Submission to Senate Community Affairs Committees

Community Affairs References Committee

Inquiry into The Factors affecting the supply of health services and medical

professionals in rural areas

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Summary

Introduction

The reason for this submission is manyfold. I want to address your particular references: a) the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres, c) current incentive programs for recruitment and retention of doctors and dentists, d) any other related matters.

I am an overseas trained doctor (OTD) or more recently called international medical graduate (IMG) who is board-certified in radiology since 1987. Therefore, my submission will be the viewpoint of a specialist. Specialist doctors are the most underrepresented medical professionals in regional as

well as rural communities in Australia. The current structure of administration of medical personnel, in particular, specialist IMGs will reduce the number of working specialists in regional and rural communities further, resulting in a disservice to the Australian public.

I will address factors that limit the supply of medical professionals to regional and rural communities, the lack of incentive programs for recruitment and retention of doctors in rural communities, and I will show you the intolerable failure of the current structure of the medical administration using my own experience.

Australia has lost its attraction during the last three years for nurses, allied health professionals and doctors. Housing is not affordable anymore, utility costs have doubled and are among the highest in western countries, internet cost and connection in metropolitan centres is similar to third world countries, the superannuation scheme has changed so much that it does not provide an incentive anymore, access to the public health care system for specialist care has decreased, red tape administration has increased to the point that it is counterproductive, the fees being charged for processing documents before working as a doctor in Australia became unreasonable and prohibitive, general cost of living is high and still on the rise. Australia is now the most expensive place in comparison to other western countries. The current situation with medical registration is slowly making the rounds in the world and distracts potential immigrant doctors to come to this country. The doctors who are now being forced to leave will tell their stories when they are back home. It needs immediate attention and careful consideration to change the current negative image that has been created by political administrative processes.

All of these factors and many more play a role to detract health care personnel to work in Australia. The number of Australian doctors and nurses who leave for opportunities in other countries has recently increased.

The choice to go to regional and rural areas, if one does not love the countryside and bush, is, as most commonly reasoned for other professions, a business decision. The current Medicare rebate system does not attract specialists to regional and rural areas. The 2010 decision to renew and to update medical equipment in defined timeframes and its legislative implementation in 2011 was a step in the right direction; however it did not provide a co-incentive for the change of equipment in the future. This produces a considerable uncertainty of sustainability for a business, especially in rural areas.
In other words, regional and rural Australia is simply financially not attractive for a medical business, e.g., private specialist practice or private hospital.

Regional and rural Australia remains attractive for those who have their families there and for those who love the lifestyle it can provide. I am one of the latter groups of people.

Factors limiting the supply of medical professionals

A) Renewal of registration

There are many factors contributing to the past and still present problem of delivering health care to regional and rural areas in Australia. I like to point out the major factor, the loss of medical professionals, in particular specialists due to denial of renewal of registration.

Since each individual specialist doctor has to renew his/her registration every year, IMGs are more scrutinized than before the introduction of the national registry AHPRA.
The Senate Finance and Public Administration References Committee reported in 2011 "The committee concludes that the mistakes, omissions and poor processes that were clearly evident from the evidence received during the inquiry calls into question the ability of AHPRA carry out its primary purpose.
…For AHPRA itself to be responsible for a breakdown of the entire system of registration of health practitioners in Australia is a dismal example of policy implementation and public administration."
Since this report became public and AHPRA was supposed to be in a better shape to deal with the task of a national registration, the process became even more stringent and less flexible than before. While the speed of the annual repetition of registration for Australian born and trained doctors might have improved; the registration process for IMGs, in particular specialists, has in the last months reached its top of absurdity.

