

# Independent review of overseas health practitioner regulatory settings

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Interim Report  
April 2023

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# Foreword

The health workforce is increasingly a globally sought after resource. Australian governments have maintained a strong commitment to growing and retaining a skilled domestic workforce. The health workforce is under significant pressures relating to COVID-19, an increasing incidence of chronic disease and growing demand in aged care, disability and mental health. We rely on and benefit from the skills of international health practitioners. In 2020, around 18 per cent of Australia's registered nurses and around 32 per cent of medical practitioners were internationally trained.<sup>1</sup>

The most important resource in our health system is its people. Australia has one of the best health systems in the world due to the skills and competencies of our health professionals. The National Registration and Accreditation Scheme (NRAS) ensures health practitioners meet consistent, high-quality, national professional standards and, once registered, can work across Australia. Registration ensures that we can be confident in the quality and safety of the health services we rely on. But standards and processes need to remain current to be effective. Regularly updated professional standards are vital to reflect changes in technology, good practice and evidence. The registration process should recognise overseas health practitioners, and respect their expertise and the important role they play.

Employers and health practitioners report our registration and related immigration processes are slower, more complex and expensive in many instances than our international counterparts. This is especially discouraging skilled health practitioners and heightening workforce shortages. For example, recruiting an overseas general practitioner (GP) can take up to 21 months and cost in excess of \$25,000 even for cohorts from fast-tracked countries, while an overseas trained nurse can pay in excess of \$20,000 and take 35 months to get their qualifications recognised.<sup>2,3</sup>

Recognising the urgency, this Interim Report (Report) identifies immediate actions that governments and regulators need to take to ensure our registration processes can be fast-tracked. These include accelerating key immigration and related checks for skilled practitioners

to alleviate urgent shortages in medical, nursing, midwifery and allied health professions. The recommendations focus on removing duplication and inefficiencies while maintaining the enduring commitment to safety, acknowledging that lack of access to health services poses its own risks to patient health. However, structural changes will also be required to address shortages and the changing skills required to meet key policy commitments in health, aged and disability care. The Report recommends a staged approach, initially focusing on areas of key skill shortage identified by health jurisdictions and employers in private, aged care and disability services.

Despite registering record numbers of health practitioners last financial year<sup>4</sup>, we need 860 more GPs and this shortage is likely to grow to 10,600 by 2031-32.<sup>5</sup> We are likely to need more than 40,000 additional registered nurses by 2026, including in aged care.<sup>6</sup> Some allied health professions are projected to grow by over 30 per cent by 2026.<sup>7</sup> Queensland alone will need an additional 37,000 health workers over the next 10 years.<sup>8</sup> Employers across public, private health, aged and social care sectors are struggling to recruit health professionals, with around half of vacancies remaining unfilled.<sup>9</sup>

The health sector remains impacted by COVID-19 peaks, such as delayed staff leave and furloughing, and deferred access to health care, including elective surgery and primary care. Many experienced staff will retire or have expressed the intention of leaving the sector over the next decade, increasing pressure on remaining staff across all professions. Demand is rising due to a growing and ageing population, increasing incidence of chronic disease and changing employee working arrangements and consumer preferences.<sup>10</sup>

Urgent action is needed to ensure all Australians can access timely and appropriate health care. Half of patients are waiting at least 40 days for elective surgery.<sup>11</sup> Some Australians are waiting longer than six years to see specialists including neurosurgeons and ear, nose and throat surgeons.<sup>12</sup> Around 40 per cent of patients are waiting 24 hours or more to see a GP for urgent care.<sup>13</sup> National Disability Insurance Scheme (NDIS) clients are waiting up to six months to see allied health professionals.<sup>14</sup>

Growing the domestic pipeline of health workers takes time, so will not address current shortages. It can take up to 10 years for a local doctor to be fully trained.<sup>15</sup> New domestic enrolments in nursing and medicine have plateaued or fallen in recent years, with the Australian health system increasingly reliant on internationally-qualified health practitioners (IQHPs) in areas of critical need.

The system is too difficult for applicants to navigate. Requirements and processes are duplicative and inconsistent. The same or similar information is often provided to multiple agencies. Applicants report they receive little or no support navigating the process.

Only cohorts from a small number of countries undergo a simpler process. Other cohorts, even from countries with similar regulatory systems, must sit exams or undertake further training to qualify, adding costs and delays. Many are subject to long periods of supervision despite having extensive clinical experience.

Advice provided to the review suggests that mid-career senior clinicians are choosing not to come to Australia due to perceived barriers, costs and uncertainties in the process. As a result, we are missing out on their knowledge and skills. Too often, applicants report that the current process makes them feel undervalued, disrespected and even demeaned.

English language requirements are more onerous than necessary to support effective communication and patient safety. Our requirements to demonstrate the written standards are higher than in the United Kingdom (UK) and New Zealand (NZ).

The visa process increases costs on employers and means it takes longer to fill vacancies. For example, employers need to advertise for domestic applicants before recruiting offshore even when there are unlikely to be any domestic candidates. Age restrictions on permanent skilled visas limit our ability to attract experienced and senior health practitioners who specialise over their career.

There is a vital need for integrated and regularly updated workforce data and national cross-sectoral strategies to inform workforce planning and policy.

Many working in the system see these problems and have been trying to fix them. Reform is challenging as changes are needed across jurisdictions and agencies, with current practices built up over many

years. Governments, professional bodies and regulators are already progressing significant improvements to parts of the end-to-end regulatory process. This Report builds on and seeks to accelerate this work, but recognises that more needs to be done to increase the number and skill mix of qualified health practitioners.

Following consultation with Health Ministers, the Australian Health Practitioner Regulation Agency (Ahpra), the National Boards and others, the Report recommends National Cabinet and the Australian Government agree to the following practical reforms:

1. Enable applicants to 'tell us once' in one place;
2. Fast track more cohorts from countries with similar regulatory systems;
3. Better recognise experience and skills to attract more experienced practitioners;
4. Align English language standards with the UK and NZ;
5. Collect and publish better workforce data;
6. Enable employers to recruit faster in areas of greatest need; and
7. Allow senior clinicians to obtain permanent residency.

These reforms will reduce duplication and inefficiency in the current process, permitting applicants to commence delivering health services sooner while maintaining the focus on public safety. They will enable Australia to recruit more practitioners at lower cost to employers and the applicants themselves, within faster timeframes. Implementing the package of reforms will enable overseas trained GPs from countries with similar regulatory systems to complete the journey in less than three months. Collectively, these reforms will increase the attractiveness of Australia as a destination for highly skilled and experienced health practitioners and encourage more of them to come to Australia.

Acknowledging the key role of Health Ministers under the NRAS and the urgency of the current situation, I recommend Health Ministers issue a direction to Ahpra and the National Boards to deliver a streamlined end-to-end registration system, expedite pathways for applicants from similar regulatory systems, and reaffirm the importance of patient safety as well as ensuring Australians can access timely and appropriate health services.

I have also identified a set of further actions for Health Ministers, Ahpra

and others to progress which will improve the applicant experience, fast track more cohorts, provide for greater flexibility and better workforce planning, and focus regulators on enhancing their performance so there is less need for future reviews.

Reforms will need to be phased in over time, with a clear implementation plan and key performance indicators to ensure responses reflect the urgency of the current situation.

Over time, the proposed actions should reduce regulatory costs for employers and overseas health practitioners coming to Australia. However, some additional upfront investment by governments will be required to accelerate work and improve systems. The alternative would be slower action or to significantly increase fees on health practitioners, as the professions must meet the full costs of regulation under the National Law, which would make it harder for Australia to attract the workforce we need.

The final report to National Cabinet later this year will consider longer-term reforms to ensure the regulatory system is fit-for-purpose and able to respond flexibly to support changes in health needs and models of care.

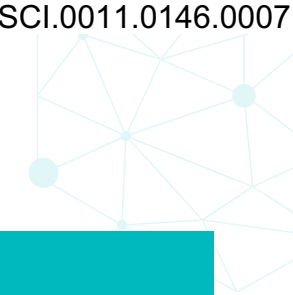
This report would not have been possible without the support of Health Ministers, Commonwealth, state and territory officials, practitioners, regulatory bodies, professional groups and employers. I would also like to thank the many overseas trained health practitioners that agreed to participate in focus groups and complete our survey. My special thanks to the Review Secretariat, led by Ms Ruth Gabbitas, comprising members from the Australian Government Department of Finance and Department of Health and Aged Care.

**Robyn Kruk AO**  
*Independent Reviewer*  
April 2023

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# **Executive summary**

# Key reforms for action now



We recommend National Cabinet endorse these key reforms to address urgent health workforce challenges

Recommendation	Who	Expected impacts	Timeline
Remove duplication and align evidentiary requirements so applicants only need to 'tell us once', with information shared across regulators and agencies. Move to a single portal over time where applicants can submit all documentation in one place.	Ahpra, National Boards, Department of Home Affairs (DoHA), Services Australia, state and territory governments	Better applicant experience and reduced time and cost. For example, estimated cost savings to a nurse or midwife of approximately \$550 by removing duplicative requirements.	Ahpra's business transformation project to be delivered by July 2023. Integration of systems with NRAS entities and agencies possible by early 2024.
Enable more cohorts from trusted countries to be 'fast-tracked' through competent authority pathways (CAPs) and transition equivalence assessments for specialist medical graduates from the specialist medical colleges to the Australian Medical Council.	Ahpra, National Boards, Accreditation Authorities and specialist colleges	<p>More applicants would save time and money and experience a less onerous process. For example, international medical graduates (IMGs) and nurses who become eligible for a CAP would save \$7,050 and \$4,250 respectively. More consistent, cost-effective and faster assessments for specialist medical graduates.</p> <p>More CAPs should result in more health practitioners choosing to come to Australia.</p>	<p>Advice on a list of potential CAPs for all professions to be provided to the Ministerial Council as soon as practicable.</p> <p>By mid-2024, all key professions and medical specialities have commenced expansion of the number of competent pathways.</p> <p>Pilot of specialist pathways, including for GPs.</p>
Better recognition of overseas health practitioners' experience and skills.	Ahpra, National Boards and specialist colleges	Attract more experienced and specialised health practitioners, by valuing their skills and experience, and better targeting supervision to where it is most needed.	<p>Ahpra to clarify existing requirements.</p> <p>An amendment to the Health Practitioners Regulation National Law Act 2009 (Qld) may be required to provide greater legal certainty.</p>
Provide applicants with greater flexibility in demonstrating their English language competency, by aligning our requirements with the UK and NZ, reducing the required score for the writing component to 6.5, but requiring an average International English Language Testing System (IELTS) score of 7 overall and 7 in each of the other three components (reading, speaking, listening).	National Boards	Based on IELTS test results for the year to February 2023, this change could improve the success rate from 26% to 40% of test takers, saving candidates time, costs and the need to sit multiple tests. This change could be expected to enable around 2,750 additional health practitioners to be registered over five years.	Changes to mandatory registration requirements require approval from the Ministerial Council, following a period of consultation by the National Boards. Likely timeframe is ~6 months, given further consultation would be required.
Department of Health and Aged Care (DoHAC) to continue workforce supply and demand modelling for medicine (generally and by specialty) and nursing, and commence work with states and territories and relevant stakeholders to address gaps in allied health workforce data to facilitate supply and demand modelling in the future.	DoHAC, state and territory governments, Ahpra and NRAS entities	Improve the ability of governments, employers, regulators and others to plan for current and anticipated workforce needs.	<p>GP workforce planning expected in the third quarter of 2023.</p> <p>Psychiatry likely to be completed in late 2024. Other specialities as resourcing allows.</p> <p>Nursing likely to be completed by end-2023.</p>
Remove or suspend labour market testing requirement for employers sponsoring priority health practitioners on certain visas and broaden the age exemptions for permanent skilled visas to encompass key health practitioners.	DoHA	<p>Removal or suspension of labour market testing requirements will reduce the end-to-end process by three months and save employers costs.</p> <p>Broadening age exemptions could lead to an additional 4,500 experienced practitioners aged 45 years and over gaining registration over five years.</p>	Minister for Home Affairs to give immediate effect through a legislative instrument.

\*The full list of reforms are attached in the recommendations table

# Current regulatory system for overseas health practitioners

Employment in the health care and social assistance sector is projected to grow by 301,000 (or 15.8%) over the 5 years to November 2026.<sup>16</sup>

## The challenge

Despite registering a record 852,272 health practitioners as at 30 June 2022,<sup>17</sup> demand for health professionals is outstripping supply. Vacancy rates are very high in most health professions across the private and public sector.

Many practitioners are opting to specialise, work in private practice or work fewer hours. Part-time employment is common for many health professions, including nursing.

Shortages exist in all states and territories, particularly in medicine, nursing, midwifery and a range of allied health professions. Priority areas identified by states and territories include GPs, registered nurses, occupational therapists, pharmacists, physiotherapists, psychologists and radiographers. Waiting times are high. Some practitioners are not taking on new patients and some communities have no permanent health practitioners.<sup>18</sup>

Acute shortages exist in some locations, especially rural, regional and remote areas, care settings and specialisations, including psychiatry, anaesthetics and obstetrics. Shortages also exist in the self-regulated health professions, including speech pathology and social work, which also support the aged care sector and NDIS.<sup>19</sup>

This problem will not disappear with the end of the COVID-19 pandemic. The World Health Organisation (WHO) predicts a shortage of 14.5

million health workers globally by 2030.<sup>20</sup>

While domestically trained practitioners must remain the bed rock of our health workforce, more IQHPs are urgently needed. Overseas trained health practitioners and students already play a key role in supplementing the domestic workforce. In 2021-22, 3,536 IMGs, 2,373 overseas trained allied health practitioners and 2,015 overseas trained nurses and midwives applied for new registration.<sup>21</sup>

**All stakeholders agree that governments must act to address current and future workforce shortages**

## The current system

The regulatory system ensures that the community has access to a safe and competent health workforce.

This review has heard that our end-to-end process for regulating overseas health practitioners is complex, slow and costly. From the applicant's perspective, assessments and processes can often be unclear, lack transparency and result in inconsistent outcomes.

The end-to-end journey is sequential, making

it slow and difficult to navigate with the visa, employer and professional recognition processes duplicative and sometimes inconsistent. Only applicants with qualifications from a small number of countries and professions are eligible for the streamlined pathways.

The requirements are particularly inflexible for experienced health practitioners that specialise over their career.

Regulatory responsibilities are highly fragmented, with roles spread across multiple parties and legislation with little coordination.

Some employers no longer consider applicants from countries without expedited registration pathways as the process is too hard and outcomes uncertain. Australia is often no longer the country of choice for the health workers we want and need.

More information on what we heard from overseas health practitioners is on page 8.

**Around half the survey respondents assessed the processes related to compiling documents, skills assessment and application for registration to be 'difficult' or 'very difficult.'**





# What we have heard

## Overseas health practitioners

“ I was extremely disappointed in the fact that although our medical training is almost identical I was not considered comparable after 15 yrs of practice... Being supervised by someone with far less experience than myself and having the official title of "registrar" when you are an experienced clinician and associate professor is demeaning and not conducive to attracting specialists to Australia. survey respondent

“ Ahpra and the council make me upload the same documents... I have to submit to Home Affairs as well. Sometimes one will accept a document, then another body will reject it. Surely, they can talk to each other. focus group participant

“ It needs to be cheaper, less time consuming and less duplication. If I was born and raised in England and never lived outside the UK, taught in an English university then I speak English, I should not need to prove this. survey respondent

“ I was head of a department for 10 years in Singapore. And here I'm being asked to put myself into the shoes of a graduate again. So, I had to prepare for the exam to think like that again, it's an art form when you've been in the workforce for so long. focus group participant



“ In hindsight, I regret commencing this process and have told colleagues overseas not to come to Australia due to the arduous registration process. survey respondent

“ I was was born and raised and taught in England. Why did I have to show that I could speak English??? It was frustrating and it was difficult to convince my previous academic institution to verify that they were taught in English. survey respondent

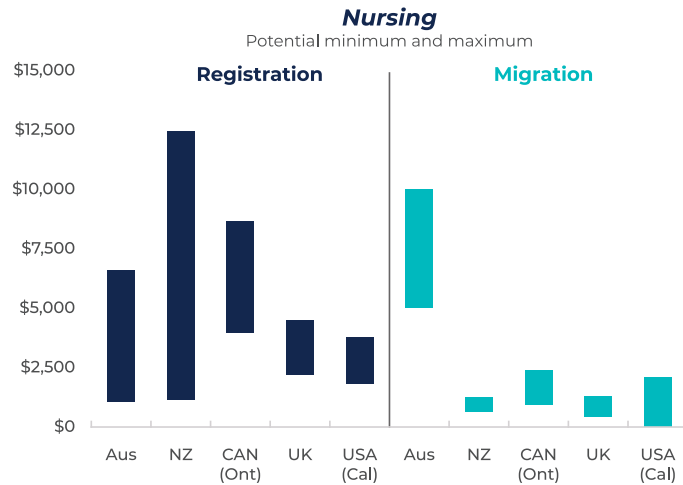
“ I felt like it was a constant "back and forth", taking one step closer to the full registration, then being informed that I had to do more things (e.g. provide more/new documents) for the next step. There was no support provided and no one that I could contact to asked questions, that had valuable information regarding my case. survey respondent

“ I wouldn't have known what to do, how to apply for things and what the process is if other people, like my friends and colleagues hadn't done it before. This way I knew what to expect and what to prepare in advance. focus group participant

“ I have technically downgraded myself from being a consultant to a registrar, which is a role deviation. Having to demonstrate the same things to people who you've trained overseas seems pointless. survey respondent

