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Ms Robyn Kruk AO
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Dear Ms Kruk

RE: Feedback on Interim Report

The Royal Australian College of General Practitioners (RACGP) welcomed the opportunity to meet with the review team recently to discuss your Interim Report on overseas health practitioner regulatory settings. We also appreciate the invitation to provide formal feedback through this submission.

The RACGP recognises that Australia is facing a looming general practitioner (GP) workforce shortage, and that under the current circumstances domestic medical graduates will not be sufficient to meet that shortage in the short term.[1] As such, ensuring attractive pathways for international medical graduates (IMGs), including specialist international medical graduates (SIMGs), is critical to serving community needs. We further recognise that Australia is only one of many destinations for doctors looking to migrate and work, and so there needs to be a robust understanding of the competition between countries for what is a scarce resource from across the world.

The RACGP is committed to serve the community by ensuring that it does not unnecessarily add burden to the process for IMGs and SIMGs, and reminds the reviewers, the Government and the public that patient safety and quality of care are paramount. Poorly equipped doctors have the potential to do harm to patients and the community, and it is important that the pathway for IMGs to practice unsupervised in Australian GP settings has appropriate checks and balances.

We note that your request for feedback specifically asks for advice on:

- the prioritisation of recommendations in the Interim Report and
- reform options missing from the Interim Report.

Of the recommendations laid out on page 5 of the Interim Report, the RACGP recommends prioritisation of:

Recommendation 1: *Implementation of a single portal for applications to remove duplication and align of evidentiary requirements for applicants.*

RACGP Comment: The RACGP acknowledges that the current system leads to duplication, particularly in terms of proof-of-identity documents. The existing Australian Medical Council (AMC) portal, which allows the specialist colleges to share their recommendations on the comparability of practitioners with the AMC and Ahpra, is an effective tool for collaboration. Its functions could be expanded or broadened for use by multiple agencies.

Recommendation 5: *Continue workforce supply and demand modelling in partnership with the states and territories and other stakeholders.*

RACGP Comment: The RACGP understands the value and importance of this work. Further the College notes the statement in the Interim Report that 'GP workforce planning is expected in the third quarter of 2023'. The College is keen to work cooperatively with relevant Federal and State Departments, Ahpra and National Registration and Accreditation Scheme (NRAS) entities to develop and input into this work.

Recommendation 6: *Removal or suspension of labour market testing requirements for employers sponsoring priority health practitioners on certain visas and broadening of the age exemptions for permanent skilled visas to encompass key health practitioners.*

RACGP Comment:

The RACGP notes the commentary on page 48 that "*most permanent Australian visas are generally only available to individuals under 45 years of age"*, and that "*many skilled health practitioners do not achieve full credentials until their 40s*". We believe it would be valuable for mid- and late-career GPs to be recognised and allowed to seek permanent residency. These practitioners can provide significant benefits to the community and will provide a net benefit to Australia. There is also the likelihood of greater retention should permanent residency be offered as an alternative to work visas.

With regard to recommendations 2, 3 and 4, RACGP provides the following comments on implementation:

Recommendation 2: *Enable more cohorts from trusted countries to be 'fast-tracked' through competent authority pathways (CAPs) and transition equivalence assessments for specialist medical graduates from the specialist medical colleges to the AMC.*

It should be noted that CAPs are a route to general medical registration, allowing practitioners to bypass a range of assessments, including the AMC examinations. While the RACGP acknowledges the need to streamline or 'fast-track' applicants through an increased number of CAPs, the College does not support the transition of equivalence assessments for specialist medication graduates from the specialist medical colleges to the AMC. The RACGP does not see that adjusting countries recognised as competent authorities and re-assigning the activity of specialist pathway comparability assessment to the AMC are related, and the former can be achieved without the latter.

Prior to any changes to CAPs, the RACGP recommends an analysis of the historic results of the AMC exams (including pass rates by country of origin) be undertaken, to assess whether candidates of any particular country pass at sufficiently high rates for the AMC to be comfortable exempting future candidates from these counties from its examinations. The RACGP would be open to further discussions on CAPs based on the results of this analysis.

With regard to the assessment of SIMGs, it must be acknowledged that specialist standards, training and accreditation in seemingly comparable health systems are not universally comparable across all specialities. For example, General Practice is not considered a speciality in New Zealand, as it is in Australia. In the USA, patients approach specialists such as paediatricians and obstetricians directly, meaning family physicians in the US have a different scope of practice and limited experience in fields that form the core of Australian general practice.

