5

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

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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]

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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 (NHRA) 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

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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 though 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

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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 PESCIs and long waiting lists with delays of up to 12 months[27], 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:

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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 PESCIs 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 PESCIs 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 PESCIs 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 the 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 PESCIs. 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 PESCIs 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 PESCIs 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 requited 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]

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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]

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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.

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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.

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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 visa[78], 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,

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 Tararewalla, *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

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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:

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]

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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.