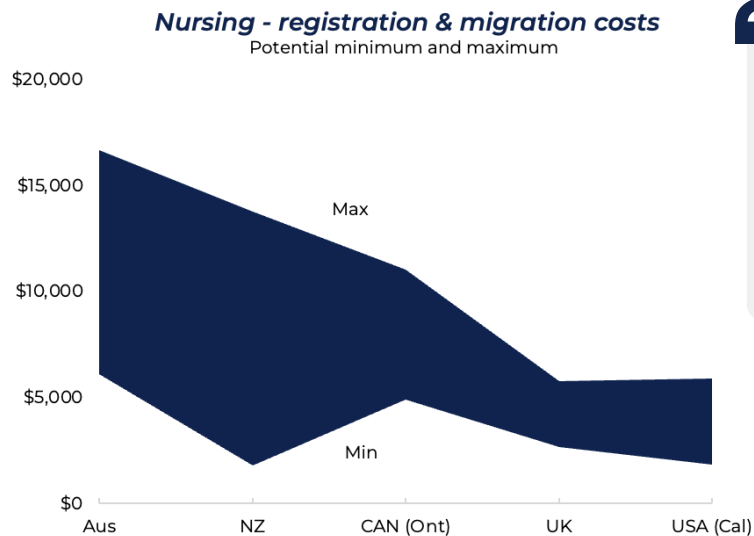
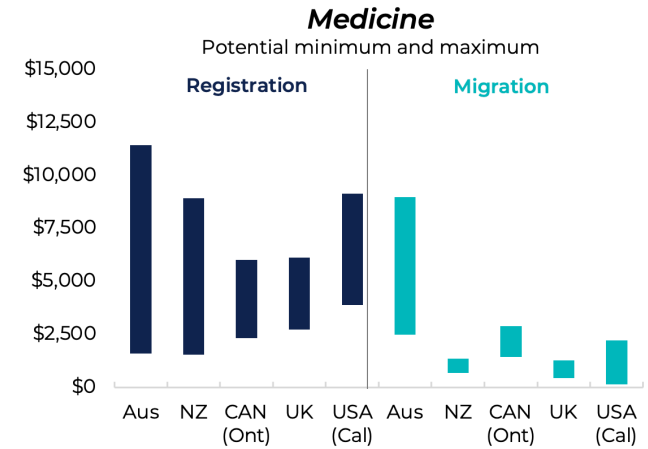


# International benchmarking

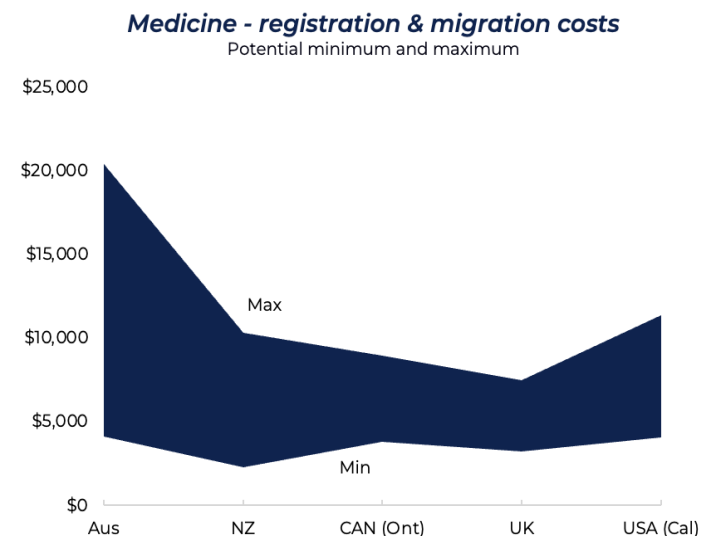


**5** The Medical Board of Australia recognises 6 competent authorities in 5 countries.<sup>24</sup>  
New Zealand recognises 23 comparable jurisdictions,<sup>25</sup> the UK 30+<sup>26</sup> and Canada 8.<sup>27</sup>

*“We are losing 60 per cent of our nurse applicants to Canada because our process is so slow. Victoria<sup>22</sup>”*



*“Some colleges ... find nobody to have comparable qualifications even if they are obtained in the UK or other generally accepted jurisdictions. Tasmania<sup>23</sup>”*



\*Note: The range of costs shown represent the unavoidable direct costs incurred by all applicants in these professions. The range of registration fees confirmed by Ahpra. The range does not capture the cost of bridging courses (around \$15,500 for nurses) and other indirect or incidental costs (e.g. travel and accommodation to sit assessments). The range of migration fees differ by visa class and include any occupation subsidies available.

# Future regulatory system for overseas health practitioners

The end-to-end process should generally take overseas applicants from competent countries less than 3 months, rather than many months or years for professions in critical need

## The future system

Australians rightly expect access to safe and quality health care regardless of where they live. To achieve this, the regulatory system needs to continue to ensure that both domestically and overseas trained health practitioners meet appropriate standards of safety and quality.

To attract the overseas health practitioners needed, we must:

- streamline the administration of the end-to-end process – applicants should only need to provide information and meet requirements once, such as English proficiency, criminal history and identity checks;
- enable more cohorts from trusted countries, with high public safety standards, to be fast-tracked;
- more flexibly assess the skills and competencies of potential applicants, especially experienced and senior health practitioners who specialise over their career, for registration, fellowship and visas;
- remove unnecessary migration barriers, such as the need for employers to test the domestic labour market first and age limits on permanent residency visas; and
- provide support, including targeted supervision and training, where needed to help migrants understand the Australian health settings and provide culturally safe care.

A phased approach needs to be taken with immediate action prioritised in areas of greatest need. Data on workforce needs to be collected, regularly

updated and published so governments, employers, the professions and education providers can better plan for current and future needs, including changes in models of care and moves to cross-disciplinary teams.

The performance of regulators – including timeframes and consistency of outcomes – must improve. Regulators need to better manage risk, be more transparent and accountable, seek to continuously improve and be 'stewards' of the system.

Reform has been progressed by Ahpra and professional bodies. However, regulators and agencies should coordinate and share more information with each other. They need to consider the impact of their decisions on the end-to-end process and the ability of Australians to access safe and quality health care.

We need to regularly benchmark the system against domestic and international best practice, to ensure it delivers timely, safe and quality care and meets Australia's workforce needs.

The self-regulated health professions, including speech pathology and social work, are also facing significant current and anticipated shortages. Ongoing alignment between the professions will be important.

More overseas health practitioners will strengthen primary care and improve the ability of Australians to access timely and appropriate health, aged and disability care.

Regulatory bodies, governments, practitioners, employers and the public should be clear on the purpose of the regulatory settings, as outlined on page 11.

## Final report

The final report will include longer-term reforms to ensure that regulatory process and decisions enable Australia to attract the overseas health practitioners needed into the future, maintaining the focus on public safety. It will consider opportunities to:

- fast-track practitioners from comparable health systems;
- further improve regulator transparency and performance and embed regulatory stewardship;
- better assess and support health practitioners, including through focusing on assessing practitioners' competencies, centralising information on the process and targeting supervision to where it is most needed; and
- develop longer-term strategic alliances with respected training facilities in the Indo-Pacific region, with recognised pathways into the Australian health workforce – where such alliances are agreed between governments as being mutually beneficial.

The final report will identify any required legislative changes and include more information on:

- the journeys and experience of overseas health practitioners;
- regulatory settings in comparable countries;
- the expected costs and benefits of the proposed reforms; and
- implementation of the proposed reform package.

# Purpose of the regulatory system

The purpose of the regulatory system should be based on clear principles that articulate expectations and enable the system to adapt as needs and circumstances change.

## Risk-based

Patient safety and quality of care should continue to remain paramount and factor in risks from lack of access to care

## Best-practice

The regulators and regulatory settings should be reviewed and benchmarked against domestic and international best practice on a regular basis

## Clear, evidence-based and cost-effective

Any requirements should be fit-for-purpose, based on evidence and imposed in the simplest way with the lowest cost for health practitioners and employers

## Responsive

Regulatory settings should support the government's broader agenda, including facilitating multi-disciplinary care and ensuring the skills of the workforce are used effectively

## Stewardship

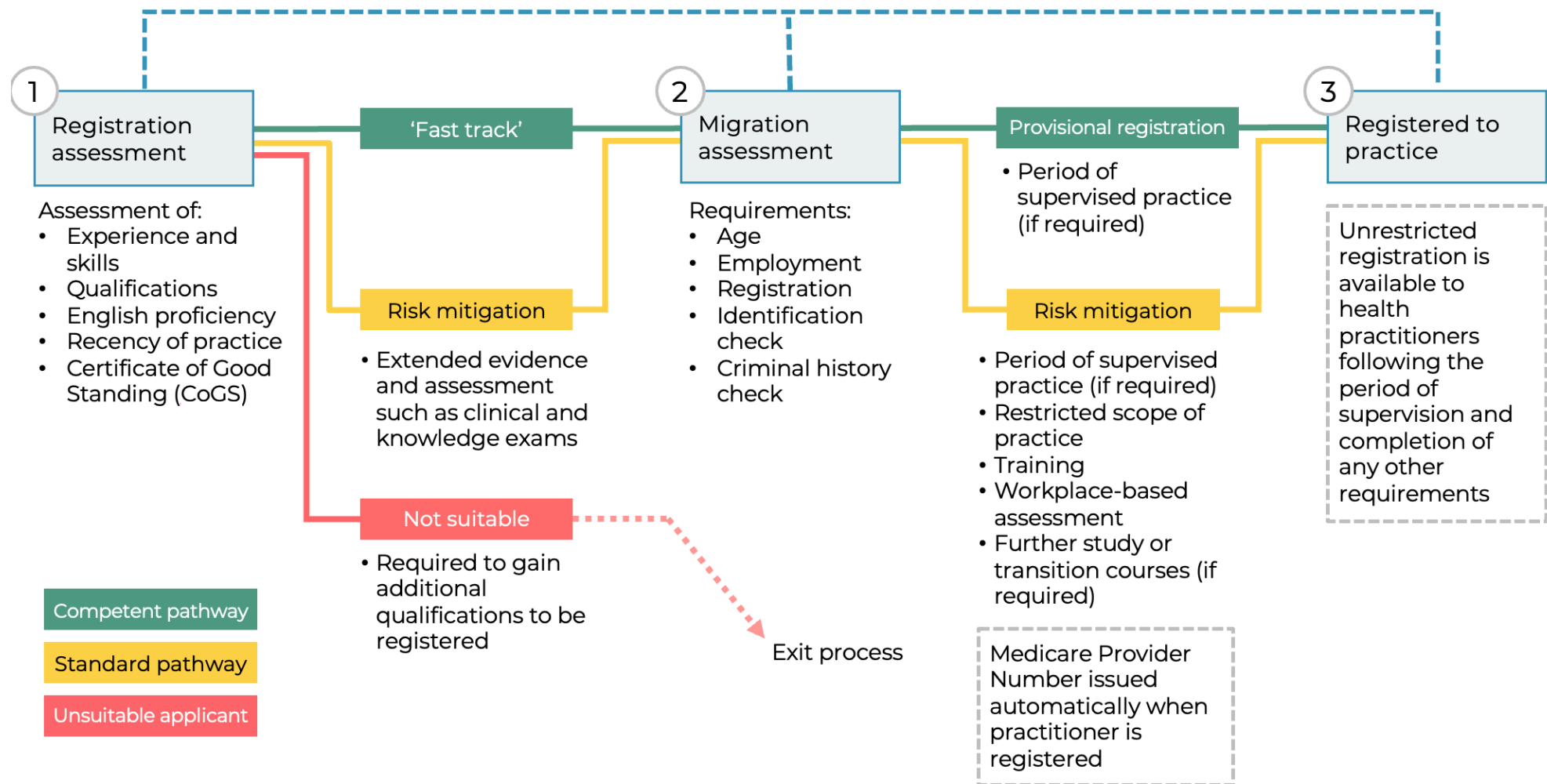
Regulators should consider the impact of their actions on the system as a whole and the parties they regulate. They should be stewards for the system



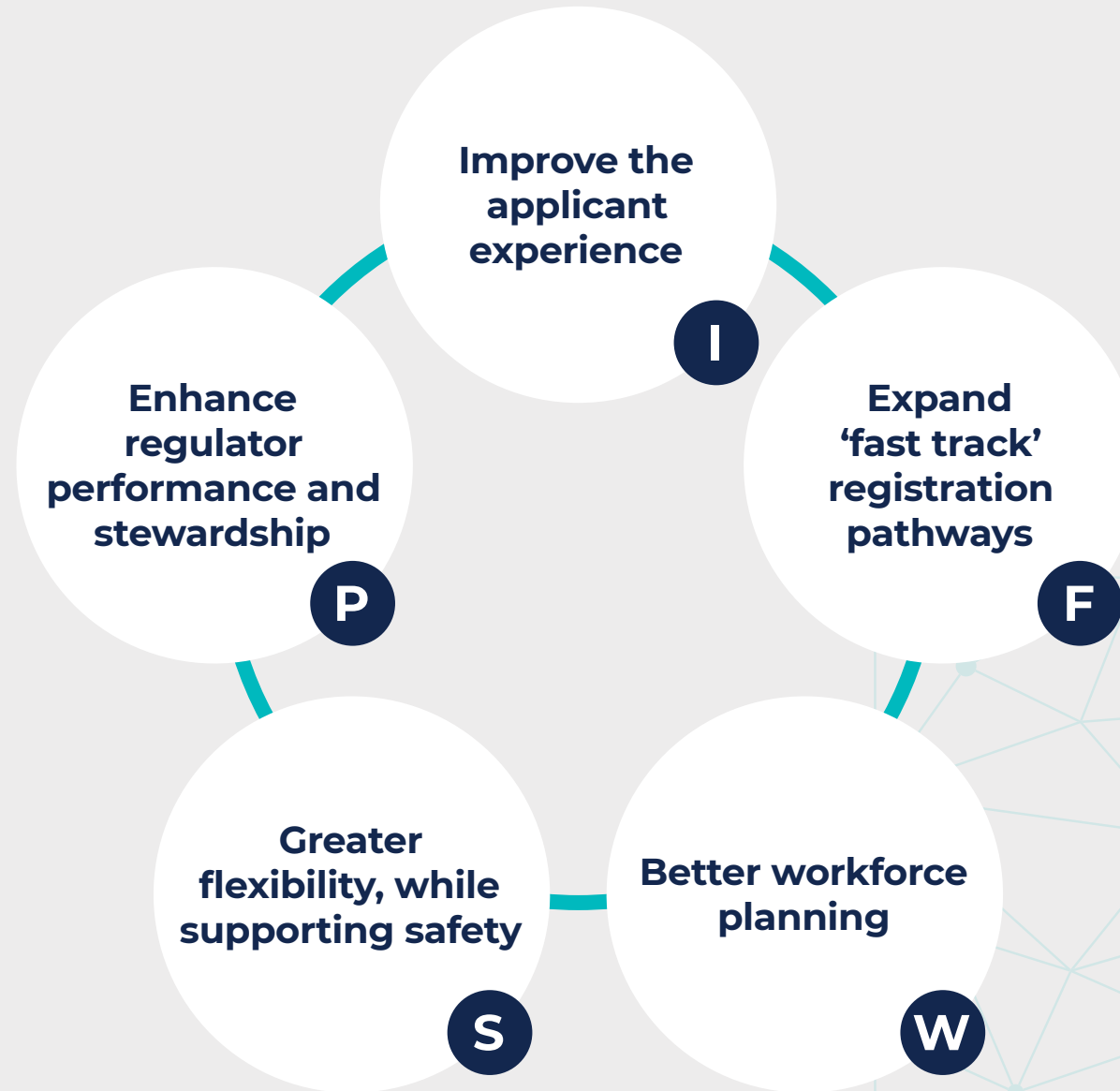
# Future state vision for the system as a whole

Objective: Reduce typical applicant journey entering through the competent pathway from 6-12 months to less than 3 months

Eliminate duplicative evidentiary requirements and share information across regulators and agencies so applicants only 'tell us once'



# Key reform priorities to support future state vision



# Key reform priorities

## Improve the applicant experience

1

We need to improve the experience of overseas health practitioners and employers in navigating the end-to-end process by:

**Removing duplication and aligning evidentiary requirements so applicants only have to 'tell us once'**, with information shared across regulators and agencies, moving to a single portal over time

**Automating and/or streamlining application steps**, such as criminal history checks, the issuance of a Medicare Provider Number (MPN) and visas

**Removing migration barriers**, including pausing labour market testing, expanding age exemptions for visas and allowing practitioners to work to their full scope of practice

**Providing more support to applicants**, with governments improving coordination on recruitment, candidate support and onboarding, and centralising information on the process



# Key reform priorities

## Expand 'fast track' registration pathways

F

We urgently need more skilled, qualified and experienced cohorts 'fast-tracked', to increase timely access to health services and reduce applicant costs by:

**Expanding competent authority pathways\* (CAPs) to specialist international medical graduates (SIMGs) and all professions in key shortage areas**, removing (wherever appropriate) requirements for further assessment of skills or qualifications

**Better recognising overseas health practitioners' experience and skills**, offering flexibility for highly skilled and experienced health professionals who specialise over their career

**Targeting scarce supervisory resources and support to where they are most needed**, reflecting the competency levels of the health practitioners – with an enhanced focus on building cultural competence for those entering through CAPs and greater support for others

**Transitioning equivalence assessments from specialist colleges to the Australian Medical Council**, to streamline assessments for all non-CAP SIMGs – colleges would retain expertise and an advisory role\*\*

**Allowing centralised support for assessing and administering applications**, with potential cost efficiencies to be gained from a more standardised process

\* A CAP refers to a (relatively) streamlined process leading to general registration, which is open to international health workers who have a relevant primary qualification and have satisfied the experience requirements of a designated overseas health institution.

\*\* Under the current arrangements, specialist colleges play a determinative role in this process.