The RACGP's 2022 Specialist Pathway Data Report provided to the Medical Board of Australia but not yet published indicates that while in excess of two-thirds of doctors who came to the RACGP on the specialist pathway did their specialist training in the UK, only 53% did their primary degree in the UK. The College also recognised as substantially comparable people whose primary degrees came from 17 countries, including Bangladesh, Burma, China, Czech Republic, Egypt, India, Iraq, Nigeria, Pakistan, Poland, Russia, South Africa, Sweden, and Yemen. We remain mindful of the use of third countries in these assessment pathways, noting the full assessment of a practitioner's capability may or may not have been undertaken in that third country. The RACGP is open to considering how it can facilitate flexibility and opportunity for IMGs from partially comparable health systems to obtain Fellowship in a way that does not compromise patient safety and quality of care.

On a note of caution, the RACGP draws attention to the 2005 Queensland Public Hospital Commission of Inquiry Report which analysed in particular the case of Dr Jayant Patel at the Bundaberg Base Hospital. The Report examined and highlighted the risks to patient safety when specialist colleges were bypassed in the assessment of SIMGs, as per Section 2.52.

Therefore, RACGP recommends consideration of an alternative option that could achieve the intent of recommendation 2:

The 2017 Deloitte Access Economics external review of the specialist medical colleges' performance - specialist international medical graduate assessment progress found that "the colleges mostly comply with the *Good Practice Guidelines"* then governing the pathway. Since the report, the Guidelines have been redeveloped into Standards, with which the RACGP is now compliant.

The RACGP sees that updating these Standards and giving the colleges the opportunity to comply with simpler, less onerous, more streamlined requirements is a simpler solution than transitioning the entire assessment process to the AMC.

As an act of good faith, RACGP has included at Appendix A, a range of measures it considers could help in achieving this simpler, less onerous and more streamlined process for IMGs and SIMGs.

Further to the above, it is important work in this space reflects the specific contexts in which many IMGs/SIMGs work. In rural and remote Australia, geographical and demographic features lead to great diversity in both the ranges of presentations a GP may encounter and the facilities that may be available to them to administer primary care. The comparability for working in a rural or remote settings may be different to urban with respect to skills, systems, support and ability to work independently.

Additionally, cultural safety is an important consideration for both patients and doctors in these communities. The RACGP consider the completion of cultural awareness and cultural safety training essential for IMGs wanting to come to Australia and setting them up for success as a GP. Considering remoteness is an indicator for chronic disease and multimorbidity prevalence and Aboriginal and Torres Strait Islander people represent over 30% of the total remote/very remote populations, it is critical IMGs are trained with the knowledge to deliver culturally safe best practice.[2] It is essential to support IMGs in the provision of culturally safe primary care.

Further information on the unique IMG/SIMG working context is available in the RACGP submission to the Parliamentary Joint Standing Committee on Migration for the Inquiry - Migration, Pathway to Nation Building.

Recommendation 3: *Better recognition of overseas health practitioners' experience and skills.*

The RACGP currently interprets the Medical Board of Australia Standards: Specialist medical college assessment of specialist international medical graduates as requiring that SIMGs be substantially comparable to an Australian-*trained* Specialist (emphasis added), which therefore automatically excludes any SIMG who did not undertake a training program. The RACGP would be pleased to better recognise overseas health practitioners' experience and skills if this requirement were reviewed or clarified – Appendix A provides suggestions on how this could be achieved.

Recommendation 4: *Provide applicants with greater flexibility in demonstrating their English language competency.*

RACGP recommends caution on this, as high-level writing skills are essential for all medical professionals. The risks of adverse outcomes due to miscommunication in written records is significant. Where possible, we would prefer that practitioners not meeting the writing standard be supported to raise their level of skill in this area, rather than lowering the required standard.

With regard to your invitation to suggest reform options missing from the Interim Report, RACGP has included some broader suggestions at Appendix B.

On behalf of the RACGP, we look forward to continuing an ongoing dialogue with your review team to progress this important matter into the future.

Kind regards

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APPENDIX A: Measures RACGP considers could be reviewed to achieve a simpler, less onerous and more streamlined process for IMGs and SIMGs.

