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Inquiry into Registration Processes and Support for Overseas Trained Doctors

February 2011

Contents

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Executive Summary

The Western Australian Department of Health (DoH) welcomes the Inquiry by the House of Representatives' Standing Committee on Health and Ageing into registration processes and support for overseas trained doctors (OTDs; more recently classified as international medical graduates [IMGs]). These medical practitioners contribute greatly to health service delivery in Australia. Rural Western Australia (WA) reports that more than 52% of the workforce has primary medical qualifications obtained overseas.

The diverse medical training and experience of IMGs necessitates rigorous and nationally consistent assessment processes to ensure these doctors are able to provide the safe standard of care expected within the Australian health care system. The current processes are time consuming, complex, and expensive, and an opportunity to review their efficiency without increasing risks to the safety or quality of health care delivery is appreciated.

WA relies on general practitioners (GPs) working in private and corporate practices in the rural and remote towns to deliver primary health care and hospital services. With the introduction of the national assessment of IMGs, however, there is now a real difficulty in recruiting new doctors to rural WA:

- Historically, around 195 IMGs come to live and work in rural WA annually; in the 2009/10 period, only 50 commenced work.
- Rural Health West (RHW) report 67 vacancies in rural general practice.
- As at 28 January 2011, the WA Country Health Service (WACHS) was actively seeking to recruit to 24 permanent vacancies.

DoH has consulted the Postgraduate Medical Council of WA (PMCWA), WACHS, WA General Practice Education and Training (WAGPET), Australian Medical Association (AMA), and RHW, and identified a number of issues that impede the recruitment process for IMGs:

(1) **Length.** Experience demonstrates it may take 5–24 months for an IMG to commence working in WA. This is exacerbated by the many professional and legal requirements required to obtain medical registration, with delays and inefficiencies at each step of the process. When an IMG is appointed to a position, the service is forced to employ locum practitioners to fill the gap whilst the IMG progresses through the process. Whilst this is expensive, it also prevents the permanent appointment of another practitioner who may be more suitable.

(2) **Complexity.** An IMG navigating the current process for national registration is required to provide many documents to varieties of organisations. DoH and other agencies have employed specific personnel and set up information resources to support IMGs, but this is not enough. Better communication is required between the agencies, and privacy factors need addressing so that data can be shared between organisations and the IMG is not forced to resubmit documents if one agency has 'lost' the data.

(3) **Expense.** As detailed in following pages, there is significant cost borne by the IMG and the employer when appointing an IMG. This includes retention activities and support for IMGs to meet the requirements for general registration.

Recommendations

This Submission makes the following recommendations:

(1) Implement benchmarking of specialist college assessment processes.

(2) Establish a centralised, coordinated, and integrated national mechanism for provision of information to prevent unnecessary duplication.

(3) Conduct a targeted awareness campaign to provide potential IMGs and employing agencies a greater understanding and awareness of registration processes.

(4) Improve accessibility to the Australian Medical Council (AMC) Clinical Examination, and provide greater support for IMGs to prepare for examinations to increase the percentage of them who pass on the first attempt.

(5) Improve accessibility and support for IMGs to enroll in Workplace-Based Assessment (WBA).

(6) Allow recruitment of IMGs to 'pool' positions, so that when registration is received they are appointed to the position most needed by the service that is suited to their skills and experience.

(7) Accelerate processing of documents.

1. Introduction

Whilst the numbers of students graduating with Australian medical qualifications are growing in WA, low numbers of experienced junior doctors and even lower numbers of senior doctors will see the reliance on IMGs continue for the short and medium term future.

In preparing this Submission, DoH has engaged in a statewide consultation of WA-based organisations involved in recruitment of IMGs. The Submission outlines areas of potential improvement in the recruitment process, emphasising those aspects particularly relevant to WA, and makes recommendations for addressing these issues. Analysis has revealed that the process is long, complex, and expensive for all parties concerned.

