Submission No. 49
(Overseas Trained Doctors)
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SUBMISSION

NSW GOVERNMENT Health
Western NSW
Local Health Network

TO:	The Secretary House Standing Committee on Health and Ageing haa.reps@aph.gov.au
RE:	Inquiry into Registration Processes and Support for Overseas Trained Doctors
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1.0 Background of Western NSW LHN

1.1 Location/Description

The Western NSW Local Health Network was created on 1 January, 2011. It previously formed the larger part of the Greater Western Area Health Service. The Western NSW LHN covers a significant proportion of Western NSW. The population is widely dispersed and totalled 266,135 at the last census.

A map and a list of the facilities within the Network are provided at Appendix 1.

1.2 Services

The services provided by the Western NSW LHN range from large, regional hospitals, providing complex, specialist care, to primary care facilities in small, remote communities. The LHN also includes the only specialist psychiatric hospital in rural NSW.

A brief summary of the facility types is as follows.

- Three regional, base hospitals at Orange, Bathurst and Dubbo.
- A specialist psychiatric hospital (Bloomfield) at Orange.
- Five district, "procedural" hospitals (i.e. hospitals which provide maternity and limited surgical services) at Parkes, Forbes, Cowra, Mudgee and Bourke.
- Eighteen multi-purpose services
- Fifteen community hospitals (three of which do not, presently, provide inpatient services).

Each facility also provides a range of community and primary care services suitable for the size of the community and surrounding areas.

1.3 Staffing

The LHN employs approximately 5,728 staff, of which 255 are medical staff. Of the salaried medical staff, 40 are specialists and the remainder are divided between career medical officers (CMO's), interns, residents and registrars.

In addition, the Network has contracts with approximately 430 Visiting Medical Officers (VMO's) of whom just over half are specialists and the remainder general practitioners (GP's). (NB: VMO figures still include doctors contracted to the Far West LHN which was formerly part of the Greater Western Area Health

Service. At this point, medical administration is still occurring across both networks.)

The vast majority of specialists and junior medical staff are employed at the three base hospitals. Medical services at other sites are predominantly provided by GP's although there are some visiting specialist services.

1.4 Medical Staffing Issues

In common with the rest of rural Australia, medical staffing levels are well below the metropolitan norms and medical vacancies are always difficult to fill. Vacancies can remain unfilled for years at a time. This applies to both specialist and generalist positions. Increasingly, smaller communities are being left without any medical cover for periods of time and, in many instances, they can be a considerable distance from the nearest hospital with a doctor on call.

The LHN is heavily reliant on overseas trained doctors (OTD's) and locums to provide medical services. Although the exact figures are not available at the time of writing, the LHN would appear to be consistent with other rural areas in having almost 50% of its medical positions filled by OTD's. More significantly, over 70% of new, senior staff appointees are OTD's. (The proportion is lower for junior medical officer positions: interns, residents, registrars.)

Locum usage has become rampant and creates serious problems in regard to the cost, continuity and quality of services. The emergency services at the base hospitals and procedural sites could not be sustained without heavy locum involvement. The only foreseeable relief from this situation would be to employ salaried doctors ("Career Medical Officers"). These jobs, however, are not acceptable to Australian-trained doctors, whose earning capacity as a locum or GP is considerably higher, and, inevitably, OTD's are the only applicants. Due to registration and Medical Council requirements, it has proven virtually impossible to place OTD's in these positions.

Many specialist services are also reliant upon locums to maintain consistent coverage. This situation is expected to ease slightly in coming months with the appointment of a number of OTD's to specialist positions in the Western NSW LHN. The lead time for recruitment of OTD's, and the constant risk of problems and delays, means that the LHN remains hopeful rather than confident of relief.

Smaller communities are reliant on private GP's, contracted to the LHN as VMO's, to provide inpatient and emergency services. The long-term, Australian-trained doctors are ageing and many are withdrawing from VMO positions or limiting their availability. Almost every GP who commences practice in a small town within the LHN is now an OTD.

2.0 Comments on TOR 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."*

2.1 Better Understanding and Acceptance of Registration Decisions by Communities

In rural communities, especially small communities, the inability to procure a doctor, because the registration of a possible candidate is unsuccessful, is a significant source of discontent. By and large, rural communities simply want a doctor for the community and have little understanding of, or sympathy for, registration requirements.

A major contributor to this situation is the inability/unwillingness of registration authorities to clearly explain registration requirements for OTD's and the reasons for the imposition of such requirements. It is suggested that a public information approach is considered, such that information is readily available to communities and community groups to address the current information gap.

