Australian
General Practice
Network

Australian General Practice Network

Submission to the Joint Standing Committee on Migration's inquiry into eligibility requirements and monitoring, enforcement and reporting arrangements for temporary business visas

February 2007

Introduction and background to submission

This submission is made by the Australian General Practice Network (AGPN) to the Joint Standing Committee on Migration's inquiry into eligibility requirements and monitoring, enforcement and reporting arrangements for temporary business visas. AGPN notes that the two areas the inquiry is particularly looking at are:

1. Adequacy of the current eligibility requirements (including English language proficiency) and the effectiveness of monitoring, enforcement and reporting arrangements for temporary business visas, particularly temporary business (long stay) 457 visas and Labour Agreements; and
2. Areas where (visa) procedures can be improved.

As the national peak body for the 119 divisions of general practice across Australia, AGPN's response will necessarily be restricted to that area of the inquiry relevant to divisions of general practice, essentially Overseas Trained Doctors (OTDs, referred to in the rest of this document as International Medical Graduates or IMGs) and particularly those who work in Australia as GPs. AGPN supports extended multidisciplinary practice team models within the general practice and primary care. As divisions are only involved in recruitment and migration processes for overseas trained *doctors* however, the relevance of visa processes to other health care professionals are omitted from this submission. AGPN still however recognises the significant role other health professionals play in the provision of primary care within the general practice setting.

In 2005, AGPN (then known as the Australian Divisions of General Practice – ADGP) made a previous submission to the Joint Standing Committee on Migration's Review of Skilled Migration which raised some points of relevance to the current inquiry. These are extended in the current submission. A copy of the previous submission is also attached.

Divisions vary in the level of direct involvement they have in migration processes during IMG recruitment and employment. Many divisions largely deal with providing on-the-ground support and orientation to IMGs and their families as well as the facilitation of mentoring and education for IMGs themselves once they are placed in a practice. A number of divisions however, especially rural ones, have a Case Management approach in which they assist with all aspects of the IMG recruitment process including immigration. Both types of involvement mean that divisions are aware both directly and indirectly, of the impact that migration processes have on the IMG, their family, the practice and the broader community. It is in this context that this response is made.

General information on the 457 visa

The 457 visa is a temporary business long stay visa that only became available for medical practitioner use once medical practitioners were added to the skilled migration list in 2004 as part of the Strengthening Medicare initiative.

Prior to that, only 422 visas were available for temporary resident IMGs to enter and work in Australia. These visas were previously quite restrictive. Originally the 422 visas only lasted for twelve months as medical registration under Area of Need was only granted for that period of time. This was then extended to two years and under Strengthening Medicare, was finally extended to four years. As a result, the 422 visas are now quite similar to the 457 visas.

The main difference between the 422 visa and the 457 visa is that police clearance is mandated for the 422 but is not usually requested for a 457, although a case manager may request additional character check information as required even with

a 457. The 457 visa process can therefore be a quicker process than the 422 if the applicant does not have to undertake police clearances as in some countries these can take months to obtain.

Main comments and issues with regard to the current visa arrangements

Visa length and ease of processes

A number of divisions have reported that the introduction of the 457 visa for medical practitioners has been useful and they encourage IMGs to apply for such a visa. In addition to the potential for applications to be processed more quickly, there is also an advantage to practices in applying for a 457 rather than a 422 visa as a single 457 application can incorporate up to five potential sponsorships (only requiring that each specific nominee is added to the application subsequently).

There is also support for the lengthening of the 422 visa from one to four years under the Strengthening Medicare initiative as this eases administrative and bureaucratic processes for IMGs and their families, and can also assist with the transition to permanent residency. There are, however, other administrative issues that require revision. These include:

- Lengthy delays from passing the clinical interview and obtaining reassurance that the IMG will be registered by the Medical Board and being granted a visa
- Delays between obtaining a visa and the issuing of a Medicare provider number.
- Requirements for IMG's already working in Australia to return to their country of origin to re-apply for a visa. This is unnecessary, inconvenient and expensive.

As a result of some of these administrative issues, practices are placed under workforce pressure and communities are further disadvantaged in their access to health care. A shortening and streamlining of processes, whilst still ensuring that high standards of entry are met, is required.

Support for the current English language proficiency requirements remain as, for IMGs, this is required for medical registration.

Access to Medicare and medical insurance

One of the largest restrictions on the 457 visas (as well as the 422) is that unless the temporary resident IMG is from a country which has a reciprocal agreement with Medicare about health care provision, the IMG and their family are restricted from claiming Medicare rebates for any health care provided to them (as health consumers) even though the IMG is working for the Medicare system itself. AGPN have raised this issue in a number of forums and have previously written to Medicare Australia in this regard recommending that the situation be changed.

