RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

The Secretary
Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
Canberra ACT 2600

Submission No. 80
(Overseas Trained Doctors)
Date: 17/02/2011

4 February 2011

Dear Secretary

Thank you for the invitation to make a submission to the Inquiry into Registration Processes and Support for Overseas Trained Doctors (OTDs).

The submission from the Rural Doctors Association of Australia (RDAA) is enclosed at **Attachment A**.

RDAA does not support the recruitment of OTDs as a short, medium or long-term solution to the rural medical workforce shortage. National self-sufficiency in medical workforce supply must be our goal.

However, RDAA acknowledges the vital role played by OTDs in delivering health care services and enriching communities across Australia. In some regions of Australia, OTDs comprise the majority of the medical workforce and provide essential health care services to communities that would otherwise go without. This contribution must be acknowledged through the provision of appropriate and ongoing recognition and support.

Where OTDs seek registration to practise in Australia, they should be appropriately assessed in a fair and transparent manner to ensure they meet standards that are consistent with their Australian counterparts. Those OTDs who are already working here, and who have not yet attained these standards should, wherever possible, receive the training, support, supervision and personal/family assistance they need to enable them to provide high quality services to the communities they serve.

RDAA calls on the Government to implement a national program for coordinating the delivery of support, assistance and accredited supervision and training to OTDs seeking to register and work in Australia.

I would welcome the opportunity for a RDAA delegation to appear before the Standing Committee's hearings.

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ATTACHMENT A

RURAL DOCTORS ASSOCIATION OF AUSTRALIA
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SUBMISSION TO THE INQUIRY IN THE REGISTRATION PROCESSES AND SUPPORT AVAILABLE TO OVERSEAS TRAINED DOCTORS

The Rural Doctors Association of Australia (RDAA) is the national body representing the interests of rural medical practitioners. Our vision is for the highest quality medical care for rural and remote communities to meet their health needs.

The RDAA's submission to the Inquiry into the Registration Process and Support for OTDs provides some general comments on overseas trained doctors (OTDs) and the rural medical workforce shortage, as well as some more specific comments on the following issues:

- OTD recruitment as a solution to the medical workforce shortage
- the 10-year moratorium for OTDs
- the impact of new registration process, and
- the need for better support for OTDs with conditional registration and for OTDs seeking full or specialist registration.

Introduction

Rural and regional Australia continues to be significantly underserviced by general practitioners and specialist medical practitioners, with most rural and remote communities still finding it increasingly to recruit and retain doctors with the training, qualifications and skills required to meet the needs of these communities. While medical practitioner supply has increased marginally overall across all areas in Australia, rural and remote communities still have a relatively low ratio of GPs proportional to their population compared to major cities and inner regional areas and there remains a considerable geographical discrepancy in access to health services.

RDAA believes that more must be done to build a sustainable rural medical workforce so that Australians who live in rural and remote areas can enjoy the same health outcomes and life expectancy as those that live in our major cities.

Medical workforce shortages began to appear more generally across Australia in in the 1990s, and were exacerbated by policies that limited the number of training places for medical students in Australia.[1] In some parts of Australia, there has been a permanent under supply of doctors for more than four decades[2].

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[1] Van Der Weyden, MB, and Chew, M (2004) Arriving in Australia: overseas trained doctors, MJA: 181 (11/12): 633-634

[2] Rural Workforce Australia (2008) *Will more medical places result in more rural GPs?* RHWA, Melbourne.

To fill this shortage, Australia has actively pursued a "short term" policy of recruiting doctors from overseas.

While a large number of doctors have come to Australia in the past 15-20 years, the rural medical workforce crisis persists. The influx of OTDs is the only reason that medical workforce numbers in rural areas are not in complete free fall. Around 50% of rural doctors are overseas trained and, in many areas, 100% of services are being provided by OTDs.

OTDs arrive in Australia with significant variability in the level of their training, experience, clinical skills and communication skills. Due to current workforce policies, they are often sent to areas where they are personally, professionally and culturally isolated. Many have limited access to the support, supervision and mentoring they need to orientate themselves to the Australian health care system and to enable them to provide the highest quality of service that meets the needs of their communities.

There is a strong and urgent need for a coordinated, national approach to providing appropriate initial and ongoing assessment, training, support, and supervision to OTDs.

OTD recruitment as a solution to the medical workforce shortage

The number of OTDs practising in Australia has sharply increased over the past fifteen years.

