1. The Review is considering recommendations to ease skills shortages in registered health professions including medicine, nursing, midwifery, psychology, pharmacy, occupational therapy, and paramedicine on the basis of current and projected labour market shortages.

a. Do you agree there are current and/or projected skills shortages in these professions?

For some professions, the issue is not a workforce supply issues, but rather an issue of maldistribution across locations and specialties. However, our data indicates that there are significant shortages among several healthcare workforces. In particular:

Nursing

Victoria's nursing workforce has grown by 29.3% between 2014 and 2022, however numerous population, infrastructure and reform factors have resulted in demand growth that is projected to outpace growth in supply. For example, implementation of the Aged Care Royal Commission recommendations is projected to require at least an additional 1,400 FTE registered nurses by October 2024. Workforce demand will be further compounded with establishment of 10 new community hospitals and expansion of numerous others.

Midwives

Early modelling by the Department of Health forecasts a possible shortfall in the short to medium term. There are also issues regarding the maldistribution of midwives and recency of practice for midwives in rural and regional Victoria.

Medicine

Victoria has grown the medical workforce by 53.4% between 2014 and 2022, however projected workforce shortfalls are expected across numerous roles which currently rely on significant international recruitment.

Psychiatrists: Victoria has a long-standing reliance on overseas trained psychiatrists, especially in the public system. Nearly a third, 28%, of psychiatrists gained their first medical specialist qualification overseas. Department of Health's baseline model is forecasting a shortage over the next 10 years. Ahpra data show that 30% of specialist psychiatrists are aged 60 years or older. Between 2015 and 2020, the workforce grew at an average rate of 4% per year, while psychiatric inpatient separations grew at 5% per year.

Ophthalmologists: There is indication that new graduate supply is not sufficient in this speciality. Growth in this workforce has not kept up with demand growth in recent years, and a significant proportion of the workforce is reaching retirement age. Ahpra data show that 34% of specialist ophthalmologists are aged 60 years or older. There is an increasing proportion of this workforce who received their first specialty qualification overseas.

General Practitioners (GP): The Australian Medical Association has recently forecast a national shortage of 10,000FTE of GPs by 2031. However, Victoria's data and modelling indicate Victoria has and will continue to have sufficient General Practitioners into the medium and longer term. However, the Department is aware of issues of maldistribution of General Practitioners including localised shortages. Data shows that there are several areas in Victoria where patients do not receive general practitioner consultations at the rate we would expect, indicating difficulty accessing services. Victoria's GP workforce is highly reliant on overseas migration, with 42.5% of GPs overseas qualified as of 2020. We note that this poses a risk to workforce sustainability, but also opportunities to align migration settings to support distribution to areas of need.

Some surgical specialties are likely to be under more stress than others. Those that our data indicate may be under stress are plastic surgery, otolaryngology (head and neck) surgery, and paediatric surgery.

Allied Health

While not in scope, there are shortages in unregistered professions, namely speech pathologists, allied health assistants, sonographers, exercise physiologists, dieticians, orthotics and prosthetics professionals and social workers.

Consideration should be given for their inclusion, given that they are widely employed across community and acute hospital settings including in Intensive Care Units and Emergency Departments, where their expertise

can prevent clinical deterioration and is necessary for timely and successful hospital discharges. Further data from these professions should be sought by peak bodies, Health networks and Victorian Public Services to address any shortages that could lead to poor patient outcomes.

b. If yes, is there any data or evidence you can provide to demonstrate these shortages?

Data can be obtained from

- Australian Healthcare and Hospitals Association https://ahha.asn.au/sites/default/files/docs/policy-issue/ahha_position_statement_-_health_workforce_3.pdf
- Health workforce shortages are reflected in modelling of Australian's Health Workforce with a deficit by 2025 of 109,500 nurses and 2,700 doctors.
- Established workforce shortages in outer metropolitan, regional and remote areas in disadvantaged populations
- Australian Financial Review June 2022 https://www.afr.com/work-and-careers/workplace/battle-for-talent-as-the-great-jobs-boom-takes-off-20220601-p5aq7u
- Decreasing trend in percentage of applications per job when compared to pre-pandemic rates in the healthcare sector.
- Ahpra annual report 2021-2022 and Victorian performance report 2021-2022
- whilst the number of registered health practitioners grew overall by 3.2% (excluding the practitioners on the pandemic sub-register) the number of registrations in Victoria reduced from 222,264 in 2021 to 217,776 in 2022. https://www.ahpra.gov.au/Publications/Annual-reports/Annual-Report-2021/Registration.aspx https://www.ahpra.gov.au/About-Ahpra/What-We-Do/Statistics.aspx
- Ahpra Physiotherapy workforce analysis 2021 noted consistent reports of national shortages in the profession for the last 27 years which are only expected to increase given the recognized importance of physiotherapy for older Australians and for those with disability under the NDIS. file:///C:/Users/vidss7t/Downloads/Ahpra-Report-Physiotherapy-workforce-analysis.PDF
- The Victorian Skills Authority (VSA) Microsoft Power BI

