7

Support for International Medical Graduates and their families

7.1 To ensure that the highest professional standards of medical care are maintained, there is clearly a need for robust processes of accreditation and registration of international medical graduates (IMGs) seeking to practice medicine in Australia. There is also a corresponding need to support IMGs as they negotiate the accreditation and registration processes. Furthermore, IMGs and their families need support which extends beyond clinical and professional orientation, to also include social and cultural support to help them as they adjust to living and working in Australia.

7.2 This Chapter examines the types of support needed by IMGs and their families prior to arrival and in the early post-arrival period as they settle into living and working in Australia. The Chapter then proceeds to examine the need for their on-going support. In particular, the Committee has focussed on identifying what type of assistance is available to IMGs who are practising or training in regional, rural and remote areas of Australia, looking closely at the need and demand for support in those areas. In addition, the Committee has considered the experience of IMGs living and training in Australia as temporary residents and the difference in the support offered to them and permanent residents.

7.3 The Chapter concludes by reviewing the accessibility of support programs to IMGs, whether they are working in regional, rural and remote areas of Australia, or working in major metropolitan centres. In this section, the Committee considers whether IMGs are provided with appropriate information regarding available support programs and how access to this information might be further improved.

Stages of support

7.4 Support for IMGs working towards gaining full registration in Australia may be categorised into two main phases:

- orientation, including but not limited to:
  - ⇒ clinical and professional orientation for IMGs, comprising a comprehensive introduction to the structure and operation of Australia's health system, and cultural awareness training; and
  - ⇒ social and cultural orientation for IMGs (and their families).
- ongoing support, including but not limited to:
  - ⇒ educational and professional development support for IMGs, including assistance with examination preparation, and mentoring and peer support opportunities; and
  - ⇒ continuing social and cultural support for IMGs and their families.

7.5 Evidence to the inquiry from the Commonwealth, state and territory health departments, peak bodies, specialist medical colleges, other training providers and individuals includes reference to a range of programs and services available to IMGs.[1]

7.6 Clearly it is beyond the scope of this inquiry to detail and critique each and every support available to IMGs. Rather, in the context of the evidence provided, the Committee considers the types of supports that are needed to assist IMGs and their families, using specific examples to illustrate benefits, deficiencies or limitations.

Clinical and professional orientation

7.7 The Committee has heard evidence from a range of stakeholders highlighting the importance of initial support and outlining various orientation programs, the features of which vary significantly in relation

1 See for example: Health Recruitment Plus Tasmania, *Submission No 32*, p 5; Overseas Trained Specialist Anaesthetists Network Inc (OTSAN), *Submission No 38*, p 3; Australian General Practice Network, *Submission No 61,* pp 2-3; Royal Australian and New Zealand College of Ophthalmologists, *Submission No 73*, p 4; Government of South Australia, *Submission No 96*, p 4.

to the timing of orientation, the duration of the program, and the topics covered in that orientation.[2]

7.8 Dr Ian Cameron, Chief Executive Officer of the New South Wales Rural Doctors Network, explained the need for different types of orientation and initial support for IMGs and their families.

> ... we have to look at clinical orientation, professional orientation and social orientation. We need to help the family. We need to look at the sort of town the doctor wants to be in and what supports that we can put in place. Most OTDs know an awful lot of clinical medicine. I would not put myself up against them most of the time. But how things are done in this country are different to how things are done in their country.[3]

7.9 Providing IMGs with access to a structured and targeted orientation program when they are first exposed to the medical system in Australia should better equip then to understand the intricacies of the Australian health system and the medical profession.

7.10 Dr Alasdair MacDonald, appearing before the Committee in a private capacity, explained the need for a detailed orientation into the complexities of the Australian health system, observing:

> ... I do suspect that there is a role for government in producing an educational package that covers off the intricacies of a health system that has a state, Commonwealth and private sectors funding mechanism, because we certainly get into difficulties with our international medical graduates not understanding what is a private patient in a public hospital, what is a private patient, what is a public patient. Although that does not impact on direct care, it causes levels of confusion whereas if you have grown up here as both a user and a professional in the health system you are much more familiar with those sorts of issues.[4]

7.11 Anecdotal evidence however suggests that IMGs who require assistance in familiarising themselves with Australia complex medical system, have not always been able to access this kind of support. For example, in his

2 See for example: Dr Sunayana Das, *Submission No 99.1*, p 2; Rural Doctors Workforce Agency, South Australia, *Submission No 83*, p 4; Eyre Peninsula Division of General Practice, *Submission No 136*, p. 2; Dr Rodney Nan Tie, *Official Committee Hansard*, 12 August 2011, p 16.

3 Dr Ian Cameron, NSW Rural Doctors Network, *Official Committee Hansard*, Sydney, 31 March 2011, p 8.

4 Dr Alasdair MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, pp 19-20. For further comment relating to the importance of orientation, see Rural Doctors Workforce Agency Inc, *Submission No 83*, pp 4-5.

submission to the Committee, Dr Sudheer Duggirala, an IMG from India, outlined his experiences working as a General Practitioner in Australia in 2006 noting.

> I had difficulties in adapting to the Australian General Practice as that was my first experience to work as a GP in Australia. I was not provided with any orientation to the Australian General Practice.[5]

7.12 Professor Kersi Taraporewalla, who appeared in a private capacity before the Committee, provided another example of an IMG who commenced his position without any formal orientation:

> I had to deal with a doctor from Mount Isa five years ago at the skills centre and he told me that before he came out here he was advised that Mount Isa was a thriving metropolis. When he finally turned up at the hospital, they said, 'Congratulations. Welcome to the hospital. By the way, you're on tonight.'[6]

7.13 The Australian Medical Council (AMC) submitted that the importance of orientation for IMGs has been acknowledged by COAG, however mandatory participation in orientation is not required as part of the National Registration and Accreditation System (NRAS) for IMGs, because of limited availability of appropriate programs:

> The 2007 COAG IMG assessment initiative proposed that all IMGs be required to complete a mandatory accredited orientation program as a formal requirement for registration. In the absence of sufficient orientation programs, the mandatory requirement for orientation was deleted from the final recommendations on the consistent national assessment processes.[7]

7.14 The AMC and other agencies identified Queensland Health's Recruitment, Assessment, Placement, Training and Support program for International Medical Graduates Scheme (RAPTS) as an example of best practice and suggested that this orientation program could provide a model for other jurisdictions to adopt.[8]

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5 Dr Sudheer Duggirala, *Submission No 12*, p 1.

6 Associate Professor Kersi Taraporewalla, *Official Committee Hansard*, Brisbane, 10 March 2011, p 51.

7 Australian Medical Council (AMC), *Submission No 42*, p 28.

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

7.15 The RAPTS program was established by Queensland Health in September 2005, following the Queensland Health Systems Review.[9] The program merged with the Queensland Health Recruitment Unit in 2008, to form Clinical Workforce Solutions (CWS).[10]

7.16 As a component part of CWS, the RAPTS program includes provision of an orientation 'Welcome Pack' to support IMGs who are new to Australia. As Dr Michael Cleary of Queensland Health's Strategy and Resourcing Division told the Committee:

> The resource is designed to cover a range of key areas. It is not devoted to only health practice. It covers things like the Australian healthcare system, working in Queensland, legislation, rural and remote services, communications, cultural, safety and so on. It also goes into things such as: what is the Australian culture and society like? How do you get Australian citizenship? How do you open a bank account in Australia? How do you get a drivers licence? We have made it as comprehensive as we can to cover both the clinical arrangements and the personal and social arrangements.[11]

7.17 Dr Cleary stated further:

> The manual has been approved by the AMC and they have regarded it as the best practice manual and best practice induction program in Australia. It has also been adopted by other jurisdictions, as well as a model that they have been looking at.[12]

7.18 The RAPTS program also includes a Clinical Attachment Program available to unemployed permanent resident IMGs seeking familiarisation with the Queensland and Australian health care system for the purpose of employment. According to Queensland Health, the program is recognised by the MBA for its limited scope of practice and safety components, allowing IMGs with a valuable upskilling or re-entry program.[13]

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9 Queensland Health, *Queensland Health Systems Review – Final Report*, September 2005, <http://www.health.qld.gov.au/health_sys_review/final/default.asp> viewed 1 February 2012.

