Recruiters of Australia and New Zealand, *Submission No 139*, p 6.

91 Mr Kevin Gillespie, *Submission No 157*, p 2.

5.139 However, given the current importance of DWS classification to recruitment of IMGs (ie enabling IMGs to qualify for a Medicare provider number), the Committee is of the view that the process for determining DWS should at least be made fully transparent. This will assist health recruitment agencies, GP practices and health services, as well as IMGs and community members, to better understand and engage with this classification system.

Recommendation 25

5.140 **The Committee recommends that the Australian Government Department of Health and Ageing produce and publish on its website a comprehensive guide detailing how District of Workforce Shortage (DWS) status is determined and how it operates to address issues of medical practitioner workforce shortages. The guide should include detailed information on the following:**

- **the methodology of DWS determination;**
- **frequency of DWS status review; and**
- **criteria for benchmarking of appropriate workforce levels.**

5.141 The Committee also notes evidence it received in relation to AoN classifications and registration processes. Although the Committee understands that there are jurisdictional variations for determining AoN positions, concerns seemed to relate to the AoN registration pathway, rather than to the use of the AoN classification itself. The Committee was particularly concerned to note that some IMGs were unaware the AoN appointments do not automatically lead to full Australian medical registration. Clearly, it is important that IMGs are made aware of the limitations associated with AoN positions, and the need for them to pursue other registration pathways if they wish to achieve General or Specialist Registration.

5.142 At the same time, the Committee is aware that prior to the implementation of the NRAS some IMGs were able to practise for many years in Australia without progressing to full registration. Now with restrictions on renewals of Limited Registration under the National Law (one year, plus three renewals), there is more impetus for IMGs to progress to General or Specialist Registration. In view of this, the Committee does not believe that there is sufficient justification to recommend that the AoN pathway

be discontinued, as it will still facilitate recruitment of IMGs to positions that are vacant and which have not been able to recruit suitable Australian trained medical practitioners.

- 5.143 With regard to DWS and AoN, it is understandable that some confusion occurs as a result of the presence of two systems of classification of workforce need. On some occasions during the inquiry the Committee was aware that the terms AoN and DWS were used incorrectly in the context of discussion, or where the terms were used loosely, as if interchangeable.
- 5.144 The Committee believes a nationally consistent and transparent approach to determining AoN based on agreed criteria is appropriate in the context of a national registration scheme. Furthermore, while acknowledging that AoN and DWS support two distinct mechanisms of addressing medical workforce shortages, the Committee believes that in establishing a national approach to determining AoN there is scope to improve alignment between AoN and DWS. At present, even though some jurisdictions only provide AoN status for positions that are located in a DWS, the Committee understands that IMGs working in AoN positions are required to obtain two separate sets of documents, one from the relevant state or territory government confirming AoN status and another from DoHA confirming DWS. The Committee considers that a nationally consistent and transparent approach to determining AoN status and improved alignment between AoN and DWS would reduce confusion and streamline administrative processes for IMGs working in AoN positions.

Recommendation 26

- 5.145 **The Committee recommends that the Australian Government Department of Health and Ageing consult with state and territory government departments of health to agree on nationally consistent and transparent approach to determining Area of Need (AoN) status based on agreed criteria. Consideration should also be given to improving the alignment between the AoN and Districts of Workforce Shortage.**

Utility of the 10 year moratorium

- 5.146 One of the most controversial aspects of the medical registration system relates to the 10 year moratorium and the operation of s 19AB of the *Health Insurance Act 1973* (the Act). As noted earlier, the aim of the 10 year

moratorium is to ensure distribution of medical practitioners to areas where there are shortages, including outer-metropolitan, regional, rural and remote locations in Australia.

- 5.147 While this aim is admirable, the Committee took evidence from individuals, organisations and agencies suggesting that the 10 year moratorium may be ineffective and even discriminatory. Specifically, several submissions to the Committee identified that the 10 year moratorium was unfairly preventing IMGs from seeking employment outside of DWS, limiting career progression, limiting access to support and development opportunities, as well as impacting on families.⁹² For example, the Rural Doctors Association of Australia (RDAA) told the Committee that:

In RDAA's view, the 10-year moratorium is discriminatory and imposes immense hardship on OTDs and their families. If there is to be a rural service obligation attached to the allocation of Medicare provider numbers, this service obligation should apply to all doctors wishing to practise in Australia, not just those who trained overseas.⁹³

- 5.148 Similarly in its submission, headspace, Australia's National Youth Mental Health Foundation, contended:

The 10 year moratorium, which requires OTDs to work exclusively in rural and remote areas for 10 years or more, has been accused of being used to 'prop up the rural and remote medical workforce'. The 10 year moratorium is viewed by many as being discriminatory and potentially harmful to both to the OTD and patient as it often places OTDs in areas where there is limited or no access to professional support or supervision in what has been described as some of the most professionally challenging clinical environments.⁹⁴

- 5.149 Dr Andrew Pesce, President of the AMA told the Committee:

... that the best way to support ... IMGs ... is to work towards removing the 10-year moratorium brought about by s 19AB of *Health Insurance Act*. It is now formal AMA policy that the

92 See for example: Australian Medical Association (AMA), *Submission No 55*, p 3; Rural Doctors Association of Australia (RDAA), *Submission No 80*, p 10; Mr Hugh Ford, *Submission No 116*, p 2; Dr Ayman Shenouda, *Submission No 132*, p 2; Dr Jonathan Levy, Australian Doctors Trained Overseas Association, *Official Committee Hansard*, Canberra, 25 February 2011, p 43.

93 RDAA, *Submission No 80*, p 6.

94 headspace, *Submission No 36*, p 5.

moratorium be removed. We know that that cannot happen overnight, but the sooner we make a decision that we should not rely on the moratorium to provide ourselves with a workforce, the sooner we will make long-term decisions that are necessary to address workforce problems, without using, I guess, a conscription model.⁹⁵

- 5.150 The AMA questioned the longer term utility of the 10 year moratorium noting the anticipated increase in Australian trained medical graduates. The AMA made the following suggestion:

Now that we have had a big increase in the number of graduates from Australian medical schools and the number is working its way through to a peak in graduations in the year 2014, it is time to phase out the moratorium requirements as we phase in the new graduates.⁹⁶

- 5.151 The Melbourne Medical Deputising Service also recommended scaling back the period of the 10 year moratorium and phasing out its application to IMGs with permanent residency status.⁹⁷

- 5.152 Conversely, the Committee took other evidence which suggested a continuing need for the 10 year moratorium to ensure that the medical staffing needs of outer- metropolitan, regional, rural and remote Australia are met.⁹⁸ For example, the submission from Tropical Medical Training (TMT) states:

It is with concern that TMT acknowledges the call by the AMA and RACGP to dispense with the 10 year Moratorium without advocating any method of ensuring regional communities in outback regions gain the medical services they require.

Dispensing with the 10 year moratorium would be especially difficult for rural and remote areas of Australia who rely on OTDs to fill over 40 per cent of their workforce. This reliance will remain for many years due to the hardships and deprivations faced by the remote areas of Australia.⁹⁹

- 5.153 In its submission to the inquiry, the Rural Doctors Network (RDN) outlined its support for retaining the 10 year moratorium as follows:
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95 Dr Andrew Pesce, AMA, *Official Committee Hansard*, Canberra, 25 February 2011, p 29.

96 AMA, *Submission No 55*, p 3.

97 Melbourne Medical Deputising Service, *Submission No 121*, p 11.

98 See for example: Rural Doctors Network (RDN), *Submission No 37*, p 18; RHWA, *Submission No 107*, p 5.

99 Tropical Medical Training, *Submission No 114*, p 8.

RDN is in favour of the retention of the Ten Year Moratorium. Without it there would be an even more desperate shortage of doctors in rural areas. RDN does not see the Moratorium as an alternative to massive extra support for rural health needed to attract Australian graduate health professionals to rural and remote areas, but acknowledges that without the Moratorium the existing shortages would be much worse.¹⁰⁰

5.154 In a supplementary submission to the inquiry, the Rural Health Workforce Agency (RHWA) further emphasised its support for the continuation of the 10 year moratorium contending that:

- the IMG recruitment strategy, and by implication the 10 year moratorium, had been successful in increasing the number of general practitioners practising in rural Australia; and
- compulsory rural service schemes, such as the 10 year moratorium, are a practical necessity in the absence of better alternatives.¹⁰¹

5.155 The inquiry also received some evidence related to s19AA of the Act and its interaction with s 19AB. In brief, s 19AA of the Act does not allow access to Medicare benefits for medical practitioners (Australian trained or IMGs) who are permanent residents or citizens unless they are Fellows of a specialist college or are doing an approved postgraduate training or workforce placement.¹⁰²

5.156 As a result, IMGs with permanent residency status may under some circumstances find that they are constrained by the requirements of both s 19AA and s 19AB. As Dr Susan Douglas told the Committee, after gaining her permanent residency, although she was still registered with the MBA in effect could not practise as s 19AA restrictions now also precluded her from accessing a Medicare provider number. Dr Douglas observed:

I was stunned! I had purposefully investigated whether becoming a permanent resident would affect my ability to practice! The devil was in the detail in that in theory I was still registered - I just couldn't practice because I didn't have a provider number.¹⁰³

100 RDN, *Submission No 37*, p 18.

101 RHWA, *Submission No 17.1*, p 4.

102 See for example: AMA, *Submission No 55*, p 4; Dr Susan Douglas, *Submission No 111*, p 15.

Approved postgraduate training or workforce placements are specified by s 3GA of the *Health Insurance Act 1973*.

103 Dr Susan Douglas, *Submission No 111*, p 15.

- 5.157 Mr Hugh Ford, an ACT based solicitor also outlined circumstances affecting an IMG client who on becoming a permanent resident, found that the provisions of s 19AA and s 19AB restricted his options to practise to a greater degree than when he had temporary residency status.¹⁰⁴ Commenting on this issue generally, the NHRA observed:

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.¹⁰⁵

Committee comment

- 5.158 The Committee notes that the inquiry attracted a significant volume of evidence relating to the issue of the 10 year moratorium. From that evidence it is clear that there are dichotomous views on the use of 10 year moratorium as a mechanism to address medical workforce shortages, and its longer term retention or revocation. Although the Committee is conscious of very strong objections to the 10 year moratorium on the basis that it is discriminatory and inappropriate, the Committee does not believe that the immediate repeal of s 19AB of the Act is a responsible course of action. This is particularly as according to some inquiry participants its removal could come at the detriment of the many regional, rural and remote communities that rely on IMGs to fill their medical workforce needs.
- 5.159 As Australia moves towards the goal of self-sufficiency for its medical practitioner workforce, the Committee understands that the utility of s 19AB as a tool to influence workforce distribution is likely to diminish in conjunction with a reduced reliance on IMGs to address workforce shortages. In view of this, the Committee supports a carefully planned, scaled reduction in the length of the 10 year moratorium would be an appropriate course of action. The Committee considers that an equitable arrangement would involve a scaling back the 10 year moratorium so that it is consistent with the average duration of return of service obligations that apply to Australian graduates of Bonded Medical Places.¹⁰⁶ To initiate this process, the Committee recommends that DoHA, in association with

104 Mr Hugh Ford, *Submission No 116*, pp 1-2.

105 NHRA, *Submission No 113*, p 30.

106 See DoHA, *Submission No 84.1*, pp 7-8; Bonded Medical Places (BMPs) are available to first year medical students who are Australian citizens or permanent residents of Australia. Following attainment of Fellowship of a specialist college, BMP graduates are required to work in a DWS for a period equal to their medical degree, referred to as the return of service obligation. Approximately 25% of Commonwealth Supported Places for medical students are BMPs.

Health Workforce Australia (HWA), assess options for a scaled reduction in the length of the 10 year moratorium and use workforce modelling to determine the implications for workforce preparation, transition, training and distribution.

Recommendation 27

- 5.160 **The Committee recommends that the Department of Health and Ageing, in association with Health Workforce Australia, examine options for a planned, scaled reduction in the length of the 10 year moratorium so that it is consistent with the average duration of return of service obligations that apply to Australian graduates of Bonded Medical Places. Workforce modelling should be used to determine the implications for workforce preparation, transition, training and distribution. The outcomes should be made publicly available.**
- 5.161 Notwithstanding the Committee's comments and recommendation, it is important that IMGs currently affected by s 19AA and/or s 19AB of the Act have access to clear and comprehensive information on the application and operation of these provisions. The Committee considers that additional information and guidance could be provided by DoHA through an enhanced DoctorConnect website and through associated supports. The Committee comments further on this proposal in Chapter 7 of the report.
- 5.162 Importantly, as Australia moves towards self-sufficiency for its medical practitioner workforce, the Committee anticipates that more measures will be needed to encourage Australian trained medical practitioners to work in areas where there are workforce shortages. The Committee understands this issue is being considered as part of HWA's Rural and Remote Health Workforce Innovation and Reform Strategy.¹⁰⁷

107 Health Workforce Australia, <<http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform/rural-and-remote-health-workforce>> viewed on 24 January 2012.

Improving administrative efficiency

- 6.1 One of the key messages received by the Committee throughout the inquiry was that much inefficiency and duplication exists within the system of accreditation and registration. Given this complexity, it is not surprising that some of the issues which have caused the most frustration for IMGs and others are those which require coordination between agencies. This frustration is compounded by the apparent duplication or confusing requirements of the various bodies involved.
- 6.2 While the Committee recognises that some of these inefficiencies are as a result of the transition to the new National Registration and Accreditation Scheme (NRAS), it seems that others may be legacy issues arising from previous systems which were operating under state and territory medical boards.
- 6.3 This Chapter considers the main administrative issues which impact on the amount of time it takes for an IMG to become registered. The Chapter considers firstly the time taken for IMGs to navigate the system and the impact on recruitment timeframes and maintaining Limited Registration.
- 6.4 The Chapter then proceeds to examine evidence relating to inefficiencies and inconsistencies in the administration of the NRAS, and concerns relating to the costs associated with obtaining full medical registration. The Chapter concludes with an examination of the mechanisms available to address systemic and professional conduct grievances.

Recruitment timeframes

- 6.5 Before examining some of the administrative inefficiencies which exist, it is useful to outline evidence regarding the delay between an IMG being

offered employment and actually taking up that appointment. Evidence indicates that the complexity and inefficiencies of the accreditation and registration system, and related processes, can lead to a delay of up to two years before an IMG qualifies for Limited Registration and can commence employment.¹

- 6.6 This prolonged delay not only impacts on the IMG and their prospective employer but also on the IMG's family which faces uncertainty about relocation to Australia. Further, the delay can have flow on effects for the communities that rely on IMGs to fulfil local requirements for medical practitioner services. The Association of Medical Recruiters of Australia and New Zealand told the Committee:

Under 2011 rules and regulations, it is difficult to predict when any doctor will be registered. When asked to predict a timeframe, we generally quote a figure for a Registrar of anything up to 9 months depending on the pathway and 12 months for a Specialist. A GP (again depending on qualifications and pathway) can take anything from 8 to 12 months.²

- 6.7 The Government of Western Australia Department of Health, Western Australia reported experience of even longer timeframes, reporting:

Experience demonstrates it may take 5-24 months for an IMG to commence working in WA. This is exacerbated by the many professional and legal requirements required to obtain medical registration, with delays and inefficiencies at each step of the process. When an IMG is appointed to a position, the service is forced to employ locum practitioners to fill the gap whilst the IMG progresses through the process.³

- 6.8 Similarly, the New South Wales Rural Doctors Network noted:

It is not uncommon for it to take 18 months to 2 years to recruit an OTD. Even then they will likely have limited registration and be required to work in an AoN, and will most definitely require District of Workforce Shortage (DWS) practice location and will require further education and/or undergo a period of supervised practice. This is an extensive time period and often gives rise to no

1 Government of Western Australia (WA) Department of Health, *Submission No 82*, p 3; NSW Rural Doctors Network, *Submission No 37*, p 10.

2 Association of Medical Recruiters of Australia and New Zealand (AMRANZ), *Submission No 139*, p 3.

3 Government of WA Department of Health, *Submission No 82*, p 3.

medical services being provided to communities or interruption to services for periods of time.⁴

- 6.9 For IMGs intending to follow a Specialist Registration pathway, the need for specialist college assessment can also add to the time it takes to achieve accreditation. As noted by Queensland Health:

The involvement of specialist colleges in the assessment of OTS may increase the recruitment and registration time of an OTD by three to six months. This highlights the need for review and enhancement of the policies, practices and processes of OTS assessment and registration within the specialist pathway.⁵

- 6.10 Expressing the level of frustration with accreditation and registration timeframes, an individual involved in recruiting IMGs for the Mater Hospital in Rockhampton informed the Committee:

The process is so slow that I always apologise in advance. The delays are frustrating for specialists who have the qualifications and the skill to work anywhere internationally and equally frustrating for private hospitals with substantial workforce problems. We have experienced many highly qualified specialists withdrawing their application. Some of the withdrawals relate to delays and other withdrawals relate to assessment.⁶

Committee comment

- 6.11 The Committee is concerned by reports of extended periods of time taken to recruit IMGs. Clearly these lengthy timeframes are frustrating for IMGs and their families, prospective employers and communities in need. Worryingly, the Committee understands that the apparent complexity of Australia's accreditation and registration systems and associated prolonged timeframes have acted as a deterrent for some IMGs, with some IMGs withdrawing their applications prior to achieving registration.
- 6.12 While it is understandable that assessment and screening processes need to be robust to ensure that IMGs are appropriately qualified and skilled to practise medicine in Australia, it has become apparent to the Committee during the course of this inquiry that there are a range of administrative inefficiencies which hinder this process unnecessarily. Many of these inefficiencies seem to arise as a consequence of poor communication and coordination between the key organisations involved in assessment,

4 NSW Rural Doctors Network, *Submission No 37*, p 10.

5 Queensland Health, *Submission No 126*, p 4.

6 Mater Hospital Rockhampton, *Submission No 92*, p 1.

accreditation and registration. These issues are considered in more detail later in this Chapter.

- 6.13 While the ultimate aim is to streamline the system to achieve maximum efficiency, the Committee considers that more transparency regarding timeframes is needed. To provide IMGs and prospective employers with some indication as to how long the various processes can take (understanding that a high degree of variability exists), the Committee believes that there is a need to establish benchmarks for timeframes with regular reporting on performance against these benchmarks. Succinct and clear data should be published on at least a quarterly basis. This not only assists IMGs and prospective employers to understand the average length of time certain processes will take, but will also provide key organisations involved with accreditation and registration with an understanding of how their processes impact on the overall timeframes.
- 6.14 In the Committee's view, IMGs and others should be aware of the expected average timeframe for undertaking each step of a particular accreditation and registration pathway. For example, information should be available on the time it may take for Primary Source Verification, or the expected waiting time to undergo the Australian Medical Council (AMC) Structured Clinical Examination (SCE) or the Pre-Employment Structure Clinical Interview (PESCI). Overall completion times should also feature in data publication and this information should be regularly updated.

Recommendation 28

- 6.15 **The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, Australian Medical Council and specialist medical colleges, publish data against established benchmarks on their websites and in their annual reports, on the average length of time taken for international medical graduates to progress through key milestones of the accreditation and registration processes. Information published on websites should be updated on a quarterly basis.**
- 6.16 The Committee is aware that under the National Law, AHPRA must submit an annual report to the Australian Health Workforce Ministerial Council (AHWMC). The report must include financial statements regarding the activities of AHPRA and each National Board (including the MBA). A report on the functions of AHPRA's activities under the National

Law must also be made. AHWMC is then responsible for ensuring that the annual report is tabled in the Parliament of each participating jurisdiction including the Commonwealth Parliament.

- 6.17 In the interests of increased transparency, the Committee views that AHPRA's annual report with respect to the functions carried out by the MBA must also include a number of other key performance indicators relating to IMGs. In the Committee's view, these indicators must include (but should not be limited to):
- the country of initial qualification for each IMG applying for Limited Registration;
 - the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and specialist medical colleges; and
 - the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for:
 - ⇒ AMC Multiple Choice Question Examination;
 - ⇒ AMC Structured Clinical Examination;
 - ⇒ AHPRA's Pre-Employment Structured Clinical Interview (PESCI);
 - ⇒ the MBA's English Language Skills Registration Standard;
 - ⇒ other MBA Registration Standards including Criminal History Registration Standard; and
 - ⇒ processes of specialist medical colleges including college interviews, examinations and peer review assessments.

