Independent review of Australia's regulatory settings relating to overseas health practitioners

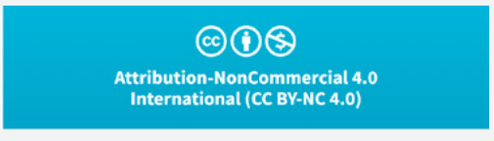
FINAL REPORT

Robyn Kruk AO

Correction Notice

Please note that a correction has been made to page 55 of this report since it was initially published. The text as initially published suggested the National Health Practitioner Ombudsman (NHPO) review of accreditation processes has concluded and made recommendations. This has been amended to clarify that the NHPO review has not concluded and any future recommendations are under consideration.

ISBN: 978-1-925537-96-3 (print)
ISBN: 978-1-925537-97-0 (online)



Material used 'as supplied'

Provided you have not modified or transformed the material in any way (including, for example, by changing the text, calculating percentage changes, graphing or charting data, or deriving new statistics from published statistics), the Department of Finance prefers the following attribution:

Source: Overseas Health Practitioner Regulatory Settings Review - Final Report, 2023

Use of the Coat of Arms

The terms under which the Coat of Arms can be used are set out on the Department of the Prime Minister and Cabinet website: pmc.gov.au/government/commonwealth-coat-arms.

Accessing this report online

regulatoryreform.gov.au

Independent review of Australia's regulatory settings relating to overseas health practitioners

FINAL REPORT

Robyn Kruk AO

Contents

Foreword		1
Executive Summary		3
1.	Case for change	18
2.	Health system and workforce context	36
3.	Key reforms to improve the end-to-end journey	41
4.	Economic impact assessment	76
5.	Implementation	81
Appendix A. Terms of reference		84
Appendix B. Engagement and consultation		86
Appendix C. Extinguished recommendations from interim report		91
Appendix D. Journey maps – Current state		93
Appendix E. Comparative study of existing registration pathways		96
Appendix F. Recent improvements that are underway		99
Appendix G. Ethical recruitment		102
Appendix H - Regulatory best practice principles for NRAS entities		103
Appendix I - Abbreviations		104
Appendix J - Glossary		105
Acknowledgements		106
References		107

Foreword

Australians reasonably expect to be able to access timely, high quality and safe health care, regardless of where they live. Australia compares favourably with other developed countries in relation to the number of registered health practitioners per person.[1] Yet the reality is too many Australians, especially those living in regional and remote areas, are finding it increasingly difficult to access healthcare. Ongoing shortages of registered health practitioners are leading to:

- some communities not having access to a general practitioner, nurse-led clinic, or dental or mental health services within a 60 minute drive[2]
- key health services, including dental and maternity services, being closed in some communities[3]
- wait times to see some medical specialists exceeding 4 years[4]
- National Disability Insurance Scheme clients waiting up to 2 years to see allied health professionals.[5]

Shortages are widespread across medicine, nursing and midwifery, and allied health professions, including dentistry, occupational therapy, physiotherapy, psychology, and radiation therapy. This puts pressure on our health system and health, aged and disability care workforces and threatens health outcomes.[6]

Australia has a strong and enduring commitment to growing and supporting its domestic health workforce to meet the needs of all communities. Internationally qualified health practitioners already supplement the domestic health workforce, filling critical workforce gaps in some of our most remote and rural locations.[7]

On 30 September 2022, National Cabinet announced a review acknowledging the pressures on the health workforce during and after the COVID-19 pandemic and amid growing concern about shortages.[8] The review sought to ensure that our regulatory settings for the registration and recognition of qualifications of internationally qualified health practitioners are fit for purpose. They must not impose unnecessary barriers or costs on practitioners and employers, while ensuring safety and quality of care. This will make it easier for Australia to attract appropriately skilled health practitioners and ensure we can compete in a strong global market.

Through our consultations, we heard 2 resounding messages about the problem and the preferred approach.

First, stakeholders strongly affirmed the nature of shortages, the poor distribution of health practitioners and impacts of shortages on communities and the existing health workforce. They stressed the need for urgent action to address shortages, including immediately increasing the number of internationally qualified health practitioners in the short term, while continuing to grow the domestic workforce over time.

Second, applicants and employers view the current end-to-end journey – which includes navigating registration, migration, Medicare and employment requirements – as inefficient, complex, costly and slow. General practitioners surveyed by the review told us they spend up to 2 years navigating this journey and most incur more than $33,000 in costs. Most nurses took more than a year before they were ready to practise and spent more than $20,000.[9] The experience is frustrating, duplicative, and demeaning, particularly for experienced, mid-career and specialised practitioners.[10]

Australian governments, the Australian Health Practitioner Regulation Agency, National Boards and Accreditation Authorities are already taking action to streamline processes and improve the experience of applicants. While this is welcome, it is unlikely to provide the number of internationally qualified health practitioners or the necessary mix of skills and experience at the speed they are needed. More needs to be done to build on and accelerate this work, while ensuring domestic and internationally qualified health practitioners continue to meet high professional standards.

Foreword - continued

The end-to-end journey needs to be efficient and able to adjust to changing models of care, workforce needs and technological developments, such as the ability to provide health services remotely. Regulatory settings must be aligned to government, applicant and community needs, and be evidence based and proportionate to risks to safety and quality of care.

Prioritising and sequencing the implementation of the recommendations will maximise benefits in the short to medium term. Feedback also highlighted the importance of ensuring we meet our needs without actively recruiting from countries with critical health workforce shortages.

Considerable improvement is possible through enhancing and accelerating existing systems and processes, given the shared commitment and sense of urgency from Australian governments, regulators and the professions. If sufficient improvements are not made within ministerially determined timeframes, then escalation measures, including reconsidering the roles and responsibilities of key decision makers and improving other aspects of the broader system, may be required.

Additional upfront funding by Australian governments is required to accelerate the development of expedited registration pathways for medical specialists, including general practitioners, and improve systems, performance and workforce data. There are constraints on funding the reforms by raising registration and related fees, as fee increases may adversely affect our ability to compete in a global market.

Timely and resourced implementation of health and migration related measures is critical for success. The review welcomes strong support and commitment from National Cabinet and health ministers. The complexity and significance of the proposed changes will require ongoing collaboration to maintain momentum and realise significant health and economic benefits.

The review would not have been possible without the support of health ministers; Commonwealth, state and territory officials; practitioners; regulatory bodies; professional groups; and employers. My special thanks to the Secretariat, led by Ms Ruth Gabbitas, comprising staff from the Australian Government Department of Finance and the Department of Health and Aged Care.

Robyn Kruk AO

Independent Reviewer

August 2023

Executive Summary

Australia is facing a shortage of key healthcare practitioners, putting the health system and existing workforce under pressure. In the short to medium term, Australia needs more skilled health practitioners – including from overseas – to ensure Australians can access high quality, timely and appropriate care.

Recognising this, National Cabinet announced an independently led, rapid review of Australia's regulatory settings for the registration of overseas health practitioners and recognition of their skills and qualifications.

The review was commissioned to ensure that regulatory settings are fit for purpose, comparable with similar countries and do not impose unnecessary barriers or costs on applicants and employers, ensuring safety and quality care.

The review is independent from, but complements, other work commissioned by Australian governments. These include the Review of the Migration System and efforts to grow the domestic health and care workforces.

The challenge

Australia's healthcare system is widely regarded as one of the best in the world.[11] This is in large part due to our health workforce, which is one of the most highly educated among member countries in the Organisation for Economic Cooperation and Development (OECD).[12] The workforce plays a critical role in enabling more than 26 million Australians to access quality healthcare services. More than 850,000 health practitioners are registered in Australia – a record high.[13]

Between 1 January 2022 and 31 July 2023, more than 27,000 internationally qualified health practitioners (IQHPs) were registered to practise for the first time in Australia. This includes almost 16,000 nurses and midwives, nearly 6,000 doctors, and more than 5,000 allied health professionals.[14]

Despite this, our healthcare system faces challenges. The ongoing impact of COVID-19 peaks, a growing and ageing population, rising levels of chronic conditions, differences in local needs, and workers wanting more flexibility are increasing pressure on service delivery. Wait times to access critical health services are high. In New South Wales, one in 10 people are waiting around 160 days for semi-urgent elective surgery and more than 20 hours in emergency departments.[15] Wait times mean some people are missing out on care.[16]

Employment in the Australian health care and social assistance industry – which includes medical practitioners, nurses, midwives and allied health professionals – is projected to grow by 301,000 (or 15.8%) over the 5 years to November 2026.[17] Such employment growth will be stronger than in the past and is projected for other industries.

Many experienced healthcare staff will retire or leave the sector over the next decade.[18] This will increase pressure on remaining staff.

There are **shortages in all states and territories** despite efforts to increase the workforce. Many public and private employers are struggling to recruit health practitioners, with around 44% of vacancies remaining unfilled.[19] The Queensland Government projects it will need an extra 37,000 health workers over the next 10 years.[20] Priority areas identified by states and territories include general practitioners (GPs), nurses, midwives, dentists, occupational therapists, physiotherapists, psychologists and radiation therapists. The review did not identify a current or projected shortage of paramedics.

Shortages also exist in the self regulated health professions, particularly in occupations with fast growing demand, such as speech pathology and social work. These professions often work alongside registered health practitioners in the health, aged and disability care sectors. Pressure in one part of the economy nearly always has an impact on service delivery in other parts.

Shortages are particularly acute in distinct locations and care settings, and key specialties. People living in regional, rural and remote areas find it harder to access many forms of care.[21] Some people do not have access to basic health services, such as GPs, nurses and mental health professionals, within a 60 minute drive. This means people miss out on or need to travel long distances to access care, increasing their expense. In many areas, some health practitioners, including paediatricians, occupational therapists and psychologists, are no longer accepting new patients.[22]

Workforce shortages contribute to reduced access to care, increased workloads for health practitioners, overuse of higher cost services (such as locums and emergency care) and poorer patient outcomes.

Australia is not unique in facing challenges in securing sufficient health practitioners. The demand for the global health workforce is growing substantially, with a shortage of more than 18 million health workers predicted by 2030.[23] Given such widespread demand, we must meet our needs without actively recruiting from countries with critical health workforce shortages. Australia can collaborate with other countries to build capacity in our region.

The lack of current, sectorally integrated, national, state and regional workforce data was highlighted as a priority for Australian governments, employers and regulators to assist with planning for current and future needs. This includes data on demand, supply, skills and location of health practitioners. The review was unable to identify an agreed and up to date set of data on the workforce. It pieces together the state of the workforce from the fragmented data available and feedback from professional bodies.

Australian trained practitioners are the bedrock, making up around 80% of our workforce.[24] Australian governments are committed to retaining and growing the domestic healthcare workforce. The Australian Government is strengthening Medicare and increasing the number of Commonwealth-supported places at universities for medical students.[25] Further, national, state, territory and regional workforce strategies exist for some key professions, with a commitment from health ministers to develop national nursing, maternity and allied health workforce strategies.

Australian governments are also looking to more effectively use and grow the skills of the existing health workforce. Examples include ensuring individuals work to their full scope of practice, enabling greater use of multidisciplinary teams, better coordinating and integrating acute and primary care, and using technology to deliver services and specialist care.

Despite such efforts, more IQHPs are urgently needed, especially experienced practitioners. IQHPs and international students who studied in Australia already play a key role in supplementing the Australian trained workforce. IQHPs improve the ability of Australians to access safe and appropriate care, increase productivity, foster innovation and lift Australia's level of economic growth.[26]

All registered health practitioners – Australian and internationally trained – must meet minimum national professional standards. Registration ensures that Australians can be confident of safe and quality care.

The key message from this review is that removing unnecessary regulatory barriers faced by IQHPs will improve care for Australians.

Key facts at a glance

Demand for health services

- Half of Aboriginal and Torres Strait Islander people wait 50 days for elective surgery.[27]
- Roughly 6% of people wait longer than 365 days for elective surgery.[28]
- Some people wait more than 500 days for elective surgery.[29]
- Around 40% of people wait at least 24 hours to see a GP for urgent care.[30]
- Four of the top 5 causes of burden of disease in Australia require ongoing support from multidisciplinary teams for effective prevention and management.[31]

Half of people wait at least **40 days** for elective surgery.[325]

Workforce supply and pipeline

- Around 860 more full time equivalent (FTE) GPs are needed now; and an extra 10,600 will be needed by 2031–32.[32]
- An estimated 2,869 more pharmacists will be needed by 2026.[33]
- More than a quarter of advertised roles in regional areas are for medical practitioners and nurses.[34]

An extra **13,000** medical practitioners, **40,000** nurses and **27,000** allied health professionals are **likely to be needed** by November 2026.[328]

44% of health professional vacancies were **unfilled** in June quarter 2023.[327]

- In 2021–22, Northern Territory Health reported almost one in 3 vacancies took longer than 6 weeks to fill.[35]
- Around 26% of GPs and 12% of nurses are aged 60 years or older.[36]
- In a recent survey around 71% of frontline health workers reported symptoms of severe or moderate burnout.[37]
- 21% of nurses and midwives working in hospitals indicated they intend to leave their current role within 12 months.[38]
- It takes between 10 and 15 years for a local GP to be fully trained.[39]

The **growth rates** for domestic enrolments in nursing, dentistry, psychology and medicine have **slowed or declined** in recent years.[326]

Skills and distribution

- There are 4 doctors per 1,000 people in Australia, which is higher than New Zealand, the United Kingdom and the United States. However, the Australian rate for doctors is lower than Germany, Norway, Sweden and Switzerland.[40]
- There are 12.8 nurses per 1000 people in Australia, a number that is only exceeded by Ireland, Norway and Switzerland.[41]

There were 41 potentially preventable hospitalisations per 1,000 people in remote areas compared with 21.9 in major cities.[329]

- The number of FTE GPs for every 100,000 people is 120.5 in major cities compared to 65.8 in very remote areas.[42]
- The number of medical specialists for every 100,000 people is 143.5 in major cities compared to 25.2 in very remote areas.[43]
- The number of occupational therapists for every 100,000 people is 74.1 in major cities compared to 23.7 in very remote areas.[44]

End-to-end journey for IQHPs*

- Occupational therapists take 48 to 135 weeks and spend up to $18,000.[45]
- Nurses and midwives take 21 to 91 weeks to be ready to practise and spend up to $34,000.[46]
- Psychologists take 59 to 126 weeks to be ready to practise and spend up to $30,500.
- Non-GP specialists take 26 to 105 weeks and spend up to $45,000.

GPs take 35 to 130 weeks to be ready to practise in Australia and they spend up to $51,000.[330]

*Note: The times reported above include the 25th and 75th percentile of recorded survey responses. The costs quoted represent the 75th percentile of recorded survey responses.

The current journey for IQHPs

The review undertook a comprehensive analysis of the end-to-end journey including conducting more than 200 stakeholder meetings and a survey of more than 1,700 IQHPs (see Appendix B for a summary of stakeholder engagement).

Feedback from IQHPs is that **the end-to-end journey is complex, costly and slow.** Applicants need to deal with many different regulators, including Australian Health Practitioner Regulation Agency (Ahpra), the Department of Home Affairs (DoHA) and Services Australia, one at a time. Too often they need to meet similar requirements and supply the same information multiple times to different regulators. For example, criminal history and qualifications are checked at least 3 times. This imposes unnecessary costs and delays on applicants. Some employers no longer consider applicants who are from countries ineligible for expedited registration pathways because of costs, uncertainty and delays.[47]

The analysis also highlighted the length and cost of the end-to-end journey, with differences across professions and pathways.

Applicants report that the assessments and regulatory processes are often difficult, with requirements that are unclear, onerous and lack transparency, and result in inconsistent outcomes. Processes can be frustrating, confusing, convoluted and duplicative.[48] Around 40% of IQHPs who responded to the survey felt that the journey negatively affected their mental health and wellbeing.

The delays and costs make it difficult for Australia to attract the best IQHPs, not just those with sufficient endurance to navigate the registration and visa processes. Additionally, overseas employers are increasingly seeking out and recruiting Australian health practitioners, including nurses and paramedics.

Practitioners who specialise can face particularly high barriers, despite being valuable to the Australian health system. Unlike graduates with recent exam experience, many struggle to demonstrate they meet the required standard. Almost half of IQHPs feel their prior professional and clinical experience is insufficiently recognised. For those who come, many need to work in more junior roles and receive lower pay for an initial period. Too often, applicants report that the process makes them feel undervalued, disrespected and even demeaned.

The review heard that Australia is often no longer the country of choice for IQHPs. Public and private health employers said mid-career and specialised practitioners are choosing not to come to Australia due to perceived barriers, costs and uncertainties in the migration and registration processes. In some cases, these practitioners are unable to have their qualifications, skills and experience recognised, so would need to retrain or undertake further study before they can be registered. As a result, Australia is limiting its ability to attract the most experienced and senior health practitioners.

Australian governments, professional bodies and regulators are aware of these problems and are working to improve the end-to-end journey. For example, Ahpra is digitising application forms and processes, while the DoHA is streamlining the processes and rules for the migration system. This report seeks to accelerate and expand on this work to improve health services for Australians.

Other countries have also streamlined and improved their end-to-end regulatory journeys for IQHPs. For example, almost all supervision for international medical graduate (IMGs) is virtual in Canada, and the United Kingdom is shifting from direct 'equivalence' of qualifications, to focusing on learning outcomes, skills and knowledge. Canada, Ireland, New Zealand and the United Kingdom offer lower cost visas.

Some stakeholders noted that it is easier, cheaper and faster for IQHPs to be registered in other comparable countries. As we are competing for health practitioners, we need to ensure our settings are internationally competitive.

Further information on the case for change and key background material on the health system and workforce are discussed in Chapters 1 and 2, respectively.

The future journey for IQHPs

This report provides **28 recommendations to improve the efficiency and effectiveness of the end-to-end regulatory journey.** They cover both health and related migration processes as they are highly interdependent. Concurrent implementation of these recommendations will increase the number of IQHPs able to join the health workforce in the next 6 to 18 months, with priority given to areas with the most significant shortages. They focus on enhancing current processes, while maintaining high standards of care.

The recommendations consolidate and prioritise the recommendations in the interim report, which was endorsed by National

Cabinet on 28 April 2023.[49] They also reflect feedback from health ministers, Australian, state and territory government departments, Ahpra, National Boards and other stakeholders. Based on this feedback and evidence provided to the review of work underway, several recommendations in the interim report have been excluded from this report (see Appendix C for a summary).

Recommendations are grouped into 5 broad reform areas:

- improve the applicant experience
- expand fast track registration pathways
- improve workforce data and planning
- increase flexibility, while ensuring safety and quality of care
- enhance regulator performance and stewardship.

Combined, these proposed actions would reduce regulatory costs (that is, time, money, and effort) incurred by employers and IQHPs looking to work in Australia. More cohorts of IQHPs who meet high professional standards will be fast tracked, saving them time and money. Unnecessary migration barriers will be removed, making it quicker for employers to fill vacancies and increasing Australia's ability to attract experienced IQHPs in acknowledged areas of need. These actions should bolster the current health, aged and disability care workforce.

A more efficient and effective end-to-end regulatory journey should also encourage more IQHPs, particularly mid-career and specialised practitioners, to seek work in Australia.

Better aligning the requirements of selfregulated and regulated professions would reduce the administrative burden on employers and ensure safe and quality care.

This report identifies a small number of priority recommendations (see Table 1), that can be delivered quickly and provide immediate benefits. These have been endorsed by health ministers. The full list of recommendations can be found at the end of this executive summary and are discussed in Chapter 3.

Table 1: Priority recommendations

Recommendation	Who	Expected impacts
Streamline, remove duplication and align standards, evidentiary requirements and policy settings across agencies and regulators involved in the end-to-end journey, so applicants only need to provide information and meet requirements once, moving to a single portal over time. **(Recommendation 1)**	Australian Government agencies (DoHA, Services Australia); Ahpra, National Boards; all jurisdictions	Improved applicant experience and reduced time and cost. Removing duplicative requirements could save a nurse or midwife $550.
Remove or suspend the requirement for employers to advertise for domestic applicants in acknowledged areas of shortage before recruiting overseas. **(Recommendation 3)** Broaden the age exemption on skilled visas to enable skilled practitioners in acknowledged areas of shortage to permanently move to Australia. **(Recommendation 4)**	Australian Government	Removing labour market testing requirements would shorten employers' recruitment times by 3 months and reduce costs.[50] Raising the age cap to 55 could lead to an additional 4,500 experienced practitioners gaining registration over 5 years.

Recommendation	Who	Expected impacts
Introduce or expand expedited pathways to registration for all professions in acknowledged areas of shortage. Eligibility for expedited pathways should be regularly considered and part of a rolling work program reported to health ministers. Priority professions to be collectively identified by health ministers. **(Recommendation 9)**	Ahpra, National Boards and Accreditation Authorities; health ministers to identify priority professions.	Greater consistency, cost-effectiveness and faster comparability assessments for specialist medical graduates. More applicants would save time and money and have a less onerous experience. IMGs and nurses who are eligible for expedited pathways would save $7,700 and $4,250 respectively. Additional expedited pathways should result in more health practitioners choosing to come to Australia.
Ensure registration assessment for all registered professions explicitly recognises skills and experience in addition to qualifications and training pathways, with conditions on registration used as a temporary risk mitigation strategy where appropriate. Legislate recognition of skills and experience to avoid doubt. **(Recommendation 10)**	Ahpra, National Boards, Accreditation Authorities; health ministers	Attract more experienced and specialised health practitioners, by valuing their skills and experience.
Support better planning for Australia's future workforce needs, including developing national workforce strategies for maternity and allied health, and finalising the nursing strategy already in development. National workforce modelling should be reviewed and updated at least every 5 years and strategies every 10 years. **(Recommendation 18)** Develop performance indicators of progress in the recruitment of more overseas health practitioners in acknowledged areas of shortage, while workforce strategies are developed. **(Recommendation 20)**	Health ministers, Department of Health and Aged Care (DoHAC), all jurisdictions; professions Health ministers; all jurisdictions; Ahpra	Improve the ability of governments, employers, regulators and others to plan for current and anticipated workforce needs.

Recommendation	Who	Expected impacts
Provide applicants with greater flexibility in demonstrating their English language competency, by: i. aligning 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 reading, speaking and listening would remain at 7 and an average of 7 overall would be required ii. recognising more programs of study conducted in English. **(Recommendation 21)**	Ahpra and National Boards	Could improve the success rate of test takers from 26% to 40%, saving candidates time, costs and the need to sit multiple tests. Could enable around 2,750 additional health practitioners to be registered over 5 years. Eligible IQHPs who don't need to sit an IELTS test could save up to $410.

Improve the applicant experience

To increase Australia's international competitiveness, we need to reform the end-to-end journey to:

- enhance the focus on and support for the applicant
- automate the issuance of Medicare provider numbers (MPNs)
- allow employers in areas of shortage to advertise for IQHPs without first advertising for domestic applicants
- provide greater flexibility on visa requirements, such as age limits for permanent visas, duties IQHPs can perform and skilled occupation lists
- provide quicker and easier pathways to permanent residency for suitable graduates in acknowledged areas of need
- remove or suspend the Skilling Australians Fund (SAF) levy for health professions, in areas of acknowledged shortage[51]
- centralise support, within and across jurisdictions, to improve efficiency and reduce costly competition for IQHPs.

Expand fast track registration pathways

Only applicants with qualifications, skills and experience from a small number of countries and professions are eligible for expedited pathways. Applicants entering through these pathways experience a quicker journey, pay less and need to meet fewer requirements.

Medical specialists do not have access to expedited registration pathways, meaning it can take years to be registered.

We need to:

- expand fast track pathways to include medical specialists and other allied health professions, prioritising areas of greatest acknowledged shortage
- better recognise the experience and skills of IQHPs, not just their qualifications, meaning more mid-career and specialised IQHPs could meet the requirements
- develop strategic alliances and recognised pathways to registration with key countries to build capacity in our region and provide more IQHPs in the longer term
- direct our scarce supervisory resources to where they are most needed and ensure they support health practitioners needs
- expand the use of workplace-based assessments (WBAs), where appropriate, to help recruit, train and retain IMGs in regional and rural Australia.[52]

We recommend strong oversight and monitoring of the implementation process based upon ministerially agreed targets. This report identifies escalation strategies if the combined impact of the recommendations does not provide timely relief in areas of key workforce shortage. This includes transitioning all or part of comparability assessments from specialist medical colleges to the Australian Medical Council (AMC) and considering existing roles and responsibilities, reflecting international best practice.

Improve workforce data and planning

The national health workforce dataset includes data on the 16 Ahpra regulated professions. However, this data is not cross sectoral and integrated, and does not capture the domestic pipeline, distribution of the workforce or available skills. This data is essential for planning for current and future needs, especially given anticipated changes in models of care and skill mix and innovations in technology. There is no single nationally consistent allied health dataset. Coverage of self regulated professions is partial or non-existent.[53]

Better and more integrated data is critical for making informed decisions on the future skill mix and distribution of IQHPs.

Supply and demand modelling is underway for GPs nurses and midwives. This work needs to be fast tracked and updated regularly. Modelling is needed for allied health and medical specialties.[54] National workforce modelling should be updated at least every 5 years and strategies every 10 years.

Workforce strategies need to take a more integrated 'whole of health workforce' view and be complementary, not contradictory.

The National Medical Workforce Strategy 2021–2031 (NMWS) is being implemented.

A strategy for nursing is being developed, but national workforce strategies for maternity and allied health do not exist and should be developed.

Data collection and sharing between the Commonwealth, states and territories specialist medical colleges is also being improved.

The review recommends health ministers:

- identify cross-cutting themes and mechanisms to deliver effective multidisciplinary workforce planning and develop integrated models of care
- develop indicators of progress in the recruitment of more IQHPs in acknowledged areas of shortage, while workforce strategies are developed.

Increase flexibility, while ensuring safety and quality of care

Stakeholder feedback suggests that the current regulatory system could be more flexible in how applicants prove or meet requirements. For example, the English language requirements can be onerous and limited testing capacity can delay IQHPs' journeys. Other OECD countries provide additional options to promote flexibility, while maintaining high standards of care.

We need to:

- be more flexible in how applicants demonstrate their English language competency to be internationally competitive
- expand testing options and access for applicants, including exploring more online and offshore options, to increase our ability to recruit IQHPs quickly and reduce costs for applicants
- ensure all IQHPs have appropriate training and ongoing support to familiarise them with the Australian healthcare system, including the importance of cultural competence and safety
- reduce barriers and improve incentives for doctors to work and train in rural and remote communities by implementing relevant recommendations from the NMWS.

Enhance regulator performance and stewardship

Regulatory settings and practice directly impacts on the supply of health practitioners and health outcomes for the community.

The National Registration and Accreditation Scheme (NRAS) ensures health practitioners in the 16 Ahpra regulated professions meet minimum profession led national standards.

Regulators are acting to improve applicants' end-to-end journeys and their performance. However, more can and needs to be done to ensure regulatory settings are appropriate, consistently applied and reflect best practice. Regular reporting on key performance metrics will promote greater transparency and accountability and drive improved regulatory performance.

Health ministers should set out their expectations for regulator performance and stewardship for all NRAS entities to give these entities greater clarity about Australian governments' expectations.

If expectations are not met, health ministers may need to consider whether further centralised oversight is required.

Economic impact assessment

The review commissioned analysis to estimate the current costs of the regulatory system and potential savings to the applicant and employer from targeted reform of the end-to-end journey for IQHPs, including:

- introducing a 'single portal' for collecting documents
- ending the need for employers to advertise for domestic applicants before recruiting overseas
- accelerating visa processing times
- allowing more IQHPs to enter through fast tracked pathways.

Reducing duplicative and onerous regulatory processes could provide annual economic benefits to the Australian economy of up to $850 million.[55]

This estimate is conservative and does not include all of the proposed reforms. The economic impact assessment is discussed in Chapter 4.

Implementation

Reforms need to be prioritised and sequenced over time, with a clear implementation plan and accountabilities, to maximise potential benefits.

National Cabinet gave health ministers the task of progressing the recommendations in the interim report and reporting back to National Cabinet as a priority, including with a fully costed implementation plan.[56]

Timely and well resourced implementation of the health and migration related measures is critical for success.

Regular and ongoing feedback to National Cabinet and health ministers by officials is important to maintain momentum.

Australian governments need to invest more up front to accelerate the work underway and ensure a solid increase in the number of suitable IQHPs in the acknowledged areas of shortage and a significantly reduced time taken to navigate the end-to-end journey. There are constraints on funding the reforms by raising registration and related fees, as such increases could adversely impact on our ability to compete in a global market.

More information on implementation and resourcing priorities is discussed in Chapter 5.

The goal of Australia's health system is to continue to provide high quality, accessible, and affordable healthcare for all Australians.[57] Ensuring the end-to-end journey for IQHPs aligns with this goal is essential.

It is important that this review and its recommendations are considered in conjunction with broader health and other reforms. These include the work to strengthen Medicare, improve care pathways, and ensure the labour market and migration system better meets Australia's needs. The collective impact of these reforms will shape the future health workforce.

In conclusion, Australian governments and regulators need to act urgently to ensure Australia can attract more IQHPs. If we succeed, we will reduce regulatory costs, speed up journey times for skilled and experienced health practitioners and improve community access to appropriate and timely health care services.

Improve the applicant experience

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
1	Streamline, remove duplication and align standards, evidentiary requirements and policy settings across agencies and regulators involved in the end-to-end journey, so applicants only need to provide information and meet requirements once, moving to a single portal over time.	Align evidentiary requirements, remove duplication, and streamline application steps	Australian Government agencies (DoHA, Services Australia); Ahpra, National Boards; all jurisdictions	Existing priority (I1, I2, I3)
2	Automate the issuance of Medicare provider numbers.	Align evidentiary requirements, remove duplication, and streamline application steps	Services Australia; DoHAC	Existing (I4)
3	Remove or suspend the requirement for employers to advertise for domestic applicants in acknowledged areas of shortage before recruiting overseas.	Remove migration barriers	Australian Government; health ministers to identify priority professions	Existing priority (I5)
4	Broaden the age exemption on skilled visas to enable skilled practitioners in acknowledged areas of shortage to permanently move to Australia.	Remove migration barriers	Australian Government; health ministers to identify priority professions	Existing priority (I6)
5	Provide greater visa flexibility by enabling key health practitioners to undertake additional duties, without needing a new visa nomination, and ensuring current skilled occupation lists are up to date.	Remove migration barriers	Australian Government	Existing (I7, I8, I12)
6	Provide greater transparency and a quicker and easier pathway to permanent residency for suitable international health graduates in acknowledged areas of shortage, who have studied in Australia.	Remove migration barriers	Australian Government; health ministers to identify priority professions	Existing – revised (I10)
7	Remove or suspend the Skilling Australians Fund levy for health professions in acknowledged areas of shortage.	Remove migration barriers	Australian Government; health ministers to identify priority professions	Existing (I11)
8	Centralise back-end support within jurisdictions, and front-end support across jurisdictions as part of the development of a single portal, to drive efficiencies and reduce costly competition for the same workforce where possible. Local communities and employers would retain a role in welcoming, supporting and retaining their workforce.	Provide more support to applicants	All jurisdictions	Existing – revised (I9, I13)

Expand fast track registration pathways

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
9	Introduce or expand expedited pathways to registration for all professions in acknowledged areas of shortage. Eligibility for expedited pathways should be regularly considered and part of a rolling work program reported to health ministers. Priority professions to be collectively identified by health ministers.	Provide more fast track pathways	Ahpra, National Boards and Accreditation Authorities; health ministers to identify priority professions	Existing priority – revised (F1, F2, F3, F4, F13, F14, S4, S5, S6)
10	Ensure registration assessment for all registered professions explicitly recognises skills and experience in addition to qualifications and training pathways, with conditions on registration used as a temporary risk mitigation strategy where appropriate. Legislate recognition of skills and experience to avoid doubt.	Better recognise health practitioner experience and skills	Ahpra, National Boards and Accreditation Authorities; health ministers	Existing priority – revised (F6, F7)
11	Health ministers to identify further action to be taken if fast tracked pathways are not widely available within agreed timelines and/or the end-to-end journey improvements fail to meet community need. Options could include: i. expanding the cohorts eligible, such as recognising comparable health systems, based on evidence and regulatory system 'fit' and learnings taken from international experience ii. centralising equivalence assessments in existing or new Accreditation Authorities.	Provide more fast track pathways	All jurisdictions, in consultation with professions and employers (public and private)	Existing – revised, escalation (F12)
12	Streamline processes, remove duplication and provide greater support to specialist comparability assessment to ensure more timely decision making and consistent outcomes.	Provide more fast track pathways	Ahpra, Medical Board of Australia (MBA), AMC, specialist medical colleges	Existing – revised (F5)
13	Transition all or part of the comparability assessments from specialist medical colleges to the Australian Medical Council if expectations are not met within agreed timelines.	Provide more fast track pathways	Ahpra, MBA, AMC, specialist medical colleges	Existing – revised, escalation (F5)
14	Explore opportunities to develop strategic alliances and provide recognised pathways to registration in our region, where such alliances are agreed between governments as being mutually beneficial.	Strategic workforce partnership	All jurisdictions; universities; Accreditation Authorities	Existing – revised (F9, F16, F17)

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
15	Supervision requirements to focus on the minimum required to build the capability of the health practitioner to deliver safe and quality health services in the Australian healthcare setting, recognising that supervisory resources are scarce. Innovative solutions, including a review of current Ahpra supervised practice framework, expansion of remote supervision models and online cultural competency and Australian health system training to be considered.	Target scarce supervisory resources to where they are most needed	Ahpra, National Boards and Accreditation Authorities; all jurisdictions	Existing – revised (F8, F15)
16	Expand the use of workplace-based assessments where appropriate, including exploring collaborative models to support IMGs with general practice and public health services to help address recruitment, training and retention challenges in regional and rural Australia.	Expand the use of workplace-based assessments	Ahpra, MBA, AMC and specialist medical colleges; employers; all jurisdictions	New

Improve workforce data and planning

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
17	Quantify workforce, skills, and distributional issues, making it easier to determine the extent of workforce shortages, factoring in changing models of care. This work should encompass needs in health, aged and disability care sectors.	Inform the development of national cross-sectoral workforce strategies	Health ministers, DoHAC; all jurisdictions; professions	Existing – revised (W1)
18	Support better planning for Australia's future workforce needs, including developing national workforce strategies for maternity and allied health, and finalising the nursing strategy already in development. National workforce modelling should be reviewed and updated at least every 5 years and strategies every 10 years.	Support better planning	Health ministers, DoHAC; all jurisdictions; professions	Existing priority – revised (W3, W4)
19	Identify cross-cutting themes and mechanisms to deliver effective multidisciplinary workforce planning and develop integrated models of care, including identifying and measuring any workforce or skill gaps.	Support better planning	Health ministers, DoHAC; all jurisdictions	Existing – revised (W4)

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
20	Develop performance indicators of progress in the recruitment of more overseas health practitioners in acknowledged areas of shortage, while workforce strategies are developed.	Support better planning	Health ministers; all jurisdictions; Ahpra	Existing revised – new priority (W2)

Increase flexibility, while ensuring safety and quality of care

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
21	Provide applicants with greater flexibility in demonstrating their English language competency, by: i. aligning 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 reading, speaking and listening would remain at 7 and an average of 7 overall would be required ii. recognising more programs of study conducted in English.	Make modest evidence based changes to English language requirements aligning with international good practice	Ahpra and National Boards	Existing priority – revised (S7, S8, S9, S14, S15)
22	Expand access for applicants to assessment, including online and offshore assessment where beneficial.	Expand testing options and access for applicants	Ahpra, National Boards and Accreditation Authorities	Existing (S1, S12)
23	Ensure all health practitioners are supported with appropriate training to familiarise them with and prepare them for safe practice in the Australian health system, regardless of their registration pathway. Consider the potential for technology-enabled orientation activities and support networks.	Strengthen context specific support	Ahpra, National Boards and Accreditation Authorities; employers; all jurisdictions	New
24	Implement relevant recommendations from the National Medical Workforce Strategy to address maldistribution of the workforce including evaluating the effectiveness of existing support structures for IMGs in rural settings, increasing the number of training pathways and posts available, and creating networks with, and connections between, metropolitan and regional health services.	Reduce barriers and improve incentives for doctors to work and train in rural and remote communities	All jurisdictions; MBA, AMC and specialist medical colleges	New

Enhance regulator performance and stewardship

#	Recommendation	Sub-theme	Who	Status (map to interim recs)
25	Health ministers set out their expectations for regulator performance and stewardship for all NRAS entities, factoring in best practice regulatory principles.	Regulatory settings are appropriate and reflect best practice	Health ministers	Existing – revised (P1, P3)
26	Develop, expand and/or enhance publicly available performance standards and benchmarks which are consistent with best practice regulatory principles, with regular public reporting against these standards and benchmarks.	Promote greater transparency and accountability	Ahpra, National Boards and Accreditation Authorities	Existing – revised (P3, P5)
27	Health ministers to develop a regulatory stewardship framework and consider appropriate oversight of the end-to-end journey, as part of its review of regulatory complexity. The framework to include examples of best practice, tools and other resources to support enhanced regulator capability.	Collaborate in the best interests of the community and adopt a continuous improvement mindset	Health ministers; Ahpra; in collaboration with all jurisdictions	Existing – revised (P2, P4)
28	Health ministers to consider whether further centralised oversight is required to support 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 registration process if expectations are not met within agreed timelines.	Collaborate in the best interests of the community and adopt a continuous improvement mindset	Health ministers	Existing – revised escalation (P5)

1. Case for change

Key points

- Too many Australians are finding it increasingly difficult to access health care.
- Demand for health services will continue to rise in coming years. Based on current settings, Australia will not produce enough health workers domestically to meet this demand.
- All states and territories are experiencing health workforce shortages which contribute to patient wait times and staff workloads.
- Areas of shortage identified by states and territories as priorities to address include GPs, registered nurses, occupational therapists, pharmacists, physiotherapists, psychologists and radiographers.
- IQHPs surveyed by the review said the end-to-end journey towards registration in Australia is complex, slow and expensive.

Demand

The demand for health services in Australia is rising as a result of our growing and ageing population, increasing levels of chronic diseases and disability, and the lingering impacts of the COVID-19 pandemic.

Australia's population is growing and ageing but we are living more years with ill health

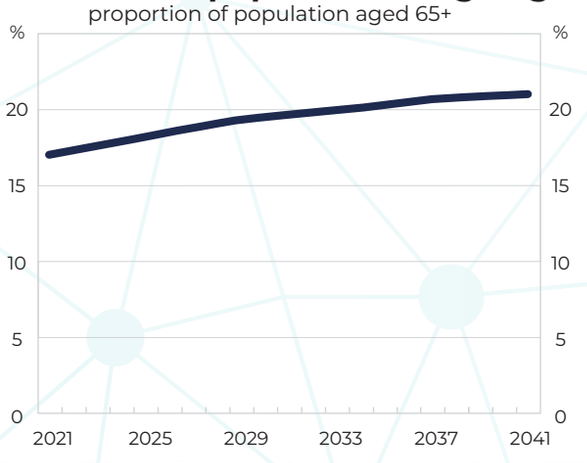
Australia's population was estimated to be 26.3 million in 2022.[58] By 2060–61, it is expected to hit 38.8 million,[59] inevitably increasing the demand for healthcare services.

In 2021, the number of people aged 65 and over was estimated to be 4.3 million, or 16.8% of the population. By 2041, this is projected to grow to 6.7 million, or 20.8% of the population (see Chart 1.1).[60]

Chart 1.1

Australia's population is ageing

proportion of population aged 65+



Source: ARC Centre of Excellence in Population and Ageing Research, 2022

Although Australians are living longer, we are also living more years with ill health.[61] Older Australians access more health services per capita than younger Australians. The hospitalisation rate for those aged 65 years and over ranges from 981 to 1,469 per 1,000 population, compared with those under 65, which ranges from 84 to 598 per 1,000 population. According to analysis by the Australian Institute of Health and Welfare, the 65 years and over age group accounts for:

- 30% of Medicare claims for unreferred GP attendances – roughly double their share of the general Australian population
- 46% of specialist attendances processed through Medicare
- 34% of health outpatient services delivered by allied health professionals
- 43% of same-day hospitalisations
- 41% of overnight hospitalisations.[62]

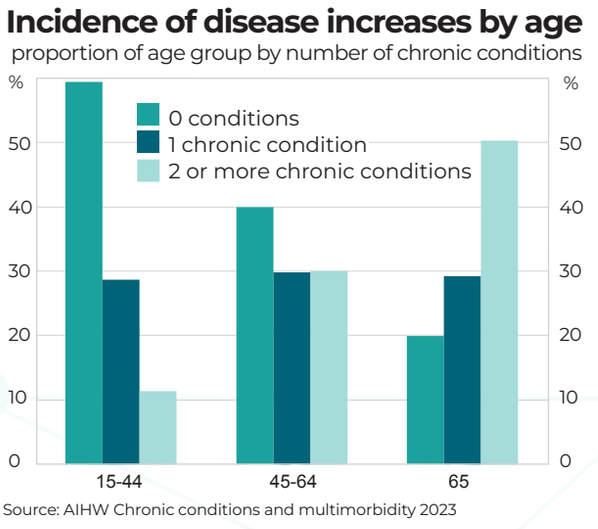
The growing proportion of the population aged 65 years and over is expected to lead to a greater than proportionate increase in demand for health services due to the higher incidence of chronic disease in this age group (see Chart 1.2).

