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JOINT STANDING COMMITTEE ON MIGRATION

Reference: Skills recognition, upgrading and licensing

WEDNESDAY, 24 MAY 2006

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JOINT STANDING COMMITTEE ON

MIGRATION

Wednesday, 24 May 2006

Members: Mr Randall *(Chair)*, Senator Kirk *(Deputy Chair)*, Senators Bartlett, Eggleston and Parry and Mr Laurie Ferguson, Mrs Irwin, Mr Keenan, Dr Lawrence and Dr Southcott

Members in attendance: Senator Parry and Mr Laurie Ferguson, Mrs Irwin, Mr Keenan and Mr Randall

Terms of reference for the inquiry:

- Investigate and report on current arrangements for overseas skills recognition and associated issues of licensing and registration for:
  - Skills stream migrants who obtain assessment prior to migrating;
  - Families of skill stream migrants, family stream migrants and humanitarian entrants who seek assessment/registration/upgrading after arrival;
  - Temporary residents who need skills assessment/recognition; and
  - Australian citizens returning after significant time overseas, with overseas qualifications.
- Consider how Australia's arrangements compare with those of other major immigration countries.
- Identify areas where Australia's procedures can be improved including in terms of:
  - Communication of processes to users
  - Efficiency of processes and elimination of barriers
  - Early identification and response to persons needing skills upgrading (e.g. bridging courses)
  - Awareness and acceptance of recognised overseas qualifications by Australian employers
  - Achieving greater consistency in recognition of qualifications for occupational licensing by state and territory regulators
  - Alternative approaches to skills assessment and recognition of overseas qualifications.

WITNESSES

FRANK, Mr Ian, Chief Executive Officer, Australian Medical Council 1

Committee met at 12.11 pm

FRANK, Mr Ian, Chief Executive Officer, Australian Medical Council

CHAIR (Mr Randall)—I declare open this public hearing of the Joint Standing Committee on Migration inquiry into overseas skills recognition, upgrading and licensing and welcome you here today. The Minister for Immigration and Multicultural Affairs has asked the committee to examine if the current processes by which migrants are assessed for entry to Australia under the skilled migration system are functioning efficiently or need to be improved. The committee is looking at skills recognition not only for migrants but also for those who come to Australia outside the skills migration system, such as temporary residents needing skills assessments and Australian citizens returning to Australia with overseas qualifications. In addition the committee is comparing Australia's skill recognition arrangements with those of other major immigration countries and is looking at whether greater consistency in the recognition of qualifications might be achieved among Australian states and territories.

I would like to now welcome Mr Ian Frank from the Australian Medical Council to this public hearing. Although the committee does not require you to give evidence under oath, I should advise you that the hearings are legal procedures of the parliament and warrant the same respect as the proceedings of the House itself. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. The committee has received your submission and it has been authorised for publication. I now invite you to make a brief opening statement, if you wish, before we proceed to questions. I add that we have endeavoured to meet with the Australian Medical Council on a number of occasions, and it is good that we can finally do so. I think you are the last participant in this inquiry, so thank you for being here today.

Mr Frank—No problem. The issue of migrant skills recognition is a very complex one. It is clearly something that has been on the federal agenda for many years. In another life, I was associated with a group called the Committee on Overseas Professional Qualifications, which set up the first examination-based assessments for overseas qualified professionals coming into Australia. I have come full circle because I am back with the Australian Medical Council, working in a similar sort of area.

This is an issue that has been on the agenda since the sixties in relation to medicine. It has also been an area where there has been a lot of controversy about the way the various processes have operated. In particular, the view or the perception has been held for many years that it was a closed shop, that it was restrictive, that there were major problems for overseas trained qualified doctors, for example, entering the workforce in Australia. In the last decade though, there has been I think a change in views. I think that because of two things, in particular. One is that it has been recognised that we have an incredibly diverse group of people who are coming in. The age distributions, the countries of training, the skills levels of the individuals differ considerably across the range. They are not like the cohorts we have of Australian medical schools that are fairly tightly bunched in terms of their ability levels and their clinical skills and so forth.

We are dealing with a very diverse group of people, a wide age range and a very complex set of backgrounds. But the other issue that I think is even more important is that only in the last couple of years, and I am talking about the last two or three years, there has been a realisation that skills recognition is more than just simply getting people past a barrier examination or a

regulatory requirement in the workforce. It has now been recognised, I think, in a number of reports that have been done, particularly the Medical Training and Review Panel report, that these people may need support beyond simply getting them registered. There needs to be some infrastructure in place to enable them to really integrate into the medical workforce in Australia and become effective clinicians and practitioners within the Australian health care system. I think that realisation is something that is really quite important and is quite a change in the attitudes that have been taken in the past in relation to this area.