# Key reform priorities

## Better workforce planning

W

We need to make better use of workforce data to inform planning, policy and evaluation. A publicly available national health workforce database which is regularly updated would improve workforce planning by:




**Quantifying workforce, skills and distributional issues**, making it easier to determine the extent of workforce shortages and key skill mixes sought in health, aged care and disability sectors




**Helping industry and service providers better plan** for Australia's future workforce needs



**Supporting the development of national workforce strategies for key health professions**, factoring in current and anticipated cross-sectoral demand



**Supporting more effective models of care**, to enhance multi-disciplinary approaches to health care delivery rather than relying on profession-by-profession approaches



**Supporting determination of performance indicators of progress in the recruitment of more overseas health practitioners**, focusing on areas of greatest need over the next two years while workforce strategies are developed

# Key reform priorities

Greater flexibility, while supporting safety

S

We need to allow greater flexibility for overseas health practitioners to demonstrate the currency of their clinical knowledge, experience and skills, while maintaining the focus on public safety by:

**Expanding testing options and access for applicants**, including through increased testing capacity at more locations (including multidisciplinary centres), and the development of online and offshore assessment capabilities where beneficial

**Aligning evidentiary requirements and increasing recognition across regulators and agencies**, to reduce costs and delays by ensuring applicants only need to demonstrate a registration standard once

**Making modest evidence-based changes to English language standards while enhancing the focus on cultural competency**, including expanding the range of recognised countries and test results accepted by National Boards\*

**Considering greater flexibility to demonstrate recency of practice**, as long as an applicant has a minimum level of experience in a comparable health setting

\* For example, aligning standards with changes made by our international peers, including reducing the required score for the writing component of the IELTS to 6.5, but requiring an average score of 7 overall and 7 in each of the other three components (reading, speaking, listening).

# Key reform priorities

## Enhance regulatory performance and stewardship

P

We need to improve regulator transparency and performance and better collectively manage or 'steward' the registration and accreditation process by:




Ensuring that performance standards and benchmarks are transparent and publicly available, with regular reporting against these metrics



Focusing regulators, agencies and governments on reducing applicant costs, while supporting patient safety and adopting a continuous improvement mindset



Promoting greater transparency and accountability for the costs met by applicants and employers, with regular review and reporting



Seeking regular feedback from applicants, employers, professional bodies and the community, to ensure regulatory settings are appropriate and reflect good practice



Supporting changes in models of care to meet future demand for health services, with regulators expected to collaborate in the best interests of the community

# **a. The problem**

# The National Registration and Accreditation Scheme is a significant reform



## A national scheme providing cross-professional consistency

- In January 2006, the Productivity Commission delivered its report, Australia's Health Workforce.<sup>28</sup> The report advocated for a national approach to health profession regulation.
- The National Registration and Accreditation Scheme (NRAS) came into effect in July 2010.<sup>29</sup>
- The NRAS ensures all regulated health professionals are registered against consistent, high-quality, national professional standards.



## ...with an emphasis on safety

- The National Law focuses on keeping the public safe by ensuring only health professionals who are suitably qualified can provide health services.
- The prominence given to safety has allowed for a coordinated approach to accreditation, registration and, to a lesser extent, notifications against practitioners.



## ...that facilitates workforce mobility

- As a national scheme, the NRAS facilitates workforce mobility. Registered health professionals can work across states and territories without having to re-register to work in different jurisdictions.
- Some of Australia's international peers have retained a provincial registration system, limiting the mobility and oversight of their health workforce.



## ...and demonstrates agility and responsiveness

- The NRAS was shown to be flexible and responsive during the COVID-19 pandemic.
- National Boards have in-built discretion to adjust requirements at short-notice.<sup>30</sup>
- COVID-19 triggered the creation of a pandemic response sub-register, streamlined application and change of circumstance processes, provided for flexibility in supervision and a shift to remote exams.



# Past reviews have informed improvements to its operation and this review

## Lost in the Labyrinth (2012)<sup>31</sup>

Improved information sharing

Exam capacity and work based assessments expanded

IMG pathways and assessment criteria clarified

## Independent Review of the NRAS (2014)<sup>32</sup>

Improved efficiency, transparency and performance of NRAS functions

Ombudsman's remit expanded to include some accreditation functions

Improved public reporting on college performance

## Independent Review of the NRAS Accreditation Systems (2017)<sup>33</sup>

Independent Accreditation Committee established

Fee setting principles and performance indicators for accreditation authorities introduced

## Independent Governance Review of the NRAS (2017)<sup>34</sup>

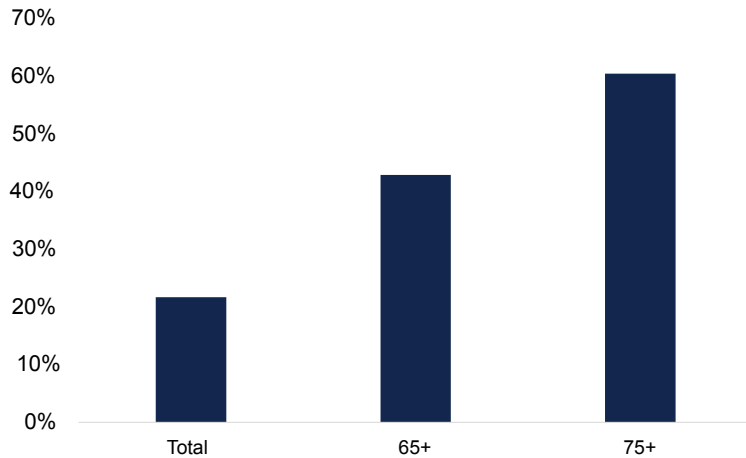
Ahpra's role in providing advice on achievements of NRAS entities clarified

Indicators for annual reporting on achievement of NRAS objectives identified

## Independent Review of Overseas Health Practitioner Regulatory Settings (2023)

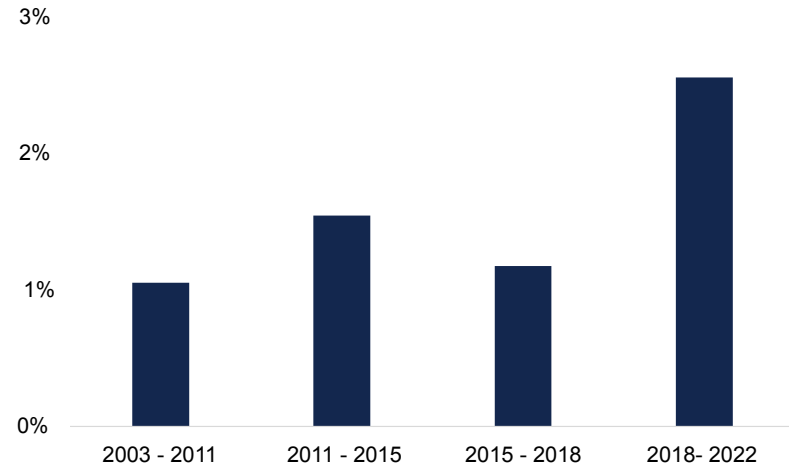
# Demand for health services is growing and likely to be persistent

**Australia's population is ageing**  
projected growth in age cohorts 2017 to 2030, percent



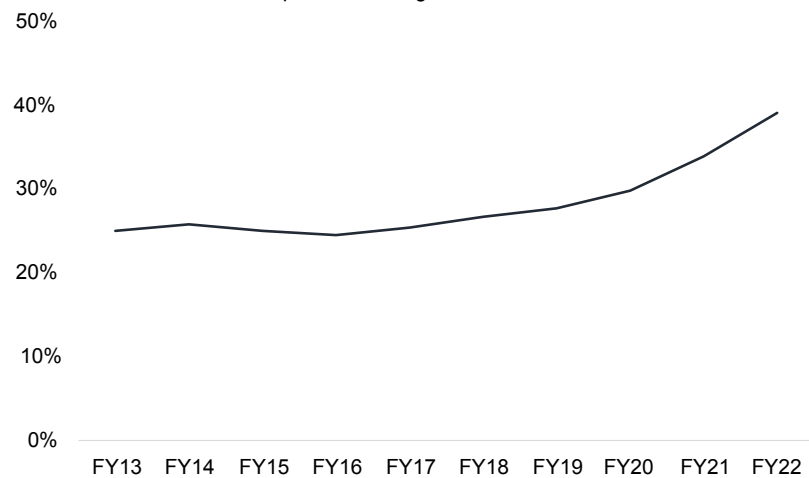
Source: ABS, Population Projections, Australia 2018

**Total disease burden is rising**  
annualised increase in total disease burden



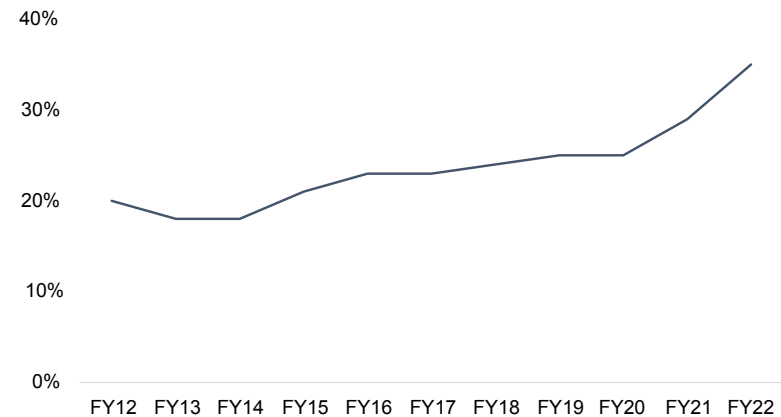
Source: AIHW, Australian Burden of Disease Study 2022

**Australians are waiting longer to see a GP**  
share of patients waiting 24 hours or more



Source: Productivity Commission, Report on Government Services 2023

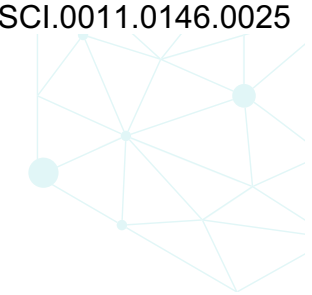
**Fewer emergency patients are seen on time**  
public hospital 'emergency' category patients not seen on time



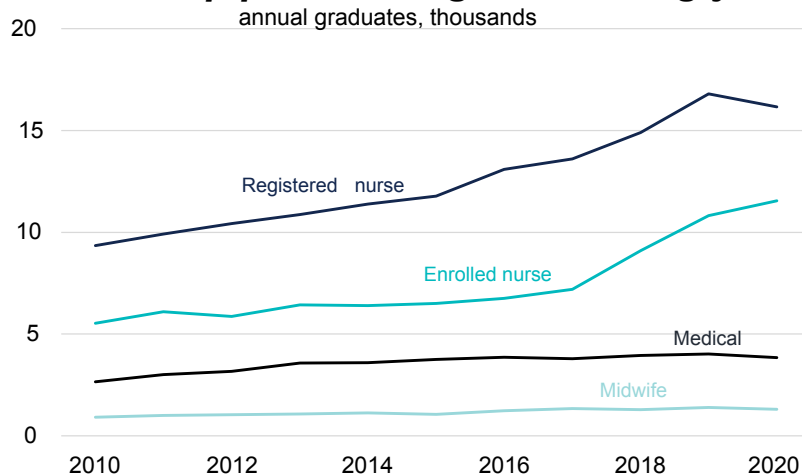
Source: Productivity Commission, Report on Government Services 2023



# Despite a strong domestic pipeline, pressures persist

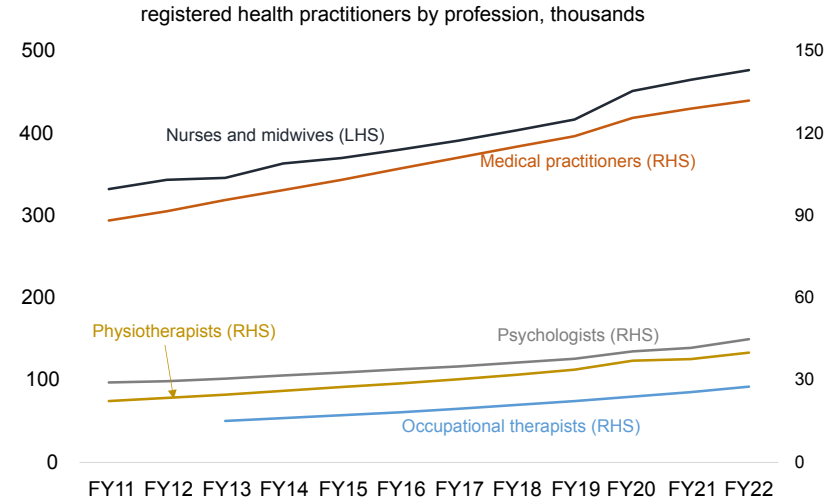


## Domestic pipeline has grown strongly



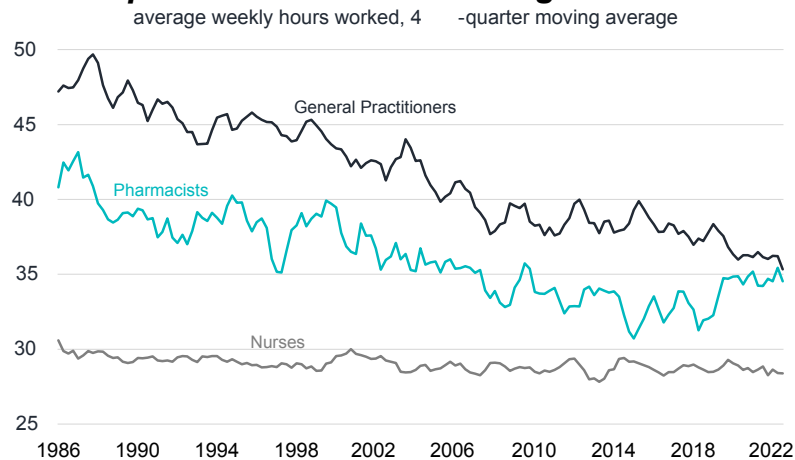
Source: OECD Statistics 2023

## Registrations have risen rapidly



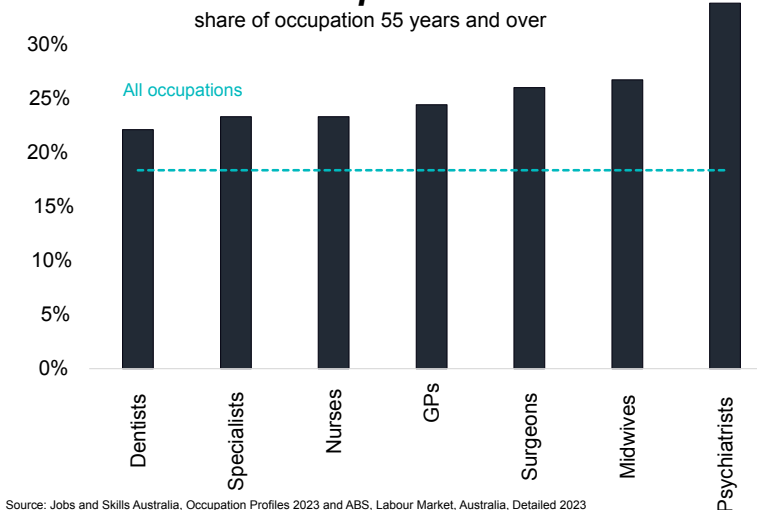
Source: Ahpra 2023

## Health professionals are working fewer hours



Source: ABS, Labour Force, Detailed, Australia 2023

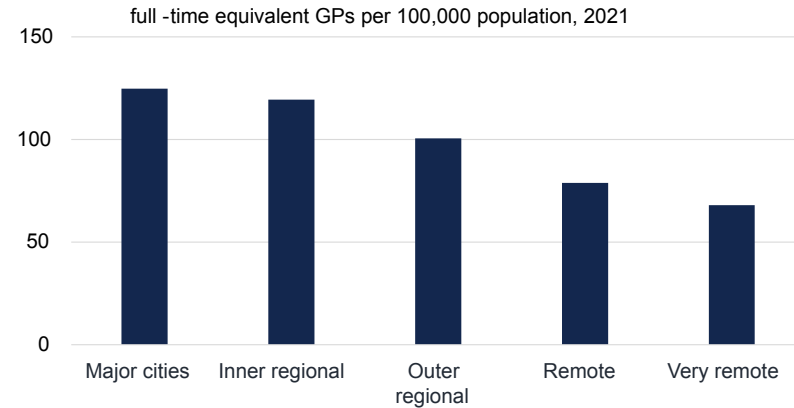
## The health workforce is older than other occupations



Source: Jobs and Skills Australia, Occupation Profiles 2023 and ABS, Labour Market, Australia, Detailed 2023

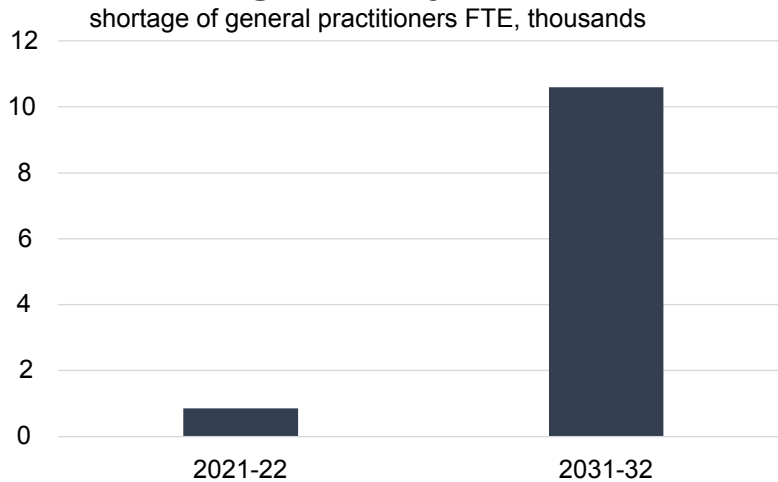
# More practitioners are needed now and into the future

## More GPs but distribution remains uneven



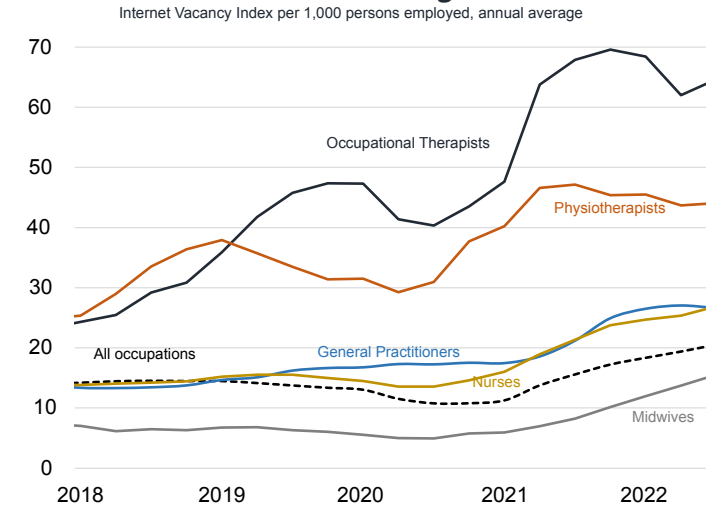
Source: Productivity Commission, report on Government Services 2023

## GP shortage is projected to rise



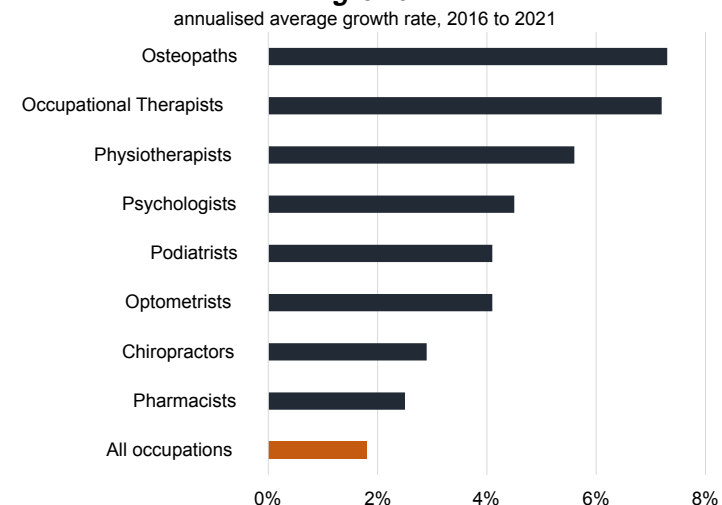
Source: Australian Medical Association

## Vacancy rates for health occupations are above average



Source: NSC Internet Vacancy Index 2022 and ABS, Labour Force, Australia, Detailed 2023

## Allied health occupations are experiencing rapid growth



Source: Department of Health and Aged Care 2023 and ABS, Census 2016 and 2021

# The Review has been asked to address these urgent workforce challenges

On 30 September 2022, National Cabinet announced an independently-led, rapid review of Australia's regulatory settings relating to overseas health practitioner registration and skills and qualification recognition.

