Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
March 2023

Feedback on the review of regulatory settings for overseas health practitioners

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.*** It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of local specialist and allied health services.

ACRRM has more than 6000 rural doctor members including over 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

Our college is dedicated to the provision of appropriately skilled doctors to serve people living in rural and remote areas including in remote Aboriginal and Torres Strait Islander communities. The College is all too aware of the need to recruit doctors to many areas of acute workforce shortage and the importance of being able to facilitate immigration solutions efficiently and responsibly. For this reason, the College has been heavily involved in these processes. For over a decade the College has been an AMC approved provider of Pre-Employment Structures Clinical Interview (PESCI) assessments in every state and Territory. ACRRM expert panels have conducted thousands of fitness for task assessments of applicants for medical registration through the Standard Pathway.

There is currently a severe workforce maldistribution which is having a direct and unacceptable impact on the health and well-being of people that live outside major cities. This maldistribution is leading to a regressive allocation of the national health spend which is exacerbating the country's socio-economic and health inequities.

It is recognised that this review is concerned with the process efficacy of the mechanisms by which Australia manages the skilled inward migration of medical and health practitioners. We would however emphasise the importance that all recommendations of this review give careful consideration of their potential impacts (both positive and negative) upon workforce distribution both in the immediate and the longer term. It is crucial that they support the Commonwealth Government's Stronger Rural Health Strategy, jurisdictional rural health workforce strategies and other key policy frameworks, toward delivering better health services for all Australians irrespective of their geography.

Response to discussion questions

ACRRM's response focuses on the medical workforce however it is noted that many of the issues raised also have pertinence to nursing and other core allied health professions. We have responded to the questions pertinent to the work of the College and where our members have a particular interest.

1. The Review is considering recommendations to ease skills shortages in registered health professions including medicine, nursing, midwifery, psychology, pharmacy, occupational therapy, and paramedicine on the basis of current and projected labour market shortages.

a) Do you agree there are current and/or projected skills shortages in these professions?

Australia's overall doctor to population ratios is among the highest in the OECD and many areas of medical practice are in plentiful supply or even over-supply.[1] Maldistribution of the medical workforce however, both in terms of location and specialisation, continues to result in pervasive workforce shortages across rural and remote Australia. These shortages are contributing to unacceptable inequities in terms of healthcare outcomes for the people affected by them.

Geographic maldistribution, the imbalance between specialist disciplines, subspecialisation and generalism and the need to move away from reliance on locums and international medical graduates are all documented in the National Medical Workforce Strategy 2021-2031. These issues persist despite increased domestic graduate numbers.

Rural and remote area workforce shortages

There is need for urgent and significant action to support the nation's rural and remote health services. The general practice workforce is ageing, and a large proportion is approaching retirement with 15% aged over 65.[2] There is risk of rural service closures without generational transfer of their practices or their knowledge and skills. Without immediate action an irreversible loss of rural/remote workforce/capacity is likely to occur.

Workforce shortages translate to longer patient wait times, lack of emergency care, and to fragmented care as rural and remote communities are increasingly serviced by short-term, temporary or locum practitioners. Reliable healthcare services are a cornerstone to rural community resilience, and the loss of services, or loss of trust in service provision can lead to

[1] Cth Dept of Health (2021) National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs.
[2] Cth Dept of Health (2021) General Practice Workforce providing Primary Care services in Australia: 27 Sept 2021. Based on the National Medical Workforce Data Set.

population loss which creates a downward spiral in terms of establishing sustainable local staff and resources.

Role of international recruitment in rural and remote workforce strategies

As identified in the National Medical Workforce Strategy, the provision of essential medical services in many rural and remote areas continues to rely heavily on active recruitment of doctors from overseas usually through recruitment policies which specify their practice in areas of service shortage.

