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ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY
AMSANT

AMSANT Policy Position: More GPs in MM7 & MM6

(and Aboriginal community controlled health services in MM5 to MM3[1])

February 2024

Recruiting International Medical Graduates Requiring Supervision and Support to Attain Fellowship of the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine in Rural and Remote Australia.

Executive summary

The purpose of this paper is to provide more detail on the AMSANT strategy to enable International Medical Graduates (IMGs) to access GP training in the NT and then in other rural and remote areas across Australia.

The paper makes clear that there needs to be a policy change at the Commonwealth level to enable suitably qualified IMGs to take up infilled, funded positions in the NT GP training program. This should be for IMGs who need to complete the full 3 years of training prior to sitting their fellowship exams as well as those who are suitable to access the *rapid pathway*.

In all cases, IMGs need to be able to access the full resources and support of the GP training program as if they were Australian graduates to give them the greatest chance of success and to ensure they are trained to the required standard as quickly as possible. They would be placed in Aboriginal community controlled health services and remote area private GP practices that are already teaching practises recognised by the Colleges and therefore have GP supervisors and other resources to support GP training.

In addition to this, we need to re-establish the pathway from temporary visas to permanent citizenship after IMGs have both passed their fellowship and also completed the required amount of time in rural and remote areas. This provides a large, non-financial incentive to take up positions in rural and remote areas that historically has proved very successful.

Introduction

There has been a shortage of General Practitioners in Australia for some time and it appears likely to grow over the coming years due to retirement of the aging workforce[2]. As few as 5% of medical students are expressing a preference to work in primary care. There is a realisation that Australia will once again have to seek doctors who wish to immigrate to Australia to provide primary care. Fifty-three percent of Australian GPs are currently international medical graduates (IMGs).

It is often not appreciated how much Australia has come to rely on IMGs to try to provide the required medical primary care workforce that is needed. In 2022 Prof Brendan Murphy, former Secretary of the Commonwealth Department of Health, explained that Australia needs 7000 new doctors every year to meet our needs and yet we only graduate 3500 per year. The over-reliance on IMGs for such a wealthy country went unnoticed for many years until COVID. For two years our borders were closed and suddenly Australia was 7000 doctors short in a total workforce of just over 100 000 doctors. When the borders re-opened, in a major policy shift by the Commonwealth

government, access to new IMGs coming to Australia was extended to the cities and especially outer urban areas. This has worked against the needs of rural and remote areas and has had a major negative impact on access to GPs in Aboriginal communities in the NT.

The people with the highest need for health care in Australia are remote Aboriginal people, followed by remote non-Aboriginal people. The need for GP led primary health care has increased over time as Aboriginal people in particular are living longer but with more complex, chronic conditions. The effort to recruit international medical graduates in the 1990s and early 2000s did lead to some longer term GPs remaining in rural and remote areas including in Aboriginal communities. The more recent recruiting drive from 2005 to 2015 did attract a lot of doctors, but despite a moratorium on working in the city, virtually all IMGs have drifted to the capital cities after fulfilling their time in rural and remote areas.

We need to consider the difference in strategies used, as well as how we minimise the barriers for doctors seeking to work in remote areas, especially time delays.

Background

The RACGP is concerned about the growing demand for general practice services despite the increased numbers of medical graduates. It appears that general practice is not an attractive profession within medicine at the present time. It has been more attractive to certain groups; specifically to women, and to doctors seeking to work part time without after-hours demands.

The Current Shortage of GPs in the NT

After contacting all clinics in the NT in late 2022, the RACGP NT Faculty estimated there were 70 general practitioners required to fill all places in Aboriginal Community Controlled Health Services, private practices and government clinics. This is a substantial shortfall.

AMSANT did its own analysis of vacant GP positions in our sector and found that about a third of funded GP positions were vacant across the NT, nearly all in remote and very remote areas.