On 8 December 2022, the Government announced the appointment of Ms Robyn Kruk AO to lead the Review. The Review's Terms of Reference are at the [Appendix](#).<sup>35</sup>

The Department of Finance and the Department of Health and Aged Care are jointly supporting the Review, working closely with state and territory governments and other stakeholders.

The Review has consulted with a wide range of stakeholders, including:

- Ahpra and the National Boards;
- professional bodies and employee representatives in the health, aged care and disability sectors;
- public and private sector employers; and
- overseas trained health practitioners and international students who have been through the registration and migration process.

## Key principles informing the Review

- 1** Australia's health practitioner registration and skills and qualification regulatory system should require overseas trained and domestically trained health professionals to meet the same standards.
- 2** Any requirements should be commensurate with risks, optimally managed and imposed in the least complex way.
- 3** Quality and safety standards designed to protect patients must be maintained, without unnecessarily restricting health workforce supply.
- 4** Regulatory settings should signal Australia as an attractive destination for internationally qualified health practitioners and not discourage recruitment and retention of global talent.
- 5** Migration should not be used as a substitute for developing and employing a domestically-trained workforce.

# And will be looking to build on and accelerate existing work underway

## Ahpra streamlining projects

- » Expanding exam capacity – 500 additional places for the Objective Structured Clinical Exams (OSCE) for nurses and midwives
- » Improving throughput of practitioners e.g. average time to assess applications reduced from 29 days to 10 days
- » Digitising application forms and processes to improve the experience for applicants – from July 2023
- » Improving information available for practitioners and employers to help them understand the regulatory requirements

## Health Workforce Taskforce

- » DoHAC is modelling workforce supply and demand for GPs and nurses
- » Developing national workforce strategies for nursing and maternity
- » Working on a national approach to subsidising migration costs

## National Medical Workforce Strategy

- » Collaborating on medical workforce planning and design, rebalancing the supply and distribution of doctors across specialities and locations, and reforming medical training pathways

## Strengthening Medicare Taskforce

- » Fast-tracking work to improve supply and distribution of GPs, nurses, pharmacists and allied health professionals
- » Reviewing barriers and incentives for practitioners to work to their full scope of practice

## Improving Care Pathways Taskforce

- » Improving care pathways for people with a disability and older Australians and reducing pressures on the health and hospital system

## A Migration System for Australia's Future

- » Ensuring the migration system better meets Australia's needs and complements the skills and capabilities of Australian workers
- » Sharpening the focus on skills, while streamlining the process, simplifying the rules and reducing complexity

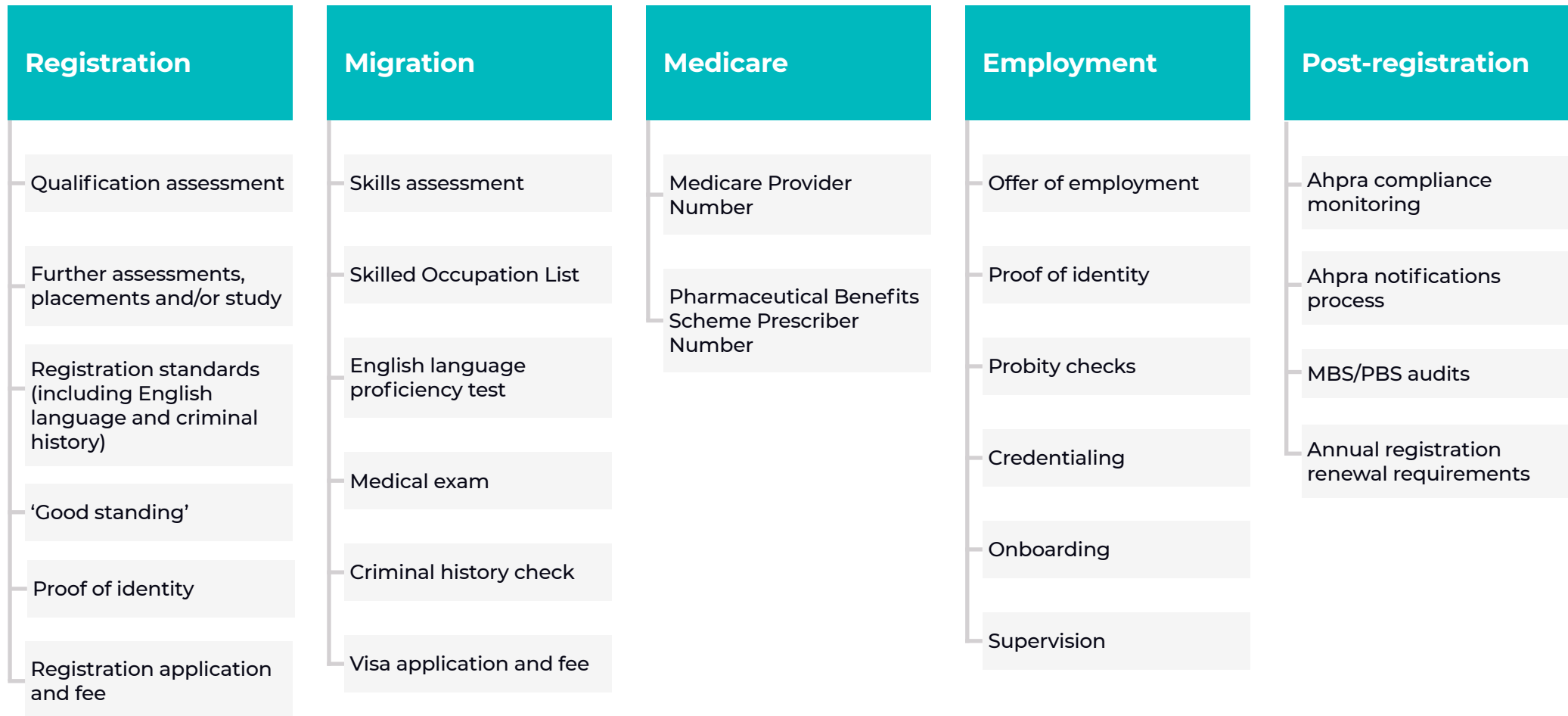
## Jobs and Skills Summit and subsequent Employment White Paper

- » Exploring issues, frameworks and policy approaches relevant to the future of Australia's labour market over the medium and long term, including in the migration system

## **b. The process**



# Applicants will engage with many regulators and checks in the end-to-end process



# Leading to a complex and costly applicant journey

## Nursing and Midwifery



### Journey Map



This map illustrates a simplified journey of an Internationally Qualified Nurse / Midwife (IQNM) seeking to practice as a registered nurse and/or midwife in Australia.

The primary journey depicted here is an IQNM applying through Stream B

### A B C

Stream A - a qualification considered to be substantially equivalent, or based on similar competencies, to an approved qualification

Stream B - a qualification that is professionally relevant, but is not substantially equivalent, nor based on similar competencies to an approved qualification

Stream C - a qualification that is not substantially equivalent or relevant to an approved qualification



An IQNM may not go through every action or step in the exact order shown. Their journey may vary primarily depending on factors such as country and duration of study, training/experience and working history.

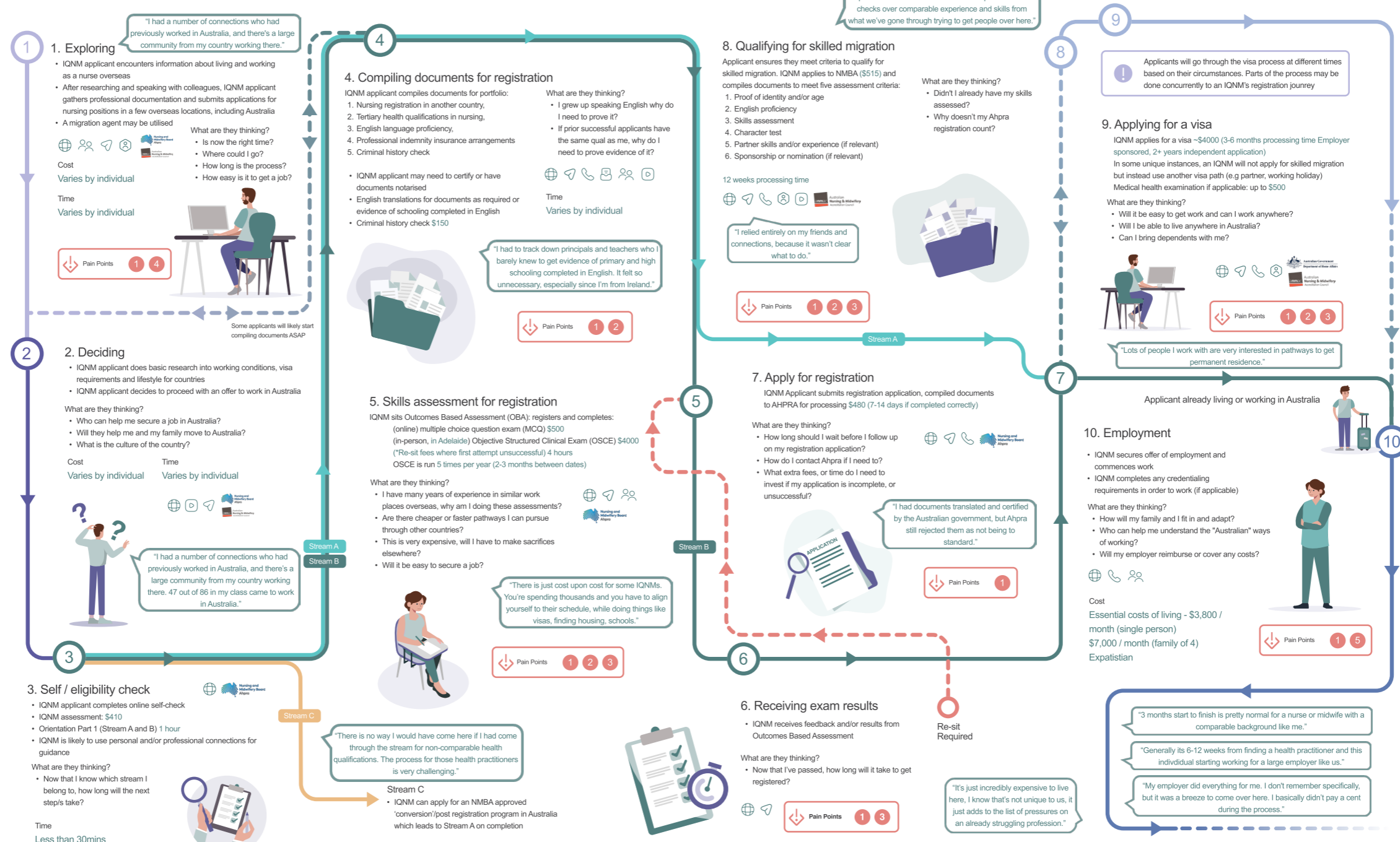


While the journey map is linear; in reality, an IQNM may dip in and out of stages or actions at different times



This map also visualises the circularity/duplication of certain steps, which result in additional complexity and user effort.

## Nursing and/or Midwifery Current State



## INTERIM VERSION

<p><b>1</b></p> <p>Costs to individual</p> <ul style="list-style-type: none"> <li>Out of pocket expenses - certification/notarisation, translation, document production fees</li> <li>Application / registration fees</li> <li>Examination fees</li> <li>Tuition / study costs (including private bridging courses)</li> <li>Travel costs (physical attendance)</li> <li>Third party/agent fees</li> <li>Opportunity cost</li> </ul>	<p><b>2</b></p> <p>Application management</p> <ul style="list-style-type: none"> <li>Liaising with parties to compile documents (universities, overseas nursing boards, former employers, work history)</li> <li>Tracking progress</li> <li>Managing scheduling, correspondence</li> </ul>	<p><b>3</b></p> <p>Process complexity</p> <ul style="list-style-type: none"> <li>Most countries' qualifications do not meet NMBA-Ahpra criteria, however many countries are considered equivalent</li> <li>High threshold for English language proficiency. IQNM applicants from English speaking backgrounds are often required to prove their schooling was completed in English</li> <li>Limited exams scheduled each year</li> <li>Requires physical presence in Australia to complete with no online options</li> <li>Duplicative processes</li> </ul>	<p><b>4</b></p> <p>Source of truth</p> <ul style="list-style-type: none"> <li>No clear source of truth to many IQNM applicants</li> <li>Official and unofficial information sources each give a siloed view of the process to live and work in Australia</li> <li>Reliance on professional / social networks to navigate information sources</li> </ul>	<p><b>5</b></p> <p>Skills transferability</p> <ul style="list-style-type: none"> <li>Am IQNMs skills may not be fully transferable to Australia, resulting in additional years of training. Often this may be equivalent to one year full-time education</li> <li>An IQNM may need more time to learn cultural / situational context and nuances</li> </ul>
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**Touch point Legend**

- Online
- In Person (incl. networks)
- Social Media
- Email
- Phone
- Post
- Migration Agent

**Logos:**

- Australian Health Practitioner Regulation Agency (Ahpra)
- Nursing and Midwifery Board Ahpra
- ANMAC (Australian Nursing & Midwifery Accreditation Council)
- Australian Government Department of Home Affairs

# Leading to a complex and costly applicant journey



**Australian Government**  
Department of Finance

## Journey Map

This map illustrates a simplified journey of an International Medical Graduate (IMG) seeking to practice as a registered doctor in Australia.

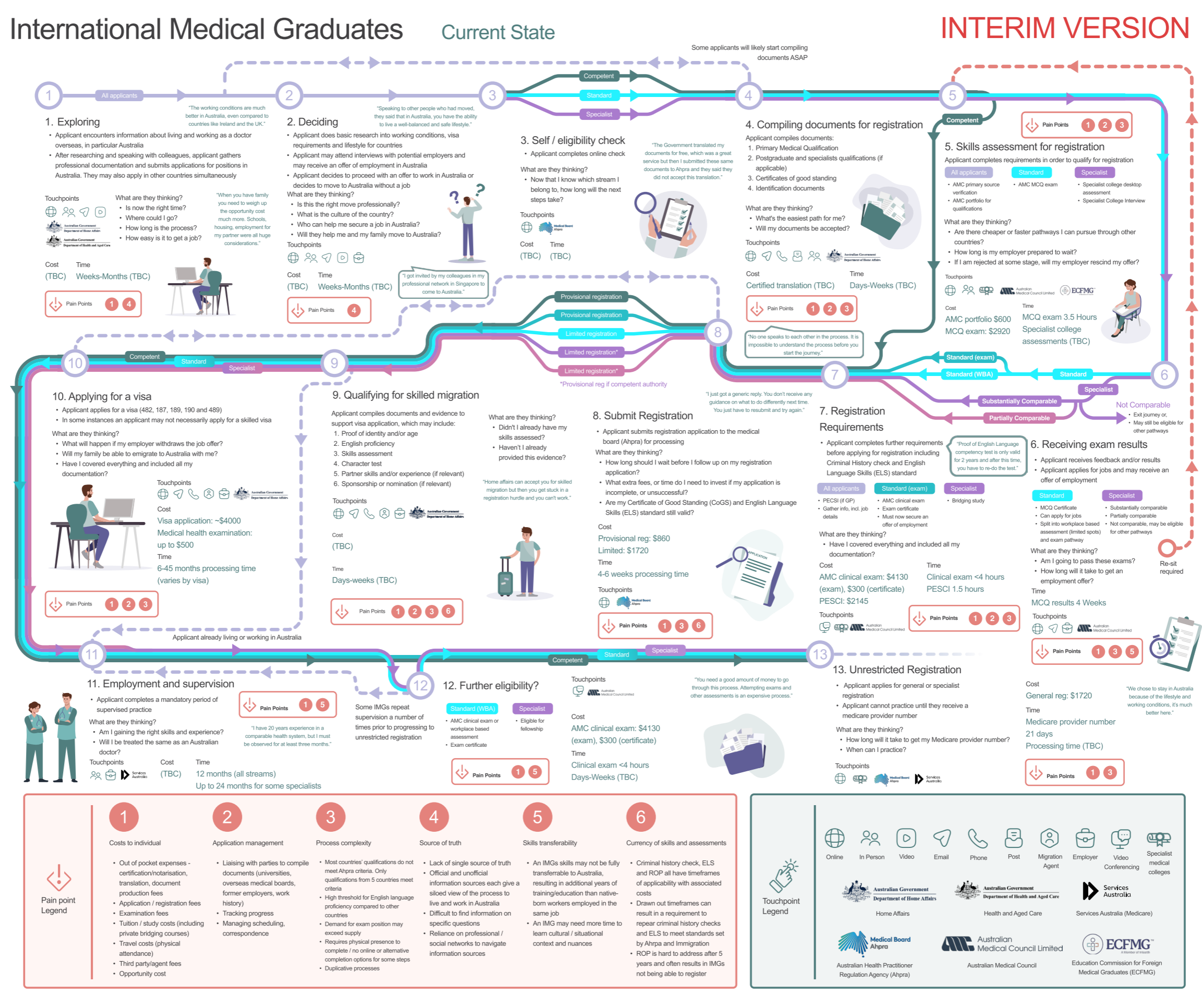
### Streams

- Competent** - Applicants registered in select countries with comparable standards to Australia.
- Standard (WBA)** - Applicants from all other countries. Pathway will diverge based on the applicant having secured employment.
- Standard (Exam)**
- Specialist** - Applicants applying for specialist recognition. Qualifications will be assessed as comparable, partially or not comparable. Specialists can be assessed via competent authority as well.
- Partially Comparable**

An IMG may not go through every action or step in the exact order shown. Their journey may vary primarily depending on factors such as country and duration of study, training/experience and working history.