3.0 Comments on TOR 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."*

3.1 Co-ordination of Information Sources

Information required by OTD's intending to work in Australia is available from many sources, including numerous Web sites. What appears to be lacking is a co-ordinating agency which is capable of directing enquirers to the appropriate source.

At present, the Australian Health Practitioner Regulation Agency (AHPRA) does not seem able to fulfil this function. A call to the Agency almost always results in a long wait, which must be

discouraging and costly for overseas callers. Similarly, most individual health services do not have ready access to the expertise or resources to deal with general enquiries.

Given the current importance of OTD's to the maintenance of rural medical services, it is suggested that a Government agency needs to establish an "office" for OTD's. It is anticipated that the Office for OTD's would provide advice on registration pathways, potential employment scenarios, relevant contacts etc.

Further, it is suggested that a case management approach be considered, i.e. with each OTD having a primary case manager to assist with the passage from expression of interest through to job placement. This approach would, of course, entail a cost, however, it could avoid some of the enormous waste of resources which already occurs through fruitless attempts by health services to employ OTD's into current vacancies. Costs could also be limited through establishing qualification and experience benchmarks, below which case management would not be considered. Much of the case management could occur on-line.

The NSW Rural Doctors Network (RDN) has, to an extent, taken on a case management role for suitable OTD's. This approach has been very successful, however, due to their resource limitations, it is understood that their activities are restricted to applicants who have a clear chance of negotiating the current pathways within a reasonable period of time.

The RDN is also focussed primarily on GP's and GP proceduralists. The need is for an agency that can develop a "career map" for specialist and generalist OTD's aspiring to work in Australia. Ideally, as well as assisting the OTD, the career map would provide potential employers with a basic guide to help in assessing the OTD's suitability for immediate, or future, employment in a particular role.

3.2 Cultural Integration of OTD's

Although it is not directly related to the terms of reference of this Inquiry, it is worth noting that the case management approach mentioned above could have other advantages.

In the rural setting, a number of problems have been experienced with the integration of OTD's from non-Western countries. The most frequent of these are as follows.

- Difficulty in accepting females in positions of authority – noting that almost all Health Service Manager positions within the LHN are filled by women.
- Difficulty in accepting the role of Australian nurses as fellow health professionals with a pro-active role to play in the treatment team.
- Difficulty in adjusting to isolation and the mono-culture which exists in many small, Western towns.

Many attempts have been made, and are still being made, to provide meaningful orientation for OTD's entering the Australian Health system. Orientation to the administrative structure of the system appears to be working quite well, however, no current orientation appears able to address the cultural issues identified above. From recent work done within this LHN, it is suggested that no "one size fits all" approach will be successful. The cultural backgrounds, experience, personalities and job destinations of the OTD's are too varied for any pre-scripted orientation to be successful.

A case management approach to OTD's entering, or trying to enter, the Australian Health System would allow an individual assessment to be made of the training an OTD may require to adapt to the cultural conditions he or she may face in local employment.

(NB: The above comments, of necessity, contain generalisations. Within the Western NSW LHN, there are some excellent doctors from non-Western countries who have adapted very well to local conditions.)

4.0 **Comments on TOR 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."*

4.1 Position Descriptions

Position descriptions have proven to be a basic, but surprisingly persistent, problem in relation to the registration and employment of OTD's. There seems to be a gap in interpretation between health services and the various authorities engaged in assessments for registration.

The primary onus is, undoubtedly, on the health service to produce a position description which clearly describes the qualifications, experience and duties required of an incumbent. Nevertheless, without comprehensive guidelines it is inevitable

that there will be variation in the quality and style of position descriptions that are presented to the relevant bodies.

It is suggested that some co-ordination between AHPRA, the Medical Councils and the Colleges, to produce an agreed guide on position description format and content, would be very useful to all concerned.

4.2 Recognition of Qualifications and Experience by Specialist Colleges

Although there is a careful assessment of the qualifications and experience of overseas trained specialists, there appears to be a blanket approach to the question of probation. In many cases, two years is clearly unnecessary and has led to situations in rural areas where "probationary" specialists have been leaders in teaching and advising their colleagues.

It is suggested that more effort needs to be made to tailor the probationary period to the individual and ensure that it is focussed on specific knowledge, experience or skills which may be in doubt.

Consistency of College assessments is also a problem, both within and between Colleges. Candidates who appear to be very similar in background can obtain quite different outcomes from the same College.

The approaches to assessment also vary between Colleges and some consistency would be useful. Greater transparency would improve the whole assessment system. It would allow health services to better understand College processes and improve recruitment decisions.

