

EDITORIAL

'The great flood': will the new SIMG expedited pathway address the deficiency in specialist medical care in rural, regional and remote Australia?

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Introduction

Through the Australian Medical Council (AMC), the Medical Board of Australia (Medical Board) and the Australian Health Practitioners Regulation Agency (Ahpra), the Australian Government has embarked on perhaps the most profound and significant change in the methodology for the selection of the specialist medical workforce that services the Australian community.

The problem

Bernard Salt, the Australian demographer, wrote an article in July this year about the problems confronting rural Australia. It is appropriate, given his expertise in this field, to quote him directly:

It is a concept many Australians understand but few if any have seen mapped...It is the great Australian Red Zone, a community of 138 mostly remote local government areas that have lost population thus far in the 21st century...About 2 per cent of the nation lives in this so-called Red Zone; it has been losing people at a rate of around 3000, or half a per cent, per year for more than 20 years...this Red Zone is pivotal to Australia's export success (and prosperity)...The big question is whether continued population loss from the Red Zone threatens the viability not just of local communities but also of local farming and mining enterprises.¹

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Herein lies the problem confronting a federal government trying to provide holistic medical care for all of Australia.

To quote Bernard Salt again, 'modern Australia is dominated by Blue Zone [read metropolitan] population and culture. Most job opportunities and population growth, most federal electorates, even Australia's popular culture is city orientated'.¹

This reality results in a critical impasse for the Australian Government because medical specialists are not 'an island'² but rather are inexorably interlinked with their social community.³ They have partners, children (with their education requirements), friends and family (particularly those requiring specialist medical care), that all, almost invariably, align with the rest of the Australian population's appetite for city or Blue Zone locations.

Servicing the medical needs of regional, rural and remote Australia is going to be increasingly difficult.

The review

The Australian Government commissioned a number of reviews to investigate methods by which regional, rural and remote Australia could be provided with specialist medical care, including from specialist international medical graduates (SIMGs):

*the most significant of which was the 'Independent review of health practitioner regulatory settings', also known as the Kruk Review, [which] made recommendations on streamlining and simplifying health practitioner regulation, with the aim of easing skills shortages in critical health professions...One of the review's recommendations with particular relevance to international medical graduates was the creation of expedited pathways for health practitioners in acknowledged areas of shortage, which are currently being established for several specialties by the Medical Board and Ahpra with assistance of the AMC.*⁴

The proposed government solution

In his plenary address at the Medical Board's annual meeting in Adelaide in 2024, Australia's former Chief Medical Officer Professor Brendan Murphy AC said:

the expedited specialist pathway being developed by the Board and Ahpra was 'essential.'

We do have health workforce shortages in Australia...but as always, the shortages in the medical workforce are not evenly distributed geographically or among medical specialists....

*For those doctors who are currently in the process of migrating, we should be doing everything possible to get them into clinical practice as soon as it is safe. We should do what we can to make migration to Australia attractive for those doctors who we really need to fill critical shortages in critical locations and specialties including, if necessary, subsidising some of the costs.*⁵

Dr Susan O'Dwyer, lead on the Medical Board's Specialist IMG taskforce, said:

the new fast track pathway would be an additional route to registration for IMGs with specialist qualifications.

Specific qualifications would be validated and become part of a published list of eligible qualifications and, if an SIMG has a qualification on the list, they would not need to apply to the [relevant] college for an assessment of their qualification...

They would instead apply directly to the [Australian] medical board for specialist registration.

Under the proposal, they [the SIMG] would then work as a specialist under supervision for six months [by whom is unclear] and complete Medical Board requirements such as cultural safety and orientation to the Australian healthcare system.

*Once the requirements are completed satisfactorily, they would be granted unconditional specialist registration.*⁵ [emphasis added]

There seem to be some fundamental flaws to this new process.

1. What if the accepted overseas qualifications are not equivalent and the training is not the same. How are the qualifications verified? As an example, the Royal Australian College of

Surgeons (RACS) has identified that the United Kingdom training in plastic surgery and ear, nose and throat surgery are not materially the same as in Australia.

2. The expedited SIMG program assumes every successful applicant is indeed as they say they are. It is predicated on success. What is the plan for failure? Who picks up the pieces? Given that the medical colleges are effectively being bypassed in this new process, how is the failing applicant supported and the community protected? Currently this work and assessment is provided pro bono by the specialists working in medical colleges.
3. The supervision and assessment process is vague and it is not clear how and by whom successful applicants will be supervised, and to what standard?
4. *Unconditional* specialist registration means the new specialist practitioners will be exposed to the same workplace and lifestyle stressors as the rest of Australia and will therefore, in all likelihood, follow the paradigm detailed by Bernard Salt¹ and eventually end up working alongside existing Australian specialists in the metropolitan Blue Zone. The Red Zone issue is not addressed by this initiative.

