Submission No. 55
(Overseas Trained Doctors)
Date: 08/02/2011

AMA

AMA submission to House of Representatives Standing Committee on Health and Ageing Inquiry into registration processes and support for Overseas Trained Doctors

February 2011
Canberra ACT

Introduction

The AMA welcomes this inquiry by the House of Representatives Standing Committee on Health and Ageing. It is a timely enquiry. We have had some registration issues manifest in the public arena with serious consequences in the affected community. It is more than two years since new pathways for registration were introduced and it is reasonable to look at the effectiveness of that intervention. Also it is 7 months into the operation of a new national system of medical registration which was a major reform exercise and there are bound to be some teething troubles with such reforms.

The AMA fully supports a robust process of assessment of IMGs and in our submissions to the Government, Medical Boards and others, we have endorsed the arrangements for IMG registration assessment and renewals to ensure only competent and qualified doctors work in Australia.

A recent summit convened by the AMA looked specifically at the issue of medical training. In a joint statement issued after the Summit by AMA, Australian Medical Students Association, the Medical Deans of Australia and New Zealand and the Confederation of Postgraduate Medical Education Councils, the signatories stressed the importance of medical workforce planning and called on Health Workforce Australia to establish a specific Medical Workforce Planning Advisory Committee which could advise Health Ministers on the number of prevocational and vocational training places required.

Implementation of this recommendation will ensure that we get maximum bang for our buck out of the increased medical school numbers and ensure we are able to move to self-sufficiency in medical workforce supply by having the full training pathway supported, for prevocational and vocational training requirements, and we have the option of also providing overseas students who have trained in Australian universities to our standards with intern places in the short term while we are still growing numbers. Overseas students currently don't have this guarantee which wastes the opportunity to benefit from their local training so we continue to maintain our reliance on overseas trained doctors.

AHMC, in 2004, adopted the *National Health Workforce Strategic Framework* (NHWSF) which sets out a range of principles and objectives for the whole of the health workforce and broad strategies for achieving those objectives. The NHWSF is intended to guide national health workforce policy and planning over a ten year time frame. It was developed in consultation with governments, consumers, carers, Indigenous groups, professional organisations, health service providers and the education and training sectors. The framework embodies seven core principles designed to provide 'a simple set of rules, guidelines and aims which allow all stakeholders to apply them to their own circumstances with a minimum of prescription'. The principles include:

1. Australia should focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market.

2. Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.

IMGs have made a very substantial contribution to the Australian Health system particularly over the last 15 years while our own locally produced medical workforce has been in undersupply. The 10 year moratorium was introduced at a time when we thought we were in medical oversupply. It was introduced along with a range of other measures on training numbers and provider numbers, which were a response to oversupply. Ironically we now know it was at precisely that time we were entering undersupply and these measures exacerbated it.

Having created the shortage, of course it was worse in rural Australia. The Government then used the moratorium powers to direct IMGs to rural practice. Given the nature of rural practice with its emphasis on resourceful individualism, generalist medical skills, isolation, lack of supervision and small communities, there could not have been a worse place to send IMGs and it is a tribute to them that they took it on and nearly 40% of the rural workforce are now overseas trained or overseas born. However, it is now time to remove the moratorium.

IMGs haven't provided a resolution to the problems of medical shortages in rural areas. They have stopped a bad situation from becoming disastrous. The fact that we had this mechanism to direct practice for a vulnerable group of doctors has impeded the development of more appropriate long term solutions in which rural positions are filled with Australian medical graduates who are encouraged into rural practice, not conscripted.

Now that we have had a big increase in the number of graduates from Australian medical schools and the number is working its way through to a peak in graduations in the year 2014, it is time to phase out the moratorium requirements as we phase in the new graduates. We also need a Rural Generalist Training Pathway similar to that already in place in Qld which has worked in attracting doctors to rural areas. It needs to be accompanied by incentives similar to the arrangements in Qld or it won't work in the rest of Australia. A key requirement of the Rural Generalist Training Pathway is to ensure there are adequate dedicated Advanced Skills Training posts in rural hospitals to train rural generalists.

