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(Overseas Trained Doctors)
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MELBOURNE MEDICAL DEPUTISING SERVICE
when quality matters

Melbourne Medical Deputising Service (MMDS)

Submission to the House of Representatives Standing Committee on Health and Ageing

'Inquiry into Registration Processes and Support for Overseas Trained Doctors'

18 February 2011

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SUMMARY OF RECOMMENDATIONS

1. *That as a key element in the delivery of primary medical care, MMDS (and other medical deputising services) be formally recognised as general practice and, accordingly, included as stakeholders to receive direct notification of all health and ageing announcements, media releases and publications relevant to general practice.*

2. *That guidelines related to workforce programs have mechanisms which allow special consideration of the circumstances of individual doctors including timelines related to the achievement of FRACGP.*

3. *That as recommended by previous Medicare Provider Number Legislation Reviews, a review committee comprising key stakeholders (including MMDS) should be constituted to ensure a formal and coordinated mechanism where issues related to the practical implementation of workforce programs can be raised and resolved*

4. *That access to higher rebate after-hours item numbers for doctors on the AMDS Program is based on:*

    - *Recognition of the value of after-hours services provided by (non-VR, primarily IMG) medical practitioners, that is, the doctors who are prepared to work the unsociable hours, fill a vital role in the delivery of appropriate and timely primary medical care after-hours should be recognised for their contribution.*

    - *A demonstrated commitment by non-VR doctors to quality improvement and continuing professional development which is verified by participation in RACGP recognised QI&CPD.*

    - *Fairness for patients treated after-hours who should not to be financially disadvantaged (1) because they became ill after hours and (2) because the doctor was non-VR – patients should not be left with the perception that primary medical care provided after hours is sub-standard.*

    - *Recognition that access to higher rebate after-hours item numbers is an important incentive in the recruitment of doctors who are prepared to provide primary care during unsociable hours on behalf of patients' usual GPs.*

5. *That the Department of Health and Ageing investigate and ascertain:*

    - *Whether the requirement to enrol for assessment leading to FRACGP or FACRRM in order to access A1 after-hours item numbers has resulted in greater numbers of vocationally registered GPs?*

    And

    - *Whether it is equitable to deny VMOs, who provide quality primary care during unsociable hours, access to A1 item numbers?*

6. *That the AHOMPs Program is redundant in the context of the AMDS Program and its QI&CPD requirements.*

7. *That the 19AB 10-year moratorium be reduced to a less extreme period of time and be scaled back gradually to ensure workforce continuity in areas specified as*

'district of workforce shortage' or 'area of need' and ultimately apply only to temporary resident doctors.

8. *That student placement programs be developed to introduce and involve medical students in the provision of primary medical care in rural, after-hours and home visiting environments.*

9. *That measures to alleviate workforce shortages focus on providing incentives (such as appropriate financial remuneration and locum back up to allow for annual leave) to attract doctors to work in these areas.*

9. *That the RACGP provides affordable and appropriate membership (comparable with that of GP Registrar) for IMGs on the practice eligible pathway to Fellowship that ensures their QI&CPD points are recorded and that provides access to GP Learning on line and other RACGP learning resources.*

10. *That website information provided by assessment and entry systems is backed up by approachable, accessible and knowledgeable trained staff.*

11. *That the assessment and entry system organisations investigate ways to improve administrative efficiency and remove unnecessary delays.*

12. *That the different options available to arrange a PESCI are well-publicised on the AHPRA website and that an information box is added to the PESCI question on medical registration application form(s).*

13. *That video conferencing be an option for IMGs who are interstate or off-shore and that the management, scheduling, interview type and content process are consistent across all PESCI providers.*

14. *That within 10 days of lodgement of a medical registration application a PESCI where required can be scheduled to take place in a timeframe of no more than one (1) month hence.*

15. *That representatives from the registrations section of AHPRA Vic visit MMDS to ensure they are fully informed about the work carried out by visiting medical officers (VMOs) and are confident about the clinical governance and support systems and accredited QI&CPD provided.*

16. *That AHPRA and the RACGP have special consideration mechanisms or discretion in order to avoid unintended consequences related to administrative processes.*

1 Introduction

(Definitions: (1) throughout this submission overseas trained doctors are defined as international medical graduates (IMGs). (2) References to 'AMDS doctors' should be read as meaning IMGs.)

