



# Literature review: the experiences of Australia's international medical graduates



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# Literature review: the experiences of Australia's international medical graduates

## Definition

In Australia, the term 'international medical graduate' (IMG) refers to doctors who have obtained their primary medical qualification in a country other than Australia or New Zealand.<sup>1,2</sup>

## The history of IMGs in Australia

Australia's history with IMGs reflects a complex journey, with many lessons learned and progress made. An end to the [Immigration Restriction Act 1901](#) (also known as the White Australia policy) in the 1970s removed the restrictions on immigration from non-European countries, with non-European IMGs among the earliest immigrants.<sup>3</sup> Before World War II, IMGs without British training generally had to requalify by attending one of four Australian universities.<sup>4,5,6</sup> However, due to the [War Precautions Act 1914–1918](#), German and Austrian doctors were ineligible to practice in Australia. During World War II, the Australian Government authorised the increased entry of refugees from Europe, including a number of Jewish doctors seeking asylum following the war.<sup>7,8</sup> At this time, the Australian branch of the British Medical Association (BMA), which was later formalised into the Australian Medical Association, was fiercely against allowing refugee doctors without British training (i.e., those medically trained outside of the United Kingdom, New Zealand, or Australia) to practice in Australia.<sup>9</sup> The BMA's concern was twofold — uncertainty of the professional standards of non-British-trained doctors and increased competition for local doctors in Australia.<sup>10,11,12</sup> These concerns led to a desire to limit the opportunities for foreign trained doctors to practice medicine in Australia.

The BMA achieved its objective of limiting foreign doctors' opportunities to obtain qualifications and medical registration in NSW. Under the [Medical Practitioners Act 1938 \(NSW\)](#), an applicant was only eligible for medical registration if their medical studies were undertaken within the British Empire, if the medical course was at least five years long, and the Medical Board recognised it as meeting the standard of their faculty's course.<sup>13</sup> The University of Sydney stated the Act was "designed to raise the standard of medical education and practice in ... [NSW]".<sup>14</sup>

A further change in legislation enabled non-British-trained doctors who had 'special qualifications' and 'special experience' in the practice of medicine or surgery to be exempt from the requirements of subsection one of the Act, as their credentials were deemed sufficient to justify waiving compliance.<sup>15</sup> However, the Act also specified the "medical board shall not, in any one year, grant the applications of more than eight persons who are not natural born British subjects".<sup>16</sup>

Following World War II, the government, having feared the threat of a Japanese invasion in 1942, adopted an urgent recruitment strategy in Europe to attract migrants. The then Prime Minister, Ben Chifley, together with Immigration Minister Arthur Calwell, championed a '[populate or perish](#)'<sup>17</sup> initiative. At this time, Australia was a large country with a small population, which had been exacerbated by the loss of a large proportion of its young men during the war.<sup>18</sup> The realisation of the need for a larger workforce and greater protection led the Australian government to consider the politics of its population and power.<sup>19</sup> Calwell estimated the population needed to increase by two per cent annually — twice as much as could be gained by natural growth.<sup>20</sup> To make up the deficit, Calwell calculated Australia would need 70,000 immigrants per year.<sup>21</sup> This culminated in the Australian [government's migration policy of 1945](#).<sup>22</sup>

Following this initiative, European refugee migration occurred at an increased rate across Australia, with 300 male and 70 female doctors estimated to have arrived between 1947 and 1951.<sup>23,24</sup> While it was reported that these doctors had been recruited, many were unable to register and be recognised as medical practitioners,<sup>25</sup> as their standards of education were considered too dissimilar to that of British and Australian universities.<sup>26</sup> Of the 370 non-British-trained doctors, only 37 were assessed as able to practice medicine in Australia.<sup>27,28</sup>

Although many of the remaining doctors completed re-qualification requirements at Australian universities, due to quota restrictions across Australia, medical registration was not possible, and they were forced to work as general labourers, or other healthcare workers, such as medical orderlies, nurses, or hospital cleaners.<sup>29,30</sup> Due to the challenges of medical registration in Australia, 34 of these refugee doctors migrated to the United States, Canada, and Ethiopia, where registration was not as demanding.<sup>31</sup> Other repercussions from Australia's complex registration

process were apparent as five refugee doctors died by suicide, including one who was barred from practicing in New South Wales.<sup>32</sup> Other factors, such as post-traumatic stress disorder, were reported as a significant contributor to poor mental wellbeing.<sup>33</sup>

Today, the acceptance of IMGs by the Australian medical profession and the general public has significantly improved since World War II, with most people recognising the important contribution IMGs make to healthcare in Australia. The current IMG registration process has also improved, allowing British and non-British IMGs who successfully meet Australian medical board and medical council assessments to register and practice independently in Australia. Despite these improvements, shortcomings in the process remain, with many IMGs finding themselves in similar predicaments to their 1940s counterparts — trapped within a complex and confusing registration process and forced to work in unskilled jobs while awaiting registration. This has significant impacts on the individual and their family, as well as the broader Australian health system.

## What prior reforms have been done for IMGs in Australia?

### Lost in the Labyrinth

Key themes emerged from the Australian government's [Lost in the Labyrinth](#) report on the inquiry into registration processes and support for overseas trained doctors. The report, published in March 2012, said IMGs felt the system lacked efficiency and accountability and was one they had very little confidence in.<sup>34</sup> The inquiry found IMGs also felt they were the subject of discrimination and anti-competitive practices, which had adversely impacted their success in registering for medical practice in their chosen speciality.<sup>35</sup> Among other issues, a major focus of the inquiry was the importance of both personal and professional support for IMG families. Specifically, the inquiry highlighted the crucial role of pre- and post-arrival orientation, access to professional development opportunities, and support networks for IMGs and their families.<sup>36</sup>

### Review of Australian specialist medical colleges (ACCC and AHWOC)

In 2004, the Australian Competition and Consumer Commission (ACCC), in collaboration with the Australian Health Workforce Officials Committee (AHWOC), conducted a review of the [Australian specialist medical colleges](#). This review examined their selection, training, and accreditation processes, with particular concern about how these processes applied to IMGs.<sup>37</sup> The aim of the review was to “explore the extent to which specialist medical colleges are operating according to the general principles of transparency, accountability, stakeholder participation and procedural fairness”.<sup>38</sup> The outcome of the inquiry report, published in 2005, consisted of 20 recommendations to improve college assessment and the accreditation processes. Recommendations included:

- further consideration to the recognition of prior overseas training
- increased opportunities for competency-based assessment and training
- greater transparency of college assessment criteria for overseas trained specialists, and
- improved access to continuing professional development for overseas trained specialists working towards specialist registration.<sup>39</sup>

### Senate Finance and Public Administrations Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)

In 2011, the [Senate Finance and Public Administration Inquiry into the administration of AHPRA](#) found AHPRA's poor administration of the registration process had adversely affected the recruitment of IMGs. The committee concluded significant improvements in the registration process were needed. It recommended the regular review and jurisdictional involvement of registration processes for IMGs and increased transparency in relation to registration timeframes for IMGs.<sup>40</sup>

Despite this, current IMGs have reported encountering similar administrative issues, indicating that these issues are still ongoing.