Recommendation 29

- 6.18 **The Committee recommends that AHPRA's annual report, with respect to the functions carried out by the MBA must also include a number of other key performance indicators providing further information to IMGs. In the Committee's view, these indicators must include (but should not be limited to):**
- **the country of initial qualification for each IMG applying for Limited Registration;**
 - **the number of complaints and appeals which are made, investigated and resolved by IMGs to AHPRA, the AMC and**

- specialist medical colleges; and
- **the number and percentage of IMGs undertaking each registration pathway (including workplace-based assessment) and their respective pass and failure rates for:**
 - ⇒ **Australian Medical Council Multiple Choice Question Examination;**
 - ⇒ **Australian Medical Council Structured Clinical Examination;**
 - ⇒ **AHPRA's Pre-Employment Structured Clinical Interview (PESCI);**
 - ⇒ **the MBA's English Language Skills Registration Standard;**
 - ⇒ **other MBA Registration Standards including Criminal History Registration Standard; and**
 - ⇒ **processes of specialist medical colleges including college interviews, examinations and peer review assessments.**

Maintaining Limited Registration

6.19 As outlined above, the timeframe needed to obtain registration can be considerable. In view of this, it is not surprising that some IMGs submitted evidence to the Committee expressing concern that under the National Law, Limited Registration may only be renewed a maximum of three times. On each occasion that renewal is sought, IMGs must demonstrate that they have made progress towards either General or Specialist Registration. The MBA provides guidance on how IMGs can comply with the latter requirement.⁷

6.20 As detailed under the National Law, once the limit of three renewals has been reached, IMGs who have not yet obtained full registration need to reapply for new Limited Registration:

If an individual had been granted limited registration in a health profession for a purpose under this Division, had subsequently renewed the registration in the profession for that purpose 3 times and at the end of the period wished to continue holding limited registration in the profession for that purpose, the individual

7 Medical Board of Australia (MBA), FAQ and Fact Sheets, *Limited Registration - Information on how IMGs can demonstrate satisfactory progress towards gaining general or specialist registration*, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2f4987&dbid=AP&checksum=IXhzMQ8%2baH95CmOzL4aYjQ%3d%3d>> viewed 1 February 2012.

would need to make a new application for limited registration in the profession for that purpose.⁸

- 6.21 As result of this, IMGs effectively have four years to progress from Limited Registration to General or Specialist Registration. A number of IMGs have expressed concerns that this four-year period is not long enough to complete the requirements to obtain full registration, particularly in the case of IMGs seeking specialist recognition. For example, Dr Chaitanya Kotapati told the Committee that:

Some of the key issues I think are the difficulty with the four-year time restriction for doctors already in specialist training in Australia, as mandated by the Medical Board of Australia for attaining general registration. It makes it impossible to meet the competing demands of AMC on the one hand and the Medical Board of Australia on the other hand. It literally becomes impossible to meet all of these requirements. This places us in a very vulnerable position.⁹

- 6.22 Similarly, Dr Sunayana Das told the Committee that:

There is an urgent need to recognise that this period of four years maximum for registration is arbitrary. It is unjustifiably too short a time for anyone to achieve specialist registration from the time of their first receiving registration.¹⁰

Committee comment

- 6.23 The Committee understands that obtaining full registration to practice medicine in Australia is a rigorous process, often requiring IMGs to pass professional examinations and undergo periods of supervised practise. Fulfilling all of these requirements often takes a number of years, and involves periods of intensive assessment which may pose difficulties for IMGs attempting to balance heavy workloads and study.
- 6.24 Nevertheless, the Committee does not believe that amending the current model of three annual renewals for Limited Registration under the National Law is warranted. The Committee understands that under some earlier state and territory registration systems there was no limitation on the number of times IMGs could apply for renewal of Limited Registration. During the inquiry the Committee received evidence from IMGs who had apparently been practising medicine in Australia under

8 *Health Practitioner National Law Act 2009* (Qld) s 72 (note).

9 Dr Chaitanya Kotapati, *Official Committee Hansard*, Brisbane, 10 March 2011, p 20.

10 Dr Sunayana Das, *Official Committee Hansard*, Brisbane, 10 March 2011, pp 21-22.

Limited Registration for many years, even decades without progressing to full registration. While recognising that the limit on the number of times that Limited Registration can be renewed under the National Law may be viewed by some as inappropriate and overly restrictive, the Committee considers this will encourage IMGs to work toward achieving full registration. The Committee supports this objective, particularly as the majority of IMGs should be able to progress to either General or Specialist Registration within this period.

- 6.25 Furthermore, the Committee understands that IMGs that have renewed their Limited Registration three times are not precluded from making a new application. If Limited Registration is granted under these circumstances, the four year period begins afresh. The MBA should further ensure that where Limited Registration is due to expire, particularly where a fresh application is required, that a renewal or expiration notices are sent to IMGs in a timely manner complete with full details of the next steps to be taken.
- 6.26 The Committee is aware that any new application for Limited Registration will require IMGs to demonstrate again that they meet all of the accreditation and registration standards. IMGs affected will need to provide proof of identity documents, undergo primary source verification through the AMC, demonstrate that they comply with the English Language Standard, and provide updated documentation relating to their work practice and registration history. The Committee is of the view that some of the concerns expressed by IMGs would be alleviated with the implementation of some basic administrative enhancements to document handling and archiving. These enhancements, in particular the development of a central document repository, are considered in more detail later in the Chapter.

Administration of the National Registration and Accreditation Scheme

- 6.27 As outlined in Chapter 1 of this report, in 2009-10 legislation was introduced in each state and territory of Australia to support the establishment of the NRAS. The Medical Board of Australia (MBA) was established under the *Health Practitioner National Law Act 2009* (Qld) the 'National Law' to develop the NRAS, with its administrative functions supported by the Australian Health Practitioner Regulation Agency

(AHPRA). The NRAS, under the auspices of the MBA as administered by AHPRA, commenced operating in July 2010.

6.28 In replacing previous state and territory based systems, the aim of the NRAS was to provide health professionals, including medical practitioners, with a simpler and more streamlined process of obtaining accreditation and registration. However, it is clear that the transition to the NRAS had not been without challenges and has presented further overall complexities. For example, Western District Health Service advised that:

The registration and qualification process for overseas trained doctors (OTD's) is burdened with overzealous administrative and accountability processes which are uncoordinated thereby increasing the complexity and risk of extraordinary delays.

Typically an OTD is required to go through the processes of the Australian Medical Council, the relevant Specialist College, AHPRA, Immigration and Department of Health and Ageing, and Medicare for a provider number.

Each of these authorities has its own administration and accountability systems that are uncoordinated, unwieldy and often duplicated or replicate the process system of each other. Each requires its own individual application based upon its own criteria.

The reality of the situation is that whilst applications from OTD's are caught up in the myriad of processes regional and rural communities are suffering.¹¹

6.29 In addition, evidence to the inquiry also indicates that a range of issues have emerged relating to the operation of the NRAS itself. Transitional issues and issues with the new NRAS itself have both contributed to inefficiencies and delays with accreditation and registration. The main issues identified are:

- difficulties experienced by IMGs transitioning from state and territory systems of accreditation and registration to the new NRAS;
- poor communication with applicants seeking information on the progress of their applications or advice on NRAS processes, including:
 - ⇒ long waiting times for responses to inquiries; and
 - ⇒ concerns with the consistency and quality of advice provided;

11 Western District Health Service, *Submission No 184*, p 2.

- frustration with documentation requirements based on poor communication and coordination between key agencies resulting in unnecessary duplication of effort, and exacerbated by inappropriate validity periods for some documents; and
- concerns with the fees and costs associated assessment, accreditation and registration.

Transition to the National Registration and Accreditation Scheme

6.30 Although this issue arose prior to the advent of AHPRA, evidence to the Committee suggests that communication from the MBA on the transition from state and territory medical boards was deficient. This was particularly apparent with respect to communication with IMGs who held registration with former state and territory medical boards in relation to the implication of their transition to the NRAS and their registration status under the National Law.¹²

6.31 For example, in his submission to the inquiry Dr Chaitanya Kotapati also commented on the issue of transition, noting:

The transition process from regional medical boards to Medical Board of Australia has not been a smooth process for many candidates. ... The level of communication process between the colleges and the Medical Board of Australia is very poor and the candidates are being pressurised by the newly established national regulatory authority for submitting support documents from college in time. The candidates or the employing authorities most of the times does not seem to have a clue about any such required documents due to the lack of communication from the Medical Board of Australia in the first place.¹³

6.32 Based on feedback from its members the Australian College of Rural and Remote Medicine (ACRRM) identified the following transitional issues:

- Poor communication and transparency by medical board of policies regarding new requirements (e.g. IELTS) and progression timeframes to gain Australian qualifications;
- Policies and processes did not provide adequate allowance for time required to meet new requirements at same time as meeting employment commitments;
- Increased costs for new requirements;

12 See for example: Dr Piotr Lemieszek, *Submission No 118*, pp 4-5; Dr Salahuddin Chowdhury, *Submission No 178*, p 1.

13 Dr Chaitanya Kotapati, *Submission No 21*, p 3.

- Lack of willingness by boards to communicate personally with OTDs impacted by these changes;
- No apparent ability to apply discretion in how to manage individual cases/applications;
- Failure to introduce supported transitional learning plans including increasing opportunities to study and re-skill particularly in the Area of Need/limited;
- registration status context;
- Limitations on OTD to be able to access requisite assessment (e.g. time delay incurred in gaining place on AMC Clinical exam); and
- Poor understanding by recruiters regarding expectations of boards.¹⁴

6.33 ACCRM also told the Committee:

The change management process between the old and new registration arrangements was not smooth but does seem to be improving. ACRRM is aware that many organisations and individuals were significantly affected at both a professional and personal level by the lack of clear, consistent and correct information about requirements, lack of communication channels and lack of ability to escalate urgent matters for resolution. For OTDs the ineffectiveness of the system had the flow on implication of compounding other highly significant issues such as immigration decisions/arrangements, employment offers, confidence in decisions to relocate their families etc.¹⁵

Committee comment

6.34 The Committee acknowledges that the transition from state and territory Medical Boards to form a single national entity was a complex and difficult undertaking, and it is not surprising that the NRAS has experienced some teething problems. One of the more challenging issues has been managing registration of medical practitioners who had previously been registered under the disparate state and territory systems. It is also clear that some IMGs are concerned by the way in which transition to the NRAS was handled. In particular it seems that the implications of the transition were not fully explained to IMGs themselves. This lack of communication was unfortunate, and has undoubtedly contributed to the confusion and angst experienced by some IMGs.

14 Australian College of Rural and Remote Medicine (ACRRM), *Submission No 103*, p 9.

15 ACCRM, *Submission No 103*, p 9.

- 6.35 In addition, some IMGs who were well advanced in the process towards full registration under state and territory medical board processes, have suggested that they have been disadvantaged as a result of the commencement of the National Law. The Committee has already noted in Chapter 1, that in June 2011 the Senate Finance and Public Administration Committee reported on the administration of health practitioner registration by AHPRA. The Senate Committee's report dealt extensively with transitional issues, as well as reviewing AHPRA's administration more generally.¹⁶ In particular the Committee notes the Senate report's first recommendation which directed AHPRA to compensate practitioners who had been de-registered as a consequence of administrative problems. The Committee supports this recommendation as a means to address any losses that IMGs may have incurred when it can be established that they were without registration due to maladministration by AHPRA.
- 6.36 On the whole however, there is little evidence to suggest that IMGs have been disadvantaged in this way. Rather, as outlined earlier, it is evident that some accreditation, assessment and registration requirements (such as English language proficiency assessment and the need to achieve full registration within essentially a four-year timeframe) are more stringent under the NRAS than under previous state and territory based systems. Although the Committee realises that the increased stringency has been a cause of discontent for some, it is an unavoidable consequence of amalgamating different systems and establishing a national system that ensures standards are sufficiently robust and IMGs have the necessary qualifications, skills and experience to practise in Australia.
- 6.37 Nevertheless, the Committee believes that where an IMG considers they have been significantly disadvantaged by the transition from the old system of registration to the NRAS, the MBA/AHPRA should ensure that the circumstances are investigated, and if necessary, rectified. The process and procedure for review should be clearly outlined on the MBA/AHPRA website. Any review should also be conducted in a timely and transparent manner.

16 Parliament of Australia, Senate Finance and Public Administration References Committee, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, June 2011.

Recommendation 30

- 6.38 **The Committee recommends that where an international medical graduate considers that the processes prescribed under the National Registration and Accreditation System have placed them at a significant disadvantage compared to their circumstances under the processes of former state and territory medical boards, that the Medical Board of Australia investigate the circumstances, and if necessary rectify any registration requirements to reduce disadvantage. The process and procedure for review should be clearly outlined. Any review should be conducted in a timely and transparent manner.**

Responding to inquiries

- 6.39 The Committee has received evidence in relation to responses to inquiries made in relation to inquiry services operated by the MBA/ AHPRA state and territory offices, as well as the AMC. The key concerns cited were that there were:

- delays in responding to e-mail inquiries;
- lengthy on hold wait times for telephone inquiries; and
- discrepancies in the quality and consistency of the advice given.

- 6.40 For example, the Australian Medical Association (AMA) noted:

If the applicant wishes to discuss the process, it is possible to wait 1 hour on the telephone and then receive an incomplete answer. It seems that everything takes 10 days. If an applicant lodges a form and wants to discuss it, a wait of 10 days is required. If an agency wishes to make enquiries on behalf of an applicant an authority to act is lodged which takes 10 days to process.¹⁷

- 6.41 Alecto Australia noted in its submission that:

The AMC call centre is often unavailable due to technical difficulties making it impossible for candidates to check on the progress of their application. There was recently a period of more than a week where it was impossible to call the AMC. The only method of communication was by email and then we had to wait for a call back. Similarly the AHPRA call centre is still unable to provide good information on any issue. It is quite common to get

17 Australian Medical Association (AMA), *Submission No 55*, p 7.

different advice from different members of staff on the same day. It is also seldom the case that the telephonist can answer a query. Typically, the caller is put on hold while the telephonist asks a manager for information.¹⁸

- 6.42 It has been suggested that insufficient training for call centre staff and high staff turnover rates could contribute to the poor quality and inconsistent advice provided in response to queries. Melbourne Medical Deputising Service's submission stated:

Since the commissioning of AHPRA in July last year we have found the processing of national registration extremely slow and while the staff on the help lines are always polite and do try to assist they field calls in a generic manner. On some occasions information provided has been found to be inconsistent and inaccurate.

On more than one occasion, when necessary information was not available from the AHPRA website, MMDS personnel have experienced 'I can't give you that information because of privacy reasons' - central call centre staff did not seem to know that a doctor's registration status is public information.¹⁹

- 6.43 Challis Recruitment also observed:

Communication with AHPRA is still very difficult via the 1300 #. There have been a number of technical issues with this telephone line and even when operational, it is very difficult reaching a member of the appropriate state medical team. Often the call is screened by the operator (who often cannot assist with the query or gives incorrect advice).

There seems to be a frequent turnover of personnel at most of the regulatory bodies which means that advice given can be sometimes incorrect due to lack of staff training/knowledge.²⁰

Committee comment

- 6.44 The Committee considers that that the transition to the NRAS should have improved the process for IMGs to obtain information pertaining to their individual circumstances. However, based on evidence provided to the

18 Alecto Australia, *Submission No 85*, p 5. See also: Western NSW Local Health Network, *Submission No 49*, p 4-5.

19 Melbourne Medical Deputising Service, *Submission No 15*, p 15.

20 Challis Recruitment, *Submission No 88*, p 11. See also: Government of South Australia Department of Health, *Submission No 96*, p 3.

inquiry it seems that current systems do not have the capacity to deal effectively with the volume of inquires from IMGs and other organisations wishing the clarify specific information regarding accreditation and registration. This has resulted in lengthy waiting times for telephone inquiries and delays in responding to e-mail inquiries.

- 6.45 In the interests of reducing waiting times and increasing efficiency, the Committee recognises the need for relevant agencies to ensure that all staff dealing with inquires have at their disposal relevant information in electronic form. This will help to ensure that queries are answered promptly and with minimal need for additional information to be sought elsewhere. Where computer-based information management systems are used, the AMC and the MBA/AHPRA should ensure that appropriate case notes detailing advice given and actions taken are entered by staff in the event that later clarification is required. To enhance the utility the AMC and MBA/AHPRA should ensure that information regarding the each IMG's accreditation and registration status is available to the relevant agencies in an appropriate and compatible form, bearing in mind the need to comply with the Australian Government's Information Privacy Principles and *Privacy Act 1988* (Cth). This matter is considered in later in the Chapter in association with a proposal to establish a central repository of documentation.

Recommendation 31

- 6.46 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency ensure that computer-based information management systems contain up-to-date information regarding requirements and progress of individual international medical graduate's assessment, accreditation and registration status to enable timely provision of advice.**

- 6.47 In addition, the AMC and the MBA/AHPRA should ensure that staff members are given adequate training in understanding the overall system of assessment, accreditation and registration so that any information provided to IMGs is reliable and consistent. The Committee also understands the frustrations of those IMGs who feel that they do not have access to an identified individual in a case management capacity

regarding either their accreditation or registration applications. The Committee will consider these options in Chapter 7.

Recommendation 32

- 6.48 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency implement appropriate induction and ongoing training for all employees responsible for dealing with inquiries. This training should include among other things, an understanding of the overall system of accreditation and registration so that referrals to other organisations can be made where necessary.**

Documentation requirements and processing

- 6.49 Providing documentation to verify that IMGs are suitably qualified, with the skills and experience to practise in Australia is a fundamental requirement of the NRAS. However, evidence to the inquiry has highlighted the difficulties faced by IMGs in dealing with their documentary evidence obligations. Adding to these difficulties, a large number of submissions have identified frustration with documents processing, apparently as a result of poor communication and coordination between key agencies. Applicants are frequently required to provide copies of the same document to multiple agencies, or even the same information, but in a different format again leading to duplication and wasted time and effort. In addition, some inquiry participants also expressed concern about the unreasonably short validity of some documents, meaning that if there are any delays documents expire and new versions have to be obtained.
- 6.50 Table 6.1 is a summary of the type of documentation which an IMG may need to provide as part of the accreditation and registration processes in order to obtain Limited Registration for an Area of Need.

Table 6.1 Documents required for an initial application for Limited Registration

▪ certified copies of all academic qualifications including examinations and assessments undertaken
▪ certified copy of primary medical degree certificate
▪ proof of internship
▪ evidence of specialist qualifications
▪ certificate of registration status or Certificate of Good Standing from previous jurisdictions
▪ curriculum vitae outlining full practice history
▪ possible criminal history in Australia and overseas
▪ details of any proposed supervised training positions
▪ proof of continuing professional development requirements and a continuation plan if required
▪ details of any relevant training and assessment
▪ details of any physical or mental impairment
▪ details of any registration or suspensions
▪ proof of any previously refused or cancelled registrations
▪ proof of any scope of practice restrictions
▪ proof of any disqualifications
▪ proof of any conduct performance or health proceedings
▪ AMC Certificate
▪ letters of recommendation from specialist medical colleges
▪ details of successful completion of AMC Multiple Choice Question Examination
▪ outcome of any PESCI assessment
▪ intended position description
▪ area of need declarations

Source: MBA, *Application for limited registration for an area of need for Specialist Practice as a Medical Practitioner*, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f1330&dbid=AP&chksum=n0YXjs4TPKZ8PWWFJRNffQ%3d%3d>> viewed 3 February 2012.

Duplication

- 6.51 In addition to supplying these documents to the AMC, specialist medical colleges and the MBA/AHPRA, some of the same documentation may also need to be supplied to prospective employers and to the Department of Immigration and Citizenship (DIAC) as part of the visa application process. The process of obtaining the required documentation from overseas educational institutions and employers can also be costly and time consuming for IMGs, while adding an additional burden on IMGs who are already navigating a complex system.
- 6.52 Outlining the enormity of supplying all of the required documentation to the key agencies involved in accreditation and registration, Challis Recruitment told the Committee:

OTDs are asked to supply documentation detailing their basic training, advanced training, papers written, basic and advanced college exam results (not just evidence of the qualifications awarded when successfully passing an examination). Most specialist assessment submissions run into hundreds of pages (and most of those documents must be correctly certified, and duplicated at least 3 times which is hugely expensive) so that each individual regulating body (AMC, College, APHRA) receives a copy for their files.²¹

6.53 With regard to IMGs seeking specialist recognition, the AMC submitted:

The specialist assessment pathway is open to criticism that an IMG has to submit the same documents to as many as four different authorities, including a certified set to AMC, a certified set to the College (if requested), a certified set to the Medical Board and possibly a certified set to an employer.²²

6.54 Ms Charlie Duncan, Recruitment and Locums Manager, Health Workforce Queensland outlined administrative inefficiencies associated with demonstrating English language proficiency, explaining:

There are problems with the process, and that is because to become registered you have to deal with multiple agencies. I will give you an example which might help. As you know, you apply through the AMC, the AMC do their step and then you apply to AHPRA. Those are two departments – and there are others involved as well – both asking doctors to provide a copy of their English language test. The AMC comes first, and they are happy to take a copy. AHPRA comes second and they have to have an original, and that original has to come directly from IELTS. So the doctor cannot even get their original so they can send a copy to the AMC and then send the original to AHPRA. They have to get an original to get a copy to the AMC, and then get another original sent directly from IELTS to AHPRA.²³

6.55 Individual IMGs have also told the Committee about their experiences with documentation and the effect of organisations losing some documentation or having multiple requests to provide the same documentation. Dr Susan Douglas told the Committee:

21 Challis Recruitment, *Submission No 88*, p 8.

22 Australian Medical Council (AMC), *Submission No 42*, p 25.

23 Ms Charlie Duncan, Health Workforce Queensland, *Official Committee Hansard*, Brisbane, 10 March 2011, p 67.

I contacted the AMC and asked what information I needed to submit because I had already submitted all of the documentation in the past, which should be in my file. The representative informed me that they didn't keep a lot of the information in their records! They also wouldn't tell me what information they actually had in my file. I couldn't believe that they expected me to repeat the process which had taken me over six months to do the first time!²⁴

6.56 Dr Chellam Kirubakaran outlined his experience as follows:

During the process of getting my initial assessment by the AMC and later by the College of Physicians, I had to submit my curriculum vitae five times. At one point I was asked to provide an 'expanded curriculum vitae' although I had given a very detailed write up, taking 27 pages in all. It appeared that the organisations kept losing my file repeatedly and there was no co-ordination between the two institutions. The 'source verification' of my qualifications was done twice and I had to pay for the second time as well.²⁵

6.57 Acknowledging administrative inefficiencies in its submission, the AMC noted:

One option being considered by the AMC is a possibility for it and the Medical Board of Australia to share access to electronically scanned documents along similar lines to the process that currently applies to primary source verification of medical documents. If successful this could be extended to participating Colleges.²⁶

Committee comment

6.58 Given the volume of documentation required in the accreditation and registration process, a reduction in the cost and time associated with the provision of these documents by IMGs will have an impact on the overall processing times for applications by IMGs. It is unclear to the Committee why the key organisations involved in accreditation and registration do not appear to have established a coordinated and streamlined system for processing of documentation.

