11 Kempeana Crescent
Alice Springs
NT 0870

The Secretary
Joint Standing Committee on Migration
Parliament House
CANBERRA
ACT 2600

30 April 03

Dear Sir or Madam:

Thank-you for the invitation to contribute to the review of skilled migration currently being conducted by the Joint Standing Committee on Migration.

This invitation was made following the publication of an article in the Medical Journal of Australia describing my move from being a GP in York, England to GP Educator in Alice Springs. The paragraph of most relevance to the committee was:

> *"Bureaucracy*
> The hardest struggle has been to navigate the path to registration and visas. Is it a deliberate ploy to use the psychology of human beings that they will want what they can't have? The espoused need for doctors in rural and remote areas, is not matched by action or policy issued by the Commonwealth to overseas doctors. Our visas arrived three weeks prior to our departure – six months after the application was submitted. We had difficulty getting a mortgage as Temporary Residents and yet buying a house seemed a logical way of ensuring a commitment to the area.
>
> Whilst I appreciate the need to maintain standards, I have only just gained Conditional Registration to work as a GP in the NT. A letter from the medical board previously advised me either to pass the AMC exam or enter a recognised training program, despite having FRACGP. I replied that it was difficult to enter a training program that I had been appointed to assist in running! (1)"

I will outline my response to the Committee's Terms of Reference. These are personal views and not necessarily those of my employer, Flinders University:

1. *The degree to which quality permanent skilled migrants are being attracted to Australia and settling well*

Skilled migrants are attracted to work in Australia but their migration requires patience, form-filling and persistence.

My husband, an ophthalmologist, and I spent six months conducting research at Flinders University in Adelaide in 1998. The path to obtaining visas for that time was long and convoluted with no sense that Australia might actually want us to come. The comparison between the warmth of the welcome made to us by people we met and worked with, and the interactions we had with those authorising visas and work permits was stark.

We enjoyed our work at Flinders and as a family we thrived on the outdoor and informal lifestyle in Australia, but were reconciled to the fact that working in Australia was not possible for English medical graduates. A year working back in the UK persuaded us that we wanted to travel again and we applied for and were offered posts in the Cayman Islands in the Caribbean. Simultaneously we heard of job openings in Alice Springs. Our decision was made because of the combination in Alice of the Australian lifestyle plus the opportunity to work in Indigenous health where we considered our medical training would be useful. We discussed in advance of our move the fact that we were committing ourselves to evenings of paperwork to arrange the move, on top of our already overwhelming work schedules.

From our perspective Australia remains attractive to skilled migrants but for medics this is against the publicity issued by the Consulate in England. We have been amazed at the warm welcome that we have had in Alice Springs. We feel very at home here and value highly our friends and the community. I have had job opportunities here that I would have waited another 10 or 15 years to get in England. Our children have adapted well and do not want to return to England.

There is some anecdotal evidence that overseas trained doctors move posts and areas in their first few years after migration. This may be due to differences in practice and culture in Australia. The changes for us have been small and we are still in the same jobs nearly three years after migration. I would recommend that the Committee contacts the State and Territory Workforce Agencies for information on the work patterns of Overseas Trained Doctors who could confirm whether such high mobility exists and their perceptions of the reason for this, and whether there are issues, which might be addressed by the Committee.

*2. The role played by State and local authorities*

I am unable to comment about the role played by local authorities as we did not access any of their migrant services. My husband is employed by the NT Department of Health and Community Services. They sponsored him and provided accommodation for us on our arrival.

*3. Whether there are policy and/or procedural mechanisms that might be developed to improve international competitiveness.*

3.1 Clear pathway for migrants

We found it hard to gain clear information about the process for migration. We bought books and subscribed to a magazine for migrants. Despite this at different stages through our application it felt as if we were stumbling over new hurdles just

when we thought we had sorted out what we needed to do. Common phrases at home were “each phone call creates another brick wall and the need for more calls” or “once you get through to the right person they are often really helpful, but more often you get passed from one office to another”. Clearer information is needed to be readily available in print and on the web.

3.2 Information about medical migration

Whilst we were in England we had no perception that we would be so welcomed as doctors. The official forms for immigration still state that points are counted against medically qualified personnel. It is not clear on these forms that there are different views for doctors prepared to work in areas of need, or where more information about this can be obtained.