10 Queensland Health, *Submission No 126*, p 30.

11 Dr Michael Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 5.

12 Dr Cleary, Queensland Health, *Official Committee Hansard*, Brisbane, 10 March 2011, p 5.

13 Queensland Health, *Submission No 126*, p 12.

Cultural awareness training

7.19 Cultural awareness is an aspect of professional orientation which has been the subject of extensive discussion throughout the inquiry. Cultural awareness extends beyond clinical competency and an understanding of how the Australian health system operates. Cultural awareness issues include:

- familiarity with Australian colloquialisms, idioms and communication styles; and
- understanding social and cultural norms as they relate to the provision of healthcare in Australia.

7.20 In hearing the evidence of various health agencies, individual medical practitioners and IMGs themselves, it is apparent to the Committee that IMGs face significant challenges in adjusting to Australian culture and the Australian health system.[14] Dr David Little, a general practitioner appearing in a private capacity, explained the difficulty that some IMGs face in working as a medical practitioner in a new cultural environment:

> Ultimately, the practise of medicine requires not just medical expertise but the skill of imparting that information to patients, and that requires not just language but cultural skills. We very specifically found that. The doctor that we had working for us who did not work too well did not have as much a problem with medical knowledge as with dealing with the patients.[15]

7.21 Dr Joanna Flynn, Chair of the Medical Board of Australia, told the Committee that in her understanding, cultural awareness does not form part of the assessment of an IMG's English language skills but rather forms part of the IMG's orientation to the Australian health system, stating:

> ... the English language test is basic competency to speak, to listen, to write and to read. It does not deal with cultural awareness, and it does not deal with issues about the use of language in a medical cultural setting. That is supposed to be part of the orientation that people get in the work setting when they start work. It is supposed

14 See for example: Australian and New Zealand College of Anaesthetists (ANZCA), *Submission No 87*, p 18; Dr Sunyana Das, *Submission No 99.1*, p. 2; Dr Christopher Hughes, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Official Committee Hansard*, Melbourne, 18 March 2011, p 50.

15 Dr David Little, *Official Committee Hansard*, Gosford, 28 September 2011, p 2.

> to orientate them to the cultural situation, the workplace and the particular needs of that context. [16]

7.22 The importance of cultural awareness for IMGs working in rural or remote locations or with Aboriginal and Torres Strait Islander communities was also raised in evidence.[17] Mr Lou Andreatta, Principal Adviser at the Commonwealth Department of Health and Ageing (DoHA), was asked by the Committee how quality and safety for patients is considered when recruiting IMGs for isolated areas in Australia, where language could be seen as problematic. Mr Andreatta responded:

> Supporting OTDs in rural communities is certainly one of the issues that we are always mindful of. We do have funding programs with our rural health workforce agencies, who have responsibility for recruitment, retention and the support of OTDs. Before they are placed in a rural location in area of district workforce shortage, the OTDs go through a number of assessments to ensure that they are the right fit for a community. Things like their language and their suitability to assimilate in a certain area are looked at. Clearly, it is almost a case management approach that the workforce agencies do in each state and territory, whereby they help and support the OTDs once they are placed in a location to ensure that they are fully assimilated and comfortable with the working environment they are placed in.[18]

7.23 Dr Peter Setchell, General Manager of Health Services for the Royal Flying Doctor Service (RFDS) also told the Committee:

> ... we would simply not be able to run a rural health service without the overseas trained doctors—issues such as language, cultural sensitivity mix and communication skills need to be very carefully considered. For example, within RFDS we have a process where all of our doctors, nurses and allied health workers undergo a very formal cultural awareness training program before we ask them to go out and work in Aboriginal communities. There are issues such as the understanding of culture, the nuances of language and Australian idioms, and so forth. There needs to be a

16 Dr Joanna Flynn, Medical Board of Australia (MBA), *Official Committee Hansard*, Canberra, 25 February 2011, p 24.

17 See for example: Ms Linda Black, *Official Committee Hansard*, Adelaide, 9 September 2011, p 9; Mr Chips Mackinolty, *Official Committee Hansard*, Darwin, 30 January 2012, p 12.

18 Mr Lou Andreatta, Australian Government Department of Health and Ageing (DoHA), *Official Committee Hansard*, Canberra, 25 February 2011, p 8.

> very robust awareness training package for overseas doctors to be able to be effective out in the bush.[19]

7.24 It is important to also recognise that cultural awareness issues can also flow from the medical profession's lack of understanding in relation to the IMG's own cultural background. As illustrated by Dr Alasdair MacDonald:

> One of the things that we run into in hospitals which have significant numbers of international medical graduates is the potential difficulty of their own interactions and of our not having adequate cultural competency in the cultures that they come from to understand their interactions, not their interactions with us but their interactions with each other. ... I personally, as a director of medicine, have had to come to understand hierarchical structures within cultures where I may have a person who regards themself, from their own culture, as superior to another person, who has to then work in the reverse model. Until somebody explains that to me, I do not get the issues that are occurring. [20]

Committee comment

7.25 The Committee views clinical and professional orientation, including cultural awareness education and training, as an important component of the introductory support needed to help IMGs adjust to working within the Australian health system and acquire an understanding of the social mores and the customs of Australian culture. In the Committee's view, the consequences for IMGs, their patients and the wider community if the IMG is not supported appropriately in this way, could be considerable.

7.26 For this reason the Committee believes that such introductory support should include, but not be limited to:

- information on immigration, with a comprehensive outline of the steps required to gain full medical registration in their chosen field. Such orientation should also include introductory information on the structure and functioning of the Australian health system;
- social orientation to be provided to the IMG and their family (if applicable) including the provision of basic information such as accommodation options, education options for accompanying family members, health and lifestyle information, access to social/welfare

19 Dr Peter Setchell, Royal Flying Doctor Service (RFDS), *Official Committee Hansard*, Adelaide, 9 September 2011, pp 15-16.

20 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 20.

benefits and services, and information about ongoing support programs for IMGs and their families;

- provision of a specific cultural awareness education and training program, which could be tailored to specific locations and where appropriate, should include training relating to specific health issues of the local community and Aboriginal and Torres Strait Islander culture. IMGs should receive general information on appropriate professional behaviour in the workplace, as well as information on their rights and responsibilities in regarding workplace bullying and harassment; and
- once employment commences, a comprehensive and structured introduction to the Australian health system and medical registration system, including a period of observation of clinical practice in the IMG's chosen field.

7.27 The Committee understands that a number of stakeholders, including the AMC, consider that the RAPTS program offered to IMGs by Queensland Health is a good example of an effective orientation program, and as such could provide a model.

7.28 As noted earlier in the report, developing a coordinated national approach to the recruitment and retention of international health professionals is one element of Health Workforce Australia's (HWA) work plan. Therefore, the Committee recommends that HWA, in consultation with key stakeholders (including the Medical Board of Australia, specialist medical colleges, workforce agencies, employers and IMGs) develop and implement a program of orientation to be available to all IMGs and their families to assist them with adjusting to living and working in Australia.