2. What, in your view, are the key strengths and weaknesses of the current regulatory settings relating to health practitioner registration and qualification recognition for overseas-trained health practitioners?

Strengths

The current regulatory requirements ensure integrity of the National Registration and Accreditation Scheme. The process has resulted in the recruitment and registration of high-quality health care professionals who meet the appropriate levels of safety and quality.

Weaknesses

While the current regulatory settings ensure the recruitment of high-quality healthcare professionals, Ahpra, the Medical Board of Australia (MBA), and the Specialist Colleges appear to be working independently to achieve this at the expense of establishing regulatory settings and processes to respond to the critical need for an adequate supply and equitable distribution of international healthcare workers in Australia.

There are a limited number of countries that hold comparable qualifications and pathways for registration in medicine, nursing and midwifery and minimal support for those who do not meet registration requirements.

For example, international medical graduates (IMGs) can only register via the Competent Authority Pathway if they have a primary qualification in medicine and surgery awarded by a training institution recognised by both the Australian Medical Council and the World Directory of Medical Schools (WDOMS) and have completed training or assessment with an approved competent authority. There are only 7 competent authorities in the UK, Canada, US, NZ, and Ireland. Therefore, most progress through the Standard pathway which involves passing the Australian Medical Council (AMC) Clinical Examination before they can apply to the Board for

registration. According to the Australian Medical Review Centre, IMGs are challenged by the requirements to obtain general registration with the pass rate for the AMC clinical Examination under 28 per cent.

Furthermore, when it comes to the registration of international General Practitioners, the Royal Australian College of General Practitioners (RACGP) recognises a limited number of countries that hold comparable qualifications for GP practice in Australia compared to New Zealand and the United Kingdom.

Most overseas nursing and midwifery qualifications are either; not substantially equivalent, nor based on similar competencies to an approved qualification (Stream B) or are not substantially equivalent or relevant to an approved qualification (Stream C).

Internationally qualified nurses and midwives who fall into Stream B are required to undertake an Outcome based Assessment (OBA) before they are eligible to apply for registration in Australia. The OBA comprises of a multiple-choice question (MCQ) exam and an Objective Structured Clinical Examination. A significant number of international nurses and midwives who do not have the appropriate skills and knowledge to practice in Australia are repeatedly sitting and failing registration exams with limited support to bridge those gaps.

Prior to 2 March 2020, internationally qualified nurses and midwives who fell into Stream C were required by the National Board prior to 2 March 2020 under s 53(c) of the National Law to undertake a bridging program following an assessment of their qualifications. However, bridging courses no longer exist and the only way to proceed in the assessment process is to upgrade their qualification that meets accreditation requirement.

3. During the pandemic, a range of regulatory settings and processes relating to registration and qualification recognition of overseas-trained health practitioners were temporarily waived, relaxed, or had greater flexibility.

a. Are there settings or processes that were particularly beneficial or challenging from a professional or employer perspective?

- The return of health professionals to practice (who had previously exited the workforce for retirement of some other reason) helped to boost workforce capacity. However, their addition could be considered a medium- longer-term strategy rather than a surge response based on anecdotal feedback that the time taken to re-train these professionals increased immediate workforce pressures. The benefits relating to reducing burnout or improving staffing ratios, may be more apparent in the medium to longer term pandemic recovery.
- Conversely, greater flexibility in regulatory settings promoted innovation by challenging traditional roles and protocols in health services. https://ahha.asn.au/sites/default/files/docs/policy-issue/perspectives_brief_no_19_health_service_innovation_during_the_pandemic_0_0.pdf

b. Do you believe any of these temporary changes were beneficial or potentially detrimental to patient safety? What opportunities/challenges may arise if these settings and/or processes are retained permanently?