The NT Government estimate that there are 1400 doctors in the NT while only 140 of these are working outside Alice Springs and Darwin. As many as half these doctors work in the 3 remote hospitals in Tennant Creek, Katherine and Nhulunbuy.

AMSANT has long advocated for radical change to the regulatory framework and incentives to attract and retain workforce in the NT. This has included a range of policy options such as geographic provider numbers for GPs, retention payments, training support for IMGs, bonded scholarships and other regulatory policies. AMSANT produced a paper of possible policy solution to the workforce crisis in 2023 and the NT Faculty of the RACGP also wrote a paper addressing the shortage of general practitioners with suggestions as what could be done to address this. As a result of significant advocacy, the Commonwealth Department of health in partnership with AMSANT convened a NT workforce summit in Alice Springs in August 2023 involving national stakeholders to develop an agreed action plan.

There have been some changes which have been a positive for workforce and conditions in the NT:

1) Reduced restrictions for doctors in MM6 and 7 as well as inclusion of one year working in Aboriginal Health for general practitioners to receive incentives as rural generalists in remote areas (10K per year) and emergency services for 20 sessions per year (10 K per year).

2) The NT PHN has committed to continue the primary care nurse graduate program established at Congress and extend this to other services in the NT – an essential element to sustaining the multidisciplinary practice so important in primary care

However, there remain serious factors depressing the retention of general practitioners which include pay and conditions and pressure of work due to the under-supply. Further, the supply of teachers, police and other essential and important services is severely challenged, threatening lifestyle and living conditions.

There are considerably more pressures depressing supply in remote regional towns and very remote communities in the NT. Over the past decade general practices have ceased to operate in Nhulunbuy, Katherine and Tennant Creek and have been replaced by doctors working from the hospitals with considerable subsidy. The government primary care services offer terms and conditions that cannot be offered by the non-government sector and the FIFO service model is not popular with many community members. Transfer of care from government to an ACCHO, and an increase service from 1 to 3 days per week, has been a factor in the return of the resident population of a Central Australian remote community. The population has increased from 48 to 138 people over a 6 month period.

Shortages in the NT GP Training Program

At the same time as the NT is experiencing a severe shortage of GPs, the GP training program has also been severely undersubscribed. The NT had got used to a system where just over fifty new GP registrars per year would commence a 2-3 year GP training program. Total GP registrar numbers across the NT were well over 250. In 2023 only 10 registrars joined the NT program and all remained in Darwin. This year 24 registrars are commencing working in the NT, including 8 transferring from interstate with support from the NT faculty and NT PHN. There are therefore many funded, vacant positions in the NT GP training program which are not accepted by Australian medical graduates. These need to be offered to suitable IMGs.

Role Substitution

Some believe that things will get better if nurses and allied health professionals provide most of the health care in remote and rural areas. While this is superficially an attractive proposition to funders, nursing and allied health professionals are just as rare and training them to operate in remote areas adds a large overhead. In addition, the complexity of the chronic conditions affecting Aboriginal people in remote and very remote areas requires health professionals at the highest level of training in clinical diagnosis and management of patients with complex co-morbidities and life threatening acute presentations. In the Australian health system this means General Practitioners. Less than 30 Podiatrists qualified in Australia last year which will exacerbate shortages already having an impact where foot care is an essential service. Nurses and general practitioners, already under pressure, will have to fill the service gap that will inevitably arise in this important area of rural and remote practice. Ensuring that there is adequate access to GP support is also likely to be an important factor in retaining other health professionals particularly remote area nurses and Aboriginal Health practitioners who may feel professionally at risk without access to GP clinical input and advice

Becoming a Specialist General Practitioner (GP)

Australia has many barriers to becoming a general practitioner for IMGs. There are essentially two major steps; the first involves the Australian Health Practitioner Registration Authority (AHPRA) and the second involves the two primary care colleges – the RACGP and ACRRM. These steps are summarised below.

1. **Apply for Medical Registration**:

International Medical Graduates (IMGs) must apply for registration with the Medical Board of Australia (AHPRA).