CHAIR—I begin by saying that it appears from your submission that there are degrees of complexity throughout the system having recognition of medical qualifications primarily as a state matter. You would be aware that the Council of Australian Governments recently announced that it had agreed to a national assessment process for overseas qualified doctors to ensure appropriate standards in qualifications and training as well as increased efficiency in the assessment process. Can you tell us how this COAG arrangement might work and how this might impact on the current assessment roles with the AMC and the specialist medical colleges in the state and territories and their boards?

Mr Frank—In effect, in Australia, as I have indicated in the submission, there has been a nationally agreed process since 1991 for full recognition of those people coming through to seek full registration as a non-specialist in Australia, or people coming through to seek full recognition as an overseas trained specialist in a field of specialty in Australia. That was agreed by health ministers at the National Health Ministers Conference in 1991 and it was implemented prior to mutual recognition coming in. One of the reasons we have the diversity we see in the system at the moment is that it has arisen out of the fact that each of the states and territories retained discretionary provisions to register people where it was in the public interest to do so. Each state and territory has taken their own views on how they have moved those things out. We take it that the COAG view is really revisiting the original intention—that there be a consistent national process in Australia—so we are assuming that the groundwork that has been done can be adapted to comply with the plans with the sort of forward reform program that COAG is thinking of developing.

But having said that, the fact is that, in the health care system in Australia, the local requirements are very different. I mean the requirements in Tasmania are very different from the requirements in Far North Queensland or Far North Western Australia. Whatever systems are put in place will have to recognise the particular problems that they have in those different areas. I suspect at the end of the day we can have consistency in process. We can have consistency in some of the methodology we use, but we will have to reflect that there are some unique problems in regional parts of Australia and different areas in Australia relating to the way health care is delivered in those areas. That has to be reflected ultimately in the assessment processes we put in place and the support services we put in place to support those people.

CHAIR—Just extrapolating from that, though, you said in your opening statement there had been this perception about a closed shop. We have had evidence before this inquiry, particularly from various subprofessionals, if you want to refer to them as that, that there appears through processes to be ways of inhibiting specialists practising and coming to this country—for example, anaesthetists. We had anaesthetists come before us as well to explain their position. But it still does not dispel the view that somebody, for example, who had been a senior anaesthetist in the United Kingdom in charge of 40 or 14 people, or something like that, had to come to

Australia and be supervised for a long period in an area of need. This still engenders images of a closed shop mentality to protect certain elements of your profession that you represent.

Mr Frank—Yes. I can see that, but it also has to be remembered that there are all sorts of reasons why people might move from one country to another in terms of what they are doing. We had a case, for example, in Queensland last year of somebody who technically was very well trained in terms of what they were doing. If you looked at their training record alone, there should have been no reason why this person could not have been employed in their capacity as a surgeon in any facility of the type he was looking at in Australia. But there is the reality in terms of the performance of that person. I do not know the judgment in relation to that particular anaesthetist but I know that one of the things that is particularly concerning some of the specialist colleges in Australia is that there needs to be some evidence. Now the issue is whether that evidence can be obtained overseas or obtained here of a person's capacity to actually perform in a clinical setting.

The best way of doing that is to put them in an observed capacity. There is discussion I know going on specifically in relation to the College of Anaesthetists of fast-tracking people who have been trained in certain systems, and that includes the United Kingdom, Ireland and one other, I think, although we are not directly involved in that process.

CHAIR—That was going to be my point, which you are now going to. Surely over all the years we have been having a relationship, particularly with Commonwealth countries and European countries such as Ireland, these recognitions could have already been in place. Why are we in 2006 still not there?

Mr Frank—For political reasons, in 1991 the automatic recognition of those countries was removed. Removal of the recognition of the United Kingdom, for example, from the medical acts in Australia, which would have allowed these anaesthetists to practise immediately, was not done on any grounds related to the technical competence of the training programs. It was taken as a political decision at that time. It was thought at the time that the differential between the former United Kingdom-type trained people and the non United Kingdom-type people was discriminatory, and so a political decision was taken to take them off the system. There was no evidence that there was a technical or standards-based reason for removing that recognition. What is happening now is that I think there is a realisation that that situation needs to be revisited.

There is currently before, or has been approved by, the health ministers advisory committee a proposal to establish a model for non-specialists called a competent authorities model. Basically, what it would mean is that anybody who has been assessed by an authority deemed to be a competent authority would be given advanced standing toward the requirements of registration in Australia. That is a way of fast-tracking people from other bodies around the world that do assessment of this type to a level that is appropriate—not necessarily directly comparable to the Australian system but appropriate to a base standard evaluation. It is a little more complex in relation to specialists because the variations in the experience of a person can have a significant impact on their capacity to perform.