Melbourne Medical Deputising Service (MMDS) is a medical deputising service (MDS) accredited by AGPAL[1] which arranges for doctors to visit and treat patients at home (private home or residential care) after hours and on behalf of the patient's usual GP. When GPs close their clinics at the end of the day, on weekends and on public holidays, they divert their phone to a medical deputising service so their patients have access to appropriate and timely medical care 24 hours a day, 365 days a year – GPs provide care for their patients in-hours and visiting medical officers (VMOs) provide care on the GP's behalf after hours.

VMOs provide excellent medicine and manage the medical problems of patients and take responsible action on any medical problem with which a patient presents.

In doing so they:

- record a history of presenting complaint, relevant history, current medications, allergies, their examination findings, a diagnosis and their management plan which may require the patient to see their regular doctor for follow up or ongoing care.
- prepare a comprehensive report for each patient seen which is transferred electronically an hour after it is completed to the clinical software of the patient's usual GP. Accordingly, VMOs play a significant part in continuity of care for the patients they attend.
- treat patients from all socio-economic and cultural backgrounds of all age groups, in their private homes or residential care facilities. Residential care includes aged care, community residential units for the disabled, youth justice centres and refugees. Patients are triaged on their symptoms by the Service, however, outcomes can range from URTI's to AMI's, requiring extensive history taking and examination by the VMO to allow formulation of an appropriate treatment and management plan.
- Contend and cope well with all the challenges posed by the provision of after-hours primary care in the home setting. The practical care provided includes but is not limited to organising emergency treatment and transfer, prescribing and administering medications, oral and IMI, suturing lacerations, nasal packing, peg tube maintenance, catheter replacement, urine testing, BSLs and observations including B/P.

As an extension of general practice there are medical deputising services across Australia. Medical deputising is an essential service within the umbrella of primary health care in Australia[2], however, medical deputising is regularly left off stakeholder

[1] A recognised accreditation agency

[2] On a national basis, each year medical deputising services provide 10 – 12 % of all primary medical care consultations – eg in 2009 the figure was 850,000 consultations

lists and overlooked for input or comment regarding government policy or departmental matters related to general practice and of significance to MMDS in particular.

As a result, MMDS believes that it[3] (and other medical deputising services) should be included in the general practice category and recognised as stakeholders to receive direct information about health and ageing announcements, media releases and publications relevant to general practice.

MMDS is one of two medical deputising services in Victoria and it has operated successfully since it was established in 1979. Each year in Victoria, MMDS facilitates the provision of 120,000 home visits, of which, some 54,000 are visits to patients in residential aged care[4]

These are significant consultation numbers and at any one time MMDS has a pool of 70 – 80 visiting medical officers (VMOs) who work predominately on a part-time basis and provide these home visits. These doctors (almost half of whom are Fellows of the RACGP) combine the work they do after hours with their in-clinic or hospital emergency department work.

Our workforce is sourced from the Australian health system – that is, doctors who trained in Australia and IMGs who have had the tenacity necessary to overcome the many hurdles encountered on the way to registration to practice in Australia (and FRACGP or recognition in another field. The MMDS workforce comprises:

- vocationally registered, FRACGPs who combine work in their own practices with part-time VMO work with MMDS;
- vocationally registered, FRACGPs who are career VMOs working only with MMDS and at a level of hours that suits their lifestyle; and
- VMOs working part-time with MMDS via the AMDS Program (this accounts for almost half of the MMDS clinical workforce)

At MMDS we have mechanisms in place that ensure we maintain a close working relationship with all our VMOs and together with what's happening in their lives in general, we stay abreast of their career progress and any difficulties encountered in this regard. In addition, MMDS provides all necessary administrative support towards medical registration, registration on approved placement programs, provider numbers and support regarding verifiable hours worked as required by RACGP assessment processes.

Accordingly, MMDS is well-placed to provide input about registration and support processes that affect IMGs who are either on-shore or off-shore.

[3] MMDS has demonstrated adherence to a continuous quality improvement model and as a result of its successful 35 year history in medical deputising as a depth of knowledge which it is happy to share in the interests of better outcomes for all concerned, not the least of which being those patients who have to rely absolutely on others for the provision of their care.

