SUBMISSION TO THE SENATE INQUIRY: The provision of general practitioner (GP) and related primary health services to outer metropolitan, rural, and regional Australians

Provided by Alecto Consulting Pty Ltd t/a Alecto Australia

About Us

Alecto Consulting Pty Ltd is a boutique medical recruitment and consulting agency with 15 years of experience in the primary healthcare industry with a specialised focus on General Practice. We work with General Practices around Australia and speak to them every day. We have a strong understanding of the challenges and opportunities in the General Practice space and therefore have a strong understanding of the workforce situation and how it applies to the operation of GP and multi-disciplinary practices.

We work diligently to understand emerging trends that may impact on Primary Health Care and actively follow policy developments that are relevant to this sector. We engage with our clients to gain a solid understanding of the impact of potential changes to government policies to ensure that our interpretation and understanding is backed by 'real life' experiences. We see firsthand how practices and GPs view the current system and how the unique hurdles within the space affect their lives and livelihoods.

Martina Stanley, one of our Directors, and Registration Manager, Megan Lewis, are elected councillors for the Association of Medical Recruiters Australia & New Zealand (AMRANZ) council and represent AMRANZ on the National Specialist International Medical Graduate Committee (NSIMGC).

Introduction

We believe the biggest impact on the provision of GP services across Australia is a policy landscape that relies too heavily on Australian trained doctors and is designed to keep out IMGs – even though they have traditionally made up almost half of the GP workforce. Budget measures designed to reduce the number of GPs in Australia continue to determine policy while the public perception is that they are designed to ensure there is an adequate supply of professionals in regional and rural communities. Current policies also tend to ignore the fact that many of the GPs who used to come to Australia are 'substantially comparable' to Australian Trained GPs and make a significant contribution to the GP workforce around Australia without any training costs to Australian taxpayers.

Summary

There is a true shortage of GPs in Australia which will only become worse over the next few years. The RACGP's Health of the Nation 2020 report confirms that Australia still relies heavily on IMGs which make up 40% of the rural workforce. However, the policy landscape is designed to keep IMGs out of Australia. The COVID-19 pandemic has exacerbated the situation but has effectively masked the impact of new policies designed to limit the number of IMGs entering the country.

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Examples of these include:

- **Continued reduction in areas eligible for DPA status** which is increasingly required for various programs including Visas for GPs but is inconsistent with the real world needs of practices especially in outer metro locations.
- Restrictions specifically for GPs on all employer sponsored visas (e.g. 186 or 482).
- **Confusing requirements** for entry into the RACGP's Specialist PEP program even 2+ years after the program were introduced.
- **Long waiting times for local GP registrars who have passed all the requirements** for FRACGP to commence work due to long waiting times for all the paperwork to be completed.
- Additional restrictions that **block IMGs from working at after hours clinics** in outer metropolitan areas even though they have always made up the bulk of this workforce.

It is worth noting that that there are currently GPs already in Australia who are keen to contribute to addressing shortages but who are unable to work due to bureaucratic obstacles. There would be hundreds of GPs available to work in rural, remote and outer metropolitan areas if these obstacles (and many others) were removed:

- **Lack of PR visa options** to provide security of tenure in Australia. The only readily available pathway to PR is the 186 TRT visa that can only be obtained after 3 years work in Australia (see Appendix A, Case Study 3)
- Lack of visa incentives for GPs to work in rural areas as there are **no fast-track visa options for doctors working in rural** and remote areas (See Appendix A, Case Study 4)
- **Delays to FRACGP, AMC and PESCI clinical exams** especially as a result of lockdowns as online options are not being fully utilised.
- **Restrictions for any non-vocationally trained GPs** to work in most metro and outer metro areas even in after-hours services. This workforce has made up the bulk of the after-hours services for the past two decades and services are closing because they lack a medical workforce.

