Senate Community Affairs Committee – Inquiry into the National Registration and Accreditation Scheme for Doctors and other Health Workers

Introduction

Rural Health Workforce Australia (RHWA) welcomes this opportunity to comment on the new national registration and accreditation scheme for doctors and other health workers. RHWA is funded by the Department of Health and Ageing and is the peak body for the Rural Workforce Agencies (RWAs), based in every State and the Northern Territory, whose role it is to recruit and support doctors in rural and remote areas of Australia.

The RWAs have more than 10 years experience of recruiting doctors, many of whom are International Medical Graduates (IMGs) who must work in rural and remote areas as a condition of the mandatory 10 year moratorium attached to their registration. Indeed, according to data published by the Department of Health and Ageing, the number of GPs practising in rural and remote areas from overseas rose from 29% of the rural and remote GP workforce in 2000-2001 to 38% by 2007-08.[1] Any changes to the registration requirements and accreditation of IMGs will therefore have a major impact upon the work of the RWAs.

From July 1st 2008 a national assessment process for IMGs was introduced. This implementation was an outcome of the February 2006 COAG meeting calling for a national process "to ensure appropriate standards in qualifications and training and improve efficiency of the assessment process".[2] This followed the Productivity Commission's report into Australia's Health Workforce just one month earlier.

It was originally intended that the scheme would be operational by December of that year. However, that proved to be impossible to achieve.

The experience of how this was implemented and the impact of the process upon the capacity of agencies on the ground to recruit IMGs to Australia will form the basis of our submission to the Senate Community Affairs Committee. We believe there are some critical lessons to be learned from the way in which the assessment process for IMGs was implemented that could have some consequences for the implementation of the national registration and accreditation scheme by July 2010.

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[1] Statistics available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/92F55029093539FACA256FFE008206BE/$File/Table%2018.pdf. Published November 2008. Accessed April 14th 2009.

[2] COAG Meeting Outcomes February 2006. Available at: http://www.coag.gov.au/coag_meeting_outcomes/2006-02-10/index.cfm Accessed April 14th 2009.

Having said that, we should state that RHWA and the RWAs are strongly supportive of a national registration and accreditation scheme to ensure that the principles of equity, transparency and consistency are foundational to our system.

Our submission is not structured specifically around the terms of reference provided but it is hoped that our comments contribute to those terms of reference.

Transitional Arrangements

We note that the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (IGA), as signed by the Commonwealth, States and Territories in March 2008, contains details on transitional arrangements following the establishment of the scheme in July 2010. We also note that these arrangements are inscribed in the *Health Practitioner (Administrative Arrangements) National Law Act 2008*.

According to the IGA of March 2008, existing external accreditation bodies will continue their functions for 3 years after July 2010. During the first 12 months they will have to satisfy the standards and criteria set by the national agency covering issues such as the processes for the assessment of individual qualifications and courses of training. After 3 years they will be subject to review.

RHWA strongly supports this transitional arrangement subject to the proviso that the standards and criteria set by the new agency are the result of significant stakeholder and consumer consultation. The IGA is silent on what might happen to accreditation bodies that fail to meet these standards and criteria within 12 months. In particular, we would ask what happens to those agencies to whom the eternal accreditation body has delegated parts of the accreditation function? Our experience with the complexities associated with the IMG assessment processes as detailed below suggests that there may need to be some flexibility around implementation. We would be keen therefore to see that the new scheme works with the processes that have been often painstakingly put in place for IMGs and does not in any way jeopardise them.

We note also that some of the problems have occurred as a consequence of introducing consistent national assessment processes whilst state and territory boards are still in existence and governed by their own different legislation.

Key Issues that arose with the IMGs National Assessment Scheme

1. Consistency

As stated above, the new system for IMGs was put in place before the establishment of a national agency for registration and accreditation. Three

particular assessment pathways for IMGs were developed, a Competent Authority Pathway, a Standard Pathway and a GP specialist pathway. However despite the apparent acceptance of the various pathways developed for IMGs, not all of them were recognised by every medical board across the country. In South Australia, for example, only the Specialist Pathway is to be made available for GPs. Yet, when the scheme was supposed to have been fully implemented (July 2008) the GP Specialist Pathway was not fully developed which means that few if any doctors are able to be recruited under this pathway. To complicate matters further, some of the jurisdictions did not even recognise general practice as a speciality.

