LICENSING AND REGISTRATION OF INTERNATIONAL MEDICAL GRADUATES (IMGs) IN CANADA AND AUSTRALIA: AN EXPLORATIVE STUDY

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ABSTRACT

Canadian and Australian licensing and registration policies regarding International Medical Graduates (IMGs) display some noticeable similarities and differences. Both receiving countries verify IMGs educational credentials, medical training, and language proficiency, apply examinations assessing the skills of this group of foreign trained doctors and tend to place IMGs in underserviced areas responding to health care workforce shortages. However, the Australian nationally regulated, focused on specific labour market needs approach to registration allows IMGs to use various pathways to registration. IMGs who enter Australia utilizing different immigration options have to be registered by the designated registration bodies and, in most cases, to have a verified offer of employment before they are granted visas by the immigration authorities. Consequently, they can start practicing medicine right after their arrival. On the contrary, their Canadian counterparts begin their licensing process only after they enter Canada as permanent residents. The urgent need for nationally consistent, pragmatic and flexible approach to licensing of foreign trained doctors in this country is emphasized.

Key words: licensing, registration, IMGs, Canada, Australia

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INTRODUCTION

The explicit objectives of Canadian and Australian licensing and registration policies in regards to International Medical Graduates (IMGs) vary remarkably. Licensing of foreign trained medical practitioners is not regulated or coordinated on the national level in Canada. Rather, the provincial and territorial licensing bodies are responsible for licensing of IMGs. The Canadian approach to licensing of foreign trained immigrant doctors stipulates that IMGs have to meet all requirements established by the Canadian licensing bodies in order to be allowed to practice medicine in this country. Meeting the Canadian standards is rationalized by the public safety concerns. The national labour market needs of the health care sector are not underlined.

On the contrary, the Australian nationally regulated and coordinated registration policies in relation to IMGs are focused on addressing the current specific labour market needs mostly in designated regions of the country. Not discharging the importance of proper medical education and training in connection with public safety concerns the Australian policy- makers prioritize the health care labour market needs in underserviced areas of this receiving country pragmatically utilizing IMGs to reach their objective. It has also been claimed that Canadian and Australian licensing and registration policies share some common patterns in regards to the assessment and evaluation of educational credentials and medical training of the studied group of medical practitioners (McGrath, Henderson, & Phillips, 2009).

This paper examines similarities and differences, convergence and divergence in contemporary Canadian and Australian licensing and registration policies concerning the studied group of immigrant professionals.

Part 1 provides a brief historical overview of Canadian and Australian selection policies in regards to highly skilled immigrants. The history of immigration of foreign trained doctors to the studied receiving countries is briefly presented in Part 2. Part 3 reviews the main contemporary features of Canadian and Australian licensing and registration policies of IMGs. The discussion and conclusions segment of the paper compares and contrasts similarities and differences of the studied policies and states various implications concerning Canadian and Australian approaches to licensing and registration of foreign trained doctors utilized by the studied countries of immigration. Policy related conclusions and some recommendation for policy improvements are also provided.

Part 1: Selection of Skilled Migrants: A Brief Historical Overview

Canada

Selection of Skilled Migrants in the1960s

It has been accentuated that the 1962 regulations can be considered as the first step towards non-discriminatory immigration policies (Boyd, 1976; Ferrer, Picot, Ridell, 2014; Kelley & Trebilcock, 2010; Troper, 1993; Walsh, 2008). The assessment of the applicants was conducted by an immigration officer. Migrants who could demonstrate the acquisition of appropriate education, vocational training and relevant skills were allowed to enter Canada as permanent residents. It has been emphasized that despite some official guidance outlined in the Immigration Counseling Handbook, for instance, immigration officials often used their discretionary power granting admission to skilled migrants (Kelley & Trebilcock, 2010). The White Paper of 1966 was commissioned by the federal Liberal government. Decreasing the number of family sponsored immigrants and focusing on the selection and admission of economic or independent migrants has been proposed by the above mentioned study (Boyd, 1976; Kelley & Trebilcock, 2010; Troper, 1993; Walsh, 2008).

In 1967 the first Canadian formalized system of selection of skilled immigrants was introduced (Kelley & Trebilcock, 2010). It has been argued that explicit indicators of racial discrimination have been eliminated from the selection process. The new selection system put emphasis on skills and educational credentials of future Canadian residents. The selection of applicants was conducted applying a point system in connection to short and long term factors. Age, education, training, occupations in demand, fluency in one of the official languages, relatives residing in Canada as well as prearranged employment in

this country were some of the criteria utilized during the selection process (Boyd, 1976; Ferrer et al., 2014; Kelley & Trebilcock, 2010; Troper, 1993; Walsh, 2008). Potential permanent residents were required to be personally assessed by an immigration official during face-to-face interviews at Canadian embassies abroad. The newly introduced selection system of skilled migrants did not specify how many individuals should be selected each year. The country of origin of future Canadian permanent residents was not considered a selection factor (Boyd, 1976; Kelley & Trebilcock, 2010; Walsh, 2008).

It has been noted that politicians, special interest groups, ethnic and church organizations, academics, the media as well as labour and agricultural organizations and members of the business community along with ordinary Canadian citizens took part in the immigration debates of the late 60s of the last century (Kelley & Trebilcock, 2010). Almost all parties that participated in the discussion (except for labour and agricultural organizations and members of the business community) presented themselves as proponents of unscreened family sponsorship. Labour and agricultural organizations were not so eager to support the proposition made by the White Paper of 1966 regarding the emphasis on selection and admission of independent or economic migrants (Kelley & Trebilcock, 2010). The leadership of the Canadian business community showed its strong support for the proposed increased admission of highly skilled immigrants. It has been underlined that such government departments as the Department of Citizenship and Immigration and the Department of Labour had quite different views in regards to the selection of skilled labour. The Department of Citizenship and Immigration argued that adaptability, age, educational credentials, and professional training of prospective immigrants should become a priority of the new selection system. On the other hand, the

federal Department of Labour suggested that the condition of the current labour market should be reflected in the selection system of that particular category of immigrants. It has been outlined that Canadian business leaders supported the position of the Department of Citizenship and Immigration. The Department of Labour's perspective was actively promoted by the members of organized labour groups. Somehow, the consensus was reached, and the 1967 selection system reflected both of the above identified approaches (Kelley & Trebilcock, 2010).

It has been pointed out that the selection system of 1967 was supported by all political parties and the majority of interest groups which took part in the immigration debates in this historical period (Kelley & Trebilcock, 2010). It has been argued that despite some changes in the composition of economic immigrants, many potential applicants from developing countries were disqualified from admission to Canada due to the increased weight of educational credentials and professional or occupational skills in the introduced selection system (Kelley & Trebilcock, 2010; Walsh, 2008). It has also been claimed that lack of Canadian visa offices in many developing countries made it problematic for skilled immigrants from these countries to benefit from the new Canadian selection system (Kelley & Trebilcock, 2010).

Selection of Skilled Migrants in the1970s

The Green Paper of 1967 was rather critical of the Canadian immigration policy of the time (Kelley & Trebilcock, 2010). According to this particular study, the growth of Canadian population correlated with negative consequences of increased urbanization and the decline of francophone population. The Green Paper presented immigrants to Canada as the cause of the stated problems. The authors of the Green Paper

recommended that the level of immigration should be connected to the national labour market needs and the immigrants had to be resettled outside of major Canadian metropolitan cities. Despite the rejection of these recommendations during the broad range of debates, some changes to the Canadian point system were suggested. The most important change was related to the implementation of a global quota for the total number of immigrants who were granted permission to come to Canada in a particular year (Kelley & Trebilcock, 2010; Troper, 1993). The officials from the immigration department would be allowed to decide on the annual quota adjusting the numbers in collaboration with the provinces. The final annual quota was supposed to be approved by the House of Commons. The global economic crisis of the 70s manifested itself in some additional changes to the Canadian selection system of skilled migrants. In 1974, all potential independent immigrants had to have a formal job offer in order to be granted permission to come to Canada (Boyd, 1976; Kelley & Trebilcock, 2010). The new Immigration Act of 1976 which was supported by almost all political parties, media, interest groups and academics came into force in 1978. Consequently, the Canadian selection system was altered highlighting practical training, experience, and occupation in demand of potential independent immigrants (Kelley & Trebilcock, 2010).

Selection of Skilled Migrants in the 1980s and 1990s

Since 1982, all independent immigrants were required to have a guarantee of pre-arranged employment in particular areas of the national labour market where Canadian permanent residents did not want to be employed. Prospective employers were required to prove that they could not find any Canadian workers to perform the job. This policy has been in place till 1986 (Green & Green, 2004).

