8th March 2023

RE: Formal submission – Ochre Health – Independent review of health pracititoner regulartory settings

Dear Ms Robyn Kruk,

We extend our thanks for your time and consideration into understanding from an employer perspective, the barriers and challenges employers face when hiring overseas health practitioners, as well as ideas for both short-term and structural reform of the regulatory system and appreciate the time spent with Mr Jason Macdonald to date discussing this important issue.

Ochre Health was founded in 2002 in the outback Australian town of Bourke, NSW. Today, Ochre is one of the only general practice organisations with a footprint from MMM1 (Metro) to MMM7 (Very Remote Australia) with 65 practices across the eastern states as well as several public contracts to provide emergency doctor coverage to the Western NSW LHD, Murrumbidgee LHD, Hunter New England LHD and the Tasmanian Health Service.

This unique perspective of General Practice enables us to be leaders in the sector, now supporting over 420 General Practitioners, including almost 100 registrar doctors. We are proud to be Australian, however, we are equally proud to support over 150 International Medical Graduates to provide quality GP services to Australian communities.

As it stands, there are a number of barriers that exist today that make it challenging to supplement our Australian trained medical workforce with those from foreign countries, including those from select 'substantially comparable countries' as comprehensively assessed by our Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. These regulatory and process barriers make it increasingly difficult to engage International Medical Graduates throughout Australia, With less than 14% of medical students now choosing General Practice as a preferred career path, the opening up of international gateways is one strategy which can quickly and without significant budget stimulus increase doctor supply to Australians who are facing unprecedented issues of access. The issue of skilled workforce in General Practice is exponentially highlighted the more rural and remote you go in Australia, and for Ochre, we understand this problem personally, with medical centres in some of Australia's most remote and isolated country. Of note, the extension of DPA status last year to MMM2 areas (outer metro) has had a significant adverse impact on the pipeline of doctors who would otherwise have had to locate in regional and rural areas of Australia. The reality is that may overseas trained doctors can now choose a Sydney suburb such as Bankstown over a rural town such as Bourke and this is areal issue on rural/regional supply.

We outline herein the current process and it's complexity – resulting in a lead time of up to 24-months to get a doctor into Australia and practicing. The New Zealand (and UK) model takes 12-weeks so Australia is now uncompetitive in an international market with short GP supply. The 7 recommendations provided in this paper are aimed at reducing or removing duplication in the regulatory framework, streamlining existing registration pathways and streamlining and integrating with other processes that impact on the workforce, such as visa application and Medicare provider number application processes In Australia, we should trust the comprehensive work done by our Colleges and make the regulatory process for IMGs that are deemed substantially comparable as streamlines as possible, similar to the work our New Zealand counterparts have accomplished. The goal, by exempting general practice from Labour Market Testing, a requirement for skilled workforce visas with Home Affairs, upgrading and strengthening AGPRA identification processes and establishing a taskforce to review Medicare provider processing times with an established SLA of 7 days, could result in 50%+ reduction in processing time for IMGs into Australian communities.

Furthermore, there is also a significant roadblocks regarding supervision, including the absence of national funding to remunerate supervisors for their time overseeing GPs in training. This is particularly an RACGP Fellowship Support Program and ACRRM Independent pathway which are most relevant to regional and rural placements as IMGs on temporary or skilled work visas as eligible. The model that drives low participation rates and the negative impact this has on rural and remote communities around Australia.

Thanks again for the opportunity to participate in providing market insight and please don't hesitate to reach us if
you have any questions or need clarifications.

Yours sincerely,

Dermot Roche

Chief Executive Officer

Contents

1. 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?

Response:

(i) Yes, we do agree there is a current and projected skills shortage, particularly in General Practice.

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

Response:

(i) Ochre health owns and operates 65 medical centres across Australia and all MMM areas. During the 2022 calendar period, appointment books of the 416 doctors averaged 102% booked, meaning doctors were seeing on average more patients than they had capacity for (Ochre, 2023). The data explains that doctors are at capacity, leading to wait time for patients.

Table 1 Ochre Health Booking fulfilment 2022 calendar year by GP category (Cubiko benchmarking for Ochre, 2023)

Category	Booking fulfilment
General Practitioner	105.85%
Locum General Practitioner	98.16%
Registrar	84.48%

(II) In regional locations (MMM3-7), the current and projected skills shortage is more severe. Ochre has 32 Medical Centres located In MMM areas and has a current GP vacancy in the market in 100% of those locations to meet patient demand (Ochre, 2023).

(iii) remote areas (MMM5-7) where GPs provide Rural Generalist VMO services to public hospital emergency department in conjunction with General Practice, the workforce is being supplemented by a locum workforce. In some cases, this workforce is being supplemented by 100% locum arrangements, with detrimental impact to continuity of care in the community, often resulting in the community having different doctors on a weekly basis. In an Ochre context, *Table 2* provides an example of the skilled workforce shortage so severe, that service is being maintained by a locum workforce.