Chronic diseases such as cardiovascular disease, cancer and diabetes are major contributors to the burden of disease in Australia. Almost half of Australians (47%) are estimated to have one or more chronic conditions.[63]

The prevalence of chronic diseases is expected to keep rising, driven by an ageing population and lifestyle factors, such as smoking and

poor diet,[64] and environmental factors, such as air pollution and climate change.[65]

Chart 1.2



Source: AIHW Chronic conditions and multimorbidity 2023

The ageing population is increasing demand for nurses in the aged care sector. The Royal Commission into Aged Care Quality and Safety notes there is a significant problem of unmet demand in the sector. As the Royal Commission's report observes,

> *'there are not enough Home Care Packages for the number of people assessed as needing them... the gap between the number of packages and the number of people waiting remains enormous. While they wait, older people are at risk of a deterioration in their health and wellbeing.'*[66]

The Royal Commission found that an additional 80,000 aged care workers will be required by 2030 and 180,000 by 2050.[67] Allied health professionals, including physiotherapists, speech pathologists, podiatrists and prosthetists, will make up a significant proportion of this workforce.

COVID-19 has increased demand pressures

The COVID-19 pandemic disrupted healthcare service availability and attendance, and border closures interrupted the inflow of IQHPs. Expected longer term consequences of the pandemic include missed or delayed diagnosis and increased chronic disease burden in the Australian community.[68] The cancellation of elective surgery and secondary and tertiary care services for prolonged periods created a backlog of patients. Despite the pandemic easing, this backlog has added further pressures on the health system and workforce.[69]

More health practitioners will be required to support policy changes

In response to the Royal Commission's recommendations, the Australian Government mandated that from 1 July 2023, residential aged care homes across Australia must have a registered nurse onsite and on duty 24 hours a day, 7 days a week (unless granted a time-limited exemption). From 1 October 2023, residential aged care homes must deliver at least 200 minutes of direct care per resident per day, including 40 minutes of care with a registered nurse.[70]

The disability sector is experiencing similar demand. The introduction of the National Disability Insurance Scheme (NDIS) has necessitated an expansion of the disability services sector. This has increased demand for disability support workers, allied health professionals, nurses and other support services staff. The NDIS National Workforce Plan: 2021–2025 states that an estimated that 83,000 new workers will be needed by 2024 to meet growing demand for care and support services.[71]

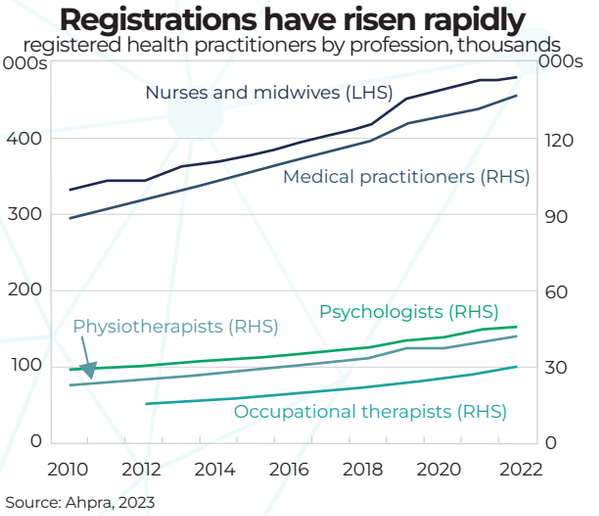
Supply (including distribution and skills)

Despite a strong domestic pipeline, pressures persist

Despite registering a record number of health practitioners (see Chart 1.3), health workforce supply pressures persist across the health system.[72]

The domestic health workforce training pipeline, especially in nursing, has grown strongly since 2010. However, the number of domestic graduates in nursing, dentistry,

Chart 1.3



Source: Ahpra, 2023

psychology and medicine have slowed or declined in recent years (see Chart 1.4).

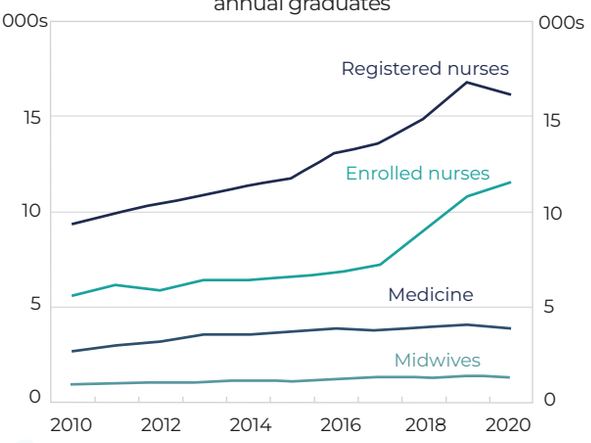
International students contribute to the Australian trained health workforce pipeline (refer Box 1.1).

Nationally, Australia compares favourably with many countries in the OECD for the number of doctors and nurses per 1,000 inhabitants (see Chart 1.5) and on indicators of the health system overall (refer Box 1.2).

Chart 1.4

Domestic pipeline has grown strongly

annual graduates

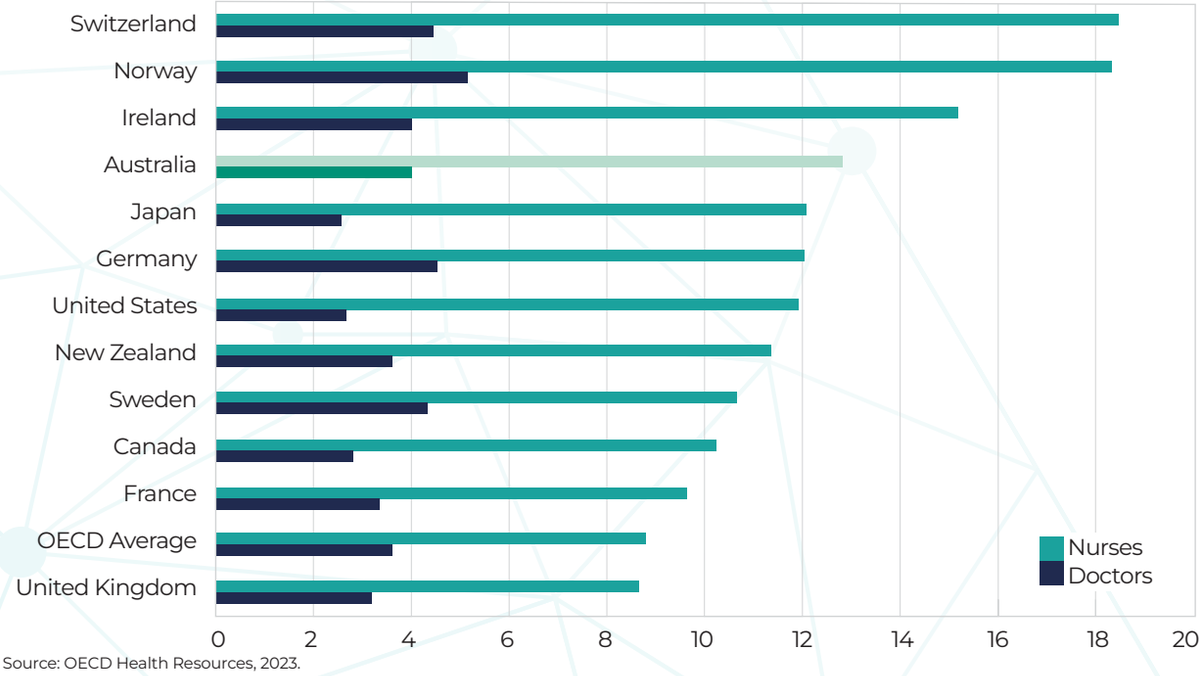


Source: OECD Statistics, Graduates, 2023.

Chart 1.5

Australia performs well on practitioner numbers

number of practising nurses & doctors per 1,000 inhabitants



Source: OECD Health Resources, 2023.

Box 1.1: International students in Australia

In 2022, close to 3,000 international students were enrolled in Australian medical schools.[73] In 2021, around 20,000 international students were enrolled in other health-related bachelor-level courses, including about 15,000 studying for nursing degrees.[74]

In 2019-20, international students contributed around $8 billion to the vocational education and training (VET) sector and $26 billion to the higher education sector.[75]

After completing their studies, some international students who gain their primary health qualifications in Australia return to their home country or migrate to a third country. However, some graduates stay in Australia and contribute to the health practitioner workforce given their qualifications are recognised here and often qualify them for skilled migration.

Box 1.2: How does Australia's health system compare to overseas counterparts?

We perform well on a range of indicators used to compare international health systems.

Australia ranks highly among OECD countries for life expectancy and citizens' perceptions of their health status.[76] However, significant differences and health inequities exist within and between population groups and geographic locations across the country.[77]

The number of health practitioners relative to our population is higher than the OECD average (see Chart 1.5). There are 12.8 practising nurses per 1,000 people in Australia, a figure that is only exceeded by Ireland, Norway and Switzerland.[78] We have 4 practising doctors per 1,000 people, which is higher than in New Zealand, the United Kingdom and the United States. However, the Australian rate for doctors is lower than Germany, Norway, Switzerland and Sweden.[79]

It is worth noting that these statistics do not tell the whole story, as they do not consider the distribution of healthcare practitioners and the ability of all communities to access health care. There is no single agreed metric for health practitioners per capita.

Aggregate numbers conceal significant geographic variation and emerging workforce trends

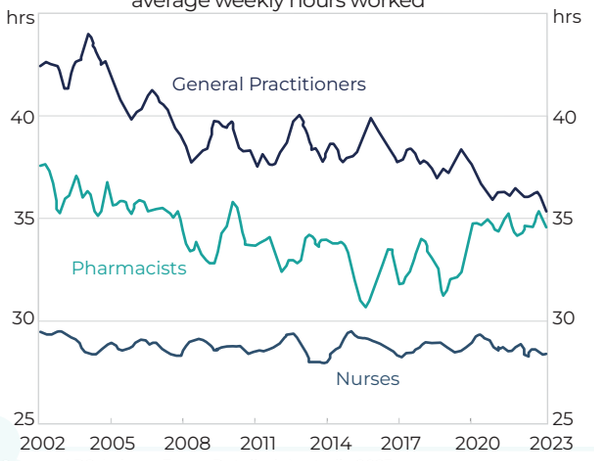
There are 7 million people living in rural and remote communities across the country.[80] These Australians experience considerably lower service levels than those living in metropolitan areas. In major cities, there are 120.5 FTE GPs per 100,000 people, compared to 65.8 per 100,000 people in very remote areas.[81] This disparity is not new, but it is exacerbated by workforce shortages, given the total burden of disease is 1.4 times higher in remote and very remote areas of Australia compared with major cities.[82]

Changing workforce preferences will continue to increase pressure on service delivery. Although the health practitioner headcount has steadily increased over the last 3 decades (see Chart 1.3), this has been at least partially offset by a decline in the average number of hours worked (see Chart 1.6). Part-time employment is common for many health professions, including nursing, which has is the greatest workforce need.

Chart 1.6

Practitioners are working fewer hours

average weekly hours worked



Source: ABS, Labour Force, Detailed, Australia 2023

In addition to working fewer hours, many practitioners are opting to specialise and/or work in private practice. This could increase costs for people accessing health services and place pressure on remaining public services.

Compounding this situation, the existing workforce is ageing and significantly older than that of other occupations (see Chart 1.7). In the wake of the COVID-19 pandemic, a growing number of practitioners have reported their intention to retire or leave employment in the health sector in the next decade. For example, in a 2022 survey of nurses and midwives working in public and private hospitals, one-fifth of respondents indicated that they intended to leave their current role within 12 months.[83]

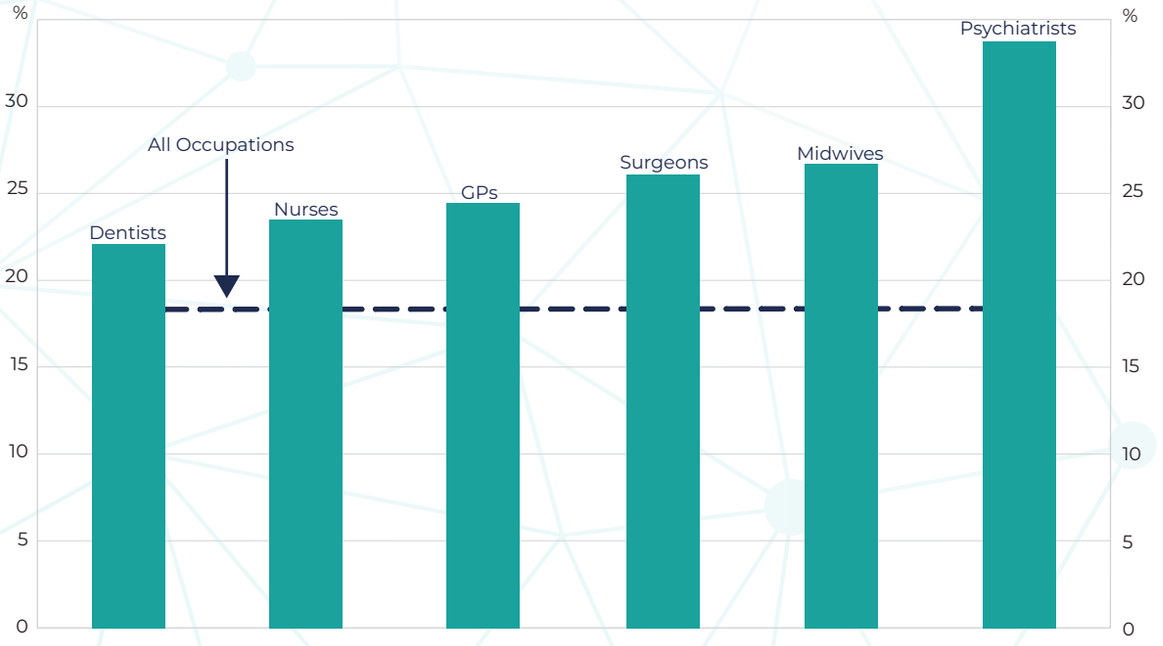
Increased rates of burnout are affecting workforce retention and care

Workplace conditions are another factor influencing health worker supply. The review heard that stress and burnout are hampering staff retention, especially of mid-career practitioners. Staff shortages place even more pressure on remaining staff to meet increasing workloads, further exacerbating the cycle. In one survey of frontline health workers, around 44% reported symptoms of severe burnout, with a further 27% reporting symptoms of moderate burnout.[84]

Chart 1.7

The health workforce is older than other occupations

share of occupation 55 years and over



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

Shortages

Shortages exist in multiple professions in all states and territories

All states and territories are experiencing health worker shortages, particularly in medicine, nursing, midwifery and a range of allied health professions. Employment in the health care and social assistance industry – which includes registered health practitioners and people employed in other care services – is projected to continue growing by 301,000 (or 15.8%) over the 5 years to November 2026.[85] It is anticipated that Australia will need an extra 13,000 medical practitioners, 40,000 nurses and 27,000 allied health professionals by November 2026. The World Health Organization (WHO) predicts the shortage could exceed 18 million health workers globally by 2030, so Australia is not alone in facing this problem.[86]

While shortages are particularly acute in rural and remote areas, even metropolitan areas are affected because of the sustained closure of international borders and lower migration numbers during the COVID-19 pandemic.[87]

Shortages are more acute in some locations, care settings and specialisations, though not every health profession is currently affected.

Areas of shortage that states and territories have identified as priorities to address include GPs, registered nurses, occupational therapists, pharmacists, physiotherapists, psychologists and radiographers (see Tables 1.1 and 1.2).

All jurisdictions identified shortages of GPs, nurses and midwives.

Smaller jurisdictions, such as the Northern Territory and Tasmania, are facing significant challenges in recruiting health practitioners. The loss of key health practitioners in these jurisdictions creates significant gaps.

Larger jurisdictions are also experiencing shortages. Queensland Health modelling projects that the state will require an additional 37,000 healthcare staff over the next 10 years.[88]

Past projections by Health Workforce Australia predicted shortages of doctors, dermatologists, ophthalmologists and psychiatrists.[89] Modelling by the Australian Medical Association estimated a shortfall of 860 FTE GPs in 2021-22 while suggesting this is likely to be an underestimate. The Australian Medical Association predicts an undersupply of about 10,600 FTE GPs by 2031-32 if GP training places continue to remain unfilled, and the rate of retirement and attrition escalates.[90]

Table 1.1: Medical practitioner shortages identified by states and territories

	NSW	Vic	Qld	WA†	SA	Tas	ACT	NT
General Practice	■	■	■		■	■	■	■
Psychiatry	■	■			■	■		
Anaesthesia	■	■	■		■			
Radiology	■		■		■	■	■	
Paediatrics		■			■	■		
Emergency Medicine	■				■	■		
Obstetrics & Gynaecology	■		■		■			
Other		■	■	■	■	■		■

† Western Australia overall shortage of medical practitioners, especially registrars and resident medical officers Source: As advised by state and territory health departments, April 2023

Specialist medical colleges highlighted shortages of surgeons, obstetricians, ophthalmologists, pathologists and psychiatrists.[91]

The uneven distribution of medical practitioners, in terms of location and specialisations, is leading to pervasive medical workforce shortages in rural and remote areas.[92]

The Nursing and Midwifery Board of Australia (NMBA) and the Australian Nursing and Midwifery Federation agreed that there are current and projected shortages in nursing and midwifery professions.[93]

Professional groups confirmed that shortages exist for occupational therapy, psychology, pharmacy, physiotherapy, dentistry and radiation therapy, especially in remote and regional areas. There are shortages across the disability and health sectors, and in public and private settings.[94] Pharmacy Guild of Australia modelling shows an estimated shortage of 2,869 pharmacists by 2026.[95]

The review heard that there are at present enough registered paramedics and graduates from paramedicine studies programs each year to meet the current need of Australian ambulance services.[96] But demand could increase in the future as ambulance services grow and more paramedics are employed in non-ambulance care settings and the private sector.[97]

Submissions by employers highlighted the extent of workforce shortages. For example, the Australian Private Hospitals Association noted that private hospitals are experiencing significant shortages of nurses, midwives, medical practitioners and allied health professionals.[98]

Vacancy rates are consistently high in most health professions (see Chart 1.8). Employers across the public and private health, and aged and disability care sectors are struggling to recruit health professionals, with around half of vacancies remaining unfilled.[99]

In 2021-22, Northern Territory Health reported almost one in 3 vacancies took longer than 6 weeks to fill.[100]

Self regulated health professions, including speech pathology and social work, are also facing significant shortages.[101] Ongoing alignment between Ahpra regulated and self-regulated professions will continue to be important to address workforce planning needs.

Table 1.2: Allied health profession shortages identified by states and territories

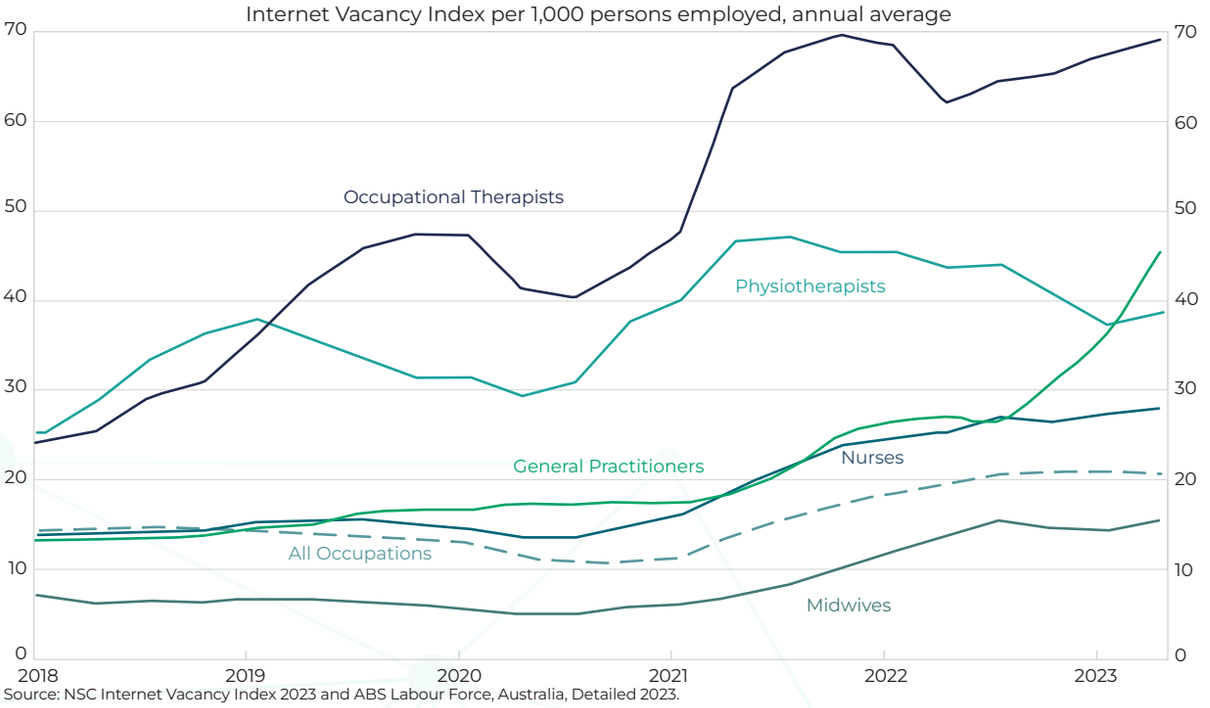
	NSW	Vic	Qld	WA†	SA	Tas	ACT	NT
Dentistry					■	■	■	■
Occupational therapy	■		■		■	■		■
Optometrists			■			■	■	
Pharmacy	■		■					■
Physiotherapy			■		■	■	■	■
Podiatry	■		■				■	
Psychology	■		■		■	■		■
Radiation therapy	■		■		■		■	
General				■				

† Western Australia indicated general shortages across allied health, especially in rural areas.
Source: As advised by state and territory health departments, April 2023

Chart 1.8

Vacancy rates are above the national average

Internet Vacancy Index per 1,000 persons employed, annual average



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

Adverse impacts of shortages

While Australia has a plan to build the domestic health workforce training pipeline (refer Box 3.8 Chapter 3), IQHPs will continue to play a key role in supplementing the workforce, particularly in areas of acknowledged shortage.[104] It takes 10 to 15 years to fully train a medical doctor locally,[105] so the plan to grow the Australian trained workforce will not address current shortages.

Australians are waiting longer to access care

Health practitioner shortages mean more people are waiting longer for health and other care. This contributes to geographic disparities in health and economic outcomes. Some people have to travel long distances to access care.

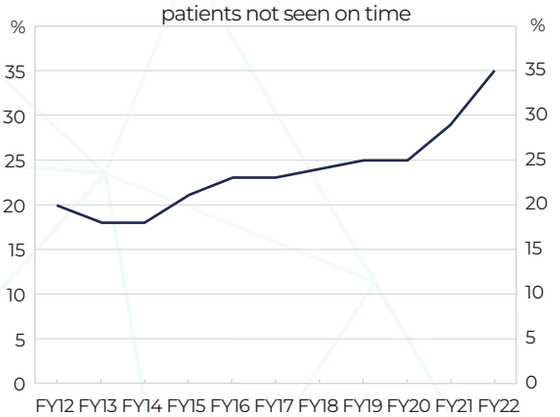
For example, some Australians are waiting more than 4 years for an initial outpatient appointment with a public specialist such as a neurosurgeon; ear, nose and throat surgeon; immunologist; or dermatologist.[106] Around 40% of people are waiting 24 hours or more to see a GP for urgent care. NDIS clients are waiting up to 2 years to see allied health professionals.[107] One in 3 psychologists surveyed by the Australian Psychological Society reported closing their books to new patients due to overwhelming demand.[108]

Longer wait times put more pressure on emergency care services. They increase the incidence of chronic conditions that could have been prevented with regular screening or managed with earlier primary care interventions. It is estimated that one-third of the disease burden in Australia is preventable.[102]

Chart 1.9

Fewer emergency patients are seen on time

public hospital 'emergency' category patients not seen on time



Source: Productivity Commission, Review of Government Services, 2023.

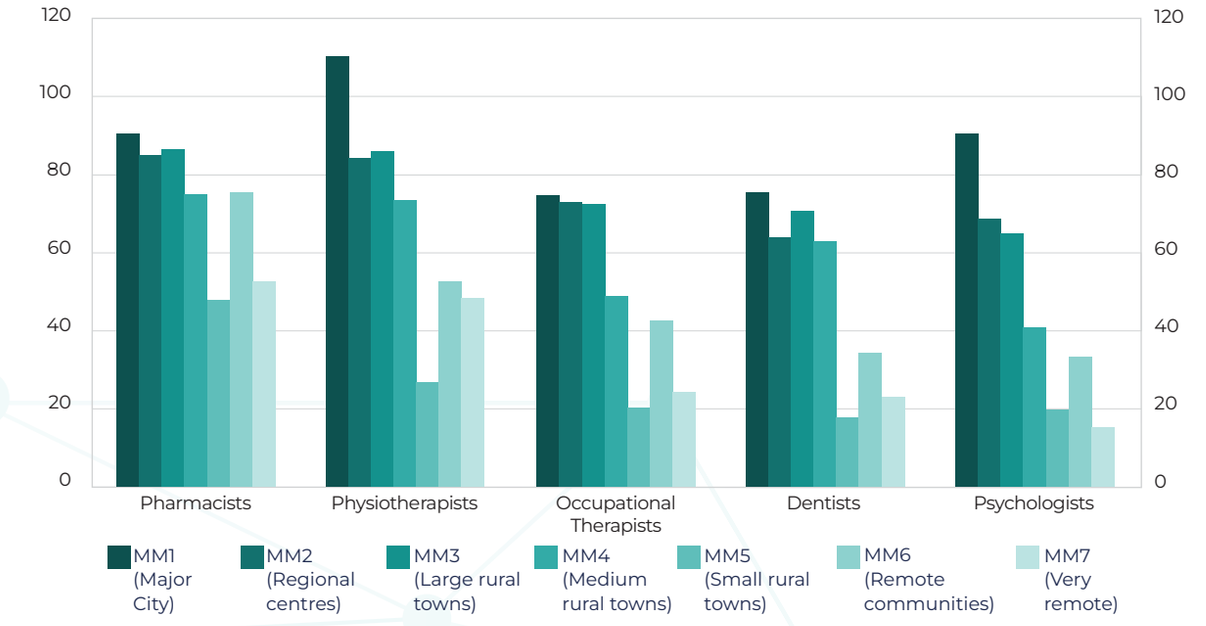
Wait time is a well-known contributor to poor patient health outcomes. In 2021-22, around 50% of people on an elective surgery waiting lists spent at least 40 days on the list before admission. Half of all Aboriginal and Torres Strait Islander people waited 50 days. Roughly 6% of patients waited longer than 365 days for elective surgery.[103]

A similar pattern is evident in wait times in emergency department presentations and for specialist appointments. According to

Chart 1.10

Remoteness impacts access to allied health services

clinical FTE per 100,000 Estimated Resident Population (EPR)
by Modified Monash Model



Source: Department of Health and Aged Care, 2023.

OECD data, more than 39% of Australians wait more than a month to see a non–GP specialist.[109] In terms of emergency department presentations, 33% of people were not seen on time (see Chart 1.9). Over time, people are spending longer in emergency.[110]

In Victoria, people wait a median 19 days for an urgent first appointment with an allied health professional in specialist hospital clinics.[111] Higher wait times apply in regional health districts, such as Barwon Health and Western Health.

Access to health practitioners declines with remoteness and plays a role in increasing health system costs.

The ability of people to access healthcare services depends on where they live. For example, the number of health practitioners per capita typically declines as remoteness increases (see Chart 1.10).

People in cities have access to more specialised services than their counterparts in regional, rural and remote areas. The density of non-GP medical specialists tends to decrease with remoteness. The number of FTE GPs per 100,000 people generally increases with remoteness from MM1 (major cities) to MM4 locations, as these regional GP roles are often broader and can include public health, hospital and emergency work.[112] The FTE GP rate per 100,000 people then decreases significantly from MM5 to MM7 (very remote) locations.

A poor distribution of key health workers puts pressure on healthcare costs due to increased spending on locum staff, recruitment efforts and training programs. It also places greater pressure on hospitals and clinics, which in turn increases the costs of the health system and diverts resources from other healthcare priorities.

Another way in which health worker shortages may adversely impact healthcare quality is through increased diagnostic error. An estimated 140,000 cases of diagnostic error occur each year, with 21,000 cases of serious harm and 2,000 to 4,000 deaths. In a 2022 survey of 719 junior doctors, Australian Medical Association Queensland found that 58% reported concern about a clinical error due to fatigue related to long work hours.[113] More than 80% of diagnostic errors in Australia are deemed preventable, and physical fatigue may play a part.[114] Research has found that '[t]he physical fatigue of healthcare workers in the workplace can have significant consequences for patient safety, including poor patient outcomes and lower quality care'.[115]

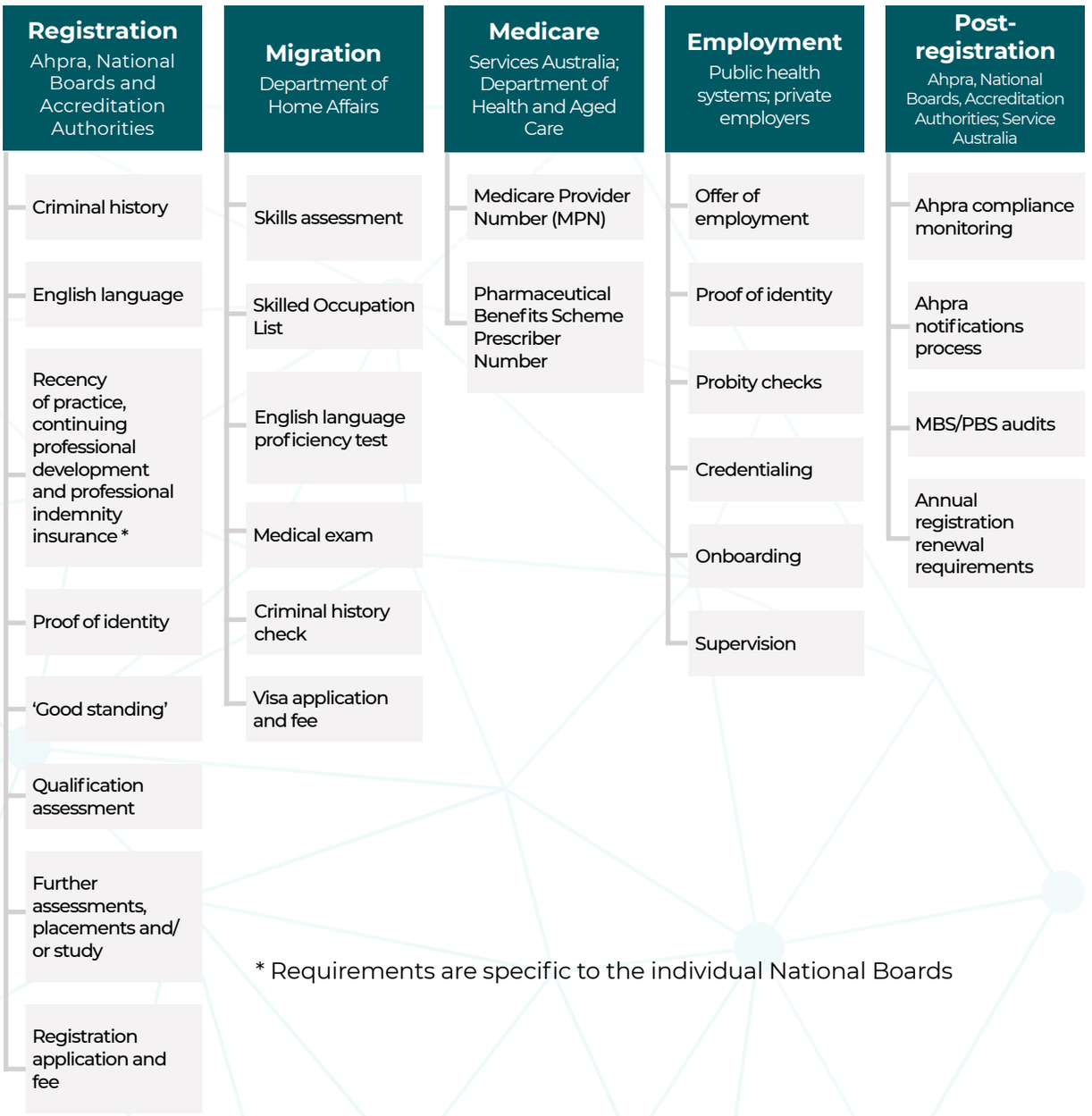
End-to-end journey

IQHPs need to meet many requirements and deal with multiple regulators

The end-to-end journey for IQHPs seeking to work in Australia demands careful navigation of requirements administered by multiple regulatory bodies, government agencies and employers. The key regulatory bodies are Ahpra, the National Boards and Accreditation Authorities, and key government agencies are DoHA and Services Australia. IQHPs may also pay migration agents to help them navigate the process.

While there are variations specific to each profession, all IQHPs will engage in the common steps outlined in Figure 1.1.

Figure 1.1: Steps in the end-to-end journey



* Requirements are specific to the individual National Boards

Applying for registration

The first step for any IQHP is to determine their eligibility for registration in Australia.[116] The *Health Practitioner Regulation National Law 2009* (Qld) (the *National Law*) specifies that all applicants must meet requirements for 5 mandatory registration standards. They relate to:

- criminal history, which is common to all National Boards
- English language proficiency, largely common to National Boards except the NMBA and Aboriginal and Torres Strait Islander Health Practice Board of Australia
- recency of practice, continuing professional development and professional indemnity insurance, which is specific to the individual National Boards.[117]

Once an IQHP has been deemed eligible, they may apply to the relevant National Board. The application includes proof of identity, qualifications, and evidence of current registration in another country. National Boards determine whether an applicant has an 'approved', 'substantially equivalent' or 'relevant' qualification. Applicants holding qualifications consistent with the first 2 categories generally need to meet fewer requirements for registration and, in some professions, are eligible for expedited pathways.

Only applicants with qualifications from a small number of countries and professions are eligible for streamlined pathways, as few countries have approved qualifications. The requirements are particularly inflexible for experienced specialist medical practitioners who choose to specialise over their career, as they are assessed on their broad skills and knowledge of the specialty.

Applicants falling outside of these categories typically progress through 'standard' pathways and experience greater regulatory interventions. They may be required to undertake further training, study or examination to address any gaps in knowledge or skills. Generally, they are subject to greater periods of supervision once they commence work.

The review heard that some employers are reluctant to consider applicants from countries other than those eligible for expedited registration pathways because the process is very difficult, slow and outcomes are uncertain.[118]

Australia is often no longer the country of choice for the health workers we want and need.[119]

Migrating to Australia

Before they can migrate, all IQHPs are required to apply for and obtain an appropriate visa enabling them to live and work in Australia.[120] To be eligible for such a visa, IQHPs typically need to meet certain requirements that can overlap with and duplicate requirements they must meet as part of the registration process. These include:

- English language proficiency tests
- identity and criminal history checks
- skills assessments, including qualifications verification
- fulfilling skills criteria
- securing employer sponsorship or nomination from an Australian state or territory.

Working in Australia

Employers require IQHPs to complete additional steps prior to commencing work, which often duplicate evidentiary requirements in the registration and migration processes. Examples include proof of identity, probity and credentialling checks.

Most professions require IQHPs to undertake a mandatory period of supervised practice. The conditions of this supervised practice period can vary by profession and according to an IQHP's qualifications and prior experience. Typically, IQHPs are granted provisional registration and become eligible for full or general registration once they satisfy additional requirements, including supervision.

For example, IMGs who register in Australia are required to undertake up to 12 months of supervision, during which they hold provisional registration.[121] After satisfactorily completing the supervision period, the IMG is eligible to apply for general registration, which allows them to practise independently.

As part of the onboarding process, IQHPs require support to understand the Australian healthcare system, including the importance of cultural competence and safety and the context in which they will be working.[122] Stakeholders have noted that this support is critical.[123] However, the review heard there is no consistent approach to orientation and cultural competency across professions, especially for common requirements.

All internationally qualified specialist GPs must undergo a minimum 6-month supervision

period under limited registration before obtaining specialist registration, to ensure competency to practise in the Australian context. Internationally qualified psychologists are required to undertake a transitional program under provisional registration before obtaining general registration to demonstrate competence in Australian ethical, legal and professional matters and working with diverse groups of people in an Australian context. Similar requirements are not observed for all registered professions.

Some National Boards provide online training modules. For example, internationally qualified nurses and midwives (IQNMs) must complete 2 online orientation modules as part of the registration process. In some professions it is left up to employers to help IQHPs understand how to navigate the Australian healthcare system and provide culturally safe care.

IQHPs must also understand the rules of Medicare and the Pharmaceutical Benefits Scheme (PBS). The onboarding process for IQHPs can vary significantly depending on their profession and employer.

Some IQHPs will also be required to apply for an MPN or PBS prescriber number. The MPN enables the IQHP to claim, refer or request Medicare services. Medical doctors and specialists commonly required these numbers; however, some allied health professionals may be eligible under certain schemes. The PBS prescriber number authorises pharmacists to dispense medication under the PBS.

Once IQHPs are practising in Australia, they are subject to the same ongoing Ahpra monitoring and compliance as other registered practitioners. This approach protects the public and manages risks to patients.[124]

Beyond the common regulatory framework established and implemented by Ahpra, National Boards, and Accreditation Authorities, each profession imposes unique regulatory interventions on its IQHPs. These regulatory differences are illustrated in the journey maps at Appendix D. Broadly, those differences relate to:

- the number and type of expedited pathways available, including eligibility criteria (see Appendix E)
- recency of practice
- continuing professional development and professional indemnity insurance
- supervision.

IQHPs report complex, slow and expensive requirements in their end-to-end journey

This review heard that the end-to-end journey for IQHPs seeking registration in Australia can be complex, slow and costly.

Overall, regulatory responsibilities across migration and registration are highly fragmented, with roles spread across multiple parties and legislative frameworks, with little coordination. No one agency or regulator has ownership of the end-to-end journey.

From the applicant's perspective, assessments and regulatory processes are often unclear, onerous and lacking transparency, and result in inconsistent outcomes. The current journey is largely sequential, making it slow. Visa, employer and professional recognition processes often duplicate the regulatory purpose, but can differ in their requirements.

The review commissioned a survey of over 1,700 IQHPs who have gained registration in Australia since 2017. The survey asked respondents about the time and costs incurred on their journey, from initially exploring options and meeting visa and professional registration requirements, through to receiving registration and commencing practice. Key statistics on

Comments from IQHPs

'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 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.'

Focus group participant

the cost and length of the end-to-end journey are shown in Charts 1.11 and 1.12, respectively.