In the early 90s the federal government proposed raising the number of immigrants who arrive to Canada on an annual basis to 250,000 by the year of 1992. The list of designated occupations regarding skilled migration was also introduced (Green & Green, 2004; Kelley & Trebilcock, 2010). It has been suggested that immigration policies of this particular period can be characterized by the increased weight put on education and sophisticated professional or occupational skills in regards to the selection approach of skilled migrants (Koslowski, 2014; Simmons, 1994). This level of immigration was supposed to be sustained until 1995. It has been claimed that regardless of the economic recession, the increase in immigration has been supported by all political parties. However, the number of immigrants accepted every year was reduced to 200,000 in 1995 (Kelley & Trebilcock, 2010). It has been argued that the Canadian government decided to reduce the admission of immigrants in order to lessen the rising ethnic tensions in the cities, to trim down expenditures related to immigration, and to respond to the assertions that some migrants can be associated with increased crime rates in Canada (Simmons, 1994). In the same year, the permanent residence fee was introduced in the sum of $975 (Kelley & Trebilcock, 2010). The Canadian selection system of this particular historical period focused on target ranges of economic migrants and did not specify actual numbers of immigrants who would be admitted. By the end of the decade, the Canadian selection system made a move from the selection approach which was based mostly on the occupational characteristics of the potential immigrants towards the human capital model rewarding applicants for their educational credentials, knowledge of official languages, adaptability, and professional experience in any skilled occupation (Ferrer et al., 2014; Koslowski, 2014).

Selection of Skilled Migrants in the early to the mid 2000s

The first decade of the 21st century brought noteworthy changes to the Canadian selection system of skilled labour. By the mid 2000s the Canadian selection system could not be longer identified as a human capital model (Boyd, 2014). In 2008, only applications of economic migrants who had at least one year of professional experience in specified occupations in demand, could prove that they had a verifiable job offer, or already have been employed or studied in Canada were processed (Boyd, 2014; Ferrer et al., 2014).

Since June 2010, the federal Conservative government reduced the number of applications of skilled migrants to 20,000 per year. Only 1,000 applications for each occupation in demand were processed each year (Koslowski, 2014). From this time on, all economic immigrants were required to go through mandatory pre-migration language testing. More restrictions came into force in 2013. Only applications of independent immigrants who could demonstrate that they had at least one year of work experience in one of the 24 specified occupations, or an approved job offer, or were eligible to make their application using the PhD stream were considered (Boyd, 2014; Koslowski, 2014).

A new Express Entry selection system of economic immigrants waas introduced in January of 2015 (Akbari & MacDonald, 2014; Ibbitson, 2014; McDonald, 2015). Potential economic migrants were required to complete an online Express Entry profile stating their educational credentials, language competency, work experience, and some other qualifications, creating a pool of candidates. These applications were evaluated by the immigration officials and the candidates with the best matching qualifications were allowed to apply for permanent residence. The non-selected applications were supposed

to be deleted from the pool after one year. Immigration authorities have claimed that the approved applications would be processed within a 6-month period (Boyd, 2014; Ibbitson, 2014).

It has been highlighted that by the mid 2000s, the number of unprocessed applications in the economic class category reached 500,000 and the estimated processing time was between 5 and 6 years (Koslowski, 2014). By the year 2008, (2 years after the federal Conservatives won the election) the number of applications which were not processed increased to 1 million (Koslowski, 2014). Considering that the federal Liberal party was in power till 2006, both main political players in this country failed to adequately address the issue of a rather noticeable application backlog.

Australia

Selection of Skilled Migrants in the 1970s and 1980s

The selection system of skilled migrants in Australia has been formalized since 1973 (Richmond & Rao, 1976; Walsh, 2008). The new admission requirements of potential immigrants did not contain any reference to any racial or ethnic criteria (McDonald, 2015; Ongley, 1995; Richmond & Rao, 1976; Walsh, 2008). It has been suggested that due to the development of political and economic ties between Australia and some Asian countries, a non-discriminatory immigration policy has been adopted (Cobb-Clark & Connolly, 1997). It has been claimed that the new Australian selection system has been modeled on the Canadian point selection system of 1967 (Cobb-Clark & Connolly, 1997; Ongley, 1995; Walsh, 2008). The Australian selection policies of the 70s addressed the need for skilled migration associated with the national economic development. Economic migrants with educational credentials and professional

qualifications related to the demand occupations in Australia were prioritized (Richmond & Rao, 1976; Walsh, 2008). In 1979, the Australian selection system of skilled migrants started to use numerical weightings for all the factors in the selection system (Ongley, 1995; Walsh, 2008). It has been suggested that the focus on language proficiency and the limited number of defined occupations in demand were beneficial for economic immigrants from traditional source countries (Ongley, 1995; Walsh, 2008).

Selection of Skilled Migrants in the 1990s

It has been claimed that the Australian selection system of economic immigrants embraced (for a rather short period of time in the early 90s) the Canadian human capital model of selection of economic immigrants (Koslowski, 2014). It has been pointed out that the selection and admission of economic immigrants should be based on their ability to contribute to the economic development and well-being of Australia (Cobb-Clark & Connolly, 1997). In 1996 the selection of economic immigrants based on the occupational skills specific approach and labour market assessment has made its return. The screening of the educational and professional credentials of economic immigrants has been enhanced and language testing before immigration was introduced. The consultations between the Australian government and industry and labour groups were utilized to establish which immigrant skills were in demand by the Australian national labour market (Koslowski, 2014).

In the late 90s, the selection system of economic immigrants has become even more rigid. Principal applicants who were assessed as being at risk of unemployment in Australia have been denied permission to come at the point of entry by the immigration officials. The official language testing has been required of immigrants from the family-

skilled categories, and the assessment of educational and professional credentials of economic migrants has become mandatory (Clarke & Skuterud, 2014). The process of redistribution of selection points regarding each selection factor has been put in place. More points were allocated for occupations in demand and university education related to specific professional fields. Principal applicants with Australian or international experience or with a verifiable job offer (occupations in demand only) started to receive more selection points. Principal applicants who were older than 45 years of age experienced point reduction. It has been suggested that the historical period of the late 90s in Australian immigration policies can be characterized by the introduction of a formal credential recognition system and the rejection of the human capital model of the selection of economic immigrants (Clarke & Skuterud, 2014; Hawthorne, 2008).

Selection of Skilled Migrants in the early to the mid 2000s

Koslowski (2014) argues that since the early 2000s the Australian selection system of economic immigrants might be defined as a neo-corporatist model. The Australian immigration officials were still using a point system as a tool of selecting economic immigrants but with intensive consultations with business leaders and labour groups (Koslowski, 2014). The skilled occupations list was developed by the Department of Immigration and Citizenship after consultations with employers and labour unions considering the needs of the national labour market in each particular sector (Koslowski, 2014; McDonald, 2015). The number of selection points required to enter Australia utilizing this particular immigration option has been bound to the conditions and needs of the national labour market. Koslowski (2014) emphasizes that Australian labour and business leaders were pressured by global markets to combine forces and assist the

Australian government in managing skilled migration in order to improve national economic competitiveness. Since July 2011, the principal applicants should have work experience in occupations on the skilled occupations list just to be considered for the processing. Since July 2012, all skilled migrants have to submit an expression of interest using the SkillSelect online system (Koslowski, 2014). Their qualifications are reviewed by the immigration officials. Only suitable candidates can submit an application for permanent residency. Skilled immigrants who are selected by their potential employers enjoy preferential treatment in the process of the evaluation of applications (Koslowski, 2014).

Part 2: History of Immigration of Foreign Trained Doctors to Canada and Australia

Canada

Historically, most immigrant international medical graduates (IMGs) came to Canada from Commonwealth countries such as Britain, South Africa or Ireland with similar and long-established professional accreditation and licensure requirements (Neiterman & Bourgeault, 2012). In the 60s and the 70s of the last century, majority of Canadian physicians went abroad to receive their education (Neiterman & Bourgeault, 2012). In the 1960s, 1,500 IMGs, mostly from the UK or Ireland, immigrated to Canada each year. The UK and Ireland medical education systems have been recognized as compatible with Canadian medical education and training (Dauphinee, 2007). It has been suggested that perceived shortages of the medical workforce led to the increased recruitment of IMGs. From the 1950s to the middle of 1970s many Canadian jurisdictions actively recruited foreign trained doctors. It has been noted that 10,000 immigrant medical practitioners have been licensed in Canada in that period which exceeded the number of Canadian medical graduates at that time. The point selection system which was introduced in 1967 considered IMGs as the most desirable applicants and defined medicine as a high demand occupation. Accordingly, the numbers of foreign trained doctors who utilized the new selection system of skilled migrants increased dramatically (Mullay &Wright, 2007). On the contrary, perceived surplus of medical professionals in this country resulted in the limitations and decreased immigration of IMGs to Canada (Bourgeault & Baumann, 2011). Opening of more medical schools in the late 70s and the growing concerns about health care costs corresponded with the assumed surplus of physicians. This situation has been reflected in the Canadian immigration approach. The

number of points in the occupational ranking for internationally trained physicians was reduced from 15 points to no points at all (Neiterman & Bourgeault, 2012). The Canadian immigration policies of the 1980s and 1990s made it even more problematic for principal applicants who wanted to come to Canada as physicians to succeed in their application process (Campbell-Page et al., 2013).