Table 2 Ochre Health sites being supported by Locum workforce due to skilled workforce shortage (Ochre, 2023)

Category	MMM	Permanent GP VMO Doctors	Locum GP reliance
Bourke, NSW	6	0%	100%
Brewarrina, NSW	7	0%	100%
Walgett, NSW	6	0%	100%
Lightning Ridge, NSW	6	30%	70%
Collarenebri, NSW	6	0%	100%
Boggabri, NSW	5	0%	100%
Queenstown, TAS	6	25%	75%

(IV) According to Australian Medical Association and their 2022 report, 'there are a range of potential outcomes in the expected gap between GP demand and supply, depending on the assumptions for demand and supply. All projection scenarios of projected growth in demand and supply however show a significant and persistent shortfall of GP FTE. There is an immediate boost in the projected GP FTE demand required to cope with the current backlog of primary care needs stemming from the pandemic, followed by a steady increase in demand as the population grows, ages, and increasingly develops chronic diseases and comorbidities over time. The AMA has estimated there is an existing shortage of GPs which is already having an impact on the 2021–22 data. A conservative estimate of the current shortage of 860 GP FTEs. A high supply scenario estimates a shortfall of 3,100 GP FTEs, where supply is boosted and demand kept to the base case, to a low supply scenario of 10,600 GP FTE shortfall by 2031–32, where AGPT places continue to remain unfilled based on general practice not being the primary choice of junior doctors, and an increase in the rate of retirement and leaving the profession'. Full report by the AMA can be found here

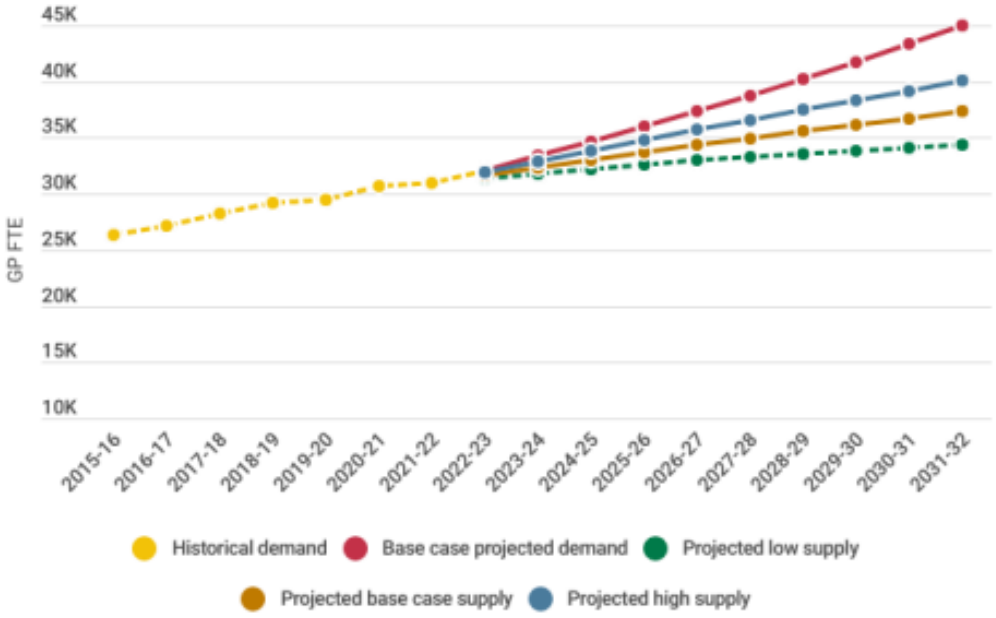


Figure 1 Scenario modelling of GP workforce demand and supply by the AMA (2022)

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?

Table 3 Ochre identified regulatory strengths

Strength	Context	Owner
1. Quality control	The current regulatory setting for registration and qualification registration is putting the highest standard on entry quality control for new registrations of medical practitioners in Australia.	Mutli

Ochre identified weaknesses in the regulatory setting for overseas trained general practice workface:

Table 4 Ochre identified regulatory weaknesses

Pain Point	Context	Owner	Solution
2. Total timeframe of the regulatory process from initial to start for International Medical Graduates	Inclusive of Agency, Medicare and Home Affairs, processing time for GPs is 12-21 months, including those in nine substantially comparable countries as officially determined by the RACGP and ACRRM (PCBC, 2022). Significantly longer to the average processing time for New Zealand of 3 months (PCBC, 2023)	Mutli	1. Streamline end to end process by removing regulatory roadblocks in Department of Home Affairs, AHPRA, and Services Australia.
3. Labour Market Testing	Extensive processes are required to 'prove' the skilled workforce is needed, despite Department of Health Distribution Priority Area (DPA) framework.	Department of Home Affairs	2. Amend regulatory requirements to recognise DPA framework and provide standing exemption to General Practitioners for all skilled worker visa types (including 482)
4. In-Principal' identification	IMGs cannot verify identification abroad, even post the visa process, or documentation certification at Australian missions (RACGP, 2022). Process causes up to 3 month delay (PCBC, 2022)	AHPRA	3. Amend regulatory requirements for identification checks to be finalised internationally, at an Australian embassy/consulate/high commission or by the Department of Home Affairs in-conjunction with the Visa approval process AND/OR digitally, enabling application for a provider number to occur sooner.
5. Supervision funding	All IMGs, even those from NZ/UK are required to have in person supervision (RACGP, ACRRM, 2023). Current programs do not fund supervision for IMGs and supervisors are limited. Programs include ACRRM IP & RACGP FSP. Due to the lack of funding, supervisors are not incentivised to participate in IMG training in Australia.	Federal Government	4. National review of IMG Supervision payment framework to expand the existing Nationally Consistent Payment framework (Department of Health, 2023) to include recognised IMG pathways, such as RACGP FSP & ACRRM IP.
6. IMG Assessment consistency	IMGs from non-substantially comparable countries are required to participate in Australian Medical Council assessment, and if required a Pre-Employment Structured Clinical Interview (PESCI). The PESCI process provides recommendations on level of clinical supervision required. This is often over-turned by the AHPRA assessment board, indicating poor alignment between the organisations.	AHPRA	5. Amend regulations have a single assessor of credentials, comparability and experience.
7. IMG application of provider number observes lengthy delays	IMGs are required to apply for provider numbers through the relative training college, who submit to Services Australia on behalf of the practitioner (ACRRM, 2023). The medical practitioner does not have access to Health Professional Online Services (HPOS)/ PRODA and the process can take up to six weeks.	Services Australia / relative College	6. Taskforce to streamline Medicare Provider Number application review timeframes. 7. Introduction of a SLA for Medicare Provider Number processing in Australia to 7 days.