I know that the roll-out is planned to do it for non-specialists in the first instance, but I know that a number of the colleges of anaesthetists—or one of them—are looking at ways in which

they can extend that same concept beyond just simply the non-specialist area into the specialist area. There are still some significant issues but one of the key parts of that is still to determine somewhere along the line that the person is able to actually function in the Australian health care system. You do not have to hold a person up to do that. You can put them into a position, evaluate them in that position by a number of various means, including simulators, in the case of anaesthetics. If they meet those requirements and demonstrate that they are quite capable of functioning under the circumstances, they would be in here, and they can be given licence to practise in that capacity.

CHAIR—Do you see any latitude—and we are not looking for Dr Death type situations—in terms of strong areas of need, like rural and remote areas, where we can give certain considerations to people being assessed for those areas?

Mr Frank—It is a difficult question to answer because the rural and remote areas are where you really want to have the better-performing people in a sense because they are isolated and often they are cut off from other support services. The ones that you are putting out there really ought to be the ones that have a very high capacity to function effectively in those sorts of environments. There is scope, if we can integrate the processes effectively, in, for example, this business of putting people into positions where they can be supervised. If there is scope within the health care system to put people into urban-based centres where they can be monitored and observed and, if necessary, up-skilled if they have to be up-skilled in some subsets, and then put out into the community, that would be a far more effective way than trying to short circuit processes of getting people out in the community. One of the difficulties is that these people have to integrate within an existing health care system—state based, perhaps. They have to be able to function within that environment. You need to at least ensure that that is being taken care of.

Interestingly enough, in the submission I refer to an inquiry that was undertaken in Canada, which has a very similar set of problems to the ones that we have with rural and remote areas. If you look at the findings of that inquiry, a large chunk of those relate to orientation or training for people to work within the systems that they are being placed into. They recognised much earlier on in the piece than we have that that is a really critical part of having these people work effectively in those areas. In the rural and remote areas, the issue of having people who are confident and able to perform is even in a sense more important than it is in the urban areas where there is often supervision or back-up or someone else who can support them. In these areas, they have to be the people functioning entirely on their own.

Mrs IRWIN—How would you then encourage these people to go to remote and rural parts of Australia? What incentive should we be offering them?

Mr Frank—There are a number of incentives. One of the interesting things in Australia is that we are asking people to come in from overseas to go and work in often very difficult areas, often culturally removed from the areas that they have come from, and they do not have access, for example, to Medicare for their own families. They do not have access in many cases to even simple things like cell phones because they cannot get the kind of credit ratings and things they need to get those sorts of things. There are a whole lot of collateral issues around the placement of these people that go beyond simply the amount of money you pay them. Give them support services. That is what I am saying about the Canadians. They have identified the need to provide

significant amounts of orientation and support services to back these guys up so that they do not feel that they are completely isolated. That is a critical part of the exercise.

CHAIR—My experience from Western Australia is that the local government authorities have been surrounding the new doctors or specialists with that sort of support when they come to their rural areas, so they pick up that area you are talking about.

Mr Frank—But that is not an integrated approach. There are some communities, in particular in Victoria, where rural workforce agencies have been very supportive and very active in that sort of exercise, but if you are talking about some of the more remote areas, if we distinguish the regional areas rather than remote, the regional exercises have worked really well. Two years ago we had a meeting of the council in Rockhampton. It is a major centre. It is not a really remote area, but they had a lot of difficulty in attracting people to come and work there. We asked them about what initiatives they had put in place that changed the circumstances because they had an improvement. They had more people. Even Australian-trained people were prepared to go and work there. The answer was very simple. Virgin airlines started to fly regular flights to Brisbane at the end of the week. It had nothing to do with the amount you were paying them, where you were housing them or what you were doing with them. It was just simply the availability of transport that made a huge difference in that one area.

What I am suggesting is that some of the solutions to these things are not directly related to the kind of technical issues of their skills and those sorts of things, though they are important issues. But there are a lot of other support issues that relate to providing the back-up for these people. As I said, there was a report produced in 1982 by the Fry committee, a Commonwealth report, which identified the need to provide support for overseas trained doctors. In 2004, the MTRP report says exactly the same thing. What have we done in the meantime? We probably have not done a lot at all, except for the local communities. That is something that needs to be co-ordinated and some effort put into it. The Canadians I think have stolen the lead on us in this area. They have identified very clearly that these are the issues that you need to be putting some resources into.

Mrs IRWIN—How bad is the doctor shortage in Australia?

Mr Frank—That is the interesting question. The AMC processes applications from people who are seeking permanent registration in Australia, so full registration as a non-specialist or as a specialist. We have figures only on the ones who are coming through our pathway. We know that back in 1992 when the health ministers agreed on this national standard policy, there were about 600 temporary resident doctors in Australia over and above the ones that were agreed to as part of the national system. In 2002-03, the figures that were being quoted were around 4,000. But I have not seen any figures publicly quoted since then. We think the shortage is 4,000 plus, but exactly what that figure is we really do not know because we do not control the data. The most recent figures I think I saw in April of last year referred to about 4,300 or 4,500, or something like that.