7.29 The Committee proposes that the program comprise key components including social orientation for IMGs and their families, cultural awareness education and training covering Australia's social, cultural, political and religious diversity, as well as a comprehensive and structured introduction to the Australian health system.

7.30 While recognising that some components of the orientation program will need to be delivered post arrival in Australia, the Committee believes that as much information as possible should be provided in an easily accessible, pre-arrival package of written material.

Recommendation 40

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

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

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

7.32 In Chapter 5 of this report, the Committee has recommended that cultural awareness training and communication be addressed in guidelines and training to support enhanced competency of clinical supervisors. Although stopping short of making a specific recommendation, the Committee is also of the view that it would be constructive for other co-workers in organisations such as hospitals or medical centres that are involved in the employment of IMGs to also undertake a component of cultural awareness training, focussing on working effectively with IMGs from culturally diverse backgrounds.

Ongoing support

7.33 If IMGs are to progress to full medical registration it is important that they receive initial support when they first arrive in Australia, and that support

is ongoing throughout the registration process. The Committee has identified a number of facets of ongoing support. These are:

- educational support and professional development, including:
  - ⇒ examination preparation; and
  - ⇒ mentoring and peer support opportunities.
- personal and family support.

Educational support and professional development

7.34 A crucial component of support for IMGs is the educational support provided to IMGs to assist them to pass the examination and training requirements involved in the various pathways to achieve full registration as a medical practitioner. Based on evidence provided, educational support consists of a number of elements, including:

- examination preparation and assistance, including access to study groups and other training facilities; and
- mentoring and peer support.

Examination preparation

7.35 In its submission, the Overseas Trained Specialist Anaesthetists' Network (OTSAN) described some of the difficulties that IMGs, particularly those working in areas where there are workforce shortages, may encounter when preparing for the examinations needed to achieve full registration:

> At the time when local candidates sit the exam they are employed in major tertiary centres, are exposed to a wide portfolio of cases, are assigned to tutors which guide them through the process, receive a multitude of tutorial and education sessions, have access to study material and most importantly can easily form connections with peers to form study groups within their departments. It is not uncommon that local candidates have their allocated study/education periods during working hours or are relieved by senior staff from clinical duties for exam preparation. In sharp contrast, overseas trained candidates work in isolation in rural centres with limited case-load, without communication tools to form study groups or local tutors who could assist them in the preparation process.[21]

21 OTSAN, *Submission No 38*, p 2.

7.36 OTSAN submitted that due to shortfalls in medical staffing, IMGs are often required to provide direct hands-on specialist care throughout the day and then prepare for their exams after hours while juggling their family life. Their submission states:

> Additional factors are advanced age, cultural differences in appearance and presentation and English as a second language which makes it hard to comprehend subtle differences in context in a time constrained exam environment. This leads to the fact that highly skilled clinicians who demonstrate excellent work performance repeatedly fail exams and finally are lost for the medical workforce because they run out of time and visa and need to leave the country.[22]

7.37 The South Australian Government submitted to the Committee that there is a significant gap in coordinated education support for IMGs in general practice, arguing that a better coordinated education support program would likely reduce examination failure rates. They submitted:

> OTDs are required to work and study for their exam but have no personal guidance to help them. This contributes to the higher failure rate for OTDs compared to doctors as registrars in a Regional Training Provider program. Support programs should focus not only on pre-exam preparation for OTDs but also on personal development within the Australian healthcare context.[23]

7.38 The Government of South Australia also provided an example of how educational support may be implemented, noting:

> The State Office of the Royal Australian College of General Practitioners has developed a good example of an effective program in South Australia. They run an exam preparation and communications workshop series targeted at OTDs undertaking (or about to undertake) the AMC certification process in South Australia.[24]

7.39 The RACGP submitted that it provides exam preparation workshops and DVDs through each state faculty, providing information and practice opportunities together with exam preparation courses and seminars that IMGs are encouraged to attend. Topics include instruction in examination techniques, clinical case discussions and clinical practice sessions. IMGs

22 OTSAN, *Submission No 38*, p 2.

23 Government of South Australia, *Submission No 96*, p 3.

24 Government of South Australia, *Submission No 96*, p 4.

are tutored by experienced members of the FRACGP examination panels.[25]

7.40 The RACGP National Rural Faculty has also produced an 11-DVD set covering a 19-week pre-exam tutorial series designed to assist IMGs, GP registrars, and other medical practitioners who are preparing to undertake the college examination.[26]

7.41 An issue that was raised with the Committee is that IMGs practising in regional, remote and rural Australia will not have the same access to educational supports. One of the challenges in completing one of the recognised pathways towards full registration as a medical practitioner in Australia is the difficulty IMGs have in leaving their practice to attend training or support programs.

7.42 In addition to making increased use of new technologies (eg on-line training, tele/video-conferencing), the Committee was told that offering locum services to IMGs is one way of addressing these issues.[27] As explained by the Committee of Presidents of Medical Colleges (CPMC), providing locum services to IMGs in more isolated areas would allow them to attend education and training activities and assessment preparation programs provided by the Colleges.

> The constraints which confront OTDs and AoN practitioners in rural areas are very real. The constant tension which exists generally throughout the health system between the provision of services to patients and training imperatives is magnified in rural locations by workforce shortages and remoteness from specialist colleagues. A major contribution to promoting the achievement of full Australian qualifications by both OTDs and AoN practitioners would be the establishment of a significant resource of locum specialists.[28]

7.43 Dr Michael Cleary, Deputy Director-General of the Policy, Strategy and Resourcing Division of Queensland Health, informed the Committee of a specialised training program it has funded to assist specialists complete their examinations, which includes provision for locum relief support:

> The funding that we have allocated provides support for back-filling, attending conferences, training programs, up-skilling

25 Royal Australian College of General Practitioners (RACGP), *Submission No 67*, pp 4-5.

26 RACGP, *Submission No 67*, p 5.

27 See for example: Mr Robert Hale, General Practice Education and Training Ltd, *Official Committee Hansard*, Canberra, 5 July 2011, p 3.

28 Committee of Presidents of Medical Colleges, *Submission No 28*, p 3.

> sessions and other such activities. It means that the doctors are able to get away from their normal work. It is very hard when you are in a regional centre; there are a lot of demands on your time. So it gives us the opportunity to provide back-filling and to support them through that type of training. We have received very positive feedback from the specialist colleges about that program.[29]

Peer support and mentoring

7.44 Peer support and mentoring are other important components of educational and moral support for IMGs. However, the capacity for IMGs to engage in networking opportunities with other IMGs in the same specialty or at the same stage of the registration process is often limited. Again, this is particularly the case in circumstances where an IMG is living and working in a rural or remote community of Australia, where they do not know or work with other IMGs.