Measure	Rationale	Benefit
Accept curricula as eligible for Substantially Comparable and Partially Comparable streams with lower comparability ratings.	Currently curricula need to be >85% comparable to that of the RACGP to be considered substantially comparable and >65% comparable to be considered partially comparable. We could lower these requirements to >75%, (for substantially comparable) and >50% (for partially comparable).	As a modern curriculum, the RACGP curriculum for general practice is structured by domains and competency outcomes. An effect of this is that many overseas curricula with different structures show low identity with the RACGP curriculum, particularly in areas such as professionalism, practice management, medicolegal dimensions, and so on. Noting that practitioners on the specialist pathway will undergo mentorship and supervision to acclimatise to Australian practice, some curricular elements may be non-essential for the purposes of this comparison.
Simplify/amend comparability assessments.	By removing the requirement for applicants to demonstrate reflective practice by writing 10 clinical case analyses, we can significantly shorten the application length, improving both the time invested by SIMGs and the time taken for RACGP review. Continuing professional development currently requires that applicants demonstrate 50 hours of CPD that would meet Australian standards. This could be reduced to allow applicants to demonstrate any 50 hours of CPD. Newly qualified SIMGs could be exempted from this required for a period of 12 months following the award of their qualification in recognition of the ongoing education undertaken as part of their training. Update the recency assessment to better recognise locum work in general practice, as is common in countries which are major sources of SIMGs.	Time savings in preparing, submitting and assessing applications. More flexibility for applicants without access to Australian-standard CPD and recognising the significant education undertaken whilst undergoing training. Better recognition of the nature of overseas general practice and the reality of international locum requirements.
Widen the type of training types considered applicable to the specialist pathway.	Currently, the RACGP assesses the training undertaken by SIMGs and compares it with the Australian General Practice Training Program (AGPT). In recognising that many Fellows of the RACGP and ACRRM did not complete AGPT, the RACGP proposes loosening this requirement to consider SIMGs who achieved Specialist status through different paths.	Better recognises the experience and skills of late-career SIMGs. This would increase the number of qualifications (and hence SIMGs) eligible to access to the specialist pathway.
Remove requirement for multi-source feedback as part of the assessment	Multi-source feedback is a valuable formative assessment for SIMGs commencing practice in Australia, however it can be burdensome for some practitioners. By making MSF optional, we can allow practitioners to gain the benefits of feedback on a timeline that suits them.	Reduces cost. Reduces administrative burden on SIMG and practices.

undertaken upon commencement of practice in Australia.		
Remove requirement for reflective essay as part of the assessment undertaken upon commencement of practice in Australia.	The reflective essay component encourages the SIMG to consider their adaptation to the Australian context, which elements of the transition are going well and which elements represent opportunities for further growth. By making the reflective essay optional, practitioners will face lower compliance burdens, and may find alternative ways to meet the same objectives.	Reduces administrative burden on SIMG.
Reduce minimum time on the Specialist Pathway from 6 months to 3 months.	The RACGP recognises that the supervision period in the Standards ranges from 3 – 12 months for substantially comparable SIMGs. As a matter of course, the RACGP recommends a minimum of six months for all substantially comparable SIMGs. To facilitate a quicker transition to specialist registration we can reduce the minimum to three months, noting that the SIMG must still schedule and satisfactorily complete workplace based assessment before Fellowship will be awarded and supervision lifted. The exact schedule of these activities will be for the SIMG to determine, noting that WBA is unlikely be feasible in the SIMG's first weeks in practice.	Creates opportunity for SIMGs to progress to Fellowship more quickly.

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APPENDIX B: Reform options missing from the Interim Report

Reform Option	Rationale	Benefit
Offer IMGs and SIMGs permanent residency without the need to move through temporary residency.	This initiative would reduce the reliance on visa sponsorship and hence reduces risk of workplace exploitation. It would also increase certainty and has many associated benefits for older, more experienced IMGs and SIMGs who may be considering relocating their family to Australia long-term. This will also reduce the financial burden of relocating. This change would also make IMGs eligible to enter Australian General Practice Training, providing them high-quality training in general practice increasing their likelihood of passing RACGP exams and becoming specialist GPs.	Makes Australia a more attractive location to practice long term.
Remove geographic practice restrictions for SIMGs.	A class exemption to the 10-year moratorium and broadening of access to Fellowship Support Program provider numbers in MM1 non-DPA areas would allow applications for provider numbers to be undertaken concurrently with college assessments, and make Australia a more attractive destination for SIMGs, particularly those whose spouses have been employed by large hospitals in metropolitan areas.	Reduced processing times. Increased attractiveness.
Additional government funding for IMGs/SIMGs undertaking training and assessments.	The Practice Experience Program, which accepted IMGs from 2019 – 2022 and SIMGs from 2021 – present, was funded by the Commonwealth government's stronger rural health strategy. However, with the cessation of funding from 30 June 2023, the cost of these programs has been borne by IMGs and SIMGs. The additional costs constitute a disincentive for some SIMGs, and could be met by further, relatively inexpensive Commonwealth funding.	Reduced training and accreditation costs for IMGs and SIMGs.
Review the burden placed on supervisors for IMGs.	There is a potential opportunity to review the paperwork requirements to attempt to simplify them, reduce the level of risk placed on the supervisor and also consider funding remuneration for supervisors.	Increases the pool of GPs willing to supervise IMGs.

References

[1] Deloitte Access Economics 2022, General Practitioner workforce report 2019, for Cornerstone Health Pty Ltd, https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-cornerstone-health-gp-workforce-06052022.pdf [Accessed 9 June 2023].

[2] Australian Institute of Health and Welfare. Rural and remote health. Canberra: AIHW, 2022. Available at www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health#Health%20risk%20factors [Accessed 9 June 2023].