Responses to the Terms of Reference

a) the current state of outer metropolitan, rural, and regional GPs and related services;

GP workforce shortages

The current state of outer metropolitan, rural and regional GP services is dominated by one theme: there is an ongoing shortage of practitioners and that GP practices cannot respond to community needs. Following the introduction of new policies in late 2018 to early 2020, the situation has become more desperate.

Daily, we receive calls from clients in all regions who are desperate for GPs and unable to meet demand to support their communities. Unfortunately, we are forced to advise them that it may take 12 to 36 months to find a doctor - if we are able to find one at all. Some of these practices have been trying to find GPs for their practice for so long, that they are now considering closing their clinics as they are no longer viable.

At Alecto, we currently have more than 1,000 GP vacancies where practices are willing to pay considerable sums of money to get more GPs to serve their community.

Reduction of IMG numbers

Over the past decade, IMGs have made up more than 40% of the GP workforce in rural and regional areas. The current philosophy of self-reliance on locally trained GPs may be achievable in the long term, but in the short to medium term it is not possible to sustain services while rejecting almost half of the usual professional workforce.

While it is widely recognised that rural and regional areas rely on the IMG workforce, bulk billing practices in outer metro are often equally desperate as they are supporting literally millions of Australians who live in these areas.

The proposed solution of relying on Australian trained doctors to support outer metro areas ignores the realities of the Australian workforce: there is adequate work available in inner suburbs in private billing practices to keep Australian GPs occupied. To be frank, why would a GP who can work in a private billing clinic on the lower North Shore of Sydney feel motivated to work in a bulk billing practice in Blacktown? This has never been attractive, and those roles have been mostly filled with overseas trained GPs.

Lack of after-hours GP services

The state of the after-hours GP workforce has deteriorated rapidly in the past three years especially in outer metro areas. Under the current policies, it is virtually impossible for non-vocationally registered GPs to work in after-hours clinics. Those who have achieved full specialist registration have no need to work in an after hours setting as there is huge demand for their services **in business hours.**

Impact of the pandemic

The pandemic has also exacerbated the situation and practices feel unsupported even though they are at the forefront of the pandemic. Some of the earlier supports such as increased staff levels at Medicare and extension of locum provider numbers were discontinued in October 2020 and not re-instated even though infection rates on the Eastern seaboard are the highest seen since the beginning of the pandemic. Constant changes to recommendations on vaccines coupled with ever changing MBS items for COVID related services, have resulted in stress that could have been prevented. GPs and support staff are exhausted and abuse by patients and suppliers is increasing - particularly in Sydney and Melbourne.

For the first time in more than ten years, we are seeing significant numbers of highly qualified GPs returning to their home country because closed borders make it impossible to visit family members overseas.

b) current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs, including policies such as:

i. the stronger Rural Health Strategy

We are not seeing improved levels of medical staffing because of the Stronger Rural Health Strategy. To the contrary, the Strategy has reduced the number of trained GPs available. We will comment on certain aspects of the strategy.

HeadsUp Tool

- There is **no public access** to information in relation to the HeadsUp tool. Information about this tool is even blocked through the link on the Department of Health's Factsheets page and does not currently work. There have been multiple attempts by the industry to discover the priority locations (separate to DPA) that need GPs. These are determined by the HeadsUp Tool and are utilised by the RACGP's PEP Specialist Stream and the Visas for GPs programs, but it is virtually impossible to find out where they are. To ensure that the workforce can be distributed correctly and to these areas of need, the data from the HeadsUp tool needs to be shared with the industry as has been done with the Health Workforce Locator for several years now.

- GP Priority Catchments are designated as needing GPs and include some non-DPA locations, but there is no information on where they are located. It is impossible to direct GPs to areas that are considered a priority location if there is no information about where these locations are. This is not just for the benefit of doctors or recruiters. If practices are not aware that they are a priority location, they will not focus their time and energy to recruit an IMG who they believe will not be able to work there.

- We have spoken to many clients in regional and outer metropolitan areas who have appealed to the Visas for GPs program due to not being about to recruit a GP, or in one case having three GPs retire at the same time, however we have not heard of one single appeal that has been granted. Although there is a new system being introduced to allow for practices to present hardship circumstances, there is no indication that successful applications will also result in being granted Health Workforce Certificates and Visas.