[4] One of the most vulnerable groups in the community, totally dependent on others to ensure they have access to appropriate medical care, adversely affected by the fact that each year fewer GPs are willing or able to visit patients in residential aged care.

Recommendation

1. *That as a key element in the delivery of primary medical care, MMDS (and other medical deputising services) be formally recognised as general practice and, accordingly, included as stakeholders to receive direct notification of all health and ageing announcements, media releases and publications relevant to general practice.*

2 Continuing Need for IMGs

Australia has long since recognised the importance of IMGs in order to alleviate workforce shortages in the provision health care for the Australian community. IMGs have made a substantial contribution to the provision of primary medical care after hours and in the home setting. They have been, and continue to be, willing and able to work where other doctors have not, for example, overnight, on weekends and public holidays including Christmas and Easter. As VMOs working with MMDS, IMGs are the doctors who provide a high proportion of all consultations for patients in residential aged care – as noted earlier, every year our VMOs provide some 54,000 home visits to patients in residential aged care. IMGs deserve respect and appropriate reward for their contribution.

There is little on the horizon to indicate that workforce shortages will ease in the future – certainly not in the provision of after-hours care. The latest MABEL Survey Report[5] found that GPs are no longer able to provide the after-hours service themselves:

- Around 50% of doctors would like to reduce their working hours.
- Around a quarter of all doctors are very or moderately dissatisfied with their hours of work.
- The first wave of the study's data collection completed in 2008 found that nearly 12% of the GP workforce was expected to retire within five years (*MO, 1 May 2009*).
- Intentions to quit are largely driven by those over 55 years old who expect to retire, and thus reflects the loss to the workforce of the 'baby boomer' generation

These indicators together with a growing and ageing population and the advent of the national call centre[6] will compound already exacerbated workforce shortages.

It is unlikely (particularly in regard to primary medical care after hours) that Australia's reliance on IMGs will diminish in the foreseeable future. (It is possible but highly unlikely that we will be able to persuade expatriates to return to Australia to provide after hours care and home visits.)

Australia needs entry systems that are rigorous but not obstructive; that encourage and support participation by IMGs in QI&CPD; and Fellowship goals that are practical and allow consideration of the circumstances of individual IMGs.

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[5] The MABEL Survey funded by the National Health and Medical Research Council (NHMRC) for five years until 2011 and endorsed by key medical Colleges and organisations.

[6] As part of the Commonwealth Health Reform agenda a National Health Call Centre to provide patients with access to telephone-based GP medical advice will come into effect 1 July 2011.

Recommendation

2. *That guidelines related to workforce programs have mechanisms which allow special consideration of the circumstances of individual doctors including timelines related to the achievement of FRACGP.*

3 Regulatory mechanisms that drive quality

Section 19AA of the *Health Insurance Act 1973* (the Act) was introduced to recognise and support general practice as a vocational specialty, as well as to provide a framework for achieving long term improvements in the quality of doctors working in Australia. The effect is that a doctor who is not vocationally registered cannot have access to a provider number (for the purposes of providing their patients with access to Medicare benefits) unless they have an exemption to Section 19AA through an approved program under Section 3GA of the Act. MMDS strongly supports this legislative approach both in principle and in practice, for example, MMDS:

- provided written support in its submission to the 2010 Medicare Provider Number Legislation Review (results to be released shortly).
- Runs a robust QI&CPD Program and monitors the progress of its doctors who are not vocationally registered. (Paragraph 5 below details the contents of the MMDS QI&CPD Program)

Section 19AA is the driving force behind the provision of quality primary (general practice) medical care for patients but in doing so it recognises that consideration needs to be given to its effect on workforce shortages. As a result, there are a number of programs under Section 3GA of the Act (which in certain circumstances provide exemptions to Section 19AA) that are designed to ease workforce shortages and at the same time require compliance with mechanisms towards improvements in the quality of doctors working in Australia.