Before 1993, IMGs who had studied medicine in the United States, Great Britain, Ireland, Australia, New Zealand, or South Africa were often exempted from postgraduate training. IMGs from all other countries had to complete some additional postgraduate training in this country. This categorization of IMGs was terminated in 1993, and now all applicants who intend to receive full registration are required to complete at least two years of postgraduate training in Canada (IEHP Report, 2010).

The new Immigration and Refugee Protection Act of 2002 which emphasized skills, training, and integration potential encouraged immigrant IMGs to identify themselves as medical professionals during the application process in order to facilitate their entry into this receiving country (Foster, 2008; Neiterman & Bourgeault, 2012). Recently, foreign trained medical practitioners immigrated to Canada from a wide range of Asian, Middle Eastern, African and Eastern European countries (Dauphinee, 2007; Foster, 2008; Neiterman & Bourgeault, 2012; Walsh et al., 2011**).** It has been argued that the profiles of recently arrived immigrant IMGs vary in regards to the duration, content, and process of medical training and clinical experience, and interpersonal competencies (Walsh et al., 2011). Nevertheless, Canada still relies heavily on international medical graduates. Since the late 1960s, the proportion of foreign trained doctors in the physicians' segment of the Canadian health care workforce fluctuated between 20% and

30% (Crutcher & Mann, 2007). The number of licensed IMGs increased significantly from 1970s (6,000 licensed IMGs) to 2006 (almost 14,000 licensed IMGs). In 2008, the majority of licensed IMGs were from the United Kingdom (2,531), South Africa (2,112), India (1,477), and Ireland (1,058). It has been highlighted that there is a considerable dissimilarity in relation to some educational and demographic identifiers of already licensed IMGs and IMGs who currently immigrate to Canada (Bourgeault & Baumann, 2011). In 1995, 35% of foreign trained doctors received their medical education in the UK or Ireland. In 2000, only 5% of foreign trained doctors obtained their medical qualifications in the mentioned countries. A reversed trend was detected for medical practitioners from South Africa. In 1995, 9% of immigrant doctors received their medical education at South African medical schools. In 2000, 24% of foreign trained doctors received their medical education in South Africa (Bourgeault, 2007).

It has been proposed that the overall proportion of IMGs in the Canadian health care workforce has decreased from 33% in the 1970s to 23% in 2000s due (to some extent) to lack of residency training spaces (Bourgeault, 2007).

Since January 2015, IMGs who intend to immigrate to Canada as principal applicants have to meet a number of requirements of the recently introduced selection system. The new immigration rules apply to all skilled migrants including those who are required to be licensed / registered by the corresponding licensing and accreditation bodies before they can work as professionals in this country (http://www.cic.gc.ca).

Australia

The first immigrant doctors arrived in Australia with the First Fleet. There were not any medical schools in Australia until 1868 and until the 20th century all Australian

doctors were trained in the UK and Ireland. It has been claimed that some of these doctors had no or little medical training and often used questionable clinical practices such as blood-letting, purging, and restraining (Iredale, 2009).

During the World War I, immigrant doctors experienced xenophobic prejudice and intolerance being labeled as outsiders by the established Australian medical community. In the 1930s, Jewish refugee doctors from Germany, Austria, Russia, and Poland were refused registration and had to complete 3 years of additional training at Australian medical schools (Iredale, 2009). Immigrant Jewish doctors were permitted to enter Australia only if they could demonstrate sufficient financial means. However, it did not make their registration process any easier and only few of them succeeded in the registration process and were able to practice medicine (Iredale, 2010). The approach to registration of foreign trained doctors in the 1930s was rather remarkable considering that only 4 medical schools existed in Australia by 1938, and there was a public outcry regarding the shortage of medical practitioners.

Noticeable shortages of medical practitioners defined the state of the Australian health care workforce in the 1950s-60s (Iredale, 2010). In 1955, The NSW Medical Practitioners Act of 1938 was amended and some foreign trained doctors from Commonwealth countries were allowed to apply for temporary registration. These immigrant doctors were granted permission to practice medicine in specified hospitals and locations for a very limited time (12 months, for instance). Immigrant doctors were allowed to apply for full registration after 5 years of practicing medicine with temporary registration status (Iredale, 2009). In 1957, some regional health authorities increased the number of doctors who were eligible for temporary registration. The members of the

Australian Medical Association were opposed to the amendments and launched a public campaign presenting foreign trained doctors as poorly trained and incompetent with questionable standards of medical ethics (Iredale, 2009). The established members of the Australian medical community also claimed that it was unacceptable that immigrant doctors competed with Australian doctors who, allegedly, practiced medicine at the highest standards. It is noteworthy that the majority of immigrant doctors who entered Australia as Displayed Persons (DP) from the Baltic states after World War II were specialists, and Australian general practitioners perceived them as a threat. It has to be pointed out that the Australian Medical Association did not object to the appointments of the DP doctors in locations with challenging work conditions and limited financial compensation (Iredale, 2009; 2010).

In the 1960s, ongoing doctor shortages led to the increase in the numbers of foreign trained medical practitioners. In the middle of 1970s, debates regarding an oversupply of doctors took place again (Iredale, 2009). The members of the AMA argued that the Australian government should limit the number of training spaces and curtail the immigration of foreign trained medical professionals. In order to assess the skills of foreign trained doctors (including general practitioners and specialists) a national examination was introduced in 1978. This examination consisted of an English language test, a multiple questions test, as well as a clinical segment. However, regional registration authorities had the power to exempt foreign trained doctors who possessed recognizable qualifications from these examinations. Some local authorities recognized qualifications of foreign trained doctors from major English speaking countries as well as countries, such as Pakistan, Lebanon, Uganda, etc.

In 1992, responding to the presumed oversupply of doctors, the Health Minister's Conference decided to implement some strategies to limit the number of foreign trained doctors entering Australia as temporary or permanent residents (Bourgeault, Parpia, Neiterman, Le Blanc, & Jablonski, 2011; Iredale, 2009). A quota system was introduced in order to decrease the number of overseas trained medical practitioners who would be eligible to apply for registration each year after they successfully passed the AMC examination. Only one hundred registration places were allocated to all foreign trained doctors. The Australian immigration authorities began deducting points from the point scores of immigrant doctors applying to enter Australia as skilled migrants. The number of deducted points increased from 10 to 25. Therefore, the selection process has become even more challenging for foreign trained doctors who wanted to enter Australia utilizing that particular immigration option. These policies, which did limit the immigration of foreign trained doctors, were supported by the members of the Australian Medical Association (Bourgeault et al., 2011). At the same time, the suggestion to eliminate temporary work visas for foreign trained doctors did not come to life and immigration of medical practitioners as temporary migrants continued and even increased by 42% by the middle of 1990s (Han, 2010; Iredale, 2009). The state authorities even provided some assistance in organizing rural recruitment agencies to recruit foreign trained doctors as temporary workers to fill vacant positions in underserviced areas (Birrell & Hawthorne, 2004; Bourgeault et al.).

Temporary residents IMGs who were able to practice medicine in Australia under conditional registration had to deal with a 10-year moratorium on charging Medicare for their services (Han, 2010). However, in 2000s, a five-year scheme was introduced

allowing temporary residents IMGs to enjoy the financial benefits of Medicare and apply for permanent residence after they worked in the area of need at least for 5 years (Birrell & Hawthorne, 2004).

The dissatisfaction of permanent residents IMGs who were unable to secure registration and were ultimately out of the Australian health care workforce for years (taking into account that temporary residents IMGs were allowed to practice medicine under conditional registration in designated areas immediately after their arrival in Australia) manifested itself in hunger strikes in Melbourne, Canberra, and Sydney in 1996-97 (Iredale, 2009). Similar permanent residents IMGs hunger strikes also took place in December of 1997 and February of 1999 (Han, 2010).

The Australian approach to immigration of medical practitioners in the 2000s resulted in a significant increase in the numbers of foreign trained doctors who entered Australia using temporary work visas and were required to work in the area of needs (AoN) or Districts of Workforce Shortage positions. Temporary residents IMGs arrived to Australia from 27 countries. Such countries as the UK, Ireland, and India have been major sources of medical migration (Iredale, 2009). In the late 90s-early 2000s, foreign trained doctors could not enter Australia as principal applicants using skilled migration option and immigrated to Australia as dependents of skilled migrants, family members or refugees (Birrell, 2004). Only since 2004 have foreign trained medical practitioners been allowed to enter Australia as skilled migrants (Birrell & Hawthorne, 2004).