- Anecdotally, altering regulations to allow returning medical and nursing practitioners to be redeployed to COVID surge areas where high risk decisions are made quickly, (e.g., ED and ICU) could also increase the risk for negative patient outcomes if these clinicians were unfamiliar with practises. More detailed feedback could be sought by the COVID-surge response team at the Department.
- In a retrospective cohort study of ICUs in Victoria, over 66.7% of ICUs reported an 'insufficient skill mix' amongst their nursing staff during the peak COVID surge December 2021- February 2022. This has been reiterated by surveys exploring the experiences of redeployed nurses who raised concerns about their ability to provide quality care when redeployed. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9742212/
- It is recommended that the education processes for staff redeployment be reviewed and to consider strategies to create more efficient and standardised training pathways for clinicians entering these areas. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9742212/

4. The end-to-end process for overseas health practitioners seeking to work in Australia can be complex, time consuming and costly. Current regulatory requirements may set unduly restrictive barriers, which in turn may deter potential practitioners from seeking to work in Australia.

a. Do you agree with this premise? If so, why?

Yes. In addition to the barriers outlined in question 2, the process to apply for a visa issued by the Australian Department of Home Affairs and register to practice in Australia with Aphra are separate and success in one does not automatically guarantee success in the other. Having multiple processes leads to many inefficiencies and duplications and subsequently becomes quite lengthy, and costly. This is a deterrent to overseas he alth professionals particularly those wanting to relocate with families given the process is much tougher than comparable countries with no guarantee of success.

When looking at the recruitment of international GPs into Australia versus New Zealand, New Zealand has a larger intake of GPs per capita with a significantly shorter processing time of three months compared to Australia which takes between 12-18months. Registration costs for NZ IMGS are significantly lower at $7-8K compared to $19-25K for Australian GPs. It is also of note the seamless process in New Zealand that involves far fewer entities involved in the process and much less duplication. It is not apparent that the efficiencies in the New Zealand process have been at the compromise of quality and safety.

Some common feedback received from health services and candidates include:

- Having to supply the same documents confirming qualifications, skills, and experience repeatedly throughout the process of migration, registration, and employment. These are usually requested in different formats.
- Documents that confirm good standing (e.g., international registration, criminal history checks) expire. Health practitioners are often required to source the same confirmations several times throughout the process causing delays, frustration, and additional costs.
- There can be significant delays obtaining comparability assessments from professional colleges and associations.
- The applicant must navigate multiple websites to assess what information they need to provide, which is timely and confusing for applicants.
- Present in person AHPRA check. When overseas health professionals are granted AHPRA registration in Australia, it is provisional until they present in person to the AHPRA office on arrival in the capital city they are working. There is a set time limit as to when they must appear in person and present their identity documents and statement of “good character” that is a document stating they have not committed any offences since they obtained an international police check (most expire by the time they arrive). Once they present to the AHPRA office, verify their identity and they receive their full AHPRA registration. For an IMG the period between an in person check and receiving a Medicare Provider number can take months. It can also take 4 weeks for the RACGP to determine eligibility for entry into the Practice Experience Program (PEP) to become vocationally registered. A recruit either remains unemployed in Australia during this period or flies back home and returns later. This is a deterrent for many.
- Regional/rural health services without knowledge of OS recruitment are struggling to complete the registration and visa processing requirements.

There is also limited capacity to support the registration process. The capacity for registration through the Australian Medical Council (AMC) National Test Centre (NTC) is limited to the number of staff and facilities which do not scale. The Nursing and Midwifery Board of Australia (NMBA) and Ahpra currently schedule Objective Structured Clinical Exams (OSCEs) up to five times per year. The OSCE is an in-person clinical assessment held only in Adelaide, meaning overseas nurses and midwives are required to tr avel to South Australia to participate.

b. What practical changes could be made to current regulatory settings to improve the end-to-end process most significantly:

Recognition and Accountability

First, and most importantly the need for recognition and acceptance amongst all health services, local, state and commonwealth departments, Ahpra, AMC, MBA, medical schools, and specialist colleges that:

- We have an issue with the supply and equitable distribution of key healthcare professionals in Australia, and
- This is a shared problem, that we all have a significant role to play in addressing without compromising quality or safety standards.