In 1998, the Australian Institute of Health and Welfare (AIHW) reported that the number of temporary resident doctors working in Australia had increased from 893 in 1993–94 to 2,224 in 1998–99, representing an increase of 124%.[3]

As at February 2008, there were 4,669 overseas trained doctors in Australia, including GPs (3,028) and specialists (1,641), who were subject to Medicare provider number restrictions. 1,437 of these overseas-trained GPs and 181 of the overseas-trained specialists work in rural and remote areas.[4]

While the recruitment of OTDs and an increase in the number of medical training places in Australian universities have contributed to a growing number of GPs in Australia, this growth does not indicate increased availability of GPs over time, as the growth in the medical workforce has not kept pace with the rate of population growth. The continuing shortage of GPs is most acute in rural and remote areas, with the most recent audit of

[3] AIHW (2000) Medical Labour Force 1998, Canberra.

[4] Australian Department of Health and Ageing (2008) *Report on the Audit of Health Workforce in Rural and Regional Australia*, Canberra.

the rural health workforce once again identifying that rural, remote and regional Australia is significantly underserviced.[5]

Rural and remote communities generally have a relatively low ratio of GPs proportional to their population. National figures for GPs (FTE)[6] per 100,000 population across different geographic areas are as follows:

Major cities	97.0 GPs per 100,000 population
Inner regional	83.1 GPs per 100,000 population
Outer regional	74.2 GPs per 100,000 population
Remote	68.2 GPs per 100,000 population
Very remote	47.1 GPs per 100,000 population[7]

Rural and remote communities also generally have a relatively low ratio of specialist medical practitioners proportional to their population. National figures for specialist medical practitioners (FTE) per 100,000 population across different geographic areas are as follows:

Major cities	122	specialists per 100,000 population
Inner regional	56	specialists per 100,000 population
Outer regional	38	specialists per 100,000 population
Remote/very remote	16	specialists per 100,000 population[8]

So while the policy of recruiting OTDs has been critical to preventing a catastrophic medical workforce shortage in some rural and remote areas, particularly in Queensland and Western Australia, this policy, along with other medical workforce policies have only had a limited impact on the ability of rural and remote communities to attract and retain doctors.

RDAA supports the Code of Practice for the International Recruitment of Health Care Professionals adopted at 5th WONCA World Rural Health Conference in Melbourne in 2002.

A key principle underpinning this ethical code is that it is the responsibility of each country to ensure that it:

- produces sufficient health care professionals for its own current and future needs
- retains them, and
- plans for both rural and urban areas.

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[5] Australian Government Department of Health and Ageing (DoHA), 2008. *Report on the Audit of Health Workforce in Rural and Regional Australia*.
[6] Full time equivalent (FTE) is based on working 45 total hours per week.
[7] DoHA, 2008; at 8. These figures are based on the AIHW's Medical Labour Force Survey 2005.
[8] Australian Government, DoHA,15.

The Code asks countries to develop and implement their own ethical recruitment policies and, among other things, consider the effect of existing recruitment policies and practices are having on poorer or developing countries. While RDAA acknowledges that State and Federal rural health workforce agencies do not actively seek to lure medical graduates away from poorer or developing countries, commercial agencies are able to pursue such recruitment.

The RDAA considers that the policy of recruiting OTDs to fill workforce shortages has distracted governments from addressing the fundamentals for sustainable practice – financial viability, professional supports, work/life balance and good infrastructure.

To this end, the RDAA urges the Australian Government to prioritise the introduction of:

- a national advanced rural training pathway, and
- an economic framework for sustainable rural practices.

The RDAA believes a national advanced rural training pathway coupled with Medicare based financial incentives for rural and remote practice will make rural generalist practice more competitive in relation to specialist practice as a career path, providing a real alternative for medical graduates who want a mix of general practice and hospital work and are considering a career as a specialist rather than a solely office-based GP.

The fields and locations in which doctors choose to practise depend, in part, on the financial incentives or compensation that they receive. Increasingly, there are concerns that doctors working as hospital locums, emergency medicine specialists or in other medical specialties now have much higher earning capacities than general practitioners, and this is putting pressure on the recruitment of doctors into rural and general practice. At the end of the day, rural doctors should be rewarded for acquiring additional skills and given targeted Medicare based financial incentives that take into account the greater isolation, costs and complexity involved with rural and remote medical practice.

The 10-year moratorium

RDAA is opposed to the policy of imposing a 10-year moratorium on OTDs.

Under this policy, OTDs with temporary residency can work as a doctor and have access to a Medicare provider numbers as long as he or she works in an 'area of need' for a minimum of ten years. The RDAA is opposed to this policy on the basis that it often coerces OTDs to work in an isolated setting where they may be called upon to deliver services that exceed the scope of their skills, qualifications and experience.