We can perhaps learn a little more from the first Medical Board report on expedited specialist pathway applications and registrations.⁶

Applications

There were 288 internationally qualified specialists who applied for registration via the expedited pathway—250 for general practice, 14 for anaesthesia, 20 for psychiatry, and 4 for obstetrics and gynaecology. The majority of applicants (86%) were from the United Kingdom.

Registrations

Specialist registration was granted to 126 general practitioners, one anaesthetist and one psychiatrist, 95% of whom required six months supervision.

Victoria had 29 registrations, Queensland had 26, NSW 21 and Tasmania zero (reinforcing our fourth concern above).

Eighty percent of registered specialist IMGs have been approved to practice in a metropolitan location. Only 20% were approved to practice in a regional, rural or remote area.

The AMC acknowledges that:

Because of the specialised nature of their knowledge, skills and experience, it is not possible for a central testing authority such as the AMC to undertake assessments of these doctors (who are sometimes referred

to as SIMGs, or Specialist IMGs). Instead Specialist Colleges, as the standard setters for their speciality, decide the degree to which they are comparable to Australian specialists in the same field.⁴

And yet the medical colleges are bypassed in this process as Dr Susan O'Dwyer clearly states:

Specific qualifications would be validated and become part of a published list of eligible qualifications and, if an SIMG has a qualification on the list, they would not need to apply to the college for an assessment of their qualification.⁵ [emphasis added]

The AMC report explains:

The comparability assessment considers factors such as the extent and relevance of postgraduate training, clinical experience, and ongoing professional development. Doctors who are deemed substantially or partially comparable are eligible for specialist registration following a period of provisional or limited registration which may include a period of peer review or supervised practice. Those who not comparable are not able to attain specialist registration in their field.

Medical specialties vary by country, influenced by market, technological and regulatory factors. If comparability is interpreted strictly, the likelihood of a specialist international medical graduate having exactly the same kind of training and experience in a similarly defined specialty is low. And indeed less than half of the applicants are eventually found to be substantially or partially comparable, and therefore able to proceed to specialist registration through the pathway.

To many doctors this is unreasonable.⁴

And yet survey responses from the same AMC report quoted SIMGs as saying:

The hospital system was very different from where I trained in terms of hours, responsibilities, processes, names of medications, investigations and even treatments.⁴

Forcing doctors to work in regional, rural or remote Australia for a predetermined period of time (also known as the Moratorium) was also seen as unfair.

The moratorium is unfair especially given that the places where IMGs are allowed to work are often isolated & where there is poor culture & discrimination. It makes no sense to force someone who does not have any local connections, knowledge or support to work in a place where there is very little to zero support.⁴

We would agree. We would add that that is also inherently dangerous.

The AMC report acknowledges that:

The Moratorium evoked mixed feelings among survey respondents. Some accepted it as part of the journey, or had an interest in working rurally. Others regarded it as an interregnum where professional development gets put on hold, where there is a risk of isolation, discrimination or family hardship. After the Moratorium requirements are completed, most doctors move away to areas which they consider better suit their own and their family's need, leaving a gap which must be filled by another generation of international medical graduates.

Analysis of the postcodes of doctor workplaces by the AMC has shown that after a few years working in remote locations, international medical graduates move to more urban locations.⁴

So according to the AMC data, forcing SIMGs to work in regional, rural and remote areas does not address the shortage of specialist medical care in the longer term.

A separate, but related issue, is the *process* of assessing and validating an SIMG wishing to relocate to Australia. It is clear this process is overly complicated and takes too long.

The relevant medical colleges see this as 'due diligence' and protection of standards and, given the harm caused by Jayant Patel in Bundaberg, this is evidently not unreasonable. The harm caused was unforgivable. The community must

be protected and be safe from any unqualified medical practitioner.

In contrast, the Medical Board accuse the medical colleges of 'restriction of trade' and 'protection of turf'.

When asked how long it took them to complete the [existing] pathway, answers varied from less than a year to over four years. Some colleges were faster than others. For example RACGP had 12% of candidates who took longer than two years to complete the pathway, but for RANZCP and RACS the percentages were 44% and 55% respectively.⁴

There is no doubt the specialist medical colleges need to improve the timeliness of their assessment of an SIMG wanting to relocate to Australia. Communities and subsequently governments are frustrated by the delay and what they see as overly rigid and bureaucratic processes. The government believes this delay is deliberate, and now believe more specialists, as a whole, is the answer.