While the journey map is linear, in reality, an IMG may dip in and out of stages or actions at different times.

This map also visualises the circularity/duplication of certain steps, which result in additional complexity and user effort.





# While our international peers have made their own regulatory process simpler and cheaper, without lowering standards

## Registration process and standards

Online applications are the norm in the UK, Canada, NZ and Ireland.

Criminal history checks: NZ only requires applicants to obtain a criminal history check if they have a prescribed matter to disclose.<sup>36</sup>

Medical specialists: NZ accepts qualifications for locum specialists, including for anaesthesia, surgery and general practice, from Australia, Canada, South Africa, the UK and the US.<sup>37</sup> The UK also accepts a range of medical specialist qualifications.

Recency of practice: the UK,<sup>38</sup> Canada<sup>39</sup> and USA<sup>40</sup> impose low or no recency of practice requirements on international registrants.

The UK is seeking to move to an online app where an IMG's identity can be verified offshore.<sup>41</sup>

In Canada, almost all supervision is now virtual for IMGs and no supervision is required for US physicians.<sup>42</sup>

Canada, NZ and the UK grant full registration, rather than provisional registration, to most qualified overseas health practitioners.<sup>43</sup>

Australia has a nationally consistent approach allowing internationally qualified health practitioners (IQHPs) to practice in all states and territories, in contrast to the USA & Canada where state/province rules apply.

## Migration

The UK,<sup>44</sup> Canada,<sup>45</sup> NZ<sup>46</sup> and Ireland<sup>47</sup> offer low-cost visas to healthcare workers.

EU citizens do not require a visa to work in any of the 27 EU member States, including Ireland.<sup>48</sup>

Australia's visa costs are typically higher than other countries.<sup>49</sup>

## Assessments

English proficiency: The UK<sup>50</sup> and NZ<sup>51</sup> have revised their requirements for internationally-qualified nurses and midwives (IQNMs), including lowering minimum scores for the writing section of the IELTS from 7.0 to 6.5. In the UK, language requirements for nurses are also changing.<sup>52</sup>

Clinical exams: Canada has transitioned medical registration examinations online, with some examinations available in over 80 countries.<sup>53</sup>

The UK Health and Care Professions Council (which regulates 15 professions) only administers competence assessments to applicants assessed as having particular deficiencies, meaning only 1-2% are required to undergo further assessments.<sup>54</sup> Assessments are tailored to only test identified deficiencies.

Australia requires applicants (except for the Competent Authority Pathway) to complete skills and knowledge competence assessments. Clinical assessments are only available in person for some professions, requiring applicants to travel to Australia. They are also offered at infrequent intervals. Some assessments are duplicated by other government agencies and/or employers.

## One stop shops and removing duplication

NZ has introduced a 'one-stop-shop' where healthcare workers can search for jobs, apply for registration and find information on the visa process.<sup>55</sup>

Ontario has removed the need to demonstrate English competency for its registration of IMGs.<sup>56</sup>

In the UK, if an applicant achieves registration, there is no English language requirement for obtaining a visa. Other common requirements are aligned.<sup>57</sup>

Australia is seeking to better coordinate its registration and accreditation processes. Some local concierge services are offered to assist candidates in navigating end-to-end processes (e.g. Western NSW LHD centralised recruitment model,<sup>58</sup> 'Community Connector Program' in Shepparton<sup>59</sup>).



# Competent Authority Pathways

Some overseas health practitioners are eligible for a streamlined registration experience utilising competent authority pathways

Our international peers adopt a range of approaches that Australia could consider for longer term development

	Competent Authority Pathways (CAPs)	Comparable Health System Pathways (CHSPs)
<b>Description</b>	<ul style="list-style-type: none"> <li>Some NRAS entities recognise trusted overseas bodies as 'competent' to perform certain functions, such as health practitioner education and assessment. Applicants assessed by these 'competent authorities' are considered to have met the same clinical knowledge and skills standards as Australian practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>Some countries use a comparable health system pathway rather than the 'competent authority' model.</li> <li>They recognise overseas health systems as 'comparable' based on similar public health systems, practice environments and registration indicators.</li> </ul>
<b>Examples</b>	<ul style="list-style-type: none"> <li>The Medical Board of Australia (MBA) currently recognises six overseas bodies as competent authorities for assessing IMG medical knowledge and clinical skills (Canada, Ireland, NZ, UK, and two US bodies).</li> <li>The Nursing and Midwifery Board of Australia (NMBA) considers nursing qualifications from Canada, Hong Kong, Ireland, the UK and USA as 'substantially equivalent' to approved Australian qualifications.</li> </ul>	<ul style="list-style-type: none"> <li>The Medical Council of New Zealand (MCNZ) currently recognises 23 countries with comparable health systems in addition to recognising two competent authorities for assessing IMG medical knowledge and clinical skills (UK and Ireland).</li> <li>IMGs can use this pathway to gain provisional general MCNZ registration without the need for further exams.</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>CAPs can streamline registration. An applicant entering through a CAP does not need to sit additional knowledge or clinical exams. IMGs are still required to undergo a period of supervision before unrestricted registration.</li> <li>The competent authorities approach allows regulators to recognise certain overseas regulators as high-quality and equivalent, even in countries where the general health system may not be seen as comparable.</li> </ul>	<ul style="list-style-type: none"> <li>CHSPs allow regulators to recognise more skilled IQHPs who have gained registration in comparable systems, who may be otherwise excluded if they gained their primary qualification in a non-comparable country.</li> </ul>
<b>Risks</b>	<ul style="list-style-type: none"> <li>Few countries and professions are currently considered equivalent to Australian standards. Assessment of CAPs can be slow and costly. There are no specialist IMG CAPs.</li> <li>May result in inconsistencies (e.g. recognising certain authorities while excluding others in the same jurisdiction).</li> </ul>	<ul style="list-style-type: none"> <li>Requires continued confidence in practitioner registration standards and clinical practice standards in the comparable health system.</li> <li>Monitoring multiple systems for changes in quality can be complex and resource-intensive.</li> </ul>

# **c. What we heard**

# Stakeholder engagement

## Overview

109

### Stakeholder meetings

The Secretariat met with system regulators, accreditors, employers (public and private), recruiters, peak bodies, government agencies, academics, insurers, think tanks and international regulators.

35

### Targeted consultations

The Secretariat heard from 35 stakeholders to gather ideas for reform and understand issues from the perspective of private employers, state health Chief Executives and representatives from associations of regulated professions, among others.

6

### Focus groups

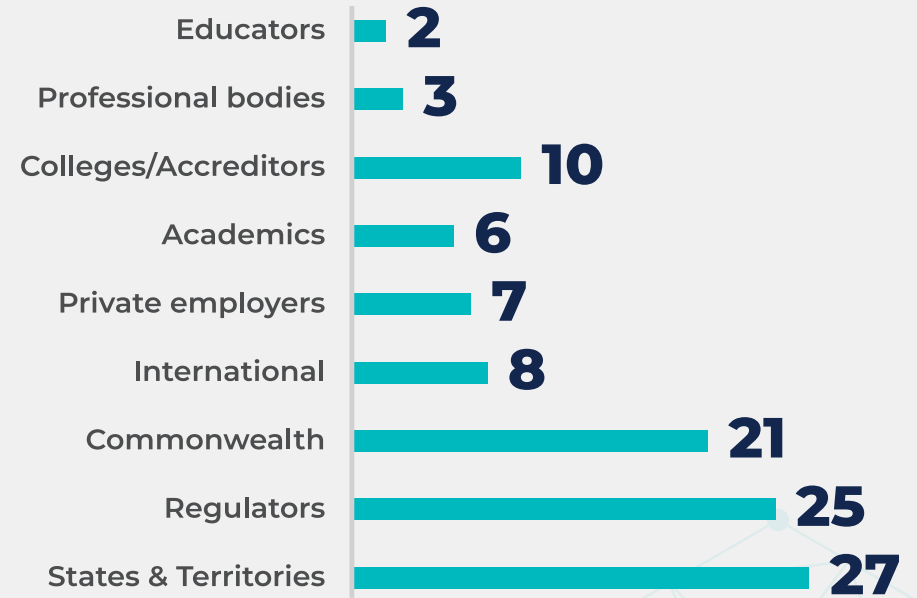
The Review facilitated focus groups with employers and IQHPs who had recently been through the immigration and registration processes.

1310

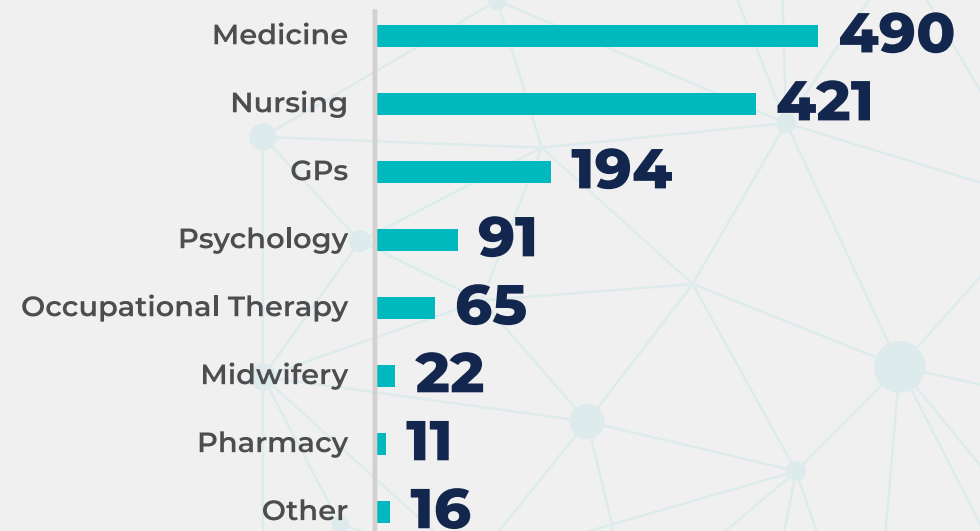
### IQHP survey respondents

The Review surveyed IQHPs who were registered or had commenced the registration process in the last five years.

## Stakeholder meetings



## Survey respondents



# What we heard

## Shortages

- States and territories identify significant shortages in nursing, midwifery and medicine, both for GPs and specialists. Shortages are generally more acute at experienced and senior levels.
- Regional and rural areas are particularly lacking anaesthetists, obstetricians and other specialists.
- Specialist workforces in smaller states and territories are vulnerable to the loss of only one or two specialists – leaving significant gaps.
- The most common allied health shortages are in occupational therapy, psychology, pharmacy and physiotherapy.

## Opportunities

- Ensure the process delivers health care practitioners who meet appropriate levels of safety and quality.
- Provide documentation and certification once.
- Provide case management support for applicants and employers.
- Establish alternative pathways such as bridging programs.
- Recognise more countries with comparable health systems and education providers as eligible for accelerated registration.
- Adopt a whole-of-system commitment to building the national health workforce.

# Health Departments

**“** *Complex and sluggish system which does not support timely recruitment and which may place Australia at a competitive disadvantage with other countries with more agile and streamlined registration and qualification assessment systems.*

**“** *There needs to be a concerted effort to find ways to support decision-makers with better data and information to guide workforce pipelines and planning.*

**“** *For a mid-senior level clinician with an established practice and settled family in their country of origin it takes a great deal of commitment from both the employing facility and the applicant to relocate to Australia.*

**“** *NSW workforce modelling to 2040 shows that under all scenarios there is a need to increase the number of doctors coming to NSW...*

**“** *Complex processes and multiple organisations involved in the assessment and recognition of qualifications and experience of overseas-trained health practitioners, resulting in delays and inefficiencies.*

**“** *It is complex, time-consuming, costly, and unnecessarily difficult for overseas practitioners to gain recognition and qualification in Australia.*

**“** *The process is much tougher than comparable countries with no guarantee of success.*

**“** *For both employers and prospective overseas employees, these processes, lack transparency around assessment, are difficult to administer and difficult to navigate.*

# What we heard

## Employers



# What we heard

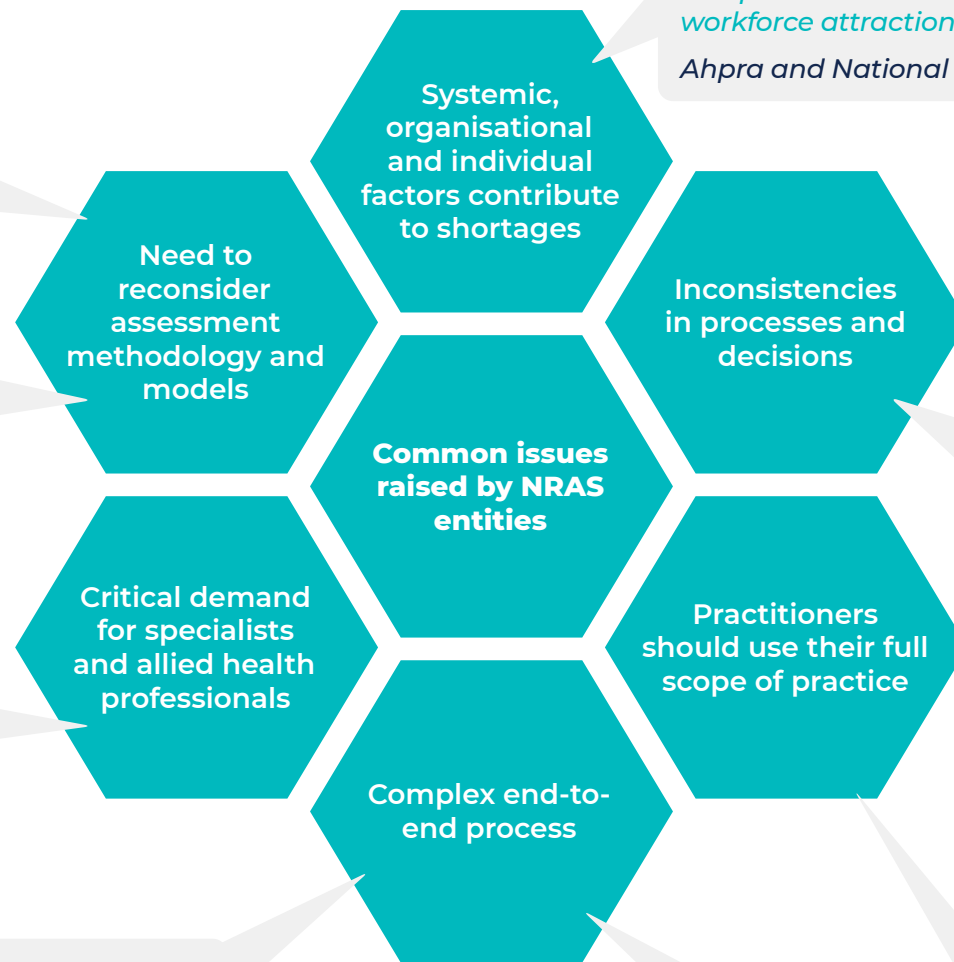
## NRAS entities (Ahpra, National Boards and Accreditation Authorities)

“ Other models for the assessment of IMGs should be considered for development and implementation in Australia. Experience is an important factor in assessing whether an SIMG meets the standard of competence.   
 AMC

“ While the assessments are robust, the assessment methodology should be revised to ensure it is still appropriate and contemporary.   
 Australian College of Rural and Remote Medicine

“ Many families comment on the difficulty in accessing allied health, psychologists, psychiatrists and paediatricians. For example, all private paediatricians in Tasmania have closed their books (i.e. no waiting lists available).   
 Ahpra Community Advisory Council (CAC)

“ It is difficult to get an accurate picture of the timeframes of the whole end-to-end process for applicants. There are significant opportunities to improve the experience and process for IQHPs by re-engineering the system as a whole.   
 Ahpra and National Boards



“ Factors at the systemic, organisational and individual level compound to create challenges in workforce attraction and retention.   
 Ahpra and National Boards

“ There are good reasons to amend the process. Arguably the strongest reason is the inconsistency between colleges in both process and decision about whether an SIMG is comparable. Data from the Deloitte report undertaken in 2018, commissioned by the MBA and Ahpra demonstrated that there was apparent inconsistency between colleges in the proportion of SIMGs assessed as being substantially comparable. Subsequently, the MBA has set standards for SIMG assessment. However, data still shows some apparent inconsistency.   
 AMC

“ The complexity for applicants comes with navigation of the multiple agencies undertaking different components of the end-to-end process. It is not always clear, even to accreditation authorities... where accurate information on other stages of the process can be sourced. Health Professions Accreditation Collaborative Forum (HPACF)

