# RURAL WORKFORCE AGENCIES

## Response to: APHRA Specialist IMG reforms - revised registration standard for specialist registration – 3 July, 2024 ('Public consultation on the revised Registration standard: specialist registration' to SIMGPathwaysReview@ahpra.gov.au)

### Introduction

This response is a collective response from the Rural Workforce Agencies (RWAs) and focuses explicitly on the standard to unlock SIMG reforms: the draft revised registration standard for specialist registration.

In addition to this response, we look forward to participating in consultations associated with any further development of the standard and related implementation of associated pathway. Please find our contact details at the end of this document.

### Rural Workforce Agencies

- Rural Workforce Agencies (RWAs) are funded by the Australian Government Department of Health to deliver a range of activities to address the access, quality and sustainability of the rural health workforce. Rural Workforce Agencies operate in each state and the Northern Territory and for 25 years have delivered a comprehensive range of health workforce programs and services in rural and regional Australia. In doing so, Rural Workforce Agencies have established and maintained collaborative working arrangements and networks with key health workforce stakeholders in rural and regional Australia. These stakeholders include Aboriginal Community Controlled Health Services, Primary Health Networks (PHNs), local communities and local health services, university medical and health faculties, Rural Training Hubs, jurisdictional health departments and other key organisations.

- Rural Workforce Agencies have a unique track record and experience in supporting communities and working with stakeholders to address health workforce shortages, and assisting the rural health workforce. Rural Workforce Agencies are not-for-profit agencies whose singular focus is on ensuring remote, rural and Aboriginal and Torres Strait Islander communities have access to highly skilled health professionals when and where they need them, now and into the future.

- Rural Workforce Agencies are uniquely placed to understand local community's health workforce needs - including conducting an annual health workforce needs assessment – and to work with communities to explore and identify innovative workforce models to support improved access, quality and sustainability of health workforce, to support improved health outcomes.

### Key messages from the Rural Workforce Agencies:

*Observations:*

The requirements for fellowship are currently auspiced by RACGP and ACCRM (the specialist colleges for General Practice. It will be important to understand how this standard will interface with the specialist recognition requirements of the specialist colleges (RACGP and ACCRM).

- Of key importance is the need for the detail of the translation of the registration standard being put into process and practice.
- Initially, the changes for specialist registration for GP and Psychiatry were supposed to be in July, and the other specialties in October. The only reference to implementation found was October 2024 with no statement about specialty discipline.
- Ensuring enough safeguards are built in for the wholesale change that is about to happen is essential.
- Of interest to the Rural Workforce Agencies, will be the implementation processes (which of course are not detailed in the consultation about the change to the standard) and time frames for assessments. Appendix C contains overarching/ high level statements without substance – how will the impact on patient and consumer health and safety be monitored?
- Although cross-referenced, we were unable to find "… a list of approved qualifications for specialist registration at www.medicalboard.gov.au" referenced on page 8 of 18.

- It is unclear the timing of the of completion of "… a Board approved orientation to the Australian healthcare system and cultural safety education" in the specialist registration process.
- Details of supervision requirements are lacking – the length of the supervision, who are approved supervisors etc. Will the process include a "provisional specialist registration" step while the doctor undertakes the board determined supervision?
- Rural communities already have a lack of experienced, suitable supervisors for existing pathways, so adding another category of doctor to be supervised is unlikely to help access to doctors in rural communities.
- Will the board define where these SIMGs will be eligible to work? Without them being on the PEP Specialist Pathway and the ACRRM Specialist pathway that currently restricts IMGS into MMM2 locations, does this mean this new fast track pathway will allow SIMGs to work in MMM1 / DPA locations? (it is very important to highlight the consideration of MMM2 – 7, as it is crucial to mitigate patient wait times and patients access to GP services in towns that are struggling with GPs)
- Similarly Aboriginal and Torres Strait Islander health/ medical services have a shortage of experienced, suitable supervisors and are unlikely to benefit from the change to the standard.
- All of the statements in the new standard seem to reflect a "tick-box exercise" with no face to face interview of the applicant as part of the registration standard which seems to contradict the statement ensure "only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are granted specialist registration".
- There is no detail on how public safety will be monitored other than by "regular review. Attachment C.
- Page 11/18 Definitions -Approved qualifications needs to be rewritten to include the new process as it still references only "…the approved qualifications for specialist registration is fellowship of a specialist medical college accredited by the AMC".
- It is unclear how application of the standard can ensure "only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are granted specialist registration".
- It is difficult to identify regulatory impacts and costs without detail.

Comments relevant not to the standard itself, but to the consequences of this pathway, include:

SIMGs are required to work under supervision for 6 months. Our questions include:

- What happens at the end of this time?
- What is the process in order for AHPRA to lift the supervision conditions?
- Can it be fast-tracked?
- Is it by exception that this timing is varied (i.e. 6 months unless otherwise indicated).

To satisfy Section 19AA one must be either "vocationally recognised as a specialist", consultant physician or specialist GP":

- Will the SIMG's overseas qualification satisfy 19AA allowing them to apply to Medicare as a recognised specialist utilising the A1 schedule?
- It would be preferable for SIMGs to gain Fellowship of an Australian GP college so that they can in turn supervise non-VR doctors in due course.
- The pathway requirements of working under supervision for 6 months and completing a comprehensive orientation and cultural awareness training within the first 3 months partially satisfy current FRACGP requirements.
- It would be a simple matter to complete the additional requirements (workplace-based peer review, core modules and units (including a self-reflective activity) and ALS) so that they could easily apply for Fellowship at the end of their period of supervised practice.