7.45 In this circumstance, an IMG's access to networking opportunities is often only available through support programs offered by training providers, RWAs or colleges. Dr Karen Douglas, appearing before the Committee in a private capacity, told the Committee:

> I think these overseas trained doctors are grappling. If they are out in the country and they are living alone, the family is there but often their children are boarding in a capital city, then they are unsupported. They might have somebody on a telephone, but I feel they need support groups. They need the ability, as we all do, to ring up and say, 'I've got a difficult case,' or, 'I've got a difficult issue here,' or, 'I'm not feeling well myself'—just to have a debrief and the ability to say either 'I'm coping' or 'I'm not coping; where do I go?'[30]

7.46 Similarly, as Dr MacDonald, a Launceston based physician, told the Committee:

> ... if we put a number of international medical graduates or even single international medical graduates into relatively isolated professional environments, we need to make sure that we put infrastructure in place. That is either infrastructure in a virtual sense, making sure that we optimally use tele-health and other facilities to case-conference—an awful lot of professionalism comes out of those corridor discussions of cases, and if you are in

29 Dr Cleary, Queensland Health, *Official Committee Hansard*, Canberra, 10 March 2011, p 6.

30 Dr Karen Douglas, *Official Committee Hansard*, Gosford, 28 September 2011, p 6.

> an isolated environment then you do not get the same opportunities for corridor consultation and corridor discussion, which are part of the collegiate professional environment.[31]

7.47 The Overseas Trained Specialist Anaesthetists' Network (OTSAN), consisting of fellows from the Australian and New Zealand College of Anaesthetists (ANZCA) seeking to assist IMGs with their education and accreditation, offers networking and educational services which ANZCA submits is designed to assist the IMGs satisfy the eligibility requirements for registration.[32] As a result of these services, ANZCA states that OTSAN participants now have a pass rate range of 73% to 81% which is comparable to Australian candidates. This compares to a pass rate of fewer than 50% for those not typically associated with OTSAN.[33]

7.48 The Royal Australian College of General Practitioners (RACGP) told the Committee of a pilot program funded by DoHA and implemented by the College during 2009-2010. The program provided IMGs who had just arrived in Australia with a peer mentor to orient them to the Australian health care system, support them to achieve recognition as a GP through the attainment of RACGP Fellowship, and to facilitate their integration into their local community. The program focussed on the peer mentor relationship, rather than formal medical supervision and medical education. All RACGP mentors were IMGs themselves who had experienced a similar pathway to RACGP Fellowship.[34]

7.49 RACGP submitted to the Committee that an external evaluation of this program found that mentoring was strongly upheld as a practical resource by IMGs with almost universal support from mentors and recipients for the ongoing provision of IMG mentoring.[35]

7.50 After hearing evidence from a range of rural stakeholders, it is apparent to the Committee that for IMGs who live in an isolated region and do not have the ability to travel far away from their home base to avail themselves of networking opportunities. As with examination preparation, access to new technologies including tele/video-conferencing and internet which allows IMGs to participate in networking and training remotely can be effective. Mr Gordon Gregory, Executive Director of the National Rural Health Alliance, told the Committee:

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31 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 16.

32 ANZCA, *Submission No 87*, p 19.

33 ANZCA, *Submission No 87*, p 19.

34 RACGP, *Submission No 67*, p 5.

35 RACGP, *Submission No 67*, p 5.

> For a doctor, a vet or an accountant, it is lack of peer support, it is lack of a good internet connection—that is one of the reasons why the Rural Health Alliance, for which we work, supports fast broadband available at an affordable price everywhere across the country. That will transform remote areas. Doctors will not go to remote areas if they are left alone. They want to work with a team, with nurses, with podiatrists. In a remote that may be impossible, but we are creating innovative ways in Australia to have outreach.[36]

Committee comment

7.51 The Committee is aware that there are already a large number of programs providing educational training support that may be accessible for IMGs. The program run by OTSAN and the RACGP's pilot program supporting IMGs, as outlined in the preceding section, demonstrate the success of this kind of support. Other notable examples of educational support programs which IMGs may be eligible to access include the Additional Assistance Scheme provided by the Rural Workforce Agencies (RWAs), the Rural Vocational Training Scheme (RVTS) and the education and training programs managed by General Practice Education and Training Limited (GPET).[37]

7.52 While not commenting on the specifics of individual programs, the Committee understands that assistance with exam preparation, access to mentoring and peer support, and opportunities for clinical observation, assistance and experience, are vital components of the supports which should be provided to IMGs in Australia.

7.53 While the specifics of program design and the eligibility criteria differ, two issues about IMG access to these educational supports were raised time and time again during the inquiry. The first issue relates to the accessibility of these programs for IMGs working in regional, rural and remote locations. The second issue relates to program eligibility criteria and IMG residency status. The Committee examines these two issues below before commenting further on educational supports for IMGs.

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36 Mr Gordon Gregory, National Rural Health Alliance, *Official Committee Hansard*, Canberra, 24 May 2011, p 5.

37 See Chapter 2 for more information.

Access to educational and training support

7.54 According to the Department of Health and Ageing (DoHA) IMGs account for approximately 46% of general practitioners practising in rural and remote areas of Australia.[38] Although it is difficult to determine precise numbers, according to DoHA's Report on the Audit of Health Workforce in Rural and Regional Australia:

> As at February 2008, there were 4,669 overseas trained doctors in Australia, including GPs (3,028) and specialists (1,641), who were subject to Medicare provider number restrictions. 1,437 of these overseas-trained GPs and 181 of the overseas-trained specialists work in rural and remote areas ...[39]

7.55 It is clear from the evidence that IMGs practising in regional, rural and remote communities frequently do not have the same access to educational and training support opportunities as their city/metropolitan counterparts.[40]

7.56 Dr Andrew Pesce, President of the Australian Medical Association told the Committee:

> We think it is vital to give IMGs access to training resources and networks, which are particularly difficult to access in rural and remote areas. If you think about it, the people who need our best support are in places where it is most difficult to deliver.[41]

7.57 In its submission to the Committee, the Rural Doctors Association of Australia stated:

> Doctors who have trained overseas will come to Australia for many reasons, including work opportunities, lifestyle and family commitments. Where these doctors have the necessary skills, qualifications and expertise to practice medicine in Australia and are willing to work in regional, rural and remote Australia, they should be welcomed and supported. If assessment processes identify that these doctors do not have the necessary skills (and many will not have the skills to meet the needs or current curricula for rural and remote practice), or that they wish to acquire these

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

39 DoHA, *Report on the Audit of Health Workforce in Rural and Regional Australia*, April 2008, Canberra, p 37.

40 See for example: Government of Western Australia (WA) Department of Health, *Submission No 82,* p 5; Dr Shakuntala Shanmugam, *Official Committee Hansard*, Cairns, 12 August 2011 p 15.

41 Dr Andrew Pesce, Australian Medical Association (AMA), *Official Committee Hansard,* Canberra, 25 February 2011, p 30.

> skills in order to practice, then they should have the opportunity to obtain these skills through established training pathways. [42]

7.58 Dr Alasdair MacDonald appeared before the Committee in a private capacity.[43] As a physician involved in peer review and assessment of IMGs both at the college and hospital level, Dr MacDonald outlined his concerns regarding the training and support of IMGs in Australia:

> ... I am particularly interested in making sure that a health system that is dependent in its regional, rural and urban fringe hospitals on international medical graduates is also providing effective collegiate support for those people, because we run the risk of making sure that their credentials, their training and their experience are comparable when they come here but often then putting them in an environment where they perhaps do not have the collegiate support that is required. They often end up in an environment where there are a number of international medical graduates constituting the majority of the workforce, and that can result in their not being well linked up with appropriate collegiate peer review and other professional activities.[44]

7.59 Evidence suggests that IMGs practising in these locations may have difficulty in accessing these supports for the following reasons:

- isolation resulting in a lack of peer support and mentorship opportunities;
- lack of access to the technology required to facilitate educational and peer support opportunities;
- heavy workloads and a lack of access to locum assistance to enable participation in educational/training opportunities; and
- lack of financial support to facilitate travel to participate in educational/training opportunities.[45]

7.60 The Committee also heard from many contributors to the inquiry suggesting that levels of educational and training support diminish even

42 Rural Doctors Association of Australia, *Submission No 80*, p 9.

43 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 16.

