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To: House Standing Committees on Community Affairs Committee
Re: Inquiry: The factors affecting the supply of health services and medical professionals in rural areas

Dear Committee Members,
Thank you for giving me the opportunity to make a submission to this inquiry. I work as an orthopedic surgeon on the South Coast of NSW. I am based in Bega. I cover an area from the Victorian border to Batemans Bay and inland to the ski slopes in the Snowy Mountains. The catchment area is about 100000 Australians living in small communities.

I like to give you my personal views about the problem of undersupply of medical professionals in rural areas. It are the views of a specialist surgeon working in a so called "area of need". I have done this for more than six years and have migrated from Europe.

My views may be perceived as simplistic as they essentially boil down to very old issues of power, influence, greed and last but not least money. My arguing follows the basic principal that nothing happens by chance. There is always a reason, a motive and a resulting intend.

I am of the opinion that the medical profession represented in form of the various medical colleges have a major responsibility in the shortage of doctors especially in rural areas.

My main point is that medical colleges hold a monopoly in Australia with regards to registration of doctors and prevent a healthy level of competition. In my case I have to deal with the Royal Australasian College of Surgeons (RACS). This college is very good in playing with words. They tend to claim that they don't actually give registration, but they omit to clarify that the registration granting Medical Board of Australia (MBA) requires the College's consent for every doctor's registration. Colleges train and control training numbers of young Australian doctors and assess international peers. This way they have total control over national and international competition. A monopoly has never been to the interest of the consumer.

I'd like to come back to my logic of reason, motive and intend.

- **Reason**: The Australian Health System is a hybrid system between public service and private business. Public service is in general of good quality but of limited availability, or accessibility especially in non urgent so called elective matters. Why??? Limited resources and funding. Why??? Hybrid public-private system enables Government to offload costs to private System. Wealthier individuals can unload the public system by going private. In general a good idea and fair. However the public system needs to

underperform and create incentives to go private. These incentives are waiting lists in order to generate business for the private sector. Who has an interest in longish waiting lists??? Government by spending less and…

- **Motive**: Medical profession by earning more for equal service. This creates a conflict of interest between service and business and explains the interest of the profession organized in medical colleges in long waiting lists. Big question??? What is an acceptable long waiting time?
- **Intend**: keep numbers of doctors in Australia low and keep barriers up to make it difficult for international doctors to come in.

- Government and Colleges have underestimated the realistic need of numbers of doctors and surgeons needed to serve the Australian public. Measures have been put in place to change this in the future. It is estimated that by 2025 self-sufficiency in demand and production of doctors is expected to occur.

- Government tried to address the gap period from now until 2025 by introducing programs like the Area of Need program trying to get doctors into Australia. The Colleges are given the task to assess these doctors, but are still holding up barriers to keep doctors out of Australia. These barriers were introduced during a time when there was a perceived oversupply of doctors.

- Profession was given the task of assessing international peers (appropriate) and to play the gatekeeper limiting the influx of international peers (not appropriate). Not appropriate as profession has a financial interest in undersupply s.o. The profession (Colleges) control numbers of doctors available to the Australian public by controlling national competition through available training and international competition through assessment of international peers. Thus effectively holding a monopoly.

- The medical profession is a highly competitive profession in all countries. It is common practice that the medical profession of one country tries to minimise international competition within it's borders. That is nothing particular Australian as such. In most other countries the medical profession is prepared to remove barriers and allow international doctors to come in when the population of that country is obviously suffering from undersupply. So far this is not happening in Australia and for sure not for RACS and their orthopaedic specialty branch the AOA (Australian Orthopaedic Association).

In my opinion the Colleges have demonstrated that they are unable to put their business interests behind the interests of the public.

Colleges are at least partially if not totally responsible for the shortage of doctors in Australia. This makes them in my opinion responsible for an environment where recruiters take irresponsible steps in recruitment. This does not excuse recruiters for putting the public at risk like in the Patel and Reeves cases, but explains how such a desperate situation could evolve where doctors are contracted who are struck off the Medical Register in the country where they come from (Patel), or have conditions placed on their practice due to mental conditions. The later was the case for Reeves. The person recruiting Reeves had information from a referee that "he was ok when normal". Reeves had a condition placed on his registration not to practice gynecology due to a mental condition. Yet he was contracted to do just that. In a healthy environment of appropriate competition these doctors wouldn't have had a chance to be employed, but the Colleges effectively eliminate competition in rural areas of Australia.

The Colleges pretend to the public that they want to protect the public from inappropriate foreign doctors by safeguarding standards. No reasonable person would ever question such intend. However the reality is very different than what this statement would reasonably mean. One would think that a doctor who can demonstrate in his current practice here in Australia that he meets or in some areas may even exceed standards of the average Australian trained colleague, would be welcomed to the Australian community. Well, that is not happening. The colleges in my case RACS look at standards of the past not the present. Their assessment is based on the training program in Germany that I entered almost 20 years ago and the exit exam I took 12 years ago. My continuous professional development after passing this exam 12 years ago and current performance are brushed aside. In my opinion RACS's assessment process is geared up to keep well performing doctors out of the Country and not intended to help fill currently vacant posts to improve outcomes of patients through availability of services in areas of need. In a hopefully ill-fated attempt they try to publically discredit me hoping to avoid a precedent leading to more qualified surgeons coming to rural areas of Australia who are not a member of their club.