1.1 The need for more doctors

Australia has a shortage of medical practitioners. WA is particularly reliant on IMGs, being the largest jurisdiction by geographical size, with its population dispersed across more than 2.5 million sq km of primarily rural and remote areas. A report from 2009 indicated that 52% of doctors in WA's rural medical workforce obtained their primary medical qualifications overseas.[1]

Commonwealth and State/Territory governments have planned, and are implementing, strategies to address this shortage. In particular, governments have recognised that it is vital for Australia to build a sustainable, Australian-trained medical workforce. It takes many years to train a doctor, with up to six years of university training (student), two to four years of prevocational training (junior doctor), and several years of vocational training (registrar) before someone may qualify as a specialist (consultant).[2]

Given this ongoing reliance on IMGs, it is paramount that registration processes be robust, easily navigated, and timely to complete.

1.2 Registration

In 2006, the Council of Australian Governments (COAG) agreed to implement Nationally Consistent Assessment Processes (NCAP) for IMGs. The AMC developed four pathways to registration for IMGs:

- Competent Authority Pathway.
- Standard Pathway.
- Specialist Pathway.
- Area of Need (AoN) Specialist Pathway.

1.3 Current status

In 2008/09, the Department of Immigration and Citizenship (DIAC) granted 4,080 visas to IMGs across three main visa subclasses (422, 442, and 457).[3] One fifth of applicants were from the United Kingdom, and there were also a significant proportion from Asian countries, particularly India. Of the IMGs applying for visas in 2008, 39% were assessed through the competent authority pathway, with 81% of that sub-group issued with advanced standing. That year, applications from 1,760 overseas trained specialists (OTSs) were processed. Of

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1 Rural Health West (2010). *MDS report and workforce analysis: 30 November 2009*. Perth: Author.

2 First-year undergraduate medical students today could only expect to qualify as specialists 12–15 years from now.

3 Medical Training Review Panel (2010). *Medical Training Review Panel 13th report* (p. 61). Canberra: Author.

those OTSs, 12% had their qualifications approved and a further 25% were deemed as needing further training or examinations.

In a 2010 DoH audit of medical specialists in public hospital settings,[4] IMGs accounted for between 23–33% of the specialist medical workforce in WA, as shown in the table below.

Table 1: Proportion of OTSs in selected disciplines in the WA public health system

Speciality	OTS	AoN determinations	Specialist per 100,000 Population (WA)	Benchmark in literature (Specialist per 100,000)
General Medicine	33%	6	3.9	5.0
General Surgery	25%	2	4.8	7.6
Orthopaedics	23%	4	3.9	4.1
Geriatrics	33%	6	17.3	4.2

At the time of audit, there was a large proportion of OTSs who held conditional registration with the Medical Board of Australia (MBA) or were employed under an AoN determination. IMGs in these situations require the greatest support to obtain full registration to allow them to work as fully integrated members of the health workforce. In rural WA, almost 100 IMGs have been identified who are not vocationally registered and who are not receiving assistance from any support scheme. Two-thirds of these IMGs were rural GPs.

2. Issues with registration processes

2.1 Length

Currently, an application to the AMC takes at least 10 days to process, and during that period no queries about the application are accepted. If there are any changes made, a gap payment of $110 and a further 10 days of processing apply. Delays can occur if there are problems with verifying qualifications issued in languages other than English. Administrative processes need to be streamlined to minimise delays.

The many professional and legal requirements required for IMGs to obtain registration in WA has resulted in delays of up to 24 months from interview to commencement of work. The unpredictability in time frames places additional pressure on the employer, who is forced to contract locum practitioners to fill the gap whilst the IMG progresses through the process. This solution is expensive, and it may not deliver the high standard of service and continuity desired by the employer.

The need to maintain position availability is a requirement of DIAC. To obtain the necessary 457 working visa the employer is required to demonstrate a contract for the exact position in the exact location the practitioner is required to work. This prevents the appointment of another practitioner, in the meantime, who may be available and more experienced. When registration processes delay arrival, the service is forced to 'fill the gap.'