Consideration should also be given to extending the number of countries, or training systems within countries, recognised as "competent authorities". Several European countries, such as Germany and the Netherlands, appear to produce doctors who are as well-trained as the recognised competent authority nations, however, they enjoy no preference over countries whose training systems are viewed less favourably.

It may be that blanket acceptance of medical practitioners from additional countries is not possible due to differences in the approach to some specialities. It could, however, be appropriate to recognise those specialities that do have equivalence to avoid unnecessary assessment and supervision requirements (all of which consume Health System resources and may deter suitable applicants).

The above comments are all made on the understanding that no lowering of Australian medical standards is intended. They are observations based on the high standard of a number of specialist applicants from non-competent authority countries.

4.3 Assessments of the Qualifications and Experience of Non-Specialist Doctors

An inordinate amount of time, money and effort is currently expended by health services in determining whether an overseas applicant may be suitable for a generalist position. This is a subjective process which may be conducted by health staff, often at a facility level, with little or no knowledge of the registration processes for OTD's. Medical administrative staff, at area health service, or health network, level may have greater experience and judgement but are rarely expert in these requirements as they are never directly exposed to the assessment process.

For hospital-based generalist positions, such as CMO's, the local assessments rarely translate to successful registration of the applicant. The success rate seems to be higher when the RDN and/or local Divisions of General Practice are involved in recruiting GP's for private practices. This may be due to the high expectations placed upon CMO's in regard to emergency skills and, in the rural setting, the greater likelihood of suitable supervision arrangements within a general practice.

Pre-registration and pre-employment assessments by an appropriate body, such as the Australian Medical Council, would greatly assist in reducing the wastage of time and effort. It would also provide more certainty and consistency for the applicant (although it is recognised that the final decision on registration is position-dependent).

Pre-registration assessments are already available to overseas-trained specialists and it would be a positive step to extend this process to generalists.

Similarly, the extension of the competent authority pathway – as described for specialists in 4.2 above – would assist with generalist recruitment.

It should be noted that the difficulties in filling CMO positions have the greatest impact on the cost of running health services. The current strength of the locum industry is based around the inability of health services to fill hospital-based generalist

positions with salaried staff. The financial impact on the health system is enormous.

4.4 Supervision

In the rural setting, the availability of supervision is another key barrier to OTD employment. There are three main scenarios.

- No specialist of the appropriate discipline is available to provide on-site supervision (particularly in a situation where an attempt is being made to establish or restore a specialist service).
- No staff doctors are available to provide supervision to hospital-based generalists.
- There is no GP available – or none willing to undertake supervision – in a town where there is no GP VMO or a gap in GP VMO services.

There are two steps which could assist in remedying this situation. The first is for the registering authorities to give greater thought to off-site supervision – in suitable circumstances, e.g. with an experienced OTD. With modern methods of communication, the wider community has grown to accept off-site supervision and management in many forms. The medical profession has already accepted the concept of off-site clinical supervision for rurally-based, fully-qualified, Australian-trained doctors and some of the techniques, such as video-conferencing, could perhaps be extended to OTD's.

The second would be to consider utilising GP VMO's for the supervision of hospital-based generalists. Although their "position descriptions" may be different, rural GP VMO's often possess the skill set required of a rural CMO.

More generally, the definition of "supervision" could be improved. The current span of supervisory situations for OTD's includes everything from oversight of a highly trained and experienced OTD, whose skills may be superior to that of his or her "supervisor", to a situation where an inexperienced OTD, with serious skill deficiencies, requires active training input from senior clinicians.

4.5 AMC Examination Part 2

Any perusal of job applications from OTD's suggests that there is a considerable number currently living in Australia. Generally speaking, these OTD's have chosen a pathway which involves entry to the Australian medical profession through prior completion of the AMC examinations, Parts 1 and 2. Part 1 can

be completed on-line from anywhere in the world whereas Part 2 must be undertaken in person.

The main barrier to the utilisation of this on-shore resource is the length of the waiting list for the Part 2 examination. Although the LHN does not have access to exact figures, we understand that it is not unusual for a candidate to wait two to three years before he or she can sit the examination.

An added problem for OTD's who choose this pathway is the potential loss of skills that can occur during the lengthy wait. Although largely anecdotal, the phenomenon of the medically trained taxi driver has some veracity.

Again, there is no suggestion that standards should be lowered, however, more frequent examination opportunities would increase the potential pool of applicants for Australian positions.