### Kruk Review

On 30 September 2022, National Cabinet announced a [review](#) into the pressures on the health workforce during and after the COVID-19 pandemic, amid growing concern about workforce shortages.<sup>41</sup> This review investigated the

Australian regulatory settings for the registration and recognition of internationally qualified health practitioners.<sup>42</sup> The report provided 28 recommendations, grouped into five broad reform areas:

1. Improve the applicant experience.
2. Expand fast track registration pathways.
3. Improve workforce data and planning.
4. Increase flexibility, while ensuring safety and quality of care.
5. Enhance regulator performance and stewardship.

These reforms aimed to improve the efficiency and effectiveness of the end-to-end regulatory journey for internationally qualified health practitioners.<sup>43</sup> The review found IMGs formed a significant part of the workforce, particularly in regional, rural, and remote areas, and they should be better supported in their day-to-day work to gain medical qualifications and registration in Australia.<sup>44</sup> In particular, the [Interim Kurk Report](#) stated “employers and health practitioners report our registration and related immigration processes are slower, more complex and expensive in many instances than our international counterparts”.<sup>45</sup>

## The current processes of recruiting IMGs to Australia

The majority of IMGs who seek registration in Australia are assessed via the [Standard pathway](#), as determined by the Australian Medical Council (AMC).<sup>46</sup> This process requires IMGs to pass two examinations (a multiple-choice exam and either a clinical exam or the Workplace Based Assessment).<sup>47</sup> Following the examinations, IMGs must spend at least a year in a supervised practice role.<sup>48</sup> IMGs pursuing general (non-specialist) registration with their primary medical qualification being obtained in one of five countries<sup>i,ii,iii,iv,v</sup> with similar training and registration systems to Australia can apply for registration through the [Competent Authority pathway](#), which exempts IMGs from the AMC exams and other administrative processes.<sup>49</sup> Finally, medical graduates who are specialists in their home country can apply for registration via the [Specialist pathway](#), and their application will be considered by the relevant Australian specialist medical college.<sup>50</sup>

The first step for IMGs applying to work in Australia is to determine their eligibility for registration.<sup>51</sup> Under the [Health Practitioner Regulation National Law Act 2009](#) (commonly referred to as the National Law), all health professionals, including IMGs, must meet mandated registration standards to work in Australia. These standards include requirements related to criminal history, English language proficiency standards, recency of medical practice experience, proof of identity, university qualifications, and evidence of current medical registration from another country.<sup>52</sup> Following this, IMGs must apply for medical registration through the relevant pathway.

The AMC and the Medical Board of Australia oversee the assessment and registration process of all IMGs in Australia to ensure they meet the required standards and gain general medical registration to enter the workforce. Before assessing applications, the AMC relies on the [World Directory of Medical Schools](#) as its primary source for verified medical schools. It checks the schools’ dates of operation and the degrees they award.<sup>53</sup> The AMC’s eligibility requirements align with those of the United States [Education Commission for Foreign Medical Graduates](#), as listed through its sponsor note in the World Directory. Therefore, medical schools for all IMG applications are checked to ensure they align with the World Directory before consideration of the application.<sup>54</sup>

Before migrating, IMGs are required to apply for and obtain an appropriate visa enabling them to live and work in Australia.<sup>55</sup> To be eligible for a working visa, IMGs must satisfy several requirements, some of which duplicate those for medical registration — for example, English language proficiency tests, proof of identity, and criminal history checks.<sup>56</sup> Beyond this, IMGs must secure employer sponsorship or nomination from an Australian state or territory health authority.<sup>57</sup> After securing employment, IMGs must satisfy additional evidentiary requirements before commencing work including, proof of identity, probity, and credentialing checks.<sup>58</sup>

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<sup>i</sup> United Kingdom (General Medical Council)

<sup>ii</sup> Canada (Medical Council of Canada)

<sup>iii</sup> United States (Education Commission for Foreign Medical Graduates of the United States),

<sup>iv</sup> Ireland (Medical Council of Ireland)

<sup>v</sup> New Zealand (Medical Council of New Zealand)

Following an offer of employment, IMGs must then undertake a mandatory period of supervised practice. IMGs who register in Australia are required to undertake up to 12 months of supervised practice, during which they hold provisional registration.<sup>59</sup> After satisfactorily completing the supervision period, IMGs are eligible to apply for general registration, which allows them to obtain a Medicare provider number and practice independently.<sup>60</sup>

### Competent Authority pathway

The [Competent Authority pathway](#) is available for IMGs who have completed their medical training in specific countries recognised by the Australian Government — the United Kingdom, Canada, the United States, New Zealand, and Ireland. This registration pathway requires IMGs to demonstrate their competence through a series of assessments, including workplace-based evaluations.

IMGs who hold a primary qualification in medicine and surgery from a training institution recognised by both the AMC and the World Directory, and who have completed training or assessment with an approved competent authority, may apply for provisional registration via the Competent Authority pathway.<sup>61</sup> Under section 53 of the National Law, the Medical Board of Australia can grant provisional or general registration on the basis of qualification equivalency or through the successful completion of an examination.<sup>62</sup> The Medical Board of Australia has determined applicants who meet the requirements of the Competent Authority pathway may be eligible for provisional registration under the National Law.<sup>63</sup> Following the satisfactory completion of 12 months of supervised practice (a minimum of 47 weeks of full-time service), Competent Authority pathway registrants may be eligible to apply for general registration with the Medical Board of Australia.<sup>64</sup>

### Standard pathway

The [Standard pathway](#) is the primary route for IMGs seeking general registration in Australia, who are not eligible for the Competent Authority pathway. Like the Competent Authority pathway, IMGs who hold a primary qualification in medicine and surgery awarded by a training institution recognised by both the AMC and the World Directory can apply for assessment under the Standard pathway.<sup>65</sup> This pathway involves passing the AMC's [Computer Adaptive Test \(CAT\) Multiple Choice Question Examination](#), which assesses clinical knowledge and proficiency in a range of medical disciplines, as well as the AMC [clinical examination](#), or equivalent [AMC Workplace Based Assessment](#).<sup>66</sup>