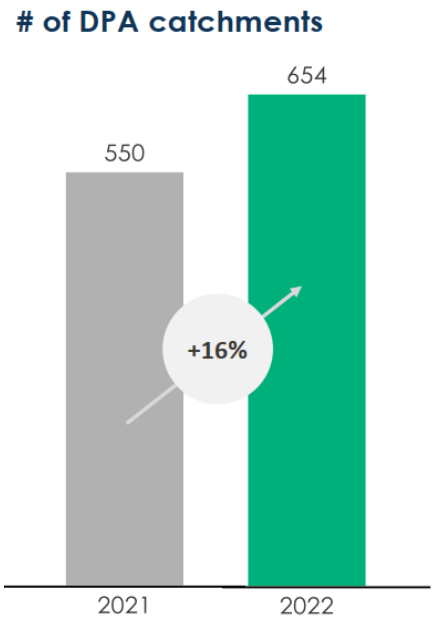
3. During the pandemic, a range of regulatory settings and processes relating to registration and qualification recognition of overseas-trained health practitioners were temporarily waived, relaxed or had greater flexibility.

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

Response:

(i) Recent changes in DPA classification with the addition of 104 additional catchments classified as a GP workforce distribution priority area (DPA) is having a negative impact on rural placements. Overseas trained doctors or foreign graduates of an accredited medical school must work in a priority area for at least 10 years to provide services covered by Medicare rebates. This is called the '10-year moratorium' (Department of Health, 2023) . Moratorium can be reduced that time through scaling, with up to a 50% reduction for RA5 (Very Remote Australia) locations. Prior to this change, if an overseas trained doctor would like to be located in a major city in Australia, they would need to work 10 years in a rural location or an area of need. However, the changes to 2022 DPA update with the addition of 104 catchments now include areas such as

- Areas of Canberra
- Wollongong
- New Castle
- Outer Sydney
- Outer Melbourne
- The full list can be found here



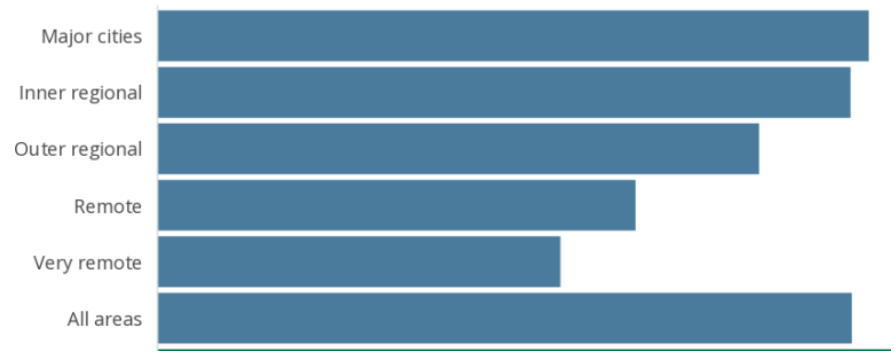


Figure 2 GP density per 100,000 population 2020 (AMA, 2022)

Figure 3 Number of DPA catchments over 2021 - 2022 (PCBC, 2023)

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

Response: No

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

Response:

(i) 'Easing' of DPA criteria is a positive influence on the net number of IMGs coming to Australia as it is more attractive to be located near major cities from our employer perspective.

(ii) However, this is at the detriment of rural locations (MMM3-7) where general practitioners per 100,000 is significantly lower than metro areas (AMA, 2022) . Our belief unless substantial regulatory and vocational change occurs, the gap in regional GP density will increase. Programs such as Moratorium for overseas trained health practitioners should be rectified to service rural communities first and be rewarded with eligibility of metro and outer metro locations after a number of service years, OR, a long term restructure of rural placement incentives for overseas trained practitioners should occur, led by a focused taskforce.

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?

Response:

(i) Fundamentally Yes.