“ We note that some health practitioners can be prevented by others from working to their full scope in the name of “patient safety”, however as consumer representatives we contend that denying patient access to a health practitioner that is trained, qualified and registered to treat them in that aspect is a greater impediment to patient safety.   
 Ahpra CAC

# What we heard

## Other stakeholders

“ It is critical that information is publicly available regarding the associated costs of National Scheme activities, and that there is transparency regarding the rationale for these charges. The NHPO similarly agrees that a Cost Recovery Implementation Statement (CRIS) for relevant activities would assist with ensuring this transparency.  
National Health Practitioner Ombudsman (NHPO)

“ If the visa wait exceeds the expiry of the APC skills assessment or English Language tests, the applicant is required to repeat the exams and pay the fees twice. The cost for sitting an IELTS exam is \$395 and the cost for an entire KAPS assessment is \$3,500  
Pharmacy Guild of Australia

“ Enhanced disclosure and transparency of planning arrangements to better align the efforts and needs of government, industry, regulators, health and higher education sectors. This would provide market and planning guidance to the higher education sector, regulatory bodies, Home Affairs, the jurisdictions and industry.  
Anonymous submission



“ With the current trajectory and trends seen in the medical (and health) workforce it appears we are unlikely to achieve domestic self-sufficiency in the short and medium term.  
Anonymous submission

“ Rural communities have fewer registered nurses, midwives, pharmacists, dentists, optometrists, psychologists, physiotherapists, podiatrists, occupational therapists and other allied health workers. Rural areas need an additional 21,357 FTE personnel in these professions to match major cities on a per-population basis.  
National Rural Health Alliance

“ Develop a fast-track pathway for highly experienced clinicians... This would enable businesses certainty in their recruitment and workforce planning and provide an appealing option for experienced candidates.  
Occupational Therapy Australia (OTA)





# **d. What we can do**



# Current and future state regulatory performance

	Current State	Future State
Risk-Based	<p>Experienced and junior overseas health practitioners are largely assessed similarly despite differences in risk<sup>60</sup></p> <p>There are a limited number of comparable qualifications and pathways for registration in areas of need. There are no fast pathways for medical specialists. Practitioners registering via CAPs must still undergo supervised practice or training<sup>61</sup></p> <p>Regulator capability and capacity to respond to changes in health care demands could be enhanced<sup>62</sup></p> <p>Regulators' access to and use of data to inform risk-based decisions about overseas practitioners could be improved<sup>63</sup></p> <p>Ahpra and National Boards periodically consult on and review registration standards<sup>64</sup></p>	<p>Regulators assess overseas health practitioners on the basis of risk, informed by greater use of intelligence and data</p> <p>Comparable pathways for registration in areas of greatest need (e.g. medical specialists) are expanded, and skills and experience, in addition to qualifications, are explicitly included when assessing clinical competence</p> <p>Regulators and their staff have the capability to consider risks in day-to-day decision-making</p> <p>Regulators work with governments to actively monitor and plan for changes to regulatory strategies and approaches needed to respond to changes in health care demands</p>
Transparent	<p>Regulators set both the assessment standards and fees for assessments of overseas practitioners and concerns are often raised about fees and costs (i.e. amount and variability among regulators)<sup>65</sup></p> <p>The internal process for assessing applicants can be unclear and lack transparency. Employers have noted that outcomes can vary for applicants within the same country<sup>66</sup></p> <p>The performance of regulators is variable, including the time between application and interview, exam or decision<sup>67</sup></p> <p>Information for applicants (e.g. about processing timeframes) is sometimes absent or difficult to find and interpret – and there is a lack of real-time updates for applicants on the progress of applications<sup>68</sup></p>	<p>Clear information is available about rationale for compliance costs – and there is more effective oversight of decisions to increase fees of all regulators</p> <p>Regulators regularly engage with stakeholders (practitioners, other regulators and the community) on development of, and reporting against, meaningful performance measures</p> <p>Regulators provide guidance and information that is relevant, clear, concise and accessible to help practitioners understand requirements</p> <p>Regulators are transparent in decision-making and provide sufficiently detailed reasons for decisions</p> <p>Regulators regularly seek out and use stakeholder feedback to inform processes, information available and decisions</p>





# Current and future state regulatory performance

	Current State	Future State
<b>Accountable</b>	Despite Ahpra and National Boards publishing quarterly and annual reports, there is a lack of routine and sufficiently detailed data on performance of most regulatory bodies. Oversight of fees and performance could be strengthened <sup>69</sup>	Regulators regularly publish detailed performance benchmarks and information, such as processing times, to ensure they are held to account for their performance
	The process is fragmented, with multiple agencies involved, which reduces accountability for the end-to-end process <sup>70</sup>	Expectations of governments on regulators is made clear – including as expectations change with changes in health care demands
	Expectations of governments on regulators may be unclear <sup>71</sup>	Review processes are cheaper and easier to access
	Regulators are not directly accountable for maximising the availability of overseas health practitioners and minimising compliance costs on practitioners and employers <sup>72</sup>	More diverse skills-base on National Boards
	Review processes are often expensive and difficult to access <sup>73</sup>	
	Health Ministers appoint the maximum allowable proportion of health professionals, which may reduce accountability and the regulatory skills available to draw upon	
<b>Stewardship and continuous improvement</b>	No one body is accountable for the end-to-end journey of overseas health practitioners	Regulators foster a culture of continuous improvement and reflection (e.g. by implementing rigorous ex-post reviews of decisions to identify learnings and explore opportunities for improvement)
	Regulators may have limited line-of-sight to how their actions affect the system and broader health outcomes	Regulators actively build staff capability and culture to embed a stewardship and continuous improvement mindset
	Regulators may not have the power, capability or capacity to be effective stewards of the system and support continuous improvement	Regulators undertake regular performance reviews to drive continuous improvement, including by benchmarking performance against, and sharing learnings with, other regulators to identify best practice
	Regulators do not always have visibility of the broader reform agenda, such as changing models of care and overseas health workforce needed now and in the future, to inform their decisions	Regulators minimise duplication and harmonise activities with other regulators to achieve better regulatory outcomes
		Regulators take into account the cumulative burden of the end-to-end regulatory process and system



# Improve the applicant experience

I

## Requiring action now

### Submit all documentation for registration and migration through a single portal

- » I1 - The Ministerial Council to provide a Ministerial Direction to Ahpra, the National Boards and their Accreditation Authorities to make clear the governments' expectation that they will deliver a streamlined, end-to-end registration system.
- » I2 - All jurisdictions, relevant Commonwealth agencies (e.g. DoHA, Services Australia), Ahpra and the National Boards to remove duplication and align evidentiary requirements, with information shared across regulators and agencies so that applicants are only required to submit documents once. Over time, these entities should collaborate on a single digital portal that can be used to share information seamlessly across regulators – making it easier for applicants to navigate the end-to-end process and centralise document collection.

### Automate and/or streamline application steps

- » I3 - The Australian Government to prioritise and accelerate work underway to share registration and migration information between Ahpra and DoHA to streamline arrangements and reduce duplicative requirements. This would:
  - remove the need for Ahpra to check domestic criminal history when an applicant has never been to Australia, once verified through DoHA;
  - remove the need for candidates to complete an in-person ID check before commencing registration;
  - remove the need for a separate English language testing requirement for migration purposes;
  - allow overseas practitioners to apply for criminal

history checks before arriving in Australia; and

- integrate criminal history checks with visa processing and credentialling.
- » I4 - The Australian Government to prioritise and accelerate an IT project to automate the MPN process by providing an end-to-end digital system, removing the need for manual processing, and reducing the timeframe to issue a MPN to 24-48 hours from registration.

### Remove migration barriers

- » I5 - The Australian Government to remove or suspend labour market testing requirements for employers sponsoring overseas health practitioners on certain visa classes where the registered profession is a high priority and on a skilled occupation list.
- » I6 - The Australian Government to broaden the age exemptions for permanent skilled visas to encompass more workers in key health professions (similar to the current treatment for academics and ICT specialists).
- » I7 - The Australian Government to allow key health practitioners to perform higher duties or tasks that do not fall under their nominated Australian and New Zealand Standard Classification of Occupations (ANZSCO) (required for a visa) but are similar to their current role, without a new nomination, as long as it is agreed by the visa holder and employer. Alternatively, visas could be granted to a health practitioner tied to a three digit 'Minor Group' ANZSCO code, to allow for the same flexibility.
- » I8 - DoHA, working together with Department of Employment and Workplace Relations and DoHAC, to review the health occupations on the skilled occupation lists and provide any

recommended changes to the Minister for Immigration no later than end-August 2023.

### Provide more support to applicants

- » I9 - Where possible, centralise back-end support within and across jurisdictions to drive efficiencies and reduce costly competition for the same workforce. Local communities would retain a role in welcoming, supporting and retaining their workforce.

## Areas for development

### Remove migration barriers

- » I10 - The Australian Government to consider granting automatic permanent residency to international students who are currently in Australia studying, or recently graduated with, a priority health qualification, where evidence of employment is provided.
- » I11 - The Australian Government to consider removing or suspending the Skilling Australia Fund levy for key health professions, noting the significant community benefit gained from the services provided by these professions and the current lack of domestic workers to fill these gaps.
- » I12 - The Australian Government to examine broadening visa categories to allow health professionals to work to their full scope of practice.

### Provide more support to applicants

- » I13 - Ahpra to create a single point of contact (e.g. case managers) so skilled migrants can understand where they are in the process of their skills assessment, registration and visa with ease.

# Expand 'fast track' pathways

F

## Requiring action now

### Expand competent authority pathways

- » F1 - The Ministerial Council to provide a Ministerial Direction to Ahpra, the National Boards and their Accreditation Authorities to make available more expedited registration pathways (including competent authority) so that applicants from comparable health systems and professions experience streamlined requirements and processes.
- » F2 – National Boards to provide urgent advice to the Ministerial Council identifying 'probable' and 'possible' trusted competent countries/authorities for key professions in shortage as soon as is practical. This advice should be based on evidence and best practice to allow a greater number of health practitioners to move through competent authority pathways.
  - By mid-2024, all key professions in shortage should have expanded the number of competent authority pathways.
  - Where no competent pathway currently exist, such as for medical specialists, Ahpra and the MBA should introduce pilots in the highest priority specialisations as a first step toward expanding to other specialities and countries.
  - For example, Ahpra and the MBA to pilot and evaluate a competent authority pathway for general practice to recognise United Kingdom and New Zealand fellowship qualifications for up to 24 months.
- » F3 - National Boards to develop and publish a list of fully and partially equivalent university qualifications and programs for each profession (similar to medicine).
- » F4 - Ahpra and the National Boards to develop and publish annually a forward work program for assessing the expansion of the number of competent authorities and country pathways for professions in areas of need.

### Transition equivalence assessments from specialist colleges to AMC

- » F5 - The assessments of equivalence for specialist international medical graduates (SIMGs) to be transitioned from the specialist colleges to the AMC. The MBA, Ahpra and the AMC should determine the transition path and timeline in consultation with specialist colleges, given their ongoing advisory role.

### Better recognise overseas health practitioner experience and skills

- » F6 - Explicitly allow relevant skills and experience to be included when assessing clinical competency, not just qualifications, by amending the *Health Practitioners Regulation National Law* enacted in each state and territory.
- » F7 - Ahpra, the National Boards and specialist colleges to increase the use of existing powers to provide limited registration and fellowship for highly skilled and experienced health practitioners who wish to work to a limited scope of practice.

### Target scarce supervisory resources to where they are most needed

- » F8 - In consultation with professions and employers, Ahpra and the National Boards to provide options for developing and funding online modules and a mentoring model to help overseas health practitioners understand the Australian system and context, reporting back to Health Ministers in late 2023. Online modules should be accessible prior to moving to Australia and could be repeated as many times as needed.

### Strategic workforce partnerships

- » F9 - The Australian Government to consider adding health into free trade agreement (FTA) negotiations with India. The sector to be consulted as part of this process.

### Areas for development

#### Expand competent authority pathways

- » F10 - The Australian Government to explore removing the exemption for medicine from the *Trans-Tasman Mutual Recognition Act 1997*. It is implemented through mirror legislation in Commonwealth of Australia, the Australian States and Territories, and New Zealand.
- » F11 - In line with developments towards mutual recognition in other skilled professions, Ahpra and the National Boards could explore options to remove skills assessment requirements (including qualification checks) entirely for health practitioners accredited and registered and held in 'good standing' by trusted overseas authorities.
- » F12 - Ahpra and the National Boards to review the settings of comparable countries to identify opportunities to fast-track recognition of registration, experience and qualifications, starting with countries

recognised by our trusted overseas partners (authorities or jurisdictions) and countries that are currently the main source of migrants for each profession.

- » F13 - Ahpra and National Boards to introduce a competent pathway for psychology, pharmacy, paramedicine and occupational therapy.
- » F14 - The MBA, working together with the AMC, to explore providing a pathway to specialist registration for specialist IMGs working in Australia under the short-term training pathway.

### Target scarce supervisory resources to where they are most needed

- » F15 - The National Boards could explore greater use of remote supervision.
  - Canada allows almost all supervision of physicians to be provided remotely.

### Strategic workforce partnerships

- » F16 - While maintaining the right to regulate for a public interest purpose, the Australian Government could push for further health liberalisation to be included in World Trade Organisation (WTO) service agreements and future relevant FTAs.
- » F17 - The Australian Government, working with industry and the higher education sector, to consider developing strategic alliances with respected health training facilities in the Indo-Pacific region to assist them in meeting Australian standards, with recognised pathways into the Australian health market – where such alliances are agreed between governments as being mutually beneficial.
  - Consider the development of bridging units to build practitioner capability to the full Australian standard scope of practice, that can be targeted at identified gaps in major source countries.
  - Australia's accreditation bodies, building on higher education partnerships, could assist in the building of in-country capacity of their local accreditation bodies, so that over time standards and processes would align with Australian standards. This would effectively expand the 'competent authority' model to more countries.



# Improve workforce planning

## Requiring action now

### Quantify workforce, skills and distributional issues

- » W1 – To inform workforce planning and provide market guidance and certainty to service providers, DoHAC to continue workforce supply and demand modelling for medicine (generally and by specialty) and nursing, and commence work with states and territories and relevant stakeholders to address gaps in allied health workforce data to facilitate supply and demand modelling in the future.
  - States and territories to facilitate all necessary health workforce data to flow to the Commonwealth, including coordinated legislative and regulatory change, if necessary, to be analysed and integrated in workforce supply and demand modelling.
  - DoHAC to provide further information to the Review (for incorporation into the final report) about the recent ‘allied health’ data gap analysis and what might be done in the short and medium term to address data availability for workforce modelling.

### Help industry and service providers to better plan

- » W2 – By end-June 2023, Ahpra, professions, employers and governments to determine performance indicators of progress in the recruitment of more overseas health practitioners, especially in areas of greatest need, over the next two years while workforce strategies are developed.

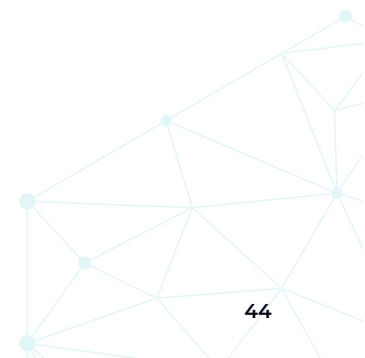
### Inform the development of national cross-sectoral workforce strategies

- » W3 – DoHAC, working with states and territories and the professions, to continue and where possible expedite development of national workforce strategies for nursing and midwifery.
- » W4 – DoHAC, working in consultation with states and territories and relevant professions, to collaborate through Health Ministers on framing and development of a national workforce strategy for allied health to facilitate planning, and a whole of health workforce chapeau strategy to integrate and coordinate cross-cutting themes and provide for effective multi-disciplinary workforce planning and development of integrated models of care.

## Areas for further development

### Inform the development of national cross-sectoral workforce strategies

- » W5 – Commonwealth, states and territories and employers to explore the scope for rotating new overseas health practitioners between metropolitan, regional and rural locations as a way of addressing distributional challenges and helping them develop networks. Current conditions on visas and access to Medicare benefits may limit rotations.



# Greater flexibility, while supporting safety

S

## Requiring action now

### Expand testing options and access for applicants

- » S1 – National Boards to develop online knowledge examination capability, where benefits can be established.
- » S2 – Ahpra, together with the relevant National Boards and Accreditation Authorities, to develop multi-disciplinary testing centres, with the first location to be based in Melbourne or Sydney (indicative cost \$2.5-\$2.6m).
- » S3 – The NMBA to provide an additional 500 places for OSCE for nurses and midwives in 2023 (indicative cost \$2.3-\$2.5m).

### Align evidentiary requirements

- » S4 – DoHA and Ahpra to align the skills assessment test for migration and registration so each applicant's skills and qualifications are assessed and verified once.
- » S5 – DoHA to ensure applicants who are required to demonstrate English language proficiency are tested only once during the application process by recognising an English language test undertaken for registration.
- » S6 – An applicant should be able to authorise Ahpra to request a Certificate of Good Standing or Certificate of Registration Status on their behalf from overseas registration authorities in jurisdictions where they are or have previously been registered.

### Make modest evidence-based changes to English language requirements

- » S7 – Regulators and agencies to expand the

range of test results that overseas students can use to meet the English Language Standard post study.

- » S8 – National Boards to align the English standard with international practice by reducing the International English Language Testing System (IELTS) test standard for written English from 7 to 6.5. The minimum scores for the other three components – reading, speaking and listening – would remain at 7 and an average of 7 overall would be required.
  - based on IELTS test results from the year to February 2023, this modest change could improve the success rate from 26% to 40% of test takers.
- » S9 – National Boards to expand the range of countries recognised as English language jurisdictions, based on evidence.

### Consider greater flexibility to demonstrate recency of practice

- » S10 – Ahpra and the National Boards to assess recency of practice at the time an application is submitted to ensure applicants are not penalised for processes and delays that are beyond their control.
- » S11 – Ahpra to work together with the National Boards to allow greater flexibility for overseas health practitioners to meet recency of practice requirements, so long as they have met a minimum level of clinical experience in a comparable health setting.
  - National Boards to report back to Health Ministers on minimum clinical experience requirements based on evidence of clinical outcomes and best practice within 12

months.