44 Dr MacDonald, *Official Committee Hansard*, Launceston, 14 November 2011, p 16.

45 See for example: Dr Felicity Jefferies, *Official Committee Hansard*, Perth, p. 2; Dr Shanmugam, *Official Committee Hansard*, Cairns, 12 August 2011, p 15.

further where IMGs are also temporary residents.[46] In this regard, Health Workforce Queensland stated:

> Funded educational support for OTDs is extremely limited and in the case of Temporary Resident OTDs virtually non-existent.[47]

7.61 Health Recruitment Plus Tasmania agreed, stating there is little to no support offered to temporary resident IMGs, who make up a significant portion of GPs in regional, rural and remote areas particularly.[48]

7.62 Rural Health Workforce Australia (RHWA) submitted to the Committee:

> Despite OTDs being such an important part of our rural and remote workforce, most support programs are not available to temporary resident OTDs. This reflects a rather old fashioned belief that these OTDs only come to Australia for a short time, whereas they usually seek permanent residency and citizenship and become long term rural and remote GPs.[49]

7.63 Noting the restricted access to many support programs, and evidence that around 70% of temporary resident IMGs eventually seek permanent residency status in Australia, Mr Chris Mitchell, Chief Executive Officer, Health Workforce Queensland, observed:

> A point to remember here is that Australia has not paid for the training of these overseas trained doctors; we have got them free. We have limited supports in their placement, we have limited supports in their orientation and there are limited supports in the ongoing training. The question is: why not fund and support temporary resident OTDs in their training because there is evidence that they will stay? And if we miss a couple and they return to their country, well, we will know they are well trained. So there is obviously a barrier to that issue. [50]

7.64 Evidence to the inquiry indicates that by restricting access to support programs to IMGs who have permanent residency status, a large proportion of IMGs who require support in working towards full

46 Queensland Health, *Submission No 12*, p 12; Mr Chris Mitchell, Health Workforce Queensland (HWQ), *Official Committee Hansard*, Brisbane, 10 March 2011, p 64; Dr Ian Cameron, NSW Rural Doctors Network (NSWRDN), *Official Committee Hansard*, Sydney, 31 March 2011, p 10; Dr Felicity Jefferies, WA Country Health Service (WACHS), *Official Committee Hansard*, Perth, 28 June 2011, p 4; Mr Robert Hale, General Practice Education and Training, *Official Committee Hansard*, Canberra, 5 July 2011, p 2.

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

48 Health Recruitment Plus Tasmania, *Submission No 32*, p 4.

49 Rural Health Workforce Australia, *Submission No 107*, p 5.

50 Mr Mitchell, HWQ, *Official Committee Hansard*, Brisbane, 10 March 2011, p 63.

registration as a medical practitioner are missing out on the opportunity to achieve these goals.

7.65 One solution proposed was for eligibility to be amended to make educational and professional development programs accessible to temporary resident IMGs provided that they can demonstrate that they are working towards full registration and intending to seek permanent residency in Australia.[51]

Committee comment

7.66 The Committee notes that there is a multiplicity of educational and training programs provided by a range of different organisations (eg governments, specialist colleges, workforce agencies, regional training providers) that may be accessed by IMGs. While evidence has highlighted the potential for these programs to improve outcomes for IMGs and the communities where they provide medical services, the Committee notes that these programs are not necessarily available to IMGs across all state jurisdictions. Further, resourcing for some of these programs continues to pose a significant challenge, with some successful pilot programs not being allocated further resources to continue.

7.67 It is apparent to the Committee that the IMGs who would benefit most from accessing these supports, including those IMGs working in regional, rural and remote locations and temporary resident IMGs, are often precluded from doing so.

7.68 In the Committee's view, a nationalised and consistent approach to the provision of ongoing education and professional development for IMGs has the potential to encourage more IMGs to remain living and working in Australia, servicing the communities who are most in need of these doctors' skills and experiences.

7.69 As mentioned earlier, in 2009 COAG established the national health workforce agency, HWA. While acknowledging that HWA is still in the process of refining its work plan, the Committee considers that developing a nationalised and consistent approach to the provision of on-going educational and training supports for IMGs should be a key component of HWA's National Strategy for International Recruitment.

7.70 Given the range of organisations involved in funding and delivery of educational and professional development supports, the Committee

51 See for example: Dr Cameron, NSWRDN, *Official Committee Hansard*, Sydney, 31 March 2011, p 10; Dr Jefferies, WACHS, *Official Committee Hansard*, Perth, 28 June 2011, p 4.

recommends that HWA consult with the relevant stakeholders (including governments, specialist colleges, workforce agencies, regional training providers and IMGs) to determine options for developing a more consistent and streamlined system of educational and training supports for IMGs. The consultation should include specific consideration of the following:

- strategies for facilitating access for IMGs working in regional, remote and rural locations, including:
    - ⇒ the potential for the innovative use of new technologies including tele/video-conferencing and internet;
    - ⇒ the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and
    - ⇒ the adequacy of financial assistance for IMGs who need to travel to access educational and training supports.
- strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and
- the financial and resource implications associated with providing wider access to educational and training supports.

Recommendation 41

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

The consultation should include specific consideration of the following:

- **strategies for facilitating access for IMGs working in regional, remote and rural locations, including:**
  - ⇒ **the potential for the innovative use of new technologies including tele/video-conferencing and internet;**
  - ⇒ **the adequacy of locum relief where IMGs need to be absent from their practice to access education support; and**
  - ⇒ **the adequacy of financial assistance for IMGs who need to travel to access educational and training supports.**
- **strategies for extending eligibility to educational and training support programs to temporary resident IMGs seeking full registration in Australia and permanent residency; and**
- **the financial and resource implications associated with providing wider access to educational and training supports.**

Personal and family support

7.72 The Committee has heard that while professional support for IMGs is important, of equal importance to the recruitment and retention of IMGs is access to personal and family support while they adapt to living and working in Australia. However, evidence indicated that IMGs and their families may also need ongoing support such as access to social networks, accommodation, employment opportunities for spouses, educational facilities for children, and access to health care.[52]

7.73 Representing the Government of Western Australia Department of Health, Dr Felicity Jefferies emphasised the importance of family support, telling the Committee:

52 See for example: Australian General Practice Network, *Submission No 61*, p 3.

> From my years of working in this area, I have found that, if you do not support the families, the IMGs leave. It is the same with any doctor in rural and remote Australia—the same with any professional really. If the family is not happy then the worker leaves, even though the worker might enjoy the job.[53]

7.74 Similarly, Ms Belinda Bailey, Chief Executive of Rural Health West, told the Committee that family support formed one of the key areas of support which led to the retention of the rural workforce:

> The evidence around retention will also say that doctors will stay if their families are happy, so we run a comprehensive family support program which includes subsidising travel for spouses to come down to Perth when we run education events, making sure that the family comes together on the weekend and that there are some bursaries available for spouses so that they can do some study when they are out there and that sort of thing.[54]

7.75 As noted earlier in this Chapter, appropriate social and cultural orientation is crucial so that IMGs and their families know what to expect when they first arrive to live and work in Australia. Mr Peter Barns, Chief Executive Officer of Health Recruitment Plus Tasmania, told the Committee that they adopt a holistic approach to recruiting IMGs and 'match' them to an appropriate position and location. According to Mr Barns, the matching process begins at an early stage:

> The doctor comes to us and we start a conversation: 'What are your needs? What are your family needs? What are you looking for? What are your five-year goals? What are your 10-year goals?' It is quite an in-depth process because you want to get the matching right so that they are not coming here and moving on all the time. We want to make sure that they are happy, because it is a pretty awful thing to come from the other side of the world and not be content in the community.[55]

7.76 The Committee also heard of attempts to match an IMG into a community where there were other IMGs or families with a similar cultural or ethnic background to provide social networks and supports. Dr Cameron explained how the NSW Rural Doctors Network undertook a kind of matching process, telling the Committee:

53 Dr Jefferies, WACHS, *Official Committee Hansard*, Perth, 28 June 2011, p 4.

54 Ms Belinda Bailey, Rural Health West (RHW), *Official Committee Hansard*, Perth, 28 June 2011, p 14.

55 Mr Peter Barns, Health Recruitment Plus Tasmania, *Official Committee Hansard*, Launceston, 14 November 2011, pp 22-23.