AHPRA has a clear motive and its chair Dr. Joanna Flynn stated it as: "Having clear and flexible registration requirements for internationally qualified specialists is important not only to these practitioners, but also for responding to workforce needs in our communities." The workforce needs in the regional and rural communities seems to be ignored.
There are numerous IMGs trained in different specialities working in regional and rural communities who already lost their registration or are about to lose it. What this means for an IMG who works here on a temporary employer-sponsored visa 457 is that he is not allowed to work in his profession and the visa becomes invalid. Consequently, the IMG would have to leave the country. This is clearly the opposite what AHPRA is supposed to do.
In my opinion, the discrepancy is a systematic mistake within the set-up of guidelines AHPRA can work with. I like to draw your attention to the

guidelines issued by the Medical Board of Australia: www.medicalboard.gov.au/codes-gidelines-policies/FAQ.aspx to click on "FAQ and Fact Sheets" and then go to "Information on how IMGs can demonstrate satisfactory progress towards gaining general or specialist registration". On pages 10 and 11 of this 13 pages long document, you will find a table outlining the registration process for a specialist IMG working in this country. For your convenience, I have attached these two pages.
You will notice, without exception, in each step of the requirements for renewal of registration, there is the specialty college as the governing agency that determines the renewal. This can lead to uncalled for denial of an application of renewal of registration. It appears to the medical professional very bizarre, non-democratic and inhuman. I will explain and demonstrate this to you below in "Other related matters".

First, let me come back to the all-governing specialist colleges. Although, I think, the idea to regulate specialists through their own colleges looks like a practical and elegant way of delegation for an administrator who is not a doctor or a doctor practising in a speciality, it inherently includes failure. The failure is clearly visible and would be a feast for any solicitor who might be interested to make a name for himself.
The specialist colleges are as far removed from any governmental body as any other private company. The specialist colleges are associations. They are registered as a "Company limited by Guarantee and not having a Share Capital" under the Corporations Act. Each of these companies has its own articles of conduct. This alone prohibits standardization in the renewal process. The specialist who might be compliant to the requirements of a certain college, might NOT be compliant when compared to the requirements of another college, regardless of the speciality.
The articles of these associations/companies line out their purposes. They clearly state mainly educational and promotional purposes. They DO NOT state that they are in any way involved in governmental registration or that they are involved with the Department of Immigration & Citizenship.
However, the current process of registering an IMG puts the specialist colleges in the position to allow a doctor to practice or not to practice in this country and the specialist colleges are in fact performing immigration policy. I do not think that this outcome was intended when guidelines for IMG specialists were formulated. The very unfortunate consequence is that specialists are suffering because of it.

Before concluding this chapter, I also like to point out that the medical professionals who are involved in positions within the college's structure do it on a volunteer basis. They are trained specialists who do not have backgrounds in management training, humanities, law, social sciences, or have developed sensitivities towards cultural differences. Now, those human

beings are being put in the position to make decisions about work and life of another fellow human being. In this society, we call people who are in such positions, judges. The judges are well qualified for the job. I do not think that any of the college serving specialists, in fact my colleagues, who are now put in the position of being a judge, wants to have the responsibilities of a judge.

The specialist college is interested in "..establishing the status of Fellowship of the College and to admit to such status Members of the College." An IMG specialist gains fellowship by passing a 9-part examination in the speciality of diagnostic radiology. This fellowship allows the radiologist IMG to apply for permanent residency and consequently citizenship. It also allows the doctor to become a member of the Medicare system which is being denied to any IMG on temporary visas. This points to another one of the incomprehensible absurdities. An IMG who works for the Medicare system is not allowed to be part of it. Any Australian doctor would feel like a second class citizen if it would be denied to him.

According to the previous Minister for Health and Ageing, the Medical Board of Australia is the institution of final responsibility in regards to registration issues.
I want to come back to the discrepancy of losing specialists in regional and rural areas while it is desired to increase them in these areas. It might very well be the desire of the Medical Board to alleviate the specialist workforce shortages; however, the Board's guidelines prevent it since the specialist colleges are actually in charge about who is working in this country. The interest of these private companies/associations does not concur with the governmental interest to provide health care for the entire Australian population.