Studies based on the MABEL dataset have found that Australian trained medical graduates today are less likely to work either as General Practitioners (GPs) or in rural communities compared to graduates of the 1970s and 1980s. Rural areas continue to remain substantially dependent on International Medical Graduate (IMG) doctors, comprising 36-38% of all GPs in small rural centres.[3] More recent studies have found that IMGs compared to Australian trained medical graduates were significantly more likely to be working in rural and remote areas and to be working as a general practitioner. The vast majority however (approximately 75%) were practicing in urban areas. [4]

The greater likelihood of IMGs practicing rurally is likely to be strongly influenced by government policies which facilitate attainment of visas and registration to immigrating doctors who practice in an area of need, including the requirement upon most IMGs to work in an area of workforce need for a period of 10 years to be able to provide Medicare billable services. Concerningly, IMGs based in rural and remote areas are significantly more likely to be recent graduates, suggesting that many may be relocating to cities at the end of obligatory terms.[5]

The skills maldistribution particularly relates to the increasing numbers of non-GP specialists and sub-specialists. These doctors do not generally provide the range of services required in rural and remote communities, which require a more generalist model of care to enable them to access as many services as possible, as close to home as possible, and in a way which is economically sustainable.

We appreciate that exploration of rural health workforce policies is outside the scope of the Review, however, it must be cognisant of potential perverse consequences and ensure that its outcomes do not serve to inadvertently exacerbate current distortions. For example, initiatives to bring more doctors and other health practitioners into the country will increase the national healthcare spend with the associated opportunity costs, and they may exacerbate over-servicing in some areas, without necessarily providing services where they are needed.

The Distribution Priority Areas (DPA) scheme provides a recent example of changes to government policies having severe perverse impacts on rural workforce. The DPA program facilitated employment of IMG doctors in the most hard-to-recruit areas in MM3-7 by conferring exemptions to them to provide MBS billable services. To address relatively minor workforce shortages in MM2 and outer urban areas, the scheme was extended last year to support employment in these areas. Within a short space of time, this triggered significant movement of IMG doctors out of MM3-7 to take up positions in MM1-2 and has made it substantially harder to recruit to MM3-7 vacancies.[6]

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[3] O'Sullivan B et al (2019) Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence *Hum Resour Health* 17: 8

[4] Yeomans N. D. (2022). Demographics and distribution of Australia's medical immigrant workforce. *Journal of migration and health*, *5*, 100109. https://doi.org/10.1016/j.jmh.2022.100109

[5] Yeomans N. D. (2022). Demographics and distribution of Australia's medical immigrant workforce. *Journal of migration and health*, *5*, 100109. https://doi.org/10.1016/j.jmh.2022.100109

[6] Sparke C (2023) '800 open job ads 'a sign of rural doctor crisis' *Australian Doctor.* 21 Feb 2023 https://www.ausdoc.com.au/news/800-open-job-ads-a-sign-of-rural-doctor-crisis/

We would also acknowledge the broader international responsibilities of our country to not build a national workforce strategy intrinsically reliant upon negatively impacting on the health services of other countries and particularly, lower-income countries.[7]

b) If yes, is there any data or evidence you can provide to demonstrate these shortages?

It is estimated that there is an annual underspend of around $4b by government in funding for health services for rural people relative to that spent on people in major cities.[8] This reflects significantly lower use of government funded health services across most key Government programs including the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). The lower per capita use of MBS funded services by rural people is a major contributing factor in this inequity.

A steep decline in utilisation of MBS services occurs with increasing levels of remoteness. This service gap is especially significant for non-GP specialist services.

The per capita number of non-GP specialist services received by people in outer regional areas was 25% lower than in major cities, and 59% lower for people in remote and very remote areas. (Compared to a 9%, and 36% respectively for GP services).

Similarly, per capita MBS funding for non-GP services declined by 16% for people in outer regional areas, and 59% for people in remote and very remote areas, compared to that spent on people in major cities. (Compared to 8%, and 28% respectively for GP services).

GP and Non-GP specialist MBS expenditure by geographic classification 2020-21						
	GP Services			Non-GP Specialist Services		
	MBSs funding	**Services per 100 people**	**MBS funding per 100 people**	**MBS funding**	**Services per 100 people**	**MBS funding per 100 people**
National	$8,753,453,966	666	$34,064	$2,347,556,834	102	$9,135
Major Cities	$6,458,349,941	675	$34,349	$1,787,621,659	106	$9,507
Inner Regional	$1,587,951,436	675	$34,916	$412,071,860	104	$9,061
Outer Regional	$577,054,190	613	$31,730	$127,310,635	80	$7,000

[7] Tam, V., Edge, J.S. & Hoffman, S.J. Empirically evaluating the WHO global code of practice on the international recruitment of health personnel's impact on four high-income countries four years after adoption. *Global Health* **12**, 62 (2016). https://doi.org/10.1186/s12992-016-0198-0