To this end, the Miller Blue Group, a private consortium of Australian and United Kingdom consultants in health care policy has been commissioned by the Australian Government through the Health Workforce Taskforce to advise the Medical Board and Ahpra on how to help provide specialist care to remote, regional and rural Australia, and address the deficiencies in access to that care.⁷

It would appear to us that the new model is to flood the metropolitan Australian market with medical specialists and then force specialists, by sheer economics, to relocate to regional, rural and remote Australia.

This new model necessarily goes against the ongoing well-documented geographical relocation from rural to urban Australia of every other notable professional service, such as banking, legal and accounting services, newspapers, and major private and government infrastructure. It also argues against the documented demographic change articulated by Bernard Salt.

An alternative solution

A more important and fundamental question is whether the Medical Board's expedited SIMG pathway that brings overseas medical specialists into the existing markets of metropolitan Australia is *the answer* to addressing the clear shortfall in

the provision of specialist medical care in regional, rural and remote Australia?

Research from James Cook University (JCU)⁸ based in far north Queensland would suggest this is not the case and documents that the long-term solutions in the provision of specialist medical care lie not in short-term placements, where overseas graduates work for a defined period in regional, rural and remote Australia before eventually relocating to metropolitan Australia. Rather, long term and definitive solutions are to be found in a fundamental and strategic reappraisal of how specialist care is delivered, by who, and where, the care is delivered.

In essence, their research would suggest the Medical Board and their consultants Miller Blue Group may have got it wrong.

The JCU research recommends preselecting medical specialists who *actually want to work* in rural and remote Australia—and then making it easier for them.

For example, figures from the JCU show almost 50% of their medical graduates now work in regional, rural and remote Australia, which is significantly higher than the other Australian universities average of 20% or the recently published figures of the Medical Board on SIMG practice locations—also 20%.⁶

Their research found 'rural training at JCU' was 'more than twice as likely to result in a practitioner practicing rurally'.⁸

The JCU research also analysed⁸ whether their graduates stay in rural, regional and remote Australia. The study assessed postgraduate years (PGY) 5–14 in 2019, using the Ahpra/Modified Monash Model (MMM) and the Department of Health's Doctor Connect website. This identified regional cities as MM2, rural as MM3–5, and remote as MM6–7.

Of the JCU graduates in 2019 (PGY 5–14), 50% worked in regional, rural and remote areas:

- 33% worked in MM2
- 14% worked in MM3–5
- 3% worked in MM6–7.

The research found that statistically significant key predictors of working in rural and remote Australia (MM3–5 and MM6–7) were:

1. rurally bonded Australian Government undergraduate Medical Rural Bonded Scholarships ($p = 0.004$)
2. graduation from JCU postgraduate general practice training program ($p = 0.001$)
3. intern training in a hospital located in a regional city ($p = 0.003$).

More generally, key predictors of JCU MBBS graduates working in rural areas (MM3–5) were:

1. rural hometown
2. application to JCU
3. choosing general practice, or
4. choosing rural generalism.

The JCU graduates working in remote Australia MM6–7 had invariably undertaken an extended 20–35 week placement in rural or remote communities.

This research and other lived experience of medical specialists working in regional, rural and remote Australia^{9,10} would suggest the answer to providing these essential Australian communities with adequate and appropriate medical care lies in recruiting doctors who actually want to work in rural Australia and then making it easier for them. The existing published research^{8,11–14} suggests key parameters to identify these doctors, and ways to encourage them to pursue a path in specialist rural medicine.

The longer-term statistics reveal that forcing doctors to work in rural Australia is unpopular and unlikely to succeed in the longer term. The comments from IMGs in the AMC's survey report⁴ highlights the difficulties faced by the AMC/Ahpra Moratorium in forcing overseas doctors to work in rural Australia. In the end, with time, they follow the trend articulated by Bernard Salt and move to the cities when they can.

The answer lies in working together, and collaboratively, with medical colleges, to develop new specialities, or subsets of existing specialities, that more accurately fulfil both the needs of the doctors who want to work in regional, rural and remote Australia, but also concomitantly and justly fulfil the specialist medical needs of communities they serve.

It is hoped the federal Minister for Health realises this, speaks to the medical colleges—and involves them in the solution.



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