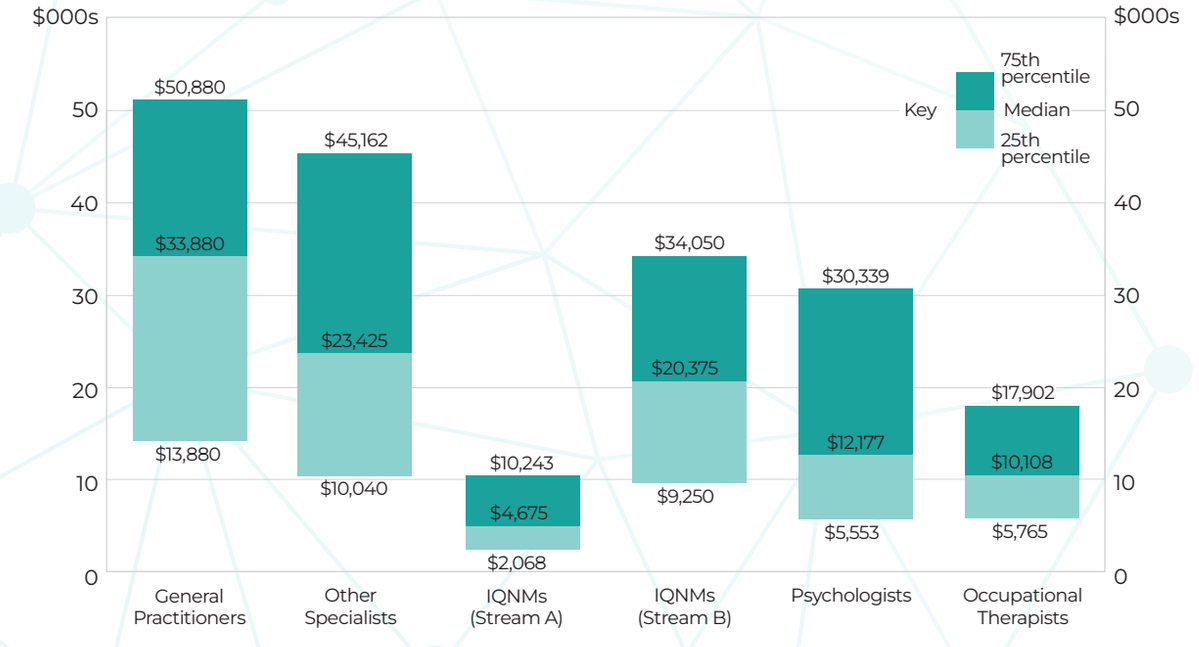
Internationally qualified GPs reported a total journey length of between 35 (25th percentile) and 130 weeks (75th percentile). The major contributors to journey length and costs related to passing the skills assessments required for registration. This cohort reported spending a median $6,000 on additional study to prepare for assessments and $6,500 on other costs. This was in addition to the $9,500 they had to spend on assessments; namely, the knowledge and clinical exams.

For IQNMs, cost and time differences largely depended on eligibility for the fast tracked Stream A pathway. IQNMs eligible for the Stream A pathway reported a median journey length of 30 weeks. Other applicants reported a median journey of 56 weeks. The difference was largely attributable to the additional study that 45% of respondents reported undertaking for the Objective Structured Clinical Exam (OSCE). The OSCE itself costs $4,000 and is currently only conducted in Adelaide, which means many IQNMs incur additional travel and accommodation costs to sit the exam.

Among allied health professionals, the survey only gathered enough responses from psychologists and occupational therapists to report statistically significant findings. Internationally qualified psychologists and occupational therapists take a median of around 93 weeks and 74 weeks, respectively, to complete the end-to-end journey. The median costs were around $12,200 and $10,100, respectively. However, these costs are not experienced equally, with psychologists indicating that fees for course enrolment range from around $900 to $34,500 (median of $5,000), and additional study costs from $2,200 to $25,300 (median of $11,000).

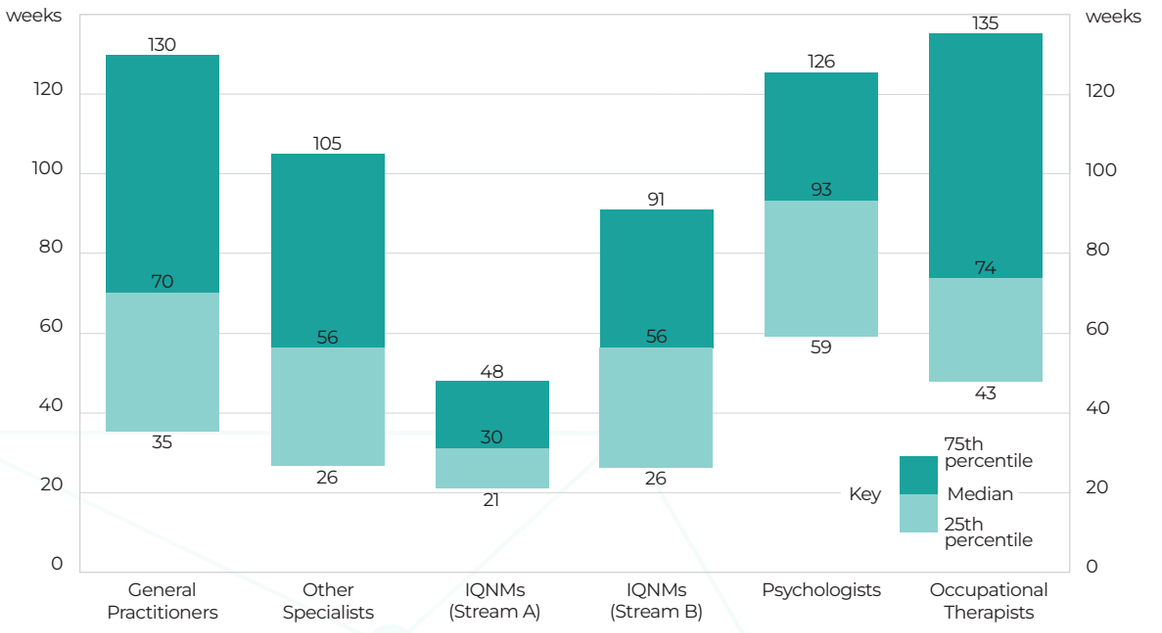
Chart 1.11

IQHPs report significant costs in the journey



Source: Accenture, Final Report, 2023.

Chart 1.12
Most IQHP journeys take over a year



Source: Accenture, Final Report, 2023.

Survey respondents also expressed how the journey made them feel (see Figure 1.2). Half of those surveyed noted they would not recommend Australia to friends or colleagues.[125]

Figure 1.2: Word cloud capturing key survey insights

The cumulative cost of regulatory requirements reduces competitiveness

The range of registration fees paid by IMGs and IQNMs are broadly comparable to the fees paid by these practitioners in other countries. However, when migration costs are added, the range of unavoidable direct costs (that is, visa fees plus registration fees) paid by these practitioners is higher than that of the countries that Australia commonly competes for IQHPs (see Charts 1.13 and 1.14).

Once other skills assessment, indirect and incidental costs (for example, travel and accommodation) are added, the costs incurred by IQHPs seeking registration to practise in Australia become substantial. Hence, efforts to attract and retain IQHPs need to consider the cumulative costs of the end-to-end journey.

Chart 1.13

IMG registration and migration costs

Potential minimum and maximum

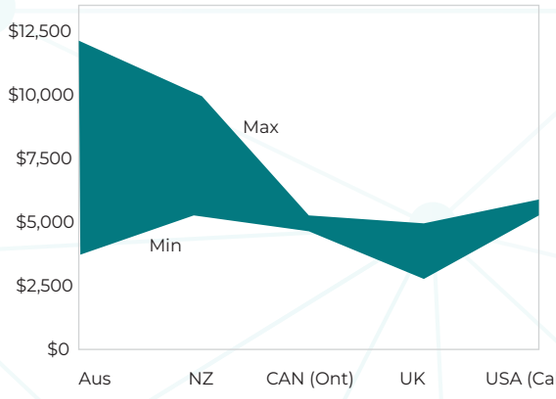
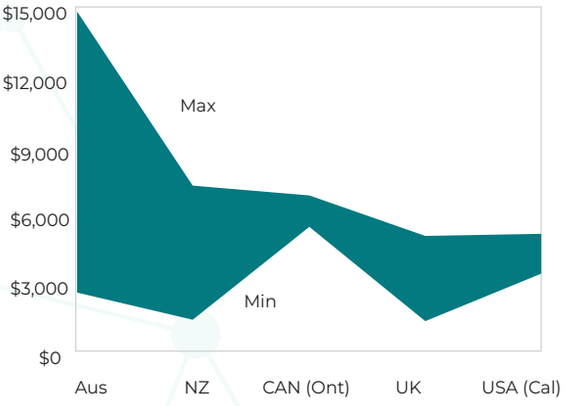


Chart 1.14

IQNM registration and migration costs

Potential minimum and maximum



International peers are taking action

Australia's international peers have made their own regulatory processes simpler and cheaper, without lowering standards. As a result, these countries are now more able to attract IQHPs.

Making online tools available

In response to the COVID-19 pandemic, many jurisdictions have phased out paper-based and in-person processes and transitioned registration processes online. Canada, Ireland, New Zealand and the United Kingdom have all implemented fully online applications. This makes it easier for IQHPs to apply while in their home country and reduces costs by eliminating the need to travel to submit application materials in person. The United Kingdom is also currently developing an online app enabling IMGs to verify their identity offshore.

Streamlining regulatory processes

Australia's international counterparts are streamlining their regulatory processes, lowering the regulatory burden and reducing duplication. For example, New Zealand regulators only require applicants to obtain a criminal history check if they have a prescribed matter to disclose.[126]

The United Kingdom has reduced duplication by only requiring proof of English language proficiency in the registration process, removing it from the visa journey. Similarly, the United Kingdom does not require IQHPs to demonstrate recency of practice, making registration more accessible.

These and other initiatives mean that international regulators typically process registration applications quicker than Australian regulators. For example, the United Kingdom's Nursing and Midwifery Council processes applications within 10 to 15 working days of receiving all required information.[127] The United Kingdom's Health and Care Professions Council is currently processing applications in approximately 15 days.[128] The Medical Council of New Zealand processes around 95% of applications within 20 working days.[129]

Fast tracking applicants already assessed by trusted authorities

Australia recognises fewer trusted authorities than some international counterparts in

relation to recognising the qualifications, experience, skills and competency of IQHPs seeking registration. Australia recognises 6 competent authorities in 5 countries for IMGs,[130] whereas the United Kingdom recognises more than 30 jurisdictions[131] and Canada recognises 8.[132] New Zealand recognises 2 competent authorities (Ireland and United Kingdom) and 24 comparable health systems for the same cohort.[133]

The European Union's common labour market means the 27 member states automatically recognise medical practitioners, nurses, midwives, dentists and pharmacists who obtained their primary medical qualification in another member state.[134]

Australia does not currently offer expedited registration for medical specialists and many allied health professions. New Zealand accepts qualifications for locum specialists, including for anaesthesia, surgery and general practice, from Australia, Canada, South Africa, the United Kingdom and the United States.[135] The United Kingdom also accepts a range of qualifications for medical specialists and allied health professions.[136]

Recognising skills and experience

The United Kingdom's General Medical Council has changed how it assesses comparability of overseas qualifications. It is now focussing on examining the educational outcomes of qualifications rather than the comparability, or 'equivalence', of specific curriculums to United Kingdom programs. The Council found the equivalence assessment process overly complicated and restrictive (for example only 3 qualifications from Australia were recognised as directly comparable through this process). The primary consideration in this new approach is whether an applicant has the 'knowledge and skill necessary for safe practice' at the level of practice and in the speciality they are applying for. This new framework will expand the possible qualifications considered as comparable when determining which applicants are eligible for fast tracked pathways.[137]

Canada, New Zealand and the United Kingdom grant full registration, rather than provisional registration, to most qualified IMGs entering their health systems. This means IMGs can start performing a broader range of procedures and roles sooner than their counterparts registering in Australia.

Australia has a nationally consistent approach allowing IQHPs to practise in all states and territories, in contrast to Canada and the United States, where state and provincial rules apply.

Greater flexibility on assessments

The United Kingdom[138] and New Zealand[139] have revised their English proficiency requirements for IQNMs, including lowering minimum scores for the writing section of the IELTS from 7.0 to 6.5.[140]

Canada has transitioned medical clinical examinations for registration online, with remote supervision ('remote proctoring'), offering some examinations in more than 80 countries.[141] The AMC also offers online clinical exams and its knowledge exam can be conducted overseas.

The United Kingdom's Health and Care Professions Council, which regulates 15 professions, including occupational therapists, physiotherapist and paramedicine only administers competence assessments to applicants assessed as having particular skills and knowledge gaps. This means only 1–2% are required to undergo further assessments, which are tailored to test identified deficiencies.[142]

Australia requires applicants – except those on the Competent Authority Pathway (CAP) – to complete skills and knowledge competence assessments. For some professions, clinical assessments are only available in-person, requiring applicants to travel to Australia. They are also offered at infrequent intervals.

Lower migration costs

Canada, Ireland, New Zealand and the United kingdom offer lower-cost visas. European Union citizens do not require a visa to work in any of the 27 European Union member states, including Ireland. By contrast, Australia's visa application charges are higher than in other countries and were increased further from 1 July 2023.[143] In addition to the regular price indexation, the Australian Government increased charges by 6% for visa applications, as well as an additional 15% for selected visitor and temporary visa subclasses.[144]

Supporting applicants through one-stop-shops and case management services

Some countries have introduced 'one-stop-shops' to remove duplication in the registration process.

New Zealand has introduced an online portal where healthcare workers can search for jobs, obtain advice on registration and visa processes, and seek settlement support once they arrive.[145] The United Kingdom has introduced a range of recruitment initiatives (refer Box 1.3).

Australia is seeking to better coordinate its registration and accreditation processes. Some local concierge services are offered to assist candidates in navigating the end-to-end journey (for example, the Western NSW Local Health District's centralised recruitment model and the 'Community Connector Program' in Shepparton, Victoria). These examples are discussed further in Box 3.2 in Chapter 3.

Box 1.3: International recruitment initiatives in the United Kingdom

Already the second largest labour market for international nurses in the world,[146] the United Kingdom is aiming to recruit over 51,000 international nurses by 2023–24, in England alone.[147] It takes 3 to 9 months to bring an international nurse to the United Kingdom, on average.[148]

To meet workforce targets,[149] the National Health Service trusts – public health service units – can claim a subsidy of A$13,000 (£7,000) per overseas nurse recruited.[150] This subsidy partially covers the estimated A$20,000 (£10,500) in upfront costs of recruiting international nurses, including relocation and examination costs that candidates would otherwise have to pay.[151] Trusts also receive assistance with conducting marketing campaigns and interviews in source countries.[152]

Recent improvements

Australian governments, professional bodies and regulators are already making significant improvements to parts of the end-to-end regulatory journey.

Ahpra is digitising application forms and processes, and some National Boards and specialist medical colleges are implementing or exploring accelerated pathways. In addition, the Health Workforce Taskforce, which reports to health ministers, is developing national workforce strategies for nursing and maternity. Further information on work underway is contained in Appendix F.

There is also related work underway to improve the healthcare and migration systems. For example, the Australian Government is developing a new Migration Strategy that aims to streamline and reduce complexity in the migration system (refer Box 1.4).

The review's recommendations seek to build on and accelerate this work, while recognising that more needs to be done to increase the number of qualified health practitioners and improve the skill mix of the workforce.

Box 1.4: Review of the migration system

In September 2022, the Hon Clare O'Neil MP, Minister for Home Affairs, announced the comprehensive review of Australia's migration system.[153] The migration review final report, delivered to Government in March 2023, examined the weaknesses of the current migration system and recommended reform directions. Many of these align with the objectives of this review.

Both reviews aim to ensure Australia is a more attractive destination for global talent.[154] Both reviews identify the importance of improving applicants' experiences by reducing complexity and streamlining the end-to-end journey.

Both reviews highlight the need for improved workforce planning to enable timelier interventions to address workforce shortages.[155]

The migration review recommends developing a forward-thinking and adaptive migration strategy with increased transparency and accountability.[156] This aligns with this review's focus on improving regulator performance and embedding stewardship, to make the regulatory system more responsive to changing workforce and community needs.

Both reviews also recognise the importance of better balancing risk with safety. For example, the migration review recommends risk based regulation of temporary skilled migration.[157]

Both reviews acknowledge the value of allowing highly skilled workers to access more efficient migration pathways, and recommend the expansion of 'fast track' pathways.[158]

In April 2023, the Government released for discussion the outline of its migration strategy, informed by the migration review findings. The final migration strategy is expected later in 2023, following further stakeholder consultation.[159]

2. Health system and workforce context

Key points

- Australia's health system is one of the best in the world, underpinned by a highly trained health workforce.
- Only registered health practitioners who are suitably qualified can practise in Australia in the 16 Ahpra regulated professions, helping to ensure a high standard of care.
- Australian trained health practitioners form the bedrock of our health workforce, comprising around 80% of registered health practitioners.
- IQHPs supplement the Australian trained workforce, helping to improve access to services, especially in regional and remote areas.
- The health care and social assistance industry employs 15% of Australia's workforce.

Health system overview

Australia's health system provides high-quality and safe and health care. Our health system is jointly run by all levels of government – federal, state, territory and local. Health services are delivered by a mix of public, private and not-for-profit providers.

Primary care is provided in the community by GPs, nurses and allied health professionals. GPs also refer people to specialist medical services where needed. Medicare – our national public health insurance scheme – provides patient rebates for most medical and diagnostic services, and a small number of allied health services.

Acute care is provided in public and private hospitals. Public hospital treatment is free for public patients, but can be subject to long wait times for elective surgery. Private hospitals cater for people who want a choice of doctor and private ward accommodation. They also include a growing number of 'day-only' specialist facilities.

Public community health facilities provide a range of other health services, including immunisation and mental health services.

Allied health professionals are involved in preventing, diagnosing and treating a range of health conditions.

As at June 2023, more than 250,000 allied health professionals were registered with Ahpra.[160]

Registered allied health professionals are university-qualified and can work within a multidisciplinary health team to provide specialised support for different patient needs. There is no one definition of allied health, with different definitions used internationally and across Australia. This review defines allied health as health professionals who are not part of the medical or nursing professions, with a focus on those regulated by Ahpra.

Many allied health professionals work across multiple sectors, including primary, acute, aged and the disability care sectors. They often work on a contractual or part-time basis. As a result, a single allied health professional may practise across multiple regulatory regimes. This creates the potential for inconsistent service delivery across sectors and may result in a higher administrative burden on the allied health professional. Consumers may also be confused about expectations for high-quality and safe care, and who to turn to if something goes wrong.

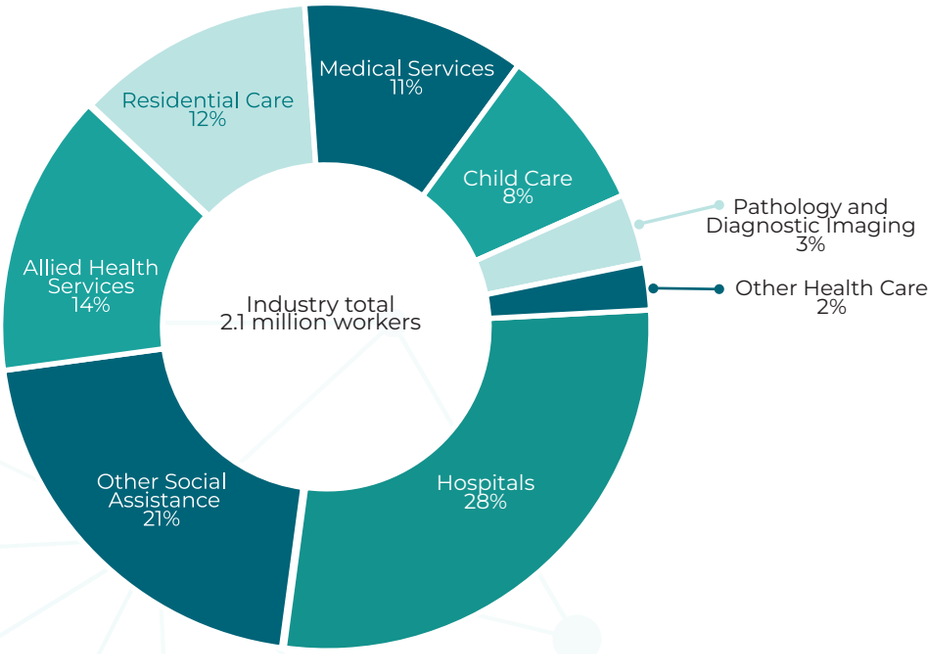
With the growing complexity of Australia's healthcare needs, responsibility for providing the care people need should be shared by cross-sectoral multidisciplinary teams. Four of the 5 top causes of burden of disease in Australia require ongoing support from multidisciplinary teams, including allied health, for effective prevention, treatment and management.[161] The WHO has identified a range of benefits from multidisciplinary collaboration and practice, including higher levels of patient satisfaction and better health outcomes.[162]

Health workforce overview

Health care and social assistance[163] is Australia's largest employing industry, accounting for more than 2.1 million workers or around 15% of the overall workforce (see Chart 2.1).[164]

Chart 2.1

Health Care and Social Assistance Industry by sector



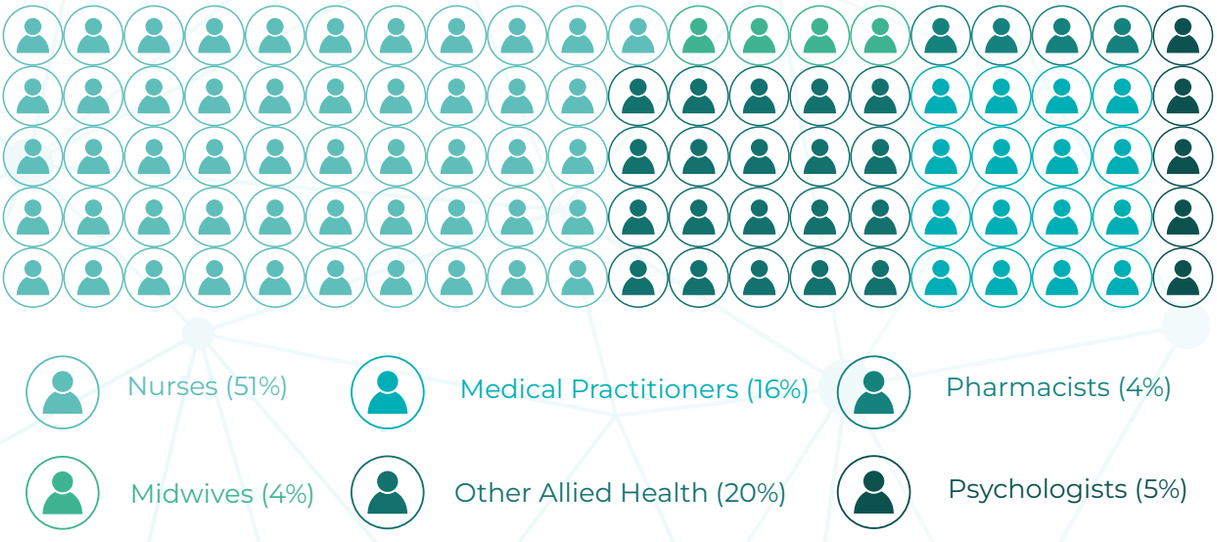
Source: Jobs and Skills Australia, February 2023.

Chart 2.2 shows the current composition of the health workforce.

Chart 2.2

Representative share of Australia's health workforce by profession

Ahpra board registration data



*Other Allied Health refers to: Aboriginal and Torres Strait Islander Health Practitioners, Chinese Medicine Practitioners, Chiropractors, Dental Practitioners, Medical Radiation Practitioners, Occupational Therapists, Optometrists, Osteopaths, Paramedics, Physiotherapists and Podiatrists.

Source: Ahpra National Boards, Statistics, 2023.

Australia will only be able to deliver access to safe and appropriate health care services if it has enough suitable health practitioners with the right skills to provide the right services in the right locations. Examining the factors influencing demand for, and supply of, health practitioners can be useful for identifying and responding to existing and emerging workforce challenges. The review acknowledges that other measures may also be required to improve healthcare access. These measures could

include empowering practitioners to work to their full scope of practice, enabling greater use of multidisciplinary teams and using technology to deliver services and specialist care.

Australian trained health practitioners remain the bedrock of our health workforce, comprising around 80% of that workforce.[165] Building and maintaining a workforce of sufficient size and capability to meet the needs of all Australian communities is a priority for all Australian governments (see Box 3.8 in Chapter 3). This work needs to consider changing models of care, differences in local needs, workforce demographics, population changes and the infrastructure and technology available to deliver sustainable, high-quality care.

IQHPs play a key role in supplementing and supporting the Australian trained workforce, especially in certain professions and specialities, and in regional, rural and remote areas (see Chart in Box 2.1). For example, more than 50% of GPs completed their initial training overseas.[166] Around 13% of Australia's nurses and around 30% of medical practitioners were internationally trained.[167]

Between 1 January 2022 and 31 July 2023, more than 27,000 IQHPs have been registered for the first time to practise in Australia. This includes almost 16,000 nurses and midwives, nearly 6,000 doctors, and more than 5,000 allied health professionals.[168]

The Australian community relies on and benefits from the skills of IQHPs (see Box 2.1).

Box 2.1: IQHPs bring significant social and economic benefits

Our high quality health system, high standard of living and competitive salaries make Australia an attractive destination for IQHPs. IQHPs also consider our regulatory settings, and the cost and availability of housing, education and childcare in their decision making.

IQHPs are important for improving the distribution of the health workforce and providing services where there is an insufficient Australian trained workforce.

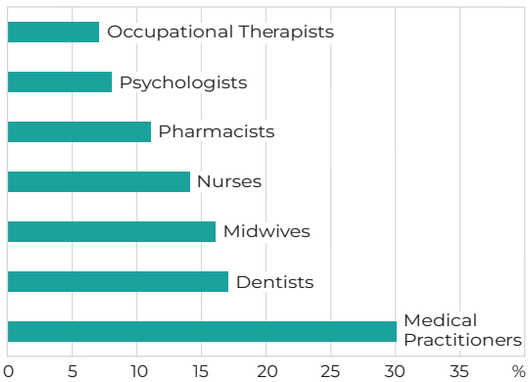
Just as IQHPs may benefit from coming to Australia, they also provide significant benefits for Australians. For example, their employment can improve health care access, increase the nation's productivity, foster innovation and contribute to Australia's economic growth over the long term.[169] Migrants also contribute to Australia's diversity, dynamism and multiculturalism.

Public and private employers have noted that IQHPs play an important role in the composition and distribution of their workforce:

- 'NT Health is highly dependent on the employment of overseas trained health practitioners, particularly in the areas of medicine, nursing and midwifery, pharmacy and dental officers.'[170]
- 'As is the case across the country, Queensland Health has a continued reliance on the international health practitioner workforce to supplement domestic supply, particularly in regional and rural Queensland.'[171]
- 'At Ochre Health, overseas trained doctors are a fundamental requirement to supplement the deficit of Australian trained graduates choosing General Practice. This requirement is amplified exponentially in regional locations (MMM3–7).'[172]

IQHPs supplement the health workforce

proportion of registered practitioners with overseas qualifications



Source: Ahpra 2023

In addition to filling urgent vacancies, IQHPs provide other benefits to the community. These include being proficient in other languages – particularly relevant for multicultural communities – and enriching the diversity of skills, experience, and knowledge of the broader healthcare workforce.

Chart note: International qualification statistics referenced are based on data from Ahpra. Variability in international qualifications data may occur, particularly where IQHPs were registered prior to the establishment of the National Registration and Accreditation Scheme in 2010.

Benefits of the National Registration and Accreditation Scheme

A national scheme providing cross-professional consistency

The introduction of the NRAS in 2010 was a significant reform to health regulation in Australia. Recommended by the Productivity Commission's 2005 report on Australia's health workforce, the NRAS replaced previous state based registration and accreditation arrangements with a nationally consistent scheme.[173]

The NRAS ensures the community has access to a safe and competent health workforce by requiring health practitioners to meet consistent, high quality, national professional standards. The national approach also facilitates workforce mobility. Once registered, health practitioners can work across Australia.

The NRAS supports profession-led standards

The *National Law*, adopted as mirrored legislation in each state and territory, established the National Boards and Ahpra.[174] The prominence given to safety has allowed for a nationally coordinated approach to accreditation, registration and, to a lesser extent, notifications against practitioners.

The NRAS covers 16 health professions:[175]

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners
- chiropractors
- dental practitioners
- medical practitioners
- medical radiation practitioners
- midwives
- nurses
- occupational therapists
- optometrists
- osteopaths
- paramedics
- pharmacists
- physiotherapists
- podiatrists
- psychologists.

Ahpra works in partnership with the 15 National Boards overseeing the professions to implement the scheme (the nursing and midwifery professions are overseen by one National Board, the NMBA). National Boards are responsible for accrediting programs of study (through their respective Accreditation Authorities), and developing registration standards, codes and guidelines for their professions. On behalf of the National Boards, Ahpra also manages applications for registration and notifications about performance and conduct – investigating where appropriate – and maintains a public register of health practitioners.

It is important to acknowledge that the NRAS does not cover all health professions. Health ministers consider risks to safety and quality of care and the public interest to determine if a health profession should be included under the NRAS. Some allied health professions, including speech pathologists and social workers, are known as self-regulated professions and have advocated for their inclusion in the scheme. They note potential benefits include protection of title and improved quality assurance and reporting, with all practitioners requiring registration to practise.

The NRAS prioritises safety but has demonstrated agility and responsiveness when required

Stakeholders said the NRAS is a robust regulatory system that prioritises safety and ensures IQHPs are as equally qualified and capable as Australian trained practitioners. They said its consistent national regulatory framework allows for practitioners to work across jurisdictions and provides greater alignment and comparability of standards across professions.[176]

The NRAS has shown it can be flexible, responding to changing needs, which was demonstrated during the COVID-19 pandemic. National Boards were able to use their in-built discretion to adjust regulatory requirements at short notice. This enabled the creation of a pandemic response sub-register to temporarily increase the health workforce in response to the pandemic. Eligible health practitioners who had been registered but had recently left practice or changed to non-practising registration were included on the sub-register. This streamlined the application and change of circumstance processes. It also aided flexibility in supervising exams, which were held remotely.

All health professionals regardless of regulatory status must comply with the National Code of Conduct for healthcare workers. This sets out the minimum practice and ethical standards with which healthcare workers must comply.[177]

Self regulated allied health professions

A number of allied health professions are not regulated under the NRAS, including social workers, speech pathologists, dietitians and exercise physiologists.

Many of these self regulated allied health professions have their own accreditation standards, overseen by professional associations. While membership to these associations is voluntary, Australian governments and some employers recognise certain professional association standards to assure a minimum level of qualifications and professionalism. Hence, a practitioner may need to become accredited with their professional association to:

- comply with state and territory regulations
- work in certain settings such as hospitals
- prescribe treatment
- qualify for Australian Government and private health insurance rebates.

3. Key reforms to improve the end-to-end journey

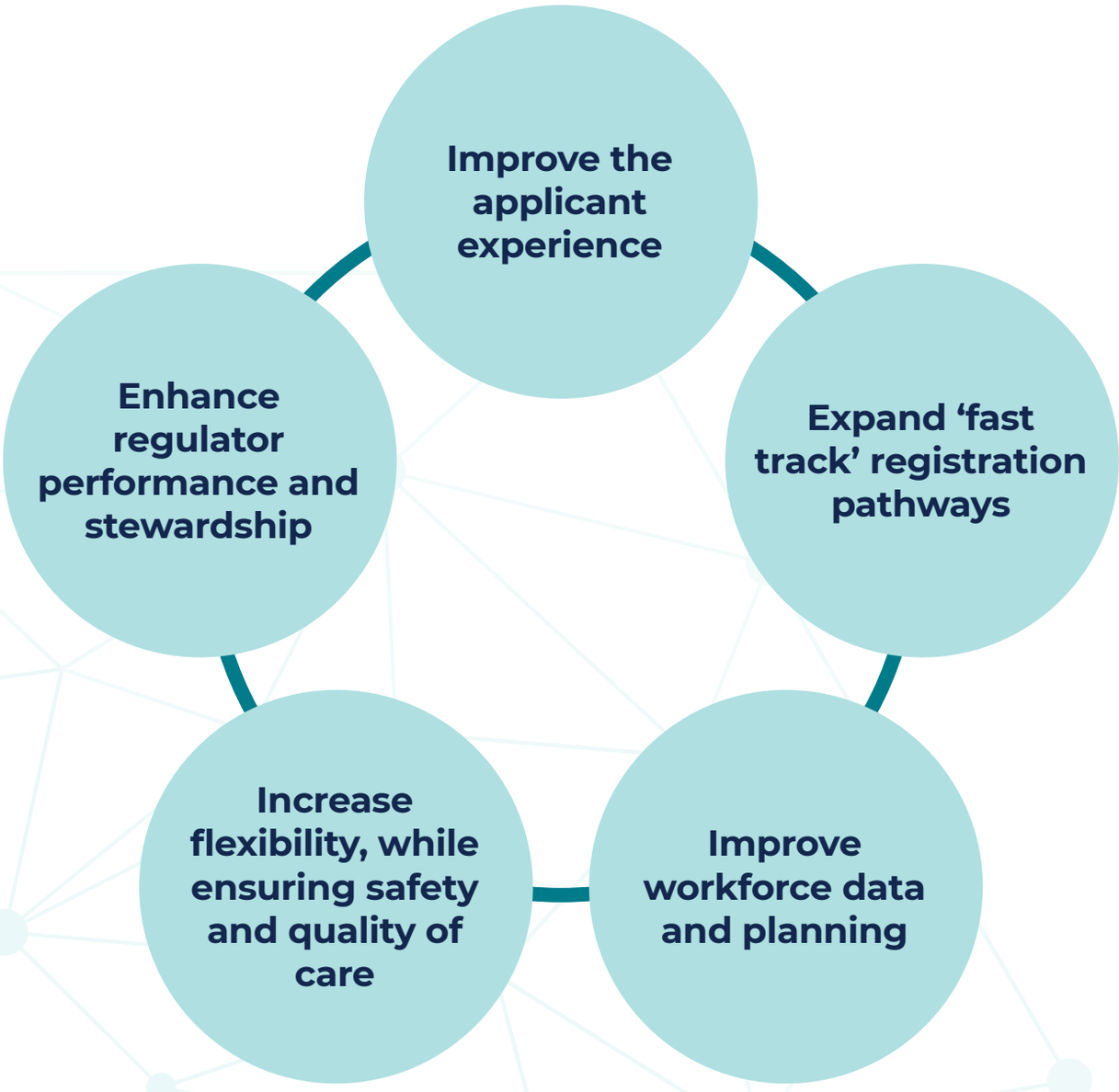
Key points

- The final report contains 28 recommendations under five broad reform areas to support an efficient and effective end-to-end regulatory journey:
  - improve the applicant experience
  - expand 'fast track' registration pathways
  - better workforce planning
  - greater flexibility, while supporting safety
  - enhance regulator performance and stewardship.
- Combined, the recommended actions will reduce regulatory costs – that is, time, money and effort – incurred by employers and IQHPs looking to work in Australia. Benefits include:
  - more cohorts of IQHPs who meet high professional standards will be fast tracked
  - unnecessary migration barriers will be removed, making it quicker for employers to fill vacancies
  - Australia's ability to attract experienced IQHPs in acknowledged areas of need will improve.
- A more efficient and effective end-to-end regulatory journey should also encourage more IQHPs, particularly mid-career and specialised practitioners, to seek work in Australia, bolstering the current health, aged and disability care workforce.
- The review has identified several 'escalation' recommendations for health ministers to implement should initial changes not generate the desired workforce response within agreed timelines. These include other methods to fast track additional cohorts of IQHPs for registration and changing roles and responsibilities of specialist medical colleges.
- Reforms to reduce migration barriers for suitably qualified, skilled and experienced IQHPs have been identified as requiring urgent action.

Framework and priority reform areas

The final report puts forward 28 recommendations under 5 broad reform areas to improve the efficiency and effectiveness of the end-to-end regulatory journey (see Figure 3.1).

Figure 3.1: Reform priorities to support an efficient and effective end-to-end journey



These recommendations consolidate the recommendations contained in the interim report, which were endorsed by National Cabinet on 28 April 2023. They factor in feedback from health ministers, officials, Ahpra, the National Boards and other stakeholders, as well as survey responses from more than 1,700 IQHPs. The recommendations are intended to:

- respond to the urgent workforce challenge by identifying and prioritising measures that can be implemented now, with immediate payoffs in terms of time and cost savings to applicants and the regulatory system
- explicitly acknowledge the current risks posed by lack of access to health services
- be ambitious, noting that access to skilled health workers is a global issue and Australia's regulatory systems need to be fit for purpose to be competitive.

Recommendations for immediate action

The review has identified a subset of priority recommendations that should be actioned now (refer to Table 1 of the Executive Summary). These priorities remain largely unchanged from the interim report endorsed by National Cabinet. These priorities have been endorsed by health ministers.

The priority recommendations are expected to have the greatest short to medium term impact by:

- allowing fast tracking of more cohorts
- better valuing the skills and experience of mid-career and specialised practitioners
- removing costly migration barriers to IQHPs in areas of acknowledged workforce need.

Improve the applicant experience

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

A system designed with insufficient focus on the applicant

Applicants engage with many regulators and agencies throughout their end-to-end journey.

Processing times across the whole journey are lengthy, given the sequential nature of the registration, visa and Medicare processes and the time taken to complete each discrete stage.

The current system is fragmented, with no single place to find information. From an applicant's perspective, it can be difficult to find out the progress of their application or receive timely advice if supporting documentation is missing. This can create a feeling of helplessness and discourage them from continuing with their application.

Agencies and regulators are aware of the problem and have recently implemented changes to address some of these issues.

DoHA has made improvements to the visa application process to address Australia's visa backlog and reinstate a 'client service culture'.[178] These improvements include designated resources to work with applicants and more staff to process key caseloads.

Similarly, Ahpra has begun streamlining registration processes, and has increased the information available to applicants. It has also increased its capacity to support the assessment of applications and provide earlier feedback to candidates on outstanding requirements.[179]

Some NRAS entities noted that they already take a user-centred approach. For example, the AMC already offers specialist IMGs an 'online self-check of eligible schools, medical degrees and graduation years [which] provides significant transparency around the recognition of overseas qualifications'.[180] Similarly, the Australian Pharmacy Council reports it has 'a well-established single portal process already in place, and a personalised candidate support team which is highly effective for our profession and receives high praise from our candidates – particularly those that are experiencing difficulties. This connection remains right through their journey, including a seamless single onboarding process to register for their exam'.[181]

While these changes have been welcomed by stakeholders, they are neither coordinated nor consistent across regulators and agencies. Applicants should be required to meet regulatory obligations that are consistent with the risks they pose, not the administrative structure and culture of individual regulators and agencies.

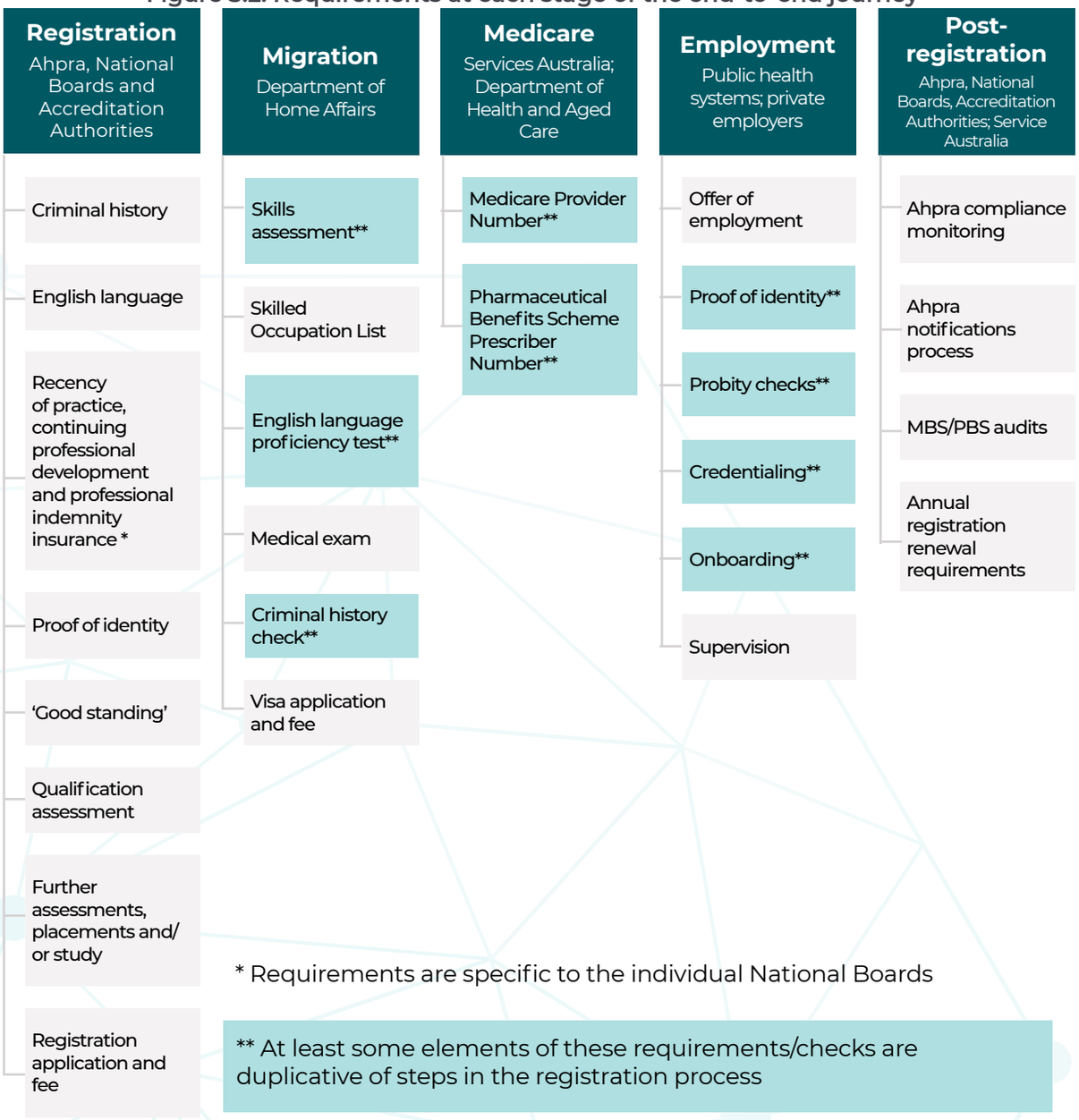
The review has heard that when considering the end-to-end journey holistically, there remains a frustrating level of duplication, and a lack of transparency regarding assessment processes and the expectations on applicants.[182] These are some common complaints.