Senator PARRY—Who calculates the figures?

Mr Frank—Nobody has a clear handle on it, and that is the problem.

CHAIR—Where do these figures come from?

Mr Frank—A combination of the AIHW, reported material from state health authorities and AMWAC reports had some of that data, but the most recent data that I have seen there was April 2005.

Senator PARRY—Can we have rudimentary figures like X number of the population requires one GP and we know we are short in these areas?

Mr Frank—There are all sorts of arguments about that, and there are people who are far better qualified than I to say to you what the doctor to population ratio should be. Clearly everyone knows that the doctor to population ratios in rural areas are way out of synchronisation to what they are in urban areas in the main centres. Interestingly enough, one of the major problem areas is not so much the remote ones but the outer metropolitan edge, the fringe between the major cities.

CHAIR—I have an electorate like that.

Mr Frank—You actually find that they are having bigger problems in those sort of areas, the areas immediately adjacent to the main client centres, but I am sure there are people in the state health authorities who, for their particular regions, could give you very accurate data as to what is going on out there.

Mrs IRWIN—Another question that I have is the committee has heard that applicants, as you would be aware, travel to Australia twice in 12 months. They come in to do an examination and they go back to their home country. Then they have to return within that 12-month period to do a practical examination.

Mr Frank—Yes.

Mrs IRWIN—Have you received any feedback from those applicants complaining about that system?

Mr Frank—Absolutely. It is really interesting. There is a two-part process for non-specialists. There used to be a written examination. It is now a computer-administrated examination and a clinical examination. They are the ones that they are talking about because, for the computer administrated or written examinations, people have to come into Australia to do those exams. Up until 1995 we used to conduct those examinations in 43 centres simultaneously overseas with the Australian centres. We were asked at that time, in 1995, through the Commonwealth Department of Health to cease doing that. That arose as a result of, let us say, confusion on the part of the Human Rights Commission that felt we were adding to the problem by running examinations offshore. We currently are working with the Medical Council of Canada in a joint project to reactivate overseas examinations. The plan is to pilot it in July this year in Hong Kong and Singapore, and in November to do it in about 10 or 12 centres overseas but with the capacity to go out to about 160 countries overseas. The stage one examination of ours will be offered by computer in overseas centres before they come here.

Mrs IRWIN—Do you think it would be a lot easier if there was a special visa that would allow them to remain in Australia for that 12-month period to do their exams and their practical work?

Mr Frank—The problem with them is that, because the demand for examination places exceeds the supply, we have currently something like a two to one plus ratio of applicants to available examination slots. We give priority to people who are sitting for the first time because the data tells us that they have the higher rate of passing. That means that usually a person can expect to do an examination within 12 months, but there may be some people, particularly those who have failed or who are repeating, who may have to wait longer than 12 months to have an attempt at the exam.

Mrs IRWIN—What countries are we getting the doctors from?

Mr Frank—In the submission I gave you, there is a profile at the back of the countries the people have come from. That is over the total period. It is really interesting that those figures represent a snapshot of what is currently happening. If you look down, for example, you will see that the largest source country we have is India. That remains the case now. Any given examination we conduct, we can do a breakdown of the countries of training of the people who are coming in. By and large, I think it is still India, Sri Lanka, the Philippines, Bangladesh and China.

Mrs IRWIN—That is, doctors from the Philippines, not nurses?

Mr Frank—That is doctors from the Philippines, yes, and South Africa. Those totals that you have there for those countries are a sort of total picture, but they actually reflect the current patterns that are coming in as well.

Mrs IRWIN—I want to refer to South Africa because just recently I attended an IPU conference in Kenya. That was a very big complaint that was coming from members of the South African government. They are very concerned about the brain drain with their doctors coming to Australia. Have you heard this as well?

Mr Frank—Yes, we have. The Australian Medical Council is part of an organisation called the International Association of Medical Regulatory Authorities. It is a peak body of all the licensing and examining bodies in medicine. At the two most recent IAMRA conferences, we had the World Health Organisation and the current president of IAMRA, who is actually the President of the Medical and Dental Council of South Africa. As a result of their plea, all of the major countries that conduct examinations, like ourselves, New Zealand, Canada and the United Kingdom, have indicated that we will not conduct our examinations in those countries.

We are not actively going to set up examination centres in South Africa, southern Africa, or southern Sahara in Africa. However, under discrimination provisions, we cannot prevent somebody from those countries doing our examinations. So if somebody turns up in Australia saying, ‘I am from South Africa,’ or, ‘I am from Kenya,’ or Nigeria, ‘and I want to sit your examination,’ we really cannot preclude them from doing it, but we will not actively set up systems in their countries. With the new systems we are talking about doing overseas, those countries are excluded from these source countries where we are going to set these exams up.