One such program is the Approved Medical Deputising Services (AMDS) Program[7]:

> *The Australian Government recognises that the provision of after-hours medical services is an area of workforce shortage. The principle behind the AMDS Program is to improve public access to after-hours medical services provided by medical deputising services.*
>
> *Medical practitioners subject to section 19AA of the Health Insurance Act 1973 may, under the AMDS Program, provide after hours services that attract benefits under the Medicare Benefits Scheme if they have a current and valid approved placement* on the Program.[8]

[7] Administered by the Department of Health and Ageing.
[8] Department of Health and Ageing, *Health Insurance Act 1973* Approved Medical Deputising Service (AMDS) Program Guidelines, 1 November 2007

MMDS is recognised by the Department of Health and Ageing (DoHA) as an Accredited Provider for the purposes of the AMDS Program[9] and has successfully participated in the Program since its inception in 1999. The AMDS Program Guidelines (updated from time to time) require all participants (and the organisation in which they work) to comply with QI&CPD activities at a level that is recognised by the RACGP.
As noted earlier, almost half of the MMDS clinical workforce are doctors on the AMDS Program and are overwhelmingly IMGs.[10] Accordingly, references below to AMDS doctors should be interpreted as references to IMGs.

Since the inception of the AMDS Program in 1999, MMDS has successfully managed some 80 AMDS doctors through the requirements of the Program, 28 of these doctors are now Fellows of the RACGP and working in general practice. At any one time, the number of AMDS doctors managed by MMDS is in the range of 35 – 45.

In the context of the prerequisites for participation in the AMDS Program (relevant experience, citizen/PR status, registration, medical indemnity cover), the profile of AMDS doctors working with MMDS is that of very experienced and mature medical practitioners.

There are a few Australian trained doctors who work as VMOs with MMDS through the AMDS Program but the majority (currently 40) are IMGs who have extensive experience as medical practitioners overseas and in the Australian health system. Their experience in Australia includes considerable ED work in both rural and urban hospitals as well as placements in rural GP clinics. They have well-established families to support including children at various stages in their education. Part-time VMO work with MMDS provides these doctors with access to supplementary income, introduces them to and/or adds to their general practice experience and provides a much needed service for the community.

The majority of the AMDS doctors who work with MMDS are on their way to Fellowship through the 'practice eligible pathway' to FRACGP[11] or are in structured GP training placements. In addition, there are a number of VMOs who have already achieved, or are progressing towards, specialist status in areas such as emergency medicine, cardiology, O&G or physician training. The combination of their continuing participation in RACGP accredited QI&CPD and their specialist training skills equips them very well to manage the presentations they encounter after hours and in a domiciliary setting (private or residential care).

As workforce shortages in the after-hours arena have worsened MMDS is now endeavouring to recruit suitably qualified and experienced doctors from overseas to work in Australia on a temporary resident visa. The pathway to medical registration for IMGs will differ according to their qualifications and experience, however, having been granted registration they will then go on to be governed by other legislative mechanisms which are in place to ensure the provision of high quality primary medical care by doctors working in Australia, that is, Section 19AA which requires vocational registration unless exempt in line with Section 3GA and subject to QI&CPD compliance.

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[9] In 2002 MMDS was the first MDS in Australia to be accredited according to the RACGP Standards for General Practices. It continues to be accredited and to operate on a continuous quality improvement model.
[10] Of the current complement of AMDS doctors 42, only 3 are in the category of Australian trained.
[11] RACGP practice pathway requires 4 years Australian, or equivalent, GP experience to be eligible for assessment to enrol for FRACGP exams.

3.1 How much QI&CPD is enough?

While it is essential that participation in QI&CPD is a mandatory requirement of the AMDS program, the requirement for 100 points a year (300 per triennium) is onerous especially when the requirement for vocationally registered GPs is 130 points for the whole triennium. (It is important to note that MMDS consultation with the RACGP and the AMA after the implementation of the AMDS guidelines, updated in 2007, revealed that such a heavy QI&CPD load was never intended.)

Recommendation

3. *That as recommended by previous Medicare Provider Number Legislation Reviews, a review committee comprising key stakeholders (including MMDS) should be constituted to ensure a formal and coordinated mechanism where issues related to the practical implementation of workforce programs can be raised and resolved.*

3.2 Effect of the After Hours Other Medical Practitioners (AHOMPs) Program

In addition to the QI&CPD requirement, doctors who provide primary medical care after hours through the AMDS Program are subject to discrimination regarding access to certain Medicare item numbers. As non-vocationally registered doctors, AMDS doctors are only allowed access to the lower rebate Medicare item numbers (unless they are registered in yet another program – the AHOMPs Program).