- Multiple agencies and regulators ask for identical or similar information, often in different formats and/or with different evidentiary requirements. This creates needless costs and delays for applicants.
- Information about how to navigate the process is difficult to find and interpret.
- There is limited real time support for applicants, particularly in navigating the discrete components of the process, compiling documentation and ascertaining the progress of their application.
- There are few opportunities to seek redress if an applicant believes regulators have erred in reaching a decision.

Duplicative and inconsistent evidentiary requirements create frustration

Requirements are duplicated and mismatched across the registration, skills accreditation, and visa processes. This is particularly the case with skills assessments, English language and criminal history requirements, and identity checks (see Figure 3.2 where duplicative requirements/checks have been highlighted in blue).

Figure 3.2: Requirements at each stage of the end-to-end journey



Criminal history and identity checks are duplicated by Ahpra and DoHA, imposing needless costs and delays on applicants. Some requirements are also onerous. Historically, applicants have been required to complete an in-person identity check in Australia before their registration could be finalised, and applicants who have never been to Australia have been required to provide an Australian residential address.

From late 2023, applicants will no longer be required to present in person as part of the Ahpra domestic criminal history checks if they have never visited Australia.

In several professions, the skills assessment for migration is undertaken by a different entity than the one for registration. This leaves some applicants who arrive in Australia, and who have met the visa requirements, unable to meet the registration requirements to practise without undertaking further study and/or assessment.[183] Such outcomes present great challenges and potential costs to the applicant and their family.

Better aligning evidentiary requirements and information sharing will save time and money

All regulators and agencies involved in the end-to-end journey of IQHPs need to adopt a more user-centred approach and consider how their requirements and decision making interact with other steps in the journey.

Submissions to this review support removing duplication and aligning evidentiary requirements to minimise the need for applicants to provide the same information multiple times, and for better information sharing across regulators and agencies.

Relevant regulators and agencies should act so that applicants are only required to submit documents once. Action should be guided by the following principles:

1. **User-centred**: the experience should be seamless from the applicant's perspective; it is up to entities to establish how to facilitate this through coordinating efforts and co-designing processes.
2. **Proportional and evidence based**: requirements should not be greater than needed to satisfy the regulatory objective, based on evidence.
3. **Quality**: high standards should be maintained, while providing greater flexibility in meeting evidentiary requirements.
4. **Trust**: where multiple entities have similar processes, requirements or checks, they should rationalise and rely on one entity's check to inform their decision making.
5. **Transparency**: entities must report regularly and publicly on their performance and progress towards achieving these outcomes.

To this end, the review considers that work to share registration and migration information between Ahpra and DoHA should be accelerated:

- remove the need for Ahpra to check domestic criminal history when an applicant has never been to Australia, once verified through DoHA
- replace the need for candidates to complete an in-person identity check with Ahpra to finalise their registration with an integrated biometric identity verification
- remove the need for separate English language testing for migration
- allow IQHPS to apply for criminal history checks before arriving in Australia
- integrate criminal history checks with visa processing and credentialing.

Automating the issuance of Medicare Provider Numbers should be rapidly extended to IQHPs

To bill Medicare, eligible health practitioners require a MPN for each practice location. The PBS prescriber number is issued at the same time as the MPN as it's part of one process and on the same form.

MPNs are requested through Services Australia. While the eligibility requirements are linked to registration or accreditation for most professions, medical practitioners must undertake additional processes to confirm training and qualifications, or seek an exemption from the restrictions set out in the *Health Insurance Act 1973* (Cth).

For example, some IQHPs must be granted a location specific exemption to bill Medicare. Services Australia can apply numerous class exemptions; however, if an application falls outside of this, it is referred to DoHAC for assessment of an individual exemption.

Services Australia and DoHAC have been working to ensure MPN registrations are processed within 28 days. However, during busy peak periods, IQHPs can wait up to 3 months to have their exemptions processed. During this time, the IQHP is unable to perform Medicare or PBS services, rendering them unable to work.

Jurisdictions supported prioritising and accelerating current work to automate the MPN process by providing an end-to-end digital system.

If implemented, the digital system may remove the need for manual processing by transmitting the required information from Ahpra to Services Australia, significantly reducing the time to issue an MPN to 24–48 hours from registration.[184]

Applicants would benefit from a 'single portal', which should make use of existing digital systems where possible

Efforts to streamline, remove duplication and automate steps would be welcomed by applicants and employers, but would only partially address the issue of IQHPs engaging with multiple regulators throughout the end-to-end journey.

Submissions to this review indicate strong, general and in-principle support for the adoption of a single portal. A single portal would provide a platform to centralise evidence collection, share information between regulators and agencies, and provide

applicants with a single place to meet their regulatory obligations. Maintaining a single portal would require regulators to work together consistently and sustainably, locking in many of the proposed reforms in this review.

However, the review acknowledges concerns raised by some stakeholders that developing a bespoke IT platform would likely require a major investment by jurisdictions and NRAS entities and would take a long time to deliver.[185]

To avoid or mitigate these risks, regulators and agencies should explore opportunities to capitalise on investments underway to deliver these outcomes.

Ahpra and DoHA are currently upgrading their digital systems, with the former intended to replace the ageing system that was developed at the commencement of the National Scheme (refer Box 3.1).

There is a limited window of time to leverage these investments in a way that maximises the benefits for the community and ensures future system interoperability. For example, Ahpra will need to become an 'accredited user' through the Data Availability and Transparency Scheme to enable it to receive information shared by Australian Government agencies.[186]

Consistent with the guiding principles underpinning collaboration, back-end solutions that are designed and agreed between entities, and that have the ability to deliver a seamless experience for applicants in a timely way, warrant higher priority than a bespoke single platform. Equally, aligning standards and evidentiary requirements will enable the information shared to satisfy the regulatory requirements of all relevant parties.

Box 3.1: Ahpra's Digital Transformation Project

Ahpra is transforming its digital systems and modernising and simplifying regulatory processes to replace the system developed in 2010. The changes are being rolled out over 2023–24 with new capabilities added with each release. The transformation project will deliver:

- new secure, single sign on to keep practitioner information secure
- integrated longitudinal student register data for improved workforce and operational planning, and more personalised engagement with students
- digital smart forms for all applications and concerns raised with Ahpra so information is entered directly in their systems
- end-to-end case management capability
- exam management capacity
- portals to provide a 'tell us once' single stop for applicants, practitioners and others to interact with Ahpra
- integrated biometric identity verification removing current costly, manual, face to face approaches.

Over time, Ahpra expects the upgraded systems will enable continuous improvement and integration with other entities.

The review also notes the non-monetary implementation barriers that would need to be overcome with any technological solution adopted, including removing (any) legislative barriers to information sharing and the creation of sufficiently robust safeguards to identify, protect, store and transmit sensitive information.[193]

A phased and piloted approach could help with implementing this significant change.[194]

As suggested by some stakeholders, in the medium term there would be benefits in exploring the portal's potential to reduce the burden of employer onboarding processes, minimising further costs and delays by reducing duplication in this step.[195] Over time, the portal could also be expanded to include applicants entering Australia in unregistered and self regulated professions, giving them the same benefits.

Ahpra notes that there will be additional costs associated with extending its digital systems to support a portal.[196] Exact costs will depend on the technological solution(s) adopted, with modest costs also likely for Australian Government agencies to enable information sharing. Ultimately, a single portal for applicants would meet the needs of users who are unfamiliar with Australian processes, setting Australia apart from its international peers.

Recommendation 1:

Streamline, remove duplication and align standards, evidentiary requirements and policy settings across agencies and regulators involved in the end-to-end journey, so applicants only need to provide information and meet requirements once, moving to a single portal over time.

Recommendation 2:

Automate the issuance of Medicare Provider Numbers.

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

Labour market testing is an unnecessary burden on employers and communities

Labour market testing (LMT) is currently required before some types of visas will be issued. For example, the Temporary Skills Shortage visa (subclass 482) short-term stream and medium-term stream and Skilled Employer Sponsored Regional (Provisional) visa (subclass 494) require an employer to demonstrate that they are unable to find a suitable Australian worker.[187] LMT generally involves advertising the position in Australia, and it delays the nomination of a visa applicant by about 3 months.

The migration review found LMT conducted by employers has been ineffective and a cause of unnecessary delay. As a result, the migration review proposed that LMT be removed.[188]

This review agrees that current LMT arrangements are unnecessarily onerous, given the relevant visas are only available to individuals who work in occupations on the Skilled Occupation List, and that health has been identified as a priority area for visa processing.[189]

While alternative evidence requirements are available for some nominees within certain Australian and New Zealand Standard Classification of Occupations (ANZSCO) groups and/or for those with annual earnings equal to, or greater than, $250,000, these should be expanded and requirements further reduced to expedite the nomination process.[190] The review considers it a priority to suspend LMT arrangements for IQHPs in acknowledged areas of shortage. Expedited action is important as health is a critical service.

Submissions from a broad range of stakeholders identified the removal of LMT as a priority, noting its potential to reduce costs and fill shortages quicker.[191] Other stakeholders expressed their concern that removal without mitigating action could be exploited to fill jobs in metropolitan areas or encourage employers to focus on recruiting IMGs over Australian trained practitioners.[192]

The review considers that the risk of displacing job opportunities for Australians is low, given skills shortages are widespread (globally) and vacancies are persistently high. Some skills, such as those of specialists, are extremely scarce.

Recommendation 3:

Remove or suspend the requirement for employers to advertise for domestic applicants in acknowledged areas of shortage before recruiting overseas.

Age restrictions deter the highly experienced practitioners our health system needs

Most permanent Australian visas are generally only available to individuals under 45 years of age, meaning many senior health practitioners are ineligible. Age caps to permanent residency are imposed to reduce the chance of a migrant's lifetime fiscal costs exceeding the revenue raised from them.

Many health practitioners do not achieve full credentials until their 30s. A practitioner will then take a decade or more to acquire the skills and experience needed to reach seniority in their field.[197] Health practitioners also tend to retire later and continue to play key roles as mentors and supervisors for domestic and international graduates in key areas of shortage.

In a globally competitive market for health talent, employers are reporting that practitioners are unwilling to move to Australia on a temporary visa. The Tasmanian Department of Health commented that age caps are 'a significant issue for Tasmania, directly impacting skilled and experience[d] medical practitioners working within our health services' and are a deterrent to those considering coming to Australia.[198] Moreover, highly skilled and experienced practitioners often migrate with their families, so may be reluctant to relocate for temporary opportunities as these are significantly less attractive to this cohort.

Increasing the number of practitioners who are eligible for exemptions to the age cap and/or raising the age cap, would increase Australia's access to the highly skilled and experienced IQHPs we need.

While raising, or expanding exemptions to, the age caps on permanent residency may have fiscal impacts, these should be weighed against the costs from lack of access to health care, including poorer health outcomes and an over-reliance on an expensive locum workforce.[199] In discussion, stakeholders identified raising the age cap to 55 years as striking the appropriate balance between managing potential fiscal pressures and gaining the specific expertise and benefits that these practitioners can bring to the Australian health context. It is worth noting that experienced IQHPs are more likely to be earning high incomes and therefore less likely to receive government support.

Raising the age cap would immediately increase Australia's access to experienced, senior practitioners, addressing urgent workforce shortages.

Recommendation 4:

Broaden the age exemption on skilled visas to enable skilled practitioners in acknowledged areas of shortage to permanently move to Australia.

Linking visas to a narrowly defined occupation code limits workforce flexibility and mobility

The skilled occupations list uses ANZSCO groupings to identify occupations in shortage.

The ANZSCO groupings limit flexibility for employers and can prevent health practitioners from upskilling and moving to areas of need as they cannot perform duties or tasks beyond their nominated ANZSCO occupation without a new nomination (except temporarily). This limits some health practitioners from working to their full scope.

The review has heard that the current skilled occupation lists have not kept pace with emerging workforce shortages.[200] Consistent with this observation, the migration review found that the lists were outdated and unresponsive to changes in the labour market.[201]

An IQHP and their employer should be able to negotiate additional duties without applying for a new visa.

Recommendation 5:

Provide greater visa flexibility by enabling key health practitioners to undertake additional duties, without needing a new visa nomination, and ensuring current skilled occupation lists are up to date.

The review supports quicker and easier pathways to permanent residency for suitable international health graduates

International students should be good candidates to move from study into Australia's permanent skilled visa stream in areas of acknowledged shortages.

However, the migration review found that many international graduates, even in areas of skill shortage, experience difficulties in our labour market.[202] For example, international graduates receive, on average, lower wages than their domestic peers – initially and after 3 years. Many also work in lower-skilled roles post-study. The migration review identified

concerns with the quality of education, the standard of English and the use of student visas for non-study purposes, such as accessing the Australian labour market.

As a result, the migration review recommended that there would be value in providing a pathway to permanent residency for those international students with the greatest potential to contribute. The review supports this recommendation.

Some stakeholders supported the provision of more pathways to permanent residency, such as transition to practice programs or other supported employment programs, available to workers on temporary visas as well as graduates in a range of areas.[203] Others were concerned about circumventing the standard visa processes and whether it would solve issues with poor distribution, especially in regional areas.[204]

Recommendation 6:

Provide greater transparency and a quicker and easier pathway to permanent residency for suitable international health graduates in acknowledged areas of shortage, who have studied in Australia.

The Skilling Australians Fund levy compounds high costs to employers

Employers must pay a training contribution charge on skilled visas, through the Skilling Australians Fund (SAF) levy. The SAF levy is designed to contribute to the broader skills development of Australians. The revenue collected is intended to be used by participating jurisdictions to facilitate the increased uptake of VET opportunities, such as apprenticeships and traineeships.[205]

Employers cannot pass on the SAF levy to the visa applicant. The levy, which depends on business size and visa type, can be up to $1,800 per person per year, or $5,000 as a one-off payment.

In the migration review, employers questioned the SAF levy's role. It recommended that fees, such as the SAF levy, should not be paid upfront.[206]

The rationale of imposing the levy to improve Australians' employment outcomes in the health sector is weak. In many instances, the SAF is unable to fund the development of a domestic health workforce because the professions in areas of shortage require higher education qualifications (usually university). The levy increases the recruitment costs of IQHPs in areas of critical health need, mainly to fund training outside of health care.

One major health employer suggested that removing the levy would provide the opportunity for further direct investment in employee training and development.[207]

The review agrees the SAF is an unnecessary burden on a health system and workforce under pressure.

Recommendation 7:

Remove or suspend the Skilling Australians Fund levy for health professions in acknowledged areas of shortage.

A lack of coordination increases system costs

There is intense competition between and within states and territories to fill key skill shortages. For example, all jurisdictions have introduced a range of monetary incentives to attract IQHPs.

Under its 'Workforce Attraction Incentive Transfer Scheme', the Queensland government pays interstate and international medical practitioners up to $70,000 to move to the state. Other jurisdictions provide incentives to help with relocation and other expenses. These incentives are typically higher for roles in rural and remote locations.

As at August 2023, no agreement had been reached between jurisdictions to limit competition for this scarce workforce. Submissions highlighted the negative impacts of this, including higher overall health costs, potential distributional issues associated with access, and a loss of in-house expertise in the public health system.[208]

While the review acknowledges the pressures faced by individual jurisdictions and health districts due to acute localised shortages, the review believes greater coordination would reduce costs for all and better support strategic workforce objectives, including those related to distribution.

Supporting applicants to navigate the process

Support services and systems can help applicants navigate complexity in the process, strengthen their understanding of the Australian health system, and help them and their families find their feet in a new country and community.

Some countries, such as Canada and New Zealand, have concierge services that help applicants find employment and accommodation, and provide information on living and working in the country.

At present, Australia lacks a dedicated national concierge service. Several submissions suggested that a lack of consistent engagement and support weakens candidate recruitment and retention.[209]

Some jurisdictions have moved to coordinated recruitment of IQHPs and to bolster their support services.

For example, WA Health launched its 'Belong' attraction campaign in October 2019 to support the streamlined recruitment of IQHPs across all health service providers. This includes creating one candidate pool for IQNMs with centralised administrative support and allocation functions.[210]

In other instances, local communities and employers provide support services as a point of differentiation.

The Western NSW Local Health District Centralised Recruitment and Candidate Engagement Model and the Greater Shepparton 'Community Connector Program' are 2 examples of local support services. (refer Box 3.2) Such programs recognise the important role that local employers and communities play in improving not only applicant outcomes, but also outcomes for the communities they serve.

Recommendation 8:

Centralise back-end support within jurisdictions, and front-end support across jurisdictions as part of the development of a single portal, to drive efficiencies and reduce costly competition for the same workforce where possible. Local communities and employers would retain a role in welcoming, supporting and retaining their workforce.

Box 3.2: Case studies of local support services

Western New South Wales

- Western NSW Local Health District (LHD) has a dedicated team which supports candidates through their journey and assists with relocating their families, including finding accommodation, to improve hiring outcomes for rural and remote hospitals.
- A key aspect of the program is making candidates feel welcome, informed and committed to working in their new role long-term.
- A comprehensive 4-week orientation program is provided, including 'scenario-based, simulation training to the bush' and helping overseas practitioners understand Australian medical settings.
- Through centralised recruitment and enhanced engagement, Western NSW LHD has seen substantial improvements in candidate-to-employee conversion rates, the time taken to recruit and the quality of hiring outcomes.
- The model is currently applied to the engagement of overseas nurses, but the process is scalable across the LHD workforce.

Greater Shepparton Victoria

- Greater Shepparton City Council through its 'Community Connector Program' offers a concierge service that assists with all aspects of relocation, including finding accommodation, a job for their partner and the right school for their children, for future employees of local businesses, including health services. The approach is person-centred and holistic.
- A key to the program's success in retention is the extended period of support for at least 12 months after relocation.
- With the introduction of the model, 77%of professionals who relocated over 12 months ago have been retained and 67% indicate their intent to stay in the region for the foreseeable future.

Expand fast track registration pathways

Recognising trusted overseas regulatory systems and more countries would increase access to health services at low risk

Expedited pathways are available from few countries

National Boards seek to determine whether an applicant has an 'approved', 'substantially equivalent, or based on similar competencies' or 'relevant' qualification.[211] This assessment is a rigorous process that is based on the comparability of an applicant's qualifications and training. Applicants holding qualifications that are consistent with the first 2 categories do not generally face substantial obstacles to registration and, in some professions, are eligible for expedited pathways.

Applicants who hold practising registration in New Zealand can also access an expedited registration pathway in Australia under the *Trans-Tasman Mutual Recognition Act 1997* (Cth). This pathway is available to practitioners in all Ahpra regulated professions, except those in medicine and Aboriginal and Torres Strait Islander Health Practitioners.[212] New Zealand practitioners submit an online registration application to Ahpra that includes proof of their current practising registration and identity. The application is assessed within 30 days.[213]

Most IQHPs enter through 'standard' pathways. The journey to registration and skills accreditation is typically lengthy and complex for these IQHPs, and they incur higher direct and incidental costs as outlined in Chapter 1. Applicants entering through these pathways will typically need to pass knowledge and clinical exams, and may undergo significant periods of supervision.

National Boards and Accreditation Authorities determine which regulatory authorities or qualifications are eligible for expedited pathways to registration (see Appendix E). Expedited pathways involve regulators making assessments up front to approve trusted overseas regulatory systems, to avoid the high costs of individual assessments later.

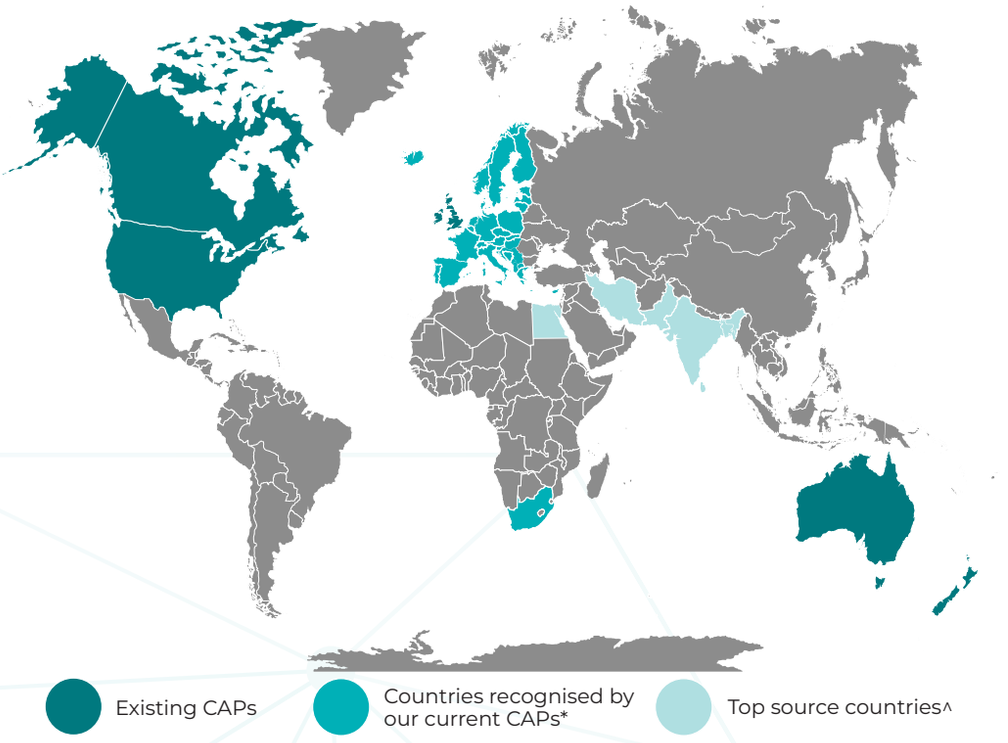
Some NRAS entities recognise trusted overseas bodies as 'competent' to perform certain functions, such as health practitioner education and assessment. Applicants who were assessed by these trusted 'competent authorities' are deemed to have met the same clinical knowledge and skills standards as Australian practitioners.

There are no expedited pathways for medical specialists. A specialist medical college will assess an IMG against the criteria for an Australian trained specialist in the same field of speciality practice, finding them 'substantially comparable', 'partially comparable' or 'not comparable'.[214] Following initial assessment, the IMG will need to undergo a period of supervised practice, which may involve the completion of a WBA or further training. This may also involve further college assessment, including examinations.

Notably, Australia recognises fewer trusted authorities (or qualifications) than some of our international counterparts with which we compete for IQHPs (see Figure 3.3). The United Kingdom offers expedited pathways to more than 30 jurisdictions, Canada recognises 8, and New Zealand recognises 2 competent authorities (Ireland and United Kingdom) and 24 comparable health systems for IMGs. As a feature of their common market, European Union member states have automatic mutual recognition for medical practitioners, nurses, midwives, dentists and pharmacists who have obtained their primary health qualification in another member state.

Figure 3.3

Expedited registration pathways available for IMGs



*These represent the countries recognsied as comparable or competent by the countries Australia currently recognises as a CAP.

^In some cases, applicants from top source countries have completed post-graduate training with recognised competent authorities, enabling them to gain expedited registration in Australia. Top source countries refer to the 10 countries where most IMGs practising in Australia have obtained their primary medical qualification according to 2022 Ahpra data, namely the United Kingdom, India, New Zealand, Sri Lanka, Ireland, Pakistan, South Africa, Bangladesh, Iran and Egypt.
Note: Australia currently recognises some of these countries as CAPs, colour-coded accordingly.

Many stakeholders support, or support in principle, the objective of enabling more cohorts to be fast tracked, provided that new expedited pathways are based on evidence and thorough assessment, and existing public health and safety standards are maintained.[215]

However, some stakeholders are less supportive, noting that these pathways already exist or that they are concerned it will lower standards.[216]

Some specialist medical colleges have concerns about introducing fast-track pathways for specialist international medical graduates (SIMGs).[217] These colleges highlighted the importance of their role in the current formal assessment process. Colleges also noted past cases where SIMGs entering through the 'Specialist pathway – area of need' (enabling an IMG to work in an identified area of need with limited registration without having gone through the full assessment process) have demonstrated deficiencies in knowledge and technical skills.[218]

An evidence based expansion of expedited pathways would provide early benefits

Australia should be aiming to attract the most talented practitioners from around the world since this maintains high standards of care and supports better health outcomes. Highly skilled and experienced IQHPs also assist with capability development of the domestic workforce and with diffusion of innovative ideas from abroad.

To achieve this objective, National Boards and Accreditation Authorities urgently need to prioritise the introduction or expansion of expedited pathways to registration for all health professions in acknowledged areas of shortage.

Expanding expedited pathways will:

- attract a stronger candidate pool by increasing the competitiveness of our process compared to Australia's international peers in a tight global labour market
- bring more skilled practitioners to Australia quicker, enabling a dynamic response to current and anticipated shortages

- reduce real or perceived impediments in IQHP registration processes and make more cohorts feel welcomed and supported.

Each profession will need to consider how they will give effect to this recommendation. A 'one-size-fits-all' approach is neither appropriate nor likely to deliver the workforce needed.

Stakeholders raised concerns about the resource and financial implications of expanding fast track pathways quickly. For instance, Ahpra notes that expanding these pathways would require upfront investment and should not be offset by levying higher fees on existing practitioners in the system.[224]

Given the resource costs involved and the feedback received, the review recommends that this work be approached in a sequenced and staged manner, based on acknowledged areas of shortage and advice from jurisdictions and National Boards. Other recommended reforms that mitigate risks and maximise early benefits – such as greater use of registration with conditions – should allow more cohorts of IQHPs from a greater variety of countries to access expediated pathways.

The review understands that preliminary advice on potential CAPs and other expedited pathways will be provided to health minsters this year. To ensure currency and safety, Ahpra and the National Boards should publish a forward work program for creating or expanding the use of expedited pathways, prioritising opportunities that are low risk and that offer potential high workforce benefits. Such advice should be embedded as part of a rolling work program reporting to health ministers.

The interim report also proposed that National Boards develop and publish a list of fully and partially equivalent qualifications for each profession. The NMBA noted that this is unlikely to be operationally or financially feasible and that a better alternative would be for National Boards to describe and communicate examples of the types, levels and qualifications considered fully and partially equivalent.[225]

Ahpra and the MBA should prioritise the introduction of CAPs or other expedited pathways in the agreed highest priority medical specialisations as a first step toward expanding to other specialities and countries. The review proposes that expedited pathways for SIMGs are provided for the 'Specialist pathway – specialist recognition' pathway, where appropriate and applicants have the necessary knowledge and skills.

For example, the review has heard that the MBA, working in collaboration with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine, should prioritise a competent pathway to recognise New Zealand and the United Kingdom general practice fellowship.

Recommendation 9:

Introduce or expand expedited pathways to registration for all professions in acknowledged areas of shortage. Eligibility for expedited pathways should be regularly considered and part of a rolling work program reported to health ministers.

Priority professions to be collectively identified by health ministers.

Better recognition of a practitioner's skills and experience is central to attracting the best workforce

The *National Law* emphasises a practitioner's qualifications for the purpose of establishing whether they are eligible for registration.[219] The circumstances in which experience can or should be considered are unclear, resulting in widely differing treatments being applied across registered professions.

However, a practitioner's formal qualifications may not reflect their current skills and competencies, as these depend on their experience and further learning undertaken throughout their career.

As outlined in Chapter 1, health practitioners often sub-specialise or reduce their scope of practice as their career progresses. This may limit their ability to demonstrate that they meet the required standard as their knowledge is assessed against the broad scope of practice of an early-career practitioner at the end of their training.

Evidence provided to the review suggests that current examinations that assess a practitioner's knowledge and/or clinical competencies favour IQHPs who have more recent experience with modern assessment modalities.[220]

Several submissions noted the requirement for experienced practitioners to undertake additional units of study,[221] or return to 'intern status',[222] before qualifying for general registration.

As a result, these practitioners may choose not to come to Australia due to perceived barriers, costs and uncertainties about the requirements they will be subject to in the registration process.

There is general stakeholder support for amending the *National Law* to make it clearer that experience and skills must be taken into account. Most stakeholders supported greater flexibility in the recognition of skills and experience obtained in comparable health systems with similar regulatory settings.[223] The review welcomes work underway consistent with this objective (see Box 3.3).

Box 3.3: Work underway to better recognise skills and experience

Nurses and midwives: The NMBA is developing a new registration standard that, if endorsed by health ministers, would provide faster pathways to registration for a broader cohort of internationally qualified registered nurses (IQRNs). The new pathways would be available to IQRNs who have already been assessed for registration in a comparable international regulatory jurisdiction and who practised for a minimum 1,800 hours in that jurisdiction. IQRNs who meet these criteria, as well as the NMBA's other mandatory registration standards, would be able to register to practise in Australia without undertaking additional assessment. The proposed new standard is founded on rigorous evidentiary work and benchmarking commissioned by the International Nurse Regulatory Collaborative from 2018 to 2023.[226]

Allied health: The Dental Board, Pharmacy Board and Physiotherapy Board have expedited pathways that recognise the skills and experience of applicants with qualifications and/or registration in comparable countries. During the COVID-19 pandemic, the Physiotherapy Board made it easier to extend limited registration, allowing candidates to continue working under supervision while engaging with the examination process.

Specialist medical colleges: Some colleges are exploring alternatives to exam-based assessments pitched at the broad generalist and entry level, noting that these assessments are not empirically validated for experienced practitioners.[227] For example, the Royal Australasian College of Surgeons is currently piloting a work-place based assessment with some IMGs as an alternative to the fellowship examination.[228]

There is scope to increase the use of registration and fellowship with conditions for experienced IQHPs

Under the *National Law*, National Boards can grant registration with conditions to IQHPs who do not fully meet the eligibility criteria or the registration standards.[229]

Yet, this is not used by some professions and there is no systematic or consistent approach.

Using conditional registration appropriately will support IQHPs to safely practise in Australia, and will make it easier to attract and retain specialist global talent. This was supported by some stakeholders, who noted that existing powers should be used more to provide registration with a limited scope of practice and fellowship to highly skilled and experienced IQHPs wishing to work to a limited scope of practice.[230]

The regulatory system should facilitate the entry of highly skilled and experienced practitioners in a way that maintains a high standard of care.

Recommendation 10:

Ensure registration assessment for all registered professions explicitly recognises skills and experience in addition to qualifications and training pathways, with conditions on registration used as a temporary risk mitigation strategy where appropriate.

Legislate the recognition of skills and experience to avoid doubt.

Alternative approaches to addressing critical workforce shortages must be considered if expectations are not met

There remains a risk that fast tracked registration pathways do not become widely available in a timely way and/or the journey improvements fail to address critical workforce shortages.

While it is encouraging to note early progress, the changes that are required to address these critical shortages are complex and reliant on an agreed acknowledgement of urgency, targeted financial support to regulatory and professional bodies, and a readiness to collaborate. Hence, the review recommends that in their implementation plan, health ministers should identify the key anticipated milestones and, if sufficient progress is not being achieved, should consider making additional changes to existing roles and responsibilities in the system. A clear time frame for escalation should be set, which should factor in the urgency and work involved.

The review found that comparability assessments conducted by specialist medical colleges are costly, with varying fees and processing time frames across colleges. Submissions noted that some colleges only review applications for SIMG recognition at specific times throughout the year.[231]

To address these issues, the interim report proposed transitioning the determinative part of comparability assessments from the specialist medical colleges to the AMC to drive greater consistency in performance and outcomes and reduce costs. Colleges would retain expertise and play a key role in the individual comparability assessment.

Stakeholders had differing views on this recommendation. Some supported centralising comparability assessments as a way to address the timeliness and consistency of IQHP assessments.[232] However, specialist medical colleges did not support this approach, arguing it did not recognise their subject matter expertise and would likely increase the administrative burden, time frames and candidate costs to achieve specialist registration.[233] The colleges noted that more consistent performance and outcomes can be better achieved through other means.[234]

Parallel to this review, and at the request of health ministers, the National Health Practitioner Ombudsman (NHPO) is reviewing the procedural aspects of accreditation processes to examine fairness and transparency (among other things).

The NHPO review has a particular focus on specialist medical colleges. The NHPO is considering recommendations to improve consistency and transparency in colleges' assessment processes.

The review considers that future NHPO recommendations have the potential to improve outcomes for SIMGs and the communities they serve if implemented in an effective and timely manner across all specialist medical colleges, and in parallel with other recommendations from this review.

In light of stakeholder feedback to this review and the NHPO's upcoming recommendations, the immediate focus should be on streamlining processes, removing duplication and providing greater support to specialist comparability assessment to ensure more timely decision making and consistent outcomes.

However, should outcomes fall short of workforce needs within ministerially agreed timelines, the review recommends that centralising comparability assessment with the AMC, in full or in part, remains as an appropriate escalation strategy available to health ministers (see Box 3.4 for detail on the key components of how the proposed model could work).

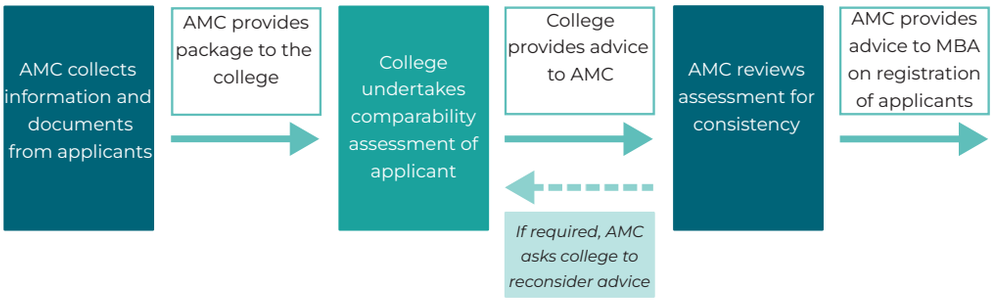
A transition to the AMC would be a means of providing support to colleges that would retain responsibility for individual assessments of an SIMG's comparability, while also providing an opportunity to drive greater consistency, and create a process and governance structure consistent with best practice regulatory outcomes.

Box 3.4: Potential AMC model

Under any proposed model it will be important to retain the role of specialist medical colleges in the individual assessment of a SIMG's comparability. However, the objectives of transitioning the determinative part of this process to the AMC will be to:

- ensure a college decision is consistent internally with other SIMGs in the same area of practice, consistent externally with other colleges and areas of practice and consistent in relation to the *National Law*
- improve the efficiency, timeliness and transparency of the SIMG assessment processes, especially in relation to timeframes and fees.

To achieve these objectives, the figure below describes how a potential model could operate:



Consistency and capacity issues in IQHP assessment also arise in the non-medical professions.

Accreditation Authorities should all prioritise addressing the issues raised through the review and in other forums. Given resourcing constraints, further steps towards centralising at least some of the procedural aspects of the equivalence assessment process in existing or new Accreditation Authorities, may offer net benefits to applicants, professional bodies and communities.[235]

Australia should also continue to follow overseas developments and should consider whether there is merit in exploring, and potentially adapting, our international peers' approaches to expedite the registration of skilled IQHPs. Particular attention should be given to the approaches taken in New Zealand and the United Kingdom (see Box 3.5).

Box 3.5: Alternative approaches adopted by international peers to fast track IQHPs

Comparable health system pathways (CHSPs) recognise the comparability of an international health system and grants fast tracked registration pathways to applicants from those jurisdictions, based on evidence. Indicators of comparability often include features of the health system, practice environments and registration indicators. CHSPs allow regulators to recognise more skilled IQHPs who have gained registration in comparable systems, who may otherwise be excluded if they gained their primary qualification in a non-comparable country.

New Zealand's CHSP model has been successful at attracting medical talent from around the globe and maintaining a high standard of care. The Medical Council of New Zealand uses a combination of CAPs (for practitioners from the United Kingdom and Ireland) and CHSPs to expedite the assessment of IMGs to obtain provisional registration without taking further exams. The Medical Council of New Zealand currently recognises 24 countries with comparable health systems.[236]

Other countries have adopted innovative reforms to streamline registration processes for IQHPs. For example, the United Kingdom has made legislative changes to make clear that when assessing IQHPs' qualifications, the primary focus is comparison of learning outcomes – that is, knowledge and skills – rather than a direct comparison of qualification curriculums. This ensures the emphasis is on comparability of competence and removes any potential bias in the assessment process.

Recommendation 11 (Escalation):

Health ministers to identify further action to be taken if fast tracked pathways are not widely available within agreed timelines and/or the end-to-end journey improvements fail to meet community need. Options could include:

- expanding the cohorts eligible, such as recognising comparable health systems, based on evidence and regulatory system 'fit' and learnings taken from international experience; or
- centralising equivalence assessments in existing or new Accreditation Authorities.

Recommendation 12:

Streamline processes, remove duplication and provide greater support to specialist comparability assessment to ensure more timely decision making and consistent outcomes.

Recommendation 13 (Escalation):

Transition all or part of the comparability assessments from specialist medical colleges to the Australian Medical Council if expectations are not met within agreed timelines.

Strategic partnerships with our Indo-Pacific neighbours offers mutual benefits

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.

Australia is a signatory to the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) which 'provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries, countries with economies in transition and small island states' (see Appendix G).[237] The Australian Government, profession groups and employers take their responsibilities under this Code seriously and do not actively recruit from the countries on the 'Safeguards List'. Notably, all of Australia's major source countries fall outside this list and, in some cases, have deliberate policies aimed at supplying health practitioners to the rest of the world (see Box 3.6).

Box 3.6: International recognition of Indian nursing qualifications

India aims to supply 300,000 healthcare workers to other countries by 2025.[238] It has signed healthcare and migration cooperation agreements with over 50 countries,[239] including:

- an agreement with Singapore, which allows nursing graduates from 7 Indian and 4 Singaporean training institutions to have their qualifications recognised in both countries[240]
- the Framework Agreement for Collaboration on Health Care Workforce with the United Kingdom,[241] which could lead to the mutual recognition of nursing qualifications and registration
- the Migration and Mobility Agreement with Germany, which reduces some bureaucratic barriers to migration for students and skilled workers.[242] In 2021, the Kerala state government also signed a memorandum of understanding with the German Federal Employment Agency for the hiring of nurses from Kerala, also known as the 'triple win programme'[243]
- the Australia-India Economic Cooperation and Trade Agreement, which encourages better registration and licensing processes, including by working towards the mutual recognition of professional qualifications and experience.[244]

There is an opportunity to strengthen and enhance our relationships with key source countries in a way that offers mutual benefits, including:

- building capacity in partner countries with higher education providers that offer Australian-standard qualifications
- establishing a more stable and predictable labour supply in the longer term
- enhancing regional security efforts by providing trade opportunities that increase the resilience of economies in partner countries.