24 Dr Susan Douglas, *Submission No 111*, p 17.

25 Dr Chellam Kirubakaran, *Submission No 122*, p 2.

26 AMC, *Submission No 42*, p 25.

- 6.59 Therefore the Committee proposes that the MBA/AHPRA and the AMC develop a centralised document repository which will enable all relevant organisations, including specialist medical colleges, to access authorised copies of documentation provided by IMGs for accreditation and registration purposes. In the Committee's view, this would greatly reduce the time and costs currently incurred by IMGs and increase the efficiency by which relevant agencies could manage accreditation and registration of IMGs.
- 6.60 The Committee anticipates that such a system would form a perpetual record of documentation submitted by individual IMGs, and that this documentation could be accessed by the relevant organisations to fulfil future accreditation and registration documentary requirements where necessary, subject to relevant validity periods. Importantly, it would negate requirements for IMGs to resubmit non time-limited documentation to relevant organisations multiple times.
- 6.61 In establishing a central document repository however, the Committee is of course aware that access by organisations involved in the accreditation and registration processes would need to comply with the Australian Government's Information Privacy Principles and any requirements under the *Privacy Act 1988* (Cth).

Recommendation 33

6.62 **The Committee recommends that the Medical Board of Australia, in conjunction with the Australian Medical Council and specialist medical colleges, develop a centralised repository of documentation supplied by international medical graduates (IMGs) for the purposes of medical accreditation and registration.**

The central document repository should have the capacity to:

- **be accessed by relevant organisations to view certified copies of documentation provided by IMGs;**
- **be accessed by relevant organisations to fulfil any future documentary needs for IMGs without the need for them to resubmit non time-limited documentation multiple times;**
- **form a permanent record of supporting documentation provided by IMGs; and**
- **comply with the Australian Government’s Information Privacy Principles and *Privacy Act 1988* (Cth).**

Consistency

6.63 Several submissions have noted inconsistencies in the documentation requirements of the different accreditation and registration agencies even though ostensibly validating the same aspect of an IMG’s application. For example, the AMC and AHPRA have different requirements for documents to establish proof of identity. To prove identity, the AMC requires IMGs to provide a certified copy of their passport, and one of the following:

- a certified copy of your driver’s licence
- a certified copy of your credit card (front and back) – only bank-issued cards will be accepted; cards for internet/electronic use only are not acceptable
- a certified copy of your International English Language Testing System Test Report Form (IELTS-TRF) (with photograph)
- a certified copy of your current registration or certificate of good standing from a relevant medical regulatory authority.²⁷

27 AMC, Assessment and Examinations, Document standards (Proof of identity), <<http://www.amc.org.au/index.php/ass/apps/id-proof>> viewed 1 February 2012.

- 6.64 In contrast, the MBA/AHPRA has more stringent proof of identity standards which require IMGs to produce at least one document from each of four categories, these being:
- Category A: Commencement of Identity
 - Category B: Link between the identity and the person by means of photo and signature
 - Category C: Evidence of identity operating in community
 - Category D: Evidence of identity's residential address.²⁸
- 6.65 While there is capacity for some overlap in the proof of identity documentation required, IMGs must provide all supporting documents again to the MBA/AHPRA irrespective of what has already been submitted to the AMC.
- 6.66 Furthermore, in some cases the acceptable form of documentary evidence differs. For example, as noted earlier in relation to provision of English language test results, organisations involved in accreditation and registration have different requirements with regard to the need to supply original documents versus appropriately certified copies.
- 6.67 Another example of inconsistency is the differing versions of curriculum vitae (CV) required by the AMC, specialist colleges and the MBA/AHPRA.²⁹ The AMC provides a template for CVs along with some additional guidance on its website.³⁰ The MBA/AHPRA also provides IMGs with a standard format for a CV, which is different to that used by the AMC.³¹ As a result IMGs have to present different versions of their CVs, containing essentially the same information. As explained below by AMC:

A common CV document was developed by JSCOTS and well supported by the Specialist Colleges. However the MBA also has a standard CV document. As a result an applicant may submit the AMC/Specialist College approved CV document and complete the assessment only to find that he or she must complete the MBA

28 Australian Health Practitioner Regulatory Authority (AHPRA), *Proof of Identity Requirements*, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f1973&dbid=AP&checksum=H7xVC2W%2bm57CqcCbJbUOrg%3d%3d>> viewed 1 February 2012.

29 Association of Medical Recruiters Australia & New Zealand, *Submission No 139*, p 4.

30 AMC, Assessment & Examinations, Specialist Pathway (Specialist recognition), <<http://www.amc.org.au/index.php/ass/apo/spp/spfr>> viewed 1 February 2012.

31 AHPRA, Standard Format for Curriculum Vitae, <<http://www.ahpra.gov.au/Registration/Registration-Process/Standard-Format-for-Curriculum-Vitae.aspx>> viewed 1 February 2012.

standard CV document when applying for registration. [The AMC/Specialist College CV document was developed and approved prior to launch of MBA so this was not an issue at the time]. This process is open to criticism for unnecessary duplication and should be addressed.³²

Committee comment

- 6.68 The Committee has already commented on unnecessary waste of time and effort resulting from administrative inefficiencies in processing of supporting documentation for IMGs. To address these concerns the Committee has recommend the establishment of a central document repository accessible to the relevant agencies. To streamline processes for document lodgement and handling further, the Committee also understands that the key agencies involved in accreditation and registration will need to develop more consistent requirements for supporting documentation.
- 6.69 While recognising that not all organisations will have identical requirements for documentation, where overlaps do occur steps should be taken to ensure that these documents need only be lodged once. It is unclear to the Committee why organisation under a national system of accreditation and registration should have differing requirements on the form (i.e. original or certified copies) and format of supporting documentation which they will accept. The Committee is concerned that such minor differences not only add to the administrative burden for organisations, but also lead to unnecessary cost and time impositions on IMGs.
- 6.70 Therefore the Committee recommends that the MBA/AHPRA, AMC and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible, with a view to further reducing duplication by preventing the need to lodge information on more than one occasion and in different forms and formats.

32 AMC, *Submission No 42*, p 25.

Recommendation 34

- 6.71 **The Committee recommends that the Medical Board of Australia/Australian Health Practitioner Registration Agency, the Australian Medical Council, and specialist medical colleges consult to develop consistent requirements for supporting documentation wherever possible. These requirements should be developed with a view to further reducing duplication by preventing the need for international medical graduates (IMGs) to lodge the information more than once and in different forms and formats.**

This documentation should form part of an IMG's permanent record on a central document repository.

Document validity

- 6.72 The Committee has heard that it is not uncommon for IMGs to encounter unexpected delays for a variety of reasons and at different stages of the accreditation and registration processes. Where supporting documents are only accepted as valid by agencies for a limited period, these delays may extend beyond that period, requiring new documents to be produced by the IMG. The Committee received a range of evidence relating to document validity, and in Chapter 5, has already recommended extending the validity period for English language test results so that they are more consistent with accreditation and registration timeframes.
- 6.73 In addition, one of the issues most frequently raised relates to the three month validity period for Certificates of Good Standing (or work practice history). In order to demonstrate an IMG's medical registration history, both the AMC and the MBA/AHPRA require IMGs to provide Certificates of Good Standing from each employer. The AMC requires IMGs to provide Certificates of Good Standing from all employers over the previous two years³³, while the MBA/AHPRA requires these Certificates from all employers over the previous 10 years.³⁴ The MBA's application forms for Limited Registration state:

You must arrange for original Certificates to be forwarded directly from the licensing or registration authority to the relevant state office of the Medical Board of Australia. Certificates submitted to

33 National Rural Health Alliance, *Submission No 113*, pp. 13 -14.

34 Medical Board of Australia (MBA), Registration Standards, <<http://www.medicalboard.gov.au/Registration-Standards.aspx>> viewed 1 February 2012.

the Board must be dated within 3 months of the application being lodged with the Board.³⁵

- 6.74 Dr Joanna Flynn, Chair of the Medical Board of Australia explained the purpose of this requirement to the Committee:

We now require anyone coming into Australia for registration to provide direct evidence to the board from the jurisdictions in which they have been registered at any time in the last 10 years that they do not have any adverse disciplinary history.³⁶

- 6.75 However, as noted by the Western NSW Local Health Network, the short period of validity for Certificates of Good Standing frequently results in IMGs having to obtain new documents part way through the accreditation and registration process:

The 'certificates of good standing' which OTD's must obtain from their home registration board (or any board they have been subject to in the last ten years) only have a life of three months. Because of delays, these certificates frequently expire mid-process causing further, unnecessary hold-ups.³⁷

- 6.76 In addition, noting that Certificates of Good Standing are required by both the AMC and the MBA/AHPRA, but at different stages of the accreditation and registration processes, the AMA observed:

Some of the documentation such as letters of good standing are repeated for AMC and MBA but by the time it is needed the second time, a new letter of good standing is required due to delays.³⁸

- 6.77 Similarly, Alecto Australia submitted:

The requirements for gaining a Certificate of Good Standing differ for the AMC and AHPRA and the processes mostly have to be conducted separately as there is often a substantial time delay in the process so that the initial [Certificates of Good Standing] may be invalid by the time the applicant is dealing with AHPRA.³⁹

35 MBA, Registration Forms, *Application for limited registration for an area of need*, p 5, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD10%2f1330&dbid=AP&chksum=n0YXjs4TPKZ8PWVfJRNffQ%3d%3d>> viewed 1 February 2012.

36 Dr Joanna Flynn, MBA, *Official Committee Hansard*, Canberra, 25 February 2011, p 18.

37 Western NSW Local Health Network, *Submission No 49*, p 10.

38 AMA, *Submission No 55*, p 7.

39 Alecto Australia, *Submission No 85*, p 4.

Committee comment

- 6.78 The Committee views that the requirement for the provision of Certificates of Good Standing should form part of the centralised document repository as outlined earlier in this Chapter. However, the three month validity period appears to create an unreasonable burden for IMGs. The basis for the very restricted period of validity is unclear, and the Committee is of the view that the validity period should be extended to 12 months for a number of reasons.
- 6.79 In the first instance, an undue burden is caused to IMGs due to the possibility that the accreditation and registration process may not be finalised within the three month validity period, and fresh Certificates may have to be obtained part way through the process.
- 6.80 Secondly, the Committee views that it is unlikely that Certificates of Good Standing issued by a past employer will change, excepting under exceptional circumstances where there is disciplinary action or other decision pending, relating to an IMG's past employment or registration. Extending the Certificate's validity to 12 months should avoid expiration of the Certificate for administrative reasons only, but would ensure that any significant change in circumstance associated with previous employment which might affect the standing of the IMG would be taken into account.
- 6.81 The Committee is of the view that where there is a lapse of time of three months or more since the last Certificate was issued, IMGs should be required to certify that they have not been employed in medical practise during that time. Where an IMG has been employed in medical practise during that period, additional Certificate(s) will be need to be provided.

Recommendation 35

- 6.82 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Registration Agency amend requirements so that Certificates of Good Standing provided by past employers remain valid for a period of 12 months, noting the following:**
- **where there is a period of greater than three months since the last Certificate was issued, applicants must certify that they have not been employed in medical practice during that period; or**
 - **where applicants have been employed in medical practice since issuing of the last Certificate, additional Certificate(s) of Good Standing must be provided.**

Certificates of Good Standing should also be available on a central document repository.

Application and assessment fees

- 6.83 The Committee has heard evidence relating to the fees payable to the AMC, the MBA and specialist medical colleges for IMGs who are undertaking their chosen pathway towards accreditation and registration as a medical practitioner in Australia.
- 6.84 The MBA told the Committee that assessment processes for IMGs are funded via a 'user pays' approach, which is an expensive process for applicants. The MBA provided a breakdown of indicative costs IMGs would usually pay to proceed down each registration pathway, including AMC fees, visa fees, MBA registration costs and relevant college fees (using the Royal Australian College of General Practitioners (RACGP) as an example). The MBA estimated that an IMG's total costs for pursuing a particular pathway is indicatively as follows:
- Competent Authority Pathway - approximately \$4 165;
 - RACGP Pathway (ranging depending on the categorisation of the IMG's comparability level) - approximately \$3 615 to \$11 900;
 - Standard Pathway - approximately \$8 730.

6.85 These estimates did not include provision for any visa or travel costs incurred by the IMG to travel for interviews, if required by the MBA or specialist medical colleges.⁴⁰

6.86 Dr Sunayana Das told the Committee that the AMC's fee structure is unfair and burdensome:

The excessive fees charged by the AMC at every stage of the process and draconian fee structure (including a \$95 'document correction fee' if any documents in an application are wrong or missing, and the fact that the AMC charges \$1.95 per minute for the privilege of talking on the phone to someone there) together with the unnecessary red tape, is designed only to raise revenue for the AMC and support its bureaucracy. It is inefficient and places a considerable unfair financial burden on salaried doctors working in the public health system.⁴¹

6.87 IMGs and relevant stakeholders also told the Committee that fees charged to IMGs pursuing specialist accreditation through one of the specialist medical colleges vary significantly between colleges and these varying costs are often not justified or warranted.

6.88 The South Eastern Sydney Local Health Network submitted as follows:

OTDs have also complained that, whilst the fees from the Department of Immigration, the AMC and the Medical Board are 'reasonable', Colleges are charging fees in the thousands of dollars, which OTDs feel does not reflect the amount of work required.⁴²

6.89 In a joint submission to the Committee, Associate Professors Michael Steyn and Kersi Taraporewalla told the Committee that fee processes across colleges should be uniform and reasonable. Discussing the process IMGs must undertake to gain a position in an Area of Need (AoN), the Associate Professors told the Committee:

There is no process which seeks justification of the amount of the fee charged and there is lack of uniformity between the colleges as to who should pay the fees.⁴³

40 For breakdown of the estimate of fees for each pathway, see AMA, *Submission No 55*, Attachment A, p 14.

41 Dr Sunayana Das, *Submission No 99*, p 3.

42 South Eastern Sydney Local Health Network, *Submission No 16*, p 2. See also: Illawarra Shoalhaven Local Health Network, *Submission No 17*, p 2.

43 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla, *Submission No 54*, p 7.

- 6.90 The Overseas Trained Specialists Anaesthetists Network (OTSAN) highlighted what it saw as a financial burden imposed by specialist medical colleges on overseas trained specialists:

For example charges that are imposed by the Australian and New Zealand College of Anaesthetists include fees for Area of Need application, paper assessment, interview, clinical practice assessment, examination/workplace based assessment etc and amount to 13,500 AUD per candidate (relevant travel costs not included) or even more if more than one attempt for exams/assessment is needed.⁴⁴

- 6.91 In response to concerns raised regarding the fee structure of specialist medical colleges, the Committee has heard arguments from colleges themselves justifying their fees.
- 6.92 Ms Dianne Wyatt, Strategic Projects Manager for the Australian College of Rural and Remote Medicine (ACRRM) noted that a staged fee approach allowed an IMG who was not assessed as substantially or partially comparable to avoid incurring further costs.⁴⁵
- 6.93 ACRRM stated that if an IMG is assessed as partially or substantially comparable, the fees for each stage of assessment are discretionary, depending on what level of comparability the IMG is assessed at:

If it is considered that they would be substantially or partially comparable, they go to interview and then there is a charge for the interview. It will depend on whether they are substantially or partially as to what the cost will be. If they are substantially, they have a year of peer review and they pay for multisource feedback. If they are partially it can be up to two years and they can have a higher level of assessment, which is also paid. So they pay for what is actually required. There is not an overall fee – for example, you are in or you are out.⁴⁶

- 6.94 Dr Richard Willis, of the Australian and New Zealand College of Anaesthetists (ANZCA) told the Committee:

As you know, the colleges are self-funded, and I guess it depends on the way that individual colleges divvy up the money that is available. Certainly the IMG process in our college is supposed to

44 Overseas Trained Specialists Anaesthetists Network (OTSAN), *Submission No 38*, p 2. See also: Queensland Health, *Submission No 126*, p 5.

45 Ms Dianne Wyatt, Australian College of Rural and Remote Medicine (ACRRM), *Official Committee Hansard*, Brisbane, 10 March 2011, p 59.

46 Ms Wyatt, ACCRM, *Official Committee Hansard*, Brisbane, 10 March 2011, p 59.

be self-sufficient, and seeing there is no money other than from subscriptions and training fees there are differences from other colleges. It would be very nice if they were all the same.⁴⁷

Committee comment

- 6.95 The Committee notes that the cost of pursuing a pathway towards accreditation and registration as a medical practitioner in Australia is significant for IMGs, particularly for those seeking specialist accreditation.
- 6.96 The Committee understands the need for colleges to itemise or stage their fees to ensure that IMGs are not paying for a stage of assessment they are not undergoing. However, from the evidence provided to the Committee it appears that the total fees applied to applicants can be significant and can be provided without appropriate justification as to why the fees for individual IMGs might vary and why there are differences between the colleges. The Committee is therefore not surprised that some IMGs are left feeling that the fees applied are inconsistent and unfair.
- 6.97 Accordingly, the Committee is of the view that the specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to IMGs seeking specialist accreditation in Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the AMC and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should also be informed about possible penalties which may be applied throughout the assessment process.
- 6.98 The Committee is also of the view that the MBA, the AMC and specialist medical colleges should review the administrative fees and penalties which are applied throughout the accreditation and specialist assessment process to ensure that these fees can be justified in a cost recovery based system.

47 Dr Richard Willis, Australian and New Zealand College of Anaesthetists, *Official Committee Hansard*, Melbourne, 18 March 2011, p 56.

Recommendation 36

- 6.99 **The Committee recommends that specialist medical colleges should consult with one another to establish a uniform approach to the fee structure applied to international medical graduates (IMGs) seeking specialist accreditation in Australia. This fee structure should be justified by the provision of clear and succinct fee information published on the Australian Medical Council and relevant college's websites, itemising the costs involved in each stage of the process. IMGs should be informed about possible penalties which may be applied throughout the assessment process.**

Recommendation 37

- 6.100 **The Committee recommends that the Medical Board of Australia/ Australian Health Practitioner Registration Agency, the Australian Medical Council and specialist medical colleges review the administrative fees and penalties applied throughout the accreditation and assessment processes to ensure that these fees can be fully justified in a cost recovery based system.**

Grievances, complaints and appeals

- 6.101 During the inquiry the Committee received evidence from IMGs and from other contributors outlining individual circumstances and detailing specific grievances. This evidence has frequently included grievances from IMGs relating to the assessment of their clinical expertise, skills and experience. While these personal experiences have provided valuable insights, from the very start of the inquiry the Committee has been explicit that it does not have the authority to investigate individual cases or the expertise to question issues of clinical judgement. Rather the Committee's considerations in relation to grievances and appeals are directed towards identifying systemic problems or deficiencies.
- 6.102 In Chapter 4 of this report, the Committee has already commented extensively on reconsideration, review and appeal of specialist college decisions relating to IMG assessment, making recommendation to increase transparency and accountability. Therefore consideration below is confined to:

- processes for dealing with administrative complaints against the AMC and National Law entities (including the MBA, AHPRA and AHPRA's Management Committee); and
- processes for dealing with allegations of bullying or misconduct.

Administrative complaints

6.103 One area of concern for the Committee is that some IMGs appear to be unclear about the options available to them to pursue administrative complaints or appeal decisions made regarding registration.⁴⁸

6.104 According to information provided by the Department of Health and Ageing:

Appeals in relation to the AMC and its processes are made to the AMC Board of Examiners where there are grounds that procedural requirements were not followed in a significant way or that the applicant believes their performance was impaired by significant deficiencies in the examination procedures beyond the applicant's control.⁴⁹

6.105 However, while information on the AMC's website indicates that all training organisations it accredits are expected to have processes for addressing grievances, complaints and appeals, there is no information provided on processes for handling complaints relating to the AMC's own processes.⁵⁰

6.106 In contrast, AHPRA's Complaints Handling Policy is available on its website.⁵¹ The policy advises:

Any person may make a complaint. To enable the timely consideration of a complaint specific details of the incident, conduct or behaviour giving rise to the complaint should be provided.

Complaints can be made over the phone, or in writing. AHPRA encourages complaints, where possible, to be submitted in writing (by email or letter).⁵²

48 See for example: Dr Emil Penev, *Submission No 3*, p 2.

49 DoHA, *Submission No 84*, p 9.

50 AMC, Accreditation and Recognition, *Complaints about Training Organisations accredited by AMC*, <<http://www.amc.org.au/index.php/ar/complaints>> viewed 26 January 2012.

51 AHPRA, Complaints, <<http://www.ahpra.gov.au/About-AHPRA/Complaints.aspx>> viewed 26 January 2012.

6.107 APHRA's Complaints Handling Policy indicates that it is guided by the following principles:

- a complainant will be treated fairly;
- a complaint will be acknowledged promptly, assessed and assigned priority;
- a complaint handling officer will provide updates and information relating to the investigation of the complaint;
- where an investigation is required it will be planned with a timeline established;
- the investigation will be objective, impartial and managed confidentially in accordance with privacy obligations;
- the investigation will aim to resolve factual issues and consider options for complaint resolution and future improvement;
- the response to the complaint will be timely, clear and informative;
- if the complainant is not satisfied with the response, internal review of the decision will be offered and information about external review options provided.⁵³

6.108 The policy also details how the response to complaints to AHPRA will be handled:

The complaint will be acknowledged in writing within 14 days. Complaints will be promptly investigated, and in most circumstances a response will be provided within 30 days. More complicated complaints may require more time to investigate. AHPRA will communicate its expectations where a longer period is required.⁵⁴

6.109 Where a complainant is dissatisfied with the outcome of the initial investigation, they have 30 days to write to the Complaints Officer outlining the reasons that for their dissatisfaction. The complaint may then

52 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 3, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d>> viewed 26 January 2012.