## Areas for development

### Expand testing options and access for applicants

- » S12 – National Boards to explore the development of online clinical examination and offshore assessment capability, where benefits can be established.

### Consider greater flexibility to demonstrate recency of practice

- » S13 – National Boards review and consult on their mandatory recency of practice standards.

### Make modest evidence-based changes to English language requirements

- » S14 – The Australian Government, working with Ahpra and the National Boards, to align the National Scheme English Language Standard to New Zealand where beneficial, to encourage candidates to apply for registration directly in Australia, rather than registering in New Zealand and subsequently using the Trans-Tasman Mutual Recognition Agreement (TTMRA) to register in Australia.
  - This would improve workforce supply and the applicant experience.
- » S15 – The National Boards to consider applicants who completed an approved program of study to have automatically met the English Language Standard requirements and would not need to take any tests or provide other evidence of proficiency.

# Enhance regulator performance and stewardship



## Requiring action now

### Performance standards and benchmarks are transparent and publicly available

- » P1 - The Ministerial Council to issue a Ministerial Direction and explanatory memorandum setting out expectations for regulator performance and stewardship for all NRAS entities.
  - The Ministerial Direction should include a requirement that registration and accreditation standards and regulatory decisions of Ahpra, National Boards and Accreditation Authorities are founded on principles of regulatory best practice (including stewardship, transparency, accountability and continuous improvement) and take sufficient account of, and balance risks associated with, workforce supply and demand and patient safety, so that all Australians can access appropriate and safe health care when required.

### Regulatory settings are appropriate and reflect best practice

- » P2 - Ahpra, in consultation with the professions and employers, to identify and promote examples of best practice across the regulatory system.
- » P3 - The Final Report to articulate best practice regulatory performance principles specific to the NRAS.
  - The Commonwealth's Regulator Performance Guide sets out expectations for best practice performance through three principles:

1. Continuous improvement and trust.
2. Risk-based and data-driven approach.
3. Collaboration and management.

- States and territories have developed similar guidance for their regulators which could be drawn upon by the Review.

## Areas for development

### Collaborate in the best interests of the community and adopt a continuous improvement mindset

- » P4 - The Ministerial Council to strengthen the stewardship role to be played by NRAS regulators to ensure they are sufficiently supporting the applicant's transition through the various touchpoints in the end-to-end process, and clearly outline the standards of competency required and what is needed to expedite the process.
  - The Ministerial Council to consider broadening Ahpra's remit to include a role of 'Chief Steward', with responsibility for supporting a bottom-up approach to development and oversight of a framework to implement a stewardship approach in the NRAS.

### Focus regulators, agencies and governments on reducing applicant costs

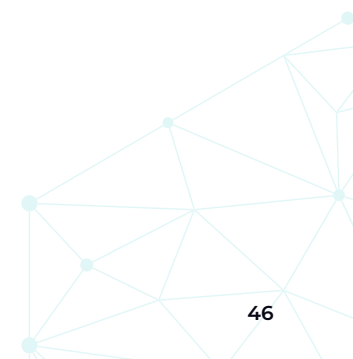
- » P5 - The Ministerial Council to ensure the National Boards and Accreditation Authorities are subject to effective oversight, governance arrangements and have the capability needed. Oversight bodies should have the authority to:
  - issue and enforce compliance with policies, procedures, standards and reporting

requirements relating to fees, governance, overseas health practitioner assessments, and performance more broadly and which align with Government expectations of regulators (e.g. Charging Framework and Regulator Performance Framework);

- conduct regular reviews of fees levied by regulators, with advice (including on fee changes) provided to the Ministerial Council; and
- provide advice to the Ministerial Council on Board composition.

### Promote greater transparency and accountability

- » P6 - The Ministerial Council to consider the benefits of a move to a more skills-based Board membership, as part of a broader consideration of governance roles and responsibilities.







# Improve the applicant experience

Remove duplicative regulatory checks and align visa and registration processes so applicants only need to 'tell us once'

## Recommendations

Requiring action now: I1, 2, 3, 4 and 9

Areas for further development: I13

### A system designed without the user in the centre

- The current system is fragmented with no single place to find information. It is not designed with the user at its centre or a party responsible for the end-to-end system.
- It can be difficult for an applicant to discover where their application is up to in the process or to receive timely advice if their application is missing key supporting documentation.

### Duplicative processes could be addressed through better alignment and information sharing

- Processing times across the whole end-to-end journey are historically lengthy, given the sequential nature of the registration, visa and Medicare processes and the time taken to complete each discrete stage.
- There is duplication and a mismatch of requirements across the registration, skills accreditation, and visa processes – particularly in relation to skills assessments, English language and criminal history requirements and identity checks.
  - In several professions, the skills assessment for migration is undertaken by a different entity than the one for registration, leaving some applicants in limbo.
- Ahpra and the Department of Home Affairs (DoHA) currently do not share data.
- This creates needless costs, such as overseas applicants being required to complete an in-person ID check ahead of starting the registration process, and applicants that have never been to Australia required to provide an Australian residential address.

### A lack of coordination can lead to increased system costs

- In the absence of a national approach to market, there is intense competition between and within states and territories to fill key skill shortages.
- An uncoordinated approach to market raises costs for all and exacerbates distributional issues.

### Applicant support systems can help applicants navigate the process

- Other countries, such as Canada and New Zealand, provide concierge services, which can include help in providing employment and accommodation and information on living and working in the country.
- Some local communities and employers provide these services as a point of differentiation.

“ Home affairs can accept you for skilled migration but then you get stuck in a registration hurdle and you can't work. Don't they talk to each other. **focus group participant** ”

“ Ahpra and the council make me upload the same documents... I have to submit to Home Affairs as well. Sometimes one will accept a document, then another body will reject it. Surely, they can talk to each other. **focus group participant** ”



# Improve the applicant experience

Remove unnecessary costs and barriers from the visa process, while allowing experienced practitioners to move to Australia permanently

## Recommendations

Requiring action now: I5, 6, 7 and 8

Areas for further development: I10, 11 and 12

### Market testing is an unnecessary burden on employees and communities in need

- Current labour market testing requirements for certain visa classes (e.g., Skilled Employer Sponsored Regional (Provisional) visa (subclass 494)) are unnecessarily onerous given these visas are only available to individuals able to work in occupations on the skills list, and that health has been identified as a priority area for visa processing.
- Current testing requirements delay employment by around three months.
- Risks are low that health professionals will replace Australian jobs given skills shortages are widespread (including globally) and some skills (such as specialists) are scarce.

“ [Labour market testing] for employer sponsored visas is a major reason for blockages. It can cause a three months delay.<sup>74</sup> Grattan Institute

### Age restrictions exclude the highly experienced practitioners our health system needs

- Most permanent Australian visas are generally only available to individuals under 45 years of age, which means many senior health practitioners are ineligible.
- In an increasingly competitive market for global health talent, employers are reporting that practitioners are unwilling to move on a temporary visa.
- Many skilled health practitioners do not achieve full credentials until their 40s – and tend to retire later – and play key roles as mentors and supervisors for domestic and international graduates in areas of key shortage.

“ I felt like I was being totally disrespected. I have 20 years experience in a comparable health system, but because of some document or bit of paper, I was told I must observe for at least 3 months. focus group participant

### Linking visas to a narrowly-defined occupation code limits workforce mobility

- The skilled occupations list identifies occupations at a detailed 5-digit level under ANZSCO.
- The ANZSCO codes limit flexibility for employers and health practitioners to upskill and move to areas of need as they cannot perform duties or tasks beyond their nominated ANZSCO occupation without a new nomination, except on a temporary basis. This has the effect of limiting some health professionals from working to their full scope of practice.

“ Everyone wants to come over on a permanent residency visa. And if we don't give it to them, they will go somewhere else where they can get it.<sup>75</sup> Western NSW LHD

### The Skilling Australians Fund levy compounds high costs to employers

- Employers must pay a training contribution charge on skilled visas – the Skilling Australians Fund (SAF) levy – to contribute to the broader skills development of Australians. The levy increases the costs of recruiting overseas health practitioners.
- Employers cannot pass the SAF levy on to the visa applicant. The levy, which depends on size of business and visa type, can be up to \$1,800 per person per year or \$5,000 as a one-off payment.
- The benefits to skill development of the domestic workforce are likely outweighed by the social costs of imposing the SAF in areas of key health shortage. The SAF acts like a tax on health care services, particularly non-government services struggling to find suitable employees.

# Expand 'fast track' pathways

Recognising trusted overseas regulatory systems can increase access to health services at low risk

## Recommendations

**Requiring action now:** F1, 2, 3, 4 and 5

**Areas for further development:** F10, 11, 12, 13 and 14

### 'Fast-track' competent pathways are available to few countries and in fewer professions

- Requiring applicants from countries or institutions with trusted comparable health systems and standards to complete a skills assessment test/s is disproportionate to the risk posed to safety and quality of care. Testing should be required only from countries or institutions that are partially or non-comparable. Recognising trusted overseas regulatory systems can 'fast track' approvals without compromising safety or quality of care.
- The list of countries where skills are recognised without the need for testing – typically NZ, the UK, USA, Canada, and Ireland – is relatively small compared to our international peers. The limited number of equivalent countries is a lost opportunity as it discourages highly competent and skilled international health practitioners from filling key skill shortages. It also contributes to perceptions of unfairness, as well as increasing costs and delays for low-risk applicants.
- Relevant Board and professional accreditation bodies currently determine which countries or institutions are eligible for this pathway. Health practitioners ineligible for a competent authority pathway face a lengthy and complex process to registration and skills accreditation, as well as incurring higher costs.
- Allied health professions have few competent authority pathways, limiting the international workforce available (for example, there are no competent authority pathways for occupational therapists).
- Medicine has five competent authority countries (USA, UK, Canada, NZ, and Ireland), while nursing has six equivalent countries (USA, UK, Canada, NZ, Ireland, and Hong Kong). There are no competent pathways for medical specialists.

“ Consistent stakeholder feedback has indicated that the end-to-end processing of health professionals from offshore and onshore immigration processing to full professional registration is currently designed to frustrate and thwart the efforts and determination of health professionals wanting to relocate and practice in Australia, and of those clinicians who are working in Australia towards ensuring safe access and relocation of health professionals for communities.<sup>76</sup> **National Rural Health Alliance**

### Centralising equivalence assessments should improve consistency and reduce costs

- Specialist medical colleges undertake an assessment to determine the comparability of an IMGs qualifications and training against those of Australian trained specialists/fellows. Accreditation functions are delegated to these third party bodies by the MBA, with the outcome critical to the decision to grant registration under the specialist or area of need pathway.
- The comparability assessments are costly, with fees varying between colleges, and are often slow, resulting in significant registration delays.
- The transfer of comparability assessments from specialist medical colleges to the Australian Medical Council (AMC) would retain a key role for colleges – who would still be required to supply documentation, standards for assessment and curriculum – but could drive greater consistency in performance and outcomes and reduce costs.

### Other low-risk opportunities to fast track applicants should be explored

- The *Trans-Tasman Mutual Recognition Act 1997* (TTMRA) facilitates the free movements of people in registered occupations between Australia and New Zealand. While the TTMRA covers nurses, medical practitioners are excluded.
  - Doctors with primary medical qualifications obtained in New Zealand are automatically granted general registration in Australia and vice-versa under separate arrangements, so it is only overseas trained doctors whose registration is not mutually recognised.
  - The fact that overseas trained doctors need to meet New Zealand's registration requirements means any risks are low.
- Specialists IMGs working in Australia under the short-term training pathway – which involves supervision – do not have a pathway to registration and must return home after two years.
  - This increases costs and turnover of specialists with experience in the Australian health system.

# Expand 'fast track' pathways

Better target regulatory resources to where they're most needed and increase system flexibility to attract the world's best health talent

## Recommendations

Requiring action now: F6, 7 and 8

Areas for further development: F15

### Our occupational licensing regime shuts out the most experienced practitioners

- Health practitioners normally specialise as their career progresses, which may limit their ability to obtain fellowships or full registration when it is linked to knowledge assessed at the entrant level or broad recent practice experience.
- These applicants often need to do further study and/or sit exams to qualify for fellowship by the medical colleges.
- Fellowships are required for overseas health practitioners to obtain senior positions in Australia and are rarely granted to highly experienced and skilled health practitioners who have specialised in a narrow scope of practice.
- The limited use of restrictive registrations makes it difficult to attract and retain specialist global talent.

### Mid-career professionals expect their skills and experience to be recognised

- Applicants from most countries need to pass knowledge and clinical exams set at the entrant level before being registered, if not covered by a competent authority pathway.
- Where required, assessments designed to establish competency and/or equivalence should include all relevant information, including qualification, skills and experience.
- The focus on qualifications or exams means many experienced mid-career and specialised health professionals, with valuable competencies in key skill shortage areas, may struggle to meet, and question the value of, requirements.
- Together with the limited use of restricted registrations and age caps on permanent residency, it has the effect of biasing the overseas health workforce to a younger and relatively less-experienced cohort.
- Support will still be required to understand the Australian system, including the importance of cultural competence and safety, as well as the rules of the Medicare and pharmaceutical benefit systems.

**“** You hear it everyday. There's shortages of GPs, clinics are closing, patients are dying, but there is absolutely no willingness to change the system from what we've seen. **”**  
*focus group participant*

### Supervision is a powerful regulatory intervention to address practitioner gaps

- Supervision is an important tool available to familiarise an overseas health practitioner to the Australian health care system (e.g. Medicare) and obtain cultural competency.
  - For example, all specialist GPs are required to undergo a minimum six month supervision period under limited registration before obtaining specialist registration.
- The lack of available supervisors, especially in regional and remote areas, limits the ability to train and register both domestic and internationally qualified health practitioners.
- In a risk-based regulatory system, regulatory resources should be targeted where they are most needed – to mitigate risks and build practitioner capability. This means that health practitioners assessed as low risk should require no or minimal supervision, while practitioners deemed higher risk are supported with greater supervision.

**“** Supervision requirements for experienced practitioners can be very challenging. A standard short term supervision requirement of 3 months should generally be sufficient for the majority of experienced practitioners. **”**  
*survey respondent*

# Expand 'fast track' pathways

Strategic partnerships with our Indo-Pacific neighbours offers mutual benefits

## Recommendations

Requiring action now: F9

Areas for further development: F16 and 17

### Australia could play a leading role in building health capacity in our region

- In line with developments in other professions and in comparable countries, Australia could play a leading role in improving standards in our region by reducing barriers to the international movement of health practitioners.
- Health has not been identified as a priority area for the international service and trade agreements.
- Free trade agreements (FTAs) provide an opportunity to facilitate the freer movement of labour and mutually recognise qualifications, registration and fellowships and streamline processes.
  - Negotiations are currently underway with India, which is the top source country for international medical graduates.
  - Australia maintains a broad right to regulate health services in the public interest. This is a long-standing practice to ensure successive Australian governments retain policy flexibility to respond to public health issues as they arise, and is consistent with common practice globally. There is strong public support for maintaining this policy flexibility.
- Trade commitments that facilitate the movement of skilled workers, including those in the health sector, only apply to temporary entry and would therefore not of themselves facilitate long-term or permanent access to the health workforce.
- However, FTAs provide some scope to advance the streamlining of the recognition of professional qualifications and licensing processes to better facilitate the two-way movement of health professionals, including through mutual recognition and related services subsector specific arrangements.

- This recruitment should be done in accordance with the World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel. The Code establishes and promotes principles and practices for the ethical international recruitment of health personnel and discourages active recruitment from countries with critical health workforce shortages.
- The development of longer-term strategic partnerships with key source countries could have multiple benefits including:
  - capacity building in partner countries – with overseas higher education providers offering Australian standard qualifications;
  - more stable and predictable labour supply in the longer term; and
  - enhanced regional security efforts, by providing trade opportunities that increase the resilience of economies in partner countries.

# 300,000

An estimate of the number of nurses and midwives that India is looking to export to global health systems<sup>77</sup>

# Improve workforce planning

Australia has some world-leading data sets that could be better utilised to inform planning, policy and evaluation

## Recommendations

Requiring action now: W1, 2, 3, and 4

Areas for further development: W5

### Publicly available modelling of shortages is essential to meet future demand

- Critical shortages are reported in nursing, midwifery, medicine, occupational therapy, speech pathology; amongst others.
- Publicly available aggregate and geographic data is needed for each profession to better plan for and respond to current and future workforce needs. This data would include the domestic workforce pipeline and other care sectors that compete for the same labour and skills, including aged, disability and social care.
- DoHAC is currently updating modelling to estimate the extent of shortages for medicine (generally and by speciality). Work is nearing completion of a sophisticated and peer reviewed supply and demand model for the GP workforce, with publishable data (including projected workforce shortages) and an interactive online platform for GP workforce planning expected in the third quarter of 2023.
- Psychiatry is the second specialty to be modelled and integrated into the planning platform – with current resourcing modelling likely to be completed in late 2024. Other specialties will be modelled and integrated to the platform over time as resources allow.
- A nurse supply and demand study is underway, and will likely be completed and integrated into the planning platform by end-2023.

“ There is a need for better national datasets that quantify the workforce, skills and distribution issues.<sup>78</sup> **Ahpra**

“ Access to timely, quality data readily available to governments and decision makers about health workforce forecasting (skills available, community needs, opportunities for adaptation, standard demographics etc) is an issue.<sup>80</sup> **WA Department of Health**

- DoHAC is also commencing work with states and territories and relevant stakeholders to identify gaps in workforce data that would allow for allied health to be modelled in the future. This needs to include the impacts of aged, disability and private providers to be meaningful, and be published and updated regularly to provide market and planning guidance to the affected sectors.
- A national workforce strategy exists for medicine to guide long-term workforce planning but not for other health professions.
- DoHAC is working with states and territories to develop a national workforce strategies for nursing and midwifery.
- There is no strategy for allied health.

