Keeping them there: shifting our focus toward IMG retention, beyond moratorium obligations

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Context

Over recent years, the Australian Government has pursued a mix of forced and incentivised distribution schemes to supplement the medical workforce in rural and remote Australia. These have included bonded scholarships, financial incentives and supplementation through skilled migration tiered to policy levers utilising scaling or gearing of incentives and return of service obligations.

For International Medical Graduates (IMGs), who are forced to work in areas of workforce need or Districts of Workforce Shortage (DWS) for a period of 10 years in order to access Medicare benefits for the services they provide, also referred to as Section 19AB restrictions or 10-year Moratorium, scaling means that they can reduce their obligations by working in the more remote areas which in turn are those areas of highest need.[1] IMGs are now disproportionately represented in rural and regional areas.[2] As of 30 June 2015, there were a total of 12,495 exemptions granted under section 19AB.[3]

Objective

To provide the key policy requirements toward longer term retention outcomes of our rural and remote IMG workforce.

Discussion

Addressing maldistribution

General practice workforce shortages persist in many parts of rural Australia and IMGs remain an integral part of our workforce. Recent policy by successive Governments has sought to balance an over reliance on skilled migration through increased medical school intake and a marked increase, almost doubling, of our domestically trained general practitioner workforce.[4] By 2015, the number of domestic medical school graduates in Australia was 3055, the number of commencements in 2016 at 3215 with more than 28% of rural background.[5]

The expansion of the GP training program provides an opportunity for focussed distribution in addressing maldistribution. It is clear though that the increased stream of local medical graduates coming through will not translate immediately into rural workforce gains and that there will be a continued reliance on IMGs for some time.[6] For a more sustainable outcome, it is therefore essential that the policy focus shifts toward IMG retention, beyond Moratorium obligations.

A key component of current policy sees a distribution strategy which is wholly reliant on holding IMGs for a fixed period in rural and remote areas. As a consequence IMGs now play a vital role in helping to ensure rural and remote communities have access to quality general practice. But this also means that they are often recruited to work in some of the most difficult environments, with little support.

It is estimated that IMGs comprise approximately 40% of the medical workforce in Australia and 46% of general practitioners in rural and remote locations.[7] If we are to address maldistribution, for a more

sustainable solution we need to start thinking beyond Moratorium obligations, towards settlement strategies which aim to keep IMGs in their rural community. This requires a renewed policy focus and considerable funding to sustain it in order to provide a strategy to support IMGs from orientation to Fellowship and beyond.

The RACGP position

For the Royal Australian College of General Practitioners (RACGP) IMGs are a vital part of our College. We have a strong focus on assisting them to achieve Fellowship and maintain a strong commitment to ensuring IMGs working in regional, rural and remote Australia are well supported. The value and contribution of IMGs is represented in College leadership: the current RACGP President, Vice President, several of the members of the College Council and State and National Censors are from international backgrounds and did not complete their primary medical qualification in Australia.

For sustainable workforce outcomes, the RACGP has always maintained that policies that provide supportive structures across the full training continuum, importantly without compulsion, are required to recruit the next generation of rural GPs.[8] Local graduates—our future generation of doctors—must be made the first priority in meeting local workforce need through guaranteed placements across the full training continuum. Other means, such as supplementation through skilled migration, should be considered only when local options, without compulsion, have been exhausted. However, in the absence of policy alternatives, the reality and legacy of the Moratorium is that rural communities now depend on their IMGs and we need to do more as a general practice community to support them.

Sustainable solutions

It is clear that the continued reliance and dependence on an IMG workforce to fill large shortfalls in rural and remote areas is not sustainable. Training capacity and the viability of future rural intake in the context of existing and continuing medical training shortfalls is a further difficulty. The policy anomalies and unequal conditions placed on IMGs need redress including in terms of accessing training and support.

We need a strategy that invests in the next generation through domestic recruitment to rural areas but which also values the existing workforce through investment in skills and retention. A focus on both recruitment and retention provides the more viable policy solution and this must include a commitment toward IMG retention, beyond Moratorium obligations.

Key points:

- Harness increased **domestic supply** for the next generation of rural GPs;
- Value the **existing workforce** through investment in skills and retention; and
- Include a **focus toward IMG retention**, beyond Moratorium obligations.

A focus on retention

It is clear IMGs continue to address critical shortages in rural and remote areas but the policy landscape is shifting. Much more emphasis is being made on reducing our reliance on IMGs.[9] This policy discussion at times is imperceptive and without regard for the contribution many IMGs have made to ensuring accessible access outcomes for rural and remote communities.

Distribution policies which can allow for self-sufficiency remain our key objective but benefits from increasing domestic supply will take time. Other policies are at work here too—with both positive and

negative impacts on rural retention. On a positive we are seeing more IMGs move from limited registration to general or specialist registration.[10]

More broadly the legacy of a forced distribution policy—the 10-year Moratorium—is that the gains for our rural communities are only short term, as doctors seek to return to more populated areas. The policy may only provide intermittent gains, and ultimately fail to provide a stable workforce for the rural and remote areas in need. For it to work, it is reliant on a longer term commitment from IMGs—a key consideration which currently lacks policy focus.