Upon successful completion of the examinations or the Workplace Based Assessment, candidates receive an AMC Certificate, a prerequisite for registration with the Medical Board of Australia.<sup>67</sup>

IMGs who have been awarded an AMC Certificate can then apply for provisional registration and must secure an offer of employment.<sup>68</sup> Following fulfilment of provisional registration and an offer of employment, IMGs must successfully complete 12 months of supervised practice (a minimum of 47 weeks full-time service) in an approved position before being eligible to apply for general registration.<sup>69</sup>

### Limited registration

Following successful completion of the AMC CAT MCQ Examination, IMGs can apply to the Medical Board of Australia for [limited registration](#).<sup>70</sup> Under limited registration, IMGs can undertake a period of postgraduate/supervised practice or work in an area of need before applying for the AMC clinical examination or the equivalent AMC Workplace Based Assessment and general registration.<sup>71</sup>

### Specialist pathway

There are two different specialist pathways in Australia — the Specialist pathway: specialist recognition and the Specialist pathway: area of need.

The [Specialist pathway: specialist recognition](#) allows IMGs to apply directly to the relevant specialist medical college, which assesses comparability against the criteria for an Australian-trained specialist in the same field of specialty practice.<sup>72</sup> With this pathway, the outcome of the specialist medical college's assessment will determine the relevant registration type. With these assessments, the relevant specialist medical college will require the IMG to undertake a period of supervised practice, which may include other requirements such as workplace-based assessments, training, or examinations, before recommending the IMG be granted recognition as a specialist.<sup>73</sup>

The [Specialist pathway: area of need](#) enables IMGs to apply directly to the specialist medical college, which assesses their qualifications and relevant experience against the specified requirements of a position in a confirmed area of need.<sup>74</sup> The areas of need are determined by the relevant state or territory health authority. The AMC, the specialist

college, and the Medical Board of Australia have no role in determining which areas are declared areas of need. While the [Specialist pathway: area of need](#) is deemed a specialist pathway, it does not lead to specialist registration.<sup>75</sup> In order to be recognised as a specialist, and gain specialist registration with the Medical Board of Australia, IMGs must be registered through the [Specialist pathway: specialist recognition](#) as well.<sup>76</sup>

### Short-term training in a medical specialty pathway

The [short-term training in a medical specialty pathway](#) allows IMGs who are qualified specialists or specialists-in-training to undertake up to 24 months of training in a specialty area in Australia.<sup>77</sup> This pathway is appropriate for IMGs who intend to complete a short period of training in Australia (up to 24 months). Short-term training in a medical specialty is not accredited by the Royal Australasian College of Physicians (RACP) and does not result in being awarded a fellowship of the RACP or specialist recognition in Australia.<sup>78</sup> Eligibility for short-term training in a medical speciality is available to IMGs who hold a primary qualification in medicine and surgery awarded by a training institution recognised by both the AMC and the World Directory and who have satisfied all the training and examination requirements to practice in their field of specialty in their country of training. IMGs who are no more than two years away from completing their specialist training overseas, are also eligible to apply for assessment under the short-term training in a medical specialty pathway.<sup>79</sup> In addition, they must have secured an offer of a training position, before applying to the Medical Board for registration via this pathway.<sup>80</sup>

Regardless of the pathway undertaken by IMGs to seek medical registration in Australia, all have been described as complex, time consuming, at times bureaucratic, stressful, and expensive.<sup>81</sup> This is particularly evident in the length of time taken to process IMG applications for medical registration and the cost of this registration process. In 2023 on average, it took 14 months and cost \$23,000 to process an IMG in Australia, whereas in New Zealand, the process took about three months and cost up to \$5,000.<sup>82</sup> Considering New Zealand, which is just across the Tasman, can complete the process in almost one fifth of the time to Australia, it begs the question, why does the process take so much longer here?

### Expedited Specialist pathway

Australia's health ministers have approved the registration standard that paves the way for a range of specialist international medical graduate (SIMG) reforms.<sup>83</sup> A new fast-track pathway to specialist registration for eligible internationally qualified medical specialists — termed the Expedited Specialist pathway — was approved on 21 October 2024.<sup>84</sup> The new Expedited Specialist pathway allows well-credentialled International Medical Specialists from similar health systems (the United Kingdom, Ireland, and New Zealand) to see Australian patients sooner.<sup>85</sup> The fast-tracked pathway is designed to remove unnecessary regulatory barriers and increase the number of SIMGs seeing patients in Australia, while maintaining high standards.<sup>86</sup> The Minister for Health and Aged Care, Mark Butler, insists there is no cause for alarm, stating: "I want to be very clear to patients and with the medical profession that we won't compromise on our very strong standards that we have here in Australia."<sup>87</sup> The AMA will continue monitoring and working with all stakeholders throughout the expedited specialist pathway implementation to ensure this process equips medical professionals with the appropriate skills to deliver high-quality healthcare.

Specialist GPs with one of the following accepted qualifications will be eligible to apply through the new pathway from 21 October 2025:

- Membership of the Irish College of General Practitioners (MICGP) from 2009 and a Certificate of Satisfactory Completion of Specialist Training (CSCST)
- Fellowship of the Royal New Zealand College of General Practitioners (FRNZCGP) from 2012
- Membership of the Royal College of General Practitioners (United Kingdom) from 2007 and a Certificate of Completion of Training (CCT).

In addition to this, specific specialist qualifications in anaesthetics, obstetrics and gynaecology, and psychiatry were added to the accepted list in December 2024, after a rigorous qualifications assessment process. Jurisdictions are now choosing the next specialties for the Expedited Specialist pathway, based on workforce priorities.

## Thorough qualification assessment

A thorough qualifications assessment process underpins the Expedited Specialist pathway:

- Specialist colleges are asked to nominate international specialist qualifications that they have generally accepted as substantially comparable to approved qualifications, through the existing Specialist pathway.
- The AMC, in consultation with specialist colleges, exhaustively assesses each proposed international specialist qualification against an established qualifications assessment framework and recommends specific qualifications to the Medical Board.
- The Medical Board decides which international specialist qualifications will be included on the Expedited Specialist pathway: accepted qualifications list.

All three qualifications on the accepted list were proposed by the specialist colleges — the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACCRM) — assessed by the AMC against the assessment framework, and approved by the Medical Board as substantially equivalent, or based on similar competencies, to an approved qualification. (Approved qualifications are the qualifications awarded by the accredited Australasian specialist colleges.)