At Ochre Health, overseas trained doctors are a fundamental requirement to supplement the deficit of Australian trained graduates choosing General Practice. This requirement is amplified exponentially in regional locations (MMM3 -7).

In the last 18 months, Ochre can report more than 150 IMGs from all origin countries have either withdrawn due to the length of processing time from verification of documents to receiving a Medicare provider number, or stalled in the middle of the process due to other constraints such as cost and/or supervision.

150 additional (trained and experienced) medical doctors would make a significant difference to GP density in areas such as rural and remote NSW, where Ochre has a substantial footprint.

It is our opinion as a leading General Practice organisation in Australia that regulatory settings can be streamlined to reduce complexity, double-handling and time required without reducing quality.

In collaboration with the Primary Care Business Council, we have outlined the process for an overseas trained medical graduate to relocate to Australia.

Figure 4 IMG process for substantially comparable GP

Figure 5 IMG process for a partially or non-comparable GP

Figure 6 IMG critical path if barriers were removed (hypothetical)

Figure 7 IMG process in New Zealand (75-150% less time than Australia)

(ii) *Figure 4* represents the current steps for an International Medical Graduate (Substantially comparable countries)

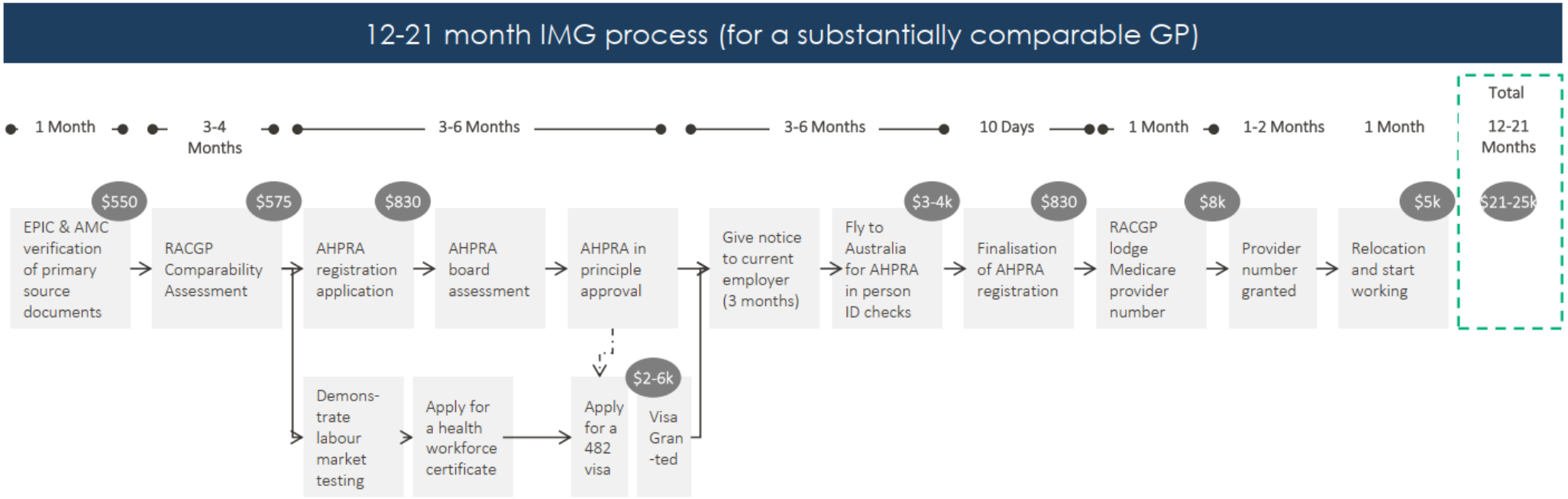


Figure 4 IMG processing timeframe (Primary Care Business Council, 2022)

Substantially Comparable Country (RACGP, 2022)	Qualification
UK	Membership of the Royal College of General Practitioner
Sweden	Certificate of Specific Training for General Practice
Canada	Certification in the College of Family Physicians
Ireland	Membership of the Irish College of General Practitioners
South Africa (ACRRM)	Fellowship of the College of Family Physicians
New Zealand	Fellowship of the Royal New Zealand College of General Practitioners
Spain	Specialist in Family and Community Medicine
Malaysia	Membership of the Academy of Family Physicians of Malaysia
Hong Kong	Fellow of Hong Kong College of Family Physicians
Malta	Specialist in Family Medicine

(iii) *Figure 5* explains additional steps required for IMGs outside of RACGP/ACRRM acknowledged countries (partially or non-comparable GP)

