NT Health – Response to Consultation Paper – Review of regulatory settings relating to registration and qualification recognition for overseas health practitioners

About NT Health

NT Health manages the Northern Territory public health system which includes the Regional Health Services.

NT Health operates across five service delivery regions to provide the full spectrum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course. Each region is a service area that aligns NT Health with the NT Government regional boundaries.

Public health services are provided through six public hospitals, including two in Greater Darwin, one in Alice Springs, Tennant Creek, Katherine and Gove. The two largest hospitals are the Royal Darwin Hospital and the Alice Springs Hospital. NT Health provides direct care to the community through 39 primary health care centres and supports 133 clinics/services operated by Aboriginal Community Controlled Health Organisations throughout the NT. Public health care accounts for 20 per cent of the NT Government's budget.

At EOFY 2021-22 NT Health employed 7868 staff who operate across five regions (Attachment A).

NT Health is highly dependent on the employment of overseas trained health practitioners, particularly in the areas of medicine, nursing and midwifery, pharmacy and dental officers.

Discussion questions

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?

Yes. As a provider of health services in some of the most remote areas of Australia, NT Health experiences significant challenges in recruiting and retaining skilled health practitioners. This has been an ongoing factor in service provision in the NT for decades.

Shortages of skilled professions can vary over time according to broader economic and social factors, for example, services are currently experiencing acute shortages of occupational therapists with the expansion of private providers for NDIS services. In the past 12 months NT Health has been unable to recruit an occupational therapist to the Katherine region.

The current decline in general practice nationally is another current factor impacting on the supply of general practitioners, with the NT currently experiencing a shortfall of 70 FTE. At present 70% of primary health positions in NT Health are filled by agency nursing and visiting medical officers.

Shortages are exacerbated by comparatively high staff turnover in the NT with pharmacy and allied health reporting approximately 30% turnover per annum.

Shortages are experienced in all regions of the NT, but are more acute in regional and remote areas. In nursing and midwifery NT Health generally has a good supply of graduate staff; however, supply of more experienced staff is more strained.

NORTHERN TERRITORY GOVERNMENT

Presently senior clinical staff in NT Health report shortages in the following skill groups:

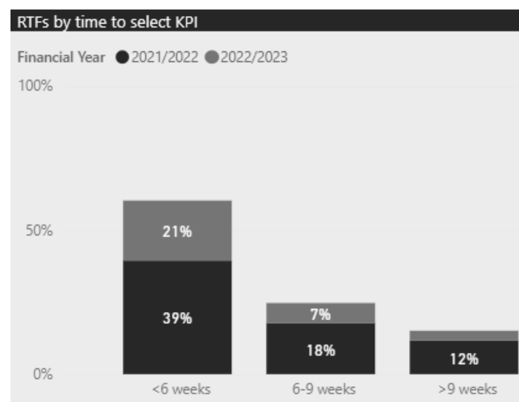
- Nursing and Midwifery:
  - Renal
  - Mental health
  - Remote health care
  - Emergency
  - Midwifery
  - Theatre
  - Peri-operative (regional)
  - Orthopaedics
- Pharmacy
- Dental officers
- Medical practitioners:
  - Resident medical officers
  - Major medical specialties
  - General practice
- Allied health:
  - Occupational therapy
  - Physiotherapy
  - Psychology

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

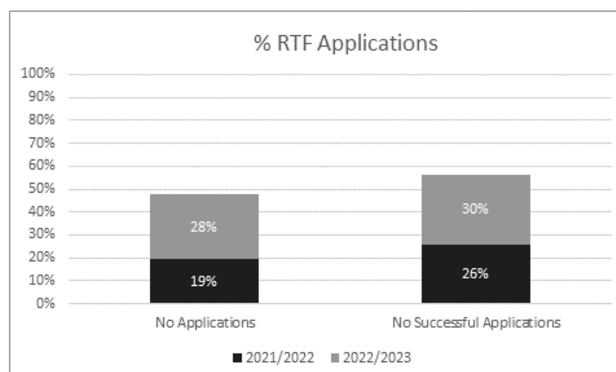
Disparate systems across NT Health mean there are limitations in available data demonstrating skill shortages; however, the following table shows YTD average paid FTE by stream and the variance to current approved budget. Allied health is captured under the 'Professional' category, but unfortunately cannot be separated out from other professional classifications across NT Health, for example self-regulated professions and medical science. This figure likely understates the true allied health vacancy rate.

Stream	YTD Avg Paid FTE	FTE Budget 2022-23	Variance	Vacancy %
MEDICAL	910	1,032	122	12%
NURSING	2,891	3,161	271	9%
DENTIST	5	22	7	32%
PROFESSIONAL	811	890	79	9%

Another indicator which may demonstrate skill shortages is the length of time to fill a vacancy. There are limitations in this data also as there may be other factors impacting on a recruitment process, for example, administrative delay. The following data also includes the non-clinical the workforce.