Stakeholders are keen for this limitation to be reviewed. Ideally, IMGs should be interviewed and appointed to a position based on their skills and experiences. This position could be at a variety of sites within the service. When IMGs complete the processes of registration and immigration, they could then be appointed to the region/site most in need of the skills and experience of the medical practitioner.

[4] WA Department of Health, Medical Workforce Branch (2010). *Specialist and Generalist Workforce Capacity project.* Perth: Author.

2.1.1 General registration

IMGs who gain registration as medical practitioners through the standard pathway have four years in which to gain general registration. This is via two methods:

(1) Clinical examination: There is currently an 18–24 month delay for applicants seeking to sit this exam. There have been steady increases in the number of exam places and variety of sites these tests are held, but high rates of failure indicate IMGs are not well supported to pass this exam on the first attempt. Each attempt requires progressing through the 'wait' period and additional financial imposts.

(2) WBA: There are currently four trial sites across Australia for IMGs, with approximately 15 places at Bunbury Regional Hospital in WA. There are many impediments for IMGs achieving general registration via this pathway, including:

- Costs associated with creating extra positions at trial sites to facilitate assessment.
- Relocating the IMG and family to allow the IMG to work out the 12 months necessary to complete the WBA program.
- Backfilling the IMG, who may be on secondment from rural or remote areas who are dependent on the services provided.

While a number of these IMGs receive support directly from employers, there is a need for additional funded programs to be established to provide high quality, appropriate training opportunities to facilitate the required educational experiences for IMGs, and specifically for GPs working in rural or regional WA.

2.1.2 Impact of AHPRA

The Medical Board of Western Australia (MBWA) managed all medical registration issues in WA before November 2010, at which time these responsibilities were handed over to the Medical Board of Australia (MBA) via the Australian Health Practitioner Regulation Agency (AHPRA). There was greater flexibility in resolving case-by-case issues prior to this transition. Difficulties in communicating with AHPRA and MBA have increased the length of time required for difficulties to be resolved and the registration processed.

2.1.3 Specialty Colleges

Inconsistencies in college assessment processes are confusing for both IMGs and their employers. Some colleges administer a standard of assessment for OTSs as the standard required for admission to the relevant specialist medical college as a Fellow. Other colleges, such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP), pitch the exam for IMGs at an experienced psychiatrist level. This places consultants practising in AoN positions at a distinct disadvantage when compared to other specialist groups.

The rate of failure in clinical examinations at various colleges is much higher for IMGs than for Australian-trained doctors. For example, only 48% of OTSs taking the Royal Australasian College of Surgeons (RACS) Fellowship examination pass, compared to 70% of Australian and New Zealand-trained doctors.[5] This highlights the urgent need to provide additional support to help IMGs work towards general registration.

Inconsistencies also exist in the time it takes colleges to assess an IMG applicant. This may be due to different schedules for board meetings, but there should be more communication and greater transparency with organisations to allow faster processing of applications.

[5] Webster, D. L., & Ellison, A. (2010). International medical graduate surgeons progress towards full specialist certification in Australia: Barriers and facilitation. *ANZ Journal of Surgery*, *80*(1–2), 8–10.

The provision of accurate statistical data about specialist assessment outcomes would benefit State/Territory health departments by ascertaining the number of substantially, partially, and non-comparable candidates assessed. This information should then be made publicly available for benchmarking of all college assessment processes, and to assist in medical workforce planning and recruitment.

2.1.4 Training

IMGs who gain registration as a medical practitioner via the competent authority or standard pathways and secure a position within the Australian health care system are unable to gain access to specialist training places until they achieve permanent residency. Stakeholders would like to see entry to specialist training places based on merit and service needs and to see that IMGs are not discriminated from accessing further training based on visa status.

2.2 Complexity

The processes involved in recruiting and registering IMGs is a long, complex, and expensive undertaking which can be a deterrent for IMGs seeking to work in Australia. Administrative contact with some or all of MBA, AHPRA, AMC, DIAC, and specialist colleges may be needed, as well as close coordination with the employing organisation.