This situation arose because there had been little or no communication with those working on the ground with IMGs – placing them in actual rural and remote practices. Thus, what appeared to be a rationalisation and streamlining of the existing processes potentially ended up causing significant recruitment delays as well as burdening IMGs with additional costs.

As a consequence of this, and following extensive further discussions and negotiations, some ten months after the process was supposed to be up and running only now are the details around the GP Specialist Pathway being implemented. And instead of the original three pathways which were designed to simplify (make more “efficient”) a complicated system, there are now 5 pathways – as the GP Specialist Pathway has been split into three different parts – fully comparable, partially comparable via qualification and partially comparable via experience – thereby further complicating what was supposed to be a simple system. In other words, instead of going back to the drawing board to see how the system could work in its entirety, there have been a series of patch-ups on the run.

In the meantime, the whole process has contributed to further confusion for potential IMGs who have looked for loopholes in the system to best achieve their aim of working in Australia.

2 Consultation and Communication

These problems could have been avoided in large part if there had been a communication strategy developed and a full consultative process implemented which was designed to uncover all the anomalies in the system and the implications of the transition for these anomalous situations. This did not occur until the process was almost at implementation stage.

With hindsight it is apparent that the changes were developed without the benefit of an overarching perspective on how this would affect all parts of the system – not just those who would be introducing and running the various pathways, but also those who would be placing the doctors on the ground as well as the end users of the system, the doctors themselves. So, although the system was built

around national principles and national pathways insufficient thought was given as to how these would relate one to the other.

We understand that there has been a more detailed consultative process for the implementation of the national accreditation and registration scheme and that there will be further consultations when the exposure draft is delivered. However, we would point to the example of the 5 year scheme as one where an extremely successful and beneficial program was jeopardised for want of proper consultation.

3. Timelines

Our experiences with the IMG assessment processes have also highlighted the problems with a fixed date for implementation rather than either a smoother transitional process or perhaps a trial process in some jurisdictions.

We are pleased to see that there will be continuity of up to three years for existing accreditation bodies should they meet the new agency's standards and criteria for accreditation processes.

4. Resources

As stated earlier, a principal rational behind the new system was to ensure appropriate standards in qualifications and training at a national level. A related consideration here was also patient safety given the high profile cases that had appeared in the media in recent years, such as Dr Jayant Patel. A key requirement of the assessment process for IMGs was orientation. Although the RWAs and RHWA have argued for the implementation of a fully funded nationally consistent (but locally tailored) orientation scheme, the new assessment processes have left this in the hands of the employer. Whilst this may be appropriate for employers, such as urban hospitals, who have the capacity to provide orientation and supervision within a well-structured environment, the same cannot be held for IMGs entering general practice in rural and remote areas.

Again, the problem was that the new assessment process was not properly designed to take into account the different working environments that IMGs would find themselves in and there appeared to be the assumption that hospital employment would be the norm. Had there been resources made available to trial the process prior to full implementation these flaws would have been revealed.

5. Balancing local needs with national processes

The IMG assessment process highlights the need to get the balance right between nationally consistent standards and flexibility on the ground. The critical

issue is that IMGs are generally applying for a particular position in a particular location – commonly rural or remote. Assessment of their skills and experience needed to be done in that context.

Lessons Learned

- Different parts of the system were driven by different priorities. For example, the Medical Boards were concerned with standards and quality whilst the recruiters were obviously concerned with recruitment. Mechanisms need to be in place that can bring these differing perspectives to bear upon the design of the overall system. This “whole of system” perspective is essential.
- Communication and consultative strategies are essential. This must involve not just have representatives of peak organisations sitting around a table but also going out and talking to smaller groups about how any changes might affect them.
- Commitments to principles must be matched by appropriate resources. Key elements of the system, such as IMG orientation, will not occur just because they are written into overarching guidelines unless thought is given to *how* it might occur across all circumstances.