## Additional safety checks

There are additional strict safety checks and balances in place to make sure new specialists coming to Australia on this pathway are safe to practice.

Specialists on the Expedited Specialist pathway must meet the same registration standards as all other specialists and doctors. These include English language proficiency, criminal history checks, and recency of practice.

Each SIMG on the Expedited Specialist pathway will be supervised for six months by an Australian-registered specialist, undergo an orientation to Australia's health system, and complete mandatory cultural safety education.

A national Medical Board committee, made up of doctors and community members, will make all registration decisions about individuals on the Expedited Specialist pathway.

The Expedited Specialist pathway will significantly boost the medical workforce while removing unnecessary barriers for IMGs.

## The importance of IMGs in Australia's health system

IMGs play a vital role in ensuring regional, remote, and rural communities have access to quality general practice.<sup>88</sup> IMGs currently comprise 53 per cent of the rural medical workforce, and more than 50 per cent of all general practitioners (GPs) in Australia,<sup>89</sup> compared to 2013 when 43.1 per cent of Australian GPs were trained overseas.<sup>90</sup> This is also reflected in the proportion of specialists who are trained overseas, with the proportion of IMG specialists being 30.8 per cent in 2013 compared to 32.8 per cent in 2019.<sup>91 92</sup>

Recruitment of overseas trained doctors to Australia is now entrenched and compounding year on year,<sup>93</sup> with 42,056 IMGs registered as medical practitioners in 2021–2022, an increase of more than 13 per cent compared to recruitment rates before the COVID-19 pandemic.<sup>94</sup> It is clear Australia's current workforce strategy in rural and remote areas is significantly reliant on retaining IMGs in these locations for a fixed period of time — areas that often offer limited support.<sup>95</sup> A health workforce with a sufficient supply of doctors (both in general practice and specialisations) is fundamental to the delivery of high-quality national healthcare. IMGs, including overseas medical students, are subject to limitations regarding where they can work and their ability to provide services under Medicare.<sup>96</sup> IMGs who obtain registration with the Australian Medical Board and practice in a location classified in the Distribution Priority Area (DPA) for GPs or Districts of Workforce Shortage for non-GP specialists<sup>97</sup> can access Medicare billing benefits under section 19AB of the *Health Insurance Act 1973*.<sup>98</sup> DPAs are regarded as regions where there are not enough doctors available to provide for the needs of the local community, and are usually regional, rural, and remote areas of Australia.<sup>99</sup> These special allowances dictate that the medical professional must work in the DPA area for a set amount of time (called a return-of-service). Typically, this period has been 10 years, which is commonly referred to as 'the 10-year moratorium'.<sup>100</sup> However, IMGs can now reduce their years of service (or

moratorium) by serving in DPAs where the needs are considered greatest, typically in remote Aboriginal and Torres Strait Islander communities. As a result of the 10-year moratorium, IMGs now comprise a disproportionately high proportion of doctors, especially in rural and remote areas, where research has shown they are more likely than local graduates to provide healthcare.<sup>101</sup>

While the number of Australian domestic medical graduates continues to increase —3,805 new medical doctors in 2023,<sup>102</sup> compared to 3,697 in 2021<sup>103</sup> — alongside the rise in IMG recruitment, Australia still faces significant workforce shortages in many areas of medicine. These include general practice and specialisations in metropolitan areas, but especially those in rural locations.<sup>104</sup> Although incentives, such as financial benefits and housing allowances, are offered to encourage more medical practitioners to work in rural and remote locations, these shortages persist.<sup>105</sup> In 2022, the AMA predicted Australia would be short 10,600 GPs by 2031–2032,<sup>106</sup> with the demand for GP services increasing by 58 per cent between 2009 and 2019.<sup>107</sup> Workforce shortages are also evident in the mental health system, with the Royal Australia and New Zealand College of Psychiatrists (RANZCP) President, Dr Elizabeth Moore, stating: “Psychiatrist and mental health staff... [are] working around the clock to make up for the shortfalls in the workforce, tackle increased demand for service and provide the best possible care to their patients, but the situation we have at the moment with a stretched-out workforce is untenable.”<sup>108</sup>

Research has shown rural Australians have poorer access to medical services in comparison to their urban counterparts. This pattern also evident in the United States, Canada, and the United Kingdom.<sup>109</sup> Currently, seven million people in Australia are living in rural and remote communities across the country.<sup>110</sup> In major cities, there are 120.5 full-time equivalent (FTE) GPs per 100,000 people, compared to 65.8 per 100,000 people living in very remote areas. 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. Although the current health workforce shortage disproportionately impacts regional, rural, and remote Australia (as domestic graduates are more likely to pursue metropolitan opportunities<sup>111</sup>), both rural and metropolitan areas are feeling the impacts. Due to workforce shortages, patients across the country are forced to seek care from emergency departments as it has become extremely difficult to obtain medical care any other way.<sup>112</sup> This not only taxes the resources at emergency departments as patients with non-emergency conditions seek medical care, but it results in genuine emergency cases experiencing longer wait times, leading to increased rates of ambulance ramping, leaving the health system in crisis. This has knock-on effects for the remaining general practitioners, with many doctors experiencing severe burnout, who subsequently leave the profession as they simply cannot keep up with the pressures placed upon them.<sup>113</sup> Presently, many doctors are delaying retirement, not taking accrued leave, and experiencing burnout due to their concern that there will be no one available to treat their patients in their absence.<sup>114</sup> In 2019, a survey of 366 GP registrars found more than 75 per cent experienced moderate to high levels of burnout during the year.<sup>115</sup>

IMGs offer significant benefits to Australia as they are usually recruited to fill the gaps in the local medical labour supply. As IMGs are required to practice in less popular workplace settings, they provide a more flexible workforce than domestic Australian doctors. These may include less favourable working conditions, such as night shifts, and geographical areas such as regional, remote, and rural areas, which many domestic doctors seek to avoid.<sup>116</sup> IMGs are nearly twice as likely to practice in outer metropolitan and remote areas (8.7 per cent of IMGs versus 5.2 per cent of local graduates), and 2.5 times as likely to be in remote and very remote areas (1.5 per cent versus 0.6 per cent).<sup>117</sup> As mentioned above, more than half of the rural medical workforce in Australia are IMGs,<sup>118</sup> with the recruitment of IMGs and their families to rural regions enriching the communities in which they live and work.<sup>119</sup>