The moratorium places OTDs in vulnerable personal, professional and economic situations, sending them to areas where they face significant isolation. This is unconscionable. Many are sent to areas where there is limited or no supervision, few or no opportunities for mentoring, and limited or no opportunities for training and development. On many occasions these doctors are separated from their families for extended periods of time.

In these circumstances, there is real danger that standards of health care delivery will be compromised.

In RDAA's view, the 10-year moratorium is discriminatory and imposes immense hardship on OTDs and their families. If there is to be a rural service obligation attached to the allocation of Medicare provider numbers, this service obligation should apply to all doctors wishing to practise in Australia, not just those who trained overseas.

Assessment processes for OTDs seeking full registration

Australia enjoys an international reputation for providing high quality medical services. The strength of this reputation is founded on the products of Australia's rigorous undergraduate education and training programs. Medical trainees are expected to undertake four to six years of undergraduate or postgraduate medical education, and four years of postgraduate training to become a GP. In addition, the national rural generalist pathway required to deliver generalist to rural and remote areas would require a further two years of training to gain the skills required for isolated areas. Assessment and supervision is stringent and ongoing, and is not simply dependent on a series of end of course examinations. As an Australian graduate, this supervision and assessment continues during the early post-graduate years and beyond in specialist training programs.

The cost of this high quality education is high. Many countries, particularly developing nations, do not have the same level of resources as Australia to spend on medical education.

The process applied to OTDs seeking registration in Australia must be able to objectively assess whether OTDs meet the same rigorous standards applied to Australian-trained doctors.

RDAA questions whether the current requirements for OTDs seeking full registration in Australia represent the most effective way to assess the skills, training, qualifications and experience of OTDs, particularly where OTDs have many years of experience. Are the requirements to sit the AMC exams, pass a structured clinical interview and complete approved supervised training the best combination for determining whether OTDs have the necessary skills and expertise?

RDAA believes that a more flexible model for assessing the skills and expertise of OTDs should be explored which allows assessments to be adapted to meet the circumstances of the individual. At the centre of this model should be competency requirements and a transparent process for assessing whether OTDs meet these competency requirements.

RDAA considers that a one-size-fits-all multiple-choice exam is a blunt instrument for initially assessing whether an OTD has the required level of competency to provide health care services in Australia. Yet on the basis of passing this exam (along with passing an English test and a desktop review of the OTD's qualifications and training), OTDs can be granted conditional registration and allowed to work in rural and remote

areas on a temporary visa in an area of need with varying levels of supervision. The fundamental flaw in this process becomes apparent when an OTD who has been granted conditional registration to work in Australia in an area of need seeks full registration at a later date but fails the structured interview. Under this process, an OTD who has been allowed to deliver health care service for several or, in some cases, many years is suddenly not considered to have the required skills. The failure of the OTD to pass the structured interview would seem to indicate that he or she should never have been granted conditional registration on the basis of passing the AMC exam in the first place.

RDAA believes that the qualifications, training, and experience of OTDs who wish to work in Australia should be assessed according to established criteria, and that they should be required to undergo an upfront assessment of the OTDs skills to ensure they meet a set of minimum competency standards. If the OTD meets the threshold requirements under this process, he or she should go through the same process as Australian medical graduates and complete formal training program that leads to appropriate credentialing (noting that some OTDs may be able to obtain credits on the basis of previous training/experience).

For OTDs that are already practising in Australia, RDAA believes that the assessment process should focus on assessing the competency of what OTDs are doing on the ground. If an OTD is found not to have the required competencies under this process, there should be a mechanism under which the OTD is offered remedial training under accredited supervision and provided the opportunity for reassessment following the completion of that training.

The processes supporting the transition to remedial training should be simplified and streamlined. At present, an OTD with a temporary work visa and conditional registration who is working in an area of need position has a Medicare Provider Number and a visa that are specific to that position. If he or she needs to change positions to access remedial training (which is likely in rural and remote areas), they must reapply for medical registration, a Medicare provider number and a visa.

The impact of new registration process

RDAA supports the application of rigorous standards to all medical graduates who wish to work as a doctor in Australia, regardless of whether these graduates are trained locally or overseas. However the current registration processes for OTDs are complex and may be intimidating in the absence of any structured support and assistance.

RDAA considers that the registration process for OTDs should afford OTDs procedural fairness and natural justice, offering avenues for appeals and/or reviews of decisions leading to deregistration.

For many OTDs who have been working in Australia in areas of need for some years, the goal posts for achieving full registration have been significantly changed. Unfortunately many of these changes have been made retrospectively, creating

significant hardship for those doctors affected.