This AHOMPs Program seems to duplicate the QI&CPD requirements of the AMDS Program.

The AMDS Program already requires compliance with RACGP accredited QI&CPD and encourages AMDS doctors to achieve vocational registration. The imposition of the constraints of the AHOMPS Program in order to have equitable access to the higher Medicare rebate discriminates against non-VR (primarily IMGs) doctors - it implies that the care they provide is second-rate and it fails to recognise the value of after-hours and home visiting services

Recommendations

4. *That access to higher rebate Medicare item numbers for doctors on the AMDS Program s be based on:*
    - *Recognition of the value of after-hours and home visiting services provided by (non-VR, primarily IMG) practitioners. That is, the doctors who are prepared to work the unsociable hours, fill a vital role in the delivery of appropriate and timely primary medical care after-hours and home visits should be recognised for their contribution.*
    - *A demonstrated commitment by non-VR doctors to quality improvement and continuing professional development which is verified by participation in RACGP recognised QI&CPD.*
    - *Fairness for patients treated after-hours at home who should not to be financially disadvantaged (1) because they became ill after hours and (2) because the doctor was non-VR – patients should not be left with the perception that primary medical care provided was sub-standard.*
    - *Recognition that access to higher rebate Medicare item numbers is an important incentive in the recruitment of doctors who are prepared to*

provide primary care during unsociable hours on behalf of the patient's usual GPs.

5. *That the Department of Health and Ageing investigate and ascertain:*
   - *Whether the requirement to enrol for assessment leading to FRACGP or FACRRM in order to access higher rebate item numbers has resulted in greater numbers of vocationally registered GPs?*

   And
   - *Whether it is equitable to deny VMOs, who provide quality primary care during unsociable hours, access to higher rebate item numbers?*

6. *That the AHOMPs Program is redundant in the context of the AMDS Program and its QI&CPD requirements.*

4 Section 19AB

While the intent of Sections 19AA and 3GA are admirable in the context of improving and maintaining the quality of doctors working in Australia, Section 19AB seems out dated and discriminatory. Its effect restricts doctors, primarily IMGs, to work only in a designated 'area of need' or 'district of workforce shortage'.

The 10-year moratorium[12] was introduced in an environment of workforce over-supply as a mechanism to control and distribute the clinical workforce to meet population needs in areas specified as 'district of workforce shortage' or 'area of need'. Whereas today (and for the past 15 years) Australia confronts a serious under-supply of doctors - workforce shortages are wide-spread and continue to worsen.

Section 19AB has not solved the problems related medical workforce shortages; it has been a 'stick' approach that has avoided proper consideration of incentives and creative programs to encourage doctors to work in areas of workforce shortage.

A 10-year moratorium seems extreme for all categories of those affected:

- IMGs who are citizens or permanent residents
- IMGs who are citizens or permanent residents and who have achieved Fellowship
- Australian trained doctors who are temporary residents
- IMGS who Temporary resident doctors

The stories about the unfairness of 19AB are many, for example, MMDS has experience with doctors who completed their medical training overseas and:

- re-trained and obtained MB BS in Australia, contributed to the community through work in hospitals and after hours through the AMDS Program and are now in rural GP training placements working towards Fellowship – remuneration is poor and most are separated from their families during the week.
- trained and worked as nurses in Australia, passed AMC exams and obtained medical registration, contributed to the community through work in hospitals

[12] Commencement and completion of the Section 19AB 10-year moratorium is influenced by the date the doctor was first registered to practice in Australia and if not Australian born, the date citizenship or permanent resident status was conferred.

and after-hours through the AMDS Program, completed GP training in rural placements and now have Fellowship of the RACGP – still constrained by 19AB

- obtained Australian medical registration, contributed to the community through work in hospitals and after hours through the AMDS program and have now achieved Fellowship – still constrained by 19AB