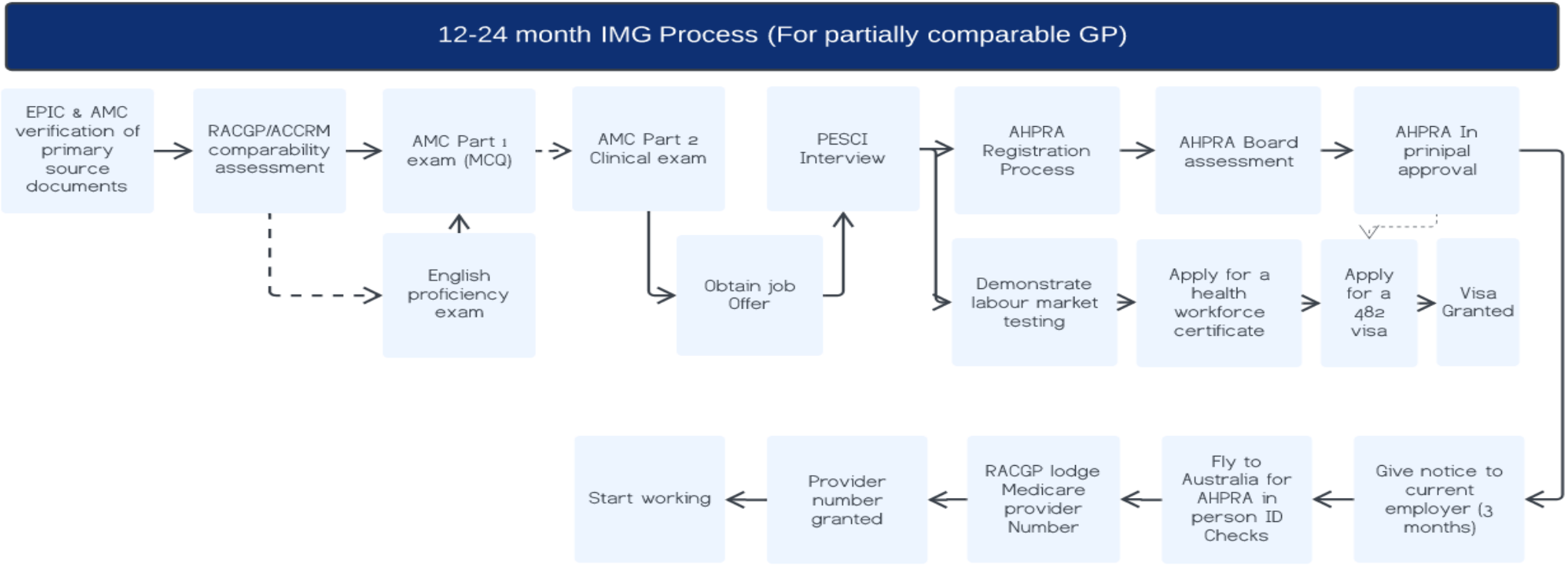


Figure 5 IMG processing timeframe for non-substantially comparable GP (Ochre, 2023)

(iv) *Figure 6* demonstrates what the critical path could look like with barriers removed. It would be possible to achieve a processing time less than 12 weeks for RACGP Substantially comparable GPs.