[8] National Rural Health Alliance. The case for better health care. NRHA, 2021 [cited 2021 Sep]. Available from: https://www.ruralhealth.org.au/content/case-better-health-care

GP and Non-GP specialist MBS expenditure by geographic classification 2020-21						
Remote/ Very Remote	$130,098,399	431	$24,619	$20,552,680	44	$3,889

Source: AIHW. (2021). *Medicare-subsidised GP, allied health, and specialist health care across local areas: 2019–20 to 2020–21.* Retrieved from https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-2020-21

2. What, in your view, are the key strengths and weaknesses of the current regulatory settings relating to health practitioner registration and qualification recognition for overseas-trained health practitioners?

The College is dedicated to ensuring that rural and remote communities can have confidence that their practitioners are fit to practice safely and to a high standard. ACRRM is aware that there have historically been instances where the processes for assessment of the fitness to practice of doctors recruited from overseas, particularly in areas of high workforce shortages such as rural and remote areas have not been sufficiently robust with negative consequences for patient's safety of care.

The College considers that the current assessment processes related to the medical practitioner's capacity to practice safely in rural and remote areas are generally sound. ACRRM recognises that there is always opportunity to further streamline administrative process and would support any opportunities where this can be achieved with no trade-off to patient safety. (These are detailed at Question 4 below).

Alongside all these considerations, there is a need to improve the alignment and accountability of individual organisations' decisions to sponsor immigration of the doctors that the country needs. Further to this, if they are to be successful, recruitment initiatives need to be aligned with appropriate strategies to support recruited doctors personally and financially.

- A key element of improving these alignments will be prioritising recruitment of doctors who have appropriate skillsets to work in the areas of highest workforce shortage. This should broadly involve systems and processes, prioritising doctors with generalist rather than specialist or sub-specialist skillsets. As such, General Practice qualified doctors, and doctors skilled in the Rural Generalist practice scope should be given especially high priority. People in regional, rural, and remote areas require local practitioners with broad skillsets to meet as many as possible of their needs close to home. Sub-specialisation involves a narrow practice scope and the support of specialised resources and staff not typically available outside cities. It also relies on a high-volume of patients with specialised needs. Thus, the more specialised a doctor is, the less likely they are to be able to practice sustainably in these areas.

- Current policies that encourage or require doctors recruited from overseas to work in rural and remote areas can be made more effective. They could better target recruitment to areas of the most serious workforce shortage. Additionally, the deficit model policies which place location restrictions upon doctors recruited to rural and remote area positions, should be complemented with enhanced financial and personal support. This support can help these doctors to settle and thrive in their rural and remote communities and to stay rural beyond their bonded terms.

- There is need to address the lack of coordination and alignment of individual recruitments with national needs and priorities. There is poor alignment of the individual decisions of hospitals and health services to recruit international doctors, and the overall national workforce training and planning. Training doctors typically involves a 10 to 12-year planning horizon while international recruitment decisions are typically motivated by a need to address an immediate

workplace gap. Unfortunately, irrespective of the value on any individual recruitment decision to fill a local service gap - particularly where this involves highly specialised urban roles, the cumulative impact of these decisions can be major workforce distortions such as currently exist in our medical workforce.[9] The substantial oversupply of predominantly urban-based emergency specialists provides a case in point.[10]

4. The end-to-end process for overseas health practitioners seeking to work in Australia can be complex, time-consuming, and costly. Current regulatory requirements may set unduly restrictive barriers, which in turn may deter potential practitioners from seeking to work in Australia.

a) Do you agree with this premise? If so, why?

IMGs face a series of obstacles to practice in Australia including the timing of provisional registration, consequences of the requirement of recency of practice and changes in rules or procedures which can beset the entire process.[11]

Likewise, our members experiencing difficulties in recruiting the doctors necessary to sustain their rural and remote practices have reported facing considerable challenges in navigating, understanding, and tracking the processes and procedures to recruit doctors to their practice from overseas.

There are long timeframes for moving through these successive stages, and requirements are also an issue. Our college's experience has been that the process takes on average, 21 months from beginning to end. This is far more than other developed countries like New Zealand or the United Kingdom.