For example, RDAA is aware of one OTD who has been working as a doctor in rural and remote Australia for 16 years who has recently failed his structured clinical interview. For the past nine years, this doctor has worked as a solo practitioner in an isolated area, unsupported and unsupervised. He has made a significant financial investment, purchasing a practice and building the practice infrastructure. This OTD received no mentoring or tutoring to assist him to prepare for his structured clinical interview, and did not have access to locum relief to allow him to have time off to prepare. He has now been deregistered.

RDAA is also aware of an experienced OTD who was deregistered after failing the AMC Clinical Examination and subsequently being advised that he had met the requirements for being made a Fellow of the Royal Australian College of General Practitioners, subsequent to his leaving the country.

RDAA is aware that an orthopaedic surgeon practising in a rural area in NSW for some years is at risk of deregistration because he has not yet passed his surgical fellowship because to do so would mean leaving his community for at least 12 months to undertake an exam, many parts of which are not relevant to his current practice (for example, the exam covers subspecialities, such as spinal surgery and paediatric surgery, which it would inappropriate for an orthopaedic surgeon to practice in a small rural hospital).

In citing these examples, RDAA is not necessarily arguing that these doctors should be allowed to continue to practise. Rather, we are arguing that any assessment process for OTDs should be practical and relevant to their current scope of practice, and be capable of determining whether they are meeting the health needs of their patients in a safe, effective and clinically appropriate manner.

The sudden deregistration and the subsequent cancellation of visas has traumatic consequences for affected OTDs and their families. It can also result in the sudden withdrawal of health care services from rural and remote areas.

Where it is obvious that an OTD is not going to be able to meet the required standards in a reasonable time frame, transition arrangements should be available to support him/her to transition to the new circumstances.

Better support for OTDs

Doctors who have trained overseas will come to Australia for many reasons, including work opportunities, lifestyle and family commitments. Where these doctors have the necessary skills, qualifications and expertise to practice medicine in Australia and are willing to work in rural and remote Australia, they should be welcomed and supported. If assessment processes identify that these doctors do not have the necessary skills (and many will not have the skills to meet the needs or current curricula for rural and remote practice), or that they wish to acquire these skills in order to practice, then they should have the opportunity to obtain these skills through established training pathways.

RDAA also considers that more resources should be made available to orientate, support, educate and train OTDs. Standardised and accredited programs should be available to all OTDs so that they can more readily integrate into the medical workforce, with more customised programs for OTDs with additional training and development needs. Funding should also be available for medical educators to supervise and mentor OTDs.

For OTDs already practising in Australia, RDAA believes that an appropriate case management model which includes expert medical input is necessary to help them navigate the process. Case managers (clinical supervision to gain training expertise and qualifications to practise) plus support could also be responsible for linking OTDs with supervisors, mentors and training programs, as required.

Better support should also be provided for the families of OTDs. The RDAA strongly supports allowing these doctors and their families to access Medicare as most of their patients do or establishing a 'private' health scheme to provide the same level of subsidy and support as Medicare. In addition, discussions should be undertaken in the COAG context to ensure that the children of OTDs are able to access public education in state schools free of charge.

Conclusion

Consistent with the WONCA Melbourne Manifesto, RDAA is opposed to the importation of doctors from overseas as a means to solve Australia's medical workforce problems.

Increased focus should be on a strategic approach to solving Australia's rural and remote medical workforce problems that will ensure that rural and remote practice is seen as a viable and professionally fulfilling career choice for either Australian graduates or doctors from overseas.

RDAA is not opposed to doctors from overseas working in Australia so long as they meet appropriate standards for their area of practice. If these doctors wish to work and live in rural and remote Australia they and their families should receive the same level of training, supervision, professional and family supports available to Australian graduates.

RDAA is opposed to discriminatory moratoria and restrictions on practice unless these same restrictions apply equally to all graduates.

There is a need for consistency and transparency in the application of standards and assessment processes. OTDs should meet the same standards as Australian-trained doctors. In the vast majority of cases this will involve OTDs obtaining relevant Australian qualifications. In a small number of cases, where doctors are currently working in rural and remote Australia and where the services provided are within their level of expertise and are of a high quality, then after a process of assessment or ongoing supervision, these doctors should be permitted to continue to practise. Where OTDs currently working in Australia do not meet these standards, they should be supported through a structured program of supervision and mentoring.

Where they are unable to achieve a satisfactory standard after this program, they should be supported during the transition to the next phase of their lives.

A coordinated and consistent national approach to the support and supervision of OTDs should be adopted, and the roles and responsibilities of all stakeholders, including professional Colleges, Training Providers, Recruitment Agencies, the Medical Board, Government Agencies, employing practices and supervisors should be clearly defined.