Visas for GPs Program

Out of hundreds of professions classified on the Skilled Occupation List (MLTSSL), this is the only profession that requires a special certificate when GPs are applying for a 482 or 186 visa.

The Visas for GPs program has become a major obstacle to engaging GPs in outer metro locations and in many rural and regional locations as well. It is ostensibly designed to move the GP workforce to locations that are classified as a Distribution Priority Area (DPA) by providing them with Health Workforce Certificates enabling them to be sponsored for a visa. However, we have been told by representatives of the Department of Health that this is a budget measure. As a budget measure, it has been successful as it has significantly limited the number of specialist GPs who want to move to Australia and thus substantially reduced the number of GPs overall.

Although the program is designed to assist recruitment in rural and regional areas, there are confusing and incomprehensible decisions made for some rural practices. There are practices in areas such as Maryborough, QLD (MMM3 section, Beaudesert (MMM4), Narrabi, NSW (MMM4), Whyalla Barson SA (MMM3), Dalby QLD (MMM4) that are not able to get approval to sponsor a GP for a visa even through appeals because they are not classified as DPA.

Health Workforce Certificates are highly discriminatory of GPs as a profession. RMOs and hospital-based doctors are exempt from this requirement. This also can lead to abuse, as GPs may struggle and have limited options if they would like to change practices.

ii. Distribution Priority Area and the Modified Monash Model (MMM) geographical classification system

The Distribution of Priority Area (DPA) and the Modified Monash Model (MMM) geographical classification systems are potentially useful ways to distribute the workforce to locations of need. However, over time these have led to stigmatisation of certain geographical areas. Moreover, the way that the status of particular locations is calculated, lacks transparency and appears to bear any reflection of the workforce realities in those areas.

The current benchmark for a DPA location is: *'Modified Monash Model (MMM) 2 average of access to GP services for IMGs'.* The reality is that there are fewer and fewer DPA locations in outer metropolitan areas, especially in Perth and Brisbane, every time this map is updated. As recruiters we are contacted by practices every day and have multiple practices in the same suburbs and towns who are desperate for GPs as patients are knocking down their doors. If the DPA classification reflects the true status of an area, why is this the case?

The need for different classifications for various Programs such as the RACGP's PEP Specialist Stream and the More Doctors For Rural Australia Program makes these classifications even more confusing for practices and GPs. We would propose that the system need to be simplified to avoid confusion and further considers the need for GPs in lower socio-economic locations where Australian Trained GPs don't want to work and bulk billing services are a specific need.

There has recently been an announcement by the Federal Regional Health Minister David Gillespie that practices can apply for an 'exceptional circumstance review' in relation to their DPA Status. Early reactions suggest the industry has concerns about the effect of this announcement because:

- Responsibility for this has been delegated entirely to RWAs who have a potential conflict of interest as they are also involved commercial recruitment.
- It is unclear in the policy whether the requirement to have a relationship with a RWA cuts out all potential for involvement by private recruiters.
- It appears that this avenue it not available to those clinics who do not have a current relationship with their local RWA. This is likely to include many outer metro practices.
- There has been no confirmation in relation to whether a practice that is granted DPA status under this review, will also be eligible for a Health Workforce Certificate under the Visas for GPs program which is essential for successful recruitment.

iii. GP training reforms

We have no comment on this topic.

iv. Medicare rebate freeze

We have no specific expertise on this topic; however, we can comment on our observations of recent changes in the industry.

- More and more practices are moving to mixed billing as bulk billing is not sustainable nor does it attract a medical workforce.
- GPs are demanding larger percentages of billings from practices due to the shortage of GPs.

c) the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia

The COVID-19 pandemic has had a significant impact on the already dire doctor shortages in outer metropolitan, rural and regional locations.