In seeking to address their own workforce shortages, other countries have been proactive in identifying and pursuing relationships with major source countries, recognising that relying on 'homegrown' sources alone would not be able to deliver the workforce needed in the short term. For example, the National Health Service (NHS) in the United Kingdom has an ambitious target of recruiting 50,000 more nurses by the end of 2025, which includes developing an ethical and sustainable international recruitment model. Importantly, the NHS model is appropriately resourced and applicant-centred, and includes effective induction, pastoral and professional support for applicants. Other countries, including Canada and Germany, are similarly prioritising the development of these relationships.[245]

More broadly, free trade agreements (FTAs) provide an opportunity to facilitate the freer movement of labour, to mutually recognise qualifications, registration and fellowships, and streamline processes. Negotiations are currently underway with India, which is the top source country for IMGs.

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.

Some stakeholders have committed to engage with the proposed FTA process and others support further exploring more recognised pathways to recognition in our region.[246]

It will be important to ensure that any alliances or agreements do not have unintended consequences, such as leaving countries within our region with critical health workforce shortages or reducing professional standards.

A range of stakeholders emphasised the importance of Australia not taking IQHPs from developing nations where their populations are experiencing much greater need.[247]

Recommendation 14:

Explore opportunities to develop strategic alliances and provide recognised pathways to registration in our region, where such alliances are agreed between governments as being mutually beneficial.

Supervision is a powerful regulatory intervention to address practitioner gaps

IQHPs in medicine and many allied health professions typically undergo a period of mandatory supervision as a step toward general registration. Supervision provides assurance to the relevant National Board and the community that the services provided by newly arrived IQHPs are safe and are not putting the public at risk. Supervision is imposed by National Boards (or on the advice of Accreditation Authorities, including specialist medical colleges) and is usually mandatory for those on limited or provisional registration.

The review considers there to be 2 distinct purposes of supervised practice, mitigating:

1. clinical risk by ensuring safe and appropriate application of theoretical knowledge and training
2. regulatory risk by ensuring that individuals develop cultural competency; understand and can navigate key clinical, social services and legal frameworks (such as Medicare); and make connections between their work and other parts of the health system.

Supervision can help provide personal and professional support, build IQHPs' professional networks, and support them in enhancing their knowledge and skills.

The level of supervision should be tailored to the needs of the IQHP, factoring in the IQHP's qualifications, experience and position. There is no one-size-fits-all solution for supervision. For example, for IMGs, the supervisor or the IMG can take direct and principal responsibility for each individual patient.[257]

The review has heard that current approaches to supervision fail to adequately distinguish between experienced and less experienced practitioners. The lack of emphasis on experience means that supervisory requirements are often costly and onerous on the practitioner and their employer. The median respondent to the review survey reported $10,000 in direct costs to the IQHP associated with supervision (mostly travel and accommodation) and a time frame of 52 weeks.[258]

All IQHPs will also require orientation to Australian culture and legal frameworks. However, with respect to clinical supervision, broadly applying blanket policy approaches (rather than sufficiently tailoring to risk), deters international health workers and places unnecessary burden on employers.

Supervision should be better targeted, administered and resourced

There are not enough supervisors or supervised spaces available to support newly-arrived IQHPs when they do not meet all the skills required.[259]

The supervision requirements imposed on a practitioner should be focused on verifying and, if necessary, building their capability to deliver high quality and safe health services in a particular healthcare setting.

To avoid creating a 'bottleneck' in the recruitment of more IQHPs, supervision should act as an enabler and be tailored to need. It should not be more onerous than required to deliver its regulatory objectives.

Requirements should also give due regard to other regulatory interventions (for example, limiting scope of practice) and institutions (for example, existing clinical governance systems and employers) that act as safeguards in the system. In the case of United Kingdom GPs seeking registration in Australia clinical risk is not the primary risk being mitigated, and health system orientation could be done with less resource commitment, enabling these doctors to work to their full scope more quickly.

Many stakeholders support improving the targeting of scarce supervisory resources to where they are needed most.[260] Indeed, some professions already provide options, such as remote supervision, to increase flexibility and provide additional options for Australian health professionals to supervise IQHPs.[248] Other suggestion include:

- setting up initial placements in hospitals for all IMGs so they can be assessed in better resourced settings to ensure they have the skills to work independently
- introducing a structured supervisory payment scheme.

The Royal Australasian College of Surgeons supports the retention of at least some onsite supervision to ensure the delivery of safe and effective clinical care to the community.[249]

Some stakeholders noted that supervision can be particularly challenging for IQHPs who work independently and/or in rural areas.[250] Different models of supervision for these IQHPs may be required.

One large medical employer noted that they are not able to provide supervision for IMGs with extensive general practice experience.[251]

There are currently limits to the number of people that an individual can supervise. Some stakeholders suggested these limits could be increased[252] and fellowed IMGs from substantially comparable countries could be permitted to supervise.[253]

The limited funding for supervisors can also deter potential supervisors.[254] While supervising IQHPs, health practitioners may see fewer patients, which lowers their income. This issue is particularly acute for the most onerous levels of supervision.[255]

Better resourcing is not the only barrier to improving supervision frameworks.

Many stakeholders raised concerns regarding the administrative burden of supervision and the resulting impacts on employers' ability to facilitate supervision. As an example, a member of Occupational Therapy Australia commented that

> *'We've recruited some highly trained, and exceptional OTs with training ... whose clinical knowledge and experience is invaluable... However; the complexity of the process, the multitude of different forms required, and the cost of the supervision that is mandated make the process one that is not feasible for all companies.'*[256]

Several submissions noted the desirability of reviewing paperwork requirements to simplify them and reduce the level of risk placed on the supervisor.[261]

Mentoring programs or online modules could be used to help IQHPs understand the Australian system and context prior to their arrival in Australia. Indeed, some professions already do this or are moving in this direction.[262]

Ahpra, the National Boards, Accreditation Authorities and specialist medical colleges should 'rightsize' supervision frameworks for experienced IQHPs in all professions, with supervisory requirements adjusted accordingly.

Although the clinical setting is an important indicator of the feasibility of any supervisory model employed, some examples of more flexible and innovative methods adopted domestically and abroad are provided in Box 3.7.

Box 3.7 Flexible and innovative methods of supervised practice or training

Organisation	Example of existing policy
Dental Board of Australia	No supervision is required for applicants who can demonstrate competence by passing written and clinical exams. These candidates progress straight to general unsupervised registration.[331]
Paramedicine Board of Australia	Where an organisation has sufficiently robust clinical governance, the Paramedicine Board may appoint a health service provider organisation as an authorised body, rather than an individual, as a health practitioner's supervisor.[332]
Pharmacy Board of Australia	The CAP for graduates from Canada, Ireland, United Kingdom and United States only requires 4 weeks – that is, 152 hours – of supervised practice.[333]
Medical Council of New Zealand	On the CAP, IMGs with a primary medical degree from the United Kingdom or Ireland who have completed their one-year internship in those countries undertake a 6-month period of supervision.[334] This is shorter than Australia's requirement for 12 months of supervised practice.
General Medical Council (United Kingdom)	All IMGs commence with full registration rather than limited registration. As a condition of full registration, an IMG must work in an approved practice setting until they have been validated at least once. Anyone who is a senior officer (for example, the medical director) can sign off on supervision.
Canada (varies based on province)	Remote supervision is used in northern Canada for GP training.[335] In some provinces, a 12 week WBA option is available for IMGs who have previously completed a residency and practised independently abroad.[336]

Recommendation 15:

Supervision requirements to focus on the minimum required to build the capability of the health practitioner to deliver safe and quality health services in the Australian healthcare setting, recognising that supervisory resources are scarce. Innovative solutions, including a review of the current Ahpra supervised practice framework, expansion of remote supervision models and online cultural competency and Australian health system training to be considered.

Some IMGs can have their clinical skills and knowledge assessed in the workplace as an alternative to sitting and passing the AMC clinical exam, known as workplace-based assessments (WBAs). In 2021–22, 156 IMGs undertook and completed a WBA. Candidates who were assessed via WBAs have a close to 100% pass rate, compared to a pass rate of 21% for those who sit the AMC clinical exam.[263]

WBAs can be used to overcome some of the known limitations of high stakes summative examinations, including constraints on the type of problems that can be simulated,[264] and loss of displayed competencies when transferred to the workplace.[265]

As noted by the Australian Pharmacy Council, the

> *'advantage of WBA is that it enables the assessment of clinical reasoning, decision making, communication skills, professional judgement and other capabilities, which can be done with a level of practicality and efficiency not always available by other means.'*[266]

The WBA program currently has a limited number of accredited providers and availability, but is rapidly expanding.[267]

Some stakeholders supported greater use of WBAs, especially in regional and rural areas.[268]

Recommendation 16:

Expand the use of workplace-based assessments where appropriate, including exploring collaborative models to support IMGs with general practice and public health services to help address recruitment, training and retention challenges in regional and rural Australia.

Improve workforce data and planning

Collect and publish data on workforce needs to inform planning, policy and evaluation

Publicly available modelling of shortages is essential to meet future demand

Ahpra, the National Boards, Commonwealth, state and territory governments, the professions and the AIHW collect and publish data on the health workforce, including on the number of students enrolled and graduating in health fields.[269] However, this data is backward looking, limited in coverage and often not sufficiently detailed.[270]

Stakeholder submissions to the review expressed concerns that Australian governments, the professions and the public do not have access to timely and high quality data. This includes data on the health workforce and for each profession, such as available capabilities and skills, their distribution, and future demand and supply. This data is necessary to guide workforce planning and decision making.[271] This data needs to be collected at a national and regional level and cover public, private and not-for-profit employers.

National workforce projections for various health professions to 2030 are contained in a series of reports.[272] However, these reports did not cover all professions in acknowledged areas of shortage and are now out of date. For example, the last report for midwives was issued in October 2019.[273]

Some jurisdictions and professions have sought to fill the gap by estimating current and projected workforce shortages.[274]

Some stakeholders noted that the lack of a body dedicated to health workforce planning means it is difficult to determine the scale of shortages, especially in regional, rural and remote areas.[275] The functions and programs of Health Workforce Australia – which previously undertook such a role – were moved to the Australian Government Department of Health to remove duplication.[276] Some stakeholders called for the return of the Health Workforce Australia or a similar agency that would be responsible for this work.

While robust workforce data is collected for regulated health professions through the National Health Workforce Data Set, nationally consistent data for self regulated health professions is partial or non-existent.

Publicly available aggregate and geographic data is needed for each profession to improve planning for and responses to current and future workforce needs. This includes needs that reflect changes in models of care. This data would cover the domestic workforce pipeline and other care sectors that compete for the same labour and skills, including aged, disability and social care. Modelling

of urban and regional populations.[277] It was also noted that it is essential to address poor distribution of the workforce together with workforce planning.[278]

The mid-term review of the National Health Reform Agreement could provide an opportunity to plan and coordinate training, recruitment and clinical care in the private and public healthcare systems.[279]

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 public data (including projected workforce shortages) and an interactive online platform for GP workforce planning expected in September 2023.

Psychiatry is the second specialty to be modelled and integrated into the planning platform. With current resourcing this modelling is 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 the findings are likely be completed and integrated into the planning platform by the end of 2023.

In 2022, the DoHAC completed an allied health data gap analysis, which assessed the quality and completeness of allied health workforce data. The findings indicate significant gaps in data collection, particularly for the self regulated professions, and poor integration of existing allied health data.

The mixed quality or lack of availability of data for allied health professions was also raised by several jurisdictions and by leaders of the relevant professional bodies.[280] In discussion with the review, the Australian Government's Chief Allied Health Officer noted that there is no national consistency in allied health data collection and that this was a critical gap in enabling better workforce planning and in identifying training opportunities for allied health professions in shortage.[281]

Additionally, collating self regulated and regulated professions in a single source of truth that includes certifications and qualifications would reduce the administrative burden on professionals and employers. It would also improve patient safety and confidence by providing clear reporting methods for professional misconduct.

DoHAC is commencing work with states, territories and relevant stakeholders to identify gaps in workforce data. To be meaningful, this data needs to include the impacts of aged, disability and private providers, and it must be published and updated regularly to provide market and planning guidance to the affected sectors.

National workforce modelling should be reviewed and updated at least every 5 years to reflect changes in workforce demand and supply.

It is important that modelling and planning take into account the workforce needs of the aged and disability care and mental health sectors, where registered healthcare practitioners play a key role. This approach should minimise the risks of unintended policy consequences if workforce shifts between sectors leaving some people with less access to care.

Stakeholder submissions noted that the current workforce shortages are likely to become more pronounced as the population ages and as the burden of disability, chronic disease and mental health increases.[283]

Australian governments also need to understand issues relating to health workforce skills and poor distribution that contribute to shortages in the aged care and disability sectors. Work is already underway in both the disability and aged care sectors to understand these issues.

Recommendation 17:

Quantify workforce, skills, and distributional issues, making it easier to determine the extent of workforce shortages, factoring in changing models of care. This work should encompass needs in health, aged and disability care

National workforce strategies crucial to guide long-term planning

The National Medical Workforce Strategy 2021–31 is guiding long-term medical workforce planning across Australia.[282]
The strategy was developed through significant collaboration and input from key medical stakeholders across the country and endorsed by health ministers in December 2021. The strategy identifies achievable, practical steps to build and maintain a high quality, effective and well distributed medical workforce.

The National Nursing Workforce Strategy is being developed to address workforce challenges and ensure Australia has a capable and resilient nursing workforce that delivers person-centred, evidence based, compassionate care. The strategy is in the early stages of development.[284]

A rural health strategy also exists covering rural and remote communities and other areas that have difficulty attracting doctors, nurses and other allied health professionals.[285]

National workforce strategies are not in place for maternity care or allied health, where significant workforce shortages have been identified. Prioritising development of national workforce strategies for these areas will help improve planning for Australia's future healthcare workforce needs. It will also identify actions which Australian governments, stakeholders and clinicians could take to support ongoing access to high-quality health, aged and disability care services.

The allied health sector has called for a National Allied Health Workforce Strategy and stronger national data to support workforce planning. The Australian Government is working with the states and territories to develop the strategy and ensure robust evidence is available for allied health workforce planning.

A summary of work underway is captured in Box 3.8.

Box 3.8: What are we doing to build the domestic health workforce?

National Medical Workforce Strategy 2021–31

The National Medical Workforce Strategy aims to build and maintain Australia's domestic workforce to meet the needs of all Australian communities. Actions are focused on:

- reforming the training pathways
- rebalancing the supply and distribution of the medical workforce
- growing generalist capability
- introducing more effective medical workforce data and supply and demand modelling to improve workforce planning.

Nurse Practitioner Workforce Plan

The Australian Government released the Nurse Practitioner Workforce Plan in May 2023 and implementation has commenced. The aim of the plan is to enhance the accessibility and delivery of person-centred care for all Australians through a well-distributed, culturally safe nurse practitioner (NP) workforce. The plan highlights a significant opportunity to increase the use of NPs to meet consumer needs. Actions focus on removing barriers affecting the NP workforce; growing, expanding and building the workforce; and increasing access to NP care.

National Nursing Workforce Strategy

The Nursing Workforce Strategy seeks to ensure that the nursing workforce is equipped, enabled, and supported to deliver care that meets the current and future needs of the Australian population. The strategy is expected to look at workforce sustainability and the nursing pathway, from novice to expert.

Allied health

Recognising the importance of allied health, the Australian Government has appointed a Chief Allied Health Officer to work across portfolios and Australian governments to represent allied health in national policy, program and funding decisions.

The Australian Government is also considering how to best use the existing allied health workforce. The 2023 Budget committed $6.1 billion to strengthening Medicare, including measures to grow a skilled and well distributed primary care workforce.

Stakeholders welcomed this work.[287] Planning and policy decisions need to start now as it can take many years to have an impact on education and practice. Some stakeholders said the current timeframes are too slow.[288] While supportive, others emphasised that we need to focus on growing our domestic pipeline and prioritise employing international students graduating from Australian universities over overseas migration.[289]

Some stakeholders noted that having an integrated workforce plan, instead of separate plans for each profession, is required to ensure high quality care for Australians now and into the future.[290]

National workforce strategies should be reviewed and updated at least every 10 years, to address changing workforce needs and challenges.

Recommendation 18:

Support better planning for Australia's future workforce needs, including developing national workforce strategies for maternity and allied health, and finalising the nursing strategy already in development. National workforce modelling should be reviewed and updated at least every 5 years and strategies every 10 years.

Recommendation 19:

Identify cross-cutting themes and mechanisms to deliver effective multidisciplinary workforce planning and develop integrated models of care, including identifying and measuring any workforce or skill gaps.

Measures of progress

While workforce strategies are developed, health ministers should develop performance indicators to assess progress on improving the end-to-end journey and on recruitment of IQHPs in acknowledged areas of shortage. These indicators should be measurable, ambitious and realistic. They will help Australian governments, regulatory bodies, the professions and the community to develop shared expectations.

Some submissions expressed support or in-principle support for establishing target metrics. But it was noted that it may take time to consult and agree on monitoring and measures.[291]

Recommendation 20:

Develop performance indicators of progress in the recruitment of more overseas health practitioners in acknowledged areas of shortage, while workforce strategies are developed.

Increase flexibility, while ensuring safety and quality of care

Increase options for applicants to demonstrate registration requirements, while maintaining high standards of care

Current English language proficiency requirements are inefficient and onerous

The National Boards require IQHPs to provide proof of English language proficiency for all registration categories.

Applicants who are unable to demonstrate proficiency through a 'primary language' or education pathway in a 'recognised country' can meet the standard through one of up to 4 English language tests.[286] The most common test is the IELTS, in which candidates must achieve an overall score of 7 and at least 7 in all 4 test components – listening, speaking, reading and writing – although applicants can achieve minimum requirements over 2 tests sat within 6 months.

IQHPs are also 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. Currently, DoHA cannot accept the registration test results in lieu of their own test.

International students studying in Australia already have to pass the IELTS (or equivalent) to enrol in university.

Australians rightly expect their health practitioners to communicate effectively in English. However, duplicative and inflexible options for demonstrating competency impose unnecessary costs on applicants and limit the pool of safe IQHPs without improving community standards of safety or quality of care.

Evidence should drive recognition of English language proficiency and be based on what is required to provide safe and quality health services.

Many stakeholders supported the interim report recommendation to reduce the IELTS test standard for written English from 7 to 6.5.[297] The minimum scores for 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, reducing the IELTS standard for written English from 7 to 6.5, while maintaining a minimum score of 7 for the reading, speaking and listening components and an average of 7 overall, would raise the success rate from 26% to 40% of test takers.[298]

Other stakeholders noted that high-level writing skills are essential for all medical professionals and were concerned that lowering the current written standard might reduce safety and quality of care if it resulted in practitioners with inadequate communication skills.[299]

While any changes should be carefully monitored for adverse impacts, the review notes that this issue applies more broadly than IQHPs – almost 70% of complaints made to the NHPO about English language issues were from applicants who had completed their Board-approved qualifications in Australia.[300]

New Zealand and the United Kingdom have allowed IQHPs greater flexibility in meeting English language proficiency requirements, exempting a wider group of people from needing to undertake tests. There is no evidence that these changes increased risk to patients.[301] Consistent with these developments National Boards could consider recognising more programs of study conducted in English to exempt more applicants from needing to undertake additional testing.

The review notes that National Boards have begun work in response to the interim report to assess and consult on changes to English language standards. The outcomes of this consultation and revised registration standards are due to be submitted to health ministers in late 2023.

Recommendation 21:

Provide applicants with greater flexibility in demonstrating their English language competency, by:

i. aligning the English standard with international practice by reducing the International English Language Testing System test standard for written English from 7 to 6.5. The minimum scores for reading, speaking and listening would remain at 7 and an average of 7 overall would be required
ii. recognising more programs of study conducted in English.

Testing arrangements put Australia at a competitive disadvantage

IQHPs applying for registration via non-expedited pathways will typically sit knowledge and clinical exams to demonstrate competency against Australian registration requirements.

Fees for conducting exams are cost recovered from applicants and can be substantial, especially when benchmarked against similar exams by international peers.

While fewer IQNMs sit Australia's OSCE – designed to assess their knowledge, skills and competence at the graduate level – compared to international peers, they will pay up to 10 times that of candidates sitting the equivalent exam in Canada, and around 3 times that of candidates in the United Kingdom.[292] Moreover, candidates who have to re-sit the OSCE in the United Kingdom will pay a lower fee the second and third time, whereas candidates in Australia will pay the same $4,000 fee at each sitting.

In 2021–22, 1,787 IMGs undertook the online or in person clinical exam (962 for the first time). Only 21% of applicants passed the AMC clinical exam.[293]

To achieve general registration through the standard pathway, an IMG and/or an employer acting 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 offered though one of 3 accredited providers. GPs required to sit the interview can wait months for a spot to become available.

The review has found that Australian applicants also incur significant incidental costs while undertaking these assessments.[294] In the last 5 years the median GP, non-GP SIMG and allied health professional reported costs of around $24,000, $26,000 and $12,000, respectively.[295]

Recognising that Australia is at a competitive disadvantage in attracting global health talent, employers and IQHPs strongly support reducing costs and increasing flexibility and options for demonstrating registration requirements.[296]

Some professions, such as medicine, psychology and medical radiation practice, offer online options. Others, such as nursing and pharmacy, provide options for IQHPs to complete some or all these exams offshore.

Meanwhile, our international peers are overhauling their own assessment processes to reduce candidate costs.

Some stakeholders indicated a preference for more in-person testing options, either in Australia or in conjunction with other overseas education providers.[304] A few stakeholders raised concerns about whether it was appropriate to use online-only testing. They did not believe such testing would provide evidence that the IQHP is safe to practise, without further evidence or some ability to directly observe applicants in a clinically relevant environment.[305]

The review welcomes recent changes that will improve access to, and the capacity of, testing facilities. Some professions, including nursing, midwifery and pharmacy, have expanded the places available to sit the clinical exams.[306] Work is also underway to secure a second multidisciplinary assessment and examination centre in either Melbourne or Sydney by the end of 2023.

These efforts should be maintained, and testing should be available online and/or offshore where appropriate, to increase access and minimise unnecessary candidate costs incurred through travel.

Recommendation 22:

Expand access for applicants to assessment, including online and offshore assessment where beneficial.

Enhanced cultural safety training is vital to help integrate practitioners into the Australian health system

The review acknowledges that even when a practitioner has demonstrated the required clinical registration standards, they will need to learn about the Australian health system, culture and legal frameworks.

Supervision frameworks, as well as support from employers and colleagues, play a significant role in aiding IQHPs to develop cultural competency. Given their importance, these avenues should be retained and strengthened wherever possible, especially as they relate to the local health practice context. However, there is merit in considering centralised delivery of cultural safety content that has common themes across all professions. It could be provided in a form that is accessible, cost-effective and efficient.

Some professions provide online orientation modules for IQHPs. For example, the NMBA requires IQNMs to pass an initial online orientation module before they can apply for registration, and a second orientation module within 6 months of becoming registered. These modules cover a range of concepts relating to the Australian healthcare context, including regulatory aspects of the health system and culturally safe care.[302]

Stakeholders consider training in cultural safety as important for patients and the IQHPs who provide their health services.[303] In particular, they highlighted that this training must provide an understanding of Aboriginal and Torres Strait Islander peoples and their specific needs within the health system.

NRAS entities should collaborate on ways to provide this training, such as through online modules, so that IQHPs can access it on demand and as frequently as necessary. The review notes that Ahpra's digital systems could be used to provide this training.

Recommendation 23:

Ensure all health practitioners are supported with appropriate training to familiarise them with and prepare them for safe practice in the Australian health system, regardless of their registration pathway. Consider the potential for technology-enabled orientation activities and support networks.

Implement key recommendations from the National Medical Workforce Strategy to address the poor distribution of health practitioners

The NMWS identified an ongoing shortage of GPs and other medical specialists in some communities. The strategy found that IMGs form a significant part of the workforce in regional, rural and remote areas. It said they should be better supported in their day-to-day work and to gain specialist medical qualifications.

For many medical trainees, the pathway to qualification as a specialist is difficult, unclear and increasingly competitive – some never achieve specialisation. Stakeholders report that there are limited training pathways and posts in regional and rural areas. IMGs have difficulty accessing support and connecting with other clinicians to reduce professional and personal isolation and help provide high-quality care.

The strategy made recommendations to address the imbalances in the distribution of medical practitioners that lead to an over-reliance on locums and IMGs in some areas. Key recommendations included:

- evaluating the effectiveness of existing support structures for rural trainees
- increasing the number of training pathways and posts available in regional, rural and remote areas
- increasing the number of trainees in undersupplied specialties and decreasing their number in oversupplied specialties
- ensuring they are given appropriate support
- developing networks of clinicians in metropolitan and regional health services.

Prioritisation should be given to recommendations that address imbalances in the distribution of medical practitioners.

Recommendation 24:

Implement relevant recommendations from the National Medical Workforce Strategy to address maldistribution of the workforce including evaluating the effectiveness of existing support structures for IMGs in rural settings, increasing the number of training pathways and posts available, and creating networks with, and connections between, metropolitan and regional health services.

Enhance regulator performance and stewardship

A modern regulatory architecture requires ongoing investment, maintenance and collaboration.

The quality of regulation and how effectively regulators perform has a profound impact on community safety and wellbeing.

Not all decision makers who are part of the end-to-end journey view themselves as regulators with responsibility for ensuring a sufficient supply of safe and high-quality health practitioners.

Regulators continue to work on improving their own performance and the end-to-end regulatory journey for IQHPs. Since the release of this review's interim report, Ahpra and the National Boards have acted to:

- accelerate business transformation projects that improve the experience of practitioners and make regulatory processes, including those that span several regulators, more efficient
- reduce the time taken to assess registration applications by increasing staffing capacity
- improve engagement with applicants, representatives of health professions, employers and recruiters about the assessment processes for registration in Australia
- more actively engage with the broader health sector, including working with relevant stakeholders on opportunities to streamline pathways for internationally-trained GPs.

However, more can be done to ensure the regulatory settings remain fit for purpose and reflect best practice. Regulators must be encouraged to take a whole-of-system, life cycle view of their regulation to ensure applicants undertaking the registration process are well supported and the NRAS delivers outcomes that are in the best interests of the community.

Regulators understand that improving the performance and collective management of the NRAS – and in turn realising the full benefits of the review – will require active and ongoing collaboration between all regulators and agencies with responsibility for regulating health practitioners. The review has heard that NRAS entities would welcome a clear statement of expectation from Australian governments in this regard and clarification about what best practice regulation should look like.

NRAS entities should strive for, and be held to, the same standards as best practice regulators

Australian Government regulators are required to approach their performance reporting in accordance with the Resource Management Guide – Regulator Performance (RMG 128) and state and territory regulators are bound by their own equivalents. Box 3.9 provides a case study of how best practice principles are applied by another regulator in the health system.

NRAS entity obligations are set out in the *National Law* and supplemented by health ministers'.

Box 3.9: Case study – Best practice health regulation in Australia

The Therapeutic Goods Administration (TGA) uses the Commonwealth's principles of regulatory best practice.

Continuous improvement and building trust

- The TGA uses its annual business plan and public performance reports to support transparency and accountability for meeting expectations of the public and Ministers.
- The TGA publishes cost recovery implementation statements outlining how it has consulted with stakeholders on changes to fees and adheres to Commonwealth Cost Recovery Guidelines.
- The TGA uses assessment reports from comparable overseas regulators when considering the authorisation of therapeutic products.

Risk based and data driven

- The TGA maintains a regulatory compliance framework articulating its approach to risk and how this informs decision-making and also publishes annual compliance priorities.
- The TGA adapted regulatory processes during COVID-19 so that adverse events reports could be more easily lodged by practitioners and accessed by vaccine developers, enhancing compliance, risk management and public confidence.

Collaboration and engagement

- The TGA consulted with stakeholders:
- to identify common pain points in the prescription medicine process, with feedback incorporated into a digital transformation project to ensure applications are easy for the user to navigate
- regarding repurposing medicines and improving access to medicines in acute-care settings, with the feedback shaping policy and regulatory reforms under consideration by the Australian Government.

Table 3.1 provides a brief comparative study of how expectations, principles and accountability mechanisms are integrated in the NRAS, Commonwealth and state and territory regulators.

Table 3.1: Comparative study of best practice regulation

	Commonwealth	State and territory	NRAS
Expectations	The objects of regulation are generally provided for in the legislation. Expectations for the practice and performance of regulators are set out in Ministerial Statements of Expectations. Regulators identify how they will deliver on expectations in a Statement of Intent.	A number of states and territories implement Statement of Expectations and Statement of Intent frameworks, similar to the practice of the Commonwealth.	Under Part 3 of the *National Law*, NRAS entities are required to: protect the public; identify and respond to risk; ensure fairness and transparency; and collaborate effectively with stakeholders. Health ministers can issue policy directions to Ahpra and National Boards.
Principles	There are 3 principles of best practice regulation: 1. continuous improvement and building trust 2. risk based and data driven 3. collaboration and engagement.	Most states and territories have best practice principles that are broadly consistent with those of the Commonwealth.	There are 8 principles underpinning the work of NRAS regulators. They cover protecting the public, identifying and responding to risk, ensuring fairness and transparency and collaborating effectively with stakeholders.
Accountability	Performance reporting is incorporated into a regulator's reporting processes (through corporate plans, annual reports and annual performance statements). These reports are subject to the scrutiny of the parliament, the Auditor-General and the public.	Most states and territories offer guides to implementing best-practice principles and improvements to practice, including requirements for public reporting of performance and effectiveness of regulation.	Ahpra must report annually to health ministers on its financial position. Ahpra provides quarterly performance reports to health ministers and publishes quarterly and annual reports. National Boards and Accreditation Authorities submit assessments of performance to Ahpra.

The review supports a clearer articulation of expectations for regulator performance and stewardship for all NRAS entities. Factoring in Commonwealth, state and territory best practice principles would align regulators with government and community expectations.

These principles are:

Transparency: NRAS entities clearly communicate regulatory requirements and processes and are transparent about their decision-making criteria and fee setting.

Accountability: NRAS entities, supported by effective oversight, ensure they are delivering NRAS' objectives and the expectations of Australian governments and the community.

Risk based and data driven: NRAS entities take a holistic view of risk management, which balances risks associated with workforce supply and demand with safety and quality of care, informed by reliable data.

Continuous improvement and stewardship: NRAS entities consider how regulatory activity and decisions affect the regulatory system as a whole and community health outcomes, in the context of changing needs.

Further detail on these principles is in Appendix H.

In many instances, NRAS settings and practices – particularly as they relate to 3 fundamental components of regulatory practice that were a focus of the review (fee-setting, performance reporting and equivalence assessments of IQHPs) – broadly align with these principles.

For example, quantitative and qualitative data on registration and accreditation performance is published on Ahpra's website and in Ahpra's and National Board's annual report. Ahpra also reports quarterly to health ministers on progress on key pieces of work, actions taken to reduce risk of harm to the public, regulatory performance and registration achievements, including those that relate to IQHPs.

However, stakeholders expressed concerns about the performance of some regulators,[309] indicating that their settings and practices do not align with best practice. In particular, the review has heard that there is an opportunity to:

- improve the consistency in how fees are levied on practitioners, ensuring that the rationale is clear and transparent, and business cases identify the efforts made to keep costs to a minimum
- increase the specificity of key performance indicators to allow for a comprehensive assessment of performance and to identify remediation strategies and support to be provided where performance does not meet expectations[307]
- ensure Ahpra reports on its performance against operational key performance indicators that capture a holistic risk based approach (for example, maximising availability of practitioners)[308]
- ensure regulatory settings can respond to workforce needs and align with broader health sector policies intended to attract and retain a sufficiently sized and skilled workforce
- drive greater consistency in the comparability assessments of SIMGs across specialist medical colleges.

Recommendation 25:

Health ministers set out their expectations for regulator performance and stewardship for all NRAS entities, factoring in best practice regulatory principles.

Recommendation 26:

Develop, expand and/or enhance publicly available performance standards and benchmarks which are consistent with best practice regulatory principles, with regular public reporting against these standards and benchmarks.

A stewardship approach would increase regulatory responsiveness and improve collective management of the entire system

The functions and responsibilities of regulators within the NRAS are deliberately dispersed due to the nature of the cross-jurisdictional regulatory system. Multiple agencies and regulators have siloed responsibilities No single entity is responsible or has accountability for the regulatory system as a whole, the end-to-end journey of IQHPs seeking to work in Australia, or the resulting impacts on health practitioner supply.

The review has heard from many stakeholders that regulators do not have the incentives, capacity or capabilities to consider how their activities and decisions affect the system as a whole, including how it is being stewarded to deliver outcomes that are in the best interests of the community. Regulators need to consider how they can:

- work with Australian governments and co-regulators to monitor, plan for and implement changes to their regulatory approaches and practices to respond to changes in healthcare demands
- improve efficiency, minimise duplication and harmonise activities with other regulators to achieve better regulatory outcomes
- take into account the cumulative burden of the end-to-end regulatory journey for IQHPs.

'While the current regulatory settings ensure the recruitment of high-quality healthcare professionals, Ahpra, 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'

Victoria Health

Despite the current settings, Ahpra and the National Boards have demonstrated a commitment to better collective management of the NRAS. In its submission to the review's interim report, Ahpra and the National Boards made a number of important suggestions to improve the end-to-end regulatory journey for IQHPs. One was to enhance the role of Ahpra as a steward of the NRAS, so that it plays a more pivotal coordinating role to support a modern and mature regulatory system with greater connectivity between all agencies responsible for the IQHP journey. This warrants consideration in future system design.

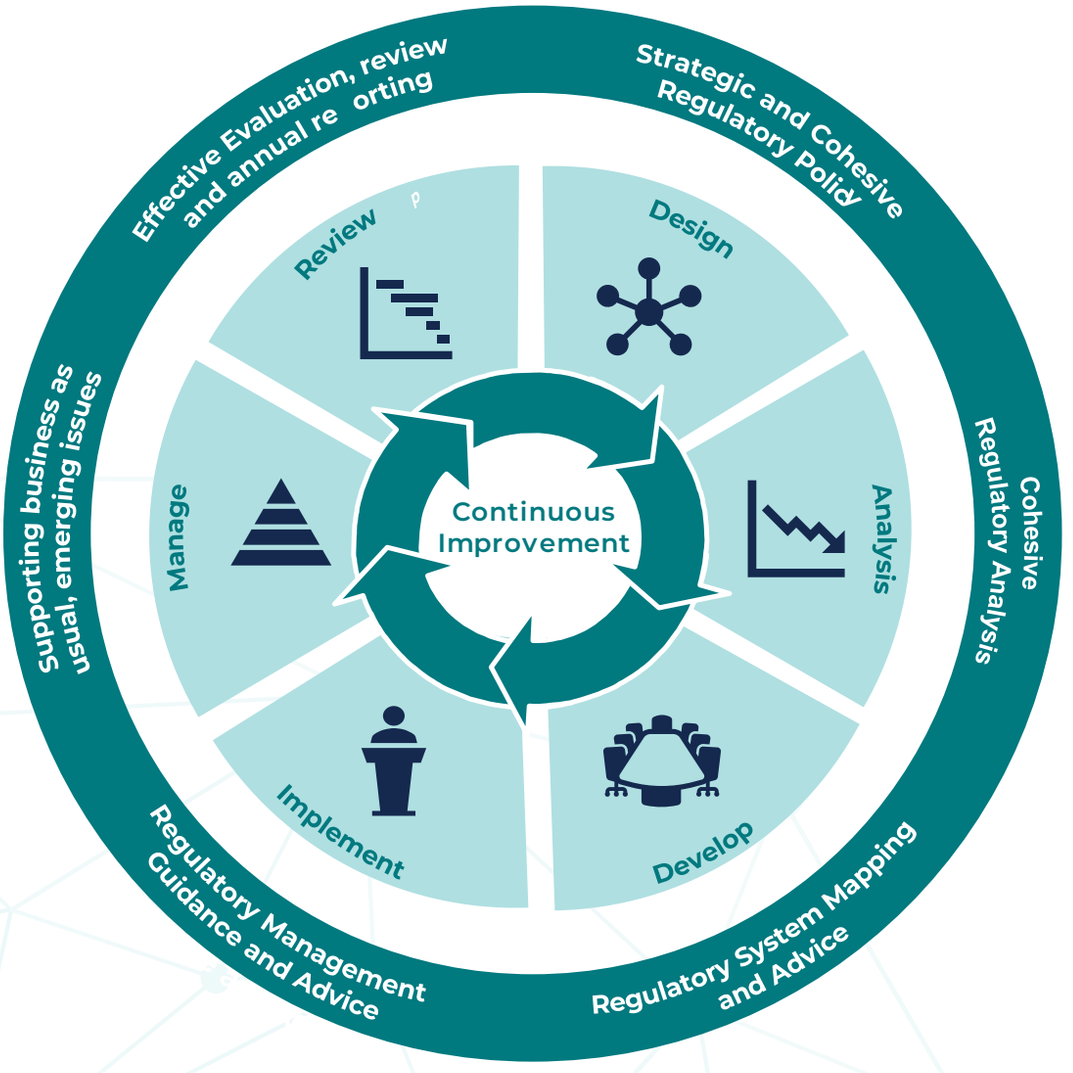
Regulatory stewardship could be used to guide a cultural change within the NRAS that would help modernise the regulatory architecture, without losing sight of the paramount importance of public protection.

Regulatory stewardship can be defined as the adoption of a whole-of-system, lifecycle view of regulation, and a proactive, collaborative approach that leads to regulation that is principles based and outcomes focused (see Figure 3.4). Put simply, regulatory stewardship is the governance, monitoring and care of the regulatory system.

Regulatory stewardship aims to ensure that all the different parts of a regulatory system work well together to achieve its goals, and to keep the system fit for purpose over the long term.

Regulatory systems that have been in place for some time, such as the NRAS, require ongoing care and maintenance to ensure goals continue to be met. This includes anticipating and responding to changes in the regulatory context over time. Examples of changes include new or revised regulations, advances in technologies and healthcare, and changes in government and societal expectations.

Figure 3.4: Regulatory lifecycle



Investing in regulatory stewardship is a way for NRAS regulators to identify, prepare for and respond to problems and risks, including as they relate to health practitioner supply. It also positions them to take advantage of opportunities to improve the performance of the regulatory system when they arise.

New Zealand is viewed as a leader in regulatory stewardship, with potential learnings for Australian regulators (see Box 3.10).

Box 3.10: Case study – Regulatory stewardship in New Zealand

The *Public Service Act 2020* (NZ) provides that public service chief executives and boards are responsible for upholding, and ensuring the agencies they lead also uphold, 5 public service principles when carrying out their responsibilities and functions. Stewardship is one of those 5 principles, with responsibilities extending to proactively promoting stewardship.

Clear government expectations

The New Zealand Government's expectations for regulatory stewardship by public service agencies form part of Government Expectations for Good Regulatory Practice, and set out responsibilities for regulatory stewards in three broad areas:

1. monitoring, reviewing and reporting on existing regulatory systems
2. robust analysis and implementation support for changes to regulatory systems
3. good regulatory practice.

Regulatory systems reporting

The New Zealand Government expects regulators to publish information about:

1. the nature, scope and objectives of each regulatory system for which they have or share a stewardship responsibility
2. current or recent reviews of those regulatory systems or findings from system assessments
3. forward plans for approved legislative or operational improvements to those regulatory systems.

Clear expectations are required to operationalise stewardship

The concept of regulatory stewardship is a new one for NRAS entities and many of the government agencies involved in regulating IQHPs. Hence, it is essential that Australian governments set clear expectations to embed a regulatory stewardship approach.

Following are some potential requirements:

- NRAS entities deliver a streamlined, end-to-end registration system.
- Ahpra and National Boards develop expedited pathways to streamline regulatory requirements.
- The standards and decisions of NRAS entities are founded on principles of regulatory best practice and take sufficient account of workforce needs and safety and quality of care, so that all Australians can access high-quality and safe care when required.
- The Ahpra Board reports to health ministers on implementation as part of regular performance reporting.

Table 3.2 envisions how regulatory stewardship could embed positive change over time.