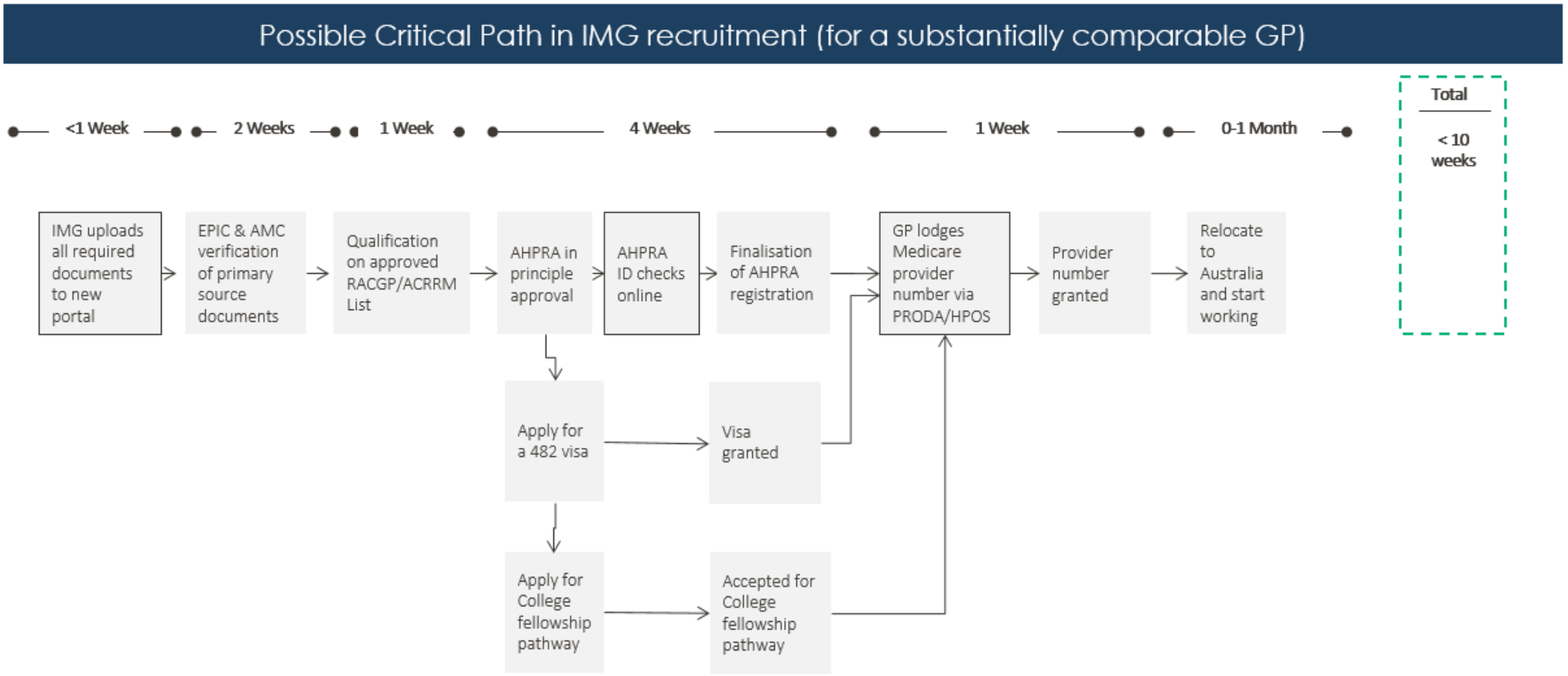


Figure 6 Critical Path review after recommendations

(v) *Figure 6* demonstrates what the critical path currently looks like in New Zealand for Substantially comparable GPs

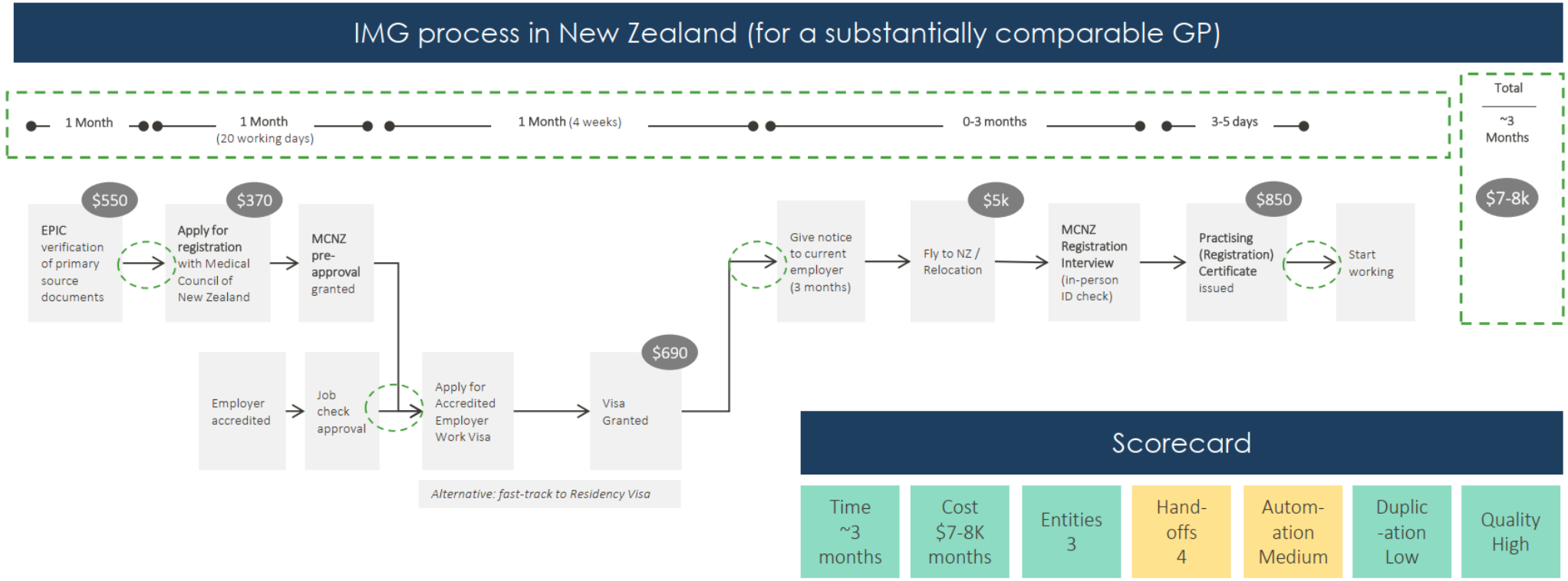


Figure 7 New Zealand process for substantially comparable GP (PCBC, 2023)

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

Response:

The following short term changes are recommended:

1. Remove the need for labour force testing and requirement to obtain a Health Workforce Certificate to prove that the skilled person is required. The Australian Department of Health and Aged Care GP Distribution Priority Area already models the requirements of GP workforce in Australia to areas of need.

2. Amend regulatory requirements to enable an overseas trained health practitioner to verify their identification abroad or using online methods. The requirement to present in person to an AHPRA agency to verify documents can be updated using latest technology and identification methods, enabling application from provider number to occur prior to the skilled worker arriving in Australia.

3. Taskforce to streamline Medicare Provider Number application review timeframes and Introduction of a SLA for Medicare Provider Number processing in Australia to 7 days. IMGs are able to access HPOS/PRODA to apply for provider number online, similar to Australian registered practitioners have access to currently.

4. National review of IMG Supervision payment framework to expand the existing Nationally Consistent Payment framework (Department of Health, 2023) to include recognised IMG pathways RACGP FSP & ACRRM IP to support IMG supervision and entry into the Australian workforce.

ii. in the medium- to longer-term?