There are three main pathways for assessment:

Competent Authority Pathway: Available to overseas-trained non-specialists and specialists, including general practitioners. IMGs who have passed recognized examinations or completed training through a Board-approved competent authority can apply for assessment under this pathway. It leads to general registration.

Standard Pathway: For IMGs seeking general registration. Applicants must have a primary qualification in medicine and surgery from a training institution recognized by both the Australian Medical Council (AMC) and the World Directory of Medical Schools (WDOMS). IMGs must pass the AMC CAT MCQ Examination before applying for registration.

Specialist Pathway: For overseas-trained specialists seeking recognition or an area of need specialist position in Australia. IMGs with a primary qualification recognized by the AMC and WDOMS, who have met training and examination requirements in their specialty, can apply under this pathway.

Short-Term Training in a Medical Specialty Pathway: For IMGs wishing to undertake up to 24 months of specialist or advanced training in Australia.

2. **Join a Fellowship Program with the RACGP or ACRRM**:

After obtaining general registration, IMGs can pursue a Fellowship program with the RACGP or ACRRM. Fellowship involves further training, assessments, and practical experience to become a fully qualified GP in Australia[3].

The rapid pathway is to enable suitable doctors to be educated and trained by a "Competent Authority" in which case your primary medical degree is recognised as well as your specialist qualification. This leads to either:

- fully equivalent recognition, a 6 month term with assessment activities and transfer of Fellowship or
- partially equivalent recognition, a 12 month term with assessment and requirement to sit the Fellowship examination.

If the doctor has not got a qualification from a "Competent Authority" the doctor has to sit the AMC examinations and undertake a year to gain registration. The doctor may then apply for training or to be accepted into the Fellowship program directly if deemed to have the necessary experience.

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A GP Recruitment Strategy for MM7 and MM6 and (Aboriginal community controlled health services in MM5 to 3[1])

Ideally doctors recruited to Australia from overseas would be chosen on the basis of their interest and ability to work in remote and rural areas. In the first major recruiting effort in the 1990s, advertisements and agents were employed for specific positions, or at least for a small region. This appears to have attracted GPs with an interest in the sort of work undertaken in MM7 and MM6.

Maintaining Standards

The best way to maintain standards is to have a competitive recruitment based on excellence in primary care and to offer training in practices that are experienced and equipped to help doctors adjust to local practice. This should ideally involve training practices that are under subscribed in remote areas; the practices are equipped and prepared to take on doctors in training and the supervisors have the skills to determine the competence and needs of the doctors seeking to work in Australia. Ideally these practices should be funded to take on these doctors in the same way they do registrars. The time in training may be as little as 6 months, and if recruited appropriately some of these doctors will undoubtedly remain working in this setting.

Removing Barriers through policy change by the Commonwealth Department of Health

To rapidly fill this workforce shortage, priority needs to be given to IMGs with:

1) A medical degree and GP training under a “competent authority”, requiring 6 months supervision and education in the Australian health system. They get Fellowship at the end of this period but will require a short administrative transition to full GP specialist practice.
2) A medical degree under a “competent authority” and partially equivalent GP training, requiring 12 months supervision and education in General Practice and the Australian health system. They have to pass the Fellowship examination at the end of this period and may require time to re-sit if they do not pass. On passing the exam, these doctors will also require a short administrative transition to full GP specialist practice.
3) IMGs who have gained full registration but have not had sufficient experience in comprehensive general practice who can access unfilled training places in the current GP training programs. Like all registrars, they will have to pass the Fellowship examination at the end of this period and may also require time to re-sit if they do not pass. On passing the exam, these doctors will also require a short administrative transition to full GP specialist practice.

By placing these doctors in a training environment at least for the first 6 months or year, they will not only have the benefit of quality local supervision recognised by the RACGP and ACRRM. These trained and experienced supervisors will also have the ability to quickly recognise difficulties and any issues of safety for the doctor or the patients. The doctor will also be advantaged in passing their Fellowship, having supervisors who understand the requirements.