Given the time it takes to train a doctor, it is likely Australia’s reliance on IMGs will continue to grow, and their importance in delivering care to Australian communities will increase, particularly as IMGs represent a flexible and cost-effective solution.<sup>120,121</sup> Beyond the medical services they provide, IMGs also contribute to the broader economy as tax paying consumers.<sup>122</sup> They also enhance Australia’s multiculturalism, enriching the country’s cultural diversity. Additionally, IMGs bring valuable clinical skills that many domestic doctors may lack, such as expertise in treating malaria, gained through relevant experience in their home country.<sup>123</sup> It is also apparent that without IMGs, many regional, rural, and remote communities would not have access to any medical services.<sup>124</sup>

## Why do IMGs choose Australia?

Australia remains a popular destination for IMGs. Australia's thriving economy, high standard of living, education/career opportunities, work-life-balance, natural beauty, and beaches make it a popular destination for IMGs looking to work abroad. Beyond this, Australia's health system is regarded as one of the best in the world,<sup>125</sup> making it a desirable country for doctors who want to work in a high-quality health system. Australia also offers very competitive salaries for doctors with junior doctors earning an annual income of \$80,000–\$140,000, GP-specialists earning \$180,000–\$350,000, and non-GP specialists earning about \$210,000–\$400,000 in 2024.<sup>126</sup> Furthermore, Australia is a safe, politically stable, prosperous, and clean country,<sup>127</sup> making it a very attractive destination for many IMGs who are fleeing politically unstable, war-torn countries,<sup>128</sup> as well as countries which experience high levels of pollution, which can cause serious health problems.

## The current supports provided to IMGs in Australia

There are several support initiatives available to IMGs entering Australia. Specifically, the Department of Health and Aged Care (DoHA) has implemented targeted programs, including the [International Recruitment Strategy](#), which was established to increase the supply of appropriately qualified IMGs to districts experiencing workforce shortage across Australia.<sup>129</sup> Under this program, funding is provided to Rural Workforce Agencies (RWAs), which help IMGs through the process of acquiring medical registration in Australia. Their support includes guidance on visa enquiries, pathways to medical registration, and skills recognition. Furthermore, the [Rural Vocational Training Scheme](#)<sup>130</sup> is a government-funded program that provides vocational training for medical practitioners working in remote and isolated communities, as well as Aboriginal and Torres Strait Islander communities.

### The RACGP's Mentoring Program

The RACGP's Mentoring Program aims to help IMGs connect with each other and manage the personal and professional challenges of becoming a GP in Australia.<sup>131</sup> Specifically, the program aims to assist IMGs who are new to Australia in understanding: (1) the Australian primary healthcare system, (2) the role of a GP in Australia, (3) the social norms and customs of Australian culture, and (4) potential career pathways, as well as the steps required to obtain full registration and Fellowship in Australia.<sup>132</sup> While the RACGP mentoring program is regarded as valuable for IMGs entering Australia, positions are limited, and selection is not guaranteed.<sup>133</sup>

### Five-Year International Medical Graduates Recruitment Scheme

The [Five-Year International Medical Graduates Recruitment Scheme](#) is only offered to experienced IMG GPs who have completed medical registration and are prepared to work in general practice locations which are, in the opinion of the Rural Workforce Agencies, the most difficult to recruit to in their respective jurisdictions.<sup>134</sup> The scheme offers incentives to IMGs who are subject to section 19AB of the [Health Insurance Act 1973](#) and work in areas classified as rural or remote DPAs.<sup>135</sup> The incentives of the Five-Year International Medical Graduates Recruitment Scheme are: (1) to provide IMGs with valuable general practice experience in a rural setting, and (2) to reduce the time IMGs must work in a DPA under their obligations for the 10-year moratorium.<sup>136</sup> The program aims to increase the supply of appropriately qualified IMGs in rural and remote Australia, enhance the professional development, skills and knowledge of IMGs in Australia, and maintain the number GPs in rural and remote areas.<sup>137</sup>

To be deemed eligible to benefit from this scheme, the IMG must:

- 1) hold or obtain appropriate registration with the Medical Board of Australia
- 2) be able to obtain a Medicare Provider Number at the relevant practice/town
- 3) intend to seek, or currently possess, permanent residency and/or Australian citizenship
- 4) be available for at least seven sessions a week as part of their placement
- 5) intend to join, or currently participate in, a relevant general practice or rural generalist training pathway that will enable them to gain specialist qualifications while working in the chosen practice for the length of their scheme agreement.<sup>138</sup>

### Recruitment agencies

Medical recruitment companies — for example, [Medrecruit](#) — are comprised of specialist individuals who provide help and advice to foreign doctors who are seeking relocation and employment in either New Zealand or Australia.<sup>139</sup> [Medrecruit](#) is a specialist health recruitment agency in Australia which features a dedicated IMG team, comprised of individuals who have personally navigated moving to New Zealand — a country with similar lifestyle

and working conditions as Australia. The team is able to provide authentic advice to current IMGs transiting to Australia.<sup>140</sup> This service is free for IMGs who are seeking to relocate to Australia or New Zealand. IMGs can contact [Medrecruit](#) by phone or email, or by leaving a message on their website. If IMGs want to access this service, they must register with [Medrecruit](#).<sup>141</sup>

While recruitment agencies aim to assist IMGs in Australia, there have been reported issues that could negatively impact IMGs. For example, if an IMG applies for a job via a recruitment agency, it frequently costs the hospital or employer an additional fee on top of the IMG's wages to hire them.<sup>142</sup> As a result, IMGs who go through recruitment agencies may be overlooked. In addition, recruitment agencies, as private businesses, are more likely to prioritise IMGs applying for registration via the [Competency pathway](#), as they tend to gain medical registration and secure employment more quickly than those applying via the [Standard pathway](#). This makes them more desirable candidates for medical recruitment agencies, as they are more likely to secure employment more quickly, generating higher revenue for recruitment agencies.<sup>143</sup>

## DoctorConnect

[DoctorConnect](#) provides information to IMGs and their employers. It aims to help IMGs understand the steps required to work as a doctor in Australia, including where they can work, and restrictions on billing patients under Medicare.<sup>144</sup> It also provides information on the incentives offered when working in regional, rural, and remote areas of Australia.<sup>145</sup>

The research provides information on five main topics:

- 1) Who can work in Australia?
- 2) Why work as a doctor in Australia?
- 3) What programs and support are available in my location?
- 4) Where can international medical graduates work?
- 5) International Medical Graduates and Medicare.<sup>146</sup>

The [DoctorConnect](#) website is an Australian Government initiative aimed at IMGs, employers, and those advising them.<sup>147</sup> [DoctorConnect](#) was developed by DoHA to support doctors trained outside of Australia and Australian medical employers. Its objective is to recruit appropriately qualified IMGs by providing an authoritative and accessible source of information on working as a doctor in Australia.<sup>148</sup>

## Monash International Medical Graduates Preparation Program

[Monash Health International Medical Graduate Preparation \(MiPreP\) Program](#) is a three-month course specifically designed for IMGs. The course is described as 'boutique', as it is only available to 12 participants at a time, intensive, and highly supported, with a dedicated senior doctor and medical education officer provided as part of the course.<sup>149</sup> The course is aimed at IMGs who are already in Australia, and who wish to enter the Australian medical workforce. It involves:

- two four-week clinical attachments as a MiPreP honorary HMO in emergency and general medicine/aged care
- two two-week intensive learning blocks.