Process improvement and cost reduction

- Create one single process for overseas health professionals who are wanting to relocate to Australia for the purpose of working in their profession. This will involve removing any duplication, reducing the number of entities involved as well as the number of handoffs and automating the process where possible. Comparing the Australian IMG process to the New Zealand IMG process is a good example of how this can be done.
- Establish effective governance and accountability arrangements between health services, state, and commonwealth departments, Ahpra, AMC, MBA Medical schools, specialist colleges with a commitment to build the supply of healthcare workers and support equitable workforce distribution without not compromising quality or safety standards.
- Automate access to Medicare Provider numbers for all eligible health professionals and remove paper-based application forms. This will align with process that exists for Medical Practitioners which enables Services Australia to receive verification of eligibility from Ahpra via data feed. Work with Services Australia to develop Business Rules and costings.
- Create one sole source of truth for international qualifications and certified documents to be used by Home Affairs, Assessment bodies and Professional colleges, Ahpra and Employers. Consider the benefits of reversing the flow of what is asked for and when to improve efficiencies.
- Simplify the Ahpra website by providing a thorough list of links to websites that the applicant will need to access for the professional registration. For example, for physiotherapists providing links to the relevant application file, the Physiotherapy Board, and the Australian Physiotherapy Council under a single heading.
- Replace the 'present in person' requirement for Proof of Identity (POI) with audio-visual link followed by in person POI with their employer upon commencement of their role.
- Reduce the time taken between cultural training and written and clinical exams.

Increased supply and equitable distribution of healthcare workers

- Implement an immediate system-based response to distribute registrars, Hospital Medical Officers (HMOs), nurses, and allied health staff more equitably between metropolitan and regional health services
- Work with the AMC and NMBA to build capacity and provide flexible delivery options to boost exam capacity.
- Provide additional on and offshore locations beyond Adelaide only, for the Objective Structured Clinical Examination (OSCE) required of Internationally qualified nurses and midwives.
- The Distribution Priority Area (DPA) includes peri-urban areas which results in doctors moving to these areas from regional areas, exacerbating workforce shortages in regional Victoria. District Priority Areas increased from 550 in 2021 to 654 in 2022. There are not enough GPs to work across these areas.
- Colleges address the maldistribution of registrars by accrediting more Distribution Priority Areas (DPAs) practices to take on registrars.
- Colleges to work with DPAs to supervision capacity of IMGs
- Understand the current capacity of medical colleges and professional bodies and target support to priority areas of workforce.

- The mandated requirement for rotations of junior staff to rural locations should be extended to all professions and craft-groups, though this requires metropolitan hospitals and professional colleges to think more broadly than the current approach.

There is a precedent for this in relation to the mandatory requirement for all interns at year level one or two to participate in a mandatory rotation within an area mental health service.

Registration standards and Eligible pathways

- Expand the number of countries with comparable health systems and education providers for accelerated registration pathways.
- Explore alternative new pathways and build comparable qualifications in countries where:
- There is a sufficient supply of healthcare workers. For example, India is a priority geography for international recruitment following the announcement by the Indian Ministry of Skill Development and Entrepreneurship in early 2021 that it would supply 300,000 healthcare workers, doctors, nurses, and allied health personnel, to countries including Australia.
- Where health services have indicated success in recruitment such as Singapore and the Philippines.
- Support target countries to build comparable qualifications for a future pipeline.
- Explore more attractive pathways for IMGs to become vocationally registered GPs. IMGs are encouraged to become vocationally registered, but they must complete the Fellowship Support Program (FSP) as the pathway for Fellowship. This is a self-funded 24-month program that may be less attractive to overseas doctors than previous programs such as the Fellowship ad eundem gradum.
- Increase availability for IMGs in the Standard Pathway to have their clinical skills and knowledge assessed in the workplace by AMC-accredited providers as an alternative to the AMC Clinical Examination to improve pass rates.
- Create Industry based learning pathways for internationally qualified nurses and midwives whose qualifications fall into Stream C.

Support for international healthcare workers

- Establish an information and assistance office to help potential recruits navigate the accreditation and registration requirements.
- Review information provided to international health practitioners providing transparent information about pass rates.
- Consider funding education modules to support successful completion of exams.
- Develop a feedback pathway in multiple instances of failure with career counselling.
- Social Services provide access to Medicare for incoming health professionals and their dependents for their visa's duration.
- Establish better partnership arrangements between health services, state and commonwealth departments, community service providers to ensure that a coordinated training program is available for specialised training of IMGs prior to placement in medical clinics.
- Identify and where possible remove barriers that restrict practice once registered. IMGS who are non-VR GPs are not eligible to claim Medicare A1 rebates for GP standard attendances as VR GPs. Under section 19AB of the Health Insurance Act 1973. They are only eligible for the same Medicare rebate if they work in a District Priority Area (DPA) or any location after regular hours. Although this was designed to support workforce distribution to areas and services in need, it can be a deterrent for an IMG who cannot work in regional areas for assorted reasons.
- Identify and address situations where IMGs are supervised by less experienced Australian doctors.