“ Initial data suggests it can take IMGs who pass exams up to two years to secure employment. This has flow on impacts for the rural medical workforce and access to health care for rural communities. While the reasons for this are unclear, possible systems barriers include... the availability of supervisors in Modified Monash 3-7.<sup>79</sup> **Australian Medical Association**

### Provide more diverse opportunities for overseas health practitioners

- Rotations allow health practitioners to gain broad experience, better networks and familiarity with various health settings.
- There are few opportunities for overseas health practitioners to rotate through regional, rural and remote areas during their period of supervision, especially in the medical specialities.
- This limited exposure reduces the likelihood of these practitioners pursuing job opportunities outside of metropolitan areas.

# Greater flexibility, while supporting safety

Increasing testing options and access will increase Australia's international competitiveness

## Recommendations

Requiring action now: S1, 2 and 3

Areas for further development: Nil

### Testing arrangements put Australia at a competitive disadvantage

- Overseas health practitioners from non-competent pathways will typically sit a knowledge and clinical exam.
- Current testing facilities have limited capacity, are difficult to access and can be costly.
- For example, Adelaide has the only testing facility offering the clinical test for nursing and midwives. The test is run five times a year and a candidate is required to pay a re-sit fee (equivalent to the original) if they are unsuccessful in passing.
- To achieve general registration through the standard pathway, a GP and/or an employer on their behalf will need to spend around \$9,000 on knowledge and clinical exams run by the AMC and a Pre-employment Structured Clinical Interview (PESCI) offered through one of three accredited providers.
- GPs required to sit the PESCI can wait months for a spot to become available.
- Comparable countries offer clinical exams at more locations, on a more regular basis, and typically at lower cost.
- Where benefits can be established, testing should be available online and/or offshore to increase access and minimise unnecessary candidate costs incurred through travel.

# \$4,000

The cost for a 'Stream B' Nurse or Midwife to sit the Objective Structured Clinical Exam.<sup>83</sup> The cost to a Nurse or Midwife in comparable countries is a 1/10<sup>th</sup> (Canada) to a 1/3<sup>rd</sup> (UK) of this.

*“ You spend \$3000 to do the AMC MCQ and are given little official guidance. There's no feeling they want to help you succeed... Where's the money actually going to. focus group participant*

# 12

The number of weeks typically taken to complete a bridging course for an overseas-trained nurse<sup>81</sup>

# 7

The number of locations in the United Kingdom where overseas-trained nurses can undertake the OSCE-equivalent<sup>82</sup>

# Greater flexibility, while supporting safety

Increase flexibility for applicants to demonstrate registration requirements, without lowering standards

## Recommendations

**Requiring action now:** S4, 5, 6, 7, 8, 9, 10 and 11  
**Areas for further development:** S12, 13, 14 and 15

### Current English language proficiency requirements are inefficient and onerous

- Australians expect their health practitioners to be proficient in English. However, duplicative and inflexible options for demonstrating competency impose unnecessary costs on applicants and limit the pool of safe workers without improving community standards of patient safety or quality of care.
- Requiring practitioners who have been educated in English, or have worked in a health system where English is the majority spoken language, to provide further evidence of English language proficiency is disproportionate to the risk.
- International health practitioners are required to meet the English language registration standard for their profession and the English language requirements for visa purposes. The requirements differ, with the registration standard being higher, and there is no current capacity for the DoHA to accept the registration test.
- NZ and the UK have greater flexibility in meeting these requirements and exempt a wider group of people from needing to undertake these tests.
- Evidence should drive recognition of English language proficiency. The written proficiency standards should be based on what is required to provide safe and quality health services.

“ I’m trying to employ an exceptional ICU nurse with almost 20 years working in the UK, but because she can’t find her Bangladeshi high school certificate, Ahpra will not accept her as comparable. Its ridiculous when the system is in crisis.  
*focus group participant* ”

### 7 The number of countries (all Anglo-sphere) typically exempt from sitting English language tests

#### Experience and clinical exams should be able to substitute for recency of practice evidence

- A practitioner is required to demonstrate recency of practice as a way of ensuring the currency of their clinical knowledge and skills.
- Recency of practice requirements have not kept pace with international best practice and can delay the employment of overseas health practitioners with legitimate reasons for not being able to meet the requirements (e.g. research sabbatical, extended caring leave, sickness/illness resulting in time off work).
- Many comparable countries have either reduced or removed their recency of practice requirements, recognising that overall clinical experience and/or clinical exams are better indicators of competence, and that the systems between countries varies.
- In some cases, practitioners who meet the recency of practice requirements at the time of submitting their application for registration subsequently lose their recency of practice status whilst waiting for their application to be processed by the relevant authorities.

#### Ahpra should be able to conduct probity checks on an applicant’s behalf, with their consent

- As part of the ‘suitability’ or probity check stage component of the registration assessment, applicants must provide a Certificate of Good Standing or Certificate of Registration Status from the registration authority in every jurisdiction in which they are, or have previously been, registered as a health practitioner.
- These Certificates are only valid for three months, meaning they can expire while an applicant awaits the outcome of other steps in the process.



# Enhance regulator performance and stewardship

A stewardship approach to regulation would provide for better collective management of the entire system

## Recommendations

Requiring action now: P1

Areas for further development: P4

### A stewardship approach would increase regulatory responsiveness

- Regulatory settings and practice impact directly on the supply of health practitioners and health outcomes for the community. Poorly designed and maintained regulatory systems not only increase the burden of regulatory entities, but have impacts on the supply of health practitioners in Australia.
- There is limited evidence that entities in the National Registration and Accreditation Scheme (NRAS) are currently incentivised, or have sufficient capability to consider how their regulatory activity and decisions affect the system as a whole and health outcomes for the community.
  - Regulators who are too risk adverse may not manage risk in a way that aligns with best practice. Current regulatory settings and regulators have largely taken a 'set and forget' approach to managing risk.
  - NRAS entities often lack the capability required to support such a best-practice approach and have limited ability to respond with agility to inevitable changes in the health system and workforce requirements.
- If adopted by the constituent entities of the NRAS, a 'stewardship' approach to regulation would likely provide better collective management of the entire foreign health practitioner regulatory system they manage on behalf of the Australian public.

“ It is not apparent data and intelligence forms the basis of assessing risk in relation to registration and qualification assessment decisions.<sup>84</sup> **NT Health**

“ Medical Colleges have a vested interest in controlling the number of specialist practitioners practising in Australia. There needs to be credible, open and transparent information about health workforce needs that can challenge or support how these organisations are responding to the need for workforce.<sup>85</sup> **WA Department of Health**

- Regulatory stewards need to be proactive and move beyond a compliance-based approach to regulatory management. Regulators have collective responsibility and accountability to ensure government's cumulative footprint is as small as possible, but as large as necessary. A stewardship approach is a central component to delivering fit for purpose, proportionate and risk-based regulation for effective and efficient government services.
- Stewards consult and communicate with each other, and seek to understand the entire regulatory system from the user perspective. Stewards rely on evidence to guide regulatory settings.
- As stewards of the system, regulators should monitor and evaluate the effectiveness of the regulatory settings and tools over time and be prepared (and have the capability to) change priorities or the tools they use.

“ While the current regulatory settings ensure the recruitment of high-quality healthcare professionals, Ahpra, the MBA and the Specialist Colleges appear to be working independently to achieve this at the expense of establishing regulatory settings and processes to respond to the critical need for an adequate supply and equitable distribution of international healthcare workers in Australia.<sup>86</sup> **Victoria Health**

# Enhance regulator performance and stewardship

A stewardship approach to regulation would provide for better collective management of the entire system

## Recommendations

Requiring action now: P2 and 3

Areas for further development: P5 and 6

### The regulatory system should be best-practice, fit-for-purpose and superior to comparable countries

- Some regulatory practices that are features of the NRAS depart from best practice principles developed by the Commonwealth and states and territories, and commonly expected of high-performing regulators.
- Ahpra and National Boards publish considerable information about fees and allocate costs based on an activity based costing methodology. However, there are some entities involved in regulation, for example Colleges, in which the fee setting is less transparent and contestable.
- There is insufficient regulatory expertise within some of the NRAS entities, with Boards largely comprised of health practitioners with clinical expertise.
- There is a lack of accountability and transparency in the self-assessment of performance of Boards and accreditation authorities – and existing performance measures lack the specificity required for a valid assessment of performance. There is insufficient separation between Ahpra and the Boards and accreditation authorities to support reliable performance assessments.
- Different accountabilities are needed for regulatory functions that seek to meet the health care demands of the community, compared to those focussed securing supply capability. Greater consideration needs to be given to the NRAS entities best placed to undertake each activity and whether existing mechanisms provide for effective oversight of these functions.

“ Establish effective governance and accountability arrangements between health services, state, and commonwealth departments, Ahpra, AMC, MBA Medical schools, specialist colleges with a commitment to build the supply of healthcare workers and support equitable workforce distribution without not compromising quality or safety standards.<sup>90</sup> **Victoria Health**

“ There is an inextricable link between the accreditation of health profession education and registration of practitioners. The reform of one must retain a high level of trust by the other. Nonetheless, these two regulatory functions require different expertise and, at least in the case of accreditation, there needs be a formal process by which cross-profession efficiency improvements and innovation can be driven.<sup>87</sup> **Woods (2017)**

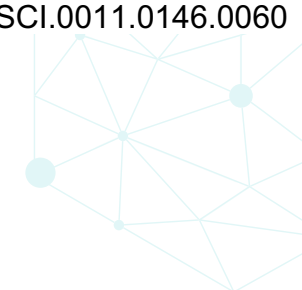
“ Current Medical Board of Australia reporting and on the ground recruitment experience highlights a significant disparity in assessment outcomes of specialists between colleges. There are a number of colleges which very rarely find an international specialist to be substantially comparable despite training and working in similar health systems.<sup>89</sup> **TAS Health**

“ The most significant issue with the employment of the IMG cohort is the timeframes and communications involved from the Australian Health Practitioner Regulation Agency (Ahpra). The current key performance indicator (KPI) is related to the date all documentation is received (i.e. 90 days). This appears to rarely be met.<sup>88</sup> **ACT Health**



# Glossary

Ahpra	Australian Health Practitioner Regulation Agency	MBS	Medical Benefits Schedule
Accreditation	Assessment of education and training courses to determine whether applicants have the knowledge, skills and professional attributes necessary to practise the profession <sup>1</sup>	MCNZ	Medical Council of New Zealand
Accreditation Authority	Committees and Councils that are assigned the accreditation function by National Boards <sup>2</sup>	MCQ	Multiple Choice Question
Accreditation Functions	Include developing accreditation standards, accrediting programs of study against approved accreditation standards and assessing overseas-qualified practitioners <sup>3</sup>	Ministerial Council	Health Ministers (previously the COAG Health Council)
AIHW	Australian Institute of Health and Welfare	MP	Medical Practitioner
Allied Health	Health professionals that are not part of the medical, dental or nursing professions <sup>3,5</sup>	MPN	Medical Provider Number
AMA	Australian Medical Association	MPS	Medical Benefits Schedule
AMC	Australian Medical Council	National Board(s)	National Health Practitioner Board
ANMAC	Australian Nursing and Midwifery Accreditation Council	National Scheme	National Registration and Accreditation Scheme
ANZCO	Australian and New Zealand Standard Classification of Occupations	NDIS	National Disability Insurance Scheme
CAC	AHPRA's Community Advisory Council	NHPO	National Health Practitioner Ombudsman
CAPs	Competent Authority Pathways – streamlined pathway to registration that does not involve additional exams <sup>4</sup>	NMBA	Nursing and Midwifery Board of Australia
CoGS	Certificate of good standing	NRAS	National Registration and Accreditation Scheme
CHSP	Comparable health system pathways	NSC	National Skills Commission
Competent Authority	International authorities recognised as competent to assess knowledge and skills of practitioners for registration <sup>5</sup>	NZ	New Zealand
CRIS	Cost Recovery Impact Statement	OECD	Organisation for Economic Co-operation and Development
DoHA	Department of Home Affairs	OSCE	Objective Structured Clinical Exams (Nursing)
DoHAC	Department of Health and Aged Care	OTA	Occupational Therapy Australia
EU	European Union	Overseas Health Practitioner	Health practitioners trained overseas and international students who have studied in Australia <sup>6</sup>
FTA	Free Trade Agreement	PBS	Pharmaceutical Benefits Scheme
GP	General Practitioner	PESCI	Pre-employment Structured Clinical Interview (Medicine)
HPACF	Health Professions Accreditation Collaborative Forum	Registration	Granted by National Boards once standards and policies are met
HWA	Health Workforce Australia	Registration standard	Define the requirements that applicants need to meet to be registered
ICU	Intensive Care Unit	SAF	Skilling Australia Fund
IELTS	International English Language Testing System	SIMG	Specialist International Medical Graduate
IMG	International Medical Graduate	Specialist	Medical practitioner with qualification in a field of specialty practice and a protected specialist title
IQHP	Internationally Qualified Health Practitioner	Specialist Medical College/College	Accreditation authority and education provider for specialist registration in Medicine. Assesses overseas trained specialist
IQNM	Internationally Qualified Nurse and Midwife	TTMRA	<i>Trans-Tasman Mutual Recognition Act 1997</i>
LHD	Local Health District	UK	United Kingdom
MBA	Medical Board of Australia	USA	United States of America
		WHO	World Health Organisation



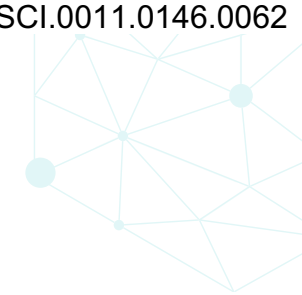
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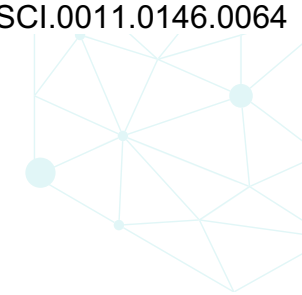
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# e. Appendix



# Appendix 1 - Terms of reference

## Background

On 30 September 2022, National Cabinet announced an independently-led, rapid review of the regulatory settings relating to health practitioner registration and qualification recognition for overseas trained health professionals and international students who have studied in Australia. These regulatory settings will be compared to those for Australian trained health professionals to ensure that unreasonable additional requirements or standards are not being applied to overseas trained professionals.

Health Ministers from each state and territory and the Commonwealth oversee the National Registration and Accreditation Scheme (the National Scheme) under the Health Practitioner Regulation National Law (the National Law), adopted by each state and territory. The National Scheme is designed to protect public safety by ensuring that all regulated health professionals are registered against consistent, high-quality, national professional standards. The Objectives of the National Law include the facilitation of rigorous and responsive assessment of overseas trained practitioners and access to services provided by health practitioners in accordance with public interest.<sup>^</sup> The Australian Health Practitioner Regulation Agency (Ahpra) works in partnership with 15 National Boards to implement the National Scheme, managing the registration and renewal processes for local and overseas qualified health practitioners, in accordance with the National Law.

The Review is independent from, but complementary to, the work National Cabinet has asked Ahpra to undertake. The Review links with the work of the Health Workforce Taskforce commissioned by the Health Ministers' Meeting, the Improving Care Pathways Taskforce commissioned by National Cabinet and the objectives and outcomes from the Jobs and Skills Summit.

## Purpose

Australia is facing a shortage of key healthcare workers, which has been heightened by the COVID-19 pandemic and is expected to continue as Australia's population ages.

To ensure that hospitals and the health system can meet demand and deliver high-quality and timely health services, National Cabinet recognises that Australia needs to supplement, in the short to medium term, the domestically trained health workforce with skilled health practitioners from overseas.

To achieve this in a highly competitive global market, our regulatory settings need to be fit for purpose, comparable to similar countries and not impose unnecessary barriers or compliance costs on migrants and employers, while preserving patient safety standards.

## Scope

The Review will deliver short-term recommendations for actions which can be implemented within 12 months to ease skills

shortages in key health professions, including nursing and midwifery, medicine, psychology, pharmacy, paramedicine, occupational therapy, and any others identified as part of the Review.

This Review will include consideration of:

- streamlining existing competent authority pathways to registration and extending these to more health professions
- streamlining and integrating with other processes that impact on the workforce, such as visa application processes, credentialing processes and Medicare provider number application processes
- the costs of training and qualification for international health workers.

The Review will also include consideration of regulatory settings in comparable overseas jurisdictions to identify best practice and opportunities for Australia to streamline and strengthen processes and settings and support global worker mobility.

The Review will report back to National Cabinet with initial recommendations for agreement in early 2023 and deliver final recommendations by mid-2023.

## Key principles

The Review will be informed by the following key principles:

<sup>^</sup> Health Practitioner Regulation National Law Act 2009, Section 3 (2), <http://www.legislation.qld.gov.au/view/whole/html/inforce/current/act-2009-045>





# Terms of reference - cont

1. Australia's health practitioner registration and skills and qualification regulatory system should require overseas trained and domestically trained health professionals to meet the same standards.
2. Any requirements should be commensurate with risks, optimally managed and imposed in the least complex way.
3. Quality and safety standards designed to protect patients must be maintained, without unnecessarily restricting health workforce supply.
4. Regulatory settings should signal Australia as an attractive destination for internationally qualified health practitioners and not discourage recruitment and retention of global talent.
5. Migration should not be used as a substitute for developing and employing a domestically-trained workforce.

appropriate support to ensure the success of the Review.

The Review will consult Ahpra and regularly update and seek input from states and territories through the Health Ministers' Meeting, First Secretaries Group, Health Chief Executives Forum and First Deputies Group.

The Review will engage with a broad range of other relevant stakeholders to ensure recommendations are practical, implementable and can deliver the health workforce Australia needs to ensure high-quality and timely health services. The Review Lead may also seek independent advice and analysis on any matter within the Review scope, and may consider convening an advisory panel of experts and/or holding public consultations for this purpose.

## Review Lead and consultation

The Review will be led by an eminent individual with relevant experience in health and regulatory policy. The Reviewer Lead will be supported by a secretariat of officials from the Australian Government Department of Health and Aged Care and the Australian Government Department of Finance.

The Review is strongly supported by state and territory governments, which are responsible for the legislative framework for health practitioner regulation, and each government will provide