The main impacts of COVID-19 have been the following:

- It is masking the real policy areas that are designed to stop the flow of GPs. Many will assume that COVID is the cause for shortages that are in fact driven by policy decisions that were made prior to the pandemic.

- There has been a decrease in IMGs arriving, both VR and Non-VR, due to border closures, uncertainty, and lack of flights. However, the main impact of this has been due to the new policies through the Visas for GPs Program, RACGP's PEP Specialist Stream and AHPRA which will be discussed in the next section, but COVID-19 provides a good mask for the real impact of these new policies.

- We are seeing more and more GPs who are opting to work in vaccination or testing sites instead of their normal general practice because they are burnt out, it is less stressful, and they earn more in some settings. One GP recently reported earning three times as much in a COVID testing service than would be possible in her regular GP clinic.

- There has been an emotional impact on GPs who are constantly at threat of contact with a COVID-19 positive patient and the threat that has to their families. They have felt a lack of support from the government in relation to PPE early in the pandemic and through the supply of vaccines. Practices are also seeing a higher level of abuse from patients than ever before due to lockdown frustrations. Some practices in lockdown zones even have some GPs who are refusing to work by Telehealth. Increasingly the medical press is commenting on this issue.

- COVID-19 has caused delays for non-VR GPs who would like to work in Australia. These GPs are those who are a key assets to regional and rural practices as they are required to work in MMM2+ locations. These GPs are required to complete a Pre-employment structured clinical interview (PESCI) by the RACGP or ACCRM to assess their eligibility to work in Australia and the level of supervision they require. The cancellation of PESCIs due to the pandemic has caused a bottleneck of doctors who are in Australia and willing to work but are not allowed to and were already facing issues with the PESCI prior to the pandemic.

d) any other related matters impacting outer metropolitan, rural, and regional access to quality health services.

There are several other factors contributing to the current shortages of GPs in all areas except inner metro suburbs with a high socioeconomic profile. We will outline some of these below:

Reliance on locally trained doctors

Only 15.2% of students indicated they would like a career in General Practice

The philosophy of self-sufficiency has guided politicians and regulators for decades and has led to increased numbers of places available in Australian medical schools. As a result, we have more medical students than ever in the Australian system. However, these students do not choose to work in General Practice.

The Medical Deans of Australian and New Zealand National Data Report 2020 shows that:

- there were only 23% who considered themselves as coming from a rural background
- their overall preference to work outside of a capital city has decreased compared with previous reports

Added to this is the reality of General Practices in outer metropolitan, rural and regional locations. They almost never receive applications from Australian trained doctors especially if they are also bulk billing practices. In our specialist GP recruitment business, we have not received a single application from an Australian trained doctor for locations like Werribee VIC, Blacktown NSW, Dandenong VIC or Beenleigh QLD (or any similar locations) in more than ten years. These locations rely strongly on the IMG workforce who will work at these locations whilst under the 10-year moratorium.

General Practice no longer a speciality of choice

GPs earn significantly less then other specialities which has been a major influence on the reduction of medical student choosing to become GPs. The recent ANZ-Melbourne Institute Health Sector Report 'The Evolution of Medical Workforce' confirmed that:

Non-GP specialists earned almost twice as much as GPs.
Their earnings also grew twice as fast such that the gap between GP and non-GP specialist earnings has widened significantly.

Despite efforts to increase the interest of students in General Practice, the number of students choosing this option is on a downwards trend. In 2018 there were only 5676 GP trainees out of a total of 21,507 training positions.

An ageing and part time GP workforce

Whilst student numbers are low, retirements are also up. The RACGP's Health of the Nation 2020 report confirms that the GP workforce is ageing with over 65% of GPs in Australia aged over 45 years old.

More than one third (37%) is aged over 55 years old compared to only 11% under the age of 35.

If GP training numbers are not increased and IMGs continue to face overwhelming barriers to work in Australia, there will be an even bigger shortage and health crisis in coming years which will impact of the health of all Australians.