53 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 4, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d>> viewed 26 January 2012.

54 AHPRA, Complaints, *Complaint Handling Policy and Procedure*, p 5, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d>> viewed 26 January 2012.

be referred to AHPRA's Chief Executive Officer who will prepare a response within 30 days.⁵⁵

6.110 Where the result remains unsatisfactory to the complainant, there are a number of avenues that may be pursued. The first of these is that the complainant may contact the National Health Practitioner (NHP) Ombudsman.⁵⁶ The NHP Ombudsman investigates complaints from people who believe they may have been treated unfairly in administrative processes by the agencies within the national scheme.⁵⁷ The NHP Ombudsman can investigate complaints made about AHPRA, the National Boards (the MBA in the case of medical practitioners), AHPRA's Management Committee or the Australian Health Workforce Advisory Council (AHWAC).⁵⁸

6.111 According to information provided by the NHP Ombudsman in its Complaints Handling Summary:

The types of complaints that can be considered in relation to the 4 agencies after 1 July 2010 include:

- allegations of an interference with privacy by one of those agencies breaching the National Privacy Principles under the Commonwealth Privacy Act 1989.
- a complaint about action taken or not taken by one of those agencies that relates to a matter of administration.
- a complaint about how one of those agencies dealt with a freedom of information matter.

6.112 If upon investigation the NHP Ombudsman finds that a National Law entity has acted wrongly or made a mistake it can recommend that the agency:

- reconsider or change its decision;
- apologise;
- change a policy or procedure; and

55 AHPRA, *Complaints, Complaint Handling Policy and Procedure*, p 5, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d>> viewed 26 January 2012.

56 AHPRA, *Complaints, Complaint Handling Policy and Procedure*, p 5, <<http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2f3427&dbid=AP&chksum=0dQv25jGCXJ4NLQpe532Kw%3d%3d>> viewed 26 January 2012.

57 Australian Government Department of Health and Ageing (DoHA), *Submission No 84*, p 9.

58 National Health Practitioner Ombudsman, <<http://www.nhpopc.gov.au/docs/Complaint-Handling-Process.pdf>> viewed 30 January 2011.

- consider paying compensation where appropriate.⁵⁹

6.113 While noting that agencies usually act on the Ombudsman's recommendations, the NHP Ombudsman cannot force an agency to comply.⁶⁰

6.114 The other avenue that may be pursued is with regard to decisions relating to registration or renewal of registration, is through the state and territory administrative appeals tribunal processes. Dr Joanna Flynn of the MBA told the Committee that following the process of internal review by the Chief Executive Officer:

In relation to any decision that the Medical Board makes, if we want to not renew a registration or not grant registration or place conditions on a registration, the first thing we need to do is to issue a notice to the practitioner proposing to do that. Then we give them an opportunity to show cause by making a submission, we hear the submission and make a decision. If the decision then is adverse to the practitioner, their right of appeal is through the administrative legal structures in the states – so in Victoria it would be the Victorian Civil and Administrative Tribunal and so on. So there is a robust, proper, legal appeals process⁶¹

6.115 Notwithstanding these complaints and appeals mechanisms currently available, a number of submitters suggested there is a need to establish an overarching independent appeals body. For example, Rural Health Workforce Australia (RHWA) told the Committee:

... we believe that there is no option but to provide powers to either a 'Regulator' or 'Ombudsman' to oversee the system of OTD assessment. There are many mechanisms to do this through either existing legislation or new legislation but without this, nothing will change as each organisation will continue to work on its own with little regard to the impact on OTDs and rural communities.⁶²

6.116 ACRRM also told the Committee:

ACRRM would give in principle support to the establishment of an external appeals body such as an ombudsman and would

59 National Health Practitioner Ombudsman, <<http://www.nhpopc.gov.au/what-we-do/office-of-the-nhp-ombudsman.aspx>> viewed 30 January 2012.

60 National Health Practitioner Ombudsman, <http://www.nhpopc.gov.au/what-we-do/office-of-the-nhp-ombudsman.aspx>

61 Dr Joanna Flynn, Medical Board of Australia, *Official Committee Hansard*, Canberra, 25 February 2011, p 22.

62 Rural Health Workforce Australia (RHWA), *Submission No 107*, p 4.

recommend the establishment of a national working group to investigate this matter and provide recommendations to government as to the feasibility, roles, functions and governance. Such an independent body should limit the cost of appeal for the OTD and speed the appeal process as it would take it out of the 'legal system'.⁶³

Committee comment

- 6.117 It is understandable that IMGs and some of those involved in assisting them through accreditation and registration believe that there is a need for more independent mechanisms of review in relation to decisions of the AMC, specialist medical colleges and the MBA/AHPRA. Importantly, in this regard the Committee reiterates the need to clearly distinguish between complaints relating to assessments of clinical competency from complaints relating to administrative and procedural issues pertaining to assessment, accreditation and registration. As previously noted, the Committee does not have the expertise to comment on specific complaints relating to clinical judgement. The Committee views the AMC, specialist medical colleges and the MBA/AHPRA as the appropriate entities to set clinical assessment standards and to assess IMGs against these standards in a fair and transparent manner.
- 6.118 The Committee also believes procedures put in place by specialist colleges and the MBA/AHPRA with respect to handling of complaints through internal review are reasonable and appropriate. The Committee also notes the independent powers available to the NHP Ombudsman to review decisions made under the National Law by the MBA/AHPRA and further opportunities for independent appeal through state and territory tribunals. Given these options, the Committee does not believe that the addition of a further independent review process is warranted.
- 6.119 However, the Committee is unclear with regard to the options that are available to IMGs that might wish to make administrative complaint in relation to the AMC's processes. Despite the AMC requiring accredited entities to have fair and transparent complaints handling and appeals procedures, the Committee was unable to find evidence on the AMC's website of equivalent processes for handling administrative complaints relating to the AMC's own processes. The Committee believes that this situation should be rectified. Furthermore, the Committee believes that where IMGs are advised of the outcome of an internal review, whether

63 ACCRM, *Submission No 103*, p 13.

this is from the AMC or the MBA/AHPRA, the advice should contain information in relation to the next step in the appeal process.

Recommendation 38

- 6.120 **The Committee recommends that the Australian Medical Council and the Medical Board of Australia/Australian Health Practitioner Regulation Agency increase awareness of administrative complaints handling and appeal processes available to international medical graduates (IMGs) by:**
- **prominently displaying on their websites information on complaints handling policies, appeals processes and associated costs; and**
 - **ensuring when IMGs are advised of adverse outcomes of any review, that the advice contains information on the next step in the appeal process.**

Dealing with allegations bullying and harassment

- 6.121 It is implicit upon all medical practitioners to act with a high degree of professionalism not only with their patients, but also with their colleagues irrespective of seniority or any perceived advantage. Individuals have the right to work in a fair, supportive and productive workplace. For these reasons, evidence of allegations of workplace bullying is of great concern.
- 6.122 The inquiry has received evidence from IMGs regarding allegations of bullying and workplace harassment they assert occurred as they worked through accreditation and registration. Evidence was also received from individuals asserting that some supervisors have experienced instances of harassment as a result of decisions they have made relating to the accreditation of an IMG. This evidence is considered below, though it should be noted that the individual cases represent only one view, and an opposing view is not being presented and has not been sought by the Committee.
- 6.123 Dr Bo Jin, an IMG, expressed concerns that he was bullied by members of a specialist medical college prior to sitting a clinical examination. He was surprised that these same staff members were his assessors for the specialist college examination. Dr Jin believes that:

They prejudged that I could not be able to pass the clinical examination because of shortage of clinical practice.⁶⁴

- 6.124 Dr Piotr Lemieszek outlined allegations of substantial bullying by supervisors in his submission. During the course of his supervision he received a number of negative assessments from supervisors regarding his performance and alleges that he experienced a number of unsavoury incidents. On one occasion, Dr Lemieszek alleges he was advised by a supervisor that:

... top marks are reserved for the top 3% of best performers, and as you are overseas trained you can not belong to this group.⁶⁵

- 6.125 On another occasion, Dr Lemieszek claims that the same supervisor told him that:

We will keep you like a dog on a leash. If you are a good puppy we will extend your leash, if not we will tighten it ... If we trust you, we will let you progress, if we do not we will limit your progress and shut you up.⁶⁶

- 6.126 Another IMG who felt he had been victimised, Dr Michael Damp, advised the Committee of his experiences when commencing work in the South Australian town of Whyalla:

On the day of my arrival in Whyalla I was met at the front door of the hospital by an Adelaide Professor of Surgery and informed that I was unwelcome in South Australia and should not consider travelling to Adelaide to partake in Surgical Departmental meetings, ward rounds etc, as 'general practitioners' were not welcome at 'surgeons' meetings.⁶⁷

- 6.127 Dr Damp added that prior to arranging several job interviews for him in Western Australia, the same Professor informed him that:

I like you but we will never accept you as a specialist surgeon in South Australia.⁶⁸

- 6.128 Dr Jonathan Levy stated that in relation to the Committee's inquiry:

It may also be of note that many doctors who *should* come forward with submissions will not, due to fear for their professional

64 Dr Bo Jin, *Submission No 26*, p 3.

65 Dr Piotr Lemieszek, *Submission No 118*, p 2.

66 Dr Piotr Lemieszek, *Submission No 118*, p 2.

67 Mr Michael Damp, *Submission No 6*, p 2.

68 Mr Michael Damp, *Submission No 6*, p 3.

position and, thus, visa eligibility and ability to remain in Australia.⁶⁹

6.129 Dr Levy proceeded to observe that despite the vulnerability of IMGs:

... [IMGs] dare not complain, for fear of local xenophobia, institutional bullying and the threat of losing their job and, thus, visa to remain in Australia.⁷⁰

6.130 The Committee understands that it is not only IMGs who feel that they have been subject to bullying in the workplace. Surveys have indicated that up to 50% of junior doctors in Australia have experienced workplace bullying.⁷¹ Some evidence has also highlighted that those working in supervisory capacities may also be subject to intimidating behaviour from those being supervised, particularly in circumstances where they may be required to give negative feedback on aspects of clinical competency. As one contributor to the inquiry related:

... supervisors must show and discuss their recommendations and reports to the supervisee before they are submitted. At best, this is a further time drain on supervisors. But most importantly, at worst, this requirement makes it extremely difficult to provide negative feedback or reports, and leaves room for coercion, or worse.⁷²

Committee comment

6.131 The instances of bullying highlighted are from a number made to the Committee, and are cause for serious concern. In addition, the Committee received a range of confidential submissions from IMGs, some of which contained significant allegations of workplace bullying. Furthermore, the Committee notes comments suggesting reluctance by some IMGs to contribute openly to the Committee's inquiry for fear of retribution.

6.132 While the Committee does not have the authority, or indeed the capacity, to investigate the circumstances of individual allegations, the fact that some IMGs feel that they have experienced bullying during accreditation and registration should be the catalyst for change.

69 Dr Jonathan Levy, *Submission No 34*, p 1.

70 Dr Jonathan Levy, *Submission No 34*, p 11.

71 Rutherford A and Rissel C, 'A survey of workplace bullying in a health sector organisation', *Australian Health Review*, September 2004, Vol 28, No 1, pp 65-72.

72 Name withheld, *Submission No 158*, p 2.

- 6.133 In considering concerns relating to bullying and harassment however, the Committee understands that these issues are not confined to IMGs, but also extend to others in the medical profession, with surveys reporting approximately 50% of junior doctors have experienced bullying in the workplace.⁷³ Clearly all medical practitioners, including IMGs, should feel that they are adequately supported by their employers, colleagues and the organisations to which they are accountable.
- 6.134 In a Position Statement on Workplace Bullying and Harassment, the AMA emphasises the importance of raising awareness of bullying and harassment issues for medical professionals, and calls for employers and specialist medical colleges to implement bullying and harassment policies. While the AMA lists a range of behaviours which may constitute bullying and harassment (eg verbal threats, physical violence and intimidation, exclusion, vexatious or malicious reports), it also emphasises the need to distinguish between bullying and a supervisor's responsibility to address performance problems through the provision of constructive feedback.⁷⁴ The Committee recognises that managing professional interactions associated with supervision and peer review can be challenging both for those being supervised and for their supervisors. As recommended in Chapter 5 of the report, the Committee believes clinical supervisors will assisted in this regard if guidelines, educational materials or training programs include information on cross-cultural awareness communication.
- 6.135 For medical practitioners who believe that they are being bullied, the AMA provides the following advice:
- document threats or action taken by the bully;
 - discuss your concerns with your supervisor (or someone equivalent if your supervisor is the bully);
 - consider making a complaint under your employer's bullying and harassment policy. If your employer does not have a policy, consider using an informal/formal complaint procedure; and
 - seek support from your peer network, colleagues, your local AMA and other organisations (eg the Australian Human Rights

73 AMA, Position Statements, *Workplace Bullying and Harassment*, June 2009, <<http://ama.com.au/node/4788>> viewed 30 January 2012. See also: *2010 AMA Specialist Trainee Survey: Report of findings*, October 2011, p 20, <<http://ama.com.au/specialist-trainees-survey>> viewed 30 January 2012.

74 AMA, Position Statement, *Workplace Bullying and Harassment*, June 2009, <<http://ama.com.au/node/4788>> viewed 30 January 2012. See also: *2010 AMA Specialist Trainee Survey: Report of findings*, October 2011, p 20, <<http://ama.com.au/specialist-trainees-survey>> viewed 30 January 2012.

Commission), who can give you advice on your options and rights and some of which may act on your behalf.⁷⁵

- 6.136 In addition to pursuing these courses of action, the Committee also notes other avenues that maybe pursued through Commonwealth, state and territory jurisdictions under industrial and occupational health and safety legislation, and anti-discrimination laws.⁷⁶
- 6.137 Although all of these courses of action are available to IMGs, it is unclear from the evidence provided, whether IMGs are appropriately made aware of the avenues they may pursue if they believe they have been bullied during the pursuit of accreditation and registration. Therefore, the Committee believes that employers of IMGs, and specialist medical colleges should actively take steps to ensure that the relevant information on workplace bullying and harassment policies is made available to IMGs. It is also of course equally important that all medical staff, including IMGs themselves, are also made aware of behaviour which may constitute bullying and harassment along with the sanctions which apply for proven contravention. Therefore the Committee believes that IMGs should be provided with general information on their rights and responsibilities in relation to bullying and harassment as part of a structured orientation to the Australian health system. This issue is addressed further in the Committee's comments on orientation for IMGs in Chapter 7.
- 6.138 Notwithstanding its observation above, the Committee is concerned that some IMGs are fearful of alerting relevant individuals or responsible organisations of bullying behaviour for fear of repercussions affecting their employment and immigration status. Assessing the scale of this problem is impossible, as there is no objective way to quantify how many IMGs who have experienced bullying, have been too afraid to pursue formal avenues of redress. Certainly anecdotal evidence to the inquiry indicates that some IMGs who believe they have been bullied do not feel in a position to take action. In particular temporary resident IMGs on 457 visa's whose continued residency in Australia is dependent on the continued support of their sponsoring employer. While recognising that IMGs in this circumstance may feel particularly vulnerable, the Committee trusts that the vast majority of employers, clinical supervisors and professional colleagues act with integrity.

75 AMA, Position Statement, *Workplace Bullying and Harassment*, June 2009, p 3, <<http://ama.com.au/node/4788>> viewed 1 February 2012.

76 AMA, Position Statement, *Workplace Bullying and Harassment*, June 2009, p 2, <<http://ama.com.au/node/4788>> viewed 1 February 2012.

- 6.139 However, addressing the realities of bullying when it does occur requires a commitment from employers to develop and implement robust workplace bullying and harassment policies. As noted, employers and employees need to be aware of their rights and responsibilities, and need to be entirely confident that these processes are fair to all concerned. Increased transparency and accountability is a necessary part of the cultural change required if concerns regarding the existence of 'boys clubs' and 'closed shops' are to be addressed.
- 6.140 To effect this outcome, the Committee recommends that the MBA, as the national agency responsible for the registration of medical practitioners, extend the obligations it applies to employers, supervisors and IMGs in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent and appropriate standards of professional behaviour and act in accordance with workplace bullying and harassment policies.⁷⁷

Recommendation 39

- 6.141 **The Committee recommends that the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies.**

77 MBA, *Guidelines – Supervised practice for limited registration*, June 2011, <<http://www.medicalboard.gov.au/documents/default.aspx?record=WD11%2f5394&dbid=AP&checksum=iOgwjgGW%2f8qVcdN0yTaPvg%3d%3d>> viewed on 1 February 2012.

Support for International Medical Graduates and their families

- 7.1 To ensure that the highest professional standards of medical care are maintained, there is clearly a need for robust processes of accreditation and registration of international medical graduates (IMGs) seeking to practice medicine in Australia. There is also a corresponding need to support IMGs as they negotiate the accreditation and registration processes. Furthermore, IMGs and their families need support which extends beyond clinical and professional orientation, to also include social and cultural support to help them as they adjust to living and working in Australia.
- 7.2 This Chapter examines the types of support needed by IMGs and their families prior to arrival and in the early post-arrival period as they settle into living and working in Australia. The Chapter then proceeds to examine the need for their on-going support. In particular, the Committee has focussed on identifying what type of assistance is available to IMGs who are practising or training in regional, rural and remote areas of Australia, looking closely at the need and demand for support in those areas. In addition, the Committee has considered the experience of IMGs living and training in Australia as temporary residents and the difference in the support offered to them and permanent residents.
- 7.3 The Chapter concludes by reviewing the accessibility of support programs to IMGs, whether they are working in regional, rural and remote areas of Australia, or working in major metropolitan centres. In this section, the Committee considers whether IMGs are provided with appropriate information regarding available support programs and how access to this information might be further improved.

Stages of support

7.4 Support for IMGs working towards gaining full registration in Australia may be categorised into two main phases:

- orientation, including but not limited to:
 - ⇒ clinical and professional orientation for IMGs, comprising a comprehensive introduction to the structure and operation of Australia's health system, and cultural awareness training; and
 - ⇒ social and cultural orientation for IMGs (and their families).
- ongoing support, including but not limited to:
 - ⇒ educational and professional development support for IMGs, including assistance with examination preparation, and mentoring and peer support opportunities; and
 - ⇒ continuing social and cultural support for IMGs and their families.

7.5 Evidence to the inquiry from the Commonwealth, state and territory health departments, peak bodies, specialist medical colleges, other training providers and individuals includes reference to a range of programs and services available to IMGs.¹

7.6 Clearly it is beyond the scope of this inquiry to detail and critique each and every support available to IMGs. Rather, in the context of the evidence provided, the Committee considers the types of supports that are needed to assist IMGs and their families, using specific examples to illustrate benefits, deficiencies or limitations.

Clinical and professional orientation

7.7 The Committee has heard evidence from a range of stakeholders highlighting the importance of initial support and outlining various orientation programs, the features of which vary significantly in relation

1 See for example: Health Recruitment Plus Tasmania, *Submission No 32*, p 5; Overseas Trained Specialist Anaesthetists Network Inc (OTSAN), *Submission No 38*, p 3; Australian General Practice Network, *Submission No 61*, pp 2-3; Royal Australian and New Zealand College of Ophthalmologists, *Submission No 73*, p 4; Government of South Australia, *Submission No 96*, p 4.

to the timing of orientation, the duration of the program, and the topics covered in that orientation.²

- 7.8 Dr Ian Cameron, Chief Executive Officer of the New South Wales Rural Doctors Network, explained the need for different types of orientation and initial support for IMGs and their families.

... we have to look at clinical orientation, professional orientation and social orientation. We need to help the family. We need to look at the sort of town the doctor wants to be in and what supports that we can put in place. Most OTDs know an awful lot of clinical medicine. I would not put myself up against them most of the time. But how things are done in this country are different to how things are done in their country.³

- 7.9 Providing IMGs with access to a structured and targeted orientation program when they are first exposed to the medical system in Australia should better equip them to understand the intricacies of the Australian health system and the medical profession.

- 7.10 Dr Alasdair MacDonald, appearing before the Committee in a private capacity, explained the need for a detailed orientation into the complexities of the Australian health system, observing:

... I do suspect that there is a role for government in producing an educational package that covers off the intricacies of a health system that has a state, Commonwealth and private sectors funding mechanism, because we certainly get into difficulties with our international medical graduates not understanding what is a private patient in a public hospital, what is a private patient, what is a public patient. Although that does not impact on direct care, it causes levels of confusion whereas if you have grown up here as both a user and a professional in the health system you are much more familiar with those sorts of issues.⁴

- 7.11 Anecdotal evidence however suggests that IMGs who require assistance in familiarising themselves with Australia complex medical system, have not always been able to access this kind of support. For example, in his

2 See for example: Dr Sunayana Das, *Submission No 99.1*, p 2; Rural Doctors Workforce Agency, South Australia, *Submission No 83*, p 4; Eyre Peninsula Division of General Practice, *Submission No 136*, p. 2; Dr Rodney Nan Tie, *Official Committee Hansard*, 12 August 2011, p 16.