Recommendations

7. *That the 19AB 10-year moratorium be reduced to a less extreme period of time and be scaled back gradually to ensure workforce continuity in areas specified as 'district of workforce shortage' or 'area of need' and ultimately apply only to temporary resident doctors.*

8. *That student placement programs be developed to introduce and involve medical students in the provision of primary medical care in rural, after-hours and home visiting environments.*

9. *That measures to alleviate workforce shortages focus on providing incentives (such as appropriate financial remuneration and locum back up to allow for annual leave) to attract doctors to work in these areas.*

5 MMDS as an example of encouraging and supporting Quality Improvement and Continuing Professional Development

MMDS has structured processes in place to manage and monitor the professional development of its clinical workforce and, in particular, doctors who are part of programs to ease workforce shortages and improve the quality of and access to care provided by medical practitioners in Australia.

It is important to note that MMDS (and medical deputising in general) does not receive any incentives or compensation from government in recognition of its investment in QI&CPD for its clinical workforce.

As an accredited RACGP QI&CPD provider, MMDS is able to provide structured learning which entitles its doctors to RACGP points that verify compliance with continuing professional development.

5.1 Induction Program

Completion of the comprehensive induction program is a mandatory requirement for all doctors new to MMDS. MMDS has a structured learning program (accredited by the RACGP as a Category 1 Active Learning Module (ALM)) which involves 12 hours of training.

This ALM is a comprehensive 3-module induction program, usually conducted on a one-to-one basis but can also be delivered as a small group induction.

Its purpose is to prepare VMOs for all aspects of treating patients at home on behalf of the patient's principal GP. The program comprises

A Predisposing module: introduction meeting, selected reading

B. Face-to-Face module is in three (3) parts:

1. MMDS policies and procedures including statutory compliance formalities; protocols for personal safety; Medicare requirements and

item numbers, Medicare On-line, Clinical reports electronically transferred to principal GPs.

2. Clinical observation shift with the MMDS medical director (or his delegate).
3. Pharmacy induction with a pharmacist who has particular knowledge of the work of deputising doctors and the medication and prescribing requirements which commonly apply to after-hours and home visits.

C. Reforcing module - reflection on feedback from medical director following his review (at the end of first month) of a new VMO's clinical notes; and evaluation questionnaire completed after appropriate time for reflection based on actual practice as a VMO.

5.2 Continuing Professional Development

MMDS provides a robust QI&CPD program for all its doctors and it includes monthly mentor meetings that specifically target doctors on the AMDS Program.

Each year the MMDS program comprises:

- monthly QI&CPD sessions (accredited by the RACGP as Category 2 QI&CPD activities)
- monthly mentor meetings (two series each year) which are accredited by the RACGP as Category 1 ALM activities). All doctors in the AMDS Program are required to attend these meetings and attendance is monitored. Each ALM comprises 5 sessions @ 1 ½ hours each, a total of 7 ½ hours for each participant. AMDS doctors are allocated to one of three groups, each group comprising 6 – 15 doctors plus a mentor/facilitator - the MMDS medical director and other vocationally registered GPs are mentors/facilitators. At each meeting at least two case studies are presented and over the course of the program all AMDS doctors will select at least one of their own consultations to present as a case study for review by their peers – this is an excellent self-directed, adult learning approach and overall encourages a collegial approach which upholds the ethic of doctors helping other doctors.

MMDS monitors the CPD progress of all its VMOs, in particular, the participation of its AMDS doctors in QI&CPD provided by MMDS – this information forms part of the annual and comprehensive progress reports about the application of AMDS Program that are provided by MMDS to the Department of Health and Ageing (copy attached).[13]

6 RACGP membership status – affordable and appropriate

Premise: that the RACGP is the authority regarding QI&CPD for general practice.

In order to have QI&CPD points (RACGP accredited or equivalent) recorded for the purposes of the AMDS Program, AMDS doctors need to either **join** the RACGP (which is what MMDS recommends at the time a new doctor is inducted) OR **register** with the RACGP as a doctor participating in the AHOMPs Program.

MMDS recommends to all its non-vocationally registered doctors that they **JOIN** the RACGP so that together with having QI&CPD points recorded they can have access to GP Learning on-line and other RACGP learning resources – thus, encouraging and emphasising the importance of QI&CPD participation.