4.6 Australian Health Practitioner Regulation Authority

AHPRA is a relatively new organisation and it is to be expected that teething problems would exist. Having acknowledged its fledgling status, the current experience of health services is that AHPRA is an impediment to efficient processing of OTD applications. The main issues are as follows.

- The time taken to process a new application is simply too long; up to three months is the present norm.
- The time required to transfer OTD registration between employers is also excessive – currently six to eight weeks.
- There is no customer-service focus – any missing paperwork evokes a bureaucratic response which involves the complete cessation of any work on the application. AHPRA needs to work with its clients.
- The "certificates of good standing" which OTD's must obtain from their home registration board (or any board they have been subject to in the last ten years) only have a life of three months. Because of delays, these certificates frequently expire mid-process causing further, unnecessary hold-ups. Such certificates need to be given a minimum currency of six months.

It is possible that if AHPRA's performance is related to the rapid integration of staff and information, and the adoption of new processes, it will improve over time. There needs to be some confidence at Australian Government level, and amongst clients, that AHPRA has the resources and culture to undertake its task effectively.

4.7 Area of Need Issues

Two problems have been noted with the new Area of Need arrangements and the move towards engagement of generalist OTD's exclusively through the standard and competent authority pathways.

OTD's who fill specialised roles in non-specialist positions will be faced with going back to basic medical theory and practice to complete their AMC Part 2. A local example would be an OTD who has specialised in a role as a Psychiatric CMO, and is skilled and experienced in that capacity, who would be faced with virtual retraining at the generalist entry level in order to maintain registration. A loss of mature, experienced doctors, fulfilling very necessary positions can be anticipated. The problems with securing new CMO's have already been canvassed in 4.3 above.

Secondly, although Area of Need status will still be available for specialist positions, new applications all require a face-to-face meeting with members of the relevant College. This is an onerous requirement for rural health services and the rationale for the impost is very unclear.

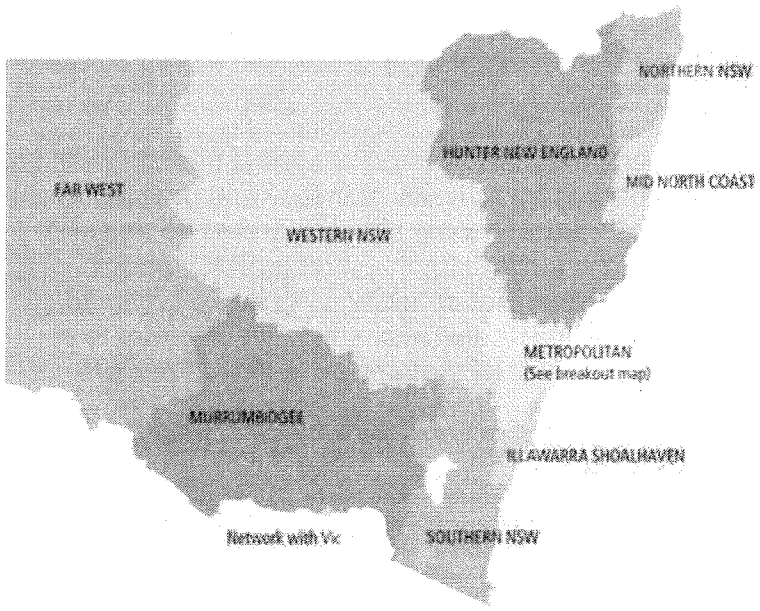
Medical administrative staff members in this LHN have already reported difficulties in arranging such meetings.

5.0 Further Information

It is to be hoped that the above information will be of assistance to the members of the current Inquiry. If clarification of any points, or further information, is required, the first point of contact is Mr Richard Elligett, Network Co-ordinator, Medical Workforce whose details appear on the front page of this submission.

Submission ends

Appendix 1



List of facilities that are part of Western NSW Local Health Network:

- Baradine
- Bathurst
- Blayney
- Bourke
- Brewarrina
- Canowindra
- Cobar
- Collarenebri
- Condobolin
- Coolah
- Coonabarabran
- Coonamble
- Cowra
- Cudal
- Dubbo
- Dunedoo
- Eugowra
- Forbes
- Gilgandra
- Goodooga
- Grenfell
- Gulargambone
- Gulgong
- Lightning Ridge
- Molong
- Mudgee
- Narromine
- Nyngan
- Oberon
- Orange/Bloomfield
- Parkes
- Peak Hill
- Rylstone
- Tottenham
- Trangie
- Trundle
- Tullamore
- Walgett
- Warren
- Wellington