National Rural Health Alliance

Appearance before House of Representatives Standing Committee on Health and Ageing

Inquiry into the registration processes and support of Overseas Trained Doctors

24 May 2011

Opening statement (edited)

Overseas Trained Doctors (OTDs) represent 29 per cent of the general practitioner workforce in Australia as a whole and 41 per cent of the GP workforce in rural and remote areas. If it were not for overseas trained doctors, many rural communities would not have any local access to doctors. These doctors are valued and appreciated by rural and remote communities across Australia.

Ideally, Australia would provide its own doctors and be less reliant on overseas trained doctors, but medical workforce planning is not an exact science. Education and training cycles in health care are long, and supply and demand signals are unclear. It is therefore helpful to have access to overseas doctors when our own supply is insufficient but, like other developed nations, Australia competes in the global market for doctors. Much to its shame, Australia now finds itself drawing on the medical reserves of countries much poorer than itself.

Most of the slight net growth from 2000-01 to 2008-09 in the number of doctors working in Australia is attributable to increases in the number of overseas trained doctors, and the Australian public has a high degree of satisfaction with the care they receive from OTDs. There is a multitude of reasons for the increased numbers of OTDs working in rural and remote Australia, and they may include the success of the so-called 'ten year moratorium'. Nevertheless, the place and value of the moratorium have now become contested issues, due to concerns about the fairness of such a scheme (seen by some as 'conscription') and concerns about the most effective balance that can be struck between 'sticks' and 'carrots'. The Alliance would like to see independent research on the impact of the moratorium on OTDs and on regional, rural and remote communities.

If Australia is to continue being part of a global market for doctors, the administrative system for the recruitment and employment of OTDs should be simplified. Currently, OTDs coming to Australia have to comply with at least eight discrete processes with separate organisations. Each of these organisations requires a wide range of forms, statutory requirements, assessments and examinations. In some cases, two or more organisations may demand the same information but require the doctor to submit it separately but with a minor variation. Many of these processes could be streamlined and simplified.

We also believe that potentially discriminatory aspects of sections 19AA of the Health Insurance Act must be changed. OTDs who are citizens or permanent residents should not have more restrictions on their ability to practise than those who are not, or are not yet, citizens of Australia.

The legislation also impacts unfairly on Australian trained doctors who have worked overseas for the greater part of their careers and wish to return to Australia. Similarly, doctors from overseas who trained at Australian universities are 'caught' in the restrictions of Section 19AA and/or Section 19AB.

It is incongruous that international medical graduates and their families do not have access to services funded by Medicare or free access to public education. While we acknowledge that such restrictions apply to other workforce categories working under temporary residence, we believe that OTDs and other essential workers should be treated as special cases. If Australia is serious about competing at a global level in attracting high quality health professionals, these restrictions on inclusion into community should be lifted. This is particularly the case as OTDs are one of the very few professional groups subject to a moratorium arrangement.

The next issue of headline importance for us goes to Australia's role as a good international citizen. Australia should encourage the recruitment of OTDs from countries with a surplus in their medical workforce, but should not actively encourage doctors from developing countries. Similarly, Australian trained doctors should be available to support developing countries and contribute to the workforce of these nations.

The Alliance believes that Section 19AB exemptions[1] should be based on the ASGC-RA classification system rather than on Districts of Workforce Shortage (DWS) and Area of Need (AoN) designations that exist at present. DWS and AON are both subject to administrative (some might say political) whim and are subject to regular changes, whereas the ASGC-RA classification, whatever its anomalies, is based on ABS data and is more predictable and constant. DWS and AON are subject to (Federal and State) Ministerial fiat; the criteria for AON applications vary between jurisdictions. Overall, the complexity of the system creates a burden for OTDs themselves, government departments, general practices, hospitals and others involved in health services.

A simpler system based on ASGC-RA would mean less confusion and more choice (OTDs could work in any part of rural Australia where there was a vacancy that suited them and where the employer was willing to be a sponsor), less use of administrative resources, and a speedier process.

In consultation with states and territories, the Commonwealth should build a stronger support system for OTDs, providing a pathway for vocational training, professional development, peer support, support for families and - of particular importance for the people of rural and remote Australia - attractive working and living conditions for rural and remote practice. Rural Workforce Agencies in each jurisdiction are well positioned to provide such support and could act as a single centralised source of information.

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[1] All overseas trained doctors (except those who received their primary degree in New Zealand) seeking to work in general practice (or in specialist services attracting a Medicare rebate) will need to be able to attract Medicare rebates and will therefore also require an exemption from Section 19AB of the *Health Insurance Act 1973*. These exemptions were introduced in 1997, which means that for the past fourteen years OTDs have been required to work in a District of Workforce Shortage for up to 10 years. This is commonly known as the 'ten year moratorium'.

Many GP support programs (eg relocation incentives) are not available to temporary resident OTDs and therefore may not maximise the opportunity to increase the medical workforce in rural communities. This reflects the old fashioned belief that OTDs only come to Australia for a short time, whereas they usually seek permanent residency and citizenship and become long term rural and remote GPs.

Financial support would be provided in this system for OTDs to undertake vocational training. They would receive appropriate supervision in rural and remote Australia. Support should be provided to facilitate effective integration of OTDs and their families into their local community. This should include support for cultural training for work with Aboriginal peoples, ongoing peer support, and assistance to access health, education and other community services taken for granted by others in the community.

To achieve full qualifications OTDs are required to complete 12 months of supervised practice. Wherever possible, overseas trained GPs could have half of their required supervised practice in a general practice setting. We propose that a rural mentoring system be established under which OTDs would work in the local community under the supervision of local, retired or retiring GPs. This would include both clinical supervision and help with local community orientation.

The Alliance also proposes that the moratorium restrictions be relaxed for OTDs who commit to working in **remote** general practice (eg RA 4 and 5). Those who commit to work in a more remote area could be permitted to undertake their 12 months' supervised practice in a general practice where the capacity exists for appropriate supervision – thus avoiding that particular bottleneck. The provision of their Provider Number would be contingent on them working in more remote areas after the specified supervision period. The practices investing in the supervision of these doctors would need to be compensated for income lost and rewarded for the investment in this workforce.

OTDs are critical to the health of Australians living in rural and remote areas. The current system for securing their services is cumbersome, difficult to manage and almost impossible to explain. It must be designed to protect quality and safety but ought not to be a test of an individual applicant's perseverance and persistence.

We are hopeful that the outcomes of this Inquiry will help improve matters.