1. If the IMG meets pre-established substantially comparable framework as declared by AMC, RACGP and ACRRM (i.e. a recognised country or institution), the candidate should bypass other assessment and transition directly to AHPRA registration process. If the IMG is not substantially comparable, they should be appropriately assessed by a single assessor, without duplication (An approved body, AHPRA or the College)

2. Establish an accredited course to ‘upskill’ overseas trained General Practitioners in the context of the Australian Health Care system, cultural sensitives and challenges, to reduce the requirement of supervision and increase quality, especially relevant to partially or non-comparable GPs. A accredited course by approved RTO’s would increase quality and reduce the Burdon on supervising GPs and/or supervising GP availability, having a significant impact on reducing or eliminating constraints to IMGs entering the workforce in Australia.

3. Additional Detail

3.1. Labour market testing required for VISA and Registration approval despite well-established models such as the Distribution Priority Area authorised by the Department of Health and Aged Care (updated July, 2022)

a. TSS visa (subclass 482) Short-term stream and Medium-term stream and Skilled Employer Sponsored Regional (Provisional) visa (subclass 494) Employer Sponsored require organisations to 'prove' the skilled workforce applicant is required, despite already being acknowledged in DPA (2019) classification for General Practitioners. Also relevant for other visa types: Subclass 482 Temporary Skills Shortage, Subclass 494 Skilled Employer Sponsored Regional (Provisional), Subclass 186 Employer Nomination Scheme, Subclass 187 Regional Sponsored Migration Scheme.

b. Despite DPA status; employers are required to undertake **Labour Force testing**; including (Department of Home Affairs, 2023):
   i. Written referral or endorsement by industry leaders/experts in their field explaining why the specific individual overseas is the only person, or one of very few people, who could undertake the nominated position, and no Australian worker is available
   ii. Copy of job advertisement
   iii. Invoices for recruitment subscription services
   iv. Job posting data metrics
   v. Copy of job advertisement
   vi. Fees or invoices for recruitment services
   vii. Summary of search undertaken
   viii. Contract between company and executive search firm

c. **Solution**: Amend regulatory requirements to recognise DPA framework and provide standing exemption to General Practitioners for all skilled worker visa types (including 482)

3.2. IMGs cannot verify identification abroad, even post the visa process, or documentation certification at Australian missions (RACGP, 2022). Process causes up to 3 month delay (PCBC, 2022).

a. If an international Medical Graduate cannot supply categories A, B, C & D to AHPRA they will only be granted an in-principal registration approval. This requires International Medical Graduates to present in-person at an AHPRA office to receive final approval of registration, in order to commence the provider number process (AHPRA, 2023). This can delay the process by 1-3 months post arrival in Australia.

b. Documentation can be certified overseas by an Australian Consulate official or justice of the peace, however, this does not form part of the AHPRA identify check process (AHPRA, 2023).

c. **Solution**: Amend regulatory requirements for identification checks to be finalised internationally, at an Australian embassy/consulate/high commission or by the Department of Home Affairs in-conjunction with the Visa approval process and/OR digitally, enabling application for a provider number to occur sooner.

3.3. Supervision funding roadblock for IMGs on temporary/skilled visa: All international Medical Graduates require a level of supervision, including Fellows of the Royal New Zealand College of General Practitioners (NZ) and Membership of the Royal College of General Practitioners (UK) (RACGP, 2022)

a) Most International Medical Graduates that enter Australia on a temporary or skilled workforce visa are not eligible for pathway programs that provide funding to the supervisor (ACCRM, RACGP, 2023)

b) Fellowship pathways, including ACRRM IP, RACGP PEP/FSP are independently or self-funded and there is no state or federal assistance. Typically, the road block is not the course costs, which can be as high as $25,000 AUD per year, the road block is the absence of payment for a supervisor.

c) Having a nominated supervisor is a core requirement of the pathway. Uptake of supervisors is extremely low, with only 10.3% of the GP workforce at Ochre being an accredited supervisor. Uptake further declines to 1.2% for pathways that are eliglbe for non-comparable IMGs.

d) For IMGs that are assessed to be on Level 1 supervision (typically non-comparable GPs) the supervision requirement is for the supervisor to be directly responsible for every patient of the IMG. Without paid supervision, there is no incentive for supervisors to take on Level 1 supervision, therefore, uptake is less than 2%.

e) For IMGs that are assessed to be on Level 2 supervision, the Supervisor shares responsibility for each patient with the IMG. The supervision must be primarily in person with the Supervisor physically present in the workplace at least 80% of the time.

f) For IMGs that are assessed to be on Level 3 supervision, the IMG will take primary responsibility for each patient. The IMG is permitted to practice alone but their Supervisor must be accessible via telephone. Additionally, it is the responsibility of the Supervisor to ensure there are mechanisms in place to ensure the IMG is practicing safely.

g) We have seen without a funding source for supervisors, majority of supervisors will only accept level 3 supervision for IMG. However, this substantially limits the market, especially is rural and remote areas. A change to the supervision framework for national consistent payments (NCP) to be expanded to cover RACGP FSP and ACCRM IP would encourage doctors to supervise level 1 and 2 IMGs.

h) Organisations, such as Ochre have no funding source to encourage fellowed GPs to supervise and are therefore required to fund supervisor payments from existing general practice margin, pass on costs to patients or arrange funding from the IMG.

i) As a result, IMGs end up in the Hospital workforce in lieu of the General Practice workforce, following the funding steam that currently exists. At Ochre, we receive up to 5 applications per week from non-comparable IMGs that would need level 1 supervision that we have no capacity to place, due to the lack of supervisors.