There is no single, clear, easily accessible path that an IMG and employer must take, which is particularly problematic for local governments or small medical practices which are not familiar with the system or not resourced to investigate the process. In WA, employers have dedicated staff to coordinate employment of IMGs.

The figure on the following page summarises the recruitment process based on WACHS experiences in 2010.

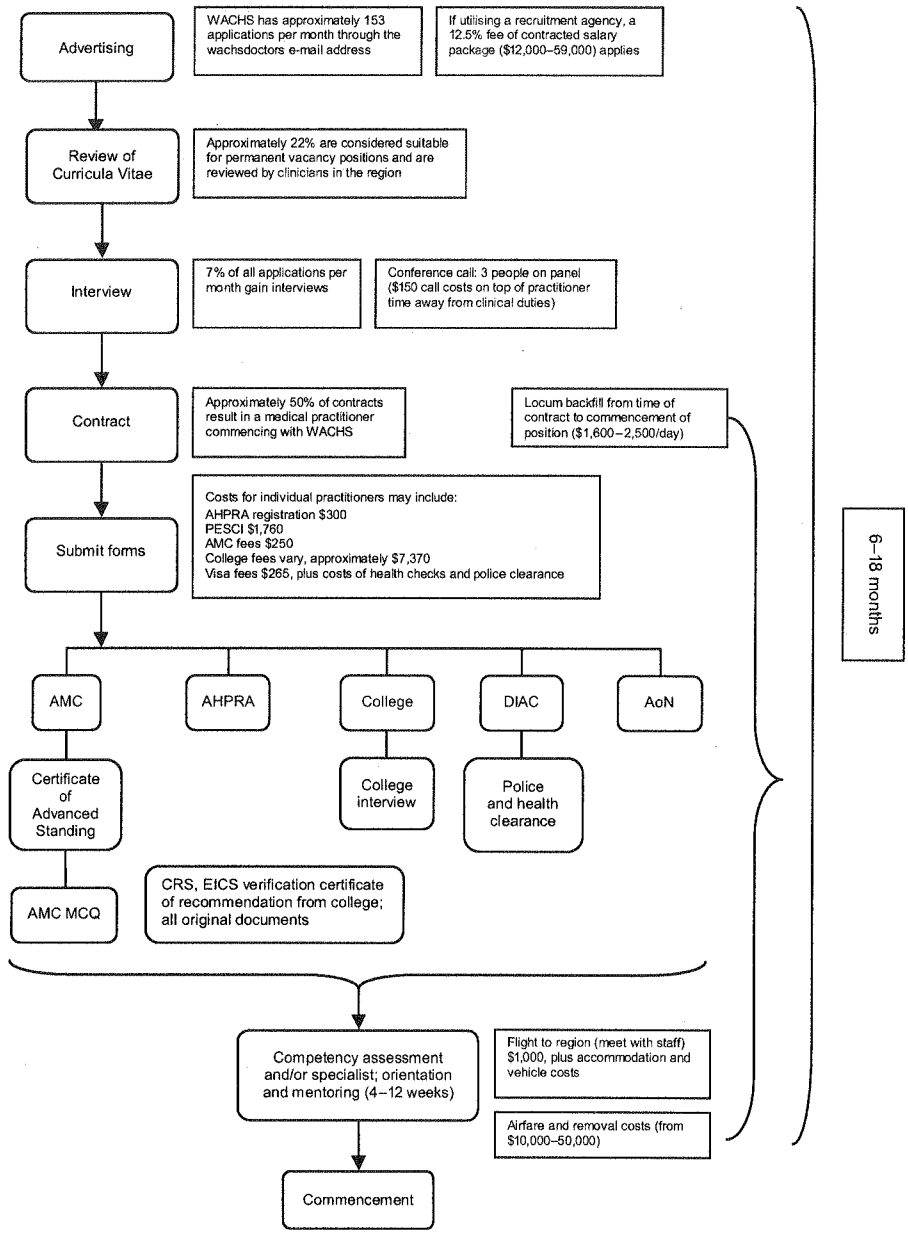

Figure 1: WACHS recruitment of IMGs, as at December 2010

AHPRA supports MBA, and several other professional boards, in implementing the National Registration and Accreditation Scheme (NRAS). WA was the last State/Territory to engage with AHPRA, and the transition from MBWA to MBA has been problematic—the new processes do not yet have the clarity and efficiency of the well-established processes under MBWA. Currently, there are discrepancies in the processes required for registration of IMGs, including the presence of both old and new forms to complete and the difficulty of establishing telephone contact with AHPRA.