Other conditions of particular visa categories can also place a financial strain on temporary resident IMGs. For example, Inability to access Medicare means the IMG and their family are required to have private health insurance which often does not cover pre-existing conditions. They are not eligible for the tax free threshold which permanent residents obtain and thus pay higher tax. They must work only for their sponsor and thus employment is very limited. Again, these aspects can deter the retention of IMGs and so impede access to health care for certain communities.

Sponsorship and employment restrictions

A condition of the 457 visa as well as the 422 is that they require an IMG to be sponsored. The employment relationship for the temporary resident IMG under these visas is thus always one of employee-employer. Under these conditions, an IMG is restricted to working only for their sponsor, irrespective of their medical registration status. This can be limiting. For example if an IMG is in a restrictive or

exploitative employment situation, they cannot easily change to another placement.

In addition, the sponsorship requirement prevents an IMG from setting up their own private practice. A number of small rural communities often rely on a single solo practitioner to provide their care. In instances where this practitioner has left or retired, an IMG can only take up the position if someone is available to sponsor them on a 457 visa. This makes filling the position even more difficult as it is usually requires a hospital or community group to take on this responsibility. It is worth considering the re-introduction of the independent business visa for certain IMGs to establish their own private practice as one way of addressing this. Any IMG applying for such a visa would need to meet strict eligibility criteria to ensure the provision of quality care.

The employer-employee relationship further restricts IMGs as they cannot claim any of the tax advantages that come from private practice. It also places a burden on the practice where the IMG is employed as they must remain responsible for any liabilities to the Commonwealth incurred by the IMG (such as any unpaid taxes or medical costs when the IMG leaves the country.)

These aspects, as well as the restricted Medicare rebate access for both IMGs and their families) can deter the retention of IMGs and so impede access to health care for certain communities.

Issues around medicals
Medicals for IMGs required as part of the visa process can apparently take a long time to obtain and so can be a cause of significant delay. Current regulations also link the level of the medical required to the type of residency (permanent or temporary). If a doctor wishes to move from temporary to permanent resident status, then the medical has to be redone at significant cost and time to the IMG.

Recognition of the need for ongoing mentoring and support for IMGs.
Once an IMG has obtained a visa and has been placed in a practice, given an induction and settled into the community there is a need for ongoing mentoring and support to ensure that compliance and maintenance of standards are met. In particular, the degree and detail of record keeping and reporting in Australia can be very different to that of the country of origin, and has on occasion been a cause for concern amongst some IMGs once that mentoring has ceased – this can be several years after being located into a practice.

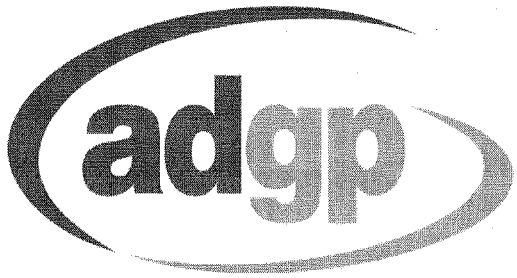
AGPN's call to action
As mentioned, certain visa categories restrict access to Medicare subsidies (as a consumer of health services) for the IMG and their family. AGPN considers that IMGs who work for the Australian health system should, along with their family, also be entitled to access Medicare benefits as a health consumer and reiterates that view here.

AGPN also suggests that the re-introduction of the independent business visa for certain appropriately qualified, experienced and skilled overseas trained general practitioners to establish their own private practice be considered as one way of helping to provide access to health care in small rural communities currently without a GP.

Additional comments
AGPN supports the recruitment and employment of IMGs in keeping with the Melbourne Manifesto. In many cases and particularly in rural areas, IMGs play an important role in assisting with Australia's doctor shortage. Reliance on importing a skilled workforce must however, remain a very small part of the solution to addressing Australia's health workforce shortage. Ways of both attracting and retaining Australian graduates within the medical, general practice and wider health workforce must be found.

Relevant processes should be in place throughout the whole recruitment, registration, assessment, employment placement, orientation and service provision process to ensure that quality practice occurs within Australian communities. Orientation and support, plus the facilitation of mentoring and continued education are some of the important ways in which divisions contribute to this on an ongoing basis.

IMGs will continue to play a very important role in addressing workforce shortages in Australia. Whilst adequate visa regulations must be in place, they should not discourage appropriately qualified and skilled IMGs from choosing to work in Australia.