3 Dr Ian Cameron, NSW Rural Doctors Network, *Official Committee Hansard*, Sydney, 31 March 2011, p 8.

4 Dr Alasdair MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, pp 19-20. For further comment relating to the importance of orientation, see Rural Doctors Workforce Agency Inc, *Submission No 83*, pp 4-5.

submission to the Committee, Dr Sudheer Duggirala, an IMG from India, outlined his experiences working as a General Practitioner in Australia in 2006 noting.

I had difficulties in adapting to the Australian General Practice as that was my first experience to work as a GP in Australia. I was not provided with any orientation to the Australian General Practice.⁵

- 7.12 Professor Kersi Taraporewalla, who appeared in a private capacity before the Committee, provided another example of an IMG who commenced his position without any formal orientation:

I had to deal with a doctor from Mount Isa five years ago at the skills centre and he told me that before he came out here he was advised that Mount Isa was a thriving metropolis. When he finally turned up at the hospital, they said, 'Congratulations. Welcome to the hospital. By the way, you're on tonight.'⁶

- 7.13 The Australian Medical Council (AMC) submitted that the importance of orientation for IMGs has been acknowledged by COAG, however mandatory participation in orientation is not required as part of the National Registration and Accreditation System (NRAS) for IMGs, because of limited availability of appropriate programs:

The 2007 COAG IMG assessment initiative proposed that all IMGs be required to complete a mandatory accredited orientation program as a formal requirement for registration. In the absence of sufficient orientation programs, the mandatory requirement for orientation was deleted from the final recommendations on the consistent national assessment processes.⁷

- 7.14 The AMC and other agencies identified Queensland Health's Recruitment, Assessment, Placement, Training and Support program for International Medical Graduates Scheme (RAPTS) as an example of best practice and suggested that this orientation program could provide a model for other jurisdictions to adopt.⁸

5 Dr Sudheer Duggirala, *Submission No 12*, p 1.

6 Associate Professor Kersi Taraporewalla, *Official Committee Hansard*, Brisbane, 10 March 2011, p 51.

7 Australian Medical Council (AMC), *Submission No 42*, p 28.

8 AMC, *Submission No 42*, p 28.

7.15 The RAPTS program was established by Queensland Health in September 2005, following the Queensland Health Systems Review.⁹ The program merged with the Queensland Health Recruitment Unit in 2008, to form Clinical Workforce Solutions (CWS).¹⁰

7.16 As a component part of CWS, the RAPTS program includes provision of an orientation 'Welcome Pack' to support IMGs who are new to Australia. As Dr Michael Cleary of Queensland Health's Strategy and Resourcing Division told the Committee:

The resource is designed to cover a range of key areas. It is not devoted to only health practice. It covers things like the Australian healthcare system, working in Queensland, legislation, rural and remote services, communications, cultural, safety and so on. It also goes into things such as: what is the Australian culture and society like? How do you get Australian citizenship? How do you open a bank account in Australia? How do you get a drivers licence? We have made it as comprehensive as we can to cover both the clinical arrangements and the personal and social arrangements.¹¹

7.17 Dr Cleary stated further:

The manual has been approved by the AMC and they have regarded it as the best practice manual and best practice induction program in Australia. It has also been adopted by other jurisdictions, as well as a model that they have been looking at.¹²

7.18 The RAPTS program also includes a Clinical Attachment Program available to unemployed permanent resident IMGs seeking familiarisation with the Queensland and Australian health care system for the purpose of employment. According to Queensland Health, the program is recognised by the MBA for its limited scope of practice and safety components, allowing IMGs with a valuable upskilling or re-entry program.¹³

9 Queensland Health, *Queensland Health Systems Review – Final Report*, September 2005, <http://www.health.qld.gov.au/health_sys_review/final/default.asp> viewed 1 February 2012.

10 Queensland Health, *Submission No 126*, p 30.

11 Dr Michael Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 5.

12 Dr Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 5.

13 Queensland Health, *Submission No 126*, p 12.

Cultural awareness training

7.19 Cultural awareness is an aspect of professional orientation which has been the subject of extensive discussion throughout the inquiry. Cultural awareness extends beyond clinical competency and an understanding of how the Australian health system operates. Cultural awareness issues include:

- familiarity with Australian colloquialisms, idioms and communication styles; and
- understanding social and cultural norms as they relate to the provision of healthcare in Australia.

7.20 In hearing the evidence of various health agencies, individual medical practitioners and IMGs themselves, it is apparent to the Committee that IMGs face significant challenges in adjusting to Australian culture and the Australian health system.¹⁴ Dr David Little, a general practitioner appearing in a private capacity, explained the difficulty that some IMGs face in working as a medical practitioner in a new cultural environment:

Ultimately, the practise of medicine requires not just medical expertise but the skill of imparting that information to patients, and that requires not just language but cultural skills. We very specifically found that. The doctor that we had working for us who did not work too well did not have as much a problem with medical knowledge as with dealing with the patients.¹⁵

7.21 Dr Joanna Flynn, Chair of the Medical Board of Australia, told the Committee that in her understanding, cultural awareness does not form part of the assessment of an IMG's English language skills but rather forms part of the IMG's orientation to the Australian health system, stating:

... the English language test is basic competency to speak, to listen, to write and to read. It does not deal with cultural awareness, and it does not deal with issues about the use of language in a medical cultural setting. That is supposed to be part of the orientation that people get in the work setting when they start work. It is supposed

14 See for example: Australian and New Zealand College of Anaesthetists (ANZCA), *Submission No 87*, p 18; Dr Sunyana Das, *Submission No 99.1*, p. 2; Dr Christopher Hughes, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Official Committee Hansard*, Melbourne, 18 March 2011, p 50.

15 Dr David Little, *Official Committee Hansard*, Gosford, 28 September 2011, p 2.

to orientate them to the cultural situation, the workplace and the particular needs of that context.¹⁶

- 7.22 The importance of cultural awareness for IMGs working in rural or remote locations or with Aboriginal and Torres Strait Islander communities was also raised in evidence.¹⁷ Mr Lou Andreatta, Principal Adviser at the Commonwealth Department of Health and Ageing (DoHA), was asked by the Committee how quality and safety for patients is considered when recruiting IMGs for isolated areas in Australia, where language could be seen as problematic. Mr Andreatta responded:

Supporting OTDs in rural communities is certainly one of the issues that we are always mindful of. We do have funding programs with our rural health workforce agencies, who have responsibility for recruitment, retention and the support of OTDs. Before they are placed in a rural location in area of district workforce shortage, the OTDs go through a number of assessments to ensure that they are the right fit for a community. Things like their language and their suitability to assimilate in a certain area are looked at. Clearly, it is almost a case management approach that the workforce agencies do in each state and territory, whereby they help and support the OTDs once they are placed in a location to ensure that they are fully assimilated and comfortable with the working environment they are placed in.¹⁸

- 7.23 Dr Peter Setchell, General Manager of Health Services for the Royal Flying Doctor Service (RFDS) also told the Committee:

... we would simply not be able to run a rural health service without the overseas trained doctors – issues such as language, cultural sensitivity mix and communication skills need to be very carefully considered. For example, within RFDS we have a process where all of our doctors, nurses and allied health workers undergo a very formal cultural awareness training program before we ask them to go out and work in Aboriginal communities. There are issues such as the understanding of culture, the nuances of language and Australian idioms, and so forth. There needs to be a

16 Dr Joanna Flynn, Medical Board of Australia (MBA), *Official Committee Hansard*, Canberra, 25 February 2011, p 24.

17 See for example: Ms Linda Black, *Official Committee Hansard*, Adelaide, 9 September 2011, p 9; Mr Chips Mackinolty, *Official Committee Hansard*, Darwin, 30 January 2012, p 12.

18 Mr Lou Andreatta, Australian Government Department of Health and Ageing (DoHA), *Official Committee Hansard*, Canberra, 25 February 2011, p 8.

very robust awareness training package for overseas doctors to be able to be effective out in the bush.¹⁹

- 7.24 It is important to also recognise that cultural awareness issues can also flow from the medical profession's lack of understanding in relation to the IMG's own cultural background. As illustrated by Dr Alasdair MacDonald:

One of the things that we run into in hospitals which have significant numbers of international medical graduates is the potential difficulty of their own interactions and of our not having adequate cultural competency in the cultures that they come from to understand their interactions, not their interactions with us but their interactions with each other. ... I personally, as a director of medicine, have had to come to understand hierarchical structures within cultures where I may have a person who regards themselves, from their own culture, as superior to another person, who has to then work in the reverse model. Until somebody explains that to me, I do not get the issues that are occurring.²⁰

Committee comment

- 7.25 The Committee views clinical and professional orientation, including cultural awareness education and training, as an important component of the introductory support needed to help IMGs adjust to working within the Australian health system and acquire an understanding of the social mores and the customs of Australian culture. In the Committee's view, the consequences for IMGs, their patients and the wider community if the IMG is not supported appropriately in this way, could be considerable.
- 7.26 For this reason the Committee believes that such introductory support should include, but not be limited to:
- information on immigration, with a comprehensive outline of the steps required to gain full medical registration in their chosen field. Such orientation should also include introductory information on the structure and functioning of the Australian health system;
 - social orientation to be provided to the IMG and their family (if applicable) including the provision of basic information such as accommodation options, education options for accompanying family members, health and lifestyle information, access to social/welfare

19 Dr Peter Setchell, Royal Flying Doctor Service (RFDS), *Official Committee Hansard*, Adelaide, 9 September 2011, pp 15-16.

20 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 20.

benefits and services, and information about ongoing support programs for IMGs and their families;

- provision of a specific cultural awareness education and training program, which could be tailored to specific locations and where appropriate, should include training relating to specific health issues of the local community and Aboriginal and Torres Strait Islander culture. IMGs should receive general information on appropriate professional behaviour in the workplace, as well as information on their rights and responsibilities in regarding workplace bullying and harassment; and
- once employment commences, a comprehensive and structured introduction to the Australian health system and medical registration system, including a period of observation of clinical practice in the IMG's chosen field.

7.27 The Committee understands that a number of stakeholders, including the AMC, consider that the RPTS program offered to IMGs by Queensland Health is a good example of an effective orientation program, and as such could provide a model.

7.28 As noted earlier in the report, developing a coordinated national approach to the recruitment and retention of international health professionals is one element of Health Workforce Australia's (HWA) work plan. Therefore, the Committee recommends that HWA, in consultation with key stakeholders (including the Medical Board of Australia, specialist medical colleges, workforce agencies, employers and IMGs) develop and implement a program of orientation to be available to all IMGs and their families to assist them with adjusting to living and working in Australia.

7.29 The Committee proposes that the program comprise key components including social orientation for IMGs and their families, cultural awareness education and training covering Australia's social, cultural, political and religious diversity, as well as a comprehensive and structured introduction to the Australian health system.

7.30 While recognising that some components of the orientation program will need to be delivered post arrival in Australia, the Committee believes that as much information as possible should be provided in an easily accessible, pre-arrival package of written material.

Recommendation 40

7.31 The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop and implement a program of orientation to be made available to all international medical graduates (IMGs) and their families to assist them with adjusting to living and working in Australia. In addition to detailed information on immigration, accreditation and registration processes, the program should include:

- accommodation options, education options for accompanying family members, health and lifestyle information, access to social/welfare benefits and services, and information about ongoing support programs for IMGs and their families;
- information on Australia's social, cultural, political and religious diversity; and
- an introduction to the Australian healthcare system including accreditation and registration processes for IMGs, state and territory health departments and systems along with Medicare.

An integral part of the orientation program should be the development of a comprehensive package of information which can be accessed by IMGs and their families prior to their arrival in Australia.

7.32 In Chapter 5 of this report, the Committee has recommended that cultural awareness training and communication be addressed in guidelines and training to support enhanced competency of clinical supervisors. Although stopping short of making a specific recommendation, the Committee is also of the view that it would be constructive for other co-workers in organisations such as hospitals or medical centres that are involved in the employment of IMGs to also undertake a component of cultural awareness training, focussing on working effectively with IMGs from culturally diverse backgrounds.

Ongoing support

7.33 If IMGs are to progress to full medical registration it is important that they receive initial support when they first arrive in Australia, and that support

is ongoing throughout the registration process. The Committee has identified a number of facets of ongoing support. These are:

- educational support and professional development, including:
 - ⇒ examination preparation; and
 - ⇒ mentoring and peer support opportunities.
- personal and family support.

Educational support and professional development

7.34 A crucial component of support for IMGs is the educational support provided to IMGs to assist them to pass the examination and training requirements involved in the various pathways to achieve full registration as a medical practitioner. Based on evidence provided, educational support consists of a number of elements, including:

- examination preparation and assistance, including access to study groups and other training facilities; and
- mentoring and peer support.

Examination preparation

7.35 In its submission, the Overseas Trained Specialist Anaesthetists' Network (OTSAN) described some of the difficulties that IMGs, particularly those working in areas where there are workforce shortages, may encounter when preparing for the examinations needed to achieve full registration:

At the time when local candidates sit the exam they are employed in major tertiary centres, are exposed to a wide portfolio of cases, are assigned to tutors which guide them through the process, receive a multitude of tutorial and education sessions, have access to study material and most importantly can easily form connections with peers to form study groups within their departments. It is not uncommon that local candidates have their allocated study/education periods during working hours or are relieved by senior staff from clinical duties for exam preparation. In sharp contrast, overseas trained candidates work in isolation in rural centres with limited case-load, without communication tools to form study groups or local tutors who could assist them in the preparation process.²¹

21 OTSAN, *Submission No 38*, p 2.

- 7.36 OTSAN submitted that due to shortfalls in medical staffing, IMGs are often required to provide direct hands-on specialist care throughout the day and then prepare for their exams after hours while juggling their family life. Their submission states:

Additional factors are advanced age, cultural differences in appearance and presentation and English as a second language which makes it hard to comprehend subtle differences in context in a time constrained exam environment. This leads to the fact that highly skilled clinicians who demonstrate excellent work performance repeatedly fail exams and finally are lost for the medical workforce because they run out of time and visa and need to leave the country.²²

- 7.37 The South Australian Government submitted to the Committee that there is a significant gap in coordinated education support for IMGs in general practice, arguing that a better coordinated education support program would likely reduce examination failure rates. They submitted:

OTDs are required to work and study for their exam but have no personal guidance to help them. This contributes to the higher failure rate for OTDs compared to doctors as registrars in a Regional Training Provider program. Support programs should focus not only on pre-exam preparation for OTDs but also on personal development within the Australian healthcare context.²³

- 7.38 The Government of South Australia also provided an example of how educational support may be implemented, noting:

The State Office of the Royal Australian College of General Practitioners has developed a good example of an effective program in South Australia. They run an exam preparation and communications workshop series targeted at OTDs undertaking (or about to undertake) the AMC certification process in South Australia.²⁴

- 7.39 The RACGP submitted that it provides exam preparation workshops and DVDs through each state faculty, providing information and practice opportunities together with exam preparation courses and seminars that IMGs are encouraged to attend. Topics include instruction in examination techniques, clinical case discussions and clinical practice sessions. IMGs

22 OTSAN, *Submission No 38*, p 2.

23 Government of South Australia, *Submission No 96*, p 3.

24 Government of South Australia, *Submission No 96*, p 4.

are tutored by experienced members of the FRACGP examination panels.²⁵

- 7.40 The RACGP National Rural Faculty has also produced an 11-DVD set covering a 19-week pre-exam tutorial series designed to assist IMGs, GP registrars, and other medical practitioners who are preparing to undertake the college examination.²⁶
- 7.41 An issue that was raised with the Committee is that IMGs practising in regional, remote and rural Australia will not have the same access to educational supports. One of the challenges in completing one of the recognised pathways towards full registration as a medical practitioner in Australia is the difficulty IMGs have in leaving their practice to attend training or support programs.
- 7.42 In addition to making increased use of new technologies (eg on-line training, tele/video-conferencing), the Committee was told that offering locum services to IMGs is one way of addressing these issues.²⁷ As explained by the Committee of Presidents of Medical Colleges (CPMC), providing locum services to IMGs in more isolated areas would allow them to attend education and training activities and assessment preparation programs provided by the Colleges.

The constraints which confront OTDs and AoN practitioners in rural areas are very real. The constant tension which exists generally throughout the health system between the provision of services to patients and training imperatives is magnified in rural locations by workforce shortages and remoteness from specialist colleagues. A major contribution to promoting the achievement of full Australian qualifications by both OTDs and AoN practitioners would be the establishment of a significant resource of locum specialists.²⁸

- 7.43 Dr Michael Cleary, Deputy Director-General of the Policy, Strategy and Resourcing Division of Queensland Health, informed the Committee of a specialised training program it has funded to assist specialists complete their examinations, which includes provision for locum relief support:

The funding that we have allocated provides support for back-filling, attending conferences, training programs, up-skilling

25 Royal Australian College of General Practitioners (RACGP), *Submission No 67*, pp 4-5.

26 RACGP, *Submission No 67*, p 5.

27 See for example: Mr Robert Hale, General Practice Education and Training Ltd, *Official Committee Hansard*, Canberra, 5 July 2011, p 3.

28 Committee of Presidents of Medical Colleges, *Submission No 28*, p 3.

sessions and other such activities. It means that the doctors are able to get away from their normal work. It is very hard when you are in a regional centre; there are a lot of demands on your time. So it gives us the opportunity to provide back-filling and to support them through that type of training. We have received very positive feedback from the specialist colleges about that program.²⁹

Peer support and mentoring

7.44 Peer support and mentoring are other important components of educational and moral support for IMGs. However, the capacity for IMGs to engage in networking opportunities with other IMGs in the same specialty or at the same stage of the registration process is often limited. Again, this is particularly the case in circumstances where an IMG is living and working in a rural or remote community of Australia, where they do not know or work with other IMGs.

7.45 In this circumstance, an IMG's access to networking opportunities is often only available through support programs offered by training providers, RWAs or colleges. Dr Karen Douglas, appearing before the Committee in a private capacity, told the Committee:

I think these overseas trained doctors are grappling. If they are out in the country and they are living alone, the family is there but often their children are boarding in a capital city, then they are unsupported. They might have somebody on a telephone, but I feel they need support groups. They need the ability, as we all do, to ring up and say, 'I've got a difficult case,' or, 'I've got a difficult issue here,' or, 'I'm not feeling well myself' – just to have a debrief and the ability to say either 'I'm coping' or 'I'm not coping; where do I go?'³⁰

7.46 Similarly, as Dr MacDonald, a Launceston based physician, told the Committee:

... if we put a number of international medical graduates or even single international medical graduates into relatively isolated professional environments, we need to make sure that we put infrastructure in place. That is either infrastructure in a virtual sense, making sure that we optimally use tele-health and other facilities to case-conference – an awful lot of professionalism comes out of those corridor discussions of cases, and if you are in

29 Dr Cleary, Queensland Health, *Official Committee Hansard*, Canberra, 10 March 2011, p 6.

30 Dr Karen Douglas, *Official Committee Hansard*, Gosford, 28 September 2011, p 6.

an isolated environment then you do not get the same opportunities for corridor consultation and corridor discussion, which are part of the collegiate professional environment.³¹

- 7.47 The Overseas Trained Specialist Anaesthetists' Network (OTSAN), consisting of fellows from the Australian and New Zealand College of Anaesthetists (ANZCA) seeking to assist IMGs with their education and accreditation, offers networking and educational services which ANZCA submits is designed to assist the IMGs satisfy the eligibility requirements for registration.³² As a result of these services, ANZCA states that OTSAN participants now have a pass rate range of 73% to 81% which is comparable to Australian candidates. This compares to a pass rate of fewer than 50% for those not typically associated with OTSAN.³³
- 7.48 The Royal Australian College of General Practitioners (RACGP) told the Committee of a pilot program funded by DoHA and implemented by the College during 2009-2010. The program provided IMGs who had just arrived in Australia with a peer mentor to orient them to the Australian health care system, support them to achieve recognition as a GP through the attainment of RACGP Fellowship, and to facilitate their integration into their local community. The program focussed on the peer mentor relationship, rather than formal medical supervision and medical education. All RACGP mentors were IMGs themselves who had experienced a similar pathway to RACGP Fellowship.³⁴
- 7.49 RACGP submitted to the Committee that an external evaluation of this program found that mentoring was strongly upheld as a practical resource by IMGs with almost universal support from mentors and recipients for the ongoing provision of IMG mentoring.³⁵
- 7.50 After hearing evidence from a range of rural stakeholders, it is apparent to the Committee that for IMGs who live in an isolated region and do not have the ability to travel far away from their home base to avail themselves of networking opportunities. As with examination preparation, access to new technologies including tele/video-conferencing and internet which allows IMGs to participate in networking and training remotely can be effective. Mr Gordon Gregory, Executive Director of the National Rural Health Alliance, told the Committee:

31 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 16.

32 ANZCA, *Submission No 87*, p 19.

33 ANZCA, *Submission No 87*, p 19.

34 RACGP, *Submission No 67*, p 5.

35 RACGP, *Submission No 67*, p 5.

For a doctor, a vet or an accountant, it is lack of peer support, it is lack of a good internet connection – that is one of the reasons why the Rural Health Alliance, for which we work, supports fast broadband available at an affordable price everywhere across the country. That will transform remote areas. Doctors will not go to remote areas if they are left alone. They want to work with a team, with nurses, with podiatrists. In a remote that may be impossible, but we are creating innovative ways in Australia to have outreach.³⁶

Committee comment

- 7.51 The Committee is aware that there are already a large number of programs providing educational training support that may be accessible for IMGs. The program run by OTSAN and the RACGP's pilot program supporting IMGs, as outlined in the preceding section, demonstrate the success of this kind of support. Other notable examples of educational support programs which IMGs may be eligible to access include the Additional Assistance Scheme provided by the Rural Workforce Agencies (RWAs), the Rural Vocational Training Scheme (RVTS) and the education and training programs managed by General Practice Education and Training Limited (GPET).³⁷
- 7.52 While not commenting on the specifics of individual programs, the Committee understands that assistance with exam preparation, access to mentoring and peer support, and opportunities for clinical observation, assistance and experience, are vital components of the supports which should be provided to IMGs in Australia.
- 7.53 While the specifics of program design and the eligibility criteria differ, two issues about IMG access to these educational supports were raised time and time again during the inquiry. The first issue relates to the accessibility of these programs for IMGs working in regional, rural and remote locations. The second issue relates to program eligibility criteria and IMG residency status. The Committee examines these two issues below before commenting further on educational supports for IMGs.