The Australian dependence on IMGs was rather evident in the first two decades of this century. Almost half of Australians with medical qualifications were not born in Australia (Hawthorne, 2015). 25% of Australian medical practitioners were trained in

other countries. From 2001 to 2006, 7,596 foreign trained doctors came to Australia using various immigration options comparing with about 4,000 foreign trained doctors who were granted visas from 1996 to 2000 (Hawthorne, 2011b). From 2005 to 2010, the majority of health professionals who entered Australia as general skilled migrants came from the UK (4,120), India (1,510), Malaysia (1,300), China (970), the Philippines (510), South Africa (500), Republic of Korea (480), Egypt (420), Singapore (390), and Ireland (350). Health professionals who arrived in Australia in the same time period utilizing 457 Long-Stay Business Visa were from the UK (9,350), India (6,420), the Philippines (1,850), South Africa (1,770), Malaysia (1,570), Ireland (1,560), China (1,380), Zimbabwe (1,180), Canada (950), and the US (830) (Hawthorne, 2011b). From 2009 to 2014, 26% of medical practitioners who entered Australia as skilled category permanent migrant primary applicants were residents of United Kingdom (Hawthorne, 2015). The stated data clearly shows that the major source of general skilled and temporary migration of medical practitioners was still the UK with India coming a distant second in both categories. These trends continued in 2014. 4,719 medical professionals have been granted visas as permanent skilled migrants in comparison with 1,935 permanent skilled visas which were issued by Australian immigration authorities in 2008-09 (Hawthorne, 2015). In 2014, 8,120 foreign trained health professionals were granted temporary 457 Long-Stay Business Visa. In contrast, in 2008-09, only 2,780 immigrant health professionals were granted the same type of visas (Hawthorne, 2015).

Part 3: Licensing and Registration of International Medical Graduates (IMGs) Canada

Becoming a Medical Practitioner: General Requirements

There are certain qualifications which a medical professional has to possess in order to obtain a full license in Canada: a medical degree from an approved university, successful completion of two years of residency training, the Licenciate of the Medical Council of Canada (LMCC), and certification provided by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada (RCPSC) (Campbell-Page et al., 2013).

Provincial and Territorial Medical Regulatory Authorities (MRAs)

Provincial and territorial MRAs take responsibility for the registration and licensing of physicians in Canada. The assessment process is implemented in order to establish a physician's knowledge, clinical skills as well as to determine reasoning abilities and appropriate professional behaviours mandatory for safe practice in this country (Walsh et al., 2011).

How Immigrant IMGs Can Become Medical Practitioners in Canada

All IMGs have to confirm that their medical degrees are from medical schools recognized by the Medical Council of Canada (MCC). The MCC is responsible for determining the authenticity of IMGs qualifications. However, the Canadian Information Centre for International Credentials indicates that provincial/territorial regulatory authorities assess IMG qualifications and issue a license to practice**.** In order to obtain a license to practice or a certificate of qualification, IMGs might have to take examinations to test their knowledge and competencies, provide prove of language proficiency, and

undergo a criminal record check. They might be required to complete a Canadian work placement or practicum, take an orientation course or a bridging program (http://www.cicic.ca).

Recognized Medical Degrees

IMGs can use the International Medical Education Directory (IMDE) to find out if their medical degrees are from recognized medical schools (http://www.cicic.ca). Not every medical school is recognized by the Medical Council of Canada. If a particular school in the source country is not recognized by the MCC, an immigrant IMG is prevented from obtaining his/her license to practice medicine in Canada at the very beginning.

Examinations

There are a number of examinations that IMGs are required to take in order to obtain a license to practice medicine in Canada. The Medical Council of Canada Evaluating Examination (MCCEE) might be taken before arriving in Canada at 500 centres in 80 countries worldwide. However, the National Assessment Collaboration examination (NAC) is administered only in Canada and cannot be taken before the IMGs successfully pass the MCCEE. The IMGs may also be required to pass the Medical Council of Canada Qualifying Examination (MCCQE) Part 1 and Part 2, which are administered only in Canada (http://www.mcc.ca/examinations/mccee). Family physicians have to pass the College of Family Physicians of Canada Certification Exam. Medical specialists have to pass the Royal College of Physicians and Surgeons of Canada Certification Exam (IEHP Report, 2010).

It has been argued that testing as a vital segment of professional licensure and certification might be applied as a toll and a structural barrier to include or exclude internationally educated professionals from practicing their regulated professions in Canada (Cheng, Spaling, & Song, 2013).

Medical Council of Canada Evaluating Examination (MCCEE)

Only 7 countries in Africa have prometric centres that offer this type of examination. Not every country in Europe has such testing facilities. Such major source countries as China and India have 13 and 10 prometric centres respectively. In contrast, the United States has 340 prometric centres for this type of examination. To take the MCCEE, an IMG needs to apply in advance for a particular session, only 4-5 sessions are offered each year. The results are available in approximately 7 weeks after the last day of the examination. The examination fee is $1,695 which might be challenging for many immigrant doctors from developing countries (http://www.mcc.ca/examinations/mccee).

It has been stressed that the pass rate of IMGs on this examination was only 65% in 2006. Many IMGs complain that this particular test is designed for young Canadian medical graduates and not for foreign- trained doctors who have usually practiced in the field for many years (IEHP Report, 2010).

National Assessment Collaboration Examination (NAC)

The NAC examination evaluates the IMGs readiness for a Canadian residency program. It is a national standardized examination accepted by the residency program directors regardless of the location of the examination. It is conducted two times per year and costs $ 2,309. The results are available in approximately two months after the examination day. In order to take this examination, the IMGs have to apply in advance.

Even if an IMG receives a pass standing on the NAC, a training position is not guaranteed (http:www.mcc.ca/examinations/nac-overview/).

Medical Council of Canada Qualifying Examination (MCCQE) Part 1

This one-day, computer-based test evaluates the competence of candidates for entry into supervised clinical practice in post-graduate training programs. It is offered two times per year. The applicants should apply in advance and the results are available in two months. Fees vary from $1,005 to $ 1,507 depending on the date of application (http://www.mcc.ca/examinations/mccqe-part-1/).

Medical Council of Canada Qualifying Examination (MCCQE) Part 2

This examination evaluates the ability of a candidate to examine a standardized (simulated patient) and perform activities such as obtaining a focus history, conducting a focused physical examination, assessing and addressing various issues concerning the patient, answering patient-related questions, interpreting X-rays, making a diagnosis, and writing admission orders. The candidates must apply in advance for this examination which is conducted two times each year. The fee is $2,409 (http://www.mcc.ca/examinations/mccqe-part-2/).

IMGs' Success Rates on the College of Family Physicians of Canada(CFPC) and Royal College of Physicians and Surgeons of Canada (RCPSC) Examinations

The success rate of IMGs on the College of Family Physicians of Canada (CFPC) certification examination is noticeably lower than the success rate of Canadian Medical Graduates (CMGs). The success rate for IMGs has decreased over time. In 2007, the success rate for IMGs was 66% (CMGs success rate regarding the same exam was

90.4%). In 2009, IMGs success rate was 64%. In 2010 only 51% of IMGs succeeded in this examination (Walsh et al., 2011).

Differences in rates of success between IMGs and CMGs on the Royal College of Physicians and Surgeons of Canada (RCPSC) examination also exist. According to the data from 2005-2009, the CMGs rate for primary specialty examination was 95%. IMGs success rate was 76% (Monavvari, Peters, & Feldman, 2015; Walsh et al., 2011).

It has been indicated that the reasons why the IMGs success rate is lower than CMGs are not determined yet. It has been suggested that the heterogeneity of the IMG population, practice eligibility and residency programs, learning and adjustment issues regarding the residency programs might correlate with the different rates of success of the described above populations of medical graduates (Walsh et al., 2011).

Duration and Financial Aspects of Licensing of Immigrant IMGs

Even if immigrant IMGs have an opportunity to take the MCCEE in their country of origin, they will still need to take up to four different examinations. Taking into account that all examinations usually take place twice a year, and the applicants must apply well in advance, the whole examination process might take from 2 to 4 years. The combined fees for MCCEE, NAC, MCCQE Part 1 and MCCQE Part 2 come up to $7,920. The fees for examinations required by the College of Family Physicians of Canada Certification and the Royal College of Physicians and Surgeons of Canada Certification are not included in these calculations.

According to IMG Ontario, there are many additional costs which have to be met by the applicants themselves, such as fees for the translation of documents, fees for obtaining transcripts, fees for notarizing degrees and transcripts, costs regarding the

preparation of credentials, language proficiency tests fees as well as travel expenses related to exams locations. Last but not least, all study materials must be purchased by the applicants themselves (http://www.imgo.ca).

Considering that the majority of immigrant IMGs come to Canada from developing countries with rather limited personal financial resources and, before they start practicing medicine in this country, they are more likely to be employed in low-skilled, low-paid jobs, one could wonder whether the studied population of immigrant professionals are able to afford the expenses related to their accreditation process and, at the same time, adequately provide for themselves and their family members (Calleija & Alnwick, 2000; Cheng et al., 2013; Foster, 2008). This financial barrier associated with licensing and educational expenses might prevent some immigrant IMGs from obtaining a full license in this country.