Australian Divisions of General Practice Ltd

Submission to the Joint Standing Committee on Migration's Review of Skilled Migration

June 2005

Introduction

This submission is made by the Australian Divisions of General Practice (ADGP) to the Joint Standing Committee on Migration's *Review of Skilled Migration.* ADGP understands that the Review is seeking community views on the entire skilled migration program. This response will however be restricted to that component of the skilled migration workforce relevant to Divisions of General Practice – namely Overseas Trained Doctors, particularly GPs. The role of divisions is principally to support private general practice, which constitutes the main body of doctors supporting the community. In this context, comments in this submission are largely restricted to doctors classed as General Practitioners (GPs) under the Commonwealth's Medicare benefits arrangements – that is privately practising doctors whose services attract Medicare rebates.

About the Australian Divisions of General Practice

ADGP is the peak national body of the Divisions of General Practice. It comprises 119 Divisions across Australia as well as the eight state based bodies that link the Divisions with state level services. Approximately 95 per cent of GPs are members of a local Division of General Practice and Divisions, in turn, are members of ADGP. Divisions are an integral component of the Australian Government's general practice strategy. They play a major part in implementing policy, supporting general practice and managing health programs at a local level and have been responsible for progressing many of the current developments in Australian general practice. ADGP, through Divisions of General Practice, provides a key local health infrastructure that enables the planning and delivery of primary care services at the local and regional level. In particular, the Divisions network is focused on supporting high quality, evidence based primary care, integrating health services and engaging the local community.

Background

Australia is facing a health workforce shortage. Many rural and remote and, increasingly, outer metropolitan regions, are without sufficient doctors, especially GPs. Although importing a skilled workforce into Australia is by no means the complete solution to this situation, Overseas Trained Doctors (OTDs)[1] who migrate to Australia as either temporary or permanent residents play an important role in helping to address the critical doctor shortage in Australia. In fact, OTDs make a significant contribution to the medical workforce, especially in many rural and regional communities (which otherwise would often lack access to any GPs) and are generally over-represented in such areas.

This need for OTDs was reinforced by the Commonwealth Government though inclusion of the Overseas Trained Doctor initiative as part of its 2004 MedicarePlus package. A specific goal of this initiative was to have an additional 725 appropriately qualified doctors working in Australia by 2007. Under the Initiative, several areas relevant to migration have already been identified and modified in order to achieve this aim. These include:

- Reduced red tape in approval processes
- Assistance for employers and overseas-trained doctors in arranging placements
- Opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements and

[1] *OTDs have more recently been referred to as International Medical Graduates (IMGs) but for the purposes of this submission the term OTDs will be used.*

- Improved training arrangements and additional support programs

As a result of the Initiative, doctors were added to the skilled migration list at the beginning of 2005, making it easier for them to gain entry into Australia and to attain permanent residency, and the length of stay for doctors on temporary visas has now been increased from two to four years.

A comprehensive information and referral website service, *DoctorConnect*, has also been established as part of the initiative in order to centralise access to information for OTDs about the various processes necessary to work as an OTD in Australia.

However, OTDs continue to face difficulties with the system and there are a number of areas that could be improved in order to assist this necessary component of the medical workforce to enter, work and live in Australia.

Issues

Complexity of the Australian Health System

One of the main issues faced by OTDs who work as GPs or other private practitioners is the complexity of the Australian health system. These complexities range from attaining Medicare provider numbers and 19AB exemptions[2] to understanding the various eligibility criteria for particular schemes which determine where OTDs can work and, in some cases, the rate at which they can be paid. Eligibility factors are also compounded in some cases by the use of different state and commonwealth eligibility definitions and criteria. For example, state definitions of *Area of Need* differ from Commonwealth definitions of *District of Workforce Shortage*, although essentially both target communities where there is a lack of doctors.

Medicare provider number legislation in particular can cause not only frustration but also concern regarding job security as there can be requirements for repeat applications and uncertainty regarding renewal. The following example from an OTD highlights the situation:

"Since 2000, to practice medicine and remain in the same town, I have been required to apply on five occasions to renew my Medicare provider numbers and 19AB exemption. Obtaining an exemption, [and] understanding the.....methodology that HIC uses, causes extreme uncertainty and frustration. (Currently I have another application before the HIC, I do not know whether it will be approved or whether, if I wish to remain in Australia I will be [needed] to relocate). On average the application is 14 pages; Medicare forms, supporting letters, certified copies of citizenship and current medical board registration. It is then sent to the HIC... who forward it to Canberra. It takes at least 4 anxious weeks waiting a reply. The majority of the documentation are duplications [from applications] sent on previous occasions. At any point, despite having a home and family in the town and practicing medicine here for 5 years, the application could be refused, so we would be forced to move else where should I wish to remain in medicine.

