Submission No. 32
(Overseas Trained Doctors)
Date: 03/02/2011

Submission – Inquiry into Registration Processes and Support for Overseas Trained Doctors

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

a. Administrative processes

The recent attempt to nationalize and streamline the process by which an OTD is assessed and registered has demonstrated that the complexity of seeking work in Australia continues to increase, not decrease. Those who have been in the industry for over a decade are able to map how the process has changed in light of negative factors (eg the Dr Patel scenario in Bundaberg leading to national assessment guidelines enforced in each jurisdiction) and positive factors (the Australian Government intention to increase standard by insisting on specialist qualifications from general practitioners wanting to access a Medicare provider number). The process is now considered one of the most complex in the world (anecdotally from incoming OTD).

An OTD needs to participate in the following process to get to a point where they do not have any concerns with their ongoing registration is Australia:

- Finding a suitable job (relevant clinical type and scope, family and social needs, District of Workforce Shortage/Area of Need)
- Eligibility to work (English language competency, Primary Source Verification of medical degrees, a pass in the AMC MCQ exam or Certificate of Advanced Standing/Specialist qualifications)
- Choosing the right registration pathway (Competent Authority, Standard Pathway, Specialist Pathway)
- Appropriate Assessment of clinical competency for a specific role (Pre-employment Structured Clinical Interview – PESCI)
- Obtaining an appropriate visa
- Registration Certificate with Conditions (time limit to general registration, upskilling, requirement to participate in Continuing Professional Development etc)
- Orientation
- Work
- Ongoing training toward General Registration (the AMC Clinical Exam) or Specialist Registration (the FRACGP or the FACRRM)
- Gaining General Registration or passing the FRACGP/FACCRM exams
- Obtaining Permanent Residency/Citizenship

Each of the above dot points have various (and sometimes contradictory) forks in the road where the OTD needs to make a decision which way to go. The interaction between dot points means the number of possible combinations and permutations increases exponentially for an individual(for example, an OTD can change registration pathways mid-journey depending on circumstances, and gaining Permanent Residency can impact on where an OTD can continue to work).

It is asking too much of an OTD (especially if they are outside the country looking to come in) to understand the variations and the implications of what they choose.

Our experience is that there will always be a level of administration, and given the number of players in the regulatory environment, it will most likely continue to be relatively complicated – no matter how much each separate organisation attempts to streamline their administration.

Websites such as www.doctorconnect.gov.au have been of some assistance to OTDs (from anecdotal evidence) but the key factor has been the link on the website to *people* who can help an individual OTD navigate the system. Constant feedback from OTDs is that once they found a person to help them they hung on like a limpet mine until they were sure of what they were doing. While it may be appealing to try and deal with a system by setting up another system (websites are examples of this) nothing seems to satisfy people's concerns like connection with another human being.

The Australian Department of Health and Ageing fund Rural Workforce Agencies in each State and Territory. The RWAs have dedicated staff whose role is to work with OTDs looking for work as general practitioners in rural areas. They are required to keep up to date with changes across Medicare, AHPRA, DIAC, the RACGP/ACRRM, DoHA and State and Territory Health Departments.

b. Accountability Measures

By accountability we are assuming it refers to the relationship between the registered OTD and AHPRA. There is no accountability between an OTD and a college until they are vocationally registered, and that would deal with the registration problem ipso facto.

To put it simply, AHPRA state on the registration certificate what the OTD must achieve to remain registered, and provide a time frame in which this must be done. The language is simple and the conditions are usually clear – either gain General Registration or Conditional Specialist Registration by the due date.

AHPRA require ongoing supervisor reports, and that's it. The do not provide mentoring, or training, or even a shoulder to cry on. It's not their job. It is up to the IMG to ensure they meet the conditions, not AHPRA. AHPRA have set up a website what an IMG can look at their conditions at any stage, so there are no excuses for not knowing what is required of you and by when.

In light of this, the accountability issue is moot.