The Monash Health International Medical Graduate Preparation costs \$ 8,000 (+10 per cent GST), and the entire fee must be paid upfront, with no refunds available under any circumstances.

## Current barriers faced by IMGs

Before arrival, the process for IMGs applying to practice medicine, obtain medical registration, and secure the appropriate visa in Australia is complex, time-consuming, costly, rigorous, and often confusing. The process involves numerous steps and requires strict adherence to the criteria and regulations prescribed by the [Australian Medical Council](#) (AMC) and the [Medical Board of Australia](#), followed by the successful securing of employment.

IMGs must first determine if they meet the eligibility criteria set by the AMC for the assessment process.<sup>150</sup> This often includes verifying medical qualifications, English language proficiency, and relevant work experience.<sup>151</sup> The AMC conducts primary source verification of the IMG's medical qualifications, which involves confirming the authenticity

of academic and professional credentials directly with the issuing institutions.<sup>152</sup> Depending on the IMG's qualifications and experience, they may need to undergo a competency-based assessment, as described above, which evaluates their medical knowledge, clinical skills, and professional attributes.<sup>153</sup> This assessment can include written examinations, clinical skills assessments, and structured interviews, all of which are costly, time-consuming and stressful.<sup>154</sup> Following this, IMGs must demonstrate proficiency in English by passing an approved [English language test](#), such as the [International English Language Testing System \(IELTS\)](#)<sup>155</sup> or the [Occupational English Test \(OET\)](#).<sup>156</sup> Following the successful completion of an approved English language test, IMGs may need to complete a period of supervised practice under the supervision of a registered medical practitioner in Australia.<sup>157</sup> Once the supervisory practice is completed, IMGs can apply for registration with the [Medical Board of Australia](#).<sup>158</sup> Registration requirements and timeframes may vary depending on the state or territory in which the IMG intends to practice.<sup>159</sup> IMGs will also need to obtain the necessary visa to live and work in Australia.<sup>160</sup> This may include applying for a temporary work visa or permanent residency through [Skilled migration program](#), in which case the visa is tied to the employer of the IMG.<sup>161</sup> Factors that exacerbate this process include the lack of a single portal to access necessary application information, which forces applicants to search through many different sources to access the requirements for the information. This can be extremely time-consuming and complex, as not all sources provide the correct information, causing the applicant to become trapped in documentative red tape.

Research cited in studies from Germany, Australia, and the United States have shown many IMGs experience workplace discrimination, marginalisation, and racism, which negatively impact their career progression.<sup>162,163,164</sup> Healthed's 2023 national survey of more than 1,800 GPs found more than one third (37 per cent) of IMGs in Australia reported experiencing racial/ethnic discrimination from patients in the past five years, while more than one quarter (26 per cent) reported experiencing racial/ethnic discrimination from colleagues within the same timeframe.<sup>165</sup>

Beyond this, many IMGs have reported feelings of isolation, and a lack of direct clinical supervision in medical settings.<sup>166</sup> This was further identified as a major issue in the [Kruk Review](#), where it was recommended Australia needs to “direct our scarce supervisory resources to where they are most needed and ensure they support health practitioners’ needs”.<sup>167</sup> A lack of support is particularly challenging for IMGs, as the majority are also adjusting to a new health system, which can be vastly different from the one in which they trained and worked, making it difficult to navigate and acclimatise.<sup>168</sup> This is made harder by having little to no professional support. While these issues are not new, with prior reforms, such as the [Lost in the Labyrinth](#) being published, little to no change has been achieved.<sup>169</sup> Similarly, many IMGs have reported experiencing cultural alienation and isolation, often finding themselves in highly challenging cultural environments.<sup>170</sup> In some cases, they are the only individual of their nationality within the community, further intensifying their sense of separation. This can be particularly confronting for IMGs who come from countries with strong cultural traditions, religious festivals, and celebrations, for example, observing Ramadan. Further barriers faced by IMGs — particularly those required by the moratorium to serve in remote Australia — include lack of job and career opportunities for their partner,<sup>171,172</sup> as well as limited access to suitable schools or childcare for their children.<sup>173,174</sup> For most IMGs, this situation forces them to choose between their career and the needs of their family, resulting in significant individual and family stress.<sup>175</sup> This situation reduces the willingness of IMGs to continue to work in rural and remote areas after completing the moratorium obligations.

A further additional complication is that, for most IMGs, their visa and work rights are tied to their employer. The [Temporary Work \(Skilled\) visa](#), or ‘subclass 482 visa’ (formerly subclass 457), allows skilled persons to come to Australia to work for an approved employer, accompanied by their immediate families, for a period of four years. Under these conditions, the employer-sponsored visa is tied to the employer who sponsored the visa.<sup>176</sup> Hence, the IMG can only legally work for that particular employer.<sup>177</sup> If they would like to work for a different employer, they need to undertake a complex process.<sup>178</sup> Because of this situation, anything that threatens their employment with that particular employer jeopardises their opportunities to continue living and working in Australia. This leaves IMGs vulnerable to exploitation and unfair working conditions, as they are unlikely to complain if they experience exploitation, due to the conditions of their visa. This is evident in individual stories from IMGs. Carly, an IMG who is on an independent pathway to RACGP fellowship, stated: “IMGs are scared to speak up about mistreatment from a practice because their visa is literally in their employer’s hands.”<sup>179</sup> Similarly, any negative reports from a supervisor could affect an individual’s temporary AHPRA registration and their road to fellowship.<sup>180</sup> IMGs fear their visa status might be in jeopardy if they report exploitation.<sup>181</sup> While recently changed penalties and courses of action exist for employers who fail to comply with sponsorship obligations — including being barred from future sponsorship arrangements, cancellation of sponsor approvals, civil penalties of up to \$118,800 with up to 2 years jail, and infringement notices for each failure, which attract civil penalties of up to \$79,200<sup>182</sup> — exploitation of IMGs remains prevalent due their fear of losing their visa, which leads to underreporting of such behaviour.<sup>183</sup>

These barriers negatively impact on the experiences of IMGs and their families. This is not in Australia's best interests, as we are — and will continue to be — heavily dependent on IMGs to provide the bulk of healthcare in Australia.