Mrs IRWIN—Because of the concerns of that particular country?

Mr Frank—It is internationally recognised that there is a real problem here, and so there is no active program. I understand, and you could probably talk to Commonwealth Department of Health and Ageing officials about that as well, that in their recruitment programs they have excluded those countries that have been agreed by the Commonwealth Heads of Government as major at-risk areas. But, as I said, at the end of the day, if somebody from those countries turns up, we really cannot say, 'Sorry, you cannot do the examination'.

CHAIR—I note with interest you have only a small number of Nigerian doctors. They must all be in Western Australia.

Mr Frank—Those figures are very deceptive. Somebody has said to us, 'Why can we not give automatic recognition to the people who do brilliantly well in those exams?' If you have a look at it, I think Latvia or one of those has a 100 per cent pass rate because all four doctors from there came and did really well, whereas England does not have a 100 per cent pass rate in those examinations. They are very small cohorts from which to draw those sorts of conclusions.

Mr LAURIE FERGUSON—I have a number of points. Firstly, following from that last point, you used the phrase 'southern Africa'. I noticed the numbers from Granada, Jamaica, Trinidad and Tobago are very small, but you take the United Kingdom example. There are grave concerns about basically stealing the whole staff of the hospital in St Kitts and Nevis or somewhere.

Mr Frank—Yes.

Mr LAURIE FERGUSON—Are you only doing it in Africa, or in a wider group of African English-speaking countries?

Mr Frank—I do not have it in front of me, but there is a list of Commonwealth countries where it has been agreed by the Commonwealth Heads of Government that we will not set processes up. When I said we are moving to 160 countries, those countries that are in that listing, and we liaised with the Commonwealth Department of Health and Ageing on that, will be specifically excluded. There is no active campaign. We are not going to be setting up examination centres in the Caribbean or southern Saharan Africa. But, as I said, the issue is, though, if they apply, we could not say no to them.

Mr LAURIE FERGUSON—All right. The second point is these statistics. The final column represents the outcome from the initial group.

Mr Frank—Yes.

Mr LAURIE FERGUSON—Have you got a parallel set of figures for those people who basically attempt both parts and the pass rate?

Mr Frank—That completion figure there that you have in the far right-hand column represents the ones who have completed both stages of the exam.

Mr LAURIE FERGUSON—No, but that also obviously includes the drop-outs who did not do both, doesn't it?

Mr Frank—No. If you have a look at the figures there, I will go to the total.

Mr LAURIE FERGUSON—One thousand and sixty-eight Indians passed, all right? Eight hundred and seventy-six of them went on to do the second exam. Two hundred and something of them must have basically not gone ahead. Is that right?

Mr Frank—That is right. Between the first and second, there is a group of people who have not proceeded into the clinical exams.

Mr LAURIE FERGUSON—All right. In other words, what I am getting at is I think you will find that the 56.25 per cent represents a percentage of the original starting group.

Mr Frank—Yes.

Mr LAURIE FERGUSON—I am interested in whether you have done figures on those who basically attempted both and passed. I am saying your figure at the end there includes the 200 Indians who did not bother going—

Mr Frank—The 54 per cent are those who actually completed all the requirements of the examination and are now registrable or registered in Australia.

Mr LAURIE FERGUSON—Yes. What I am getting at is that there could be a particular country or a particular series of countries which, for reasons you might be able to give us, basically do not go from the first to the second.

Mr Frank—Yes.

Mr LAURIE FERGUSON—They pass, but do not attempt the second.

Mr Frank—Yes.

Mr LAURIE FERGUSON—I am interested in whether you have done any statistics—in other words, if you have another column—that only show the pass rates of those who attempted both. Are you with me?

Mr Frank—If you look at the bottom line on the bottom table on page 7, there is a bottom figure there of 4,888.

Mr LAURIE FERGUSON—Yes.

Mr Frank—They are the people who have completed all stages of the process.

Mr LAURIE FERGUSON—I understand.

Mr Frank—So they are out of the system and have completed. Of the total 8,921 who commenced, that is your total completion rate against the 54 per cent.

Mr LAURIE FERGUSON—I am sorry, I understand that. The committee might be able to do this itself. You might comment further on why you think there is a drop-out between the two examinations, with people who do pass and do not bother going ahead. That is interesting to us as well. But what I was getting at is I am just interested in whether there is any statistically interesting figure between these countries in terms of those who actually attempted both examinations. Put to one side the people who do not proceed. They are an issue in themselves, right?

Mr Frank—Yes.

Mr LAURIE FERGUSON—But anyway if you have not done it—

Mr Frank—No. If you have a look at that figure of 5,723, that would be the total number of people who have tried both parts. They are the ones who have done both part one and part two. Of that number, 4,888 are the ones that have passed part two, and therefore have qualified.