For those IMGs who were caught in the change-over from the state based system to AHPRA, our recommendation is that they should be given clear conditions which meet the new guidelines and then simply expected to meet them. AHPRA should not be expected to provide support to meet the conditions, however. See 2a below.

c. Better Understanding of Assessment Processes

Any OTD who is not vocationally recognised and who is looking for work as a GP has to be clinically assessed for the position they want to take up. Each OTD must participate in a Pre-Employment Structured Clinical Interview (PESCI). The AMC accredit PESCI providers in each jurisdiction to conduct the interviews. Each PESCI provider conducts their interviews slightly differently but they must sit within the AMC guidelines.

The issues which have arisen since the introduction of the PESCIs nationally (PESCIs have been conducted in NSW, SA and Tasmania since 2001) include:

- Capacity of the providers to conduct timely interviews (with reports of significant waiting times)
- Consistency in the quality of the interviews
- Consistency in the outcome of interviews between providers (the same candidate may fail an interview with one provider but pass in the next jurisdiction)

It is possible that these are teething issues as the PESCI providers build their experience and capacity (the Tasmanian provider during 2001 – 2010 reported that they did take a year to fully appreciate how recruitment, assessment, orientation and ongoing training fit together). From an OTD consumer view, however, it would be helpful if there were some benchmarks to rely on – especially in regard to the frequency of interviews and being able to access an interview in a timely manner.

There is a flow on effect when the PESCI interviews are not timely, in that the other bodies involved in the recruitment and placement process (AHPRA, DIAC, Medicare) still have to process their pieces of the jigsaw and it can mean placement can be held up by months in some cases.

The particular weakness in the PESCI process is there is often little connection between the outcome of the interview, the orientation of the OTD and their ongoing training. This connection is vital for both the safe practice of the clinician and for their ability to meet their registration conditions. In smaller jurisdictions such as Tasmania, the RWA works with the PESCI provider and AHPRA to ensure that areas of upskilling identified at the interview are included in the registration conditions, and are then referenced in the initial orientation program and the ongoing IMG Training Program (both facilitated by the RWA). This ensures that any future supervisor, medical educator or Regional Training Provider can tailor their support efforts accordingly.

d. Appeal Mechanisms

This is not an area we should get into.

e. Community Education

If we have good doctors supported to meet their conditions who end up vocationally recognised as general practitioners and keep working in Australia then we won't need to educate the community.

Even communities who are about to lose their doctor understand when you are able to say 1. They knew what was required of them before they signed up; 2. They have had significant support to get there, and they haven't met the mark; 3. They have options (going back to the hospital to learn more in a supervised environment etc).

It does mean, however, that the supports do need to be in place (See 2 below).

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

a. Current Support Programs

Depending on your registration and visa status, there are three support programs available for IMGs progressing toward specialist registration. Most IMGs, however, are not eligible for these programs. A précis is provided below:

1. The Australian General Practice Training Program (AGPT). This is the GP Registrar program. It is the largest and best funded program. IMGs must be permanent residents and hold general registration to be eligible to apply however, and this cohort does not make up the majority of IMGs in the workforce. The numbers are capped as well, so there are limits to the number of IMGs who can access support through this program.
2. The Rural Vocational Training Program. This program was set up to compensate for the fact that the Regional Training Providers were not flexible enough to accommodate IMGs who were already in a practice and who would have had to move to join the AGPT. This program allows IMGs to remain in their original community and access support through distance education and intensives. The eligibility criteria is more open than the AGPT, but the costs per participant are higher and the numbers are significantly lower.
3. The Fellowship Support Program. This program is administered by RWAs. Only IMGs who are on the Rural Locum Relief Program or the Five Year Scheme are eligible for support through this program. RWAs are allocated $7,000 per IMG to support them toward the Fellowship of either the RACGP or ACRRM. RWAs run different programs which reflect the geographic and demographic differences in the GP workforce in each jurisdiction . There are up to ????300???? participants in this program at any one time.