Since arriving in Alice I have become aware of the work of Northern Territory Remote Health Workforce Agency, and am now a Board member. I support their work in recruitment of medical staff and consider that my path might have been easier if I had been through their program. There is a need for a united recruitment policy and action between all Workforce Agencies, rather than the piecemeal recruitment from individual agencies. Similar agencies should exist to assist the recruitment of specialist medical staff or this work could be taken on by the current GP Workforce Agencies.

A readily accessible flow diagram of the process of applying to work as a doctor is needed. The stages include obtaining:

A suitable post
Working visa –either temporary or permanent
Medical registration
Recognition of qualifications by professional colleges
Provider number and prescriber number from Medicare – prerequisites are visa and registration
Medical indemnity insurance

It should be possible to have all this organised prior to arrival in Australia, but I have yet to meet a doctor who has achieved this. The resulting delay in starting work can mean financial hardship at a time when outgoings are high as deposits are needed and purchases made.

This flowchart should be supplemented by a booklet which outlines the roles of the Medical Boards, the professional colleges, DIMA, HIC etc. Since my arrival here I have answered numerous enquiries from doctors both here and in the UK trying to find out what the process of coming to work here involves.

3.3 Improved access to the Australian Embassy in the UK

Getting through to the Australian Embassy in the UK was a challenge. The hours that calls are answered are very limited which is not easy when working. Calls would often be on hold in a queue for up to 45 minutes.

3.4 Timely processing of visa applications

There is a need for the process of visa applications to be speeded up. We applied for our visas six months prior to our departure. They arrived three weeks before we left. We were told that the visas are only processed according to the planned date of departure from England. The visa forms tell you not to book a flight until the visa has been issued. This is inconsistent.

The delay in the visa meant that we continued to pack up and leave our jobs without any certainty that we would be let into Australia. This is unacceptable for a country that is actively trying to recruit medical personnel to areas of need.

This delay in the visas also cost more money to our employers. We did not book a removalist until the visas came through, as per the official recommendation, and the only company who could do the move at such short notice were expensive.

3.5 Visas for part-time employees

My post with Flinders University was advertised as entitling me to apply for permanent residency. In order to spend the necessary time settling the children, finding permanent accommodation etc, I did not wish to work full-time. This meant that I was not entitled to apply for permanent residency. I think this stipulation needs review considering the number of doctors and other professionals who are choosing not to work full-time. Now that we are settled I am working full-time.

3.6 Coordination between medical boards, professional colleges and the Department of Immigration and Multicultural Affairs

The Royal Australian College of General Practitioners recognised my English qualifications which was great. The NT Medical Board did not recognise the FRACGP as a specialist qualification and took considerable persuading that I did not need to be in supervised practice. I consider that a period of six months of supervision is good practice to ensure that the doctor is adjusting to Australian medical practice but time beyond this should not be necessary. Once I had the FRACGP I could have applied for permanent residency but again my part-time work blocked this.

The specialist medical colleges should be encouraged to be open to appropriately trained medical specialists. Even when my husband had been recognised by the College of Ophthalmologists we were given conflicting advice as to whether DIMA would issue a permanent residency visa. Again, our application was an act of faith (and considerable cost) rather than having any certainty that we would be able to stay. We are glad that we have now been granted permanent residency and still intend to stay in Alice, but regret the extra costs incurred as temporary residents, such as health insurance as we had restricted access to Medicare.

3.7 Access to transport, phones and accommodation

We were fortunate in being offered temporary hospital accommodation. Accommodation should be offered on such temporary bases to all skilled migrants. Assistance with getting a mortgage would create a competitive advantage over other countries seeking skilled migrants. The banks are reluctant to make loans to people who have been in the country for less than two years. We were enabled to buy a house through a 'friend of a friend' rather than through the official bank procedures. This was one of many examples where the official line was that it was not possible but the local community were so keen to help that ways round the official line were found.

When we moved it was difficult to get a mobile phone if you hadn't had an address for at least a month. I suspect things are easier now.

In summary, we are glad to be here but still tell our friends who are considering migration, that it can be done but it is hard work.

Thank you for the opportunity to contribute to the review and I hope sincerely that the outcome of the review is a smoother path for others making their way to Australia.

Yours sincerely

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Ref:
Wearne Susan
Reflections on a year in the outback
*Medical Journal of Australia* 2002: 177 (2); 117-118