The Government of Ontario admits that the assessment process is complex and lengthy, and an applicant has to be committed financially to achieve his or her objective (http://www.imgo.ca). The Government of Ontario website advises immigrant IMGs that they need to save money to pay for examinations and warns them that they will not be able to study full-time for these examinations. Any form of financial support from the federal or provincial/territorial governments is not identified anywhere in the relevant literature.

Postgraduate Medical Training

In order to work as a family physician in Canada, medical school graduates usually have to have at least 2 years of postgraduate medical training completed in this country. Training for other specialties takes about 4 or 5 years (Boyd & Shellenberg,

2007). Not all specialties are open to IMGs. For instance, the Ontario Ministry of Health and Long-Term Care decides (once a year) which specialties are offered to IMGs (http://www.imgo.ca).

Some IMGs might be allowed to take the RCPSC certification exam without post-graduate training completed in Canada. These IMGs have completed their post-graduate training in specific jurisdictions such as Australia, Hong Kong, Singapore, Ireland, The UK, New Zealand, or South Africa. Candidates from the US may also be exempt from the requirement to complete their residency training in Canada. IMGs' training is evaluated by the RCPSC for approval. It is important to mention that if a medical professional has not practiced medicine for more than 3 years, he or she will need to go through residency training again regardless of his/her previous post-graduate medical training or professional experience (Campbell-Page et al., 2013).

Between 1993 and 2004, only a limited number of dedicated postgraduate positions for IMGs were available. Consequently, obtaining a residency placement can be seen as a major obstacle to become licensed for immigrant IMGs in this country (Neiterman & Bourgeault, 2012). In 1996, only 24 out of 500 foreign trained doctors received residency positions in Ontario (Basran & Zong, 1998). In 1998, all Canadian postgraduate programs offered only 297 postgraduate positions for IMGs (Walsh et al, 2011).

The opportunities for IMGs for postgraduate training vary around the country. For instance, British Columbia used to provide only two entry positions for postgraduate training each year which were funded by the Ministry of Health (Andrew & Bates, 2000). Only two residential positions were available in this province for 400 unlicensed IMGs in

2003. In 2012, only 18 residential positions were available for 400 IMGs who were residents of BC. Only 200 residency positions are offered by the province of Ontario for more than 5000 unlicensed IMGs who live in this province (Neiterman & Bourgeault, 2012).

The Canadian Resident Matching Service (CARMS) is a computerized matching system designed to match available resident positions around the country to applicants seeking these positions. It is a two-step annual process. The first iteration tries to match the majority of candidates with their first choice of residency. All unmatched candidates and remaining residency positions go to the second iteration. IMGs residing in all Canadian jurisdictions (except Alberta) can utilize the CARMS to apply for a residency position (IEHP Report, 2010). It has been pointed out that depending on the province and the first or second iteration, IMGs may apply to the same or separate stream of positions than Canadian graduates in one or all disciplines (IEHP Report, 2010). According to the CARMS, in 2008 2,228 IMGs applied for residency positions. Only 23.5% of applicants in the first round and 5.2% of participants in the second round were able to secure a residency spot (Neiterman & Bourgeault, 2012). The first iteration of the 2010 CARMS indicated that 1532 IMGs applicants competed for only 299 residency positions (Campbell-Page et al., 2013).

It has been argued that between 5 and 10% of IMGs will be able to succeed in getting their residency placements. Despite limited numbers of residency spots, there are vacant residency positions, especially in Quebec and Ontario. In 2007, there were 154 vacant residency positions while 1,056 IMGs were not able to obtain a spot. In 2008, there were 121 vacant positions available with 881 IMGs left out struggling to secure an

available residency position. In 2009, 126 residency positions were vacant for the corresponding 1,001 IMGs who were not able to get hold of a residency position (IEHP Report, 2010).

IMG Ontario cautions that in order to obtain a residency position, IMGs should be prepared to endure a very challenging and competitive selection process. Such variables as performance on written and clinical exams, past medical experience, and performance in medical school as well as demonstrated skills and strengths of the applicants are taken into consideration during this selection process (http://www.imgo.ca).

Limited access to postgraduate training can be viewed as a major obstacle for many IMGs who intend to work in their matched jobs in this country (Campbell-Page et al., 2013; Neiterman & Bourgeault, 2012).

Full and Provisional Licenses

A full medical license allows a medical professional to practice medicine without any restrictions or limitations (Campbell-Page et al., 2013).

Some IMGs can practice medicine in Canada under a provisional license. Depending on the province, this type of license might be called provisional, temporary, or restricted (Foster, 2008). These licenses might provide an opportunity to practice medicine without passing the MCC examination and participating in Canadian postgraduate training (IEHP Report, 2010). Some conditions might be attached to these particular types of licenses, such as a Return of Service agreement, practicing medicine in underserviced communities, or having a supervisor for a particular length of time (Campbell-Page et al., 2013). The success of such programs might be debatable. For

instance, in Manitoba only 12 out of 76 applicants were accepted by the MLPIMG program in 2008 (IEHP Report, 2010).

Teaching of IMGs

It has been accepted by Canadian medical educators that teachers were poorly prepared to teach IMGs (Walsh et al., 2011). Despite the recognized importance of orientation programs, these programs are not developed by utilizing the same national standards. Some jurisdictions do not offer any particular preparation. The duration of pre-residency preparation programs might range from a few days to three months. The only specialized IMG residency program is offered at the University of British Columbia. In all other provinces IMGs who complete the orientation program apply to a regular training stream as Canadian Medical Graduates (Walsh et al., 2011).

It has been debated whether the availability of resources and clarity of approaches to the numerous professional and personal issues faced by IMGs are perceived similarly by medical leaders, teachers, and IMGs themselves. It has been argued that medical leaders and teachers believe that the needed resources are available and straightforward. However, the IMGs state that they do not receive enough guidance from these medical leaders and teachers in regards to accessing information on learning issues (Walsh et al., 2011). Both, IMGs and medical leaders and teachers, agree that a comprehensive orientation program should include detailed information concerning the Canadian federal and provincial health care systems, the principles of Medicare, and licensing requirements relevant to a particular training environment (Walsh et al., 2011).

Language Support Programs

In order to become fully licensed, IMGs have to demonstrate English or French proficiency (Assels, 2010; IEHP Report, 2010; Neiterman & Bourgeault, 2015). Medical associations claim that language proficiency is related to public safety. However, there are disagreements between licensing authorities and immigrant IMGs regarding the recognized levels of language proficiency. It has been suggested that the knowledge of technical terms, the number of known words as well as the accent of an applicant might be perceived differently by two sides of this dispute (Boyd & Shellenberg, 2007). It has been reported that linguistic analysis and training assessment processes are not able to properly identify the language skills needed for successful performance in a clinical setting. Specialized medical language support programs have not been developed (Walsh et al., 2011). It has been stressed that accessibility of occupation- specific language training is essential for immigrant IMGs. Occupation-specific language training is not offered in all Canadian jurisdictions. In addition, available language training programs vary in quality, as well as in its relevance to the language requirements of particular regulated occupations (Assels, 2010).

Bridging Programs

The objectives of bridging programs are to improve the academic and professional skills and language abilities of internationally trained professionals as well as to provide them with required and relevant work experience (Assels, 2010). However, bridging programs are only available in some Canadian jurisdictions and not for all regulated professions. These bridging programs are quite expensive and rather lengthy.

Students in many bridging programs are not eligible for financial aid and student loan programs (Assels, 2010).

Return-of-Service Agreement

Even before an immigrant IMG is able to obtain a license to practice medicine, he or she has to sign a Return of Service agreement. An IMG who signs this contract is required to work for several years in an underserviced area which experiences a shortage of doctors (http://www.imgo.ca). It is a rather universal requirement for IMGs to commit to a Return-of-Service agreement and practice medicine in an underserviced area in order to get a residency position. Some urban ethnic communities might also be defined as underserviced, and immigrant IMGs with the same ethnic background may be utilized serving these clients. The Return-of-Service obligation does not allow immigrant IMGs to practice medicine in his or her ethnic community immediately after receiving a full license. It has been argued that IMGs are forced to sign these agreements which permit them to be employed in their intended occupation in Canada (Walsh et al., 2011).

Australia

Becoming a Medical Practitioner: General Requirements

The process of becoming a medical practitioner in Australia often starts when Australian students complete an undergraduate degree before applying to a medical school (McNamara, 2012). The majority of Australian medical schools offer a 4-year medical degree program. Some Australian medical schools offer an undergraduate program which takes 5-6 years to complete (http://www.gamsat.acer.edu.au).