Mr LAURIE FERGUSON—Right.

Mrs IRWIN—Qualified to?

Mr Frank—Register.

Mrs IRWIN—Register here, in Australia?

Mr Frank—Yes.

Mrs IRWIN—Okay. We have a doctor shortage. How many of the 4,888 took up positions in Australia?

Mr Frank—I could not tell you that.

Mrs IRWIN—It would be interesting to find out.

Mr Frank—Bear in mind about these figures that you asked about ones that did not proceed. There is an interesting set of figures here. We have a lot of people from China who did the examinations some years ago before Hong Kong was taken over by the Chinese. They did part one, but they did not present for part two. I am sure that had the situation of the takeover been a little more disruptive, they would have all turned up for the part two examination.

Mr LAURIE FERGUSON—You mentioned at one stage that because of the outcome originally, the states had a right on public interest grounds, or whatever. Could you comment on what you might have seen as some of the more questionable grounds of public interest that particular states might have, you know—

Mr Frank—When I say ‘questionable grounds’, we have quoted another set of figures in here. If you take a look at the total number of 4,000 temporarily resident doctors that we have got in the country at the moment, and we assume that something like two-thirds of those are cycling—that is, that some of those are here for more than 12 months so that not all of them will turn over within that 12-month period—but let us say about 3,000 maybe are turning over, all the data that we are getting from the Commonwealth and the input from these people tells us about 25 per cent of those guys are going to be specialists. We know from the figures that we are seeing that only about a third of those specialists are coming through our assessment pathways.

We do not know what happens to the other two-thirds. We know that some of them are being badged as occupational trainees and so they are not appearing on anybody’s statistics as being part of the area of need workforce, but they are actually physically in the hospitals and become part of the hospital workforce. But they are not figures that you can pinpoint very clearly. There is a large cohort of those people who are coming through the system and are being registered to our knowledge without anybody having assessed their skills at all. They may have done a paper review of them and that may be okay. That may be perfectly reasonable. They may look down and say, ‘Look, this guy has had all this background experience and there should not be a problem,’ but if that is the case then you would think you would get them through and linked up into the fellowship programs of the colleges, so you could get them tied into the ongoing peer review or peer assessment type of programs. But they are not appearing in those areas.

There has got to be an indeterminate number of people who are being put into positions with either little or no formal assessment of their capacity to function. I am not talking about their academic competence. I am talking about their capacity to actually work in the health care system. We get from medical boards reports of the problems that they are having with these people, particularly in communications skills areas, and in other major areas. Gaps in medical knowledge is another major area that was identified by the Northern Territory report that they did at the end at last year, and that is a worry. These people are not being screened, which means also we are not identifying what their deficiencies are and therefore nothing is probably being done, other than on an ad-hoc basis, to make sure that they are overcoming those deficiencies.

CHAIR—This is where COAG can help a bit and collect data?

Mr Frank—Talking about nationally consistent approaches is terrific—if they are national, and if they are consistent. Up to now the track record has been that we have agreed on these nationally consistent approaches but they have not been implemented in that way because everyone has taken on their discretionary provisions and put people in areas where they felt there was a need to do so. There may be a legitimate need. Constantly we hear from the health authorities: ‘It does not matter what the standard of this guy is. We need to have a doctor in that town.’ That argument is ‘any doctor; what you really need,’ or do you want to have someone who is competent? Maybe the answer is not to worry about putting doctors in there but putting good quality nurse practitioners in those areas who may be better qualified for the kind of work that you are doing there than trying to get a doctor who does not know our health care system and putting them into an area where they really are not all that comfortable and they cannot communicate with their peers and colleagues.

CHAIR—That is an interesting point of view.

Mr LAURIE FERGUSON—In a case I had recently—and I am not saying that this person had an argument, quite frankly at the end of the day—they had a series of interns or something, although there is probably a better term for it. They go to a doctor in Sydney and they practise under them for a while. Do you know what I am talking about?

Mr Frank—Yes.

Mr LAURIE FERGUSON—As I say, I am not really going in to bat for him because he seemed to have personality difficulties, et cetera. But how much of a problem do you have in getting practices, et cetera, to provide that facility for doctors? Is that an issue?

Mr Frank—Yes, it is, and it is one of those terrible things. The classic case we now have is the Patel case in Queensland where, because of that one individual and one set of circumstances, the reputation of overseas trained doctors, and of doctors who are Australian trained but with ethnic backgrounds, has really been thrown into turmoil. People are much more reluctant to take these people on board, even though they are highly competent people. Similarly in Victoria a couple of years ago, there was one incident involving a person who was an observer in one of the metropolitan hospitals and who was interfering with a female patient. As a result, the hospital was advised by the police that they could not let anybody in who was not a fully registered medical practitioner. Those sorts of things happen from time to time.