[13] as submitted to AH GP Section, June 2010

MMDS requires that all its doctors have an RACGP number and has mechanisms in place to monitor compliance.

Options for non-vocationally registered doctors

Membership/Register Option	Cost per annum	Access to GP Learning and other RACGP learning resources
AHOMPS	423.00	x
GP Registrar	310.00	√
Associate ≤ 20 hrs	498.00	√
Associate ≥ 20 hrs	995.00	√

Many MMDS doctors (primarily IMGs) are working towards Fellowship of the RACGP via the Practice eligible pathway[14] and are **registered** with the RACGP in the AHOMPs category. Although the cost is similar to that which applies to other categories, the AHOMPs category does not give these doctors access to GP Learning on-line and other RACGP learning resources.

Also, it is not clear if the assessment of full-time and part-time is consistent across different areas at the RACGP. The membership area defines full-time as ≥ 20 hours per week whereas the assessment area seems to define full-time as 37 hours per week – it could be construed that this adversely affects IMGs, eg, if they join as associate members they are required to pay the full-time fee ($995.00) at the 20 hours per week point but for the purposes of assessment of experience, they are not credited with full-time status unless they meet the 37 hours per week measure.

Recommendation

9. *That the RACGP provides affordable and appropriate membership (comparable with that of GP Registrar) for IMGs on the practice eligible pathway to Fellowship that ensures their QI&CPD points are recorded and that provides access to GP Learning on line and other RACGP learning resources.*

7 Assessment and Entry Systems

Evaluation and verification of qualifications and suitability for particular positions must be rigorous but not obstructive.

MMDS personnel have witnessed the difficulties encountered by IMGs in finding a way through the maze of complex information. Each step in the process is long and frustrating, the overall financial cost for IMGS is many thousands of dollars and they are at a loss to understand why everything is so hard when dealing with the relevant assessment and entry systems (AMC, AHPRA and RACGP) -– it's as though these particular bodies don't want the IMGs to progress.

[14] Practice Eligible Pathway

Prerequisite: 4 years Australian equivalent general practice experience, 1 year of which must be in an Australian setting. IMGS apply to have their experience assessed. From this they ascertain how much Australian general practice experience they need, ie, 1 year or more. Once the College has assessed their overall general practice experience as equivalent to 4 years full-time, IMGs are eligible to apply to enrol to sit the exam.

There are valid reasons why the entry system processes are complex, however, it's important to remember that one size does not fit all and a simple 'let me help you' approach takes no more time and in the long term is beneficial for all concerned.

Recommendations

10. That website information provided by assessment and entry systems is backed up by approachable, accessible and knowledgeable trained staff.

11. That the assessment and entry system organisations investigate ways to improve administrative efficiency and remove unnecessary delays.

7.1 Australian Health Practitioner Regulation Agency (AHPRA)

While MMDS is sympathetic to the administrative workload and difficulties that may be related to the introduction of the national registration scheme, our experience with AHPRA has been most unsatisfactory.

7.1.1 Case Study 1 - IMG off shore

5th August 2010	Application lodged with AHPRA Victoria
29th September 2010	Wrote to Medical Board Australia (MBA) with concerns about delay in the process.
12th October 2010	Advised by MBA that the enquiry had been forwarded to State office (in this case Victoria) where individual registrant queries are handled.
16th November 2010	Formal notification from AHPRA Vic that the doctor had been placed on PESCI (pre employment structured clinical interview) waiting list of 4 – 6 months, however, no scheduled or indicative date was available. We were told that we would be given a few weeks' notice once the date was set. A few weeks' notice may work for a doctor who is on-shore but it is not at all helpful for a doctor who is off-shore and needs to arrange a visa in order to travel to Australia to complete the PESCI – such visa application requires written evidence of the purpose and date for which the doctor is required.
6th December 2010	Follow-up email enquiry to registration manager Vic – no response
13th January 2011	Further follow-up email to Vic registration manager. Email response from person responsible for scheduling PESCIs in Victoria: *'...still some way down the PESCI waiting list; I suggest you make contact with South Australia RACGP.'*

This suggestion was acted on immediately and the doctor is now booked to complete the PESCI 31 March 2011 in Adelaide – it would have saved a lot of angst for the doctor (and others) if we had known about this option earlier.