In addition to this, GPs are working less hours on average per week then previous years. Whilst the gender gap is closing, female GPs are also confirmed to see patients for longer consultations than their male counterparts. The RACGP's report confirms that *"This combination of factors could mean a larger head count of GPs will be needed in future to provide the same level of patient access."*

Policies designed to discourage IMGs from entering Australia

The 10-year moratorium is the most significant tool used to discourage IMGs from entering the Australian system and has been in place for about 25 years. To our knowledge it is the most severe moratorium of any jurisdiction in the world. In addition, new policies are introduced regularly to limit the flow of IMGs into the country to the point where there are very few new GPs joining the Australian system from overseas.

The main policies affecting IMG numbers are:

- RACGP's PEP Specialist Stream for Specialist GPs (see Appendix B)
- Visas for GPs program (as previously mentioned, see Appendix A, case studies 3 and 4)
- Medicare processing times (up to 15 weeks for newly arrived GPs on Specialist PEP program)
- AHPRA identification checks to finalise registration only allowed onshore
- PESCI requirement for Standard Pathway GPs with 12-24 months wait time for completion (see Appendix A, case studies 1 and 2)

PESCI Requirement

The PESCI requirement is another example where the GP sector has been disadvantaged when compared with other medical specialities. Doctors arriving from overseas without recognised GP qualifications are required to take the PESCI exam before working in an internship setting in General Practice. The same doctor wishing to undertake an internship in a hospital is not required to pass this hurdle.

The PESCI is a significant factor in restricting the GP workforce and a major barrier for practice who cannot wait years for a GP to start at their practice. These GPs all start on Level 1 supervision, the level of an intern, they are there to learn. Yet the PESCI examiners expect that they have experience dealing with Australian practice issues when they are applying to work in Australia for the first time.

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Appendix A

Case Study 1 – Dr SZ's PESCI Process

Dr SZ is a non-VR Doctor who wants to commence working as a GP in Australia under the standard pathway. We started working with her almost 2 years ago and yet have been unable to help her commence supervised practice anywhere in Australia.

We managed to secure a position with level 1 supervision (meaning the supervisor takes full responsibility and oversees all patients) in Kalgoorlie, WA in late 2019. This is a DPA and MMM3 location, six and a half hours drive east of Perth. This GP holds a Doctor of Medicine, a Masters of Internal Medicine and a PHD from overseas. Since being in Australia she has taught human physiology, pathophysiology and pharmacology, clinical features of diseases, taking medical history and physical examination at a university in Sydney. She had also completed both parts of the AMC examinations.

She applied for the PESCI in May 2020 through ACCRM, at the beginning of July she received an email confirming her PESCI date at the end of July 2020 via zoom. In mid-August she was advised she had not passed due to not having experience in Aboriginal Health. She completed learning modules in Aboriginal health and since she was unable to travel to WA due to border closures, she completed an observership at a practice in Sydney. She re-applied for the PESCI and was given a date in February 2021. She was advised that she was not successful on the second attempt, telling us *'Everything that was a positive last time was a negative this time'.*

After failing the second PESCI, she contacted some hospitals and offered to even work as a volunteer but was not successful and one medical manager advised her that the best thing to do is to go back to the medical school and re-graduate. A qualified doctor with two Masters degrees and a PHD was advised to go back to medical school. The process has caused a lot of stress, depression and has been extremely expensive for the doctor costing $50,000 over the years. She has lost the courage to continue fighting the systems.

Here are a few of the comments shared in her emails following her second failure of the exam:

Early Feb 2021:
Unfortunately, again it is a failure. They were not happy with everything, even what was positive last time, they saw now negative.
I feel such a failure. I do not know what to do.What a waste of money and time!
Recently, many issues happened, we got car accident, thank God we were not harmed but we lost the car. I had to do an operation and with the PESCI, we were drained.
I am working at two places at the moment to salvage the situation and I will not be able to try again before the end of July if I will try and I am not confident at all.
I think, it is pointless repeating PESCI, without going to the clinic.I cannot think of anything, kind of lost.