I would like to suggest that the monopoly of the colleges needs to be challenged. The registration granting Medical Board should be given the power to give registration to doctors with equivalent qualification to college fellows. There should be no further requirement for colleges to state to the MBA that overseas trained doctors have fulfilled all requirements to become fellows. It should be sufficient if they are deemed fully comparable or equivalent. The difference to eligibility to fellowship may sound trivial, but keeps the option to deny registration even if the qualification is sufficient, but the doctor has not fulfilled all requirements to become a member of the club.
You may be aware that I made a submission to the parliamentary inquiry into the registration processes of overseas trained doctors. My submission is No 66. Overseas trained doctors make up a very large part of doctors working in rural Australia. If their recruitment and registration can be streamlined and barriers removed, then supply of medical professionals to rural areas can be improved. For this reasons the

recommendations I have suggested to the committee members of the parliamentary inquiry are also relevant for this senate inquiry. I have copied these suggestions below.

Thank you very much for giving me the opportunity to make a submission to your inquiry. Please don't hesitate to contact me should you have any questions. I would be prepared to come to Canberra if so required.

Kind regards

Christpoh Ahrens

PS: suggestions to parliamentary inquiry:

To: House Standing Committee on Health.

Dear Committee members,

I had a long time to think about the recommendations that I would like to see coming out of this inquiry. I first was not quite sure if it was appropriate to give you my thoughts on this, but I was assured that you would welcome it.

No one would seriously question that foreign doctors should have equivalent standards to Australian doctors. It needs to be defined what these standards are. Currently these standards only include standards of medical educations i.e. comparability of training programs and exams passed. **I think standard of current practice or performance should be added as an alternative.** My feeling would be that a time of let's say five years of independent work at consultant level prior to coming to Australia sounds like a reasonable minimum. Doctors who can demonstrate such experience are probably safe to work in Areas of Need. Further assessment in Australia should then be based on standard of performance in the job here.
For young doctors coming to Australia the current assessment of training programs and exams may continue, but could also be treated more flexible by adding the option of working in a large teaching hospital to verify their standards and skills without having to redo exams.
The above alternative of standard of current practice would not be a breach of terms of reference for this inquiry, as it doesn't question the standards currently existing and doesn't lower standards for IMG's. It will actually make the assessment of standards more relevant and up to date.

For each medical specialty a list of countries should be created where the standard of medical care is equivalent. The emphasis should be on standard of care. Standard of medical education bears the risk that certain Colleges who believe their training is the best in the world can set themselves aside. In the unlikely event that colleges or academies of other leading countries come to the agreement that their Australian counterparts are indeed the best in the world then this claim may stand as substantial.

It will be more important that culture and values in overseas countries are similar as well as good command of the English language in understanding and speaking. I think your inquiry has highlighted this. This is far more important than total equality of how medical knowledge is taught during the training program.

Once a list of such countries has been developed and standard of current practice is added as an assessment tool, then vast numbers of doctors will consider Australia as a destination. This bears the risk of too many doctors coming. **Therefor particularly for specialists a moratorium should continue**. It can be debated how long it should be, but without it there will be a real risk that specialists take up Area of Need positions as an entry into the country and end up in the cities. Which is exactly what you don't need. This is best avoided with an ongoing moratorium of considerable time. Specialists will never be sent to remote areas, as there are no specialist positions in these areas. This is obviously different for GP's. And I can't comment for them. Specialists for rural areas would be preferably of advanced age as they bring a maximum of experience along. It is also likely that they no longer have children in school age requiring quality education, which may be difficult to find in the country. I'm sure there will be enough doctors in their 50th who would consider a life in the beautiful countryside of Australia if they are not scared off to take a ridiculous registrar exam. Your inquiry is full of evidence that there are well functioning doctors of advanced age filling Area of Need positions who find it difficult to work and pass these exams. Contrary there is evidence that doctors may be able to pass exams with support, but then fail to deliver in the job. So if you have doctors that perform well then give them the opportunity to be assessed on their results in the job!!!

Sorry you can probably feel that I'm getting a bit worked up here. I have been confronted with too much #!@?! (Male cow droppings) from RACS.

I would like to propose another recommendation. I think **the monopoly that only fellows of colleges can get registration should be reconsidered**. The MBA has already a rule that a doctor doesn't need to maintain fellowship with a college in order to get registration. However the relevant college needs to state that a doctor has passed all requirements to be eligible to fellowship. Comparability or equivalency to a fellow is currently not enough. I think this should be reconsidered. It may be worthwhile to inquire how New Zealand handles this issue. Apparently the registering body, not the colleges make the decision especially in areas of need.

Last but not least important a **truly independent appeals process like an ombudsman** needs to be put in place. Someone who can make a decision in the interest of the public, independent from interests of organizations, professional bodies, or individuals.

I wish you all will have an enjoyable Christmas time and a good start into the new year
Kind regards
Christoph Ahrens