If the Government genuinely wants rural and remote Australians to have access to a highly skilled, sustainable medical workforce, then it needs to move away from this "stopgap" policy. Instead, it needs to adopt a much more robust package of incentives and support mechanisms that encourage increasing numbers of locally trained doctors and appropriately skilled IMGs alike to consider a career in rural and remote practice in coming years. The AMA has already identified a range of such incentives including:

- eligibility to get access to Medicare and public education for IMGs and their families, and
- the implementation of the AMA/Rural Doctors Association of Australia Rural Rescue Package, which would provide further enhancements to rural isolation payments, as well as rural procedural and emergency/on-call loadings.

The moratorium provisions were introduced via Section 19AB of the Health Insurance Act. A clear strategy needs to be developed to allow Australia to move away from its unhealthy reliance on Section 19AB as a means of resolving rural and remote medical workforce shortages. With medical school graduate numbers increasing dramatically, Australia has the

potential to encourage additional graduates to consider a career in rural and remote medical practice and correct the maldistribution of the medical workforce.

The best acknowledgement the Government could make of the contribution of the IMGs to the Australian Health system would be to remove the 10 year moratorium. We think they should do so and AMA would be prepared to work with the Government to bring this about in an orderly manner. It would need to be phased out to coincide with the arrival of new medical school graduates already commenced and which peaks in 2014 onwards.

We also acknowledge, that under our proposal to abolish the ten-year moratorium requirements under Section 19AB of the Health Insurance Act 1973, IMGs who have not gained fellowship or do not hold specialist recognition would still be subject to the restrictions under Section 19AA. This effectively means that an IMG without full registration who wishes to receive the higher GP rebates will need to work in an area of need to maintain registration and a district of workforce shortage to be eligible for the higher rebates and these are mostly available in rural and remote areas.

The Government's biennial review of the provider number legislation is required to report on the operation of Section 19AA when it concludes its review shortly. The AMA has made a submission to the review and we have pointed out there is a clear interaction between Sections 19AB and 19AA – when an IMG moves from temporary resident status to permanent residency, they must not only satisfy the requirements of section 19AB, but section 19AA as well. As a consequence, we have taken this opportunity to outline clearly in this submission our position on the ten-year moratorium policy under Section 19AB.

Recommendation 1: The Government should abolish the 10 year moratorium applying to IMGs and work with the medical profession to ensure it is implemented in an orderly manner.

Recommendation 2: The Committee should recommend the implementation of a Rural Generalist Training Pathway with Federal Government leadership and resources to attract the appropriate number of doctors into rural and remote practice.

Recent changes

The Government moved to raise standards and increase national consistency for the recognition of IMGs progressively from 2008. There was an acknowledgement in this that standards had not been appropriate in the past as the composition of IMGs arriving in Australia changed from those countries with similar and familiar medical training to those with different or unfamiliar medical training.

On 1 July 2010, the standards were further changed to provide for national registration and accreditation. What we now have is very much a new system, with new players, new staff, more bureaucracy, less management by the medical profession and a more centralised system. While in time it may improve, there are currently still significant problems for many doctors trying to progress to full registration.

One aspect of this new system was the decision to require the large number of IMGs who had been working for various periods in the Australian health system under temporary registration, to move within three years to achieve full specialist registration. A significant

part of the political impetus for this House of Representatives inquiry arose from this group of practitioners, some of whom have been unsuccessful to this point in time in their attempt to move to full specialist registration.

The decision to require this group of practitioners to move to full specialist registration is supported but the decision has placed a strain on the resources of a newly established registration system and it is not surprising there have been problems. If there was concern about a small number of practitioners who may not have been performing to acceptable standards, it would have been better to prioritise those for conclusive assessment rather than force the whole group to quickly achieve full specialist registration. Also, there are doubts about some of the assessment instruments used to make these assessments such as the Pre-employment Structured Clinical Interview (PESCI).

We have raised these issues with the Medical Board of Australia (MBA) and the Australian Medical Council (AMC). In a letter dated 5 November 2010, the AMA President raised two issues; the appropriateness of some of the assessment mechanisms and instruments that are being used and the capacity constraints of the current assessing bodies which appear to be making it very difficult to deal with the introduction of these assessment requirements for all IMGs currently registered under limited registration for area of need.

On 8 November 2010, the MBA announced that it would conduct a review, which would include these two issues. It would conduct the review in association with the Australian Medical Council (AMC). The Board has advised that it will provide further updates on the review of IMG related issues after it has carried out its preliminary work with the AMC. We deal with these in more detail later in this submission.

The House of Representatives Committee has established three terms of reference and we comment on each of these in the following section.