The advantage to the training practices that are undersubscribed is the maintenance of their training orientation and service level with a steady workforce even when there are not sufficient GP Registrars.

The terms and conditions for these placements should be set out as it is for registrars. This means that until these doctors obtain their fellowship they will be able to access funded training positions under the Aboriginal health training program when they are working in Aboriginal community controlled health services. This will ensure that these doctors are not exploited and remove the recruitment advantage gained by practices taking any doctors desperate to access an Australian visa.

There has been a dramatic rise in the number of IMGs seeking to work in Australia. The RACGP trained 40 general practitioners last year, and has 400 or so applying for training this year. It is estimated by experts that this could increase to 1000 next year and be of the same order of magnitude as the Australian General Practice Training Program.

The costs to the doctors is another concern, particularly as time delays mean living without an income. The RACGP is expecting to charge $12,000 per term which reflects the cost of offering the supervision and education required. There is a consequent advantage to offering better and cheaper options in remote areas; reducing time delays, improving supervision and support and even removing costs to those who commit to working in the period for some time.

The Northern Territory as a Priority Region

This approach should commence in the NT for the first 12 months to determine whether it is possible to attract and train doctors effectively in this setting. As a second step this “remote advantage” scheme could then be extended in these restricted categories Australia wide. It should apply to doctors working in Aboriginal community controlled health services and private GPs but not to NT government GPs who already enjoy salary and conditions far above the rest of the workforce and are reported to be accessing MM7 retention payments even though they do not live in MM7 communities.

Length of Stay and Long Term Retention

In order to promote the retention of the GPs there should be a reward system based on the successful “OTD” scheme introduced in 1999 by then health minister Michael Wooldridge. This is based on accessing permanent citizenship and the freedom to then practice in Australian unrestricted and differing lengths of stay depending on remoteness. Up until this point all IMGs will be on some form of temporary visa but with the commitment that once they have obtained their fellowship they will only need to serve out their required time and they will then be granted full citizenship.

The length of time required prior to obtaining full citizenship would be:

1. MM7 – 5 years
2. MM6 – 10 years
3. MM5 to 3 - 15 years

This would mean that GPs could not leave as soon as they become fully qualified to go and work in the cities.

The existing GP retention payments should also apply once a doctor has completed their length of stay requirement in each of these remoteness categories. This would provide an additional financial incentive to stay beyond the time when they receive citizenship and could leave which in some cases would then lead to even longer retention.

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Appendix 1

The Kruk Report

Barriers for OTDs and IMGs in Rural and Remote Australia: A Comprehensive Analysis[4]

1. Regulatory Hurdles:

Kruk Report Findings: The Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners, led by Ms. Robyn Kruk AO, highlights the need for reform in the current regulatory system for OTDs and IMGs. The existing process can be complex, time-consuming, and costly.

Recommendations: The report recommends streamlining regulatory settings to simplify the process, making it quicker and more affordable for international health practitioners to work in Australia. These reforms aim to balance safety standards while facilitating timely access to healthcare1.

2. Recognition of Qualifications:

Challenges: OTDs and IMGs often face difficulties in having their qualifications recognized in Australia. The process involves assessments by the Australian Medical Council (AMC) and the Medical Board of Australia (MBA).

Kruk Report Insights: The report emphasizes the need for a more efficient and transparent recognition process.

Proposed Solutions: Implementing clearer guidelines, reducing assessment time, and providing better support for candidates during the qualification recognition process.

3. Cultural Adaptation and Language Proficiency:

Cultural Challenges: Moving to rural and remote areas can be culturally challenging for OTDs and IMGs. They must adapt to local customs, practices, and patient expectations.

Language Proficiency: Effective communication with patients is crucial. The Kruk report suggests language proficiency assessments and targeted language support programs.