> There is a lot of stuff around the professional but especially, as we have already said, there are things around the family and the social aspects, including kids. We give the doctors that come through us money to do a site visit to go and look at a town. We look at things like religion. If the doctor is a Coptic Christian then there are some towns where there are a number of Coptic Christians and they may feel more comfortable in that town than if they went to a town where they did not have any of that religious support. We look at how old are the children and what are the schooling needs. All of those things we try and do during the matching process so that they will have more social support available when they go out there.[56]

7.77 Other personal and family support issues which that have been raised with the Committee include whether health care benefits and access to public education should be freely available to IMGs and their families, regardless of residency status. Mr Ian Frank, Chief Executive Officer of the AMC, said that although Australia brings about 4 000 or more people from overseas every year to service the national health care system, a large proportion of IMGs servicing rural areas cannot access Medicare when their own children get sick. Mr Frank told the Committee:

> They have to send their kids back home to be taken care of. What message are we sending to IMGs if we are bringing them out here, expecting them to run health services for us, looking after our families and kids, but we do not provide them with that kind of support themselves?[57]

7.78 Dr Ilian Kamenoff, an IMG working in Bundaberg who migrated to Australia 11 years ago outlined his experience as follows:

> I have been working in Australia for 11 years. I have two children born in Australia. I have no status in the country. I have no Medicare access. Since my wife is a NZ citizen and qualifies for Medicare benefits I have to pay Medicare Levy and surcharge without having access to Medicare benefits. Since I don't have access to Medicare I pay private Health cover as a visitor ... after 11 years in the country. The reason for this anomaly is that access to Medicare is on individual base (visa) but the Family Tax benefits are based on my income. That is why I have to pay higher tax and

56 Dr Cameron, NSWRDN, *Official Committee Hansard*, Sydney, 31 March 2011, pp 16-17.

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

> not to have access to Medicare and at the same time to pay higher Private health cover.[58]

7.79 As Dr Felicity Jefferies, Executive Director, Clinical Reform, WA Country Health Service told the Committee:

> It has been a huge issue for doctors over many years. They come in and work in the health care system, they pay the Medicare tax levy and they do not get any benefits from it. It has been a big issue. DIAC have always said to us, and I have brought it up over the years, that, if we do it for the doctors, we have to do it for every temporary resident coming in. They have been very reluctant to change it because of the policy implications across the board. I do not know about that. I know that, when we employ them in WA Health, part of our role is looking after their health. We do that while they are our employees. They get access to free health care.[59]

7.80 The National Rural Health Alliance Inc submitted:

> In terms of acceptance as a member of the local community and other supports, it is incongruous that IMGs and their families do not have access to Medicare funded services and to free access to public education. While we acknowledge that such restrictions apply broadly to other workforce categories working under temporary residence, if Australia is serious about competing at a global level in attracting high quality health professionals, these restrictions on inclusion into community should be squarely addressed.[60]

7.81 Similarly, the NSW Rural Doctors Network also argued inequities in the treatment of temporary resident doctors:

> Immigration issues can be complicated. Temporary resident doctors may not be able to sign contracts, take out loans or have access to Medicare for their own health needs. In NSW they have to pay for their children's education even at public schools. Given that they pay equal tax and make an immense contribution to society by working in rural areas this seems rather inequitable.[61]

7.82 Information from DIAC indicates that in 2010-11, around 3,000 of the 4,000 IMGs present in Australia under the skilled migration program, are

58 Dr Ilian Kamenoff, *Submission No 5*, p 3.

59 Dr Jefferies, WACHS, *Official Committee Hansard*, Perth, 28 June 2011, p 9.

60 National Rural Health Alliance Inc, *Submission No 113*, p 25. See also: Mr Gordon Gregory, National Rural Health Alliance Inc, *Official Committee Hansard*, Canberra, 24 May 2011, p 1.

61 NSW Rural Doctors Network, *Submission No 37,* p 20.

subject to the 457 Temporary Business (Long Stay) visa. In relation to this, Mr Kruno Kukoc, First Assistant Secretary, Migration and Visa Policy Division, DIAC, advised the Committee:

> The 457 visas are temporary visas. As such, the holders do not have access to any social security, community support or general government support.[62]

7.83 Mr Kukoc noted that a further condition of the visa is that holders are required to maintain private health insurance.[63] Mr Kukoc advised that:

> Normally the legislation in all portfolios works on the basis of permanent residents. All income support, various government support, is based either on permanent residency or citizenship requirements. Occasionally, for example, social security law can also give access to some income support like special benefits to non-permanent residents.[64]

7.84 When questioned further about the conditions associated with the 457 visa, such as access to Medicare benefits, Mr Kukoc explained these do not fall within DIAC's policy portfolio. Rather, each benefit is governed under separate legislation which is implemented by another agency - for example, social security benefits are governed by the Social Security Act.[65]

7.85 Mr Kukoc explained the potential consequences of extending the eligibility of various benefits to people holding a 457 visa:

> I will just point out that we have around 130,000 457 visa holders in the country. We have close to one million people on various temporary residence visas. That includes New Zealanders. There are some significant implications of any policy that would change access to various government support benefits or welfare benefits to allow temporary residents access to those; it would have a significant fiscal impact. But I am not in the position to talk about that.[66]

Committee comment

7.86 The Committee is pleased to see that recruitment and health workforce agencies recognise personal and family support as a crucial factor in the

62 Mr Kruno Kukoc, Australian Government Department of Immigration and Citizenship (DIAC), *Official Committee Hansard*, Canberra, 11 October 2011, p 4.

63 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 8.

64 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 8.

65 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, pp 7-8.

66 Mr Kukoc, DIAC, *Official Committee Hansard*, Canberra, 11 October 2011, p 8.

support of IMGs. In the Committee's view, this factor is relevant to the ongoing recruitment and retention of IMGs in Australia, particularly in regional, rural and remote communities. The Committee understands from the evidence put before it that there are a ways in which family support is provided to IMGs and their families. Such support is provided indirectly through matching an IMG to a particular community during the recruitment process; and directly through support programs available to family members of IMGs, such as networking events, subsidising travel and other supports.

7.87 The Committee perceives that offering support targeted to an IMG's family will have the effect of increasing the rate of retention of IMGs, particularly in regional, rural and remote communities across Australia. The Committee is also of the view that supporting an IMG's family will also ease some of the stress placed on an IMG whilst they are working towards full registration, resulting in more IMGs remaining living and working in Australian communities, where they are highly valued and where the communities are in need of the IMG's ongoing services. Such a system should include a particular emphasis on the educational needs of children, along with support and employment prospects for spouses.

7.88 As with other forms of support, the Committee understands that access to personal support from IMGs and their families will vary depending on the IMG's individual circumstances, including the accreditation and registration pathway selected and the IMG's involvement with recruitment or workforce agencies. In view of the evidence which highlights the importance of ongoing personal and family support, the Committee is keen to ensure that there is wider access to these kinds of supports. Therefore, the Committee recommends that Health Workforce Australia, in consultation with key stakeholders (including recruitment and workforce agencies, IMGs and their families) develop a cohesive and comprehensive system of ongoing support options for IMGs and their families as an integral part of its National Strategy for International Recruitment.