## What do other countries do to support IMGs? How does this differ to Australia?

Australia's comparable international peers in IMG recruitment have made significant improvements in attracting and recruiting medical doctors, by streamlining the process and reducing costs, all without compromising standards. As a result, these countries are now more attractive to IMGs than Australia. In response to the COVID-19 pandemic, a number of countries — including Canada, Ireland, New Zealand, and the United Kingdom — have implemented online medical registration application processes through online portals.<sup>184</sup> This allows overseas medical doctors to apply from their country of residence, reducing their costs by removing their need to travel to submit application documents in person.<sup>185</sup> Beyond this, the United Kingdom is developing an online app, enabling IMGs to verify their identity without the need to travel<sup>186,187</sup> again reducing unnecessary costs.

Comparable countries have also streamlined their regulatory frameworks, to reduce regulatory burden, and paperwork duplication. For example, New Zealand only requires that applicants provide a criminal history check if they have a serious criminal conviction or prescribed matter to disclose.<sup>188</sup> The United Kingdom has streamlined the process further by only requiring proof of English language proficiency for registration, removing it from the visa application, thereby reducing duplication and costs.<sup>189</sup> In contrast, the process of medical registration in Australia involves the duplication of documentation, including skills assessment, English language proficiency tests, criminal history checks, proof of identity, probity checks, credentialing, and onboarding as part of employment.<sup>190</sup> Regarding the English language proficiency tests, a separate English language competency assessment is required at both the registration and migration stages of an IMG's journey to Australia.<sup>191</sup> This duplication imposes unnecessary costs to IMGs, without raising patient standards or patients care. These initiatives by comparable countries streamline the medical application process, allowing it to be completed in a shorter timeframe, making these countries more attractive options for IMGs.

Other comparable countries have also streamlined and improved various aspects of the registration process for IMGs. For example, almost all supervision for IMGs in Canada is virtual,<sup>192</sup> and currently the United Kingdom is moving away from direct 'equivalence' of paper qualifications and shifting its focus toward clinical skills — specifically learning outcomes, practical abilities, and medical knowledge<sup>193</sup> — when assessing IMG applications and registrations.

Australia also has significantly higher migration costs compared to counterpart countries. For example, Canada, Ireland, New Zealand, and the United Kingdom offer lower-cost visas to IMGs.<sup>194</sup> In contrast, Australia's visa application charges are also higher than other countries. These costs continue to rise, with the latest increase on 1 July 2023.<sup>195</sup> Australia also recognises fewer overseas competent authorities for medical registration. Compared to Australia, which only recognises five competent authorities — Canada, Ireland, New Zealand, the United Kingdom and the United States)<sup>196</sup> — the United Kingdom recognises more than 30 jurisdictions, while Canada recognises eight.<sup>197</sup> Similarly, New Zealand accredits two competent authorities — Ireland and the United Kingdom — and 25 comparable health systems.<sup>198</sup>

Country specific reforms to streamline the registration process are summarised below.

### New Zealand:

- Introduced an online portal that enables healthcare professionals to search for jobs, receive guidance on registration and visa processes, and seek settlement support upon arrival.<sup>199</sup>
- Offers concierge services that help applicants find employment and accommodation and provide information on living and working in the country.<sup>200</sup>
- Offers lower-cost visas.

### Canada:

- Conducts all IMG supervision virtually.
- Offers lower-cost visas.
- Provides an online application process.

- Grants full registration to most qualified IMGs entering their health systems, allowing them to perform a broader range of procedures and roles sooner than in Australia.

### United Kingdom:

- Shifting away from direct 'equivalence' of qualifications, instead focusing on learning outcomes, skills, and medical knowledge.
- Offers lower-cost visas.
- Provides an online applications process.
- Currently developing an online app that enables IMGs to verify their identity offshore.
- Requires only one proof of English language proficiency test.
- Grants full registration to most qualified IMGs entering their health systems, allowing them to perform a broader range of procedures and roles sooner than in Australia.

## Australian doctors' perspective on IMGs

It is important to consider whether IMGs are filling positions or fellowship places which would otherwise go to Australian doctors, leaving less opportunities for Australian-trained doctors. During the 1980s, Australia experienced a surplus of doctors. Australia's doctor-to-patient ratio was high by international standards and too many GPs were working in metropolitan areas.<sup>201</sup> This surplus was largely blamed on an oversupply of IMGs.<sup>202</sup> As a result, Australia sought to reduce the number of IMGs migrating to Australia as either temporary workers or as permanent residents. The most effective measure for reducing IMG intake was implemented in 1992, restricting the rights of recently arrived IMGs — who were permanent residents of Australia and had passed AMC-accredited exams — to practice medicine.<sup>203</sup> Additional measures were introduced from the early 1990s to restrict IMGs working on temporary visas. These measures reduced the number of IMGs who were able to work in Australia, despite them being qualified to do so.

An additional requirement for IMGs was implemented in 1992. Candidates were required to re-sit the AMC CAT MCQ examination if they failed the AMC clinical examination within three successive attempts.<sup>204</sup> Before this, IMGs could fail the AMC clinical examination an unlimited amount of times without needing to re-sit the AMC CAT MCQ examination.<sup>205</sup> Furthermore, in 1992, the AMC imposed harsher requirements on IMGs by restricting the number of IMGs who could progress to the AMC clinical examination.<sup>206</sup> The proposal aimed to limit the number of IMGs eligible to undertake the AMC clinical examination to the top 200 performers in the AMC CAT MCQ examination, regardless of how many actually passed.<sup>207,208,209</sup> Furthermore, the AMC proposed a five-year timeframe in which IMGs had to pass both the AMC CAT MCQ and AMC clinical examination — while also ranking within the top 200) — a process which often took years.<sup>210</sup> In 1996, federal legislation was introduced under the [Health Insurance Act 1973](#), ensuring that even if permanent resident IMGs gained AMC registration, they were required to wait 10 years before being eligible to bill Medicare.<sup>211</sup> In Victoria, the Department of Employment Education and Training halted its subsidisation of courses designed to assist IMGs in preparing for the AMC MCQ CAT examination in the late 1980s.<sup>212</sup> In addition, a further assessment of English language competency was introduced in 1996, which was incorporated into the AMC clinical examination at the end of the pre-registration process.<sup>213</sup>