36 Mr Gordon Gregory, National Rural Health Alliance, *Official Committee Hansard*, Canberra, 24 May 2011, p 5.

37 See Chapter 2 for more information.

Access to educational and training support

7.54 According to the Department of Health and Ageing (DoHA) IMGs account for approximately 46% of general practitioners practising in rural and remote areas of Australia.³⁸ Although it is difficult to determine precise numbers, according to DoHA's Report on the Audit of Health Workforce in Rural and Regional Australia:

As at February 2008, there were 4,669 overseas trained doctors in Australia, including GPs (3,028) and specialists (1,641), who were subject to Medicare provider number restrictions. 1,437 of these overseas-trained GPs and 181 of the overseas-trained specialists work in rural and remote areas ...³⁹

7.55 It is clear from the evidence that IMGs practising in regional, rural and remote communities frequently do not have the same access to educational and training support opportunities as their city/metropolitan counterparts.⁴⁰

7.56 Dr Andrew Pesce, President of the Australian Medical Association told the Committee:

We think it is vital to give IMGs access to training resources and networks, which are particularly difficult to access in rural and remote areas. If you think about it, the people who need our best support are in places where it is most difficult to deliver.⁴¹

7.57 In its submission to the Committee, the Rural Doctors Association of Australia stated:

Doctors who have trained overseas will come to Australia for many reasons, including work opportunities, lifestyle and family commitments. Where these doctors have the necessary skills, qualifications and expertise to practice medicine in Australia and are willing to work in regional, rural and remote Australia, they should be welcomed and supported. If assessment processes identify that these doctors do not have the necessary skills (and many will not have the skills to meet the needs or current curricula for rural and remote practice), or that they wish to acquire these

38 Australian Government Department of Health and Ageing (DoHA), *Submission No 84*, p 4.

39 DoHA, *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008, Canberra, p 37.

40 See for example: Government of Western Australia (WA) Department of Health, *Submission No 82*, p 5; Dr Shakuntala Shanmugam, *Official Committee Hansard*, Cairns, 12 August 2011 p 15.

41 Dr Andrew Pesce, Australian Medical Association (AMA), *Official Committee Hansard*, Canberra, 25 February 2011, p 30.

skills in order to practice, then they should have the opportunity to obtain these skills through established training pathways.⁴²

7.58 Dr Alasdair MacDonald appeared before the Committee in a private capacity.⁴³ As a physician involved in peer review and assessment of IMGs both at the college and hospital level, Dr MacDonald outlined his concerns regarding the training and support of IMGs in Australia:

... I am particularly interested in making sure that a health system that is dependent in its regional, rural and urban fringe hospitals on international medical graduates is also providing effective collegiate support for those people, because we run the risk of making sure that their credentials, their training and their experience are comparable when they come here but often then putting them in an environment where they perhaps do not have the collegiate support that is required. They often end up in an environment where there are a number of international medical graduates constituting the majority of the workforce, and that can result in their not being well linked up with appropriate collegiate peer review and other professional activities.⁴⁴

7.59 Evidence suggests that IMGs practising in these locations may have difficulty in accessing these supports for the following reasons:

- isolation resulting in a lack of peer support and mentorship opportunities;
- lack of access to the technology required to facilitate educational and peer support opportunities;
- heavy workloads and a lack of access to locum assistance to enable participation in educational/training opportunities; and
- lack of financial support to facilitate travel to participate in educational/training opportunities.⁴⁵

7.60 The Committee also heard from many contributors to the inquiry suggesting that levels of educational and training support diminish even

42 Rural Doctors Association of Australia, *Submission No 80*, p 9.

43 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 16.

44 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 16.

45 See for example: Dr Felicity Jefferies, *Official Committee Hansard*, Perth, p. 2; Dr Shanmugam, *Official Committee Hansard*, Cairns, 12 August 2011, p 15.

further where IMGs are also temporary residents.⁴⁶ In this regard, Health Workforce Queensland stated:

Funded educational support for OTDs is extremely limited and in the case of Temporary Resident OTDs virtually non-existent.⁴⁷

7.61 Health Recruitment Plus Tasmania agreed, stating there is little to no support offered to temporary resident IMGs, who make up a significant portion of GPs in regional, rural and remote areas particularly.⁴⁸

7.62 Rural Health Workforce Australia (RHWA) submitted to the Committee:

Despite OTDs being such an important part of our rural and remote workforce, most support programs are not available to temporary resident OTDs. This reflects a rather old fashioned belief that these OTDs only come to Australia for a short time, whereas they usually seek permanent residency and citizenship and become long term rural and remote GPs.⁴⁹

7.63 Noting the restricted access to many support programs, and evidence that around 70% of temporary resident IMGs eventually seek permanent residency status in Australia, Mr Chris Mitchell, Chief Executive Officer, Health Workforce Queensland, observed:

A point to remember here is that Australia has not paid for the training of these overseas trained doctors; we have got them free. We have limited supports in their placement, we have limited supports in their orientation and there are limited supports in the ongoing training. The question is: why not fund and support temporary resident OTDs in their training because there is evidence that they will stay? And if we miss a couple and they return to their country, well, we will know they are well trained. So there is obviously a barrier to that issue.⁵⁰

7.64 Evidence to the inquiry indicates that by restricting access to support programs to IMGs who have permanent residency status, a large proportion of IMGs who require support in working towards full

46 Queensland Health, *Submission No 12*, p 12; Mr Chris Mitchell, Health Workforce Queensland (HWQ), *Official Committee Hansard*, Brisbane, 10 March 2011, p 64; Dr Ian Cameron, NSW Rural Doctors Network (NSWRDN), *Official Committee Hansard*, Sydney, 31 March 2011, p 10; Dr Felicity Jefferies, WA Country Health Service (WACHS), *Official Committee Hansard*, Perth, 28 June 2011, p 4; Mr Robert Hale, General Practice Education and Training, *Official Committee Hansard*, Canberra, 5 July 2011, p 2.

47 Health Workforce Queensland, *Submission No 44*, p 5.

48 Health Recruitment Plus Tasmania, *Submission No 32*, p 4.

49 Rural Health Workforce Australia, *Submission No 107*, p 5.

50 Mr Mitchell, HWQ, *Official Committee Hansard*, Brisbane, 10 March 2011, p 63.

registration as a medical practitioner are missing out on the opportunity to achieve these goals.

- 7.65 One solution proposed was for eligibility to be amended to make educational and professional development programs accessible to temporary resident IMGs provided that they can demonstrate that they are working towards full registration and intending to seek permanent residency in Australia.⁵¹

Committee comment

- 7.66 The Committee notes that there is a multiplicity of educational and training programs provided by a range of different organisations (eg governments, specialist colleges, workforce agencies, regional training providers) that may be accessed by IMGs. While evidence has highlighted the potential for these programs to improve outcomes for IMGs and the communities where they provide medical services, the Committee notes that these programs are not necessarily available to IMGs across all state jurisdictions. Further, resourcing for some of these programs continues to pose a significant challenge, with some successful pilot programs not being allocated further resources to continue.
- 7.67 It is apparent to the Committee that the IMGs who would benefit most from accessing these supports, including those IMGs working in regional, rural and remote locations and temporary resident IMGs, are often precluded from doing so.
- 7.68 In the Committee's view, a nationalised and consistent approach to the provision of ongoing education and professional development for IMGs has the potential to encourage more IMGs to remain living and working in Australia, servicing the communities who are most in need of these doctors' skills and experiences.
- 7.69 As mentioned earlier, in 2009 COAG established the national health workforce agency, HWA. While acknowledging that HWA is still in the process of refining its work plan, the Committee considers that developing a nationalised and consistent approach to the provision of on-going educational and training supports for IMGs should be a key component of HWA's National Strategy for International Recruitment.
- 7.70 Given the range of organisations involved in funding and delivery of educational and professional development supports, the Committee

51 See for example: Dr Cameron, NSWDRN, *Official Committee Hansard*, Sydney, 31 March 2011, p 10; Dr Jefferies, WACHS, *Official Committee Hansard*, Perth, 28 June 2011, p 4.

recommends that HWA consult with the relevant stakeholders (including governments, specialist colleges, workforce agencies, regional training providers and IMGs) to determine options for developing a more consistent and streamlined system of educational and training supports for IMGs. The consultation should include specific consideration of the following:

- strategies for facilitating access for IMGs working in regional, remote and rural locations, including:
 - ⇒ the potential for the innovative use of new technologies including tele/video-conferencing and internet;
 - ⇒ the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and
 - ⇒ the adequacy of financial assistance for IMGs who need to travel to access educational and training supports.
- strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and
- the financial and resource implications associated with providing wider access to educational and training supports.

Recommendation 41

7.71 The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop a nationally consistent and streamlined system of education and training supports for international medical graduates.

The consultation should include specific consideration of the following:

- strategies for facilitating access for IMGs working in regional, remote and rural locations, including:
 - ⇒ the potential for the innovative use of new technologies including tele/video-conferencing and internet;
 - ⇒ the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and
 - ⇒ the adequacy of financial assistance for IMGs who need to travel to access educational and training supports.
- strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and
- the financial and resource implications associated with providing wider access to educational and training supports.

Personal and family support

7.72 The Committee has heard that while professional support for IMGs is important, of equal importance to the recruitment and retention of IMGs is access to personal and family support while they adapt to living and working in Australia. However, evidence indicated that IMGs and their families may also need ongoing support such as access to social networks, accommodation, employment opportunities for spouses, educational facilities for children, and access to health care.⁵²

7.73 Representing the Government of Western Australia Department of Health, Dr Felicity Jefferies emphasised the importance of family support, telling the Committee:

52 See for example: Australian General Practice Network, *Submission No 61*, p 3.

From my years of working in this area, I have found that, if you do not support the families, the IMGs leave. It is the same with any doctor in rural and remote Australia – the same with any professional really. If the family is not happy then the worker leaves, even though the worker might enjoy the job.⁵³

- 7.74 Similarly, Ms Belinda Bailey, Chief Executive of Rural Health West, told the Committee that family support formed one of the key areas of support which led to the retention of the rural workforce:

The evidence around retention will also say that doctors will stay if their families are happy, so we run a comprehensive family support program which includes subsidising travel for spouses to come down to Perth when we run education events, making sure that the family comes together on the weekend and that there are some bursaries available for spouses so that they can do some study when they are out there and that sort of thing.⁵⁴

- 7.75 As noted earlier in this Chapter, appropriate social and cultural orientation is crucial so that IMGs and their families know what to expect when they first arrive to live and work in Australia. Mr Peter Barns, Chief Executive Officer of Health Recruitment Plus Tasmania, told the Committee that they adopt a holistic approach to recruiting IMGs and 'match' them to an appropriate position and location. According to Mr Barns, the matching process begins at an early stage:

The doctor comes to us and we start a conversation: 'What are your needs? What are your family needs? What are you looking for? What are your five-year goals? What are your 10-year goals?' It is quite an in-depth process because you want to get the matching right so that they are not coming here and moving on all the time. We want to make sure that they are happy, because it is a pretty awful thing to come from the other side of the world and not be content in the community.⁵⁵

- 7.76 The Committee also heard of attempts to match an IMG into a community where there were other IMGs or families with a similar cultural or ethnic background to provide social networks and supports. Dr Cameron explained how the NSW Rural Doctors Network undertook a kind of matching process, telling the Committee:

53 Dr Jefferies, WACHS, *Official Committee Hansard*, Perth, 28 June 2011, p 4.

54 Ms Belinda Bailey, Rural Health West (RHW), *Official Committee Hansard*, Perth, 28 June 2011, p 14.

55 Mr Peter Barns, Health Recruitment Plus Tasmania, *Official Committee Hansard*, Launceston, 14 November 2011, pp 22-23.

There is a lot of stuff around the professional but especially, as we have already said, there are things around the family and the social aspects, including kids. We give the doctors that come through us money to do a site visit to go and look at a town. We look at things like religion. If the doctor is a Coptic Christian then there are some towns where there are a number of Coptic Christians and they may feel more comfortable in that town than if they went to a town where they did not have any of that religious support. We look at how old are the children and what are the schooling needs. All of those things we try and do during the matching process so that they will have more social support available when they go out there.⁵⁶

- 7.77 Other personal and family support issues which that have been raised with the Committee include whether health care benefits and access to public education should be freely available to IMGs and their families, regardless of residency status. Mr Ian Frank, Chief Executive Officer of the AMC, said that although Australia brings about 4 000 or more people from overseas every year to service the national health care system, a large proportion of IMGs servicing rural areas cannot access Medicare when their own children get sick. Mr Frank told the Committee:

They have to send their kids back home to be taken care of. What message are we sending to IMGs if we are bringing them out here, expecting them to run health services for us, looking after our families and kids, but we do not provide them with that kind of support themselves?⁵⁷

- 7.78 Dr Ilian Kamenoff, an IMG working in Bundaberg who migrated to Australia 11 years ago outlined his experience as follows:

I have been working in Australia for 11 years. I have two children born in Australia. I have no status in the country. I have no Medicare access. Since my wife is a NZ citizen and qualifies for Medicare benefits I have to pay Medicare Levy and surcharge without having access to Medicare benefits. Since I don't have access to Medicare I pay private Health cover as a visitor ... after 11 years in the country. The reason for this anomaly is that access to Medicare is on individual base (visa) but the Family Tax benefits are based on my income. That is why I have to pay higher tax and

56 Dr Cameron, NSW RDN, *Official Committee Hansard*, Sydney, 31 March 2011, pp 16-17.

57 Mr Ian Frank, AMC, *Official Committee Hansard*, Melbourne, 18 March 2011, p 17.

not to have access to Medicare and at the same time to pay higher Private health cover.⁵⁸

- 7.79 As Dr Felicity Jefferies, Executive Director, Clinical Reform, WA Country Health Service told the Committee:

It has been a huge issue for doctors over many years. They come in and work in the health care system, they pay the Medicare tax levy and they do not get any benefits from it. It has been a big issue. DIAC have always said to us, and I have brought it up over the years, that, if we do it for the doctors, we have to do it for every temporary resident coming in. They have been very reluctant to change it because of the policy implications across the board. I do not know about that. I know that, when we employ them in WA Health, part of our role is looking after their health. We do that while they are our employees. They get access to free health care.⁵⁹

- 7.80 The National Rural Health Alliance Inc submitted:

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.⁶⁰

- 7.81 Similarly, the NSW Rural Doctors Network also argued inequities in the treatment of temporary resident doctors:

Immigration issues can be complicated. Temporary resident doctors may not be able to sign contracts, take out loans or have access to Medicare for their own health needs. In NSW they have to pay for their children's education even at public schools. Given that they pay equal tax and make an immense contribution to society by working in rural areas this seems rather inequitable.⁶¹

- 7.82 Information from DIAC indicates that in 2010-11, around 3,000 of the 4,000 IMGs present in Australia under the skilled migration program, are
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58 Dr Ilian Kamenoff, *Submission No 5*, p 3.

59 Dr Jefferies, WACHS, *Official Committee Hansard*, Perth, 28 June 2011, p 9.

60 National Rural Health Alliance Inc, *Submission No 113*, p 25. See also: Mr Gordon Gregory, National Rural Health Alliance Inc, *Official Committee Hansard*, Canberra, 24 May 2011, p 1.

61 NSW Rural Doctors Network, *Submission No 37*, p 20.

subject to the 457 Temporary Business (Long Stay) visa. In relation to this, Mr Kruno Kukoc, First Assistant Secretary, Migration and Visa Policy Division, DIAC, advised the Committee:

The 457 visas are temporary visas. As such, the holders do not have access to any social security, community support or general government support.⁶²

7.83 Mr Kukoc noted that a further condition of the visa is that holders are required to maintain private health insurance.⁶³ Mr Kukoc advised that:

Normally the legislation in all portfolios works on the basis of permanent residents. All income support, various government support, is based either on permanent residency or citizenship requirements. Occasionally, for example, social security law can also give access to some income support like special benefits to non-permanent residents.⁶⁴

7.84 When questioned further about the conditions associated with the 457 visa, such as access to Medicare benefits, Mr Kukoc explained these do not fall within DIAC's policy portfolio. Rather, each benefit is governed under separate legislation which is implemented by another agency - for example, social security benefits are governed by the Social Security Act.⁶⁵

7.85 Mr Kukoc explained the potential consequences of extending the eligibility of various benefits to people holding a 457 visa:

I will just point out that we have around 130,000 457 visa holders in the country. We have close to one million people on various temporary residence visas. That includes New Zealanders. There are some significant implications of any policy that would change access to various government support benefits or welfare benefits to allow temporary residents access to those; it would have a significant fiscal impact. But I am not in the position to talk about that.⁶⁶

Committee comment

7.86 The Committee is pleased to see that recruitment and health workforce agencies recognise personal and family support as a crucial factor in the

62 Mr Kruno Kukoc, Australian Government Department of Immigration and Citizenship (DIAC), *Official Committee Hansard*, Canberra, 11 October 2011, p 4.

63 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 8.

64 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 8.

65 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, pp 7-8.

66 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 8.

support of IMGs. In the Committee's view, this factor is relevant to the ongoing recruitment and retention of IMGs in Australia, particularly in regional, rural and remote communities. The Committee understands from the evidence put before it that there are a ways in which family support is provided to IMGs and their families. Such support is provided indirectly through matching an IMG to a particular community during the recruitment process; and directly through support programs available to family members of IMGs, such as networking events, subsidising travel and other supports.

- 7.87 The Committee perceives that offering support targeted to an IMG's family will have the effect of increasing the rate of retention of IMGs, particularly in regional, rural and remote communities across Australia. The Committee is also of the view that supporting an IMG's family will also ease some of the stress placed on an IMG whilst they are working towards full registration, resulting in more IMGs remaining living and working in Australian communities, where they are highly valued and where the communities are in need of the IMG's ongoing services. Such a system should include a particular emphasis on the educational needs of children, along with support and employment prospects for spouses.
- 7.88 As with other forms of support, the Committee understands that access to personal support from IMGs and their families will vary depending on the IMG's individual circumstances, including the accreditation and registration pathway selected and the IMG's involvement with recruitment or workforce agencies. In view of the evidence which highlights the importance of ongoing personal and family support, the Committee is keen to ensure that there is wider access to these kinds of supports. Therefore, the Committee recommends that Health Workforce Australia, in consultation with key stakeholders (including recruitment and workforce agencies, IMGs and their families) develop a cohesive and comprehensive system of ongoing support options for IMGs and their families as an integral part of its National Strategy for International Recruitment.

Recommendation 42

- 7.89 **The Committee recommends that Health Workforce Australia, in consultation with key stakeholders, develop a cohesive and comprehensive system of ongoing support options for IMGs and their families as an integral part of its National Strategy for International Recruitment. Such a system should include at a minimum, a particular emphasis on the educational needs of children, along with support and employment prospects for spouses.**
- 7.90 With regard to accessing benefits, such as Medicare patient benefits for IMGs who are temporary residents, the Committee appreciates that on one view, it appears unjust and inequitable that IMGs providing crucial health services to Australians are not in a position to access these health services via the Medicare system themselves, even though they are generally subject to the Medicare levy and pay tax earned on their Australian income.
- 7.91 However, the Committee is also alert to the fact that significant consequences may flow from extending the eligibility for access to Medicare, social security benefits and education to temporary residents who hold a class 457 visa, as this visa extends a large number of migrants working over a number of professions. Further, if such benefits were extended to temporary resident IMGs and not other professions, this would also have a discriminatory effect and disadvantage temporary residents working outside the medical profession.
- 7.92 In view of the potentially significant and wide ranging consequences, the Committee is of the view that it would not be appropriate to make any recommendation for change to 457 visa conditions in the context of the current inquiry.

Navigating the system

- 7.93 Over the course of this inquiry, the Committee has not only been interested in what support programs are available to IMGs and their families, but what support they can access to assist them in navigating what is still a complex system.