Integration supports

There has been plenty of policy commentary on how best to support IMGs both in orientation and in an ongoing way through professional support and training. Firstly, it is imperative that IMGs are better supported in orientation to personal and professional life in Australia, and have access to the training and education they may need to best adjust to life as a GP in an unfamiliar health system.

Programs must be available to help orientate IMGs to the health care system and the rural context, and ensure ongoing support is accessible to assist in achieving Fellowship. The RACGP works hard to support all IMGs in Australia with ongoing education and professional resources particularly in their pathway to Fellowship, which includes targeted support as part of the General Practice Experience (Practice Eligible) pathway.

Looking toward retention factors, past studies indicate that retaining IMGs in rural and remote areas not only relies on professional supports but essential community integration considerations. These including a supportive community which can meet specific social and cultural needs and that support their family needs extending to educational facilities for children and work for partners.[11,12,13]

Research undertaken from the perspective of the IMG has been valuable in identifying the broader supports required. A 2009 study listing supports in facilitating effective integration provided eight key strategies from the IMG viewpoint. These included practical supports such as better information provision to IMGs before departure from their country of origin and ensuring support for IMG families once here; better information provision on websites, the need for more support for bridging courses, more observer programs and providing a liaison point at hospitals; as well as reducing difficulties with passing the AMC examination and relaxing the rules about when and where IMGs can practise medicine.[14]

Data showing reduced reliance (over time)

Recent registration data from the Medical Board of Australia (MBA) appears to show a reducing reliance on IMGs with the number of limited registrants decreasing. The data shows that since 2011 the number of IMGs working on limited registration in areas of need has dropped (over five-year period). MBA figures show 6221 IMGs on limited registration in 2011 dropping to 3455 in June 2015. The number of IMGs on limited registration in areas of need had also fallen from 2335 to 1261.[10]

The Board cites a number of factors impacting including the increase of Australian trained graduates as well as some IMGs progressing past limited registration and meeting requirements for general or specialist registration. There were 765 practitioners with limited registration granted general registration and 338 practitioners with limited registration granted specialist registration between 1 July 2014 and 30 June 2015.[10]

The most recent Medical Training Review Panel (19th Report) stated that as of 30 June 2015, there were a total of 12,495 IMGs with section 19AB exemptions, a 12.2% increase from the 11,138 at 30

June 2014.[3] This indicates a continued strong reliance on workforce supplementation through migration.

Conclusion and recommendations

A renewed policy focus

In planning for Australia's future rural GP workforce, a balanced approach is required to counter workforce attrition shock associated with an ageing workforce and departures from rural areas by IMGs beyond Moratorium. It is important to note that rural areas which are almost entirely serviced by limited registration IMGs are also limited in terms of training capacity. There is a shortage of experienced, senior GPs to undertake supervision in these underserviced areas.

Harnessing domestic supply through an expansion of the training system to facilitate access to high quality training and supervision in rural and remote areas is vital to ensure positive early exposure to rural general practice. It is therefore necessary that future policy decisions pertaining to the Skilled Occupations List (SOL) must also take into account system capacity, both in training and workforce, as well as the need to accommodate and fully utilise the domestic supply coming through.

Planning now to work through the rural 'hot spots' in the communities most at risk of losing their GP including those nearing completion of their Moratorium obligation should be prioritised. For IMGs—in keeping them there—we need to ensure that adequate planning is occurring to assess the rural hotspots particularly for IMGs as they meet their Moratorium obligations. More attention is required to encourage IMGs to remain in their rural community, yet there seems little policy inclination to do so. We also need to maintain a future focus on streaming local graduates to rural and remote areas rather than rely on a forced distribution scheme.

The implementation of an Integrated Rural Training Pipeline for Medicine will strengthen efforts and provide stronger workforce distribution results over time provided the right mix of incentives are prioritised. But retention of IMGs longer term requires more policy attention focusing on a broad range of supportive factors and integration supports as previously identified. The redistribution challenge ahead in ensuring investment return in increased domestic graduates must in no way compromise IMGs who have already committed to their community. These doctors play a vital role in rural and remote communities and their contribution should be valued and rewarded through a retention strategy moving forward.

Recommendations

1. Plan now to prioritise those areas most at risk of losing their rural GP through workforce attrition factors which include an ageing rural GP workforce and IMGs exiting as they fulfil their Moratorium obligation.

2. A suite of redistribution policies should be developed which focusses on three areas:
    - harnessing increased domestic supply for the next generation of rural GPs;
    - valuing the existing workforce through investment in skills and retention; and
    - ensuring a focus toward IMG retention, beyond Moratorium obligations.

3. For IMGs in rural and remote Australia the focus should include a mix of retention strategies and education supports toward Fellowship which encourage a permanent place in the community they've served.

4. Future policy decisions pertaining to the SOL must take into account system capacity, both in training and workforce, as well as the need to accommodate and fully utilise the domestic supply coming through.

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Presenter

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