We note that there have been a number of improvements in the system for collation and verification of documentation for registration and accreditation of IMGs such as the AMC Electronic Portfolio of International Credentials (EPIC)[12] and that the MBA has developed a set of standards for specialist colleges for the assessment of specialist IMGs qualifications and training.[13] Ahpra has also reported that following disruptions during the pandemic, the number of IMGs arriving in Australia has returned to pre-Covid-19 levels and the agency is speeding up the assessment of applications by IMGs seeking to work in Australia.[14] The College would not like to see are return to these arrangements which we would expect to lead to further backlog and increased workforce shortages.

Other deficits of the current processing arrangements include the following:

- There are substantial up-front costs imposts on applicants which need to be met prior to their being able to receive registration and thereby earn income. This is placing considerable strain on often vulnerable families, especially where they need to relocate to take up roles.

- The system requires applicants to repeatedly undertake (and pay) for PESCI assessments for every single role for which they apply, irrespective of whether the scope and role could be

[9] Cth Dept of Health (2021) National Medical Workforce Strategy: 2021-31 Investing in our medical workforce to meet Australia's health needs.
[10] Cth Dept of Health (2017) Australia's Future Health Workforce – Emergency Medicine: Nov 2017. https://www.health.gov.au/resources/publications/emergency-medicine-australias-future-health-workforce-report?language=en
[11] International medical graduates (IMGs) in cul-de-sacs: "lost in the labyrinth" revisited? Neville D Yeomans, Ayaz Chowdhury and Alan Roberts Med J Aust 2022; 216 (11): || doi: 10.5694/mja2.51516 Published online: 23 May 2022
[12] Australian Medical Council. Primary source verification [website]. https://www.amc.org.au/assessment/psv (viewed March 2023).
[13] Medical Board Ahpra Standards, Reports and Resources https://www.medicalboard.gov.au/registration/international-medical-graduates/specialist-pathway/guides-and-reports.aspx (viewed March 2023)
[14] ACRRM welcomes news to support international doctors applying to work in Australia, Dec 20,2022 https://www.acrrm.org.au/about-us/news-events/news/article/2022/12/20/acrrm-welcomes-news-to-support-international-doctors-applying-to-work-in-australia

considered equivalent to other PESCI assessments. This places considerable undue burden upon applicants, and redundant cost and resource imposts upon the system.

- There is a lack of standardisation of orientation and training/support programs for IMGs that are linked to Australian Fellowship programs

b. What practical changes could be made to current regulatory settings to most significantly improve the end-to-end process:

i. over the next 12 months

ii. in the medium- to longer-term

While the assessments are robust, the assessment methodology should be revised to ensure it is still appropriate and contemporary. We note that this was introduced in 2010 and we are not aware of any comprehensive review having been undertaken of these processes. Work Based Assessment (WBA) options for GPs need to be given more comprehensive consideration. ACRRM trialled these in 2010 but at that time the AMC took a very cautious approach to the pilot and were unable to support the approach without prohibitive levels of resource and compliance. The pandemic experience has driven substantial progress in distance-based methodology and delivery for assessment and this should be leveraged to develop more time and cost-effective approaches especially for doctors in rural and remote areas.

Some other approaches to improving processes and systems might include the following:

- We would see value in approaches such as developing a more comprehensive one-stop, user-friendly interface point, which provided all key information with clear links to all other key information sources and related agencies.

- Similarly, there is opportunity for the MBA/Ahpra or other key authorities to provide case studies, FAQs, factsheets, and other resources which Colleges and other key organisations could provide to support them in giving helpful advice to both recruiting doctors and international doctors who may wish to immigrate to Australia.

- Wherever practical and appropriate we would see value in better system transparency particularly regarding the capacity to track processes and the timing of administrative steps.

- The College would however caution against an approach which emphasised provision of detailed assessment outcomes by different providers. Ultimately the system cannot compromise the quality and safety of patients, given there is an element of profit motive to the system this approach risks creating a systemic incentive to all providers to compromise robust assessments in favour of being able to market better pass rates.

- The MBA sets an accreditation standard for PESCI assessments of overseas doctors seeking registration in Australia. We would see value in the provision of some more detailed information to support consistent understanding of this safety and quality benchmark.

ACRRM is ideally placed to provide education, collegiality, and support to IMGs to help them to practise confidently in rural and remote areas and meet the healthcare needs of those communities and is committed to continuing to provide this.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.