4. Professional Isolation and Support Networks:

Isolation: Working in rural and remote areas can lead to professional isolation. OTDs and IMGs may lack peer support and mentorship.

Kruk Report Recommendations: Establishing robust support networks, mentorship programs, and regular professional development opportunities.

5. Incentives and Retention Strategies:

Attracting and Retaining: Rural and remote areas often struggle to attract and retain healthcare professionals. The Kruk report advocates for financial incentives, educational opportunities, and lifestyle benefits.

Community Engagement: Building strong community ties and involving OTDs and IMGs in community activities can enhance retention.

6. Infrastructure and Resources:

Resource Disparities: Rural and remote areas may lack adequate healthcare infrastructure, technology, and resources.

Kruk Report Insights: The report emphasizes the need for targeted investments in healthcare facilities, telehealth services, and professional development opportunities.

7. Bridging the Gap:

Collaboration: Stakeholders, including government bodies, medical colleges, and local communities, must collaborate to address these barriers.

Kruk Report's Call to Action: Implementing the report's recommendations will require concerted efforts from all stakeholders.

In conclusion, overcoming barriers for OTDs and IMGs to become GPs in rural and remote Australia necessitates systemic reforms, cultural sensitivity, and community engagement. The Kruk report provides a roadmap for achieving these goals, ensuring equitable access to healthcare across the country.

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Appendix 2

RACGP Steps To Fellowship

Steps to Fellowship as described by the RACGP[5]. There are many links on this page pointing out further information.

1. Complete Primary Source Verification
   a) Check the instructions from the AMC about having your medical qualifications verified.
   b) Create an Electronic Portfolio of International Credentials (EPIC) account and confirm your identity. Indicate on the form that you plan to apply to the AMC.
   c) Set up an online AMC portfolio.
   d) Upload your qualifications to your EPIC account and request that an EPIC report be sent to the AMC. You and the AMC will be notified when the check has been completed.

2. Apply for the RACGP's comparability assessment
   a) Read the RACGP Guide to completing the PEP Specialist Stream comparability assessment.
   b) Sign up for an RACGP account.
   c) Access the RACGP comparability assessment application platform.
   d) Pay your application fee.
   e) Complete your comparability assessment application within six months of payment. Comparability assessments may take up to 10 weeks to process. You will be advised of your comparability outcome via email. Comparability assessment outcomes are valid for a year from the date of the outcome letter.

3. Secure an offer of employment in general practice
   a) Find employment or contact a Rural Health Workforce Agency or a medical recruitment agency for assistance

4. Apply to the RACGP for approval of your job offer
   a) Obtain letter of offer and employment contract from your employer.
   b) Ensure your offer of employment meets the conditions for a 3GA program provider number.
   c) Upload information about your job offer including supervisor details, the scope of practice and location to the PEP - Specialist Stream application platform.
   d) RACGP assessors will review the information.
   e) Once your job offer is approved, you can apply for AHPRA medical registration.

5. Apply to AHPRA for the appropriate registration
   a) The RACGP uploads Report 1, which is an interim outcome assessment, to the AMC portal:
      - Substantially comparable: Apply to AHPRA for provisional registration
      - Partially comparable: Apply to AHPRA for limited registration
      - Non-comparable: Apply for the competent authority or standard pathways.
   b) Translate all documents into English and certify.
   c) Complete English language test (if needed).
   d) Complete criminal history check.

e) Ensure you meet the registration standards.
f) Complete AHPRA registration application.
g) AHPRA will assess your application against the registration standards and decide if you are eligible for registration. AHPRA says now takes 10 days.
h) If you are eligible, you will receive a notice of in-principle approval from AHPRA.
i) If you are granted registration, your name will be published on the National Register of Health Practitioners within two weeks.