After graduating from a medical school, future medical practitioners are required to complete two years of pre-vocational training (PGY1 and PGY2). The graduates go

through a 12-month internship (PGY1) (usually in a hospital setting) which is a supervised period of training before they are registered. The second postgraduate year (PGY2) is residency which should be successfully completed before enrolling in a postgraduate vocational training. The vocational training is provided by specialist medical colleges and might last from 3 to 8 years (htpp://www.ama.com.au; http://www.surgeons.org; McNamara, 2012; Paltridge, 2006).

According to Health Practitioner Regulation National Act (2009), every medical practitioner is required to be registered with the Medical Board of Australia. Australian medical practitioners can practice medicine under different registration categories, such as general, specialist, provisional, limited, and non-practicing. All applicants for medical registration have to comply with numerous requirements before they become eligible for registration. Such mandatory registration standards as Continuing Professional Development Registration standards, Criminal History Registration Standard, English Language Skills Registration Standards, Professional Indemnity Insurance Registration Standard, Recency of Practice Registration Standard should be met by all applicants for registration (http://www.medicalboard.gov.au).

The Australian Medical Regulatory Authorities: Roles and Responsibilities

Australian Medical Council (AMC)

The Australian Medical Council can be defined as an independent national organization responsible for standards of medical education and training (http://www.amc.org.au). According to its mandate, the AMC establishes policies and procedures for medical programs of Australian and New Zealand educational institutions. The AMC assesses the medical programs and the educational institutions which offer

them to the students. The assessment of international examining and accreditation bodies is also a part of the AMC responsibilities. Specialist medical colleges in Australia are also assessed by the AMC employing the recognized accreditation standards. The knowledge, clinical skills and professional attributes of medical practitioners who acquired their qualifications overseas and seek registration to practice medicine in Australia are also assessed by the Australian Medical Council (http://www.amc.org.au; http://www.medicalboard.gov.au).

Medical Board of Australia

The Medical Board of Australia plays an important role in the national health care system. It is responsible for registering medical practitioners and medical students and for developing standards and guidelines for the medical profession (http://www.medicalboard.gov.au). The investigation of complaints in regards to medical practitioners and the approval of accreditation standards and accredited courses of study is the responsibility of this regulatory authority. The Medical Board of Australia also assesses overseas trained doctors who intend to practice medicine in Australia. Each of the Australia's state and territory has State and Territory Boards which are established and supported by the Medical Board of Australia (the National Board). State and Territory Boards are allowed to register individuals and make their own decision regarding complaints about medical practitioners adhering to the national policies established by the Medical Board of Australia (http://www.medicalboard.gov.au). About 600,000 registered health practitioners are currently regulated by 14 national boards (Alen, 2013).

The Australian Health Practitioner Regulation Agency (AHPRA)

Since July 2010 AHPRA regulates 14 health professions following the Health Practitioner Regulation National Law through the National Registration and Accreditation Scheme (http://www.ahpra.gov.au). AHPRA and the 14 national boards collaborate in the delivery of the scheme. Registration of health practitioners, public protection, establishment of national standards, audit of compliance, management of complaints regarding health practitioners, management of the online register, accreditation of training and education are particular domains in which AHPRA and national boards cooperate. The assessment of international medical graduates (IMGs) is the prerogative of a national board's accreditation authority (the AMC, for instance). The national board sometimes might assess qualifications of internationally educated health professionals (Alen, 2013).

How Immigrant IMGs Can Become Medical Practitioners in Australia

Internationally trained health professionals arriving in Australia might be identified as permanent or temporary residents IMGs. International medical graduates (IMGs) can be granted a temporary or permanent visa to enter Australia. IMGs might enter Australia as permanent residents using the General Skill Migration Program, the Employer Nomination Scheme, or the Regional Sponsored Migration Program. If international medical graduates determine that they are not able to meet the requirements of one of the skilled immigration option or they decide to enter Australia on a temporary basis, they might choose to apply for a temporary visa (Northern Sydney Local Health Network [NSLHN], 2011). International medical graduates also can immigrate to Australia as dependents of GSM migrants or through family and humanitarian categories

(Bourgeault, Parpia, Neiterman, Le Blanc, & Jablonski, 2011; Hawthorne, 2011a; http://www.amc.org.au; http://www.border.gov.au; http://www.doctorconnect.gov.au).

The process of registration with a relevant national board and the process for applying for a visa to the Australian Department of Immigration and Border Protection are separate and success in one of the processes does not necessarily results in a successful outcome in the other process. In order to receive any type of visas IMGs have to comply with numerous requirements established by the Australian immigration authorities. Overseas practitioners are required to meet criminal history standard. An international criminal history check will be conducted in every country where an applicant had resided for more that 6 months since the age of 18. The applicant is responsible for the cost of his or her international criminal history report (http://www.ahpra.gov.au; http://www.border.gov.au).

All IMGs have to meet the English language skills standard as well. IMGs have to submit evidence of their English language proficiency to the Medical Board of Australia regardless of their registration categories. They have to reach a minimum score in each component of such tests as International English Language Testing System (IELTS), Occupational English Test (OET), or some specified alternatives. IMGs can take IELTS tests at the accredited testing centres which are located in various locations around the world. All the relevant information regarding this particular examination is provided by the IELTS website. Language Australia is responsible for administering the OET. IMGs might obtain information regarding locations, time, and costs by visiting the Language Australia website (http://www.doctorconnect.gov.au). The Medical Board of Australia might grant exemptions from the English language proficiency requirements if an

applicant completed secondary education in English in Australia, Canada, New Zealand, Republic of Ireland, South Africa, United Kingdom, or United States of America (http://www.ahpra.gov.au; http://www.amc.org.au). Health examination of IMGs and their family members is also a part of the visa application process (http://www.border.gov.au).

Registration of Permanent Residents IMGs

All IMGs must verify their medical qualifications using the Educational Commission for Foreign Medical Graduates (ECFMG) Electronic Portfolio of International Credentials (EPIC). IMGs have to submit their medical qualifications directly to ECFMG's Electronic Portfolio of International Credentials as well as apply online to the Australian Medical Council to produce an AMC portfolio. The establishment of an AMC portfolio costs $ 500 AUD (http://www.amc.org.au). The AMC's qualifications portal will receive the EPIC report. The AMC's portal is utilized by the Medical Board of Australia for their registration procedure and by specialist medical colleges for assessment. The ECFMG is an organization that has its offices in the United States. If the US Department of Treasure prohibits interactions between the US organizations and permanent residents of specific countries, IMGs from these countries will not be able to utilize the mentioned verification services. These IMGs will have to be verified by the AMC directly. IMGs can find out if their medical schools and qualifications are recognized by the AMC using an online referral tool. IMGs can also use a self-check to decide their eligibility for a particular assessment pathway. There are 3 assessment pathways such as Competent Authority Pathway, Standard Pathway, and

Specialist Pathway which might be utilized by IMGs who intend to register to practice medicine in Australia.

Standard Pathway

IMGs who are awarded their primary qualifications in medicine and surgery by an educational institution recognized by the AMC, and who are not eligible for Competent Authority or Specialist Pathways might apply for the Standard Pathway. The applicants will be assessed by the AMC employing the CAT MCQ Examination and the AMC Clinical Examination. Some applicants might be assessed by the mentioned examinations and workplace place- based assessment of their clinical skills and knowledge by an AMC accredited authority. The AMC examinations are designed in accordance with medical knowledge, clinical skills, and attitudes which should be demonstrated by graduates of Australian medical schools before they start medical training. The AMC CAT MCQ Examination is a computer adaptive multiple choice test which assesses applicants' knowledge regarding general practice, internal medicine, surgery, psychiatry, pediatrics, gynecology and obstetrics. The AMC clinical examination evaluates applicants' clinical skills in the same areas. The applicants' communication abilities are also verified during this examination. The CAT MCQ examination authorization costs $2,720 AUD. All applicants must successfully pass the AMC CAT MCQ examination before they can proceed to the AMC clinical examination (http://www.amc.org.au).

Australian Medical Council Multiple Choice Question (AMC MCQ) Examination

The AMC Computer Adaptive Test (CAT) MCQ Examination is conducted in one session which lasts three and a half hours (http://www.amc.org.au). Examination centres are located worldwide. There are 7 examination venues in Australia and 29

examination venues in 23 countries. 5 of these examination venues are located in India. There are no MCQ examination venues in Africa and there are only 2 examination venues in Latin America (Sao Paulo, Brazil and Mexico City, Mexico). An applicant has to apply to the AMC for authorization to take a MCQ examination. The authorization will be valid for 12 months. The applicants might purchase AMC textbooks in order to prepare themselves for the examination. They might also use MCQ Trial Examination which consists of 50 multiple choice questions, may be completed online, and costs $25 AUD.

The MCQ Examinations are held a few times every month and the results are available in 4 weeks after the examination. The applicants will receive the examination result by mail form the AMC (http://www.amc.org.au).