Stakeholders identified duplication in processes in submission of forms and expressed frustration when hearing reports of IMGs who were required to complete an entire new application because their documents were not notarised by the same public official.

It was identified that Criminal Record Screening (CRS) is completed initially to meet purposes of immigration, again to meet purposes of AHPRA, and a third time to meet employment purposes, simply because the information is not shared.

In order to appoint an IMG to a vacancy, the employer must demonstrate that the position is designated as AoN. In order to obtain AoN status at a state level, the position must be categorised as within a District of Workforce Shortage (DWS).

DWS is not the best measure of need for rural areas. McGrail and Humphreys (2009) have noted: "An area's DWS status reflects whether the ratio between population size and the number of services provided within an SLA is below the national average. It should be noted, however, that its value is questionable because population-provider ratios are a poor measure of access, particularly for 'small' rural areas and its dichotomous definition does not allow small areal variations to be detected."[6] For example, people from outlying towns coming in to a larger regional centre for medical attention will make the practical population catchment of that centre's DWS area bigger than what is used to calculate DWS.

Other factors that may affect DWS determinations are how many GPs work in surrounding areas and what responsibilities they hold (e.g., duties in hospitals, nursing homes, or mining sites). Rural WA cannot be equitably compared with most other jurisdictions due to its significantly greater geographical size, with many isolated towns' health service needs being serviced by doctors based at larger regional centres. Currently, as soon as a centre gains enough doctors to provide supervision, it loses its DWS status, which means that an IMG cannot be recruited into the surrounding areas and have the required supervision.

DWS is administered by the Commonwealth, which may not understand the 'hub effect' whereby a number of doctors service surrounding areas rather than having individual doctors in a location with no support. At times, DWS status has been removed from sites without warning without a realisation that these doctors are providing necessary services to a much larger catchment area.

2.3 Expense

The costs of recruiting IMGs should be measured in both time and money. Recruiting an IMG is a labour-intensive process, and often potential recruits withdraw from the appointment due to the difficult process.

The financial cost of these processes has been estimated at $300,000–500,000 per IMG recruited to work in rural WA. These costs include recruitment agencies' fees, the cost of a locum to fill the position until the IMG can start work, airfares, relocation costs, interviews, and registration fees, as shown in the table below.

[6] McGrail, M. R., & Humphreys, J. S. (2009). Geographical classifications to guide rural health policy in Australia. *Australia and New Zealand Health Policy, 6*, 28.

Table 2: Estimated costs involved in recruiting an IMG to work in rural WA

Stage	Cost
Recruitment agency fees (minimum 12.5%)	
Junior doctor	$12,000
Registrar	$53,000
Consultant	$59,000
Locum fees (average of $1,600–2,500 per day)	
Locum on Medical Services Agreement while IMG takes position	$208,000–325,000
Locum agency fees	$26,000–40,625
Employment interview	$150 + costs of panel members
Registration fees	$1,300
Pre-Employment Stuctured Clinical Interview fees	$1,760
AMC fees	$225
College fees	$6, 040 – $ 7,240
Visa fees	$265 + costs of health checks and police clearance
Airfare and removal costs	From $10,000 - $50,000
Car hire and airport pickup	$432 + accommodation
Total	**$256,000–486,000 conservatively**

In at least one case, where an IMG was recruited to work in rural WA, costs came to almost $550,000. The table below outlines the costs incurred for recruitment of a specialist in 2008.