Recommendation 42

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

7.90 With regard to accessing benefits, such as Medicare patient benefits for IMGs who are temporary residents, the Committee appreciates that on one view, it appears unjust and inequitable that IMGs providing crucial health services to Australians are not in a position to access these health services via the Medicare system themselves, even though they are generally subject to the Medicare levy and pay tax earned on their Australian income.

7.91 However, the Committee is also alert to the fact that significant consequences may flow from extending the eligibility for access to Medicare, social security benefits and education to temporary residents who hold a class 457 visa, as this visa extends a large number of migrants working over a number of professions. Further, if such benefits were extended to temporary resident IMGs and not other professions, this would also have a discriminatory effect and disadvantage temporary residents working outside the medical profession.

7.92 In view of the potentially significant and wide ranging consequences, the Committee is of the view that it would not be appropriate to make any recommendation for change to 457 visa conditions in the context of the current inquiry.

Navigating the system

7.93 Over the course of this inquiry, the Committee has not only been interested in what support programs are available to IMGs and their families, but what support they can access to assist them in navigating what is still a complex system.

One-stop shop and case management

7.94 A number of contributors suggested that a 'one-stop shop' or case management approach could alleviate some of the difficulties experienced by IMGs attempting to meet all of the professional and personal requirements that will enable them to live and work in Australia. For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) suggested:

> It may, however, be prudent for one agency that deals with all applicants (eg AMC, or AHPRA), or which may be able to be seen as 'neutral' in the context of any assessment or registration outcomes (eg Commonwealth Department of Health and Ageing) to be charged with the responsibility, and resourced appropriately, to produce clear materials that succinctly explain all steps of the process and the roles of the different agencies. This role could be expanded to ensure dissemination of information to relevant stakeholders, as well as act as a 'one stop shop' source of information for OTDs.[67]

7.95 Dr Jennifer Alexander, Chief Executive Officer of the Royal Australasian College of Physicians told the Committee:

> You will see that we have made a recommendation that consideration be given by government to the creation of an agency that pulls together the information required by immigration, the medical boards et cetera. We have recommended that consideration be given to pulling that together so that there is a one-stop shop to enable doctors to know that they have to complete this in order to get to that next step.[68]

7.96 Professor John Svigos, a Consultant Obstetrician and Gynaecologist, also supported this concept:

> The suggestion of a 'one stop shop', as consistently mentioned, of a 'neutral' agency (eg Commonwealth Department of Health and Ageing) to embrace IMG's and be charged with the responsibility to produce clear information that succinctly explains all steps of the assessment process and subsequent registration procedures and the roles of the different agencies must be seriously considered and supported. Such a 'shop' will need to be adequately resourced and appropriately staffed and would have

67 RANZCOG, *Submission No 45*, p 8.

68 Dr Jennifer Alexander, Royal Australasian College of Physicians, *Official Committee Hansard*, Canberra, 25 February 2011, p 57.

> the additional responsibility of ensuring that the above information is disseminated to all stakeholders viz the communities requesting/requiring an OTD, the jurisdictional/hospital representatives providing employment and the potential support personnel who may be required.[69]

7.97 Similarly, Ms Belinda Bailey of Rural Health West considered that a national agency would need to take on the role of providing a one-stop shop for IMGs.[70] In contrast, Mr Ian Frank representing the AMC, suggested, a series of state based or jurisdiction agencies might be preferable to a single national agency, as this would enable assistance to be tailored to take in to account local circumstances (eg employment conditions etc).[71]

7.98 Dr John Keenan, Director of Swan Kalamunda Health Service, suggested rather than a designate one-stop shop, it would be preferable to improve communication between the different agencies responsible for the administration of different processes that IMGs need to interact with, saying:

> ... I think the basic bones are already there within the structure that we have; it is just that they do not work well together. The colleges are separated out from the AMC; the AMC is separated out from the registration system. What we need is a cohesive management profile between the colleges—of course, I have left out the immigration process as well.[72]

7.99 However, Dr Beth Mulligan, Director of Clinical Training and Chair IMG Subcommittee with the Tasmanian Government Department of Health and Human Services was concerned about the feasibility of a one-stop shop, observing:

> I do not know that it can be a one-stop shop, to be perfectly honest. I think it is a fairly complex process. If we can look, instead, at making the processes more streamlined and more efficient, that is probably a better outcome than trying to do a one-stop shop. We absolutely have to have checks and balances, and I do not think a one-stop shop can have the expertise that we need to get us to the

69 Professor John Svigos, *Submission No 165*, pp 1-2.

70 Ms Bailey, RHW, *Official Committee Hansard*, Perth, 28 June 2011, p 15.

71 Mr Frank, AMC, *Official Committee Hansard*, Canberra, 19 August 2011, pp 13-14.

72 Dr John Keenan, Swan Kalamunda Health Service, *Official Committee Hansard*, Perth, 28 June 2011, pp 24-25. See also: Dr Jennie Kendrick, Royal Australian College of General Practitioners, *Official Committee Hansard*, Melbourne, 18 March 2011, p 69.

> point where we have a safe doctor that we can put into our health system.[73]

7.100 A slightly different perspective on the role of a one-stop shop was put by Dr Michiel Mel of Boyup Brook Medical Services in Western Australia. Dr Mel expressed concern that medical practitioners from developed westernised countries were being deterred from living and working in Australia by the bureaucracy and red tape associated with IMG accreditation and registration. Dr Mel asserts that a one-stop shop may minimise the red tape:

> I think the real solution to optimise the process would be to erect a 'one stop shop' for OTDs rather than having many different agencies, colleges and government agencies bouncing the OTDs around and shuffle paperwork to certify a doctor fit to treat the Australian public. The representatives of a 'one stop organisation' would be in much closer contact with an OTD to help him/ her through the system and therefore would have much greater understanding and much better judgement of an OTDs qualifications and performance in Australian practice.[74]

7.101 A number of the rural health workforce agencies indicated that they already take a case management approach to recruiting IMGs.[75] For example, Rural Workforce Agency, Victoria (RWAV) advised:

> RWAV has established a case-management system to assist an OTD navigate the maze of assessment, registration, immigration, provider number and placement processes involved in securing work in Victoria. The case-management system also assists practices seeking to navigate through the complex requirements set by Commonwealth and State governments such as Area of Need and District of Workforce Shortage approvals needed to be able to employ an OTD.[76]

7.102 In its submission, RWAV outlined the success of this approach, noting:

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73 Dr Beth Mulligan, *Official Committee Hansard*, Launceston, 14 November 2011, p 14.

74 Dr Michiel Mel, *Submission No 77*, p 4.

75 See for example: Ms Bailey, RHW, *Official Committee Hansard*, Perth, 28 June 2012, p 13; Mr Barns, Health Recruitment Plus, *Official Committee Hansard*, Launceston, 14 November 2011, p 22.