Australian Medical Council (AMC) Clinical Examination

The AMC Clinical Examination is a multidisciplinary clinical assessment which evaluates candidates' clinical skills and communication abilities using a 16-component multi-station assessment (http://www.amc.org.au). Candidates will go through 20 stations (4 stations are designed for rest only) and will be required to perform a number of clinical tasks. Each station (which may use patients, standardized patients or role-playing patients) should be successfully passed during a 10-minute period. The successful competition of the examination requires candidates to pass 12 out of 16 stations. The test is marked as Pass or Fail only. The results for this test are available on-line at 9am on the Thursday following the examination. Clinical examinations are held in the national test centre in Melbourne and Perth and Townsville hospitals. The AMC clinical examination can be taken on weekdays or Saturdays right through the year. The AMC clinical

examination cost $3,530 AUD. Candidates who passed the AMCQ examination should apply for AMC clinical examination online. Candidates who passed the clinical examination will receive the AMC certificate (http://www.amc.org.au).

Before applying for general registration IMGs who chose the Standard Pathway must go through 12 months of supervised practice (47 weeks of full time service). IMGs have to also meet all registration standards established by the Board (http://www.medicalboard.gov.au).

Competent Authority Pathway

International medical graduates who posses a primary medical qualification or have been trained and assessed in the United Kingdom, Ireland, USA, Canada, or New Zealand might meet the eligibility criteria for the Competent Authority Pathway (handbook, 2011). The Competent Authority Pathway might be utilized by overseas-trained non-specialists as well as specialists like general practitioners, for example. (http://www.amc.org.au). The Medical Board of Australia recognizes some international competent authorities regarding the assessment of the applied medical knowledge and basic medical skills of IMGs. Competent authorities such as General Medical Council (United Kingdom), Medical Council of Canada (LMCC), Educational Commission for Foreign Medical Graduates of the United States (USMLE), Medical Council of New Zealand (NZREX), and Medical Council of Ireland have been approved by the Medical Board of Australia (http://www.medicalboard.gov.au).

Since July 2014, IMGs who choose the Competent Authority Pathway have to apply to the Board for provisional registration. All applicants still have to apply to the AMC for primary source verification (PSV) of their qualifications before applying to the

Board for registration. IMGs have to secure an offer of employment before they apply to the Board for registration (http://www.medicalboard.gov.au). Considering the nature of the non-specialist position and level of risk, the Board might require an applicant to undertake a pre-employment structured clinical interview (PESCI) before applying for provisional registration.

The Pre-Employment Structured Clinical Interview (PESCI)

The Medical Board of Australia defines the PESCI as an objective assessment of IMGs' knowledge, skills, and clinical experience regarding a particular position (http://www.medicalboard.gov.au). The PESCI is conducted by the AMC accredited PESCI providers such as Australian College of Rural and Remote Medicine (all states), Health Workforce Assessment Victoria, Postgraduate Medical Council of Victoria, Queensland Health, and Royal Australian College of General Practitioners (Northern Territory, South Australia, Tasmania). The panel of three interviewers (two of them are medical practitioners and one could be a lay person) apply structural questions and scenarios in regards to a specific position to determine the suitability of a candidate for this position. The PESCI panel provides recommendations to the Board and might find a candidate not suitable for the discussed position. The PESCI panel also advises the Board if any additional education or training is needed. The PESCI panel recommendations on the level of supervision are also considered by the board. If an IMG decides to apply for another position, a new PESCI might be required (http://www.medicalboard.gov.au).

IMGs who are eligible to utilize the Competent Authority Pathway and have verified employment positions and supervision arrangements will be granted provisional registration allowing an applicant to fulfill the requirement of a 12-month period of

supervised practice (at least 47 weeks of full time service should be successfully completed). If IMGs successfully complete their 12-month supervised practice period they might be granted general registration by the board. If an IMG fails to meet general registration requirements, he or she is allowed to renew twice his or her provisional registration (http://www.medicalboard.gov.au).

Specialist Pathway

International medical graduates who want to apply for the assessment of their comparability to the standards required from Australian-trained specialists or IMGs specialists who wish to apply for an Area of Need specialist level position might utilize the Specialist Pathway (http://www.amc.org.au). IMG specialists who intend to practice unsupervised or independently in Australia might make use of Specialist Pathway – specialist recognition. IMG specialists who received an offer of employment to work in a designated Area of Need specialist position in Australia might choose Specialist Pathway – area of need option. IMGs' qualifications in medicine and surgery should be obtained from a medical school recognized by the AMC and their medical schools should be listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research. They also have to verify their credentials with the AMC before applying for this particular pathway. Since July 2014, in order to be recognized, IMGs must apply directly to the specialist medical college utilizing an application from a particular college website. A specialist medical college will assess the application and this assessment will establish the type of registration an IMG is eligible to apply for to the Medical Board of Australia. An IMG will be notified by the college regarding the results of its assessment. A separate fee for

assessment is charged by each specialist college. The decision on the type of registration granted lies with the Medical Board of Australia (http://www.amc.org.au; http://www.doctorconnect.gov.au). If IMGs are not eligible for the Specialist Pathway they might consider the Competent Authority Pathway or the Standard Pathway as alternative options for registration.

Registration of Temporary Residents IMGs

IMGs can immigrate to Australia as temporary 457 visa migrants (Hawthorne, 2011b; http://www.amc.org.au; http://www.doctorconnect.gov.au). This visa gives skilled workers an opportunity to be employed in Australia in their nominated occupation by their approved sponsor for up to 4 years (http://www.border.gov.au). Before they can be granted the mentioned visa, IMGs have to be nominated by an approved employer, demonstrate that they possess the required skills, and meet various registration and licensing requirements including vocational English. English language proficiency of IMGs will be determined by the immigration officials utilizing such tests as International English Language Testing System (IELTS), Occupational English Test (OET), Test of English as a Foreign Language internet-based test (TOEFL iBT), Pearson Test of English (PTE) Academic test, Cambridge English: Advanced (CAE) test. IMGs have to reach certain scores on any of these tests to demonstrate the required level of English proficiency. IMGs might be required to have higher English language proficiency scores because of licensing and registration requirements of the assessing authorities (http://www.border.gov.au). IMGs and their family members must comply with specific health requirements and have to submit the results of their health examinations (which are valid for 12 months). IMGs and their family members might be required to purchase

health insurance before they are granted this type of visa by Australian immigration authorities. If IMGs are permanent residents or citizens of New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia, or Norway, they can enjoy reciprocal health care agreements between Australia and the above mentioned countries. These health care agreements only cover the cost of essential medical services and privately purchased health insurance is still recommended (http://www.border.gov.au). IMGs would also have to meet the requirements of the character test. They will be asked to provide a police clearance certificate for each country where they have lived for 12 or more months over the last 10 years since they reached 16 years of age. Individuals with a substantial criminal record (12 months or more in prison / suspended sentence), members of groups or organizations which are suspected by the Minister of Immigration of involvement in criminal conduct will not pass the character test. There are many other detailed requirements which should be met in order to pass the character test. IMGs who are permanent residents of 36 designated countries will have to submit their biometrics (a facial image and a 10-digit fingerprint scan) to the Australian immigration authorities (http://www.border.gov.au).

Prospective employers of IMGs have to be approved by the immigration authorities and might be accredited if they have a satisfactory history of previous sponsorships (http://www.border.gov.au). Employers of IMGs have to comply with their sponsorship obligation. They will be monitored during and after the sponsorship. If an employer does not comply with sponsorship obligations, he or she might be bared from sponsoring or his or her existing sponsorship approval can be cancelled. One of the most noticeable requirements of the approved sponsorship is that the terms and conditions of

employment for sponsored temporary workers should be the same as the terms and conditions of employment which are provided to an Australian working in the same position in the same location (including wages) (http://www.border.gov.au).

IMGs with a temporary resident status are required to work in an Area of Need (AON) or District of Workforce Shortage (DWS). Most overseas trained doctors will receive a limited registration and will have to go through a period of supervised employment in an Area of Need (http://www.doctorconnect.gov.au). An Area of Need for health services is a jurisdiction where there are not enough medical practitioners providing their services in a specific health profession adequately meeting the needs of the local population. State or territory governments make determinations regarding immigration and registration of IMGs in the designated Areas of Need. The Department of Health defines Districts of Workforce Shortage in connection with access to Medicare (http://www.doctorconnect.gov.au; http://www.medicalboard.gov.au). The process of temporary migration of internationally educated health professionals put certain responsibilities and obligations on IMGs themselves as well as on their potential employers. As it was already mentioned, IMGs who decide to enter Australia as temporary residents should apply for Temporary Work (Skilled) visa (subclass 457). IMGs who receive this type of visa are allowed to work in their nominated occupation for their approved employers for up to 4 years. IMGs who receive this visa can bring their family members to Australia and enter or leave Australia as many times as they want. In order to receive the subclass 457 visa, IMGs have to find a position for which they can be sponsored by their potential employer. To find a suitable position, IMGs might contact a recruitment agency or a Rural Workforce Agency (RWA) in any state or territory. The

services of RWAs are free. One of the conditions of receiving the subclass 457 visa is that IMG applicants have to provide evidence from the Medical Board of Australia that they are eligible for limited registration (http://www.doctorconnect.gov.au; NSLHN, 2011).