Table 3: Actual costs involved in recruiting an OTS to work in rural WA

Stage	Cost
IMG's first visit to region	$1,500
AMC assessment fee	$225
College assessment fee	$7,000
College interview	$1,500
Pay during three months initially based at a metropolitan hospital	$115,000
Locum fees for 18 months	$1,000,000
Locum's housing	$8,000
Locum's vehicle	$15,000
Less staff salary	-$600,000
Total	**$548,225**

This case involved not only a large financial cost, but also a significant time investment, as evident in the following timeline:

(1) June 2007 – position advertised.

(2) September 2007 – IMG interviewed for position.

(3) November 2007 – contract offered.

(4) December 2007 – contract accepted; locum commenced in role, as incumbent resigned.

(5) January 2008 – IMG visits regional hospital.

(6) February 2008 – AMC application commenced.

(7) May 2008 – AMC gives approval for College to begin assessment of qualifications.

(8) May–September 2008 – Documents collated to support assessment by College.

(9) October 2008 – College assessment undertaken.

(10) January 2009 – IMG approved to commence three months of practical experience at a metropolitan hospital.

(11) April 2009 – Practical assessment concluded.

As this case demonstrates, there are significant costs to the health system in the recruitment of IMGs. It is in the best interests of the employer (in this case, the WA State Government) to invest in ensuring that employees (IMGs) are valued and continuing members of the local workforce and community. To achieve this, support must be provided to encourage and support IMGs in their movement towards general registration and becoming a vocationally registered member of the medical workforce. DoH and other agencies have employed specific personnel and set up information resources to support IMGs, but more support is needed.

3. Recommendations

(1) Implement benchmarking of specialist college assessment processes.

Colleges should clearly articulate the process and documentation required for IMGs to obtain full college recognition.

All colleges should be uniform with their requirements for AoN IMGs to enable the employer to better assist the IMG with application for consideration of AoN position.

The colleges should invest capacity to better support AoN IMGs to meet college requirements of full registration. IMGs employed in AoN positions are often the most professionally isolated, with limited access to peer review, clinical audits, workshops, and other professional development opportunities necessary for preparation for exams.

Colleges should agree on acceptable pass requirements. For example, WACHS AoN psychiatrists have experienced great difficulty meeting RANZCP requirements as they indicate their exam is set at the experience and knowledge of an experienced Australian trained practitioner, not at that of an entry level specialist (as is the standard set by other colleges).

There no accurate statistical data available about specialist assessment outcomes, therefore State/Territory health departments have no information to ascertain the number of substantially, partially, and non-comparable candidates assessed. This information should be made publicly available for benchmarking of all college assessment processes, and to assist in medical workforce planning and recruitment.

(2) Establish a centralised, coordinated, and integrated national mechanism for provision of information to prevent unnecessary duplication.

The current process requires IMGs to prepare information and have original copies notarised several times in order to meet the requirements of the various professional bodies in their quest for national registration. Providing a repository for IMG applicants' documents on a centralised database that is accessed by professional bodies, such as the AMC, specialty colleges, and AHPRA, would allow consistency and accuracy of the information received by each organisation. This would minimise the paperwork and

complexity surrounding an IMG application and reduce the time wasted in repeated independent applications. Better coordination and clarity around the roles and responsibilities of the various parties and easier access to information would improve the process. Currently an IMG seeking to work in WA is required to meet criminal record clearance for DIAC, for AHPRA, and for the employer, as no agencies are allowed to share the results.

(3) Conduct a targeted awareness campaign to provide potential IMGs and employing agencies a greater understanding and awareness of registration processes.

There is an identified need for enhanced communication regarding all assessment pathways for IMGs and the various roles of each stakeholder. This would prevent duplication of information provision by the IMG, and allow employers to better prepare for the appointment of an IMG.

A public awareness campaign by the Commonwealth Government would also be beneficial to promote greater understanding of the role IMGs provide to the national health care system, particularly in remote and rural regions. Doctors, employers, and the general public can be influenced by adverse media coverage if it is not balanced by the provision of positive information.

(4) Improve accessibility to the AMC Clinical Examination, and provide greater support for IMGs to prepare for examinations to increase the percentage of them who pass on the first attempt.