Late Feb 2021
I feel like being in a roller coaster at the moment with so many things happened and still happening in my life. If I am not drowned at the end of it, praying it will end, I may be able to fight back again.
At the moment, I am drained, exhausted with deep uncertainty, according to the Australian standard, once I pass AMC MCQ and AMC clinical, I proved myself to be able to practise in Australia, I see no point in what they are doing, but cannot do anything about it.
The interview felt like a war but with velvet gloves.

I feel embarrassed to contact dr. P, who waited for me such a long time to have this result and I know it was a very good chance and I am so devastated to lose it.mI want to thank you and Megan, for everything you have done for me and I appreciate any advice you can give.

July 2021

After failing the second PESCI, I contacted some hospitals and offered to even work as a volunteer, in exchange with their help with AHPRA registration, but was not successful and one medical manager advised me that the best thing to do is to go back to the medical school and re-graduate, can you imagine that?

I hold an AMC certificate which is equal to graduation from Australia, if not, why the IMG need to do it then?

It was a great waste of money and time loaded with extreme level of stress, anxiety and depression.

The way they structured PESCI is nothing compared to real life practice; therefore, it is pointless. Imagining a patient (whether face to face or online) is not the same like being with a real patient in a real setting.

My supervisor, who is recognised as a supervisor by Australian standards committed himself to take responsibility for all patients while I am learning for as long as it takes for me to practise under level 1 supervision, it should be enough commitment to ensure my safe practice. Apparently, not.

What else they are after?, more money drained from us, IMGs?

Fine, we accepted their game, to this date, the medical licencing process costed me more than A$50,000 and still nothing in return. It took me long, because I did not have the money they require, I came from a country torn by civil war, I brought no money on with me, and sometimes, I had to support my family over there, I needed money to support life expenses here and also to pay them.

Dr SZ is happy to speak as witness and tell her story if this is helpful to the cause.

Case Study 2 – Dr SN's PESCI Process

Dr SN is a Non-VR Doctor who was offered a position with level 1 supervision in a outer metropolitan suburb of Melbourne at the time the location was a DPA locations. Dr SN applied for the PESCI with the RACGP in February 2020. A few months ago, the practice owner and his wife met with her and her husband for dinner. She was in tears with frustration and discouragement over the delays. Following that meeting he began to advocate with various parties and contacted the RACGP with concerns about the process. The response provided in early June 2021:

> *Unfortunately, the suspension of PESCI for 4 months has meant we have a backlog of more than 12 months of candidates across the country. We have offered PESCI as equitably as possible to those candidates, while endeavoring to minimize the risk to them. Unfortunately, COVID is the overriding reason for this backlog, for the caution and for the extended waiting times. We continue to work through the backlog of applications in as fair a manner as possible.*

In June 2021 she finally was given a PESCI date in August 2021, however this has since been cancelled due to the new COVID-19 restrictions in place in Victoria even though the session was taking place via Zoom. No date has been set for a further session.

Case Study 3 – Dr DB's experience with Visas

Dr DB is a fully qualified, specialist GP who has been working in Australia since the start of 2019. She is currently under a 482 temporary skilled working visa, however because she has turned 45, there is no pathway to permanent residency available to her in Australia. Dr DB has worked on the frontline of the pandemic in Victoria since the first testing site opened. She has worked at both state and federally funded sites. Her dream is to work for a community health organisation and has a specialist interest in aged care/caring for elderly patients.

However, she is not about to move from her current role to this new role because she cannot get Permanent Residency because she cannot obtain a Health Workforce Certificate. She says that in this climate where everything including borders is uncertain, it is difficult to not have the stability a Permanent Residency visa would bring. She has dedicated herself to helping the Australian community and is recognised as the same as an Australian trained doctor, yet she does not feel supported. She is not even able to access Medicare for her personal health because she has a German passport.

Dr DB is happy to speak as witness in relation to her situation.