The doctor's Certificate of Good Standing has now expired – in many parts of the world obtaining another is both difficult and dangerous. AHPRA apparently has the option to consider if circumstances warrant a waiver of the currency requirement for the good standing certificate, however, it will not do this until after the IMG has completed the PESCI.

Since the commissioning of AHPRA in July last year we have found the processing of national registration extremely slow and while the staff on the help lines are always polite and do try to assist they field calls in a generic manner. On some occasions information provided has been found to be inconsistent and inaccurate. On more than one occasion, when necessary information was not available from the AHPRA website, MMDS personnel have experienced 'I can't give you that information because of privacy reasons' – central call centre staff did not seem to know that a doctor's registration status is public information.

As directed by the AHPRA central call centre, we have made many enquiries to the AHPRA Victorian office. We are very concerned about the lack of response to messages and the lack of information available from the Victoria office and the detrimental effect this has on our IMG candidates.

When dealing with AHPRA nothing has been forthcoming in the way of options or possible solutions – as noted above, we have only just discovered that there are options other than AHPRA for an off-shore IMG to complete a PESCI – a simple phone call or email much earlier would have avoided all the angst.

The way things are progressing, it is likely the doctor's English Test will expire and AHPRA will require the doctor to go through the process again (more time, more money). It is hoped that AHPRA can apply a special consideration approach and accept that the verification of English language skills in the PESCI process is adequate evidence.

PESCIs

We understand (as recently advised by AHPRA) that off-shore IMGs can arrange a PESCI through AHPRA, Health Workforce Assessment Victoria or the RACGP (SA) and that PESCIs are currently only available in person on-shore in Australia. Although AHPRA has not mentioned ACRRM, we understand that ACRRM can arrange PESCIs. At this stage we are not sure if our (MMDS) off-shore IMG candidates are eligible to access the ACRRM process, however, the ACRRM website certainly indicates that video conferencing is available for both off-shore and on-shore doctors.

We understand that individual state offices of AHPRA differ in the way they manage and schedule PESCIs and that there is inconsistency in the way PESCI providers ensure that interview content is relevant. For example, one provider may properly require full information about the position for which an IMG is being considered whereas another will not. Differences in the way medical registration is handled at the state level seems inconsistent with the intent of national registration.

Recommendations

12. *That the different options available to arrange a PESCI are well-publicised on the AHPRA website and that an information box is added to the PESCI question on medical registration application form(s).*

13. *That video conferencing be an option for IMGs who are interstate or off-shore and that the management, scheduling, interview type and content process are consistent across all PESCI providers.*

14. *That within 10 days of lodgement of a medical registration application a PESCI where required can be scheduled to take place in a timeframe of no more than one (1) month hence.*

15. *That representatives from the registrations section of AHPRA Vic visit MMDS to ensure they are fully informed about the work carried out by visiting medical officers (VMOs) and are confident about the clinical governance and support systems and accredited QI&CPD provided.*

7.1.2 Case Study 2 – IMG Application to renew registration

5th November 2010	application to renew limited medical registration lodged. Expiry date on current registration was 11th January 2011 so renewal submitted in timely manner and with all required supporting documentation including RACGP assessment and enrolment statement which verifies that doctor (1) sat exam 20 October 2010 but failed by .79 of 1 mark and (2) is well on the way to achievement of Fellowship of the RACGP.
2nd December 2010	Registration Committee scheduled to consider application.
9th December 2010	Registration Manager advises doctor that renewal has not been approved and will be forwarded to Registrations Director for further consideration. The doctor is most distressed, FRACGP is within sight and previous applications have never been a problem.
11th December 2010	RACGP Deadline to enrol to re-sit exam. Unable to enrol without registration, no RACGP discretion, only option is to sit in the second half of the year which of course affects all related dependency timelines.
22nd December 2010	Registration renewal approved

MMDS is confident that the doctor concerned would be more than happy to take the Inquiry Committee through chapter and verse of her experiences with the administrative hurdles of both the RACGP and AHPRA.

Recommendation

16. *That AHPRA and the RACGP have special consideration mechanisms or discretion in order to avoid unintended consequences related to administrative processes.*