6. Apply to Department of Home Affairs for appropriate type of visa (if required)
   a) Check which visa options would suit your need with Department of Home Affairs Visa Finder (for example, with pathways to permanent residency for temporary residents, direct pathways to permanent residency, temporary business sponsored visas)
   b) For enquiries about 3GA programs and visa status, please contact your local Rural Workforce Agency for assistance
   c) The Temporary Skill Shortage Visa (subclass 482) medium-term stream is the most common pathway for migrating to Australia as a doctor and requires that you be sponsored by an Australian medical practice or hospital. For this visa, follow the step-by-step guide here.

7. Apply to enter the PEP – Specialist Stream program
   a) Apply to enter the PEP – Specialist Stream within 12 months of receiving your comparability assessment outcome.
   b) Provide evidence of the following:
      - AHPRA medical registration, including your name, must be on the National Register of Health Practitioners.
      - An approved job offer.
      - Completion of an advanced life support course.
      - An agreement with a suitable supervisor and two supervisor training plans completed by your practice.
   c) If all requirements are met, you will be provided with the Fellowship pathway agreement.
   d) Pay the invoice and return a signed program agreement to the RACGP.

8. Apply to RACGP for a Medicare provider number
   a) Complete the Medicare provider number application form and submit it to the RACGP.
   b) The RACGP will help you to apply for an approved placement, a Medicare provider number and to have your approved placement entered into the Register of Approved Placements.
   c) It can take up to 12 weeks for the Medicare provider number application form to be processed by the RACGP, the Department of Health and Aged Care and Medicare. Contact approvedplacement@racgp.org.au if you have any questions.
   d) You will receive an approved placement outcome letter issued directly from Services Australia or Medicare that outlines your specific provider number, placement address, exemption/s, and placement start and end dates.

9. Complete the PEP Specialist Stream program's six-12-month term and workplace-based assessment

a) Commence work in the RACGP-approved practice within six calendar months. The PEP – Specialist Stream 6-12 month term commences from the first day of work.
b) Submit to RACGP and the Medical Board of Australia your AHPRA orientation report (ORIG-30 form) and AHPRA work performance report (WRIG-30 form).
c) Complete all the workplace-based assessment components within three to six months of commencing work. These include:
   - online core learning units and reflective activity
   - Complete Doctor's Interpersonal Skills Questionnaire (DISQ), Colleague Feedback and Evaluation Tool (CFET) and self-appraisal, together known as "multisource feedback"
   - a clinical assessment visit from a medical educator who will observe you in practice during four consultations (direct observation) and conduct clinical case analyses
   - a clinical case analysis that involves the assessor selecting patients seen by you in the preceding week and asking you questions about aspects of the case.
d) Complete other assessment requirements, including RACGP core modules, a self-reflective activity and workplace-based peer review.
e) More information about the 6-12 month Specialist program can be found in the Specialist Participant Guide[6]

10. If you are deemed partially comparable, sit the RACGP Fellowship exams
    a) Check the Fellowship Exams Policy to see if you have satisfied the educational, training, experience and administrative requirements prior to enrolling in the Fellowship exams, to better ensure exam readiness and success.
    b) Enrol in the RACGP Fellowship exams via the RACGP website.
    c) Complete and pass the:
       - Applied Knowledge Test (AKT)
       - Key Feature Problem (KFP) exam
       - Clinical Exam

11. Apply for Fellowship
    a) Check and ensure you have met the Fellowship requirements.
    b) Apply to the RACGP for Fellowship as soon as you've met the Fellowship requirements.
    c) Once you have received confirmation of Fellowship, apply for specialist registration with AHPRA.

[1] For the purpose of this paper Darwin is to be considered as an MM3 locality as AMSANT believes it has been wrongly classified as MM2 and Danila Dilba should be eligible for this program as if it was in an MM3 locality. Darwin is significantly more isolated than all other MM2 localities throughout Australia.
[2] Health of the Nation Report, Royal Australian College of General Practitioners 2023.
[3] IMG Roadmap to RACGP Fellowship
[4] Kruk Health Practitioner Regulatory Settings Review | Regulatory Reform. 2024