There are limited opportunities for Permanent Residency for GPs on the whole but more so for those aged over 40-45. We recently worked with another GP who holds specialist registration with AHPRA but is over 40 years old. He was prepared to go to any location and was offered a position in a MMM6 location. But even the regional and rural permanent residency pathways do not consider professions such as GPs.

Case Study 4 – Dr AH's lack of support to work in a remote location

Dr AH worked in regional Australia for five years but returned to Europe in early 2020 because he was unable to get Permanent Residency for himself and his family due to a technicality in his employment and the fact that he was over 45 years of age. During this time, he was appointed as an Associate Professor and assisting with training of medical students at a Rural Clinical School as well as working as a highly regarded GP.

He contacted us in January 2021 and was keen to return. He had maintained his FRACGP and Specialist Registration and wanted to return to Australia. Because of the visa hurdle he was willing to work in a remote location to get his PR visa quickly and then bring his family to live with him. He was welcomed by a practice in Port Hedland, WA (MMM 6 classified as very remote) with open arms and was keen to take up the position.

We consulted a leading migration law firm and a boutique migration agent but were unable to find a visa category that included incentives for a GP to work in a remote location. In fact, there would be no difference whether he worked in an inner metropolitan area (MMM1) or a remote area. As a result, he declined the opportunity to return to Australia.

Appendix B – RACGP PEP Specialist Stream

The RACGP PEP Specialist Stream was introduced on 1 September 2019 for General Practitioners wishing to work in Australia whom hold a specialist qualification and was a way of ensuring the college came into line with other colleges assessment processes. Most applicants come from substantially comparable countries such as the United Kingdom and Ireland. These GPs need to work in a DPA location under this program.

Previously, these GPs would have had access to a number of exemptions are provided under subsection 19AB(3) of the Act. The ss19AB(3) exemptions include but are not limited to: after-hours, locum, spousal, academic and DPA class exemptions. The Guidelines also include a replacement provision (allowing a s19AB DPA exemption to be passed on where the departing practitioner has ceased working in the local area) and a provision for the service location's DWS/DPA status at the time of contract negotiations to be considered (where the practice has since lost their DSW/DPA status). However, these are not available to GPs coming in on this specialist program. **This has had a significant impact, in particular on female GPs** who were not able to access a spousal exemption. Many of these GPs had spouses who were trained specialists working at metropolitan hospitals, however given they are now unable to work many are choosing not to come to Australia at all which will have an impact on tertiary hospitals in the future.

There have also been inconsistencies in the program's rules and transparency. For example, a UK trained GP who worked in Australia 10 years ago, is unrestricted in Medicare's view but is still required to work in a location dictated by the RACGP. This GP was a citizen of Australia but was still forced to provide a Health Workforce Certificate from the Visas for GPs program. Likewise, the RACGP also have stated that there are locations classified as priority areas that are not DPA, however there is no list available for the public.

In 2019, the RACGP received 192 specialist GP applications compared to 52 applications in 2020. Applications to the RACGP have been steadily declining since the introduction of the PEP.

The role of the medical colleges has always been to ensure the quality of GPs. The MBA guidelines do not mention that it is the Specialist Medical Colleges' role to determine where a SIMG can work. However, upon raising these issues with the Minister for Health was advised that the RACGP's PEP Specialist stream is a tool for workforce distribution.

In addition to this, the PEP Specialist stream processing times vary between 2 to 6 months giving no transparency to the applicants. Upon arrival in Australia, GPs currently need to complete two weeks quarantine prior to presenting to their practice to do their AHPRA Identification Check, before applying back to the RACGP to get a provider number. Upon this, the RACGP makes the application to Medicare for the provider number, but this process can take up to 12 weeks. Therefore, the GP is in the country, not working and sometimes accompanied by their family, for 4 months before they can start earning a wage. This is a major barrier and is not something that should be asked of by anyone. This process needs to change. If AHPRA was to allow the GPs to complete their AHPRA Identification check offshore, such as at an Australian Embassy, then this would make this process much shorter.