I think part of the program I mentioned earlier about the need to provide support and infrastructure beyond simply getting through an examination or a registration provision is the fact that we have to start educating people on both sides of the equation as to what these people mean and constitute in terms of skills base. I think that is happening. I think the programs that are coming up and the mentoring programs that are being developed and some of the other programs that are now being put forward at a state level are very, very positive initiatives and are beginning to work well. But there is still a fair bit to be done in this area to make sure that we get rid of any biases that are there in terms of these people not being able to function in the Australian health care system. They are going to drain more of your resources because of language difficulties and orientation difficulties, but if we can put that effort in up-front, you may find that that situation could be eased.

Mr KEENAN—What is the AMC's relationship to government?

Mr Frank—We are an independent standards body. We report to health ministers but we are not part of the Commonwealth or the state health departments.

Mr KEENAN—Who funds you?

Mr Frank—A combination of funds. We get grants from the Commonwealth and from the state and territory medical boards but 80 per cent of our income comes from the fees and charges we levy for our examination processes, our publications, our accreditation of medical schools and specialist colleges.

Mr KEENAN—You were talking about the decision of mutual recognition and what happened with some countries prior to 1991. The federal government took that decision to reverse that.

Mr Frank—No. New South Wales took the lead in 1987—my understanding is that it was under political pressure—by removing the United Kingdom recognition from its system. When New South Wales knew mutual recognition was coming in—and the problem with mutual recognition was that, if one state had a standard different to any other, then that would be the lowest common denominator that would allow people to enter through the system—agreement was taken by all the health ministers at that time that they would remove the United Kingdom qualifications from the list of recognised qualifications and, in the case of Tasmania, the South African qualifications. They were all taken off the system in 1991 in anticipation of the mutual recognition scheme coming into operation.

But as I mentioned before, there was no technical evidence to support that decision. Our accreditation process with Australian and New Zealand medical schools was originally based on the General Medical Council accreditation process, so the systems are identical in that sense.

Mr KEENAN—It seems like an extraordinarily silly thing to do, in hindsight anyway.

Mr Frank—At the time, that might not have been perceived that way. It obviously was not perceived that way.

Mr KEENAN—The ACCC reviewed the medical colleges. How far advanced are we on some of those recommendations that the ACCC has made?

Mr Frank—There are quite significant advancements. The College of Surgeons has a specific reporting framework within that review process. It has to continue to report its advances. It has made a number of advances in a number of areas. The jurisdictions have established a project team whose job it is to monitor compliance in all those areas because, as you probably know, after they did the College of Surgeons, they then rolled it out to all the other specialist colleges so they are all now captured by this.

The Australian Medical Council's role in that is that each of those colleges has to report certain activities and certain functions, decisions, actions, and they do that as part of an annual review of their training programs as part of our accreditation. We monitor those, and if there is non-compliance, then we report it up the line to health ministers and to the ACCC. It is early days though still. The Commonwealth has put money in to provide for rapid assessment units to advance some of these things. We are working with the colleges now to bring those initiatives forward.

Mr KEENAN—Are the colleges cooperative?

Mr Frank—Yes, they are. The biggest problem they have, I think, is resourcing because most of the work that is done by colleges is pro bono. Getting people together to do these sorts of things is not easy. There is also a problem in that the colleges are large-scale operations. They are national operations. The one thing that they are going to have to monitor themselves, as we have to in our own examination processes and probably all the medical schools do, too, is to ensure that the processes are applied consistently. That is something that the ACCC has identified. There are mechanisms put in place that would enable the colleges to do that, if they comply with the requirements of the ACCC.

CHAIR—There are three brief questions that as part of the inquiry we need to have you address briefly. You detailed in your submission the amount of material available for overseas doctors regarding registration and assessment requirements in Australia. Do you believe that there is sufficient coordination of material for potential migrants, through the Department of Immigration and Multicultural Affairs, for example? What is your assessment of the DoctorConnect website?

Mr Frank—I think it is early days on the DoctorConnect website, but we have no doubt from the feedback we are getting from overseas trained doctors that it is a very, very positive initiative. It has not been up for a year yet. It is just really still starting but certainly the feedback we have had from people applying to us and from information that they have channelled through to us indicates that internationally it is a well-recognised source. One of the problems with this area is it is not necessarily the quality or the quantity of the information you provide; it is whether people are actually prepared to go and look at it.

One of the interesting things about applications from specialists, for example, is that about one in eight applications is complete in the sense that, if you lay down what it is that they need to put in so that they can be evaluated by the colleges, only about one in eight has all the material you want. These are very intelligent people and the material is carefully laid down. It is really a compliance issue. The Canadians report between one in five and one in nine are complete, so they are seeing the same problem that we are. In some ways the trick is not that there is sufficient information—because I think there is overall; indeed, there is now, through the web systems that we all have and it is pretty readily available—it is understanding the processes and being able to navigate those. That is something I think needs to be reviewed constantly both for us and for DoctorConnect. It is also the fact that people simply do not bother going and looking for the information and then they wonder why things do not work when they get to the other end.