Terms of reference

Recognising the vital role of Colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs), the committee will:

1) Explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges' assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions;

The Colleges have co-operated with the Government's desire for a national assessment process for overseas qualified doctors to ensure appropriate standards in qualifications and training and to increase the efficiency of the assessment process. This followed on from a 2005 research report by the Productivity Commission into Australia's health workforce and a 2006 COAG consideration of the matter.

A recognised pathway for assessment of overseas trained specialists has always existed, but the Colleges have agreed to remove some of the variability in those processes through the work of the AMC Joint Standing Committee on Overseas Trained Specialists. The outcomes from this deliberation include:

- classifying overseas-trained specialists (in comparison with Australian-trained specialists) as "substantially comparable", "partially comparable" or "not comparable" (previously, colleges had used different terminology);
- allowing those who are considered "substantially comparable" to gain fellowship without the need for further examination (some colleges previously required examination, even for substantially comparable specialists, but now most do not, and the remainder are moving in this direction); and
- allowing assessment of suitability for an area-of-need position and of additional requirements to gain college fellowship to occur simultaneously (previously, this would have required two similar assessments at different times, but now a single assessment can be done at the beginning of the process and any additional requirements highlighted).[1]

The Colleges' assessment panels formed to make decisions about whether the training levels of applicants are substantially, partially or non comparable consist of persons from outside the College and include a jurisdictional representative. In addition, the Colleges all have appeal processes with outside representation.

The College comparability assessment processes are reasonably simple compared to the totality of the registration process and they are reasonably well explained on the relevant websites. It does seem that we have come a long way and if further improvements can be identified, it should be possible to implement them cooperatively.

Some of the impetus for this Committee Inquiry arose from events in Cairns and Townsville described in the Parliamentary debates. The AMA is not able to determine whether the concerns arise from some possible defect in the College processes for handling such matters or from some broader issues affecting medical registration in Australia or because of the actions of certain individuals. We are prepared to be of further assistance to the Committee on these matters if we can.

There are a number of more general issues, which have come to our attention under this term of reference. These include a lack of understanding of the new MBA and AMC processes, duplication in the steps involved, delays in progressing through the system and the sometimes high costs involved for IMGs and others in achieving full registration.

Most of this information has come to us from other primary sources involved in registration issues. The Committee will be able to make a judgement if our observations are consistent with information coming via other submissions to the Inquiry.

There is still uncertainty about the role of each of the bodies involved in the medical registration decisions which includes the Medical Board of Australia (MBA), AMC and the Colleges. There is a lot more AMC involvement now in all registration applications. AMC must verify the qualifications for all applicants and refer these to the relevant international bodies and then to the relevant Colleges for further assessment. AMC conducts the MCQ and clinical exams. Applicants submit the relevant paperwork in good faith with the accompanying fee. If the paperwork does not include all the required documentation, the

[1] MJA 2008; 188(8): 464-468

AMC will request by email the additional paperwork. The applicant provides the additional information and pays an additional fee for the incomplete application.

If the applicant wishes to discuss the process, it is possible to wait 1 hour on the telephone and then receive an incomplete answer. It seems that everything takes 10 days. If an applicant lodges a form and wants to discuss it, a wait of 10 days is required. If an agency wishes to make enquiries on behalf of an applicant an authority to act is lodged which takes 10 days to process.

The processes are funded via user pays so there may not have been sufficient up front investment in trained staff etc and this may be causing some of the delays in responding. It is a very expensive process for the applicants but not a responsive service and there is no alternative provider. Indicative costs for the typical pathways are at **attachment A**. These include costs other than AMC costs.

Some of the documentation such as letters of good standing are repeated for AMC and MBA but by the time it is needed the second time, a new letter of good standing is required due to delays. The second letter of good standing required by the MBA also needs to cover the last 10 years also but these can be difficult to obtain from the relevant authorities in other countries. On arrival in Australia the IMG is required to undertake a police check as part of registration with the MBA, even though they may have never lived in Australia. It would be more sensible to require production of a police clearance from the country of origin available on arrival or a police clearance in Australia and an Australian clearance on reregistration 12 months later.

Videoconferencing is not routinely available so travel is required for applicants needing to attend interviews. Interview availability is limited and the results of interviews are not communicated quickly leading to delays in subsequent stages of the process such as visa applications.