In 2016, the Department of Health and Aged Care called for 41 roles — including GPs, anaesthetists, cardiologists, paediatricians, general and specialist surgeons, and psychiatrists — to be removed from the [Skilled Occupation List \(SOL\)](#),<sup>214</sup> making it more challenging for overseas-trained doctors to obtain employment in Australia.<sup>215</sup> This policy was introduced in response to claims Australian-trained doctors were struggling to secure positions due to the high number of overseas-trained doctors.<sup>216</sup> Several studies and government reviews support this, demonstrating that Australia's approach to medical workforce planning over the past few decades has been dominated by the view that there are too many doctors,<sup>217,218,219</sup> with overseas-trained doctors largely being blamed.<sup>220,221</sup>

Over the past 15 years, Australia has been experiencing a doctor shortage due to past policy choices. This shortage is expected to worsen, as currently only one in seven medical graduates are choosing general practice as their preferred career — down from one in two just a few years ago.<sup>222</sup> Given the current medical workforce shortages and the burn-out many doctors are experiencing, it is likely that Australian doctors' views on IMGs have shifted. For example, Dr Janice Bell, Chief Executive Officer (CEO) of the Western Australian General Practice Education and Training (WAGPET), stated: "I'm very nervous turning off the tap of doctors coming from overseas... it could be tragic for many parts of WA."<sup>223</sup> Meanwhile, Dr Nicole Higgins, President of the Royal Australian College of General

Practitioners (RACGP), commented on workforce shortages, saying: “Rural and remote communities are particularly affected... but there is a simple solution to boost the numbers of GPs in the short-term: we can and should be doing much more to attract IMGs to Australia, and to support and retain them as valuable community members.”<sup>224</sup>

## Challenges faced by IMGs

IMGs face several challenges when adapting to the Australian healthcare system, including cultural differences, language barriers, and unfamiliar medical norms — particularly within Australian medico-legal frameworks. Adjusting to Australian cultural values and approaches to patient autonomy and shared decision-making can be difficult. The balance between patient autonomy, shared decision-making, and health system resourcing can vary significantly, even between similar countries. In Australia, where patient health literacy and healthcare resourcing are relatively strong, there is a high degree of emphasis on patient autonomy. Patients have the right to make informed decisions about their treatment, including the right to refuse treatment — even if their decision contradicts medical advice or results in suboptimal outcomes. However, patients cannot insist on doctors performing futile treatments or treatments with unacceptable risks. When patients request treatments that are either harmful to them or futile, the treating doctors must have the skills and understanding to explain the situation and why they cannot offer these treatments. IMGs may find it challenging to navigate situations where patients refuse life-saving interventions or request treatments considered futile, especially if they have not received appropriate induction and training. Doctors must possess the expertise and communication skills to effectively explain situations where patients request treatments that are harmful, futile, or pose an unacceptable level of risk.

## Australia’s ethical and moral considerations in recruiting IMGs

The continued recruitment of IMGs to solve Australia’s medical workforce shortages raises both ethical and moral considerations. While Australia sources IMGs from many countries, the majority are recruited from India, the United Kingdom, and South Africa<sup>225</sup> — countries which are also experiencing significant medical workforce shortages.<sup>226,227,228</sup> The majority of Australia’s IMGs are recruited from India,<sup>229</sup> a developing country with a population of more than a billion people and a shortage of more than 600,000 doctors.<sup>230</sup> This situation raises the question of whether Australia’s reliance on IMGs is consistent with Australia’s obligations as a responsible global citizen, particularly as Australia has the ability to train doctors domestically through its world-class medical education system.<sup>231</sup> It is broadly considered that the National Health Service (NHS) in the United Kingdom is breaking as Australia continues to poach its doctors. This raises the question of whether this action is consistent with our responsibilities as a global citizen and how the recruitment of IMGs must acknowledge the broader global context. However, it is important to note that IMGs choose to move to and practice in Australia for many reasons, including:

- fleeing war and persecution
- escaping the suppression of individual rights, particularly of female doctors
- seeking opportunities for better pay, career advancement, and education, both for themselves and their children
- seeking to work in better health systems<sup>232</sup>
- improving overall life prospects for themselves and/or their family<sup>233</sup>
- leaving broken health systems in other countries — for example, British doctors leaving the NHS, with the British Medical Association (BMA) describing them as “underpaid, underappreciated, and under pressure”.<sup>234</sup>

The decision for IMGs to live and work in Australia must therefore be weighed against the impact their recruitment will have on their home countries.

## The need for a data registry for Australia’s IMGs

There is currently insufficient data available to make detailed system-wide decisions. The AMA has been working with AHPRA for a year to develop a data report which can be published to improve our understanding in this significant workforce area. Despite our best efforts, AHPRA has not had sufficient resourcing over the past 12 months to make this data or report available. There needs to be a greater priority placed on this vital area of our health workforce.

Such a repository of data would ensure important information is accurately recorded and readily accessible. This initiative is closely linked to the broader need for a dedicated authority, Health Workforce Australia, which would oversee the strategic planning and management of the Australian healthcare workforce. By centralising data and resources, Health Workforce Australia could facilitate more responsive and effective workforce planning, addressing the growing demand for healthcare professionals in a timely manner. The current system's indolence not only hampers the timely deployment of qualified IMGs but also exacerbates workforce shortages. A robust data registry, supported by a co-ordinated health workforce strategy, is crucial to optimising the utilisation of IMGs and enhancing the overall efficiency and responsiveness of Australia's healthcare system.

## Next steps

While the contribution of IMGs in Australia is recognised, the current barriers and supports do not reflect their contribution. In particular, the convoluted, costly, and complex application process, as well as the unnecessary red tape and document duplication, need urgent reform. IMGs must be able to make the decision to work in Australia based on full and accurate information relating to the position to be filled and other conditions which may affect their work, life, and living conditions. This is currently not the case. These redundant and counterproductive barriers should be identified, and measures should be taken to streamline and improve them. This will not only improve the overall IMG experience, but also the Australian health system more broadly. Furthermore, as stated above, these improvements are in Australia's best interest, as our current reliance on IMGs is only expected to increase. To ensure Australia's future healthcare needs are catered for, Australia needs to remain an attractive destination for IMGs and their families. Australia must replicate the improvements made by other countries to remain competitive.

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