Despite now being an Australian citizen, having invested significantly in making this country home, I feel, like the majority of OTD's, exploited and used by a system that takes but gives little in return."

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[2] *Section 19AB of the Health Insurance Act 1973 states that services provided by OTDs will not attract Medicare benefits for a period of 10 years from the time they become registered as a medical practitioner for the purposes of the Health Insurance Act. Exemptions to this act enable OTDs to access Medicare and work as privately practising GPs in areas of high need in Australia.*

Some of these complexities have started to be addressed through enterprises such as the OTD initiative. For example, understanding the system is aided by developments such as *DoctorConnect* as it enables access to comprehensive information about living and working as a doctor in Australia through a single source. However, improvements could still be made by standardising definitions around eligibility for workforce programs and by enhancing systems around provider number applications and registration processes.

Medical Boards: Consistency of standards

Working as a GP within Australia is complicated by the fact that each state has its own Medical Registration Board and each has different standards and requirements which must be met in order to work in a particular state. Although this issue is also faced by Australian trained doctors who wish to relocate, for OTDs it adds to the complexity of dealing with a new system and the uncertainty of where and for how long they will be able to work. For many OTDs it is difficult to understand why, if they have already proved eligible to work in one part of Australia, they must prove their eligibility again in order to work in another part of Australia.

The introduction of a common, high quality, standard national medical registration would alleviate much of this frustration and uncertainty and further help to reduce the red tape involved in registration approval processes over time for both OTDs and Australian trained doctors.

Support, training and mentoring for OTDs

Changing from one culture to another and adapting to the Australian lifestyle is a challenge faced by all migrants. In some ways, this challenge is intensified for OTDs, In many cases, OTDs fill vacancies that are hard to fill by doctors trained in Australia. This often means employment in rural and remote areas, in a range of clinical situations. To deal with these circumstances adequately, OTDs require not only sufficient medical knowledge and peer support, but also cultural awareness training/exposure and experience. This is particularly true for GPs who deal with patients on a more holistic basis and need to have strong communication skills. This is beyond English language ability but also includes the ability to appreciate the culture and environment in which a person lives. A number of Divisions already assist OTDs through peer support, cultural and general orientation programs. Such programs help OTDs to adapt to the Australian way of life and can also play a part in increasing their length of stay. With adequate resourcing, still more could be undertaken to provide this necessary assistance which is a factor in the recruitment and retention of OTDs to areas of high need.

Related to this is the issue of training and clinical support. As many OTDs work in rural and remote locations, they often need particular medical skills because these areas often lack other medical infrastructure such as specialists and adequately equipped hospitals etc. It is therefore important that the process of recognising equivalence of overseas qualifications also includes ensuring that the OTD has the relevant experience to fill the intended position. Ongoing training and mentoring support can further assist with this.

Equity with Australian Doctors

There is a perception amongst some OTDs that the pay and conditions they work under are less than those afforded Australian trained doctors. Although this is not by any means true for all cases, the situation can be compounded when OTDs feel

locked into unsatisfactory work contracts because of visa requirements and provider number restrictions. More flexibility within the system might assist those OTDs who are genuinely experiencing difficulties to move to another area where they are needed.

Another parity issue faced by OTDs with certain types of visas, is that they and their families are unable to access the Medicare system as users when they enter Australia. The irony whereby OTDs cannot access care through a system within which they are providing care is unacceptable and needs to be redressed.

Other issues: building public confidence

Repercussions from the recent incident regarding a Queensland based OTD (a hospital based surgeon) has led in some areas to a misplaced lack of confidence in OTDs. While it is outside the scope of this Review to deal with such issues, it further highlights some of the difficulties that OTDs face when working in Australia. As a result of this incident, the Queensland GP Alliance have developed a *Position Statement on IMGs – Quality, Standards and Support.* The statement (attached at Appendix A) also reinforces a number of the points made above and outlines several useful suggestions of relevance to this Review.

Conclusions

OTDs play an important role in the Australian medical workforce, particularly in areas of workforce shortage such as rural, remote and regional areas.

Skilled migration programs must encourage and support OTDs to continue to work in Australia whilst ensuring that quality patient care will not be compromised.

Issues of clinical and cultural support and orientation must continue to be addressed. Whilst Divisions already help with this, especially in rural areas, with more resourcing, the provision of support could be increased.

Complexities of Medicare and other aspects of the Australian health care system could be improved to make it easier for OTDs to navigate their way through the system. In particular, the introduction of consistent national standards for registration processes and requirements would be welcomed. The inability of some OTDs to access Medicare as users (patients) must be redressed.