The introduction of national registration and accreditation has led to increased delays in handling applications for registration by the MBA also and these applications involve higher costs for applicants. The AMA has received advice from British Medical Association stating that potential UK applicants are being deterred from applying because job offers lapse before registration paperwork can be processed. UK applicants should be among the simplest applications for registration given that we recognise the qualifications of UK applicants. This would indicate the AHPRA processes have not yet settled down. We need these doctors but they are not able to be recruited.

There have been some celebrated recent cases (Dr Patel) of which we are all anxious to avoid repetitions. We understand this is driving a culture of defensive regulation where individuals are not prepared to make decisions without matters being referred up the line, and for policy to be cleared by Ministers etc. This makes the whole process slower and there is a sheer volume of work factor which is also making timely decision making difficult.

We also recognise that delays can occur on the part of applicants. All the documents involved have to be original or certified copies and they have to be transmitted by post rather than fax or email again to guard against fraud and impersonation. However, this can lead to delays imposed on applicants by the process but also attributable to applicants and it would be useful to understand the relative contributions to these delays.

We recognise that a lot of effort has gone into educational material to assist applicants and others to understand the process. There is information on the Doctor Connect website and both AMC and MBA have extensive material on their websites. The Colleges describe their assessment and appeal processes to varying degrees, some such as RANZCOG are well described. What is not clear is whether the material is found to be useful by the people who use it.

Recommendation 3: Introduction of a requirement for public reporting of the time taken to achieve registration via the various categories/pathways (with IMG identified as a separate group to be reported on) and the costs involved so that policy makers can intervene if there is an issue emerging. In an environment where monopoly regulators exist, it is a reasonable step towards better accountability. This should lead to the development of a service charter setting out maximum timeframes for the completion of applications and the creation of an independent complaints body to look at cases where the timeframes are not met.

Recommendation 4: That MBA and AMC be required to consult with stakeholders such as registrants, workforce agencies and relevant membership organisations on a regular basis and to identify what the problems are and develop solutions. This could also be a forum for discussion of the appropriateness of educational materials leading to improvements being made.

2) Report on the support programs available through the Commonwealth and State and Territory Governments, professional organisations and colleges to assist OTDs to meet registration requirements, and provide suggestions for the enhancement and integration of these programs; and

Generally speaking those medical practitioners seeking registration via the Competent Pathway require minimal support. Medical Practitioners attempting to achieve full Specialist registration via the Standard Pathway especially those seeking specialist registration as a General Practitioner do require support.

The Government fully funds up to 1200 GP training places through GPET for doctors wishing to be specialist GPs and who have general registration and permanent residency. These doctors undergo well supported and resourced training programs through regionally based training providers leading to Fellowship of RACGP or ACRRM and unrestricted practice.

There are three categories of IMGs wishing to achieve GP Fellowship and unrestricted practice who could be better supported with good effect. There are IMGs who have not been able to pass the AMC clinical examinations and therefore have not been able to secure permanent residency and so are not eligible for entry to GPET programs. There are IMGs who have passed AMC clinical examinations and have permanent residency but have not been able to achieve selection into the GPET stream of GP training. They may not have been able to achieve this because they are less competitive due to language and other issues. The third category is doctors undertaking the standard pathway independently towards Fellowship of RACGP or ACRRM again not via the GPET path.

Support is needed to help the doctors in these three streams to achieve Fellowship and specialist registration with unlimited practice rights. Given the different circumstances of the doctors in the three streams, the first step would be a needs assessment. Once this has been done, we would hope that the majority of those needs can be met by giving the doctors access to GPET training provider resources and programs. This would need to be done in a way which did not prejudice the interests of the GP Registrars in the GPET program itself but AMA believes this could be achieved

It is unlikely that the needs of the doctors in the three streams mentioned are very different to those of the GP Registrars selected into the GPET program so that they could be met from existing resources. The IMGs in these three streams lack access to educational networks and peer support groups to share knowledge and experience and a decision to allow access to the resources of the GPET training providers would create those networks in addition to the education and support directly provided.

Access to the regional training providers would assist with clinical training, preparation for exams, language training support, etc which are likely to be issues high on the list of needs. There may need to be limits to ensure the GP Registrars on the GPET program are not negatively affected.

If such access could be achieved, it would give the MBA, and if required AMC, other options to help progress applicants towards the Fellowship rather than terminate their registration. It is inappropriate to terminate the services of a medical practitioner who is or can make a valuable contribution simply because no other options have been developed.