B) Standard of health care

In defence of the establishment of new administrative hurdles and more regulation for the medical professional workforce, it has been the mantra of almost everyone involved within the administration that the increase in regulations is necessary to keep the high standard of medical care where it is. I am of a different opinion. I am for an increase of the standard of medical care in this country.

It would be difficult to prove that the standard of health care can be increased by more regulations. There is no country on this planet which could be used as a role model to prove it. Certainly, Australia is no exception.
In fact Australia does not have the standard of diagnostic radiological services enjoyed by other western civilized countries. It would incomprehensible to any European or American to deny them access to magnetic resonance imaging (MRI) of certain body parts within their health

insurance systems. There are numerous MRI examinations which are not Medicare accessible, nor are most Australian radiologists trained in interpreting those examinations.
Another example of low standard of health care in my field of expertise is the prevention of osteoporosis. Quantitative measurements of bone density are Medicare rebatable after the age of 70 years or after the occurrence of a low impact fracture when younger. This does not help the prevention of fractures in patients in a younger age who might be predisposed to osteoporosis. To make my point clear, a dentist would find it absurd to treat a patient only after a tooth is already fallen out, or a cardiologist would only be allowed to treat hypertension after the patient had already a brain haemorrhage.
Does standard of care include the waiting time for a knee replacement of 6 months, for a hip replacement of 9 months, for spinal surgery of more than 12 months? Imagine one of your children would be that patient who has to wait. What would you do then?
There are numerous other examples of low standard within the Australian health care system compared with the rest of the western world. This is a factor limiting the supply of medical professionals.

Of course, there are examples of very high standards in health care in this country. However, health care is a subject of individual care not averages. The high standards exist right next to the low standards.

I am here, gladly so, to help increase the standard.
The idea of the medical administration that passing an exam of a specialist college for a 60 year old radiologist with 30 years experience (that is me) would maintain the standard, is outside of any understanding within the range of human thinking.

C) Low Medicare billing

On average, the GP attendances in Australia attract a fee charged around $45.50. This is barely above the RVS valuation of 10 years ago. The AMA determined in 2011 that a fair and reasonable rate would $66.
From a radiologist point of view, the situation is even worse than it is for GPs. A CT-scan of the chest requires high skills and fine tuned understanding of changes in pulmonary tissues for interpretation from a radiologist. The Medicare rebate rate had been in 1998 $259.30. It is now at $250.75. It represents a devaluation of 31% after CPI adjustment for the past 12 years.
It is expected that the health professionals should know and put into practice the innovations, new techniques, new drugs, new procedures and breakthroughs of the last 12 years but accept to get paid with prices from 12 years ago.

As long as the Australian Medicare system does not put a proper value on the quality and comprehensive care that the physicians in this country provide, the standard of care will not rise. "If we don't, our patients will continue to receive a rebate that does not reflect the value of the care that they receive and we will have contributed to the demise of private medical practice," said the AMA.

This factor limits the investment in regional and rural medical practices in general to the point that the serious question about the future looms in front of everyone who wants to practice outside metropolitan areas.

The Medicare rebate must increase considerably to make regional and rural Australia attractive to specialist health care set-ups.

Incentive programs for recruitment and retention of doctors

To my knowledge, there are no viable incentive programs available for specialist doctors that would help them to move and to practice in regional and rural areas.

The most prudent "incentive" would be the increase of Medicare rebate for specialist services. Other incentives would be financial subsidies for equipment renewal and upgrades when practicing in regional and rural areas.

Another factor which would be essential when incentive programs are being considered in the future is an incentive for the female partner or wife to move outside of metropolitan Australia. Why not providing subsidized airplane ticket coupons, car and petrol incentives for a period of two to three years to the specialist's family for at least a once-per-month-trip to the area which they have left behind?

The decision to move to a different area is always a family decision. I am wondering why Australia does not consider this fact as other developed countries do. Why is there a lack of understanding of modern management thinking?