76 Rural Workforce Agency, Victoria (RWAV), *Submission No 91*, p 9.

> As a result, GP commencements in practice have increased from 36 doctors in 2007 to 141 in 2009-2010. GP commencements from July 2010 to January 2011 are currently 77.[77]

7.103 Noting the success of its case management approach, the Rural Doctors Workforce Agency (RDWA) in South Australia outlined the supports it offers its IMGs, saying:

> This includes:
>
> - Initial screening for suitability for rural practise in SA
> - Information on the various pathways and elements to registration
> - Visa support
> - Information for family members.
>
> Once identified as suitable for rural practise, the ROWA:
>
> - Case manages applicants through vacancy options
> - Provides paid site visits for the applicant and partner
> - Provides information to enable with application for PESCI and AHPRA to be as straightforward as possible
> - Assists with visa paperwork, hospital credentialing
> - Provides contract, business and financial information and grants
> - Once contracted to practice, provides a resettlement support program that includes a relocation grant.[78]

7.104 RDWA suggested that its case management system could provide the basis for a national case management model.[79]

Committee comment

7.105 The Committee notes that there was general in-principle support for the concept of a one-stop shop to assist IMGs to navigate all of processes associated with living and practising medicine in Australia. These processes not only include those associated with medical accreditation and registration, but also those associated with immigration, and finding suitable employment. However, on closer investigation, it is apparent that the concept of a one-stop shop has a different meaning for different people. Even among those who supported the concept there were differing views on how a one-stop shop should be administered and which organisation or agency would be the most appropriate host. There

77 RWAV, *Submission No 91*, p 11.

78 RDWA, *Submission No 83*, p 4.

79 RDWA, *Submission No 83*, p 4.

were also differing views about the scope of its activities, whether it should provide national or jurisdictional services, and the level of support it should provide, ranging from information only, to a more intensive service providing individual case management.

7.106 The Committee also notes that support for the one-stop shop was not universal. Several inquiry participants suggested that if the lines of communication between the AMC, the specialist medical colleges and the MBA/AHPRA were improved and systems were better coordinated as intended under the NRAS, this would negate the need for a one-stop shop. The Committee has already identified the need for better communication between these key organisations. It would be easier for IMGs to navigate and engage with the accreditation and registration processes if the Committee's recommendation to establish a centralised document repository and database to track an applicant's progress was implemented.

7.107 However, the Committee understands that IMGs are also required to engage in processes which extend beyond those administered by the AMC, specialist medical colleges and MBA/AHPRA. These include immigration processes, as well as Commonwealth, state and territory government processes associated with finding suitable employment and applying to claim Medicare provider benefits. IMGs need to understand how each process operates in isolation, but also needs to recognise how each process interacts with the others. Evidence suggests that the case management services, such as those provided by the rural health workforce agencies, are valuable in assisting IMGs to navigate all of these processes effectively.

7.108 In view of the range of complex processes and numerous organisations that IMGs will need to engage, the Committee considers that the concept of establishing a one-stop shop to assist IMGs warrants further consideration. Therefore the Committee recommends that HWA, as part of its National Strategy for International Recruitment program, examine options for establishing a one-stop shop for medical practitioners. In addition, HWA should consider the feasibility of providing individualised case management services to IMGs to assist them in navigating accreditation and registration processes, as well as immigration processes, and Commonwealth, state and territory processes associated with employment and accessing Medicare provider benefits. In developing the most suitable model for such a service, HWA should consider the proposed scope of this service and the range of assistance provided, having regard to available resourcing.

Recommendation 43

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

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

Accessing information

7.110 For IMGs who are interested in coming to Australia to practice medicine, accessing accurate and comprehensive information is crucial. The same is also true for IMGs once they have arrived in Australia, while they are progressing to full Australian registration. Earlier in the report reference has been made to the DoHA's DoctorConnect website. DoHA submits that DoctorConnect provides a starting point for IMGs and employers, noting:

> Information within this site includes: Rural Health Workforce Strategy initiatives; a map containing geographic information and corresponding incentives available; ASGC-RA explanation; and links to relevant stakeholders. Information for OTDs includes: choosing Australia as a place to work; assistance for employers of OTDs; details about the April 2010 amendments to section 19AB of the *Health Insurance Act 1973*; and a checklist of medical registration and immigration requirements.[80]

7.111 However, evidence has included differing views relating to the utility of the DoctorConnect website. Criticisms have raised issues regarding the accuracy and completeness of information provided, as well as its utility in assisting users to navigate complex processes and understand the range of support programs available to them.[81] For example, ACRRM submitted to the Committee that the availability and quality of information was an issue pertinent to IMGs. ACRRM noted feedback from its membership

80 DoHA, *Submission No 84*, p 16.

81 See for example: Dr Jonathan Levy, *Submission No 34*, p 4; Royal College of Pathologists of Australasia (RCPA), *Submission No 72*, p 4.

indicating that the information on DoctorConnect was not always up-to-date and was sometimes difficult to understand.[82]

7.112 Tropical Medical Training (TMT) based in Queensland made the following suggestion to improve access to information for IMGs:

> Enhance the Doctor Connect website - or alternative - to provide clear and concise guidelines for OTDs seeking additional support for their application and migration to Australia and detail how each listed service supports the OTD, and at what out-of-pocket cost, to achieve their Fellowship training program.[83]

7.113 A number of inquiry contributors suggested that the utility of DoctorConnect could be improved if it was also supported by a telephone helpline to assist with specific questions or clarification.[84] For example, Alecto Australia noted that:

> The DoctorConnect website is not linked to a telephone helpline and so it is not possible to put any queries to the Department of Health and Ageing except by email. This makes it difficult for doctors to get specific information about individual cases.[85]

7.114 In a similar vein, Health Recruitment Plus Tasmania advised the Committee:

> Websites such as www.doctorconnect.gov.au have been of some assistance to OTDs (from anecdotal evidence) but the key factor has been the link on the website to *people* who can help an individual OTD navigate the system. Constant feedback from OTDs is that once they found a person to help them they hung on like a limpet mine until they were sure of what they were doing. While it may be appealing to try and deal with a system by setting up another system (websites are examples of this) nothing seems to satisfy people's concerns like connection with another human being.[86]

Committee comment

7.115 The Committee understands that access to accurate and comprehensive information is needed to assist IMGs to develop a thorough

82 Australian College of Rural and Remote Medicine (ACRRM), *Submission No 103*, p 12.

83 Tropical Medical Training, *Submission No 114*, p 11.

84 See for example: Alecto Australia, *Submission No 85*, p 4; ACRRM, *Submission No 103*, p 12; National Rural Health Alliance Inc, *Submission No 113*, p 19.

85 Alecto Australia, *Submission No 85*, p 4.

86 Health Recruitment Plus Tasmania, *Submission No 32*, p 2.

understanding of the all of the processes involved when seeking to relocate to Australia to practice medicine, and the supports available to them and their families. While noting comments in evidence relating to its limitations, the Committee supports the intent of the DoctorConnect website and appreciates the challenges associated with developing a web-based resource of this kind that is both comprehensive and user-friendly.

7.116 The Committee has noted earlier in the report that as part of its National Strategy for International Recruitment, HWA is working towards establishing a single website portal under its International Health Professionals Website Development Project. As the Committee has only limited information on the scope of this project, it is unclear whether this website portal will ultimately replace DoctorConnect. In addition, the Committee does not have information on the anticipated timeframe for delivery of the project.

7.117 In the absence of more detailed information on HWA's International Health Professionals Website Development Project, the Committee makes recommendations for the enhancements to the DoctorConnect website. These recommendations should equally apply to HWA's International Health Professionals Website should it eventually replace DoctorConnect. Specifically, the Committee recommends that DoHA expand the DoctorConnect website to include a register of support services available to IMGs in the various agencies around Australia, including details of location, eligibility, duration and timing, cost, and whether the program is available electronically/remotely.

Recommendation 44

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

- **details of location;**
- **eligibility;**
- **duration and timing;**
- **cost; and**
- **whether the program is available electronically/remotely.**

7.119 In addition, the Committee notes that currently e-mail is the only option available to DoctorConnect users who have questions or wish to seek clarification. The Committee believes that the utility of the DoctorConnect website would be improved if also supported by a telephone help line. The help line should provide assistance with navigating and clarifying information on the site.

Recommendation 45

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

Steve Georganas MP
Chair