Table 3.2: Regulatory stewardship framework for the NRAS

From (current experiences)	To (future experiences)
Regulatory stewardship is a new concept for NRAS entities. The understanding of stewardship across the NRAS is inconsistent.	All NRAS entities are supported by Ahpra to understand stewardship and how they contribute to it. Ahpra could consider clarifying roles and responsibilities and identifying overlaps and gaps.
Entity leaders do not have consistent visibility of system performance to inform whole-of-system decision making and prioritisation.	All NRAS entities can access system performance data to inform scheme decision-making and prioritisation.
Technical knowledge and skills are often more highly valued than skills that would support a regulatory stewardship mindset.	Technical and stewardship skills are valued. Entities can access resources to develop skills that support stewardship.
NRAS entities' resources are typically directed to urgent registration and accreditation priorities, leading to deprioritisation or limited capacity for systematic improvements.	NRAS entities are resourced to identify and deliver systematic improvements.
The lack of consistent high-quality data and information makes decision making siloed and more difficult.	NRAS entities can access data and knowledge they need to make evidence-based decisions.
System monitoring and evaluation is ad hoc, and there is no systematic approach. IQHP's insights have limited impact on design and delivery.	Monitoring and evaluation are embedded in the policy design and delivery and take account of IQHPs insights and experiences.
NRAS entities have fragmented knowledge about emerging trends and international regulatory practice.	Ahpra disseminates knowledge about best practice and emerging trends to the NRAS community of practice.
Regulatory issues must be pressing or raised as part of a review process before NRAS entities invest in resolving them.	NRAS entities understand how broader trends and issues in the health system may affect them and respond proactively.
Regulators are incentivised to respond to demands for change individually without a scheme-wide lens to ensure the response is consistent or complementary across NRAS entities.	Opportunities for whole-of-system change are identified by the Ahpra Board and there are clear priorities.

Implementing a regulatory stewardship framework for the NRAS

The review acknowledges that it will be a challenge for NRAS regulators to find the time and resources, and to develop the capability, for regulatory stewardship and have framed recommendations with this in mind. However, the review also notes that these investments, if they lead to more stable regulatory systems over time, can help to mitigate costly crisis driven regulatory interventions.

The review recommendations aim to establish the foundations of stewardship within the NRAS, recognising work to fully embed stewardship is a longer-term goal.

The review is aware that health ministers will be considering options to improve the effectiveness and efficiency of the NRAS as part of a review of regulatory complexity. The review considers this process and related outcomes as a good opportunity for ministers to provide clear direction to regulators on the issues raised here.

Consistent with other recommendations in this review, health ministers should also consider the effectiveness and ability of existing oversight functions to deliver the change required.

Recommendation 27:

Health ministers to develop a regulatory stewardship framework and consider appropriate oversight of the end-to-end journey, as part of its review of regulatory complexity. The framework to include examples of best practice, tools and other resources to support enhanced regulator capability.

Recommendation 28:

Health ministers to consider whether further centralised oversight is required to support 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 registration process if expectations are not met.

4. Economic impact assessment

Key points

- The review commissioned work to estimate the value of potential savings that could be delivered through targeted reform of the end-to-end journey for IQHPs.
- The review estimated that reducing duplicative and onerous regulatory processes could provide annual economic benefits of up to $850 million. This estimate is likely to be conservative as it does not include all the proposed reforms.

Regulation should be efficient and effective to deliver maximum value to the community

The NRAS aims to ensure that communities have access to a safe and competent health workforce by requiring health practitioners to meet consistent and high quality national professional standards. This protects communities – the nation's human capital – from harm and in doing so creates considerable value.

Where regulation imposes costs on the community, these costs should be proportionate to the value added by the regulation. For example, regulators impose fees on applicants for the assessments they administer – such as knowledge and clinical exams – to establish an IQHP's skills and competencies. If efficient and effective, the costs imposed by regulators and agencies in the end-to-end journey reflect the value of these regulatory services to the community.

However, regulation that imposes unnecessary barriers or compliance activities (that do not improve safety or quality of care), erodes the value of the regulatory services and imposes unintended costs on individuals, the health system, and society more broadly. Most notably, this manifests in processes that are overly complex, lengthy and costly, which can prevent or delay an IQHP's ability to deliver health services in acknowledged areas of shortage.

A survey of recently arrived IQHPs was used to estimate the regulatory system's economic impacts

National Cabinet requested that the review should ensure current regulatory settings are efficient and effective, while maintaining the core objective of the regulatory system.

To this end, the review commissioned research and analysis to estimate the current costs of the regulatory system and the value of potential savings that could be delivered through targeted regulatory reform (that is, benefits to individuals, the health system and society).[310]

With Ahpra's help, the review surveyed more than 1,700 IQHPs who had gained registration in Australia since 2017. The survey asked respondents to report on the time and costs they incurred at each stage of the end-to-end journey, as well as associated impacts on their mental health, employment, and sense of social belonging in Australia. The review was not able to interview or survey individuals who elected not to complete the end-to-end journey.

The economic impact framework in Table 4.1 outlines the qualitative and quantitative impacts captured by this research and analysis.[311] The framework considers impacts across 4 broad categories:

1. **consumer deficit** – costs to individuals who 'consume' health services.
2. **labour deficit** – costs to the IQHPs navigating the end-to-end journey.
3. **producer deficit** – costs to the health system as a result of staff shortages.
4. **community impact** – direct and indirect benefits to the community due to a larger workforce.

Table 4.1: Economic impact framework

		Measurement	Assessment	What is captured
Economic Impact Framework	Consumer deficit	Increase in burden of disease	Qualitative	Reduced number of health practitioners reduces expected daily-adjusted life years of population
		Reduce patient productivity	Qualitative	Increased length of stay and lower quality of care impacts patients ability to return to productive work
	Labour deficit	Costs to IQHPs stratified by: • Registration fees and other related costs • skilled migration fees and other related costs incurred • Visa fees and other related costs	Quantitative	Additional costs to IQHPs throughout the process compared to a reasonable level of journey cost
		Forgone marginal income from underutilisation of IQHPs	Quantitative	Lost income for IQHPs who spend longer in underutilised roles than expected due to the length of the registration process
		Burden on mental wellbeing for IQHPs	Qualitative	• Impact on the mental wellbeing of IQHPs during the process • Increased levels of absenteeism and presenteeism during the process
	Producer deficit	Backfill cost of staff shortages	Quantitative	Overtime premium costs borne by hospitals to ensure quantity of care with local staff in the interim period before IQHPs can start work
		Cost of visas paid by employers	Quantitative	Costs incurred by employers for visas for sponsored IQHPs
		Cost of delay due to labour market testing	Quantitative	The additional premium cost to hospitals to ensure quality of care during the registration process
		Increased workforce turnover	Qualitative	Increased spending on workforce recruitment and training
		Increased length of patient stay	Qualitative	Increased costs for patients staying in hospital longer
		Increased re-admissions	Qualitative	Increased patient re-admissions and Emergency Department presentations
	Community impact	Community benefits from IQHPs entering the workforce	Qualitative	Indirect and induced impacts on employment and consumption in the broader community from IQHPs entering the workforce

To measure the potential benefits of reform, the review modelled the economic impact of the current regulatory system, using three key quantitative measures:[312]

1. costs incurred by IQHPs to complete the end-to-end journey
2. backfill costs to the health system due lengthy registration and migration processes
3. income foregone by IQHPs awaiting the outcome of these processes.

Despite not being quantified in the analysis, the impacts described qualitatively in Table 4.1 (above) are likely to incur significant actual costs on IQHPs and the health system. For example, other impacts associated with shortages (beyond the quantified overtime costs) include increases in staff turnover, patient readmission, length of hospital stay and negative patient outcomes. They can also decrease productivity and quality of care. Moreover, the impact on applicant's mental health and wellbeing was a concerning survey insight (see Box 4.1, below).

Hence, the costs and potential benefits of reform reported here are likely significantly underestimated.

Targeted reform could deliver significant benefits to IQHPs and the health system

Once the cost of the current regulatory system had been established, the review estimated the regulatory savings that could be delivered by reducing the length and cost of the end-to-end journey, as well as other key reforms outlined in Chapter 1. The 4 key drivers of regulatory savings that were identified from the recommendations are described in Table 4.2.

Box 4.1: Impacts of current regulatory settings on applicants' mental health and wellbeing

Survey data shows that 40% of health practitioners reported that the registration journey in Australia had a negative impact on their mental health and wellbeing.

For example, specialists who reported needing to undertake assessments or interviews with specialist medical colleges recorded skills assessment for registration as more difficult and negatively impactful to their mental health than most other candidates.
Of these candidates, 56% reported this stage was either 'difficult' or 'very difficult', and 57% reported it had 'negative' or 'significant negative' impact on their mental health.

Some practitioners develop negative attitudes toward Australia. The survey shows that 2 in 5 doctors in specialist medical colleges said the process has negatively impacted their views of Australia. Almost 50% said that their sense of belonging in Australia was negatively impacted by the registration process and 60% would not be likely to recommend the process.

Table 4.2: Drivers of regulatory savings

Driver	Change	Cohort affected	Is there a time impact?	Is there a cost impact?
Document collection	Upload documents compiled for registration to a central portal, reducing time by 3 to 8 weeks depending on the profession	All IQHPs	Yes	Yes
Visa processing times	Accelerate processing times for visa applications by 0 to 6 weeks depending on the profession	All IQHPs	Yes	No
Number of applicants entering through fast track pathways	Expand fast track cohorts in each area of practice by 10 to 20 percentage points	Nurses and midwives: 40% to 50% SIMGs/IMGs: 10% to 20% Allied health: 10% to 20%	Yes	Yes
Labour market testing	Remove 12 week labour market testing	Temporary skilled visa holders (~27% of all IQHPs)	Yes	No

Note: The base proportion of cohorts that have already been fast tracked are based on survey responses that exclude nurses and midwives from New Zealand who registered under the *Trans-Tasman Mutual Recognition Act 1997* (Cth).

The 4 recommended changes to the current regulatory settings are estimated to generate up to $850 million in regulatory savings (avoided economic costs) annually, which will be shared by the health system and health practitioners. These avoided economic costs are captured in Figure 4.1, with assumptions outlined in Table 4.3.

Figure 4.1: Potential regulatory savings of key reforms

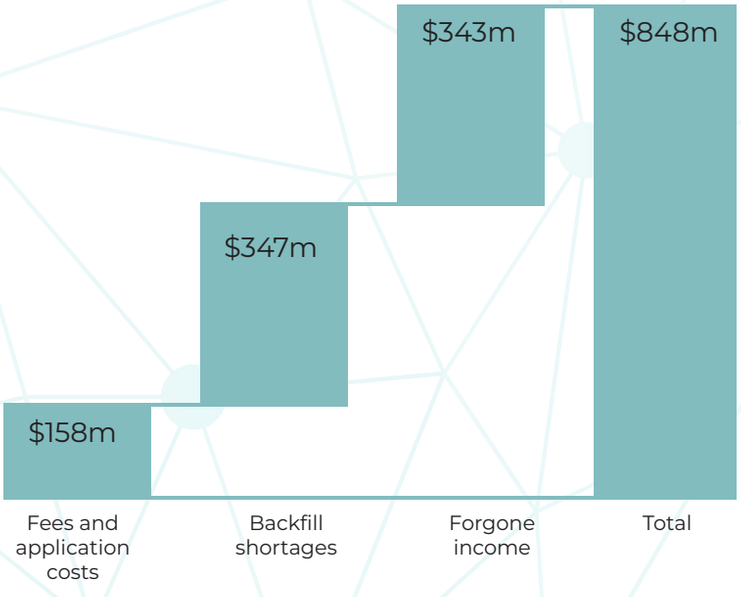


Table 4.3: Assumptions of the regulatory impact analysis

Regulatory saving (avoided cost)	Estimated saving	Impact
Fees and application costs	Up to $158m	Streamlining the end-to-end journey and reducing duplicative processes will reduce the registration and migration fees IQHPs are currently required to pay. • For example, eliminating the need to complete an English language competency test at both the registration and migration stages of the journey will save IQHPs the additional fee of a second test. • Increasing the number of fast tracked cohorts will reduce costs to IQHPs as fewer applicants will be required to complete additional training or knowledge and competency tests, which can contribute significantly to the total cost of the end-to-end journey. • There will also be a reduction in the costs of delays associated with the removal of labour market testing.
Backfill costs due to health system shortages	Up to $347m	The cost of staff shortages accounts for nearly 60% of the total cost of the current regulatory system quantified in the economic framework. • For example, the cost of finding labour to provide or backfill healthcare services during periods when IQHPs are awaiting registration is typically paid at a premium through overtime salaries or employing casual staff. • Reducing the time taken to navigate the end-to-end journey allows IQHPs to fill shortages and commence work more quickly, lowering costs borne by the health system to maintain a constant supply of health services. • Note that significant costs associated with backfilling shortages remain because the reforms can reduce, but not eliminate, shortages.
Foregone income	Up to $343m	As a result of a streamlined end-to-end journey, health practitioners can commence employment in Australia sooner, thereby spending less time underemployed or unemployed, or waiting to commence supervision or unsupervised work.

The analysis describes (but does not quantify) other likely reform benefits. These include:

- a decrease in the burden of disease due to fewer instances of delayed or deferred care
- an increase in the safety and quality of, and access to, care
- a decrease in workforce turnover associated with burnout
- an increase in the number and quality of IQHPs seeking registration in Australia due to a comparatively more attractive end-to-end journey.

In prioritising reform, ministers need to weigh the potential benefits of reform with the costs of implementation, which include upfront investments in the visa, registration and accreditation processes. However, as explained above, the actual regulatory savings will likely be much greater than those quantified in this framework.

5. Implementation

Key points

- National Cabinet tasked health ministers with progressing the recommendations as a priority and reporting back with a fully costed implementation plan.
- Efficient and effective implementation of the health and migration related measures is critical for success. However, implementation must be flexible and adapt as circumstances change.
- Additional targeted upfront funding from Australian governments is likely to be required to make the changes in the recommended timeframes.

Implementation – key success factors

National Cabinet tasked health ministers with progressing the recommendations as a priority and to report back to National Cabinet with a fully costed implementation plan. The implementation plan is being prepared in parallel with this report.

The key elements of successful implementation include:

- using existing governance mechanisms where possible
- making accountabilities clear
- prioritising and phasing in reforms over time
- investing upfront to increase capability and capacity
- incorporating regulatory good practice and adapting as circumstances change
- implementing escalation strategies for reforms that do not yield sufficient benefits within the expected time frames.

National Cabinet and health ministers should oversee implementation, given the multiple requirements and regulatory entities involved.

System changes and dedicated resources may be required to support improvements and maximise outcomes.

Governance and accountability

Where possible, existing governance arrangements, such as the Health Workforce Taskforce, should be used to ensure the reforms are delivered quickly and in alignment with related work that is underway. The taskforce draws on the expertise of all jurisdictions and advises health chief executives and health ministers on short and medium term actions that are required to address key health workforce challenges across the care sectors. The taskforce oversees implementation of health ministers' agreed strategic priority actions.

Deliverables need to be clearly defined as responsibilities and recommendations are dispersed across multiple bodies. Effective coordination and clear accountabilities will be important and should be captured in the review's implementation plan.

> *"Longer-term investment and collaboration across multiple agencies and jurisdictions will be imperative to ensure success.*
>
> WA Health submission to final report

Commitment to reform

A public commitment to reform by all key stakeholders is required to support sustainable long term change.[313]

Timely and concurrent implementation of health and migration related measures is critical for success. The review welcomes the National Cabinet and health ministers' strong support and commitment to reform. Given the complexity and significance of the proposed changes, ongoing collaboration and monitoring – to maintain momentum and realise the significant health and economic benefits – will be required.

> *This work will require the commitment of national government agencies and regulators if it is to be implemented successfully. Without will and commitment from national agencies, we cannot achieve this important goal. We are ready to work with the Commonwealth and their agencies to achieve this.*

Ahpra and National Boards submission to final report

Importance of prioritising and sequencing

Priorities have been identified on the basis of their potential impact in the short to medium term. These have been tested with the Health Workforce Taskforce and other key stakeholders and have been endorsed by health ministers.

Stakeholders agreed on the importance of taking a prioritised and staged approach in ensuring the reforms are implemented efficiently and effectively.

Targeted funding will be needed

The NRAS and other regulatory entities require support to implement the proposed reforms.

Regulators have a broad span of control and are required to manage competing priorities in exercising their decision-making roles. Many National Board members, for example, are registered health practitioners who undertake their regulatory role alongside a full practice workload.

Additional targeted, upfront resources and funding are likely required to:

- align evidentiary requirements, remove duplication and streamline application steps (Recommendation 1)
- automate the issuance of the MPN (Recommendation 2)
- provide more support to applicants (Recommendation 8)
- provide more fast track pathways, including for GPs and other medical specialists (Recommendation 9)
- target scarce supervisory resources to where they are most needed (Recommendation 13).

Relying on fee increases to fund reform will adversely impact Australia's ability to compete in the global market.

> *Ahpra has advised it will soon implement a significant systems and process upgrade across its regulatory activities. Further integration with migration and visa and other systems will be established to remove duplication and move towards the 'tell us once'. Any additional funding beyond registrant fees should be identified to support this recommendation.*

NSW Health submission to final report

> *We believe that implementation of these much-needed reforms in a timely manner will require more than what registered health practitioners can and should fund. The quantum of funding necessary to make the changes in the recommended timeframes means it is not feasible nor appropriate for internationally trained health practitioners and Australian registered health practitioners to be required to fund the costs via their application and registration fees. In the absence of another funding source for these reforms, we will not be in a position to progress as recommended.*

Ahpra and National Boards submission to final report

Taking an adaptive approach

Enhancing and accelerating existing systems and processes will bring big improvements. However, implementation must also be flexible so the approach can be adjusted based on outcomes and circumstances, or if sufficient progress is not made within ministerially determined timeframes.

Regular reporting will help National Cabinet and health ministers monitor progress and adapt as required.

The escalation measures outlined in Chapter 3 include reconsidering the roles and responsibilities of key decision makers and improving other aspects of the broader system. These recognise that existing systems and structures may not be able to deliver the workforce needed and that more significant structural change may be required.

Regulatory best practice on implementation

Chapter 3 discusses ways to improve regulator performance. This mindset should also apply to implementation. Best practice with respect to implementation requires:

- cultivating a culture that is open to change and seeks to continuously improve
- engaging and collaborating across all parts of the regulatory and policy system
- reporting on the status of implementation regularly and transparently
- measuring and evaluating outcomes.

Submissions highlighted the importance of ongoing collaboration, co design of appropriate strategies and greater transparency in the process, actions and decisions by health ministers.[314]

Appendix A. 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.[315]

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:

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.

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 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.

Appendix B. Engagement and consultation

The review was tasked to consult with a wide range of stakeholders to ensure recommendations are practical, implementable and capable of delivering the health workforce Australia needs to ensure high quality and timely health services.[316] The review adopted a consultative approach – which was appropriate given the time constraints of a rapid review, the significant number of stakeholders involved, and the complexity of the current system.[317]

Key stakeholders were identified very early in the review as part of developing a stakeholder engagement plan. As such, consultation activities were coordinated with stakeholder groups who:

- design and implement the current regulatory system, including health ministers, health chief executives, Ahpra, National Boards, Accreditation Authorities, specialist medical colleges, and relevant Australian Government agencies (for example DoHA and Services Australia)
- interact with the system – including public and private employers, and IQHPs – to understand their 'lived experience'.

Additionally, the review sought views from the National Health Practitioner Ombudsman, the Australian Commission on Safety and Quality in Health Care, other relevant Australian Government agencies (for example, the Productivity Commission), peak professional bodies, universities, industry experts, rural advocacy groups and community representatives.

Engagement with international regulators was a priority. This enabled benchmarking of Australia's regulatory settings against those of global counterparts, drawing on international best practice. Officials and regulators from Canada, New Zealand and the United Kingdom were open and willing to sharing information about their regulatory system, across all regulated health professions.

Working to a compressed National Cabinet time frame, the review took a phased approach to consultation to:

- discover – understanding the regulatory settings and pain points, particularly from an employer and IQHP perspective (December 2022 to February 2023)
- test – assessing and prioritising initial recommendations with key partners (such as Australian governments and regulators) for the interim report to National Cabinet (March to April 2023)
- iterate – validating recommendations with stakeholders for the final report to National Cabinet (May to July 2023).

Consultation activities tended to be limited to smaller stakeholder meetings and roundtables, international dialogues, policy design workshops and interdepartmental meetings. These types of interactions fostered genuine dialogue, with frank feedback from participants. Sharing of insights and data from this process proved valuable in selecting, designing, and prioritising reforms.

To develop a robust impact analysis of the current regulatory system, Accenture was engaged via an open tender process to design and deploy a survey for recently arrived IQHP's. Accenture facilitated focus groups for IQHPs and employers, and prepared maps of the end-to-end journey for different health practitioners. This primary research is a key feature of this final report as it demonstrates the complexity and costs of IQHPs current journey. This is the first time the costs of the entire journey have been quantified. It also helped quantify the benefits of reform, which further supports the case for change.

The review coordinated 2 targeted submissions processes. The first, throughout February and March 2023, sought stakeholder feedback on the end-to-end journey. The second, in May and June 2023 (following the release of the interim report), sought stakeholder feedback on initial recommendations – specifically, what should be prioritised and what, if any, reform options were missing.

The response to the interim report was overwhelmingly positive. A few stakholders concluded the findings positively. However some stakeholders raised several significant concerns, including:

- the transition of comparability assessments from specialist medical colleges to the AMC

- streamlined pathways for cohorts from other comparable health systems
- the implementation of time frames and funding
- a one-size-fits-all approach across professions
- limited focus on allied health.

In response, the review refocused engagement activities in the time remaining to further unpack sensitivities with stakeholders. Where possible, the review has sought to address these concerns in the final report, without jeopardising the level of ambition or sense of urgency.

The review is grateful for the participation of all stakeholders and the insights shared through the review process.

Stakeholders groups consulted

This list includes stakeholder groups consulted (via meetings or targeted submissions processes) singly or as part of a forum. It does not include individuals.

- Aboriginal and Torres Strait Islander Health Practice Accreditation Committee
- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Ahpra Accreditation Committee
- Ahpra Community Advisory Council
- Allied Health Professions Australia
- Aspen Medical
- Australasian College of Dermatologists
- Australasian College of Paramedicine
- Australian Acupuncture and Chinese Medicine Association
- Australian and New Zealand College of Anaesthetists
- Australian Association of Social Workers
- Australian Capital Territory Department of Health
- Australian Chiropractors Association
- Australian College of Rural and Remote Medicine
- Australian Commission on Safety and Quality in Health Care
- Australian Criminal Intelligence Commission
- Australian Dental Association
- Australian Dental Council
- Australian Health Practitioner Regulation Agency (Ahpra)
- Australian Institute of Health and Welfare
- Australian Medical Association
- Australian Medical Council
- Australian Nursing and Midwifery Accreditation Council
- Australian Nursing and Midwifery Federation
- Australian Osteopathic Accreditation Council
- Australian Pharmacy Council
- Australian Physiotherapy Association
- Australian Physiotherapy Council
- Australian Podiatry Association
- Australian Private Hospitals Association
- Australian Psychological Accreditation Council
- Australian Psychological Society
- Australian Society of Medical Imaging and Radiation Therapy
- Avant Insurance
- Benevolent Society
- Better Medical
- Cabrini Health
- Catholic Health Australia
- Charkos Global
- Chinese Medicine Accreditation Committee
- Chinese Medicine Board of Australia
- Chiropractic Board of Australia
- College of Intensive Care Medicine of Australia and New Zealand
- Community Connector Program (Greater Shepparton)
- Council of Chiropractic Education Australasia
- Council of Deans of Nursing and Midwifery

- Council of Presidents of Medical Colleges
- Dental Board of Australia
- Department of Employment and Workplace Relations
- Department of Foreign Affairs and Trade
- Department of Health and Aged Care
- Department of Health and Social Care (UK)
- Department of Home Affairs
- Department of the Prime Minister and Cabinet
- Department of the Treasury
- East Coast Apprenticeships
- Eastbrooke
- Faculty of Medicine and Health, The University of Sydney
- Federation of Medical Regulatory Authorities Canada
- First Deputies Group
- First Secretaries Group
- ForHealth Group
- General Medical Council (UK)
- Goulburn Valley Health
- Grattan Institute
- Heads of Departments and Schools of Psychology Association
- Health and Care Professions Council (UK)
- Health Chief Executives Forum
- Health Ministers' Meeting
- Health Professions Accreditation Collaborative Forum
- Health Workforce Queensland
- Health Workforce Taskforce
- HR+
- Medical Board of Australia
- Medical Council New Zealand
- Medical Council of Canada
- Medical Deans Australia and New Zealand
- Medical Radiation Practice Accreditation Committee
- Medical Radiation Practice Board of Australia
- MedicalOne
- Myhealth
- National Aboriginal and Torres Strait Islander Health Worker Association
- National Alliance of Self Regulating Health Professionals
- National Health Practitioner Ombudsman
- National Rural Health Alliance
- New South Wales Department of Health
- New Zealand Ministry of Health
- Northern Territory Department of Health
- NSW Rural Doctors Network
- Nursing and Midwifery Board of Australia
- Nursing and Midwifery Council (UK)
- Nursing Council of New Zealand
- Occupational Therapy Australia
- Occupational Therapy Board of Australia
- Occupational Therapy Council

- Ochre Health
- Office of the National Rural Health Commissioner
- Optometry Australia
- Optometry Board of Australia
- Optometry Council of Australia and New Zealand
- Orbona Foundation
- Osteopathy Australia
- Osteopathy Board of Australia
- Paramedicine Accreditation Committee
- Paramedicine Board of Australia
- Partnered Health
- Pharmaceutical Society of Australia
- Pharmacy Board of Australia
- Pharmacy Guild of Australia
- Physiotherapy Board of Australia
- Podiatry Accreditation Committee
- Podiatry Board of Australia
- Primary Care Business Council
- Productivity Commission
- Promising Potential
- Psychology Board of Australia
- Queensland Department of Health
- Ramsay Health Care
- Royal Australasian College of Medical Administrators
- Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australian and New Zealand College of Ophthalmologists
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian and New Zealand College of Radiologists
- Royal Australian College of General Practitioners
- Royal College of Pathologists Australasia
- Rural Doctors Association of Australia
- Rural Doctors Workforce Agency (SA)
- Rural Health West (WA)
- Rural Workforce Agency NT
- Rural Workforce Agency Victoria
- Services Australia
- Society of Hospital Pharmacists of Australia
- Sonic Healthcare Australia
- South Australian Department of Health
- St John of God Health Care
- Tasmanian Department of Health
- Toowong Private Hospital
- UnitingCare Australia
- Universities Australia
- Victorian Department of Health
- Western Australian Department of Health
- Western NSW Local Health District

Appendix C. Extinguished recommendations from interim report

Recommendation	Map to interim report	Rationale for removal
Provide more fast track 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.	Lower priority. Will be partially addressed by other skills recognition recommendations.
Provide more fast track pathways	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.	Work is already in progress.
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.	Has been replaced with new recommendations regarding maldistribution, in light of stakeholder feedback about practical implementation.
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.	This is being addressed through the work of Ahpra and National Boards to improve timeframes for application processing and assessment.
Consider greater flexibility to demonstrate recency of practice	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.	Flexibility is being explored in the recency of practice review, including whether a minimum level of clinical experience in a comparable health setting would provide enough public protection or would introduce unacceptable risks. Benchmarking with other jurisdictions regarding clinical experience requirements is also being undertaken.

Recommendation	Map to interim report	Rationale for removal
Consider greater flexibility to demonstrate recency of practice	S13 – National Boards to review and consult on their mandatory recency of practice standards.	The review is progressing, and stakeholder consultation is expected to occur later in 2023.
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.	Health ministers to consider as part of its review of regulatory complexity.

Appendix D. Journey maps – Current state

Australian Government
Department of Finance

Current State 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.

The colours of each stage represent the difficulty of each stage, based on survey data.

Nursing and/or Midwifery

1. Exploring

"I had a number of connections who had previously worked in Australia, and there's a large community from my country working there."

- IQNM applicant encounters information about living and working as a nurse overseas
- After researching and speaking with colleagues, IQNM applicant gathers professional documentation and submits applications for nursing positions in a few overseas locations, including Australia
- A migration agent may be utilised

What are they thinking?
- Is now the right time?
- Where could I go?
- How long is the process?
- How easy is it to get a job?

Cost: Varies by individual

Time: Varies by individual

Pain Points 1 4

Some applicants will likely start compiling documents ASAP

2. Deciding

- IQNM applicant does basic research into working conditions, visa requirements and lifestyle for countries
- IQNM applicant decides to proceed with an offer to work in Australia

What are they thinking?
- Who can help me secure a job in Australia?
- Will they help me and my family move to Australia?
- What is the culture of the country?

Cost: Varies by individual

Time: Varies by individual

"I had a number of connections who had previously worked in Australia, and there's a large community from my country working there. 47 out of 86 in my class came to work in Australia."

Stream A
Stream B

3. Self / eligibility check

- IQNM applicant completes online self-check
- IQNM assessment: $410
- Orientation Part 1 (Stream A and B) 1 hour
- IQNM is likely to use personal and/or professional connections for guidance

What are they thinking?
- Now that I know which stream I belong to, how long will the next step/s take?

Time: Less than 30mins

Stream C

"There is no way I would have come here if I had come through the stream for non-comparable health qualifications. The process for those health practitioners is very challenging."

Stream C
- IQNM can apply for an NMBA approved 'conversion'/post registration program in Australia which leads to Stream A on completion

4. Compiling documents for registration

IQNM applicant compiles documents for portfolio:
1. Nursing registration in another country,
2. Tertiary health qualifications in nursing,
3. English language proficiency,
4. Professional indemnity insurance arrangements
5. Criminal history check

What are they thinking?
- I grew up speaking English why do I need to prove it?
- If prior successful applicants have the same qual as me, why do I need to prove evidence of it?

- IQNM applicant may need to certify or have documents notarised
- English translations for documents as required or evidence of schooling completed in English
- Criminal history check $150

Overall time ~ 8 weeks

"I had to track down principals and teachers who I barely knew to get evidence of primary and high schooling completed in English. It felt so unnecessary, especially since I'm from Ireland."

Pain Points 1 2

5. Skills assessment for registration

Overall time ~ 5 weeks

IQNM sits Outcomes Based Assessment (OBA):

Stream A:
(online) multiple choice question exam (MCQ) $500

Stream B:
(online) multiple choice question exam (MCQ) $500
(in-person, in Adelaide) Objective Structured Clinical Exam (OSCE) $4000
(*Re-sit fees where first attempt unsuccessful) 4 hours (only for Stream B)
OSCE is run 5 times per year (2-3 months between dates)

What are they thinking?
- I have many years of experience in similar work places overseas, why am I doing these assessments?
- Are there cheaper or faster pathways I can pursue through other countries?
- This is very expensive, will I have to make sacrifices elsewhere?
- Will it be easy to secure a job?

"There is just cost upon cost for some IQNMs. You're spending thousands and you have to align yourself to their schedule, while doing things like visas, finding housing, schools."

Pain Points 1 2 3

6. Receiving exam results

Wait time for results ~ 2.5 weeks

- IQNM receives feedback and/or results from Outcomes Based Assessment

What are they thinking?
- Now that I've passed, how long will it take to get registered?

Pain Points 1 3

Re-sit Required

"It's just incredibly expensive to live here, I know that's not unique to us, it just adds to the list of pressures on an already struggling profession."

7. Apply for registration

IQNM Applicant submits registration application, compiled documents to AHPRA for processing $480 (7-14 days if completed correctly)

What are they thinking?
- How long should I wait before I follow up on my registration application?
- How do I contact Ahpra if I need to?
- What extra fees, or time do I need to invest if my application is incomplete, or unsuccessful?

"I had documents translated and certified by the Australian government, but Ahpra still rejected them as not being to standard."

Pain Points 1

Stream A
Stream B

8. Qualifying for skilled migration

"Our IQNMs are not valued for their skills and experience. There is a focus on certain qualifications or checks over comparable experience and skills from what we've gone through trying to get people over here."

Applicant ensures they meet criteria to qualify for skilled migration. IQNM applies to ANMAC ($515) and compiles documents to meet five assessment criteria:
1. Proof of identity and/or age
2. English proficiency
3. Skills assessment
4. Character test
5. Partner skills and/or experience (if relevant)
6. Sponsorship or nomination (if relevant)

What are they thinking?
- Didn't I already have my skills assessed?
- Why doesn't my Ahpra registration count?

12 weeks processing time

"I relied entirely on my friends and connections, because it wasn't clear what to do."

Pain Points 1 2 3

9. Applying for a visa

Applicants will go through the visa process at different times based on their circumstances. Parts of the process may be done concurrently to an IQNM's registration journey

Overall time ~ 13 weeks

IQNM applies for a visa ~$4000 (3-6 months processing time Employer sponsored, 2+ years independent application)
In some unique instances, an IQNM will not apply for skilled migration but instead use another visa path (e.g partner, working holiday)
Medical health examination if applicable: up to $500

What are they thinking?
- Will it be easy to get work and can I work anywhere?
- Will I be able to live anywhere in Australia?
- Can I bring dependents with me?

Pain Points 1 2 3

"Lots of people I work with are very interested in pathways to get permanent residence."

Applicant already living or working in Australia

10. Employment

Supervision time ~ 4 weeks

- IQNM secures offer of employment and commences work
- IQNM completes any credentialing requirements in order to work (if applicable)

What are they thinking?
- How will my family and I fit in and adapt?
- Who can help me understand the "Australian" ways of working?
- Will my employer reimburse or cover any costs?

Cost
Essential costs of living - $3,800 / month (single person)
$7,000 / month (family of 4)
Expatistian

Pain Points 1 5

"3 months start to finish is pretty normal for a nurse or midwife with a comparable background like me."

"Generally its 6-12 weeks from finding a health practitioner and this individual starting working for a large employer like us."

"My employer did everything for me. I don't remember specifically, but it was a breeze to come over here. I basically didn't pay a cent during the process."

Living and working in Australia

Pain point Legend

1. Costs to individual
   - Out of pocket expenses - certification/ notarisation, translation, document production fees
   - Application / registration fees
   - Examination fees
   - Tuition / study costs (including private bridging courses)
   - Travel costs (physical attendance)
   - Third party/agent fees
   - Opportunity cost
2. Application management
   - Liaising with parties to compile documents (universities, overseas nursing boards, former employers, work history)
   - Tracking progress
   - Managing scheduling, correspondence
3. Process complexity
   - Most countries' qualifications do not meet NMBA-Ahpra criteria, however many countries are considered equivalent
   - High threshold for English language proficiency. IQNM applicants from English speaking backgrounds are often required to prove their schooling was completed in English
   - Limited exams scheduled each year
   - Requires physical presence in Australia to complete with no online options
   - Duplicative processes
4. Source of truth
   - No clear source of truth to many IQNM applicants
   - Official and unofficial information sources each give a siloed view of the process to live and work in Australia
   - Reliance on professional / social networks to navigate information sources
5. Skills transferability
   - Am IQNMs skills may not be fully transferrable to Australia, resulting in additional years of training. Often this may be equivalent to one year full-time education
   - An IQNM may need more time to learn cultural / situational context and nuances

Touch point Legend

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

Australian Health Practitioner Regulation Agency (Ahpra)
ANMAC
Home Affairs

Australian Government
Department of Finance

Current State 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

Competent - Applicants registered in select countries with comparable standards to Australia.

Standard (WBA)

Standard (Exam)

Standard - Applicants from all other countries. Pathway will diverge based on the applicant having secured employment.

Specialist

Partially Comparable

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.

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.

The colours of each stage represent the difficulty of each stage, based on survey data.

International Medical Graduates

Some applicants will likely start compiling documents ASAP

All applicants

1. Exploring

- Applicant encounters information about living and working as a doctor overseas, in particular Australia
- After researching and speaking with colleagues, applicant gathers professional documentation and submits applications for positions in Australia. They may also apply in other countries simultaneously

"The working conditions are much better in Australia, even compared to countries like Ireland and the UK."

Touchpoints

What are they thinking?
- Is now the right time?
- Where could I go?
- How long is the process?
- How easy is it to get a job?

"When you have family you need to weigh up the opportunity cost much more. Schools, housing, employment for my partner were all huge considerations."

Time
Varies by individual

Pain Points 1 4

2. Deciding

- Applicant does basic research into working conditions, visa requirements and lifestyle for countries
- Applicant may attend interviews with potential employers and may receive an offer of employment in Australia
- Applicant decides to proceed with an offer to work in Australia or decides to move to Australia without a job

"Speaking to other people who had moved, they said that in Australia, you have the ability to live a well-balanced and safe lifestyle."

What are they thinking?
- Is this the right move professionally?
- What is the culture of the country?
- Who can help me secure a job in Australia?
- Will they help me and my family move to Australia?

Touchpoints

Time
Varies by individual

"I got invited by my colleagues in my professional network in Singapore to come to Australia."

Pain Points 4

Competent
Standard
Specialist

3. Self / eligibility check

- Applicant completes online check

What are they thinking?
- Now that I know which stream I belong to, how long will the next steps take?

Touchpoints

Cost (TBC)
Time (TBC)

"The Government translated my documents for free, which was a great service but then I submitted these same documents to Ahpra and they said they did not accept this translation."

4. Compiling documents for registration

Applicant compiles documents:
1. Primary Medical Qualification
2. Postgraduate and specialists qualifications (if applicable)
3. Certificates of good standing
4. Identification documents

What are they thinking?
- What's the easiest path for me?
- Will my documents be accepted?

Touchpoints

Time
8 - 10 weeks

Pain Points 1 2 3

"No one speaks to each other in the process. It is impossible to understand the process before you start the journey."

Competent

Pain Points 1 2 3

5. Skills assessment for registration

Overall time 24 - 27 weeks

Applicant completes requirements in order to qualify for registration

All applicants
- AMC primary source verification
- AMC portfolio for qualifications

Standard
- AMC MCQ exam

Specialist
- Specialist college desktop assessment
- Specialist College Interview

What are they thinking?
- Are there cheaper or faster pathways I can pursue through other countries?
- How long is my employer prepared to wait?
- If I am rejected at some stage, will my employer rescind my offer?

Touchpoints

Cost
AMC portfolio $600
MCQ exam: $2920

Time
MCQ exam 3.5 Hours
Specialist college assessments (varies by college)

Provisional registration
Provisional registration
Limited registration
Provisional registration
Limited registration

6. Receiving exam results

- Applicant receives feedback and/or results
- Applicant applies for jobs and may receive an offer of employment

Standard
- MCQ Certificate
- Can apply for jobs
- Split into workplace based assessment (limited spots) and exam pathway

Specialist
- Substantially comparable
- Partially comparable
- Not comparable, may be eligible for other pathways

Re-sit required

What are they thinking?
- Am I going to pass these exams?
- How long will it take to get an employment offer?

Wait time for results ~ 8 weeks

Touchpoints

Pain Points 1 3 5

Standard (exam)
Standard (WBA)
Standard
Specialist
Substantially Comparable
Partially Comparable
Not Comparable
- Exit journey or,
- May still be eligible for other pathways

"I just got a generic reply. You don't receive any guidance on what to do differently next time. You just have to resubmit and try again."

7. Registration Requirements

- Applicant completes further requirements before applying for registration including Criminal History check and English Language Skills (ELS) standard

"Proof of English Language competency test is only valid for 2 years and after this time, you have to re-do the test."

All applicants
- PESCI (if GP)
- Gather info, incl. job details

Standard (exam)
- AMC clinical exam
- Exam certificate
- Must now secure an offer of employment

Specialist
- Bridging study

What are they thinking?
- Have I covered everything and included all my documentation?

Cost
AMC clinical exam: $4130 (exam), $300 (certificate)
PESCI: $2145

Time
Clinical exam <4 hours
PESCI 1.5 hours

Touchpoints

Pain Points 1 2 3

8. Submit Registration

- Applicant submits registration application to the medical board (Ahpra) for processing

What are they thinking?
- How long should I wait before I follow up on my registration application?
- What extra fees, or time do I need to invest if my application is incomplete, or unsuccessful?
- Are my Certificate of Good Standing (CoGS) and English Language Skills (ELS) standard still valid?

Cost
Limited (completed the AMC MCQ; enabled IMG to undertake post-graduate training, supervised practice or work in an area of need): $1720
Provisional reg (completed AMC MAC and AMC clinical; secured an offer of employment): $860

Time
4-6 weeks processing time

Pain Points 1 3 6

Touchpoints

9. Qualifying for skilled migration

Applicant compiles documents and evidence to support visa application, which may include:
1. Proof of identity and/or age
2. English proficiency
3. Skills assessment
4. Character test
5. Partner skills and/or experience (if relevant)
6. Sponsorship or nomination (if relevant)

What are they thinking?
- Didn't I already have my skills assessed?
- Haven't I already provided this evidence?

Touchpoints

Overall time ~ 13 weeks

"Home affairs can accept you for skilled migration but then you get stuck in a registration hurdle and you can't work."