It is support we are suggesting, not a reduction in standards. Fellowship, or the equivalent of Fellowship, is still the end point for everyone.

Recommendation 5: that the Committee recommends the opening up of existing training resources, already funded by the Federal Government, to IMGs in the three streams identified above in order to help them achieve full specialist registration.

The above comments relate to General Practice but exactly the same comments can be made about other specialist practice. There is no equivalent to the Federally funded GPET for other specialist practice and the Colleges need to rely on the resources of the public hospital system to meet the training needs identified for partially comparable specialist IMGs working towards Fellowship and specialist registration.

The Colleges do not have the resources available to establish fully tailored bridging and mentoring programs for IMGs and the cost of doing so on a user pays basis would be prohibitive. There may be a role for greater Federal support for the Colleges to develop such programs which is a matter the Committee may wish to pursue with the colleges.

3) Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies.

National registration has introduced a range of new, nationally consistent standards for limited registration for IMGs, including a standard for limited registration for postgraduate training or supervised practice and a standard for limited registration for area of need.

The interaction between the registration requirements, visa requirements and provider number requirements is complex and delays at any point in any of these processes can be cumulative, with all of the processes needing to be done within the right timeframe and in the right order before the IMG can begin working. Some parts of this complex process cannot be initiated until the doctor has arrived in Australia and until other parts of the process have been completed. These are often the very doctors who our 'area of need' communities need to start work urgently so as to ensure ongoing medical services are available.

Some barriers are not directly related to registration. Because IMGs lack permanent residence, they may not have access to Medicare entitlements or equal access to education entitlements for their children and they cannot access social welfare support. Some even find it difficult to establish mobile phone contracts with telephone providers. They are asked to perform in the most difficult medical environment with little medical and peer support but also no support for their own or their family's medical and educational requirements. The Committee should examine these issues and other barriers experienced by IMGs.

The main registration related impediments for IMGs are the introduction of a changed and tougher system combined with the expectation that a very large group of IMGs who have only achieved limited registration can progress through this new system to achieve full registration within a tight timeframe while working full time in busy practices. Many of these practitioners are working in communities where their services are highly valued and in high demand.

For medical practitioners working in areas of need with limited registration needing to move to full registration or to work in another location, an aspect of their assessment by the MBA now may involve the Pre-employment Structured Clinical Interview (the PESCI). As stated earlier, the AMA has raised with the Medical Board of Australia whether the PESCI is the right tool for the job. AMA believes this is an issue that can be examined by the MBA in the review it has already announced. While the PESCI is used for initial pre-employment assessment of a doctor for a particular job, prior to initial registration, as an assessment after that time it may not be the most appropriate tool to use. A PESCI test is a pre-employment evaluation, looking at whether the applicant is able to do a particular job. It is not a detailed performance assessment of the medical aptitude and performance of the doctor.

It should not lead to the immediate cancellation of the temporary registration of an applicant providing a valuable service in a community but instead, identification of needs in order to achieve registration and the support necessary to reach those needs.

The effective operation of Section 3GA of the Act requires fair, transparent, consistent, appropriate and timely assessment of IMG qualifications and experience by employers, the AMC, the MBA, Medicare Australia and the Commonwealth Department of Immigration.

It can be a complex process to get all of the regulatory requirements in place at the right time and in the right order. An additional complexity has now arisen as a result of new national registration arrangements introduced from 1 July 2010.

There are some administrative requirements under national registration now imposed that may not have been required in the past by some jurisdictions. These are proving troublesome for the first tranche of IMGs seeking assessment through the new national arrangements. These include:

- a requirement to meet new English language standards (which has been the source of some complaint by applicants across a number of registered health professions), and
- an inflexible requirement to provide statements of good standing from previous registration authorities. Some current applicants are reporting it is not possible to obtain these from authorities in their former countries, especially those who come from countries with less organised systems or unstable governments.

Other early concerns under national registration relate to the MBA's difficulty in processing applicants in a timely manner, particularly for IMGs whose applications were caught in the transition from state-based medical registration to national registration on 1 July 2010. The AMA acknowledges that the board's processes are gradually improving as the new administrative processes are further consolidated.

The AMA continues to fully support a fair and robust registration and renewal assessment process for IMGs, to ensure that only competent and qualified doctors can work in Australia. However, a review of current arrangements is needed to ensure that we have fair and appropriate assessment arrangements that do not prejudice these doctors or the communities they work in or seek to work in.