This means there is little to no support for temporary resident IMGs, who make up a significant portion of GPs in rural and remote areas particularly. In South Australian the State Government has invested money in the education and training of all IMGs and the success in that State is reflected in this commitment. Tasmania has a program which includes all IMGs regardless of residency (funded using an underspend from another contract, with clinical input from the Regional Training Provider) which means all IMGs there are part of an ongoing program monitoring their progression and supporting them with a limited menu of activities. Both these jurisdictions report high percentage passing rates amongst their IMG participants.

Other activities which are not ongoing included:

1. Rural Outreach for Vocational Education (ROVE). This program was funded with an underspend from the AGPT. Ten Regional Training Providers ran pilot programs (for up to three years) to see what the best methods were to support IMGs working as GPs. The program was not funded after the pilots however, due to a lack of funds.
2. IMG mentoring. The RACGP conducted a short mentoring program for IMGs, which, while it was not a training program per se, was appreciated by IMGs who participated.

b. Suggestions for Improvements and Integration

Clinical training support for IMGs is not a priority for most governments, even though OTDs comprise a significant portion of the rural and remote workforce.

The obvious systematic answer would be to use the existing framework for GP training and extend that to include IMG training. The AGPT and the RVTS are dedicated to the task of training prospective GPs. These two organisations cover the entire country. It would make sense to explore ways and means of using the existing infrastructure to deliver clinical support to another section of the workforce who would benefit from it. If the Government considered the ROVE pilots to be too expensive, we would suggest they convene a meeting with those RTPs who conducted the pilots, include the RVTS and the RWAs and see if collectively the people who provide the support can come up with a model which meets the needs of the OTDs.

The issue appeared to be a question of cost. The ROVE pilots were not significantly innovative, with the majority of cases trying to shoe horn the IMG into the registrar model. In other words, most RTPs seemed to think they needed as much money to support the OTD as they did for a registrar. The reality is that most IMGs are past registrar level in their clinical competency, and the type of training they need is different from what the RTPs provide to registrars. This is where the innovation needs to come in.

One approach would be to spend more time, money and energy in the orientation period. If there was a mandatory 4 week course (including being clinically observed) for all OTDs before they commenced work in their practice then this could possibly pick up most of the ongoing training issues for the individual OTD. A significant portion of the OTDs needs could be met if the curriculum included, but was not limited to:

- Setting up a training program with the individual OTD to follow
- Working with other professionals in the Australian health system
- An Advanced Life Support course,
- Communication in the Australian context,
- Women's and Children's Health,
- Mental Health and
- how to navigate the health infrastructure (DVA, Medicare, Workers Compensation, Authority prescriptions etc etc)

The OTD would work during the four weeks to ensure the experiences were as hands-on and real-life as possible.

These courses could be offered by group practices in larger regional areas (for example, Launceston or Hobart in Tasmania) and tied in to areas where there is a shortage of GP services (such as refugee health). As there is a constant stream of OTDs relocating to rural areas, the practice would be able to maintain the level of service to their community on an ongoing basis.

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

a. Removing Barriers to specialist qualifications for OTDs

This is probably picked up in the earlier remarks. If the OTD knows what they need to do, has a plan on how to get there, can access appropriate support depending on where they are working then it is reasonable to leave the hard work of preparing for their exam to them.

b. Promoting Pathways (with emphasis on rural and regional areas)

Promotion of the *available* pathways is not a problem. Most OTDs know about the AGPT (and are not eligible); most know about the RVTS (and the numbers are restrictive); OTDs who are eligible for the RWA support are already receiving this (but it is inadequate and too limited). If a pathway were to be made available to all OTDs (including the Temporary residents who are not eligible for any of the above) then promoting it would be a simple matter of attaching an electronic flyer to the registration certificate when an OTD is registered by AHPRA (everyone is given a registration certificate) or just making it a mandatory requirement of their registration that they enroll in one of the available training programs and provide evidence to AHPRA that they are participating on a annual basis.

In order to promote something, however, that thing must be available.