Pain Points 1 2 3 6

Competent
Standard
Specialist

10. Applying for a visa

- Applicant applies for a visa (482, 187, 189, 190 and 489)
- In some instances an applicant may not necessarily apply for a skilled visa

What are they thinking?
- What will happen if my employer withdraws the job offer?
- Will my family be able to emigrate to Australia with me?
- Have I covered everything and included all my documentation?

Touchpoints

Cost
Visa application: ~$4000
Medical health examination: up to $500

Time
6-45 months processing time (varies by visa)

Pain Points 1 2 3

Applicant already living or working in Australia

Competent
Standard
Specialist

11. Employment and supervision

- Applicant completes a mandatory period of supervised practice

What are they thinking?
- Am I gaining the right skills and experience?
- Will I be treated the same as an Australian doctor?

"I have 20 years experience in a comparable health system, but I must be observed for at least three months."

Touchpoints

Time
12 months (all streams)
Up to 24 months for some specialists

Pain Points 1 5

Some IMGs repeat supervision a number of times prior to progressing to unrestricted registration

12. Further eligibility?

Standard (WBA)
- AMC clinical exam or workplace based assessment
- Exam certificate

Specialist
- Eligible for fellowship

Touchpoints

Cost
AMC clinical exam: $4130 (exam), $300 (certificate)

Time
Clinical exam <4 hours

Pain Points 5

"You need a good amount of money to go through this process. Attempting exams and other assessments is an expensive process."

13. Unrestricted Registration

- Applicant applies for general or specialist registration
- Applicant cannot practice until they receive a medicare provider number

What are they thinking?
- How long will it take to get my Medicare provider number?
- When can I practice?

Touchpoints

Cost
General reg (IMG has completed 12 months of supervised practice): $1720

Time
Medicare provider number
21 days

"We chose to stay in Australia because of the lifestyle and working conditions, it's much better here."

Pain Points 1 3

Pain point Legend

1 Costs to individual
- Out of pocket expenses - certification/notarisation, translation, document production fees
- Application / registration fees
- Examination fees
- Tuition / study costs (including private bridging courses)
- Travel costs (physical attendance)
- Third party/agent fees
- Opportunity cost

2 Application management
- Liaising with parties to compile documents (universities, overseas medical boards, former employers, work history)
- Tracking progress
- Managing scheduling, correspondence

3 Process complexity
- Most countries' qualifications do not meet Ahpra criteria. Only qualifications from 5 countries meet criteria
- High threshold for English language proficiency compared to other countries
- Demand for exam position may exceed supply
- Requires physical presence to complete / no online or alternative completion options for some steps
- Duplicative processes

4 Source of truth
- Lack of single source of truth
- Official and unofficial information sources each give a siloed view of the process to live and work in Australia
- Difficult to find information on specific questions
- Reliance on professional / social networks to navigate information sources

5 Skills transferability
- An IMGs skills may not be fully transferrable to Australia, resulting in additional years of training/education than native-born workers employed in the same job
- An IMG may need more time to learn cultural / situational context and nuances

6 Currency of skills and assessments
- Criminal history check, ELS and ROP all have timeframes of applicability with associated costs
- Drawn out timeframes can result in a requirement to repear criminal history checks and ELS to meet standards set by Ahrpa and Immigration
- ROP is hard to address after 5 years and often results in IMGs not being able to register

Touchpoint Legend

Online, In Person, Video, Email, Phone, Post, Migration Agent, Employer, Video Conferencing, Specialist medical colleges

Australian Government Department of Home Affairs — Home Affairs

Australian Government Department of Health and Aged Care — Health and Aged Care

Services Australia — Services Australia (Medicare)

Medical Board Ahpra — Australian Health Practitioner Regulation Agency (Ahpra)

Australian Medical Council Limited — Australian Medical Council

ECFMG — Education Commission for Foreign Medical Graduates (ECFMG)

Australian Government
Department of Finance

Current State Journey Map

This map illustrates a simplified journey of an international allied health practitioner (HP) seeking to practice in Australia.

Professions

- Paramedicine
- Occupational Therapy (OT)
- Psychology
- Pharmacy

A HP may not go through every action or step in the exact order and duration 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 mostly linear; in reality, a HP 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.

The colours of each stage represent the difficulty of each stage, based on survey data.

Allied Health

1. Exploring

- Applicant encounters information about living and working as a health practitioner overseas, in particular Australia.
- After researching and speaking with colleagues, applicant gathers professional documentation and may submit applications for positions in Australia. They may also apply in other countries simultaneously.

"The working conditions in Australia were very attractive to me. The hours are much more reasonable."

Touchpoints

What are they thinking?
- Is now the right time?
- Where could I go?
- How long is the process?
- How easy is it to get a job?

Pain Points 1 4

Time
Varies by individual

"It's very expensive here, but the lifestyle is very desirable."

2. Deciding

"It was a lifestyle choice to come live and work in Australia."

- Applicant does basic research into working conditions, visa requirements and lifestyle in various countries.
- Applicant may attend interviews with a number of potential employers and may receive amongst others, an offer of employment in Australia.

What are they thinking?
- Is this the right move professionally?
- What is the culture of the country?
- Who can help me secure a job in Australia?
- Will they help me and my family move to Australia?

Touchpoints

Pain Points 1 4

Time
Varies by individual

3. Self / eligibility check

Applicant completes a self-check or an official eligibility assessment to see if they meet eligibility criteria and if they do, it will determine their streaming path.

What are they thinking?
- Now that I know what path I belong to, how long will the next step/s take?

All applicants
Self-check
Less than 30mins

Pharmacy
Eligibility Check
$1310 (8 weeks processing time)

"The information on the website doesn't have the correct information and information provided via a phone call differs. I would like someone to speak to who knows the whole process."

Pain Points 1 5

4. Skills assessment for registration

Overall time 8 - 12 weeks

Applicant conducts assessments through relevant authorities to determine if their qualification is comparable.

What are they thinking?
- Are there cheaper or faster pathways I can pursue through other countries?
- How long is my employer prepared to wait?
- If I am rejected at some stage, will my employer rescind my offer? Will I be able to reattempt?

Paramedicine
Apply to have qualifications recognised by paramedicine board (Ahpra) $400
Submit qualification portfolio to Ahpra for assessment

Occupational Therapy
Desktop Assessment (up to 4 weeks)
- Proof of identity
- Proof of qualification
- English language competency

Psychology
Desktop Assessment:
- Qualification comparable to 6 years Australian study; or
- Qualification comparable to 4-5 years Australian study

Pharmacy
Competency Assessment of Overseas Pharmacists (CAOP) exam (Canada, Ireland, New Zealand, the UK or the USA): $1,910
Knowledge Assessment of Pharmaceutical Sciences (KAPS) exam (all other countries): $2,190

Pain Points 1 2 3 5

5. Registration requirements

"I had to do a $1000 international criminal history check even though I haven't left Australia for 2 years."

Wait time for results 2 - 4 weeks

Some applicants will undertake further assessment and/or bridging study.

What are they thinking?
- How long will it take to be assessed?
- Will I be able to reattempt if I fail or am rejected?
- If I haven't secured an offer for employment, how long will it take?

Paramedicine
- Applicants assessed as comparable can apply for registration
- Relevant qualifications complete Competence Assessment $2200

Pharmacy
Resit exam if unsuccessful or exit journey.

"Ahpra wouldn't accept my thesis even though I had evidence of my placement hours. I had to do further study which I'd already done."

All applicants
If qualification is not comparable, applicant must complete bridging or further study, or exit journey.

Pain Points 1 3

6. Apply for registration

Applicant applies for registration. The type of registration will depend on the pathway they are applying through.

What are they thinking?
- How long should I wait before I follow up on my registration application if I need to?
- What extra fees, or time do I need to invest if my application is incomplete, or unsuccessful?

Paramedicine
Registration $472

Occupational Therapy
Limited registration $1500

Psychology
Provisional registration $1135

Pharmacy
Competent path: limited registration ~$440
Knowledge path: provisional registration ~$670

Pain Points 1 3

"I had to do an English test to get my initial registration. I have to do another English test to gain full registration. Do they actually think my English will decrease after 2 years studying and working in Australia?"

"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."

"With the broader challenges around mental health access, the process seems illogical for a professional."

7. Supervision and/or employment

Overall time 26 - 52 weeks

Applicant completes mandatory supervised practice as per their pathway requirements.

What are they thinking?
- What will happens if I am found unsuitable during the practice?
- How much out of work time will this take up for me?
- If I haven't got a job yet, will my supervisor offer me ongoing employment?

"It's like being a student all over again. You have to get out of the mentality of working for 10 years and go back to basics, it's hard."

Occupational Therapy
Supervision agreement with employer submitted to OTC 6 months

Psychology
Transition program 3 months or Internship 1 year

"A one year unpaid internship which requires working 4 days a week is almost financially impossible. I relied heavily on my partner."

Pharmacy
Limited registration 153 hours
Provisional registration 1824 hours

Pain Points 1 5

"I found my supervisor was really helpful to learn the system, especially the NDIS."

8. Further assessment

Some applicants will undertake further assessment prior to being eligible for full registration.

What are they thinking?
- Will I be able to reattempt if I fail or am rejected?
- If I haven't got a job yet, will it take long to find one?
- Will it impact my visa?

Pain Points 1 3

Psychology
National psychology exam $450

Pharmacy
APC written exam $730
Ahpra oral exam $225

"My employer made this process a lot easier, by helping to walk me through the process."

9. Full registration

Applicant applies for full/general registration.

What are they thinking?
- How long will it take to get my Medicare provider number? (if applicable)
- When and where can I practice?

"I'm an experienced Occupational Therapist, but learning the Australian system took some time."

Paramedicine
Employer determines additional assessments/ training requirements, for example:
- Ambulance Victoria Assessment Centre
- NSW Ambulance Credentialing committee

Occupational Therapy
General registration ~$250

Pharmacy
General registration ~$740

Psychology
Assessment $510
General registration $415

Pain Points 1 2

1. Qualifying for skilled migration

Applicants will go through the visa process at different times based on their circumstances

Overall time 13 - 17 weeks

Applicant compiles documents and evidence to support visa application, which may include:
1. Proof of identity and/or age
2. English proficiency
3. Skills assessment
4. Character test
5. Partner skills and/or experience (if relevant)
6. Sponsorship or nomination (if relevant)

What are they thinking?
- Didn't I already have my skills assessed?
- Do I need someone to help me?

Paramedicine
Skills assessment $968

Occupational Therapy
Desktop assessment $1,200

Psychology
Application fee $1,233

Pharmacy
CAOP and KAPS results used for skills assessment

Pain Points 1 2 3

2. Applying for a visa

Overall time 13 - 15 weeks

Applicant applies for a visa:
- English test
- Skills assessment (from previous)
- Medical exam $500
- Criminal history check

In some instances an applicant may not necessarily apply for a skilled visa.

What are they thinking?
- What will happen if my employer withdraws the job offer?
- Will my family be able to emigrate to Australia with me?

Paramedicine
Visa $2770-$4240
Processing time 4 - 60 months)

Occupational Therapy
Visa up to $4240
Processing time 14 days - 3 months)

Psychology
Visa $4240
Processing time 2 - 3 months)

Pharmacy
Visa $4240
Processing time (TBC)

Pain Points 1 2 3

Pain point legend

1. **Costs to individual**
   - Out of pocket expenses - certification / notarisation, translation, document production fees
   - Application / registration fees
   - Examination fees
   - Tuition / study costs (including private bridging courses)
   - Travel costs (physical attendance)
   - Third party / agent fees
   - Opportunity cost
2. **Application management**
   - Liaising with parties to compile documents (universities, overseas medical boards, former employers, work history)
   - Tracking progress
   - Managing scheduling, correspondence
3. **Process complexity**
   - Most countries' qualifications do not meet criteria, however many countries are considered equivalent
   - High threshold for English language proficiency. Applicants from English speaking backgrounds are often also required to prove their schooling was completed in English
   - May require physical presence to complete / no online or alternative completion options for some steps
   - Duplicative processes
4. **Source of truth**
   - No clear source of truth to many applicants
   - Official and unofficial information sources each give a siloed view of the process to live and work in Australia
   - Difficult to find information on specific questions
   - Reliance on employers and professional / social networks to navigate information sources
5. **Skills transferability**
   - Skills may not be fully transferrable to Australia, resulting in additional years of training
   - A HP may need more time to learn cultural / situational context and nuances

Touchpoint Legend

Online, In Person, Video, Email, Phone, Post, Migration Agent, Employer

Australian Health Practitioner Regulation Agency (Ahpra)

Australian Pharmacy Council
OT Council Australia
Australian Psychological Society
Department of Home Affairs

Appendix E. Comparative study of existing registration pathways

	Nursing & midwifery	International medical graduates (IMGs)	Specialist international medical graduate (SIMG)	Occupational therapy	Paramedicine	Pharmacy	Psychology	Canada (Ontario province)	New Zealand	United Kingdom
Fast track pathways										
Fast track pathway available?	Yes Stream A applicants eligible for this fast track pathway (applicants considered to hold substantially equivalent qualifications)	Yes A Competent Authority Pathway (CAP) is available to IMGs who obtained qualifications from recognised authorities	No. While there is a fast track to general registration (see IMG column), there is no fast track leading to specialist registration.	No Applicant must establish that their qualifications are accredited by the World Federation of Occupational Therapy or are comparable with country education profiles produced by the Australian Government Department of Education	No However, New Zealand qualifications are recognised under the Trans-Tasman Mutual Recognition Arrangement (TTMRA). Some qualifications deemed substantially similar to Australian qualifications can be fast tracked.	Yes Pharmacy Board of Australia provides a CAP. However, knowledge exam still required.	No However, applicants assessed against approved criteria as being comparable to qualifications accredited at the 6th year of study are fast tracked. New Zealand qualifications are recognised under the TTMRA.	Nursing and midwifery: No (each province and territory has separate nursing and midwifery regulators, so registration processes vary) IMGs: Yes SIMGs: Yes Allied health: Mix of pathways available according to profession. Australian qualifications recognised for all allied health professions.	Nursing and midwifery: Yes IMGs: Yes SIMGs: Yes Allied health: Mix of pathways available according to profession. Australian qualifications recognised for all allied health professions.	Nursing and midwifery: No IMGs: Yes SIMGs: Yes Allied health: Partial. The UK has mutual recognition with European Union member states. The Health and Care Professions Council conducts case-by-case assessments of applicants' qualifications and if the required standards are met, grants registration without further assessment.
Recognised authorities & countries	Five countries likely to be recognised: • Nursing only: • Canada • Hong Kong Nursing and midwifery: Ireland • the UK • the US	Six CAPs recognised across 5 countries: • Canada • Ireland New Zealand • the UK • the US	Applicants in the specialist pathway assessed on a case-by-case basis.	Applicants assessed on a case-by-case basis. However, New Zealand qualifications are automatically recognised under the TTMRA.	No comparable countries automatically recognised. Applicants are assessed on a case-by-case basis. However, New Zealand qualifications are considered 'approved'.	Four countries recognised as providing comparable qualifications for CAP: Canada, Ireland, the UK and the US. New Zealand qualifications are recognised under the TTMRA.	No comparable countries or authorities automatically recognised. Applicants are assessed on a case-by-case basis.	Nursing and midwifery: N/A IMGs and SIMGs: Eight countries recognised, including Australia, Hong Kong, Ireland, New Zealand, Singapore, South Africa, Switzerland and the UK. Qualifications from the US are automatically recognised. Allied health: N/A	Nursing and midwifery: Six, including Australia, Canada, Ireland, Singapore, the UK, and the US. IMGs: Two competent authorities (Ireland and the UK) and 24 comparable health systems. SIMGs: Automatically recognises Australian qualifications, and regards Canada, Ireland, the UK and the US as comparable. Allied health: Countries commonly recognised as comparable: Canada, Ireland, the UK and the US.	Nursing and midwifery: N/A IMGs: Expedited pathways available to 30+ countries. SIMGs: Certain postgraduate qualifications recognised as comparable from 14 countries and the EU. Allied health: N/A

	Nursing & midwifery	International medical graduates (IMGs)	Specialist international medical graduate (SIMG)	Occupational therapy	Paramedicine	Pharmacy	Psychology	Canada (Ontario province)	New Zealand	United Kingdom
Cost to applicant	$1,400 approximate minimum cost comprising: • $309 application fee for general registration (Ahpra) • $180 general registration (Ahpra) • $410 International English Language Testing System (IELTS) • $61 Criminal History Check • $410 Internationally Qualified Nurse and Midwife Assessment	$2,700 approximate minimum cost comprising: • $200 fee for fast tracked application (Ahpra) • $860 provisional registration fee (Ahpra) • $600 qualification portfolio assessment (Australian Medical Council (AMC)) • $1,000 Workplace-based Assessment (AMC) • Applicants must undergo skills assessment by Ahpra and 12 months of supervised practice (minimum of 47 weeks of full time). Applicants must have completed at least 4 weeks full time in 1 registration period (152 hours total) or 12 weeks full time over 3 consecutive registration periods (456 hours total).	$2,700 approximate minimum cost comprising: • $200 fee for fast tracked application (Ahpra) • $860 provisional registration fee (Ahpra) • $600 qualification portfolio assessment (AMC) • $1,000 Workplace-based Assessment (AMC)	$200 approximate minimum cost comprising: • $123 application fee for general registration • $123 registration fee for general registration	$800 approximate minimum cost comprising: • $190 application for general registration • $240 registration fee for general registration • $400 qualifications assessment	$2600 approximate minimum cost comprising: • $219 application for general registration • $439 registration fee for general registration • $1950 Competency Assessment of Overseas Pharmacists exam	$2,100 approximate minimum cost comprising: • $509 application for general registration • $415 registration fee for general registration • $450 National Psychology Exam • $718 overseas assessment fee	Nursing & midwifery: N/A. IMGs: $4,500 approximate minimum cost comprising: • $261 credential verification fee • $303 application fee • $2,049 registration fee • $149 Criminal History Check • $1,687 Medical Council of Canada Qualifying Exam. All overseas applicants must complete the relevant Royal College Specialty Exam and practice requirements. SIMGs: Applicants may need to undergo training assessment program. Allied health: N/A	Nursing & midwifery: $1,100 approximate minimum cost comprising: • $475 credential verification fee • $329 Trans-Tasman Application fee • $126 Annual Practising Certificate • $149 Criminal History Check IMGs: $1,600 approximate minimum cost comprising: • $156 credential verification fee • $568 registration fee • $896 Practising Certificate SIMGs: Additional costs for specialist recognition. IMGs and SIMGs from competent countries must have practiced for at least 33 months for at least 20 hours per week in the 48 months prior to application in one or more comparable health systems. Allied health: Costs vary across professions. Supervised practice commonly required.	Nursing & midwifery: N/A. IMGs and SIMGs: $1,000 approximate minimum cost comprising: • $158 credential verification • $51 Provisional Registration • $366 full registration fee (discounted rate for newly qualified doctors)/ $876 Full Registration • $410 IELTS Additional costs exist for registration with relevant specialist medical colleges. Must provide evidence of acceptable internship or clinical experience. Mandatory supervision period only required for provisional registration. No recency of practice requirements apply for IMGs or SIMGs. Allied health: N/A
Other pathways										
Eligibility	Stream B – applicants who hold qualifications deemed to be relevant, but not substantially equivalent to Australian qualifications	For applicants who are ineligible for a CAP	Available to SIMGs who have been assessed by an AMC accredited specialist medical college as being eligible for fellowship	All applicants (except those who obtained their qualifications in New Zealand)	Applicants deemed to have i) a qualification that is substantially equivalent to an Australian qualification; or ii) a qualification that is relevant and who have also completed a competency assessment.	Applicants who did not acquire qualification from, or have qualification adjudicated by, Canada, Ireland, New Zealand, the UK or the US.	A postgraduate qualification in psychology that is considered comparable to an approved Australian qualification.	Nursing & midwifery: All applicants. IMGs: Applicants who have not trained in comparable countries. SIMGs: Applicants who have not trained in comparable countries. Allied health: Applicants assessed on case-by-case basis.	Nursing & midwifery: Applicants who did not obtain qualifications from comparable countries. Nursing applicants with no clinical experience cannot apply. IMGs: Applicants not included in CAPs or from comparable health systems. SIMGs: Applicants with qualifications outside Australia and New Zealand. Allied health: Non-Australian qualified applicants and those not trained in comparable countries.	Nursing & midwifery: All applicants take the standard registration pathway. IMGs: Applicants with qualifications that are relevant to the UK but that are non-European Economic Area qualifications. SIMGs: Applicants who do not obtain comparable qualifications. Allied health: All applicants assessed on case-by-case basis.

	Nursing & midwifery	International medical graduates (IMGs)	Specialist international medical graduate (SIMG)	Occupational therapy	Paramedicine	Pharmacy	Psychology	Canada (Ontario province)	New Zealand	United Kingdom
Cost to applicant	$5,700 approximate minimum cost comprising: • $410 Internationally Qualified Nurse and Midwife Assessment • $309 application fee for general registration • $180 general registration • $410 IELTS • $61 Criminal History Check* • $317 Registered Nurse Multiple Choice Question (MCQ) Exam • $4,000 Objective Structured Clinical Exam (OSCE)	$9,400 approximate minimum cost comprising: • $860 fee for application (Ahpra) • $860 registration fee (Ahpra) • $410 IELTS • $61 Criminal History Check* • $600 qualification portfolio assessment (AMC) • $2,920 MCQ Exam (AMC) • $3,730-$4,130 Clinical Exam (AMC) Additional costs for specialist medical college fellowship. Theory and clinical examinations and a 12-month supervised practice period in approved position required (minimum 47 weeks full time).	$10,100 approximate minimum cost comprising: • $1,500 specialist application fee (Ahpra) • $860 registration fee (Ahpra) • $410 IELTS • $61 Criminal History Check* • $600 qualification portfolio assessment (AMC) • $2,920 MCQ Exam (AMC) • $3,730-$4,130 Clinical Exam (AMC) All applicants must have worked 4 weeks full time equivalent in one year or 12 weeks full time equivalent over 3 consecutive years.	$2,700 approximate minimum cost comprising: • $123 application fee for general registration • $123 registration fee for general registration • $1,500 Occupational Therapy Council of Australia qualification assessment and cultural training • $1,000 supervised practice Prior to registration, applicants must undergo assessment to determine whether their qualifications are suitable as well as a supervised practice period. Applicants must also successfully complete a cultural responsiveness and awareness program.	$3,000 approximate minimum cost comprising: • $190 application for general registration • $240 registration fee for general registration • $400 qualifications assessment • $2,200 Paramedicine Competency Assessment (if required)	$2,800 approximate minimum cost comprising: • $219 application for general registration • $439 registration fee for general registration • $2230 Knowledge Assessment of Pharmaceutical Sciences (KAPS) exam Applicants are required to pass the KAPS exam and complete a period of supervised practice assigned by the Pharmacy Board of Australia.	$2,600 approximate minimum cost comprising: • $509 application for general registration • $415 registration fee for general registration • $718 overseas assessment fee • $410 IELTS • $61 Criminal History Check* • $450 National Psychology Exam All applicants for general registration must complete the National Psychology Exam. Supervision requirements also apply, with an internship or transitional program including practice under observation generally required.	Nursing & midwifery: $2,800 approximate minimum cost comprising: • $1,030 Credential Verification • $403 initial application fee • $429 initial registration and first year of membership • $410 IELTS • $428 NCLEX Exam • $53 Jurisprudence exam All nursing applicants must pass the National Council Licensure Examination for Registered Nurses (NCLEX). Most provinces and territories require registration exams for midwives. Recency of practice for nursing differs by province/territory. IMGs: $4,800 approximate minimum cost comprising: • $261 credential verification fee • $303 application fee • $2,049 registration fee • $410 IELTS • $61 Criminal History Check* • $1,687 Medical Council of Canada Qualifying Exam At least 12 months clinical postgraduate medical training required. SIMGs: Costs vary by specialisation. All applicants must pass Medical Council of Canada Qualifying Exam. Allied health: Costs vary across professions. Applicants must have professional education assessed through a refresher program or a Prior Learning Assessment and Recognition.	Nursing & midwifery: $10,200 approximate minimum cost comprising: • $475 credential verification • $469 Application fee • $126 Annual Practising Certificate • $149 Criminal History Check • $8,940 Competence Assessment Programme All nurses must have practised for at least 2 years (including minimum 2,500 hours) within the previous 5 years. IMGs: $7,400 approximate minimum cost comprising: • $156 credential verification fee • $540 registration fee • $896 Practising Certificate • $5,348 NZ REX Clinical Exam • $410 IELTS. Complete 12 months supervised full time work, be recommended for registration by a Council-approved supervisor. If no other pathways apply, applicants may need to sit the New Zealand Registration Examination. SIMGs: Costs vary across specialisations. Applicants must provide 3 references to support application and GPs must include list of publications, recertification details in country of origin and other requirements. Allied health: Costs vary across professions for exams and supervised practice.	Nursing & midwifery: $2,600 approximate minimum cost comprising: • $283 credential verification • $310 Registration fee • $410 IELTS • $61 Criminal History Check* • $168 Test of competence. • $1,400 Objective Structured Clinical Exam (OSCE) All applicants are required to pass the Test of Competence. Various recency of practice conditions apply, for example, completion of 750 hours over the previous 5 years, 450 hours over the previous 3 years. IMGs and SIMGs: $3,400 approximate minimum cost comprising: • $158 credential verification • $51 Provisional Registration • $366 (discounted rate for newly qualified doctors)/ $876 Full Registration • $410 IELTS • $516 Professional and Linguistic Assessments Board (PLAB) Test 1 • $1,890 PLAB Test 2 Allied health: Costs vary across professions. All applicants undergo initial assessment round. Non-standardised assessments also required.

Considerations:

- *Cost of criminal history check varies depending on country of origin.
- Limited information available for some boxes. If little or no information is provided, this does not necessarily mean the information, requirements, pathways, etc., do not exist, rather that information is not currently accessible.
- Processes and costs sourced from relevant Australian and international registration authorities for each profession.
- Exchange rates: Units of Foreign Currencies per Australian Dollar 7 August 2023 (Commonwealth Bank Australia):
  - US Dollar: 0.63100
  - NZ Dollar: 1.0793
  - UK Pound: 0.49410
  - Canadian Dollar: 0.84180

Appendix F. Recent improvements that are underway

Examples of work by Australian governments, regulators and other entities that will help to improve the end-to-end journey for IQHPs are given below.

Ahpra streamlining projects

Key initiatives by Ahpra and the National Boards include:

- expanding exam capacity, by providing 500 additional places for the OSCE for nurses and midwives, reducing wait times
- improving throughput of IQHP applications, reducing the average time to assess applications from 29 days to 10 days
- digitising application forms and processes for all professions from July 2023, to improve the applicant experience (see Box 3.1 for further details)
- improving the amount and quality of information available for practitioners and employers, to help them better understand regulatory requirements
- placing more senior staff on the frontline to help assess applications to identify missing information sooner. This could cut the time taken to request additional information from 4 weeks to just 7 days.

Nursing and Midwifery Board of Australia

The NMBA is developing a new Registration Standard: General registration for internationally qualified registered nurses that will provide an accelerated registration pathway for eligible IQRNs who hold registration in an approved comparable jurisdiction.[318] The board is also developing an OSCE preparatory program for IQRNs, based on extensive consultation and skills gap analysis. This program is expected to commence in late 2023 and cost IQRN applicants around $1,100 each.

The NMBA has commissioned a review of its mandatory IQNM Orientation modules to assess their relevance and effectiveness. The review is expected to recommend enhancements, including options to strengthen IQNM knowledge of culturally safe and respectful care.

Physiotherapy Board and Australian Physiotherapy Council

The Physiotherapy Board and Australian Physiotherapy Council introduced an Express FLYR pathway that enables applicants registered in Canada, Hong Kong, Ireland and the United Kingdom to have a fast track journey with no assessments. Applicants registered in the Netherlands, Singapore and South Africa have a streamlined journey with written assessments.[319]

A new website is being developed and is due for launch in September 2023. The modernised website will improve usability, accessibility and navigation for applicants. The Australian Physiotherapy Council has significantly increased its staffing in response to an increase in applications.

Australian Medical Council

The AMC conducted a review of its clinical examination, focusing on a potential shift from solely judging competence and performance to judging and guiding competence and performance. No definite decision has been made about the future assessment models and tools.

The AMC clinical examination review also links to the AMC's IMG Journey Mapping Project, which is a research project that is expected to finish in late 2023. It aims to design evidence informed strategies to enhance IMG experiences and performance that contribute to Australian health workforce needs.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists is developing a women's health workforce map and multidisciplinary training opportunities to support workforce development. The college has memorandums of understanding with key stakeholders, including the Australian College of Midwives, to support collaboration and development of multidisciplinary care pathways. It is also undertaking a cultural safety project to train practitioners in providing culturally appropriate care to reduce the risk of poor outcomes for Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities.

Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons engages with overseas healthcare systems through its Global Health program. This program supports specialist medical education, training, capacity development and medical aid in 15 countries in the Asia-Pacific region.

The college is currently piloting a workplace-based assessment, known as External Validation of Professional Performance, as an alternative to the Fellowship exam for some specialist SIMGs.[320] This aims to allow greater flexibility for specialist IMGs to demonstrate currency of clinical knowledge, experience and skills on their path to Fellowship. The pilot will conclude at the end of 2023, with potential implementation in 2024.

Australian Dental Council

The Australian Dental Council introduced a dedicated candidate support team, which has significantly reduced the processing time of initial assessments. While initial assessments took up to 6 months at the peak of the COVID-19 pandemic, they are now taking less than 4 weeks. More candidates are submitting correct documentation, enabling faster processing.

Australian Government Department of Health and Aged Care

The DoHAC is modelling workforce supply and demand for GPs and nurses.

State and territory governments

Several states and territories are streamlining their recruitment and onboarding processes by centralising recruitment campaigns and administration.

Health Workforce Taskforce

The Health Workforce Taskforce, which reports to health ministers, is developing national workforce strategies for nursing and maternity, and a national approach to subsidising migration costs. The taskforce is also supporting the implementation of the National Medical Workforce Strategy 2021–2031 and the National Mental Health Workforce Strategy.

National Health Practitioner Ombudsman review

The NHPO is reviewing NRAS Accreditation Authorities' existing processes and procedures, focusing on specialist medical colleges. The review is nearing completion.

Strengthening Medicare Taskforce Report

The Strengthening Medicare Taskforce Report outlines a vision for Australia's future primary care system. The report recommends significant changes to how primary care is funded and delivered to enable high quality, integrated and person-centred care for the Australian public.

In response, the Australian Government has announced a package of measures to provide better access to affordable care, cheaper medicines and a stronger health workforce.[321] These measures include:

- supporting workforces to work at top of scope, including pharmacists and paramedics
- expanding the nursing workforce to improve access to primary care
- improving access to and delivery of after-hours primary care
- investing in digital health to improve health outcomes

2023–24 Budget included $7.5 billion to support these measures over 5 years from 2022–23.[322]

Improving Care Pathways Taskforce

National Cabinet tasked first secretaries to advise on:

- improving care pathways for people with disability and older people
- addressing pressures on the health and hospital system.

First Ministers have agreed to implement a first tranche of reforms to streamline worker screening, improve worker safety, and develop the Aboriginal and Torres Strait Islander care and support workforce.[323]

Aged Care Industry Labour Agreement

The Aged Care Industry Labour Agreement is addressing workforce shortages in the aged care sector by streamlining migration processes. A similar model may be useful to address other health workforce shortages.

The agreement enables participating aged care providers to sponsor overseas workers on the Temporary Skill Shortage visa (subclass 482) in direct care occupations, such as nursing support workers, personal care assistants, and aged or disabled carers.

After 2 years of full-time work experience in Australia in a relevant direct care occupation, overseas workers are eligible for sponsorship for permanent residency under the Employer Nomination Scheme visa (subclass 186).

To access the agreement, aged care providers must enter into a memorandum of understanding with the relevant trade union: the Australian Nursing and Midwifery Federation, the Health Services Union or the United Workers Union.

These agreements aim to streamline the process for international care sector workers to come to Australia by:

- providing a pathway to permanent residency
- streamlining the visa nomination process and providing priority processing, removing the need for labour market testing for each vacancy
- easing post-work qualification requirements
- easing English language proficiency requirements for workers with relevant community language skills.

A Migration System for Australia's Future

The Review of the Migration System Final Report 2023 has been released and recommends that the migration system should better meet Australia's needs and complement the skills and capabilities of Australian workers. It recommends a sharpened focus on skills, while streamlining processes, simplifying rules and reducing complexity (see Box 1.4 for further details).

Jobs and Skills Summit and subsequent Employment White Paper

The Employment White Paper will provide a roadmap for Australia to build a bigger, better trained and more productive workforce. This is designed to boost incomes and living standards and to create more opportunities. The paper will explore issues, frameworks and policy approaches that are relevant to the future of Australia's labour market over the medium and long term, including the migration system.

It will build on the outcomes of the Jobs and Skills Summit and will have an overarching focus on the objectives of full employment and productivity growth, and women's economic participation and equality. The paper is expected to be released by the end of September 2023.

Budget 2023–24 included $125.8 million over 4 years to continue implementing outcomes from the Jobs and Skills Summit. The aim is to strengthen the migration system to ease critical skills shortages across the economy and build a more productive workforce. This includes $75.8 million to extend current surges in visa processing resources to ensure timely visa processing and improve systems.[324]

Appendix G. Ethical recruitment

The WHO Global Code of Practice on the International Recruitment of Health Personnel provides a framework for member states to support the ethical international recruitment of healthcare workers. While the WHO Code is voluntary, it establishes a best practice approach to international recruitment of health professionals that benefits all nations.

The Code has 4 objectives:

- establish best practice principles
- improve legal and systemic approaches to recruitment
- support development of appropriate agreements and treaties
- support international cooperation to strengthen developing nations' health systems.

Member nations are encouraged to work with health professional recruiters and employers to ensure that recruitment is fair and considers the legal responsibilities of health professionals to their home country.

To support the implementation of the Code, the WHO publishes the Health Workforce Support and Safeguards List, which identifies countries experiencing critical healthcare workforce shortages and discourages recruitment from those countries.

Australia does not actively recruit IQHPs from countries on this list.

The inclusion of countries on the list is based on the availability of necessary health services and the ratios of doctors and nurses per 10,000 people. Fifty-five countries across Africa, the Eastern Mediterranean, South-East Asia, and the Western Pacific are currently on the list. The Code does not prevent individual medical practitioners from these countries from applying for vacancies overseas and seeking migration opportunities.

Appendix H. - Regulatory best practice principles for NRAS entities

Principle 1: Transparency

Be transparent and responsive regulators

Regulators should:

- provide guidance and information that is relevant, clear, concise and accessible to assist IQHPs to understand regulatory requirements
- engage regularly with stakeholders – in particular, IQHPs – such as by providing real-time updates on application progress and publishing and reporting against processing timeframes
- ensure the transparency of decision-making in assessing applicants – including the process for determining educational equivalence or comparability – and provide sufficiently detailed reasons for decisions
- make the rationale behind the setting of fees publicly available (including increases) and actively engage with stakeholders to identify solutions to avoid or reduce unnecessary costs.

Principle 2: Accountability

Be accountable to the purpose of regulation

Regulators should:

- regularly publish performance reports, including on comparative performance over time and efforts to rectify under performance
- ensure performance reporting is specific to key performance indicators and includes the effectiveness of operational performance measures, designed to maximise the availability of safe and competent practitioners, respond to changes in workforce demands, and minimise regulatory burden
- be transparent about how they assess applications, including whether decisions are reviewable.

Principle 3: Risk based and data driven

Take account of and balance risks by leveraging data and technology

Regulators should:

- take an evidence based approach to decision-making that acknowledges and balances risks associated with workforce supply and demand, and patient safety
- ensure compliance and cost burdens are proportionate to risk (for example, consideration that IQHPs with more experience and qualifications might pose fewer risks)
- actively monitor and plan for changes in the operating environment, including priority areas of need that will be influenced by changes in models of care and practitioner scope of practice
- build capability in the use of workforce data and improve digital literacy to better understand and manage risks.

Principle 4: Continuous improvement and stewardship

Adopt a whole-of-system perspective and continuously improve regulation

Regulators should:

- create mechanisms to embed feedback from stakeholders – including – IQHPs, employers, professional bodies and the community – in the regulatory process to support continuous improvement of the NRAS
- consider the cumulative burden of the end-to-end regulatory process for IQHPs to minimise duplication and harmonise activities with other regulators, including by sharing intelligence and producing common guidance
- have well-articulated, embedded and transparent organisational values, including an expression of commitment to upholding and proactively promoting stewardship
- take a broad perspective of the regulatory and policy environments – for example, by conducting environmental scans and considering best practice examples from other countries and regulatory systems.

Appendix I. - Abbreviations

Notation	Description
Ahpra	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
ANZSCO	Australian and New Zealand Standard Classification of Occupations
CAP	competent authority pathway
CHSP	comparable health system pathway
Cth	Commonwealth
DoHA	Department of Home Affairs
DoHAC	Department of Health and Aged Care
EU	European Union
FTE	full time equivalent
FTA	free trade agreement
GP	general practitioner
IELTS	International English Language Testing System
IMG	international medical graduate
IQHP	internationally qualified health practitioner
IQNM	internationally qualified nurse or midwife
IQRN	internationally qualified registered nurse
LHD	local health district
LMT	labour market testing
MBA	Medical Board of Australia
MPN	Medicare provider number
NDIS	National Disability Insurance Scheme
NHPO	National Health Practitioner Ombudsman
NMBA	Nursing and Midwifery Board of Australia
NMWS	National Medical Workforce Strategy 2021–31
NP	nurse practitioner
NRAS	National Registration and Accreditation Scheme
NZ	New Zealand
OECD	Organisation for Economic Co-operation and Development
OSCE	Objective Structured Clinical Exams (nurses and midwives)
PBS	Pharmaceutical Benefits Scheme
SAF	Skilling Australians Fund
SIMG	specialist international medical graduate
TGA	Therapeutic Goods Administration
UK	United Kingdom
US	United States
WBA	workplace-based assessment
WHO	World Health Organization

Appendix J - Glossary

Notation	Description
accreditation	Assessment of education and training courses to determine whether applicants have the knowledge, skills and professional attributes necessary to practise the profession.
Accreditation Authority	Committee or council that is assigned the accreditation function by a National Board.
accreditation function	Includes developing accreditation standards, accrediting programs of study against approved accreditation standards and assessing overseas-qualified practitioners.
allied health	Health professionals who are not part of the medical, nursing or midwifery professions.
Competent Authority	International authority recognised as competent to assess practitioners' knowledge and skills for registration.
Competent Authority Pathway (CAP)	Streamlined registration pathway where no additional clinical or knowledge assessment is required as the health practitioner holds qualifications and/or registration granted by a recognised Competent Authority.
implementation plan	Plan indicating how recommendations from the review will be implemented (by who, when and if there is an associated fiscal cost).
National Board	Each health profession that is part of the NRAS is represented by a National Board. The Boards protect the public and are also responsible for registering practitioners and students, as well as other functions, for their professions.
National Cabinet	A forum for the Prime Minister, state premiers and territory chief ministers to meet and work collaboratively.
National Law	Short title of the *Health Practitioner Regulation National Law Act 2009* (Qld), adopted as mirrored legislation in each state and territory of Australia, that established the National Registration and Accreditation Scheme for registered health practitioners.
National Scheme	Refers to the National Registration and Accreditation Scheme for health practitioners, also known as the NRAS. The National Scheme protects the public by creating a framework for the regulation of 16 health professions in Australia through the National Boards and the Australian Health Practitioner Regulation Agency (Ahpra).
overseas health practitioner	A health practitioner who has trained overseas or an international student who studied in Australia.
registration	A health practitioner must hold registration to practise and use a protected title. National Boards grant registration to practitioners who have met the standards and requirements for their profession.
registration standard	Requirements defined by the National Boards that applicants need to meet to gain registration.
specialist	A medical practitioner with qualifications in a field of specialty practice and a protected specialist title.
specialist medical college/ college	An Accreditation Authority and education provider for specialist registration in medicine that assesses specialist international medical graduates.