The MBA needs to examine the requirements and administrative processing arrangements for IMG applications, in consultation with stakeholder groups, and re-examine the appropriateness of some of the requirements for IMGs and the administrative processes in place for assessing their applications. The AMA has welcomed the MBA's recent announcement that it will work with the AMC to determine the terms of a review of the assessment pathways for IMGs.

Recommendation 6: that there be a rigorous examination of the appropriateness of the instruments used to assess and re-assess IMGs for registration and re-registration of doctors currently working in Australia. As part of this process, it is recommended that IMGs, with limited registration, who have been working in Australia for 5 years or longer, who may be presently required to do a PESCI, be assessed in a more appropriate manner while the review is being undertaken.

Concluding remarks

These are important issues. The entry into the workforce of the newly trained Australian medical graduates is an opportunity to release IMGs from a very heavy burden of practising medicine in one of the most difficult environments possible without the level of support they deserve.

The AMA is not advocating a lowering of standards but a recognition of a significant contribution in difficult circumstances and now a chance to take a place in the Australian health system on an equal footing through the abolition of the 10 year moratorium. In doing so, we indicate a willingness to work with the Government to ensure a satisfactory transition

to the post moratorium environment which includes of necessity a Rural Generalist Training Pathway with appropriate Federal Government leadership and resources.

AMA also strongly supports extending the existing GP training infrastructure to IMGs needing assistance to meet AMC clinical requirements, needing support to achieve selection to the GPET training program or needing support to meet the College Fellowship requirement independently.

AMA believes there is a need for consultation by the regulators with the IMGs, workforce agencies and the relevant membership organisations to improve mutual understanding and smooth out obstacles, which are always present in new systems.

We would be happy to present further evidence to the committee.

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Federal AMA
Canberra
February 2011

Attachment A

Registration Pathways - Breakdown of Fees Involved

Competent Authority Pathway	
Australian Medical Council	
Assessment for Advanced Standing for the AMC	$600
Assessment of workplace-based performance (12 months supervised practice)	$275
EICS Verification	$230
Visa/Sponsorship (457 Visa)	
Sponsorship Application Fee	
Visa Application Fee (exclusive of costs relating to Medicals and Penal Clearance)	$260
Medical Board Registration	
Initial Application Fee	$650
Pre Employment Structured Clinical Interview	$1,500
Annual Registration Fee	$650
	$4,165
RACGP Pathway - Category 1	
Australian Medical Council	
Preliminary application fee	$285
EICS Verification	$230
Royal Australian College of General Practitioners	
Application Fee for Categorisation Process	$195
Membership Fee (Annual Fee)	$995
Application processing fee for Fellowship Ad Eundum Gradum	$350
Visa/Sponsorship (457 Visa)	
Sponsorship Application Fee	
Visa Application Fee (exclusive of costs relating to Medicals and Penal Clearance)	$260
Medical Board Registration	
Initial Application Fee	$650
Annual Registration Fee	$650
	$3,615
RACGP Pathway - Category 2	
Australia Medical Council	
Preliminary Application Fee	$285

EICS Verification	$230
Royal Australian College of General Practitioners	
Application Fee for Categorisation Process	$195
Fitness for Intended Clinical Practice Interview (FICPI)	$1,500
Membership Fee (Annual Fee)	$995
IMG Liaison Support (Annual Fee)	$1,740
RACGP Fellowship Examination	$5,910
Visa/Sponsorship (457 Visa)	
Sponsorship Application Fee	
Visa Application Fee (exclusive of costs relating to Medicals and Penal Clearance)	$260
Medical Board Registration	
Initial Application Fee	$650
Annual Registration Fee	$650
	$11,900

Standard Pathway	
Australian Medical Council	
Non Specialist Pathway Fee	$230
AMC MCQ	$2,100
AMC Clinical (if applicable)	$2,850
EICS Verification	$230
Visa/Sponsorship (457 Visa)	
Sponsorship Application Fee	
Visa Application Fee (exclusive of costs relating to Medicals and Penal Clearance)	$260
Medical Board Registration	
Initial Application Fee	$650
Pre Employment Structured Clinical Interview	$1,760
Annual Registration Fee	$650
	$8,730

Please Note:

Fees excludes any visa / travel costs to Australia to undertake interviews etc that may be required by College or MBA