The following graph illustrates the percentage of NT Health medical, nursing, dental and professional vacancies which have been advertised and received no applications and no successful applications. Noting the limitation mentioned above in separating allied health positions within the 'professional category, the graph indicates a decline in successful recruitment actions over the period 2021 to YTD 2023.



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?

Key strengths:

- Ensures only suitably qualified health practitioners are registered.
- National registration allows for mobility across jurisdictions.
- Public safety is maximised and risk is minimised.

Weaknesses:

- Complex and sluggish system which does not support timely recruitment and which may place Australia at a competitive disadvantage with other countries with more agile and streamlined registration and qualification assessment systems.
- It is not apparent data and intelligence forms the basis of assessing risk in relation to registration and qualification assessment decisions.
- System requires applicants to submit duplicate materials to different authorities, for example criminal history checks.
- Change to the service requirement from two years to three years for an appropriate IMG supervisor has impacted upon the number of IMG's that can be supervised.
- Ahpra can be slow in providing updates on progress with assessments.

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?

These were of minimal benefit as recruitment from overseas had ceased with border closures.

b. Do you believe any of these temporary changes were beneficial or potentially detrimental to patient safety?

No.

c. What opportunities/challenges may arise if these settings and/or processes are retained permanently?

None.

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. End-to-end process is administratively time consuming, expensive and difficult to navigate for practitioners, especially when combined with visa and migration processes.

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

i. over the next 12 months

- Conduct a review of the end-to-end registration and qualification assessment process utilising business process re-engineering principles to identify inefficiencies and opportunities for streamlining systems.
- Implement an alternative to the document notarising requirement for overseas practitioners which can be especially time consuming and difficult.
- Consider allowing a single employer training plan for generic medical positions e.g. resident medical officers, recruited from competent authority pathway jurisdictions such as the UK, rather than requiring the submission of individualised plans.
- Provide a visual roadmap of the registration and qualification assessment process in a format that is easy to understand for overseas practitioners.
- Research best-practice registration and assessment processes in comparative countries/jurisdictions to inform a medium and longer term reform process, noting there should be no diminution in standards.

ii. in the medium- to longer-term?

- Leverage new and emerging technologies, e.g. AI which can be utilised in streamlining registration and assessment processes.
- Review existing competent authority pathways and opportunities for expansion while maintaining existing public health and safety standards. A cautious approach is recommended.
- Consider the feasibility of expanding the TTMRA model to other like countries. Caution advised.
- Review current and projected health workforce needs to inform strategies for increasing the supply of the domestic workforce.
- Identify opportunities to reduce costs for practitioners, e.g. examinations, to increase Australia's competitiveness.
- Consider a single point-of-entry model for overseas registration and assessment processes.

- Examine learnings from the revalidation process which can be applied in the assessment of overseas practitioners.
- Review the requirement for an overseas pharmacist to undertake a long period of supervised practice. This means they are not able to fill acute shortage positions and results in increased workload for an already short workforce.

5. If you are an overseas health practitioner or employer – are there any thoughts you would like to share in terms of your experience of the end-to-end process for working in Australia or employing an overseas-trained health practitioner?

Example 1

The following is an example provided by a physiotherapist who migrated from India to the NT.

- Arrived in Australia 2009- he held a 457 visa as his wife was the primary applicant.
- Time from start of registration process to successful registration: 4 years.
- Total Cost $8500 plus airfares and accommodation.
- Initial assessment submitted 29/10/2015; Outcome 9/11/2015 ($1100)
- Written exam 03/03/2016; Outcome 04/04/2016 ($1900)
- Clinical Assessment: Fee paid 13/05/2016. Three clinical assessments in Sydney (at different times throughout 2017- one fail and resit 21/03/2018)- totalling 4 trips to Sydney and a cost of $4125.00 for the clinical exams. Total wait time for clinical exams – 22 months. This was the main delaying factor.
- APC General registration competed 22/3/2018. Then Ahpra 2 months later.

Example 2

The following example is from a Malaysian born, UK trained, medical practitioner who migrated to the NT in 2022.

1. AHPRA require a criminal check by a 3rd party provider usually fit2work which costs 100s of dollars. The 3rd party companies don't share the actual reports, just a reference number. During the visa application process, the home office requires a direct report from the national police database (in my example ACRO from the UK) which further costs 100s of dollars. Essentially ACRO have been paid twice by me (first through the 3rd party and then directly). If AHPRA would accept either 3rd party or direct police reports, it could save money.

2. English language requirements could definitely use some updating. Illustrated by myself, Malaysian citizen sat IELTS Academic after my A Levels in 2010 and got into British medical school (5 year program as standard) and then followed on with 7 more years of work, 5 in specialist training. However the phrasing in the requirements especially the (6 years of continuous education in recognised country) meant that I had to sit an additional English language test (also 100s of dollars). This was the biggest rate limiting step as they are usually long waiting lists and people have to travel interstate to find a spot in any of the exam options available.