Acknowledgements

We acknowledge and thank the following staff from the Department of Finance and the Department of Health and Aged Care who have worked on this final report:

From the Department of Finance:

- Jason McDonald, First Assistant Secretary
- Ruth Gabbitas, Head of Secretariat
- Michael Howes, Director
- Mary Boyle
- Jamie Chhen
- Tracy Cole
- Renee Collins
- Félix Delhomme*
- Gayan Fernando
- Phillip Gaertner
- Claudia Hilton
- Simeon Kynoch
- Georgina McCrossin
- Andrej Pavković
- Charity Rentsch
- Dr Sukrit Sabhlok

*NSW Treasury Secondee

From the Department of Health and Aged Care:

- Adjunct Professor Andrew Singer AM FACEM FIFEM GAICD, Principal Medical Adviser
- Teresa Gorondi, Director
- Rhys Ban
- Helen Evans-Turner
- Amber Mardon

References

1 Organisation for Economic Cooperation and Development (OECD), Health resources – nurses; Health resources – doctors [data set], data.oecd.org, 2023, accessed 24 July 2023.

2 Fergus Gardiner et al, Equitable Patient Access to Primary Healthcare in Australia, Royal Flying Doctor Service, 2020, pp 8, 19.

3 M Cunningham, 'Closure of Geelong maternity hospital could "put lives at risk" amid baby boom', The Age, 29 January 2023, accessed 20 July 2023; T Shepherd, 'Maternity crisis: pregnant women left in despair as facilities disappear in regional Australia', The Guardian, 27 February 2023, accessed 20 July 2023; South Australia Department for Health and Wellbeing (SA Health), interim submission, 2023, p 4.

4 Victorian Agency for Health Information (VAHI), Specialist clinic routine first appointments – 90th percentile waiting time [data set], March 2023, accessed 1 August 2023; Department of Health Tasmania (Tasmania Health), Estimated Outpatient Appointment Waiting Times [data set], June 2023, accessed 1 August 2023; SA Health, Quarterly Specialist Outpatient Waiting Time Report [data set], March 2023, accessed 1 August 2023.

5 National Disability Services, New report shows critical need for allied health workers, as wait lists grow across the country [media release], 9 August 2023.

6 This review defines allied health as health professionals who are not part of the medical or nursing professions, with a focus on those regulated by Ahpra.

7 Queensland Health, interim submission, 2023; Ochre Health, interim submission, 2023; Department of Health, National Medical Workforce Strategy 2021-2031, Australian Government, 15 March 2022, p 40.

8 The Hon A Albanese MP, Meeting of National Cabinet [media release] 30 September 2022, accessed 1 August 2023.

9 Ochre Health, interim submission.

10 Accenture, Health Practitioner Regulatory Settings Review: Final Report, July 2023.

11 S Ireland, 'Countries with the best healthcare systems 2021', CEO World Magazine, accessed 18 July 2023. https://ceoworld.biz/2021/04/27/revealed-countries-with-the-best-health-care-systems-2021/ and Legatum Institute, Legatum Prosperity Index, accessed 18 July 2023. https://www.prosperity.com/rankings

12 The Hon M Butler MP, Speech to the National Press Club, Department of Health and Aged Care, 2 May 2023.

13 Data as of 30 June 2022 from Ahpra and National Boards (Ahpra), Annual Report 2021/22, 2022, p 48.

14 Ahpra, Information for international practitioners, accessed 20 July 2023. https://www.ahpra.gov.au/Registration/International-practitioners.aspx

15 New South Wales Bureau of Health Information, Healthcare Quarterly: Tracking public hospital and ambulance service activity and performance in NSW, June 2023, p 19.

16 Some people leave public hospital emergency departments without being treated: NSW Bureau of Health Information, Healthcare Quarterly, Tracking public hospital and ambulance service activity and performance in NSW, p 9.

17 National Skills Commission (NSC), Projecting employment to 2026, Australian Government, 29 March 2022.

18 Royal Australian College of General Practitioners (RACGP), General Practice: Health of the Nation 2022, 2022, p viii; Australian Nursing and Midwifery Federation (ANMF), National COVID-19 Survey 2022 – Public and Private Hospitals, 2022, p 16.

19 Jobs and Skills Australia (JSA), Skills Shortage Quarterly, Australian Government, March 2023.

20 Queensland Health, interim submission, p. 2.

21 Measured by the rate of clinical Full-Time Equivalent (FTE) practitioners per 100,000 people. Australian Institute of Health and Welfare (AIHW), 'Rural and remote health', 2022, accessed 18 July 2023. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

22 M Liotta, 'Paediatricians float solutions for deteriorating access problems', newsGP, 31 August 2022, accessed 18 July 2023; R Devlin, 'Hurry Up and Wait', Source Kids, accessed 4 July 2023; Australian Psychological Society (APS), 1 in 3 psychologists are unable to see new clients, but Australians need help more than ever [media release], 2022, accessed 11 August 2023.

23 World Health Organization (WHO), Global strategy on human resources for health: Workforce 2030,

2016, p 44.

24 Data for 2022 from Australian Government Department of Health and Aged Care (DoHAC), Health Workforce Data, accessed 18 July 2023. https://hwd.health.gov.au/

25 The Hon M Butler MP, Rebuilding Medicare for the 21st Century [media release], 28 April 2023, accessed 11 August 2023; Australian Government, Budget Paper No 2: Budget Measures, 2023.

26 Commonwealth of Australia 2023, Review of the Migration System 2023.

27 AIHW, Elective surgery [data set], aihw.gov.au, 2022, accessed 1 August 2023.

28 AIHW, Elective surgery.

29 NSW Bureau of Health Information, Healthcare Quarterly: Tracking public hospital and ambulance service activity and performance in NSW, p 22.

30 PC, Report on Government Services (E-Health), p 24.

31 AIHW, Australian Burden of Disease Study 2022, Australian Government, 2022.

32 Numbers are for FTE GPs. Australian Medical Association (AMA), AMA report confirms staggering undersupply of GPs in the next two decades [media release], 25 November 2022, accessed 18 July 2023.

33 Pharmacy Guild of Australia (PGA), interim submission, 2023, p 3.

34 K Houghton, A Barwick and S Pregellio, Regional Jobs 2022: The Big Skills Challenge, Regional Australia Institute, May 2023.

35 Northern Territory Health (NT Health), interim submission, 2023, p 2.

36 PC, Report on Government Services (E-Health), pp 40, 110.

37 N Smallwood et al, 'High levels of psychosocial distress among Australian frontline healthcare workers during the COVID-19 pandemic: a cross-sectional survey', General Psychiatry, 2021, 34 (5):5.

38 G Berlin et al, Should I stay, or should I go? Australia's nurse retention dilemma, 2022, accessed 25 May 2023. https://www.mckinsey.com/industries/healthcare/our-insights/should-i-stay-or-should-i-go-australias-nurse-retention-dilemma

39 Health Workforce Australia (HWA), Australia's Future Health Workforce – Doctors, Department of Health and Aged Care, Australian Government, 2014.

40 OECD, Health resources – doctors [data set], data.oecd.org, 2023, accessed 24 July 2023.

41 OECD, Health resources – nurses.

42 DoHAC, 2022 data provided to the review, 2023.

43 Data for 2020 from AIHW, 'Rural and remote health'.

44 DoHAC, 2021 data provided to the review, 2023.

45 Accenture, Health Practitioner Regulatory Settings Review: Final Report. Based on results from a survey of over 1,500 IQHPs conducted between 29 March 2023 to 21 April 2023.

46 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

47 Meeting with St John of God Healthcare, 10 February 2023.

48 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

49 The Hon A Albanese MP, Meeting of the National Cabinet – A Better Future for the Federation [media release], 28 April 2023, accessed 19 July 2023.

50 Australian Government Department of Home Affairs (DoHA), Nominating a position, accessed 1 August 2023. https://immi.homeaffairs.gov.au/visas/employing-and-sponsoring-someone/sponsoring-workers/nominating-a-position/labour-market-testing

51 Employers must pay a training contribution charge on skilled visas – the Skilled Australians Fund (SAF) levy – to contribute to broader skills development of Australians. The SAF, which varies based 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. See DoHA, Cost of sponsoring, accessed 1 August 2023. https://immi.homeaffairs.gov.au/visas/employing-and-sponsoring-someone/sponsoring-workers/learn-about-sponsoring/cost-of-sponsoring

52 Workplace Based Assessments (WBAs) enable some IMGs to have their clinical skills and knowledge assessed in the workplace, rather than through clinical exams.

53 Health Policy Analysis, Allied health workforce data gap analysis, reported prepared for the Department of Health, Australian Government, 2022, p 26.

54 Health Policy Analysis, Allied health workforce data gap analysis.

55 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

56 The Hon A Albanese MP, Meeting of the National Cabinet – A Better Future for the Federation.

57 HWA, Australia's Future Health Workforce – Doctors, p 4.

58 Australian Bureau of Statistics (ABS) (2023), National, state and territory population, accessed 24 July

2023. https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release

59 Australian Government Department of the Treasury (Treasury), 2021 Intergenerational report, Australian Government, June 2021, p viii.

60 T Wilson and J Temple, 'New population projections for Australia and the States and Territories, with a particular focus on population ageing', ARC Centre of Excellence in Population Ageing Research Working Papers, 2022.

61 AIHW, 'Chronic condition multimorbidity', 2021, accessed 24 July 2023. https://www.aihw.gov.au/reports/chronic-disease/chronic-condition-multimorbidity/contents/chronic-conditions-and-multimorbidity

62 AIHW, 'Older Australians', June 2023, accessed 11 August 2023. https://www.aihw.gov.au/reports/older-people/older-australians/contents/about

63 AIHW, 'Chronic conditions and multimorbidity', 30 June 2023, accessed 24 July 2023. https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity

64 AIHW, 'Chronic conditions and multimorbidity'.

65 NSW Government, Climate impacts on our health and wellbeing, accessed 24 July 2023. https://www.climatechange.environment.nsw.gov.au/climate-impacts-our-health-and-wellbeing; Better Health Channel, Climate change and health, accessed 24 July 2023. https://www.betterhealth.vic.gov.au/health/healthyliving/climate-change-and-health

66 Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, 2021, p 192.

67 Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, p 52.

68 Allied Health Professions Australia (AHPA), Australians are delaying healthcare appointments and tests during COVID-19 [media release], 9 June 2020, accessed 11 August 2023.

69 National COVID-19 Health and Research Advisory Committee (NCHRAC), Strengthening Australia's health system post COVID-19, National Health and Medical Research Council, 2022.

70 DoHAC, 24/7 registered nurse responsibility, accessed 1 August 2023. https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/24-7-rns

71 Australian Government Department of Social Services, NDIS National Workforce Plan: 2021-2025, June 2021, p 10.

72 Data as of 30 June 2022 from Ahpra, Annual Report 2021/22, p 48.

73 MDANZ, Medical Student Numbers [dataset], 2022, accessed 1 August 2023.

74 Department of Education, Higher Education Enrolments Data 2021 [analysis of data provided to the review], 2023.

75 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 24.

76 AIHW, 'International health data comparisons', 2022, accessed 12 July 2023. https://www.aihw.gov.au/reports/international-comparisons/international-health-data-comparisons

77 AIHW, 'Social determinants', 2022, accessed 12 July 2023. https://www.aihw.gov.au/reports-data/behaviours-risk-factors/social-determinants/overview

78 OECD, Health resources – nurses.

79 OECD, Health resources – doctors.

80 ABS (2023), Regional population, accessed 24 July 2023. https://www.abs.gov.au/statistics/people/population/regional-population/latest-release

81 DoHAC, 2022 data provided to the review, 2023

82 AIHW, Rural and Remote Australians, 2022, accessed 24 July 2023. https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/overview

83 G Berlin et al., Should I stay, or should I go? Australia's nurse retention dilemma.

84 N Smallwood et al, 'High levels of psychosocial distress among Australian frontline healthcare workers during the COVID-19 pandemic: a cross-sectional survey', p 5.

85 NSC, Projecting employment to 2026.

86 WHO, Health workforce, accessed 24 July 2023. https://www.who.int/health-topics/health-workforce

87 R Leach, 'Temporary migration and COVID-19 labour market considerations', National Skills Commission, 29 June 2021; NSC, Skill shortages and labour market tightness: a global perspective, 24 March 2022.

88 Queensland Health, interim submission, p 2.

89 DoHAC, Australia's Future Health Workforce reports, accessed 20 July 2023. https://www.health.gov.

au/resources/collections/australias-future-health-workforce-reports

90 AMA, The general practitioner workforce: why the neglect must end, November 2022.

91 Royal Australian and New Zealand College of Ophthalmologists (RANZCO), Vision 2030 and beyond, accessed 18 July 2023. https://ranzco.edu/home/community-engagement/vision2030-beyond/; Royal College of Pathologists of Australasia (RCPA), final submission, 2023, p 1; Royal Australian and New Zealand College of Psychiatrists (RANZCP), final submission, 2023, p 1; Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), final submission, 2023, p 1.

92 Australian College of Rural and Remote Medicine (ACRRM), interim submission, 2023.

93 Nursing and Midwifery Board of Australia (NMBA), interim submission, 2023.

94 Occupational Therapy Australia (OTA), interim submission, 2023, p 3; APS, interim submission, 2023, p 1; PGA, interim submission, p 3; Australian Society of Medical Imaging and Radiation Therapy, interim submission, 2023, p 1; Australian Dental Association (ADA), interim submission, 2023, p 2.

95 PGA, interim submission, p 3.

96 Meetings with the Paramedicine Board of Australia (PBA), 19 December 2022, 20 June 2023.

97 The Hon Dan Andrews MP, Growing Victoria's Paramedic Workforce To Ease Pressure [media release], 28 July 2022, accessed 1 August 2023.

98 Australian Private Hospitals Association, interim submission, 2023, p 1.

99 NT Health, interim submission, p 2.

100 NT Health, interim submission, p 2.

101 Department of Health Victoria (Victoria Health), interim submission, 2023, p 1.

102 Health Services Union, Reform Critical: A Fragmented Health System at Breaking Point, 2023, p 53.

103 AIHW, Elective surgery.

104 NSC, Projecting employment to 2026.

105 HWA, Australia's Future Health Workforce – Doctors.

106 S Dalzell, 'Specialist wait times data show patients are waiting years for crucial appointments', ABC, 20 April 2023, accessed 24 July 2023. https://www.abc.net.au/news/2023-04-20/specialist-wait-times-blow-out-years-waiting-list/102232032

107 National Disability Services, New report shows critical need for allied health workers, as wait lists grow across the country.

108 Z Rizmal and L Kewley, 'One in three psychologists have closed their books and children are being left behind', ABC, 23 February 2022, accessed 24 July 2023. https://www.abc.net.au/news/2022-02-23/children-mental-health-treatment-psychologist-shortage-regions/100854252

109 World Population Review, Health Care Wait Times by Country 2023, accessed 24 July 2023. https://worldpopulationreview.com/country-rankings/health-care-wait-times-by-country

110 AIHW, Emergency department care, [data set], aihw.gov.au, 2023, accessed 24 July 2023. https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

111 VAHI, Urgent first appointments [data set] vahi.vic.gov.au, 2023, accessed 12 July 2023.

112 The areas are defined by the Modified Monash Model - areas classified MM 2 to MM 7 are rural or remote. DoHAC, Modified Monash Model, accessed 14 August 2023. https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

113 AMA, Resident Hospital Health Check Survey 2022, accessed 24 July 2023. https://www.ama.com.au/qld/campaigns/resident-hospital-health-check

114 I Scott and C Crock, 'Diagnostic error: incidence, impacts, causes and preventive strategies', Medical Journal of Australia, 2020, 213(7): 1.

115 Petra Bywood et al, Fatigue and Burnout in healthcare: prevalence, impact and interventions, Institute for Safety, Compensation and Recovery Research, 2020, p 30.

116 Ahpra, Information for international practitioners.

117 Ahpra, Registration standards, accessed 24 July 2023. https://www.ahpra.gov.au/registration/registration-standards.aspx

118 Meeting with St John of God Healthcare, 10 February 2023.

119 Victoria Health, interim submission, p 4.

120 DoHA, Entering Australia, accessed 14 August 2023. https://immi.homeaffairs.gov.au/entering-and-leaving-australia/entering-australia/can-i-go-to-australia

121 Medical Board of Australia (MBA), Supervised practice for international medical graduate guidelines, accessed 14 August 2023.

122 The goal is to ensure Aboriginal and Torres Strait Islander people receive clinically and culturally safe care. See Ahpra, National Scheme Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy, accessed 14 August 2023.

123 Ahpra Community Advisory Council, final submission, 2023, pp 1-2; RACGP, final submission, 2023, p 3; NMBA, final submission, p 2.

124 Ahpra, Monitoring and compliance, accessed 14 August 2023. https://www.ahpra.gov.au/registration/monitoring-and-compliance.aspx

125 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

126 A 'prescribed matter' includes, for example, a criminal charge that carries a term of imprisonment of three months or more.

127 Meeting with Nursing and Midwifery Council United Kingdom, 3 February 2023.

128 Meeting with Health and Care Professions Council United Kingdom, 2 February 2023.

129 Meeting with Medical Council of New Zealand, 19 June 2023.

130 These are Canada, Ireland, New Zealand, the United Kingdom and the United States of America.

131 General Medical Council UK, European Economic Area country qualifications, accessed 14 August 2023. https://www.gmc-uk.org/registration-and-licensing/join-the-register/eea-countries

132 Royal College of Physicians and Surgeons of Canada, International medical graduates, accessed 14 August 2023.

133 Medical Council of New Zealand, Comparable health system criteria, accessed 14 August 2023.

134 European Commission, Automatic recognition, accessed 14 August 2023.

135 Medical Council of New Zealand, Approved qualifications for locum tenens specialist appointments, accessed 7 August 2023.

136 The Health and Care Professions Council UK, which regulates 15 allied health professions, recognises qualifications on a case-by-case basis, determining eligibility for registration as the first priority and only requiring applicants to complete competence assessments if specific gaps are identified.

137 Meeting with General Medical Council UK, 7 June 2023.

138 Nursing and Midwifery Council UK, Accepted English language tests, accessed 20 July 2023.

139 Nursing Council of New Zealand, Internationally Qualified Nurses, accessed 23 March 2023.

140 In most cases, test takers are still required to achieve a minimum overall score across all sections - reading, writing, speaking and listening. Ahpra allows applicants to combine results over two sittings within a 6-month period to achieve the minimum of 7 for each component, whereas NZ and the UK only accept a single sitting.

141 Medical Council of Canada (MCC), MCC Qualifying Examination Part I, accessed 14 August 2023.

142 Meeting with Health and Care Professions Council UK, 2 February 2023.

143 Australian Government, Budget Paper No 2: Budget Measures.

144 Australian Government, Budget Paper No 2: Budget Measures.

145 Health New Zealand, Make a difference somewhere different, accessed 14 August 2023.

146 J Buchan, 'Brexit, Covid and the UK's reliance on international recruitment', Nuffield Trust blog, accessed 24 July 2023.

147 K Garratt, The NHS Workforce in England, House of Commons Library UK, 2023, p 48; National Health Service (NHS), The NHS Long Term Plan, UK Government, 2019.

148 Department of Health and Social Care UK, 50,000 Nurses Programme: delivery update, UK Government, 2022.

149 Department of Health and Social Care UK, 50,000 Nurses Programme: delivery update.

150 NHS Employees, 'Additional funding for international nurse recruitment', NHS Employers News, 22 September 2022, accessed 24 July 2023.

151 P Ramanathan, Australian Health Workforce: Analysis and Proposals [unpublished report], 2023; Oxford University Hospitals, Recruiting in India, accessed 24 July 2023.

152 Oxford University Hospitals, Recruiting in India, accessed 24 July 2023.

153 Parkinson, Howe and Azarias, Review of the Migration System Final Report.

154 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 23.

155 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 77.

156 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 84.

157 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 9.

158 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 71.

159 DoHA, Migration Strategy, accessed 1 August 2023.

160 Analysis of each National Board's quarterly registration statistics from Ahpra, Registration Data, accessed 11 August 2023. Includes practising and non-practising registrations for all NRAS allied health professions: Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, chiropractors, dental practitioners, medical radiation practitioners, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, physiotherapists, podiatrists and psychologists.

161 AIHW, Australian Burden of Disease Study 2022.

162 WHO, Framework for action on interprofessional education and collaborative practice, 2010, p 19.

163 The 'Health Care and Social Assistance Industry' is an Australian and New Zealand Standard Industrial Classification Division that covers services including hospitals, general and specialist medical, pathology and diagnostic imaging, aged and residential care, allied health (such as dentists, optometrists, physiotherapists and chiropractors), child care and disabilities assistance. Not all workers employed in the Health Care and Social Assistance Industry are health practitioners.

164 NSC, Health Care and Social Assistance, accessed 24 July 2023. https://labourmarketinsights.gov.au/industries/industry-details?industryCode=Q.

165 DoHAC. Health Workforce Data.

166 RACGP, General Practice Health of the Nation 2022, p 16.

167 Ahpra, May 2023 registrant data provided to the review. Statistics referenced are based on best available data from Ahpra. Variability in international qualifications data may occur, particularly where data is sought on internationally qualified health practitioners who were registered prior to the establishment of the National Registration and Accreditation Scheme in 2010.

168 Ahpra, Information for international practitioners.

169 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 5.

170 NT Health, interim submission, p 1.

171 Queensland Health, interim submission, p 1.

172 Ochre Health, interim submission, p 8.

173 PC, Australia's Health Workforce, Australian Government, 2005.

174 Health Practitioner Regulation National Law Act 2009 (Qld); Health Practitioner Regulation National Law (NSW); Health Practitioner Regulation National Law Act 2009 (Vic); Health Practitioner Regulation National Law Act 2010 (ACT); Health Practitioner Regulation (National Uniform Legislation) Act 2010 (NT); Health Practitioner Regulation National Law Act 2010 (Tas); Health Practitioner Regulation National Law Act 2010 (SA); Health Practitioner Regulation National Law Act 2010 (WA).

175 DoHAC, National Registration and Accreditation Scheme, accessed 24 July 2023. https://www.health.gov.au/our-work/national-registration-and-accreditation-scheme

176 NT Health, interim submission, p 3; Victoria Health, interim submission, p 2; SA Health, interim submission, p 3.

177 COAG Health Council, National Code of Conduct for Health Care Workers, accessed 14 August 2023. https://www.health.qld.gov.au/

178 The Hon C O'Neil MP, Australia's Migration System [media release], 27 April 2023, accessed 14 August 2023.

179 Ahpra, interim submission, 2023, p 8; Ahpra, International health worker registrations grow to pre-pandemic levels [media release], 20 December 2022, accessed 18 July 2023; Ahpra, Measures announced to safely welcome more international practitioners [media release], 28 April 2023, accessed 18 July 2023.

180 Aspen Medical, interim submission, 2023, p 9. RACGP, final submission, p 1 notes that the Australian Medical Council (AMC) portal is an "effective tool for collaboration" and "[i]ts function could be expanded or broadened for use by multiple agencies".

181 Australian Pharmacy Council, final submission, 2023, p 14.

182 Accenture, Health Practitioner Regulatory Settings Review: Final Report; RANZCP, final submission; Australasian College of Dermatologists (ACD), final submission, 2023; Uniting Care, final submission, 2023; APS, final submission, 2023.

183 Nurses, midwives, dental hygienists and therapists, paramedics and psychologists are among the IQHPs where current misalignment exists.

184 A fully automated system would see IQHPs provide all information required for the MPN to Ahpra during the registration application, with no further input required. Partial automation would see Ahpra transmit the vast majority of the information required, with the practitioner then prompted to input

any outstanding information with the timeframe dependent on the IQHP immediately actioning this request.

185 Royal Australasian College of Surgeons (RACS), final submission, 2023, p 1; Australian Physiotherapy Council, final submission, 2023, p 4; Society of Hospital Pharmacists of Australia (SHPA), final submission, 2023, p 1. In addition, Parkinson, Howe and Azarias, Review of the Migration System Final Report, pp 167-172 acknowledges the significant ICT investment required to modernise systems and deliver the desired experience for clients.

186 The Data Availability and Transparency Scheme was established under the Data Availability and Transparency Act 2022 (Cth) with the aim of increasing the availability and use of Australian Government data to deliver better government services, inform policies and programs and support research and development.

187 DoHA, Nominating a position.

188 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 8.

189 DoHA, Skilled visa processing priorities, accessed 19 July 2023. https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-processing-times/skilled-visa-processing-priorities

190 Relevant Australian and NZ Standard Classification of Occupation (ANZCO) groups include Minor Group 253 – Medical Practitioners (except General Practitioner (253111) and Medical Practitioners not elsewhere classified (253999; Nuclear Medicine Specialists and Sports Physicians); Unit Group 4111 – Ambulance Officers and Paramedics. Refer DoHA, Nominating a position for alternative arrangements.

191 Tasmania Health, final submission, 2023, p 2; Victoria Health, interim submission; Royal Australian and New Zealand College of Ophthalmologists (RANZCO), Final Submission, p 1; RDAA, final submission, p 2; RACGP, final submission, p 2; Uniting Care, Final Submission, p 3; Ramsay Healthcare, final submission, 2023; Queensland Health, final submission; Ochre Health, final submission; ANZCA, final submission.

192 Royal Australian College of Medical Administrators (RACMA), final submission, 2023; ACRRM, final submission, 2023; AMA, final submission, 2023.

193 RACS, final submission; Australian and NZ College of Anaesthetists (ANZCA), final submission, 2023.

194 The Australian Physiotherapy Council supported such an approach. See Australian Physiotherapy Council, final submission, p 4.

195 Rural Doctors Association of Australia (RDAA), final submission, 2023, p 2; Victoria Health, final submission, p 5.

196 Email from Ahpra to the Review, 3 July 2023.

197 For example, the ANZCA in their final submission commented that "peak performance" is often around 50 years of age.

198 Tasmania Health, interim submission, p 2.

199 The RACGP, final submission, p 2 suggested mid and late-career GPs "can provide significant benefits to the community and will provide a net benefit to Australia".

200 For example, the Australian Dental Council (ADC) notes in their interim submission, p 2 that "dental professions are not currently listed on any skilled occupation list as an in demand profession".

201 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 74.

202 Parkinson, Howe and Azarias, Review of the Migration System Final Report, pp 103-122.

203 Office of the Chief Nursing and Midwifery Officer Queensland (CNMO Qld), final submission, 2023, p 1; Uniting Care, final submission, p 3.

204 ACRRM, final submission, p 3.

205 National Partnership on the Skilling Australians Fund, accessed 19 July 2023. https://federalfinancialrelations.gov.au

206 Parkinson, Howe and Azarias, Review of the Migration System Final Report, p 85.

207 Ramsay Healthcare, final submission, p 2.

208 For example, Ramsay Health Care, interim submission, 2023, p 9 notes that government incentives limiting eligibility to public healthcare workers has the effect of draining the private sector workforce, which in turn increases the unmet demand for public hospitals.

209 AMA, final submission, p 5; RACMA, final submission, p 2; APS, final submission, p 3.

210 Department of Health Western Australia (WA Health), Be part of WA Health, accessed 7 August 2023. https://belong.health.wa.gov.au/

211 The wording of "approved", "substantially equivalent" and "relevant" comes from the National Law.

212 Although excluded from the TTMRA, all NZ medical degrees and most specialist qualifications (where there are bi-national colleges) are automatically recognised as part of AMC processes.

213 Ahpra, Information for international practitioners.

214 MBA, Specialist pathway – specialist recognition, accessed 20 July 2023. https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway/Specialist-recognition.aspx

215 For example, NMBA, interim submission; NT Health, interim submission; Royal Australasian College of Physicians (RACP), final submission, 2023, p 2.

216 For example, the Australian Physiotherapy Council (interim submission) and the Australian Pharmacy Council (interim submission, p 3) note that fast-track pathways already exist; and the Pharmaceutical Society of Australia (final submission, p 2) and a range of specialist medical colleges consider existing processes are robust and appropriate.

217 RACP, final submission, p 4; ACRRM, final submission, p 3; RACS, final submission, p 2; RANZCP, final submission, p 2.

218 Note that this pathway does not lead to specialist registration. IMGs who wish to gain specialist registration need to meet the requirements of the "Specialist pathway - specialist recognition".

219 See for example, National Law section 53.

220 AMC, presentation to the Health Workforce Taskforce Registration and Assessment Tiger Team, January 2023; Meeting with the NMBA, July 2023; Round table with the Council of Presidents of Medical Colleges (CPMC), July 2023.

221 Ramsay Health Care, interim submission, p 3.

222 APS, interim submission, p 4.

223 NSW Health, interim submission; APS, interim submission; Australian Physiotherapy Council, interim submission; Council of Deans of Nursing and Midwifery (CDNM), final submission, 2023.

224 Aphra, final submission, p 2.

225 NMBA, final submission, p 1

226 NMBA, interim submission; NMBA, final submission, p 2.

227 Meeting with CPMC, 3 July 2023

228 RACS, final submission, pp 2-3.

229 Ahpra, Annual Report 2021-22, p 50.

230 RACS, final submission, p 2. Note that National Boards are responsible for the decision to grant registration, while fellowship can only be granted by a specialist medical college.

231 Australian Capital Territory Health Directorate (ACT Health), interim submission, p 3.

232 NSW Health, interim submission, p 5; Tasmania Health, interim submission; NT Health, interim submission.

233 For example, ACRRM, final submission; ACD, final submission; RANZCOG, final submission.

234 RACS, final submission.

235 M Woods, Independent Review of the Accreditation Systems within the National Registration and Accreditation Scheme for health professions, 2017 was supportive of the amalgamation of accreditation bodies "for efficiency and effectiveness purposes should such amalgamation be agreed" (p 115).

236 Medical Council of New Zealand, Comparable health system criteria.

237 WHO, Global Code of Practice on the International Recruitment of Health Personnel, p 3.

238 P Ramanathan, Australian Health Workforce: Analysis and Proposals.

239 P Ramanathan, Australian Health Workforce: Analysis and Proposals.

240 Indian Government, India signs Mutual Recognition Agreement (MRA) in Nursing with Singapore [media release], 1 June 2018, accessed 24 July 2023; Indian Nursing Council, The Comprehensive Economic Cooperation Agreement Between the Republic of India and the Republic of Singapore Mutual Recognition Agreement on Nursing Services, 2005.

241 UK Government, Framework agreement between the Government of India and the Government of the United Kingdom of Great Britain and Northern Ireland for collaboration on health care workforce, 2022.

242 German Government, Germany and India sign migration agreement [media release], 5 December 2022, accessed 20 July 2023.

243 Express News Service, 'Kerala govt signs MoU with German employment agency for recruitment of nurses', Indian Express, 2 December 2021, accessed 24 July 2023.

244 Australian Government Department of Foreign Affairs and Trade (DFAT), Australia-India ECTA Annex 8C Professional Services, 2022.

245 P Ramanathan, Australian Health Workforce: Analysis and Proposals; Oxford University Hospitals, Recruiting in India.

246 NMBA, final submission, p 2; WA Health, final submission, p 1; NSW Health, final submission, p 4.

247 Ahpra Community Advisory Council, interim submission, p 4.

248 The Occupational Therapy Council of Australia (OTC) allows for remote supervision. See Supervision Guidelines for Occupational Therapy, accessed 20 July 2023. https://www.otcouncil.com.au/wp-content/uploads/OTBA-Supervision-guidelines-for-occupational-therapy-February-2018.pdf

249 RACS, final submission.

250 OTC, interim submission, p 3.

251 Ochre Health, interim submission.

252 WA Health, interim submission, p 4, Primary Care Business Council at RACGP IMG workshop, 13 June 2023.

253 Ochre Health, final submission.

254 IMGs entering Australia on a temporary or skilled visa are not eligible for pathway programs that provide funding for supervisors. See Ochre Health, interim submission.

255 The Ochre Health interim submission and final submission note that only around 10 per cent of its GP workforce are accredited supervisors.

256 OTA, interim submission, p 4.

257 MBA, Supervised practice for international medical graduate guidelines.

258 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

259 National Rural Health Alliance (NRHA), interim submission, p 2.

260 NRHA, interim submission.

261 RACGP, final submission; OTA, interim submission.

262 For example, the NMBA and the Occupational Therapy Board of Australia provide these opportunities

263 AMC, Annual Report 2021-22, 2022, pp 83, 88.

264 C Liu, 'An introduction to workplace-based assessments', Gatroenterol Hepatol Bed Bench, 2012, 5(1): 24-28

265 G Ponnamperuma, 'Workplace based assessment', Oxford Textbook of Medical Education, 2013, pp 537-548.

266 Australian Pharmacy Council. Introduction to WBA tools, accessed 26 July 2023. https://www.pharmacycouncil.org.au/workplace-based-assessment/wba-tools/introduction/

267 As of 20 July 2023, there were 19 AMC accredited WBA providers. https://www.amc.org.au/assessment/pathways/overview/standard/wba-standard-pathway/accredited-assessment-programs/

268 ACRRM, final submission, pp 9-10; AMC, interim submission, p 2.

269 The DoHAC provides online access to the National Health Workforce Dataset, which covers different professions, geographic regions and demographics, while the Department of Education publishes selected higher education statistics.

270 ADA, interim submission.

271 WA Health, interim submission; NSW Health, interim submission; Ahpra, interim submission.

272 HWA, Australia's Future Health Workforce – Doctors.

273 DoHAC, Australia's Future Health Workforce report ¬- Midwives, Australian Government, 2019.

274 Queensland Health, interim submission; AMA, interim submission; PGA, interim submission, p 3.

275 AMA, interim submission; Health Professions Accreditation Collaborative Forum (HPACF), interim submission, 2023, p 2.

276 Health Workforce Australia (Abolition) Bill 2014 (Cth) explanatory memorandum.

277 ACRRM, final submission.

278 RACS, final submission.

279 Ramsay Health Care, final submission.

280 NT Health, interim submission; Victoria Health, interim submission; Queensland Health, interim submission; WA Health, interim submission; Meeting with Anita Hobson-Powell, Chair, National Alliance of Self-Regulating Health Professionals, 26 June 2023; Meeting with Bronwyn Morris-Donovan, CEO, Allied Health Professions Australia, 26 June 2023; Meeting with Dr Anne-Marie Boxall, Australian Government, 26 June 2023.

281 Meeting with Dr Anne-Marie Boxall, Australian Government, 5 July 2023.

282 Department of Health, National Medical Workforce Strategy 2021–2031, Australian Government, 2021.

283 OTA, interim submission.

284 DoHAC, National Nursing Workforce Strategy, accessed 7 July 2023. https://www.health.gov.au/our-work/national-nursing-workforce-strategy

285 DoHAC, Stronger Rural Health Strategy, accessed 20 July 2023. https://www.health.gov.au/topics/rural-health-workforce/stronger-rural-health-strategy

286 IQHPs from seven countries are typically exempt from needing to sit English language tests: Australia, the US, the UK, Canada, NZ, Ireland and South Africa. See https://www.ahpra.gov.au/registration/registration-standards/english-language-skills/faq.aspx

287 Uniting Care, final submission; Australian Pharmacy Council, final submission.

288 AMA, final submission; Aspen Medical, interim submission.

289 CDNM, final submission; CNMO Qld, final submission.

290 HPACF, interim submission, p 2: "What is lacking is an integrated workforce plan which articulates the skills needed to ensure high quality care for Australians now and into the future".

291 ACRRM, final submission; NSW Health, final submission.

292 British Columbia College of Nurses and Midwives, Exam (Rex-PN), accessed 20 July 2023. https://www.bccnm.ca/LPN/applications_registration/exam/Pages/Default.aspx; Nursing & Midwifery Council UK, OSCE: Test of Competence, accessed 20 July 2023. https://www.nmc.org.uk/registration/joining-the-register/toc/toc-2021/osce.

293 AMC, Annual Report 2021-22, p 83.

294 Incidental costs include costs associated with eligibility checks, document collation, preparatory courses/study, relocation costs and 'other' related skills assessment costs.

295 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

296 Aspen Medical, final submission, p 1; WA Health, interim submission, p 4.

297 Ahpra, interim submission; Uniting Care, final submission; Tasmania Health; interim submission; NT Health, interim submission; NSW Health, interim submission.

298 Unpublished data provided by Ahpra to the Review, March 2023.

299 ACRRM, final submission, p 8; AMA, final submission, p 3; RACGP, final submission, p 3; College of Intensive Care Medicine of Australia and NZ, final submission, p 3; CNMO Qld, final submission, p 2.

300 NHPO, interim submission, p 6.

301 Ahpra, interim submission, p 7.

302 NMBA, Orientation to healthcare in Australia, accessed 20 July 2023. https://www.nursingmidwiferyboard.gov.au/Accreditation/IQNM/Orientation-Part-1-and-Part-2.aspx

303 Ahpra Community Advisory Council, final submission, pp 1-2; RACGP, final submission, p 3; NMBA, final submission, p 2; Australian Pharmacy Council, final submission, p 4.

304 CNMO Qld, final submission, p 3; WA Health, interim submission, p 3.

305 NMBA, final submission, p 4; ADC, final submission, p 1.

306 The NMBA has facilitated an additional 500 examination places in 2023 for internationally qualified registered nurses and midwives to sit the OSCE and there are ongoing negotiations with Adelaide Health Simulation aimed at maintaining increased capacity through the rest of 2023 and 2024.

307 Ahpra's review of accreditation arrangements is considering outcomes of an internal audit of Ahpra's accreditation agreements which recommended greater specificity of KPIs in Accreditation Agreements.

308 Operational KPIs are set out in Health Profession Agreements and Accreditation Agreements.

309 Ahpra, Reputational insights 2021: practitioner perceptions of the Australian Health Practitioner Regulation Agency and the National Boards, 2021.

310 Accenture, Health Practitioner Regulatory Settings Review: Final Report.

311 Note that the framework does not seek to quantify any benefits related to induced demand, both in terms of the quantity or quality of overseas trained health practitioners that may be encouraged to seek registration in Australia if regulatory processes were improved.

312 The review assumed an annual inflow of IQHPs of 15,000 based on pre-pandemic numbers. The estimated annual cost of current regulatory arrangements is $2.6 billion. Around 60% of these costs relate to backfilling shortages in the health system. A higher number of IQHPs would increase the estimated regulatory costs.

313 Ahpra, final submission, 2023; WA Health, final submission.

314 APS, final submission, p 3; AMA, final submission, p 5.

315 National Law, section 3(2).

316 See Appendix A – Terms of Reference for the Review of Australia's regulatory settings relating to health practitioner registration and skills and qualifications recognition.

317 The approach to stakeholder engagement has been informed by best practice set out in The Australian Public Service Framework for Engagement and Participation, Australian Government, 2020 and A Guide to the Right Engagement, Australian Government.

318 NMBA, final submission, p 2.

319 Australian Physiotherapy Council letter to Robyn Kruk, 3 July 2023..

320 RACS, final submission, pp 2-3.

321 The Hon M Butler MP, Rebuilding Medicare for the 21st Century.

322 Australian Government, Budget Paper No. 2: Budget Measures, p 147.

323 DoHAC, National Cabinet Statement on a better future for the federation [media release], 28 April 2023, accessed 20 July 2023.

324 Australian Government, Budget Paper No. 2: Budget Measures, p 162.

325 Productivity Commission (PC), Report on Government Services (E-Health), Australian Government, 2023.

326 Australian Government Department of Education, 2021 Student enrolments by field of study and field of education [data set], education.gov.au, accessed 23 June 2023; Medical Deans Australia and New Zealand (MDANZ), Student Statistics Report 2021: Snapshot of Findings, accessed 19 July 2023. https://medicaldeans.org.au/md/2021/11/MDANZ-Student-Statistics-Report-2021.pdf

327 Jobs and Skills Australia (JSA), Skills Shortage Quarterly, Australian Government, March 2023.

328 NSC, Projecting employment to 2026.

329 Table 10A.67 from PC, Report on Government Services (E-Health).

330 Accenture, Health Practitioner Regulatory Settings Review: Final Report. Based on results from a survey of over 1,500 IQHPs conducted between 29 March 2023 to 21 April 2023.

331 Dental Board of Australia, General Registration, accessed 20 July 2023. https://www.dentalboard.gov.au/Registration/Overseas-Practitioner-Registration/Dentists.aspx.

332 Meeting with PBA, 19 December 2022.

272 Knowledge testing is still required. Details at Registration Standard: Supervised Practice Arrangements, accessed 20 July 2023. https://www.pharmacyboard.gov.au/Registration-Standards.aspx

334 Medical Council of NZ, UK and Irish medical graduates, accessed 20 July 2023. https://www.mcnz.org.nz/registration/getting-registered/registration-pathways/general-scope/uk-and-irish-medical-graduates/

335 S Wearne, 'Remote supervision in postgraduate training: a personal view', Medical Journal of Australia, 2013, 198(11).

336 MCC, Practice-ready assessment, accessed 20 July 2023. https://www.mcc.ca/assessments/practice-ready-assessment/