CHAIR—The AMC website states:

> As from January 2006, all applicants for the AMC examination … and the AMC—Specialist College assessment pathway … will require primary source verification of the medical qualifications through the International Credentials Service of the Educational Commission for Foreign Medical Graduates.

Can you give us an update on this, how you think it is going, and what the benefits are?

Mr Frank—Yes. That system has been available internationally for agencies like the AMC and the state and territory medical boards only since 2002. It is been operating in the US since the 1950s for the United States licensing processors. Basically, it vets all the material that comes in. It sends it back to the issuing institution and confirms that that particular award or qualification was awarded to that individual. It has also a vast library of documentation that can enable us to very quickly identify fraudulent documents or problems with documentation. We have been using it unofficially, or we have been using it for problem cases, for about the last year or so or a little over a year. We brought it on line from the beginning of this year. It is really only again in its early stages.

We have experienced some difficulties with some out of the way places like Iran, Iraq, and areas like that, but with the basic ones that we are getting through now, we have got an electronic link between the AMC and the ECFMG, so it is not subject to the normal post type disturbances.

We are assuming that, with a couple more things in place, this should be a very smooth operation. I should explain that nobody is held up because of it. In other words, when an applicant applies to the AMC, we do an initial vetting of the application ourselves. If it looks as though from our records and our databases that this is a bona fide application, we let the person proceed and send the documentation off for verification. So the only people who would be held up would be people we identified from our sources initially who had a problem. We would then send the documentation off for verification but we would not let that person proceed in the process if there was a risk that the documents were fraudulent. The ECFMG would then conduct their review. If it came back and it was okay, we would release that person and let them go forward. If it came back and indicated there was a problem then we would notify the relevant authorities in Australia.

CHAIR—On fraud, do you work with the fraud section of DIMA?

Mr Frank—No, not usually. We work directly with the state and territory medical boards because they are usually through DIMA by the time they come to us.

CHAIR—You commented on the importance of bridging courses for the overseas trained doctors and state that:

> The scale of resources necessary to support comprehensive bridging courses … whilst manageable with 140 candidates per year, becomes more of a problem with [AMC's current] 900 candidates per year.

How are you addressing this difficulty? What needs to be done in this area?

Mr Frank—I think I have quoted in that submission that there have been a number of inquiries done, including the original Fry committee in 1982 and more recently the MTRP and ARTD surveys that indicate that this is not a homogeneous group of people we are talking about here and their needs are not homogeneous. Given there is going to be for the foreseeable future a limitation on the resources available, those resources really have to be tailored to the needs of the particular individual. What happened when the first lot of grants were approved in 1990 and subsequently was that everyone focused on the outcomes to such an extent that they would pre-test the people they were putting into the bridging programs. Those guys did not need bridging. It was the next cohort down that needed the bridging.

I think that in applying what limited resources there are, those resources really have to be targeted to the needs of the individual. Currently the Commonwealth government under the Strengthening Medicare initiative has set up a system to develop learning profiles for individual OTDs who had been unsuccessful in their examinations in the past. I think that is a very positive step and that is going in the right direction. It will mean that the resources that are available can be tailored to the particular needs of the individuals, rather than simply basing it on the ones that perhaps are going to get through these examinations anyway. I think that is a really positive initiative.

Mr LAURIE FERGUSON—Is it by nationality rather than by where people receive training?

Mr Frank—No. The countries listed there are countries of training, not nationality.

Mr LAURIE FERGUSON—Thank you very much.

CHAIR—You do not have any migration issues that you wish to apprise us of?

Mr Frank—No. I think if you consider the medical workforce shortage we are in at moment, it is somewhat ironic that not that long ago, and certainly within my lifetime with the AMC, we used to impose points penalties on overseas trained qualified medical practitioners coming into this country. It just demonstrates the complexity of workforce planning and planning generally in these areas. This is not an area that lends itself particularly well to what you might call sudden reversals of policy. Unfortunately it has been an area that has been characterised by that in a lot of different aspects of what is going on, at both state and federal level. It is a really complex piece of machinery. If we are going to start tinkering with it, we would need to be very careful about what we are doing.

CHAIR—I am sure that will be registered. Thank you for attending today's hearing. The secretariat will send you a copy of the transcript for any corrections that need to be made. I would be grateful if you could also send the secretariat any additional material you have undertaken to provide as soon as possible. As there were some members of the committee who were not able to be present today, the secretariat may also send you some additional questions in writing that we would appreciate you answering.

Mr Frank—Absolutely.

Resolved (on motion by **Mr Keenan**, seconded by **Mr Ferguson**):

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.55 pm