There is an issue around wait time for those wishing to sit the AMC Clinical Examination, currently at 18–24 months. This causes enormous difficulties for IMGs seeking to join training programs or obtain general registration within the four years required by national legislation. The wait time may be able to be reduced and the exam format reviewed to reduce the difficulties faced by IMGs waiting to join college training programs and/or obtain general registration.

Better preparation of IMGs to pass the required exam/assessment at first attempt would be a good investment of funds. Support could make use of web-based and real-time technology and point-to-point education tutorials linking individuals and groups to share experiences.

Introducing additional subsidies for travel and attendance at courses, more funding for educational resources, more positions for trainers and educators, and funding for locum backfill would all facilitate better study opportunities for IMGs, and thus, greater likelihood of obtaining full registration and being able to address community health care needs sooner.

(5) Improve accessibility and support for IMGs to enroll in WBA.

WBA programs, an alternative route to the AMC Clinical Examination to general registration, are being piloted in a number of jurisdictions, but have not yet been implemented on a national basis and will not reduce waiting lists for the AMC Clinical Examination in the short term. Rolling out these programs nationally will necessitate hospitals being able to provide more resources for the associated training and assessment needs. Resources and support are required to backfill the IMGs employed in rural areas to allow the individual and family to relocate to the WBA site in order to meet requirements for general registration, whilst also allowing service delivery to continue in the rural site.

(6) Allow recruitment of IMGs to 'pool' positions, so that when registration is received they are appointed to the position most needed by the service that is suited to their skills and experience.

A large drawback for employers appointing IMGs is the delay in commencement necessitated by national registration, immigration, and relocation. Whilst the position has been 'promised' to an IMG, the employer cannot re-offer the position to another medical practitioner (even if the more recent practitioner is Australian-trained, more experienced, or will be available sooner). The service is required to backfill the 'promised position' with a locum. Large employers, such as WACHS, can guarantee that permanent vacancy for suitable IMG medical practitioners based on service need and uniform rates of attrition. It would be extremely sensible if, in appropriate circumstances, the employing agency could interview and appoint successful IMGs with necessary skills and experience to a 'pool' position. This would mean that they are successfully appointed, and as soon as they obtain national registration and are able to relocate to WA, they would be appointed to the next available position that suits their skills and abilities.

(7) Accelerate processing of documents.

AHPRA and the AMC both have a high load of administrative work with the increasing numbers of IMGs migrating to Australia, so any measures taken to accelerate processing of documents by these organisations would accelerate assessment and registration processes. Currently, any form presumed to be incomplete or incorrect is returned and the entire process begins again, sometimes repeatedly. Without improvement, these areas will remain as bottlenecks.

4. Conclusion

DoH values the substantial contribution made by IMGs to the Australian medical workforce. There is a high reliance on IMGs to provide health service delivery especially in the rural and remote regions of WA. It is evident there have been situations where the implementation of NCAP for IMGs has not seen a smooth transition and the opportunity to provide feedback for the review by the Standing Committee is appreciated.

Appendix: Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMC	Australian Medical Council
AoN	Area of Need
COAG	Council of Australian Governments
DIAC	Department of Immigration and Citizenship
DoH	Western Australian Department of Health
DWS	District of Workforce Shortage
GP	General Practice or General Practitioner
IMG	International Medical Graduate
MBA	Medical Board of Australia
MBWA	Medical Board of Western Australia
MCQ	Multiple Choice Question
NCAP	Nationally Consistent Assessment Processes
NRAS	National Registration and Accreditation Scheme
OTD	Overseas Trained Doctor
OTS	Overseas Trained Specialist
PESCI	Pre-Employment Structured Clinical Interview
PMCWA	Postgraduate Medical Council of Western Australia
RACS	Royal Australasian College of Surgeons
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RHW	Rural Health West
WA	Western Australia
WACHS	Western Australia Country Health Service
WAGPET	Western Australian General Practice Education and Training
WBA	Workplace-Based Assessment