The Overseas Trained Doctor taskforce has already begun to address some of the migration issues relating to OTDs. The *DoctorConnect* website is also helping to bring many disparate sources of information together to assist OTDs and their potential employers in the process of finding out about working as a doctor in Australia. However, these are only the first steps in developing a more robust framework for the recruitment and retention of OTDs.

The recommendations in the Position Statement of the Queensland GP Alliance (Appendix A) offer a useful way forward regarding the employment of OTDs in Australia to enable the continued delivery of high quality and safe health care to all Australians.

Appendix A

QUEENSLAND GP ALLIANCE

International Medical Graduates – Quality, Standards, and Support
Position Statement (revised June 2005)

Terminology

For the purposes of this statement, all doctors with medical qualifications attained outside Australia shall be referred to collectively as International Medical Graduates (IMGs). This is increasingly becoming the accepted term for this group of medical practitioners.

Preamble
There is a well-documented shortage of doctors internationally, including Australia, where IMGs play a crucial role in addressing medical workforce shortages. Currently rural workforce data shows that 41 per cent [n=388] of rural and remote GPs are overseas trained, and of these 54 per cent [n=211] are Australian citizens or permanent residents. In Queensland, it is estimated that there are over 1,000 IMGs practising medicine, which represents approximately 25 per cent of the general practice workforce.

Historically, IMGs in Australia came from predominantly Western and English speaking backgrounds. This is distinct from the current influx of IMG recruits from an increasingly diverse array of countries with differing disease demographics, languages and cultures.

Furthermore, it should be noted that immigration arrangements enable IMGs to work in Australia under 'temporary' visas for up to four years (with ability to reapply upon completion) without the application of vetting mechanisms or preparatory support.

The medical profession has a responsibility to inform and impress upon governments the mounting relevance of sufficient policy to address this trend, in a fashion that both ensures professional and personal support for internationally recruited doctors, and inturn the maintenance of clinical quality, and patient safety.

Quality, Standards, and Support
Recognising the irregularity in the standards applied, and the support offered to IMGs, this paper has been developed as a unified, overarching statement of principle on the standards and quality elements that should apply to IMGs wishing to enter general practice or rural medicine in Australia. This paper has been developed in acknowledgement of the significant amount of work required to define the processes, legalities, and funding elements necessary

for the issues described to be suitably executed. This work will need to be progressed with State medical registration boards, Colleges, workforce agencies, Divisions of General Practice, Australian Medical Association, Rural Doctors Association of Australia, and Governments.

The Queensland General Practice Alliance (the Alliance) believes that the relevant colleges should identify the standards applied to IMGs, and that these standards should be congruent with those expected of Australian graduates. Commensurate with this criterion is the need for Governments to ensure all IMGs are afforded the same degree of professional and social integration opportunities available to Australian medical graduates.

In order to facilitate the development of these principles, the Alliance puts forth that the following sequence of safety and quality procedures must be applied and provided to all IMGs before, during, and subsequent to arrival in Australia.

1. Prior to arrival, a preliminary assessment comprising of a qualification and "good standing" check, language testing, reference check, and utilisation of an online assessment tool;
2. Following successful completion of the above, an IMG applying for a GP position in Australia will undergo clinical, communication and cultural skills assessment upon arrival, to ensure the IMG candidate is matched with an appropriate job placement. These elements should be linked to state medical board registration;
3. A standard and accredited orientation program, comprising specific orientation to rural medical practice and introduction to the Australian healthcare system and general practice.
4. An IMG would then be placed to an Area if Need, District of Workforce Shortage or similar GP position, and would be supervised for 12 months by an Australian recognised practitioner (a 'supervisor'). This would be direct supervision where possible, or via remote supervision where necessary, utilising existing and proven mechanisms (such as the Remote Vocational Training Scheme arrangement). The supervisor would report on progress (against a standardised set of skills) and outcomes with a registering body that would, at the end of the period, issue corresponding right to unrestricted practice in areas of need, admission to further bridging or training, or in extreme circumstances - the denial of application for registration;
5. IMGs must enter a fellowship preparatory program and attain fellowship within a specified period; and
6. IMGs may be offered an additional period of six months local supervision if required.

The Alliance acknowledges a need to develop these programs:

- Appropriate for the individual IMG;
- Acknowledging the need to develop Recognition of Prior Learning processes;
- With regard to the intended mode of practice and tenure;

- Understanding that safety and quality procedures 4 - 6 would not be applicable for short term IMG locums.
- Under the auspices of the relevant colleges; and
- With regard to adequate and appropriate accreditation, remuneration, training, indemnity, and support for the supervisors and mentors involved.