Example (non-comparable):

A South African General Practitioner who has recently interviewed for our St Helens medical centre in Tasmania (MMM5). She does not have a South African GP Fellowship and is therefore regarded as substantially comparable, resulting in the doctor to complete AMC1 (MCQ exam), AMC2 (Clinical Exam) is assessed as requiring 12 months of level 1 supervision. This candidate has 17 years of GP, ED and Urgent care experience and who sailed through the Ochre clinical interview and passed AMC1 and AMC2 is required by the framework to require substantial level of supervision. However, due to her temporary/skilled work VISA, this candidate, despite her experience is only eligible for training pathways that are self-funded with no funding for supervising doctors. This candidate that she will need and the fact that there is no payments for supervision is lost to the system and does not have the opportunity to start in the system, unless a supervisor takes the candidate on under good will, or is incentivised by the registrar, the general practice organisation. For this example, despite 17 years of General Practice experience, level 1 supervision dictates the supervisor must be on-site 100% of the time and oversee all patient management decisions. Without funding, the supervisor would be subject to considerable personal financial loss in order to meet the supervision requirements. For this classification of doctors, there is no 'flight school equivalent' for doctors.

It should be noted, at Ochre, we receive 25+ applications per month from IMGs from non-comparable countries with extensive General Practice experience, that we are not able to provide supervision for, despite our footprint of 65 medical centres across Australia. Instead, we are forced to utilise locum doctors to provide continuity of service, at the cost of continuity of care for communities in rural and remote Australia.

j) **Solution**: National review of IMG Supervision payments and expand the existing Nationally Consistent Payment framework (NCP) (Department of Health, 2023) to include recognised IMG pathways, such as RACGP FSP & ACRRM IP. Ideally, an increase in remuneration and recognition for supervisors would substantially support the intake of IMGs, despite the lengthy processing time.

3.4. IMG Assessment consistency:

a) Despite specialist level qualifications in general practice (e.g. fellowship) being formally recognised in 9 countries by RACGP and a total of 13 countries by ACRRM as substantially comparable to Australian General Practice, Specialist IMGs are still required to undertake assessment by RACGP/ACRRM as a comparability assessment (ACRRM, 2023).
b) According to the RACGP (2023), the comparability assessment for IMGs that already meet the approved qualification list assesses items such as:
    a. Recency of practice
    b. Continuity of practice
    c. Continuing Professional Development
    d. Qualifications
    e. Training Route
    f. Curriculum
c) Post completion of College/AMC assessment, the AHPRA board conducts an additional assessment including:
    a. Qualifications
    b. Recency of practice
    c. Continuity of practice
    d. Scope of practice
    e. International English Language Test System (IELTS)
    f. Internship and other supervised practice details

g. Practitioner registration history: If you have been registered outside of Australia, the Board requires a Certificate of Registration Status or Certificate of Good Standing from every jurisdiction outside of Australia.
h. international criminal history check (ICHC)
i. appropriate professional indemnity insurance
j. Continuing Professional Development
k. Impairments
l. Evidence of completion supervised practice

d) Outcomes from the AHPRA assessment can change the outcome from the College assessment, which duplicates assessment.
e) The process is further complicated when considering applicants from non-substaintially comparable countries. In addition to the above assessments, IMGs outside of the preferred country list are required to take:
   a. AMC Part 1 – Multi Choice Question exam
   b. AMC Par 2 – Clinical exam
   c. Pre-Employment Structured Clinical Interview (PESCI)

f) **Solution**: If the IMG meets pre-established substantially comparable framework as declared by RACGP and ACRRM, the candidate should bypass college assessment and transition directly to AHPRA registration process. If the IMG is not substantially comparable, they should be appropriately assessed by a single assessor, without duplication (An approved body, AHPRA or the College)

3.5. IMGs are required to apply for provider numbers through the relative training college, who submit to Services Australia on behalf of the practitioner (ACRRM, 2023). The medical practitioner does not have access to Health Professional Online Services (HPOS)/ PRODA and the process can take up to 12 weeks (Ochre, 2022).

4. The College (RACGP or ACRRM) submit an application on the IMGs behalf to Services Australia to ensure formal acceptance of a place on the Fellowship Pathway has been received and processed, and the doctor is working in an accredited Training Post, and/or the post is approved by the College as a suitable placement for the individual doctor's training and/or learning needs (ACRRM, 2022).
5.
6. Submission by the college occurs after official approval of AHPRA registration.

7. IMGs that are registering in Australia for the first time are unable to submit an application via Health Professional Online Services (HPOS)/ PRODA which results in an instant provider number for existing practitioners (Services Australia, 2023)

8. **Solution**: Taskforce to streamline Medicare Provider Number application review timeframes and Introduction of a SLA for Medicare Provider Number processing in Australia to 7 days. IMGs are able to access HPOS/PRODA to apply for provider number online which is cross-checked to national database of approved training placements.

References:

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