One-stop shop and case management

7.94 A number of contributors suggested that a 'one-stop shop' or case management approach could alleviate some of the difficulties experienced by IMGs attempting to meet all of the professional and personal requirements that will enable them to live and work in Australia. For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) suggested:

It may, however, be prudent for one agency that deals with all applicants (eg AMC, or AHPRA), or which may be able to be seen as 'neutral' in the context of any assessment or registration outcomes (eg Commonwealth Department of Health and Ageing) to be charged with the responsibility, and resourced appropriately, to produce clear materials that succinctly explain all steps of the process and the roles of the different agencies. This role could be expanded to ensure dissemination of information to relevant stakeholders, as well as act as a 'one stop shop' source of information for OTDs.⁶⁷

7.95 Dr Jennifer Alexander, Chief Executive Officer of the Royal Australasian College of Physicians told the Committee:

You will see that we have made a recommendation that consideration be given by government to the creation of an agency that pulls together the information required by immigration, the medical boards et cetera. We have recommended that consideration be given to pulling that together so that there is a one-stop shop to enable doctors to know that they have to complete this in order to get to that next step.⁶⁸

7.96 Professor John Svigos, a Consultant Obstetrician and Gynaecologist, also supported this concept:

The suggestion of a 'one stop shop', as consistently mentioned, of a 'neutral' agency (eg Commonwealth Department of Health and Ageing) to embrace IMG's and be charged with the responsibility to produce clear information that succinctly explains all steps of the assessment process and subsequent registration procedures and the roles of the different agencies must be seriously considered and supported. Such a 'shop' will need to be adequately resourced and appropriately staffed and would have

67 RANZCOG, *Submission No 45*, p 8.

68 Dr Jennifer Alexander, Royal Australasian College of Physicians, *Official Committee Hansard*, Canberra, 25 February 2011, p 57.

the additional responsibility of ensuring that the above information is disseminated to all stakeholders viz the communities requesting/requiring an OTD, the jurisdictional/hospital representatives providing employment and the potential support personnel who may be required.⁶⁹

7.97 Similarly, Ms Belinda Bailey of Rural Health West considered that a national agency would need to take on the role of providing a one-stop shop for IMGs.⁷⁰ In contrast, Mr Ian Frank representing the AMC, suggested, a series of state based or jurisdiction agencies might be preferable to a single national agency, as this would enable assistance to be tailored to take in to account local circumstances (eg employment conditions etc).⁷¹

7.98 Dr John Keenan, Director of Swan Kalamunda Health Service, suggested rather than a designate one-stop shop, it would be preferable to improve communication between the different agencies responsible for the administration of different processes that IMGs need to interact with, saying:

... I think the basic bones are already there within the structure that we have; it is just that they do not work well together. The colleges are separated out from the AMC; the AMC is separated out from the registration system. What we need is a cohesive management profile between the colleges – of course, I have left out the immigration process as well.⁷²

7.99 However, Dr Beth Mulligan, Director of Clinical Training and Chair IMG Subcommittee with the Tasmanian Government Department of Health and Human Services was concerned about the feasibility of a one-stop shop, observing:

I do not know that it can be a one-stop shop, to be perfectly honest. I think it is a fairly complex process. If we can look, instead, at making the processes more streamlined and more efficient, that is probably a better outcome than trying to do a one-stop shop. We absolutely have to have checks and balances, and I do not think a one-stop shop can have the expertise that we need to get us to the

69 Professor John Svigos, *Submission No 165*, pp 1-2.

70 Ms Bailey, RHW, *Official Committee Hansard*, Perth, 28 June 2011, p 15.

71 Mr Frank, AMC, *Official Committee Hansard*, Canberra, 19 August 2011, pp 13-14.

72 Dr John Keenan, Swan Kalamunda Health Service, *Official Committee Hansard*, Perth, 28 June 2011, pp 24-25. See also: Dr Jennie Kendrick, Royal Australian College of General Practitioners, *Official Committee Hansard*, Melbourne, 18 March 2011, p 69.

point where we have a safe doctor that we can put into our health system.⁷³

- 7.100 A slightly different perspective on the role of a one-stop shop was put by Dr Michiel Mel of Boyup Brook Medical Services in Western Australia. Dr Mel expressed concern that medical practitioners from developed westernised countries were being deterred from living and working in Australia by the bureaucracy and red tape associated with IMG accreditation and registration. Dr Mel asserts that a one-stop shop may minimise the red tape:

I think the real solution to optimise the process would be to erect a 'one stop shop' for OTDs rather than having many different agencies, colleges and government agencies bouncing the OTDs around and shuffle paperwork to certify a doctor fit to treat the Australian public. The representatives of a 'one stop organisation' would be in much closer contact with an OTD to help him/ her through the system and therefore would have much greater understanding and much better judgement of an OTDs qualifications and performance in Australian practice.⁷⁴

- 7.101 A number of the rural health workforce agencies indicated that they already take a case management approach to recruiting IMGs.⁷⁵ For example, Rural Workforce Agency, Victoria (RWAV) advised:

RWAV has established a case-management system to assist an OTD navigate the maze of assessment, registration, immigration, provider number and placement processes involved in securing work in Victoria. The case-management system also assists practices seeking to navigate through the complex requirements set by Commonwealth and State governments such as Area of Need and District of Workforce Shortage approvals needed to be able to employ an OTD.⁷⁶

- 7.102 In its submission, RWAV outlined the success of this approach, noting:

73 Dr Beth Mulligan, *Official Committee Hansard*, Launceston, 14 November 2011, p 14.

74 Dr Michiel Mel, *Submission No 77*, p 4.

75 See for example: Ms Bailey, RHW, *Official Committee Hansard*, Perth, 28 June 2012, p 13; Mr Barns, Health Recruitment Plus, *Official Committee Hansard*, Launceston, 14 November 2011, p 22.

76 Rural Workforce Agency, Victoria (RWAV), *Submission No 91*, p 9.

As a result, GP commencements in practice have increased from 36 doctors in 2007 to 141 in 2009-2010. GP commencements from July 2010 to January 2011 are currently 77.⁷⁷

7.103 Noting the success of its case management approach, the Rural Doctors Workforce Agency (RDWA) in South Australia outlined the supports it offers its IMGs, saying:

This includes:

- Initial screening for suitability for rural practise in SA
- Information on the various pathways and elements to registration
- Visa support
- Information for family members.

Once identified as suitable for rural practise, the ROWA:

- Case manages applicants through vacancy options
- Provides paid site visits for the applicant and partner
- Provides information to enable with application for PESCI and AHPRA to be as straightforward as possible
- Assists with visa paperwork, hospital credentialing
- Provides contract, business and financial information and grants
- Once contracted to practice, provides a resettlement support program that includes a relocation grant.⁷⁸

7.104 RDWA suggested that its case management system could provide the basis for a national case management model.⁷⁹

Committee comment

7.105 The Committee notes that there was general in-principle support for the concept of a one-stop shop to assist IMGs to navigate all of processes associated with living and practising medicine in Australia. These processes not only include those associated with medical accreditation and registration, but also those associated with immigration, and finding suitable employment. However, on closer investigation, it is apparent that the concept of a one-stop shop has a different meaning for different people. Even among those who supported the concept there were differing views on how a one-stop shop should be administered and which organisation or agency would be the most appropriate host. There

77 RWAV, *Submission No 91*, p 11.

78 RDWA, *Submission No 83*, p 4.

79 RDWA, *Submission No 83*, p 4.

were also differing views about the scope of its activities, whether it should provide national or jurisdictional services, and the level of support it should provide, ranging from information only, to a more intensive service providing individual case management.

- 7.106 The Committee also notes that support for the one-stop shop was not universal. Several inquiry participants suggested that if the lines of communication between the AMC, the specialist medical colleges and the MBA/AHPRA were improved and systems were better coordinated as intended under the NRAS, this would negate the need for a one-stop shop. The Committee has already identified the need for better communication between these key organisations. It would be easier for IMGs to navigate and engage with the accreditation and registration processes if the Committee's recommendation to establish a centralised document repository and database to track an applicant's progress was implemented.
- 7.107 However, the Committee understands that IMGs are also required to engage in processes which extend beyond those administered by the AMC, specialist medical colleges and MBA/AHPRA. These include immigration processes, as well as Commonwealth, state and territory government processes associated with finding suitable employment and applying to claim Medicare provider benefits. IMGs need to understand how each process operates in isolation, but also needs to recognise how each process interacts with the others. Evidence suggests that the case management services, such as those provided by the rural health workforce agencies, are valuable in assisting IMGs to navigate all of these processes effectively.
- 7.108 In view of the range of complex processes and numerous organisations that IMGs will need to engage, the Committee considers that the concept of establishing a one-stop shop to assist IMGs warrants further consideration. Therefore the Committee recommends that HWA, as part of its National Strategy for International Recruitment program, examine options for establishing a one-stop shop for medical practitioners. In addition, HWA should consider the feasibility of providing individualised case management services to IMGs to assist them in navigating accreditation and registration processes, as well as immigration processes, and Commonwealth, state and territory processes associated with employment and accessing Medicare provider benefits. In developing the most suitable model for such a service, HWA should consider the proposed scope of this service and the range of assistance provided, having regard to available resourcing.

Recommendation 43

7.109 **The Committee recommends that Health Workforce Australia (HWA), as part of its National Strategy for International Recruitment program, examine options for establishing a one-stop shop for international medical graduates (IMGs) seeking registration in Australia. Serious consideration should be given to the feasibility of providing an individualised case management service for IMGs.**

In developing the most suitable model for such a service, HWA should consider the proposed scope of this service and the range of assistance provided, having regard to available resourcing.

Accessing information

7.110 For IMGs who are interested in coming to Australia to practice medicine, accessing accurate and comprehensive information is crucial. The same is also true for IMGs once they have arrived in Australia, while they are progressing to full Australian registration. Earlier in the report reference has been made to the DoHA's DoctorConnect website. DoHA submits that DoctorConnect provides a starting point for IMGs and employers, noting:

Information within this site includes: Rural Health Workforce Strategy initiatives; a map containing geographic information and corresponding incentives available; ASGC-RA explanation; and links to relevant stakeholders. Information for OTDs includes: choosing Australia as a place to work; assistance for employers of OTDs; details about the April 2010 amendments to section 19AB of the *Health Insurance Act 1973*; and a checklist of medical registration and immigration requirements.⁸⁰

7.111 However, evidence has included differing views relating to the utility of the DoctorConnect website. Criticisms have raised issues regarding the accuracy and completeness of information provided, as well as its utility in assisting users to navigate complex processes and understand the range of support programs available to them.⁸¹ For example, ACRRM submitted to the Committee that the availability and quality of information was an issue pertinent to IMGs. ACRRM noted feedback from its membership

⁸⁰ DoHA, *Submission No 84*, p 16.

⁸¹ See for example: Dr Jonathan Levy, *Submission No 34*, p 4; Royal College of Pathologists of Australasia (RCPA), *Submission No 72*, p 4.

indicating that the information on DoctorConnect was not always up-to-date and was sometimes difficult to understand.⁸²

- 7.112 Tropical Medical Training (TMT) based in Queensland made the following suggestion to improve access to information for IMGs:

Enhance the Doctor Connect website - or alternative - to provide clear and concise guidelines for OTDs seeking additional support for their application and migration to Australia and detail how each listed service supports the OTD, and at what out-of-pocket cost, to achieve their Fellowship training program.⁸³

- 7.113 A number of inquiry contributors suggested that the utility of DoctorConnect could be improved if it was also supported by a telephone helpline to assist with specific questions or clarification.⁸⁴ For example, Alecto Australia noted that:

The DoctorConnect website is not linked to a telephone helpline and so it is not possible to put any queries to the Department of Health and Ageing except by email. This makes it difficult for doctors to get specific information about individual cases.⁸⁵

- 7.114 In a similar vein, Health Recruitment Plus Tasmania advised the Committee:

Websites such as www.doctorconnect.gov.au have been of some assistance to OTDs (from anecdotal evidence) but the key factor has been the link on the website to *people* who can help an individual OTD navigate the system. Constant feedback from OTDs is that once they found a person to help them they hung on like a limpet until they were sure of what they were doing. While it may be appealing to try and deal with a system by setting up another system (websites are examples of this) nothing seems to satisfy people's concerns like connection with another human being.⁸⁶

Committee comment

- 7.115 The Committee understands that access to accurate and comprehensive information is needed to assist IMGs to develop a thorough
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82 Australian College of Rural and Remote Medicine (ACRRM), *Submission No 103*, p 12.

83 Tropical Medical Training, *Submission No 114*, p 11.

84 See for example: Alecto Australia, *Submission No 85*, p 4; ACRRM, *Submission No 103*, p 12; National Rural Health Alliance Inc, *Submission No 113*, p 19.

85 Alecto Australia, *Submission No 85*, p 4.

86 Health Recruitment Plus Tasmania, *Submission No 32*, p 2.

understanding of the all of the processes involved when seeking to relocate to Australia to practice medicine, and the supports available to them and their families. While noting comments in evidence relating to its limitations, the Committee supports the intent of the DoctorConnect website and appreciates the challenges associated with developing a web-based resource of this kind that is both comprehensive and user-friendly.

- 7.116 The Committee has noted earlier in the report that as part of its National Strategy for International Recruitment, HWA is working towards establishing a single website portal under its International Health Professionals Website Development Project. As the Committee has only limited information on the scope of this project, it is unclear whether this website portal will ultimately replace DoctorConnect. In addition, the Committee does not have information on the anticipated timeframe for delivery of the project.
- 7.117 In the absence of more detailed information on HWA's International Health Professionals Website Development Project, the Committee makes recommendations for the enhancements to the DoctorConnect website. These recommendations should equally apply to HWA's International Health Professionals Website should it eventually replace DoctorConnect. Specifically, the Committee recommends that DoHA expand the DoctorConnect website to include a register of support services available to IMGs in the various agencies around Australia, including details of location, eligibility, duration and timing, cost, and whether the program is available electronically/remotely.

Recommendation 44

7.118 **The Committee recommends that the Australian Government Department of Health and Ageing expand the DoctorConnect website to include a register of support services available to IMGs in the various agencies around Australia, including information on:**

- **details of location;**
- **eligibility;**
- **duration and timing;**
- **cost; and**
- **whether the program is available electronically/remotely.**

7.119 In addition, the Committee notes that currently e-mail is the only option available to DoctorConnect users who have questions or wish to seek clarification. The Committee believes that the utility of the DoctorConnect website would be improved if also supported by a telephone help line. The help line should provide assistance with navigating and clarifying information on the site.

Recommendation 45

7.120 **The Committee recommends that the Australian Government Department of Health and Ageing provide a telephone help line to answers questions and provide clarification on information provided on the DoctorConnect website.**

Steve Georganas MP
Chair



Appendix A – List of submissions

- 01 Name withheld
- 02 Dr Elwin Upton
- 03 Dr Emil Penev
- 04 Overseas Doctors Forum Australasia
- 05 Dr Ilian Kamenoff
- 06 Mr Michael Damp
- 07 Mr Vick Kandiah
- 08 Dr Oliver van Hecke
- 09 Takalvan Medical Centre
- 10 Dr Nasir Mehmood Baig
- 10.1 Dr Nasir Mehmood Baig
- 10.2 Dr Nasir Mehmood Baig
- 11 Name withheld
- 12 Dr Sudheer Babu Duggirala
- 13 Associate Professor John Stokes
- 13.1 Associate Professor John Stokes
- 14 Dr Frank Quigley
- 15 Name withheld
- 16 South Eastern Sydney Local Health Network
- 17 Illawarra Shoalhaven Local Health Network

-
- 18 Dr Mohammed Anarwala
 - 19 Prof Ratilal Laloo
 - 20 Australian Health Practitioner Regulation Agency
 - 21 Dr Chaitanya Kotapati
 - 21.1 Dr Chaitanya Kotapati
 - 22 Dr Richard Lunz
 - 23 North Metropolitan Area Health Service
 - 24 Dr Paramban Rateesh
 - 25 Confidential
 - 26 Dr Bo Jin
 - 27 Peninsula Health
 - 28 Committee of Presidents of Medical Colleges
 - 29 Name withheld
 - 30 Dr Prashanta Mitra
 - 31 Dr Michael Galak
 - 31.1 Dr Michael Galak
 - 32 Health Recruitment Plus Tasmania
 - 33 Hollywood Private Hospital
 - 34 Dr Jonathan Levy
 - 35 Mr Dennis Gonzaga
 - 36 headspace
 - 37 NSW Rural Doctors Network
 - 38 Overseas Trained Specialist Anaesthetists Network Inc
 - 39 Name withheld
 - 40 Confidential
 - 41 Royal Perth Hospital
 - 42 Australian Medical Council
 - 42.1 Australian Medical Council

-
- 42.2 Australian Medical Council
- 43 The Royal Australian and New Zealand College of Radiologists
- 44 Health Workforce Queensland
- 45 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- 45.1 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- 46 Name withheld
- 47 Dr Anatole Kotlovsky
- 47.1 Confidential
- 47.2 Confidential
- 48 Confidential
- 49 Western New South Wales Local Health Network
- 50 Dr Christopher Butt
- 51 Medical Board of Australia
- 52 Dr Leong-Fook Ng
- 52.1 Dr Leong-Fook Ng
- 52.2 Confidential
- 52.3 Confidential
- 53 Australian Government Department of Education, Employment and Workplace Relations
- 54 Associate Professor Michael Steyn and Associate Professor Kersi Taraporewalla
- 55 Australian Medical Association
- 56 Mr Ian Shaw
- 57 Confidential
- 58 Confidential
- 59 Numurkah District Health Service
- 60 Dr Navin Naidoo
- 61 Australian General Practice Network

-
- 62 Dr John Emery
 - 63 Mrs Doone Lamb
 - 64 Mr David Lamb
 - 64.1 Mr David Lamb
 - 65 The Royal Australasian College of Physicians
 - 65.1 The Royal Australasian College of Physicians
 - 65.2 The Royal Australasian College of Physicians
 - 66 Dr Christoph Ahrens
 - 66.1 Dr Christoph Ahrens
 - 66.2 Dr Christoph Ahrens
 - 66.3 Dr Christoph Ahrens
 - 66.4 Dr Christoph Ahrens
 - 67 Royal Australian College of General Practitioners
 - 68 Dr Johannes Wenzel
 - 69 Australian Orthopaedic Association Limited
 - 70 Dr Ghaleb Jaber
 - 71 Dr Kishor Desai
 - 72 The Royal College of Pathologists of Australasia
 - 73 Royal Australian and New Zealand College of Ophthalmologists
 - 74 Royal Australasian College of Surgeons
 - 74.1 Royal Australasian College of Surgeons
 - 75 Rural Health West
 - 76 Name withheld
 - 77 Dr Michiel Mel
 - 78 Dr David Wood and Dr David Levitt
 - 79 Dr Diane Mohen
 - 80 Rural Doctors Association of Australia
 - 80.1 Rural Doctors Association of Australia

-
- 81 General Practice Network Northern Territory
- 82 Government of Western Australia Department of Health
- 83 Rural Doctors Workforce Agency South Australia
- 84 Australian Government Department of Health and Ageing
- 84.1 Australian Government Department of Health and Ageing
- 85 Alecto Australia
- 86 Confidential
- 87 Australian and New Zealand College of Anaesthetists
- 88 Challis Recruitment Pty Ltd
- 89 Name withheld
- 90 Private Hospitals Association of Queensland
- 91 Rural Workforce Agency Victoria
- 92 Mater Hospital Rockhampton
- 93 Confederation of Postgraduate Medical Education Councils
- 94 Dr Nalakath Shamimudeen
- 95 Ms Meredith Gavanon
- 95.1 Ms Meredith Gavanon
- 96 Government of South Australia Department of Health
- 97 Dr Linh Trinh
- 98 Confidential
- 99 Dr Sunayana Das
- 99.1 Dr Sunayana Das
- 100 Dr Drajendra Moodley
- 100.1 Dr Drajendra Moodley
- 101 Australian Doctors Trained Overseas Association Inc
- 102 Dr Ponraja Thuryrajah
- 103 Australian College of Rural and Remote Medicine
- 104 Dr Sayed Hashemi

-
- 105 Victorian Medical Postgraduate Foundation Inc
- 106 Mayo Private Hospital
- 107 Rural Health Workforce Australia
- 107.1 Rural Health Workforce Australia
- 108 Mr Craig Wilmot
- 109 The Hon Bob Katter MP
- 110 Mr Michael Suss
- 111 Dr Susan Douglas
- 112 The Royal Australian and New Zealand College of Psychiatrists
- 112.1 The Royal Australian and New Zealand College of Psychiatrists
- 113 National Rural Health Alliance
- 113.1 National Rural Health Alliance
- 114 Tropical Medical Training
- 115 Friendly Society Private Hospital
- 116 Mr Hugh Ford
- 117 Confidential
- 118 Dr Piotr Lemieszek
- 119 General Practice Education and Training Limited
- 120 Sarina Clinic
- 121 Melbourne Medical Deputising Service
- 121.1 Melbourne Medical Deputising Service
- 122 Dr Chellam Kirubakaran
- 123 Dr Michael Jacob
- 124 New South Wales Government Department of Health
- 124.1 New South Wales Government Department of Health
- 125 Dr Luma Al-bayati
- 125.1 Dr Luma Al-bayati
- 126 Queensland Health
- 127 Name withheld
- 128 Confidential

129	Dr John Meaney
130	Dr Donald Pitchford
131	Name withheld
132	Dr Ayman Shenouda
133	Name withheld
134	Dr Robyn Iredale
135	Group of Concerned Burra and District Residents
136	Eyre Peninsula Division of General Practice
137	Confidential
138	Mr Ben Combe
139	Association of Medical Recruiters Australia and New Zealand
140	Dr Azhar Ahmad
141	Confidential
142	Mr Geoff Copland
143	Mr Brian Hoffman
144	Dr Christopher Frahm
145	Dr Tony Marshal
146	Confidential
147	Confidential
148	Graduate School of Medicine, University of Wollongong
149	Confidential
150	Dr Helmut Schoengen
151	Ms Kathryn O'Neill
152	OET Workshop Pty Ltd
153	Dr Pramudi Neelapriyantha
154	Centre for Adult Education
155	IELTS Australia Pty Ltd
156	Pearson Asia Pacific

157	Mr Kevin Gillespie
158	Name withheld
159	Confidential
160	Ms Kathy Ingham
161	Dr Mulavana Parvathy
162	School of Medicine and Health, University of Newcastle
163	Centre for Medical Professional Development
164	Confidential
165	Associate Professor John Svigos
166	Dr Joseph Thomas
167	Confidential
168	IMG Inquiry Recommendation Working Group
169	Name withheld
170	Mr Chris Johnson
171	Hunter Urban Division of General Practice
172	NSW Rural Doctors Network
173	Reliance Medical Practice
174	Northwest Victoria GP Educators Group
175	Australian Competition and Consumer Commission
176	Central Coast Local Health District
177	Confidential
178	Dr Salahuddin Chowdhury
179	Mr Ron Jontof-Hutter
180	Educational Testing Service TOEFL
181	Australian Government Department of Human Services (Medicare)
182	Dr Naftaly Zuker
183	Confidential
184	Western District Health Service



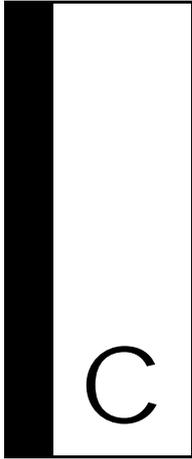
Appendix B – List of exhibits

- 1 Provided by Dr Elwin Upton
Correspondence between Dr Upton, Australian Medical Council and the University of Manitoba (Canada)
(Related to Submission No 02)
- 2 Provided by Dr Ilian Kamenoff
Article: *OTDs ask for 'a fair go'*, Australian Doctor, 2004
(Related to Submission No 05)
- 3 Provided by NSW Rural Doctors Network
McFayden, L, (2006), *The History and Politics of GP Registration in NSW to 2006* (extract from chapters 4 & 5 of PhD thesis)
(Related to Submission No 37)
- 3.1 Provided by NSW Rural Doctors Network
PATHWAYS to Recognition as a GP in Australia, May 2008, *Flowchart of what use to be and how easily it was represented*
(Related to Submission No 37)
- 3.2 Provided by NSW Rural Doctors Network
NSW Rural Doctors Network: Minimum Data Set Report, 30 November 2009
(Related to Submission No 37)
- 3.3 Provided by NSW Rural Doctors Network
NSW Rural Doctors Network Business Plan 2010-2011 and Strategic Plan 2010-2013
- 3.4 Provided by NSW Rural Doctors Network
IMG Survival Guide: A Medical Observer Publication
- 4 Provided by Numurkah District Health Service
Booklet: *Road from Damascus to Cobram*

- 5 Provided by The Royal Australasian College of Physicians
Appendix 1-Sub 65 - Trainee pathways for Physicians and Paediatricians
(Related to Submission No 65)
- 5.1 Provided by The Royal Australasian College of Physicians
Appendix 2-Sub 65 - Overseas Trained Physician/Paediatrician Interview Report Form
(Related to Submission No 65)
- 5.2 Provided by The Royal Australasian College of Physicians
Appendix 3-Sub 65 - Referee's Report on an Overseas Trained Physician/Paediatrician
(Related to Submission No 65)
- 5.3 Provided by The Royal Australasian College of Physicians
Appendix 4-Sub 65 - Peer Review Report on an Overseas Trained Physician/Paediatrician
(Related to Submission No 65)
- 6 Provided by Royal Australasian College of Surgeons
RACS Policy documents: International Medical Graduates
- 6.1 Provided by Royal Australasian College of Surgeons
RACS Policy document: Appeals Mechanism, Issue date: January 2009, Revision No. 2
(Related to Submission No 74.1)
- 7 Provided by Rural Health West
OTD's Recruitment and Registration Process - Five Case Studies - Three Anecdotes
(Related to Submission No 75)
- 8 Provided by Australian and New Zealand College of Anaesthetists
Appendix 1-Sub 85: Education and Training of Anaesthetists; Appendix 2-Sub 85: Regulation 23; Appendix 3-Sub 85: Frequently asked questions for IMGS
(Related to Submission No 87)
- 9 Provided by Private Hospitals Association of Qld
Appendix A-Sub 90: Peer Review Report on an OT Physician/Paediatrician; Appendix B-Sub 90: MBA Work Performance for limited registration
(Related to Submission No 90)
- 10 Provided by Australian and New Zealand College of Anaesthetists
Pamphlet: About ANZCA; and ANZCA Bulletin, December 2010

- 11 Confidential
- 12 Provided by National Rural Health Alliance
Appendix A-Sub 113: Member Bodies of the National Rural Health Alliance; and Appendix B-Sub 113: AMC 11 Step Specialist Pathway
(Related to Submission No 113)
- 12.1 Provided by National Rural Health Alliance
Appendix C-Sub 113: Overview of AMC pathways (courtesy IHPV); and Appendix D-Sub 113: The Death of a Rural Workforce Data - A draft Discussion paper
(Related to Submission No 113)
- 13 Provided by Melbourne Medical Deputising Service
Checklist for AMDS Medical Practitioners at Melbourne Medical Deputising Service
(Related to Submission No 121)
- 14 Provided by Health Workforce Queensland
Health Workforce Qld, Qld Minimum Data Set Report, 30 November 2010
- 15 Provided by Australian Government Department of Health and Ageing
Long, E, A Review of Section 19AB Guidelines and A Model for Revision, File no. 2006/0422 212, July 2006
- 16 Provided by NSW Department of Health
NSW Department of Health, Policy Directive: Area of Need Program and Procedures, Doc No PD2010_070, Dec 2010
(Related to Submission No 124)
- 17 Provided by Rural Workforce Agency Victoria
Flowchart: RWAV Recruitment and Case Management Process, March 2011
- 18 Provided by Rural Doctors Association of Australia
Report: Viable Models of Rural and Remote Practice Stage 1 and Stage 2 Reports, October 2003
- 19 Provided by Western Australia Government Department of Health
Statement and Recommendations at OTD PH in Perth, 28 June 2011; and Workplace-Based Assessment Cost-Benefit Analysis (Executive Summary)
- 20 Provided by General Practice Education and Training Limited
Table: General Practitioner Training Statistics, 2010-2012
- 21 Provided by Adelaide to Outback GP Training Program Inc

- GP Training Program Kit, "*Customised, Personalised, Specialised*"
- 22 Provided by Rural Doctors Workforce Agency SA
Communities are people, 2009/2010 Annual Report
- 23 Provided by Dr Nicola Dean
Questionnaire responses for Doctors who have migrated to Australia
- 24 Provided by NSW Rural Doctors Network
Chart: *NSW RDN Proposed Overseas Trained Doctor Medical Registration Process in Australia*
- 24.1 Provided by NSW Rural Doctors Network
Chart: *Overseas Trained Doctors Applications to NSW RDN 2004-2011*
(Related to Submission No 37)
- 25 Provided by Australian Government Department of Immigration and
Citizenship
Pamphlet: *Visas for Doctors*
- 26 Provided by Dr Maree Puxty
Opening statement by Dr Puxty at public hearing in Newcastle, 21 September
2012
- 27 Provided by Educational Testing Service TOEFL
Appendix A-Sub 180: *Linking TOEFL IBT Scores to IELTS Scores - A Research
Report*; and Appendix B-Sub 180: *Official and Examinee Copies of TOEFL Score
Reports*
(Related to Submission No 180)



Appendix C – Other documentary evidence

In addition to submissions and exhibits, a large volume of documentary evidence was submitted to the inquiry, principally from IMGs.

This evidence comprised:

1. Provided by Dr Richard Lunz (Related to Submission No 22)
Correspondence between Dr Lunz and Australian Medical Association Victoria
2. Provided by Dr Prashanta Mitra (Related to Submission No 30)
Correspondence to The Hon Bruce Scott MP; and Dr Prashanta's career summary
3. Provided by Mr Ian Shaw (Related to Submission No 56)
Various pieces of correspondence; and Complaint files
4. **Confidential**
5. Provided by Dr Christoph Ahrens (Related to Submission No 66)
Various pieces of correspondence to Minister Roxon and letters of support for Dr Ahrens
6. **Confidential**
7. **Confidential**
8. Provided by Name withheld (Related to Submission No 76)
Various pieces correspondence regarding past 5 years work to be counted towards 10 year moratorium
9. Provided by Dr Ponraja Thuryrajah (Related to Submission No 102)
Various pieces of correspondence concerning registration; Examination results; and Performance Feedback

10. Provided by Mayo Private Hospital (Related to Submission No 106)
Correspondence from and to College of Surgeons; and Curriculum Vitae for Dr Watters
11. Provided by Dr Luma Al-bayati (Related to Submission No 125)
Various pieces of correspondence including Dr Al-bayati's curriculum vitae; Letter from Department of Immigration; Certificate
12. Provided by Dr Paramban Rateesh (Related to Submission No 24)
Various pieces of correspondence from the Medical Board of Australia to Dr Rateesh; Article: Opportunity Knocks; and Article: Keeping your finger on the pulse
13. Provided by Queensland Health (Related to Submission No 126)
RAPTS Clinical Workforce Solutions "Orientation resource for International Medical Graduates" Dec 2010; District specific information; and Information Booklet
14. **Confidential**
15. Provided by Dr Bo Jin MD, PhD (Related to Submission No 26)
Various pieces of correspondence from RACP, Language Australia, ANZAC Institute and letters of support for Dr Jin
16. Provided by Dr Christopher Butt
Example of Occupational English Test Qualitative Feedback report
17. Provided by Group of Concerned Burra & District Residents
Lower North 10yr Local Health Service Plan 2010-19 & Policy for Credentialing and Defining the Scope for Medical and Dental Practitioners, Apr 2009
18. Provided by Dr Azhar Ahmad (Related to Submission No 140)
Centre for Adult Education Statement of Results: Occupation English Test
19. **Confidential**
20. Provided by Association of Medical Recruiters Australia & New Zealand (Related to Submission No 139)
Appendix 1: Application for registration as a medical practitioner in Qld (General & special purpose registration); Appendix 2: Application for limited registration for an area of need as a Medical Practitioner (Medical Board of Australia); Appendix 3: Levels of Supervision; Appendix 4: Email from R Kymantas from the RACGP dated 18 March 2011; and Appendix 5: Email from Meredith Bickley from AHPRA dated 8 April 2011

21. **Confidential**

22. Provided by Dr Michael Galak (Related to Submission No 31)
Various pieces of correspondence regarding Dr Galak's Application for Specialist Registration dated May 2011

23. Provided by Dr Sudheer Babu Duggirala (Related to Submission No 12)
Letter of support from RACGP for Dr Duggirala

24. Provided by Mr Tony Crook MP
Documents tabled by Tony Crook MP to the House Committee on Health and Ageing: 22 August 2011

25. **Confidential**

26. **Confidential**

27. Provided by Dr Leong-Fook Ng
Various pieces of correspondence regarding Dr Ng's registration

28. **Confidential**

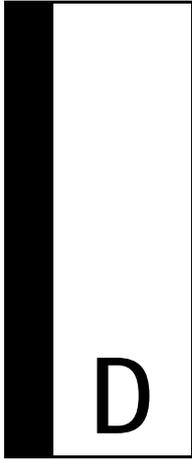
29. Provided by Dr Salahuddin Chowdhury (Related to Submission No 178)
Registers of Practitioners reference material, certificates, and various pieces of correspondence

30. Provided by Hunter New England Local Health District
Reference documents

31. **Confidential**

32. Provided by Dr Naftaly Zuker
Various pieces of correspondence containing Dr Zuker's Curriculum Vitae; letter from the Royal Australian and New Zealand College of Obstetricians & Gynaecology

33. Provided by Mr Nasir Baig
Various pieces of correspondence from Centre of Adult Education



Appendix D – List of public hearings

Friday 25 February 2011 – Canberra

Australian Medical Association

Mr John O’Dea, Director, General Practice

Dr Andrew Pesce, President, Australian Medical Association

Australian Doctors Trained Overseas Association

Dr Susan Douglas, Vice President

Dr Jonathan Levy, Member

Australian Government Department of Health and Ageing

Mr Lou Andreatta, Principal Adviser

Ms Kerry Flanagan, Acting Deputy Secretary

Mr Dave Hallinan, Assistant Secretary

Ms Gay Santiago, Assistant Secretary, Workforce Branch

Dr Andrew Singer, Principal Medical Adviser

Medical Board of Australia

Dr Joanna Flynn, Chair

Royal Australasian College of Physicians

Dr Jennifer Alexander, Chief Executive Officer

Thursday 10 March 2011 – Brisbane**Australian College of Rural and Remote Medicine**

Ms Marita Cowie, Chief Executive Officer

Ms Dianne Wyatt, Strategic Projects Manager

Doctors Forum

Dr Sunayana Das

Dr Sudheer Duggirala

Dr Chaitanya Kotapati

Dr Paramban Rateesh

Health Workforce Queensland

Ms Charlie Duncan, Recruitment and Locums Manager

Mr Chris Mitchell, Chief Executive Officer

Private Capacity

Dr Viney Joshi

Dr Rajendra Moodley

Associate Professor Michael Steyn

Associate Professor Kersi Taraporewalla

Queensland Health

Dr Michael Cleary, Deputy Director-General, Policy, Strategy & Resourcing Division

Friday 18 March 2011 – Melbourne**Alecto Australia**

Mrs Martina Stanley, Director

Australian and New Zealand College of Anaesthetists

Dr Richard Willis, Director, Professional Affairs IMGs

Australian Medical Council

Mr Ian Frank, Chief Executive Officer

Mr Philip O'Sullivan, Specialist Assessment

Private Capacity

Dr Michael Galak

Royal Australasian College of Surgeons

Mr Ivan Thompson, Deputy Chair, Board of Surgical Education and Training

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Dr Christopher Hughes, Chair, OTS/ AoN Committee

Royal Australian College of General Practitioners

Dr Jennie Kendrick, Fellow and Censor-in-Chief

Rural Workforce Agency Victoria

Mr Claire Austin, Chief Executive

Thursday 31 March 2011 – Sydney**Committee of Presidents of Medical Colleges**

Dr Michael Hollands, Treasurer, Royal Australasian College of Surgeons

Professor Kichu Nair, Member, Joint Standing Committee on Overseas Trained Specialists

Dr Christine Tippett, Chair, Joint Standing Committee on Overseas Trained Specialists

Doctors Forum

Mr Nasir Baig

Dr Christopher Butt

Dr Bo Jin

New South Wales Government Department of Health

Ms Robyn Burley, Director

New South Wales Rural Doctors Network

Dr Ian Cameron, Chief Executive Officer

Royal Australian and New Zealand College of Ophthalmologists

Dr Stephen Cains, Chairman, Specialist International Medical Graduates Committee

Ms Susanne Tegen, Chief Executive Officer

Royal Australian and New Zealand College of Psychiatrists

Associate Professor John Allan, Chair, Committee for Specialist International Medical Graduate Education

Dr Vikas Garg, Chair, Overseas Trained Psychiatrist Committee

Royal Australian and New Zealand College of Radiologists

Mr Donald Swinbourne, Chief Executive Officer

Royal College of Pathologists of Australasia

Dr Debra Graves, Chief Executive Officer

Associate Professor Paul McKenzie

Tuesday 24 May 2011 – Canberra**National Rural Health Alliance**

Mr Gordon Gregory, Executive Director

Ms Beth Johnston, Policy Adviser

Ms Martina Stanley, Consultant

Thursday 31 May 2011 – Canberra**Rural Doctors Association of Australia**

Ms Jenny Johnson, Chief Executive Officer

Dr Paul Mara, President

Tuesday 28 June 2011 – Perth**Doctors Forum**

Dr Kishore Desai

Dr Ponraja Thuryrajah

Hollywood Private Hospital (Ramsay Health Care)

Dr Margaret Sturdy, Director of Medical Services

Swan Kalamunda Health Service

Dr John Keenan, Area Director, North Metropolitan Health Services Director,
Clinical Services

WA Country Health Service

Dr Felicity Jefferies, Executive Director, Clinical Reform

Tuesday 5 July 2011 – Canberra**General Practice Education and Training Ltd**

Mr Robert Hale, National General Manager, Quality and Education

Tuesday 11 August 2011 – Cairns**Clifton Beach Medical Centre**

Dr Stuart Phillips, General Practitioner

Private Capacity

Mr Brian Hoffman

Mr Vickneswaran Kandiah

Dr Shakuntala Shanmugam

Queensland Health

Associate Professor Neil Beaton, District Executive Director of Medical Services,
Cairns & Hinterland Health Services District

Friday 12 August 2011 – Townsville**Tropical Medical Training**

Mr Ian Hook, Chief Executive Officer

Associate Professor Rodney Nan Tie, Director of Medical Training

Private Capacity

Dr Frank Quigley

Professor Ajay Rane

Professor John Stokes

Tuesday 16 August 2011 - Canberra**Private Capacity**

Dr Christoph Ahrens

Dr Ayman Shenouda

Friday 19 August 2011 - Canberra**Australian Health Practitioner Regulation Agency**

Ms Kym Ayscough, New South Wales Manager

Australian Medical Council

Mr Ian Frank, Chief Executive Officer

Medical Board of Australia

Dr Joanna Flynn, Chair

Tuesday 23 August 2011 - Canberra**Private Capacity**

Mr Tony Crook MP, Member for O'Connor

Wednesday 31 August 2011 - Melbourne**IDP Education Pty Ltd**

Mr John Belleville, IELTS Director

IELTS Australia Pty Ltd

Mr Geoffrey Crewes, Regional Manager

Melbourne Medical Deputising Service

Ms Patricia Coles, Corporate Affairs Associate; and

Dr Jonathan Levy, Deputy Medical Director.

OET Workshop Pty Ltd

Ms Marg Tolliday

Person International

Mr Fraser Cargill, Vice-President Government Relations, Asia Pacific

The Occupational English Test Centre, Centre for Adult Education

Mr Gerrard Neve, Manager

School of Languages and Linguistics, The University of Melbourne

Professor Timothy McNamara, Professor

Private Capacity

Mr David Lamb

Mrs Doone Lamb

Mr Michael Suss

Friday 9 September 2011 - Adelaide**Adelaide to Outback GP Training Program Inc**

Ms Linda Black, Chief Executive Officer

Group of Concerned Burra and District Residents

Mr Raymond (Peter) Brodie, Member

Mrs Helen Edwards, Member

Mr Evan Hawke, Member

Ms Helen Szuty, Member

Private Capacity

Dr Nicola Dean

Associate Professor John Svigos

Rural Doctors Workforce Agency

Ms Lyn Poole, Chief Executive Officer

Royal Flying Doctor Service

Dr Peter Setchell, Health Services

Sturt Fleurieu General Practice Training

Dr Bruce Mugford, Chief Executive Officer

Tuesday 20 September 2011 - Canberra

Australian Competition and Consumer Commission

Mr Scott Gregson, Group General Manager, Enforcement and Compliance

Ms Louise Macleod, Director, Compliance Operations

Tuesday 27 September 2011 - Newcastle

GP Access (Hunter Urban Division of General Practice)

Ms Jeni Scott, Practice Workforce Officer

Hunter New England Local Health District

Dr Anthony Llewellyn, Executive Medical Director

New South Wales Rural Doctors Network

Mr Mark Lynch, Acting Chief Executive Officer

Mr Anthony Miles, Director, Medical Recruitment and Retention

School of Rural Medicine, University of New England

Dr Maree Puxty, Tabelands Clinical School, Joint Medical Program

Private Capacity

Mrs Kathy Ingham

Professor Balakrishnan (Kichu) Nair

Dr Mulavana Parvathy

Dr John Relic

Mrs Julie Wein

Doctors Forum

Professor Wolfgang Gowin

Dr Ariane Kersting

Dr Martin Larisch

Dr Mani Panat

Dr Aditee Parab

Wednesday 28 September 2011 - Gosford**Central Coast Division of General Practice**

Dr Phil Godden, Chair

Mr Matt Hanrahan, Chief Executive

Dr Alison Latta, Director of Medical Services

Mr Richard Nankervis, Chief Executive Officer

Erina Fair Medical Centre

Mr Peter Carr, Owner/Managing Director

Private Capacity

Dr Rodney Beckwith

Dr Karen Douglas

Mr David Little

Dr Christine Wade

Tuesday 11 October 2011 - Canberra**Australian Government Department of Immigration and Citizenship**

Mr Kruno Kukoc, First Assistant Secretary, Migration and Visa Policy Division

Mr Michael Willard, Acting Assistant Secretary, Labour Market Branch,
Migration and Visa Policy Division

Tuesday 1 November 2011 - Canberra**Australian Government Department of Human Services**

Ms Sheila Bird, General Manager, Health Programs Division

Mr Sam Campisi, National Manager, Multicultural Services

Mr Robin Salvage, National Manager, Families and Child Care Programs

Monday 14 November 2011 - Launceston**Tasmanian Government Department of Health and Human Services**

Ms Erin Bowen, Director Human Capital

Dr Beth Mulligan, Director of Clinical Training/Chair IMG Subcommittee

Health Recruitment Plus Tasmania

Mr Peter Barns, Chief Executive Officer

Launceston General Hospital

Mrs Deborah West, Resident Staff Coordinator

Private Capacity

Dr Alasdair MacDonald

Rural Health Workforce Australia

Dr Kim Webber, Chief Executive Officer

School of Medicine, University of Tasmania

Associate Professor Jan Radford, Deputy Associate Head, Launceston Clinical
School

Associate Professor Kim Rooney, Associate Head, Launceston Clinical School

Monday 30 January 2012 - Darwin**Aboriginal Medical Services Alliance of the Northern Territory**

Dr Andrew Bell, Medical Director

Mr Chips Mackinolty, Manager, Research Advocacy Policy

Mr John Patterson, Chief Executive Officer

General Practice Network Northern Territory

Dr David Thurley, Clinical Services Adviser

Miss Angela Tridente, Manager

Private Capacity

Dr Salahuddin Chowdhury