In order to obtain limited registration for area of need, IMGs should apply to the Medical Board of Australia (http://www.medicalboard.gov.au). To receive a limited registration IMGs have to meet numerous registration standards approved by the Board such as English language skills, recency of practice, professional indemnity insurance arrangements, and continuing professional development. IMGs have to also provide proof of identity to the Board. IMGs have to submit to the Board evidence that they hold a primary degree in medicine and surgery and have completed an approved course of study at a medical school which is listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research. IMGs have to verify their medical qualifications through primary source verification of medical qualifications from the Educational Commission for Foreign Medical Graduates (ECFMG) International Credential Service (ICS) and provide the results of this verification to the Board. IMGs have to submit to the Board evidence of successful completion of a medical internship. According to the Australian Medical Council (AMC), an approved course of study indicates that IMGs completed a medical curriculum of 4 academic years and have been entitled to register in the country which issued their degrees to practice medicine (http://www.medicalboard.gov.au). An applicant has to submit his/her curriculum vitae to the Board. An applicant has to go through a criminal history check following the guidance from the Board or AHPRA. An applicant

has to submit the following information regarding his or her potential employer: the confirmation of the offer of employment, employer's contact details, a description of the position including clinical responsibilities, qualifications and professional experience associated with the position, contact details of the proposed principal supervisor and co-supervisors, a supervision plan (which is able to meet the Board's requirements for supervision of IMGs), and a continuing professional development activities plan in line with the Board registration standards for continuing professional development. Evidence of area of need declaration for the geographical area and /or the type of health service for which there is a need should be also submitted by the applicant (http://www.medicalboard.gov.au). An applicant has to submit evidence to the Board that he or she is eligible for Standard pathway or Specialist pathway – area of need pathways to registration. An applicant might be required to submit the results of a pre-employment structured clinical interview (PESCI). The approved by the Board provider should confirm that the applicant is suitable for a particular position. If an applicant decides to demonstrate eligibility for the standard pathway, he or she has to submit evidence that the Australian Medical Council Computer Adaptive Test (CAT) MCQ Examination has been successfully passed. If an applicant chooses the Specialist pathway – area of need to registration, he or she has to submit evidence from an accredited by the AMC specialist medical college that his or her specialist qualifications have been evaluated regarding a particular area of need position and a confirmation that he or she is suitable for this position. Any limitations on the nature and extent of practice should be also included (http://www.medicalboard.gov.au).

Limited registration is granted up to 12 months by the Medical Board of Australia. Limited registration can be renewed only 3 times (htpp://www.medicalboard.gov.au). If a medical practitioner who holds limited registration intends to practice medicine after 3 renewals, he or she has to complete a new application for registration. Applicants who apply to work in a general practice position have to have at least 3 years of experience working in general practice or primary care. After successful registration IMGs have to follow numerous requirements regarding their employment. IMGs with limited registration for area of need have to comply with the approved by the Board supervision plan. They have to also comply with a registration standard for continuing professional development and demonstrate satisfactorily work performance in the position for which they received registration to practice. It is expected that IMGs with limited registration for area of need intend to meet the requirements for general or specialist registration if they want to renew their registration for more than 3 times (http://www.medicalboard.gov.au).

When IMGs with limited registration for area of need apply for renewal of their registration, they have to satisfy the Board's requirements regarding compliance with the standards and their work performance. Work performance will be evaluated by the Board using work performance reports submitted by the applicant (http://www.medicalboard.gov.au). An applicant might be required to undergo an examination or an assessment in order to show satisfactory work performance. IMGs have to also demonstrate that they are able to meet the requirements for general or specialist registration after 3 renewals of their limited registration. If an IMG wishes to change the employer, an application for a change in circumstances has to be submitted.

The same information as for a previous limited registration as well as a work report from an applicant's previous supervisor and evidence from specialist medical college supporting an applicant's change in circumstances (for specialists of area of need only) should be submitted to the Board. A new PESCI as well as a new area of need declaration should also be submitted to the Board (http://www.medicalboard.gov.au).

Evaluation of Current Australian Registration Policies of IMGs

Australian Medical Council (AMC) Examinations

It has been argued that the AMC examinations (which consist of the MCQ and a clinical examination) are very challenging for many IMGs (Douglas, 2008; Han & Humphreys, 2005; McGrath, Henderson, & Phillips, 2009; McGrath, Wong, & Holewa, 2011; Spike, 2006; Sullivan, Willcock, Ardzejewska, & Slaytor, 2002). It has been reported that between 1978 and 1993, only 35% of IMGs had been able to pass the first part of the AMC examinations during their first attempt (Iredale, 2010). It has been indicated that between 1999 and 2004, only 55.8% of IMGs who took the MCQ examination were able to succeed in this assessment. The passing rate in the clinical examination in the same period of time was 57.8% (Spike, 2006). Only half of all IMGs taking the MCQ and clinical examinations in 2002 have passed these tests (Birrell & Hawthorne, 2004). It has been argued that IMGs demonstrate lower passing rates than their Australian counterparts in regards to the same type of examination (McDonnell & Usherwood, 2008). Passing rates varied significantly depending on the country or the region of candidates. Only 21% of candidates from non-Commonwealth Asian countries passed this examination. 33% of candidates from Eastern Europe and 61% of candidates from the UK, Canada, and Ireland were successful in passing this examination (Iredale,

2010.) The passing rates of the clinical test showed great variability as well. This test was passed by 6% of French candidates, 29% of candidates from Germany, 42% candidates from the Netherlands, and 19% of candidates from Vietnam (Iredale, 2010).

It has been pointed out that the overall passing rate of the AMC examination was 36.8% in the late 70s-80s. Candidates from South Africa, Canada, and the USA demonstrated better performance regarding these exams. Nevertheless, only 12% of candidates were able to pass both parts of the AMC examination on their first attempt (Iredale, 2009).

The review of the existing literature does suggest that many IMGs currently experience noticeable problems in their successful completion of the required AMC examination. According to the data provided by the Australian Medical Council regarding the MCQ and clinical examination outcomes by selected countries, from 1978 to 2010, 6,241 candidates from India took the MCQ examination. Only 3,183 candidates from this country successfully passed the MCQ examination (Hawthorne, 2011b). During this period, 2,870 clinical candidates from India attempted to pass this type of examination and only 1,600 succeeded. The same pattern might be noticed for the MCQ and clinical candidates from Sri Lanka, Egypt, Pakistan, Philippines, Bangladesh, and China. Candidates from Iran have been more successful in passing this examination. 726 out 1,204 Iranian candidates passed the MCQ examination. 314 out of 484 Iranian candidates successfully passed the clinical examination. 586 out of 895 candidates from Iraq had been able to pass MCQ examination and 371 out of 623 candidates from the same country were able to pass the clinical examination. 683 out of 924 candidates from South Africa have passed the MCQ examination. 444 out of 564 candidates from the

same country passed the clinical examination (Hawthorne, 2011b). German candidates had some difficulties in passing both types of examinations. Only 325 out of 531 German candidates passed the required MCQ examination. The clinical examination was passed by only 186 out of 296 German candidates. Candidates from UK / Ireland seemed to be more successful in passing the required examinations (at least on the MCQ exam). However, their passing rates are still relatively low. Despite being candidates from countries which are considered as competent authorities by the Australian licensing and accreditation bodies, only 791 out of 992 UK or Ireland candidates were able to successfully pass the MCQ examination. Only 368 out of 650 candidates from the same countries had been able to pass the clinical examination. The passing rate of the UK or Ireland candidates on the clinical examination is not superior to the passing rates on clinical examination demonstrated by candidates from India, Sri Lanka, Pakistan, China, Nigeria, Iraq, or Iran (Hawthorne, 2011b).

The analysis of the passing rates regarding the MCQ examination using the candidates' country of origin as a major contributing factor to the outcome of the test is rather inconclusive. For instance, in 2002, 80% of candidates from Bangladesh passed the MCQ successfully. Only 47% of candidates from India successfully passed the same test in that year. If 87% of candidates from Iraq (which is a non-English-speaking country and it is not considered as a competent authority) successfully passed the MCQ examination, only 74% of candidates from the United Kingdom have been successful in that assessment. Candidates from Pakistan (75% passing rate), Sri Lanka (82% passing rate), and South Africa (88% passing rate) also demonstrated better performance on this test than their counterparts from the United Kingdom (Birrell, 2004).

The clinical part of the AMC examination shows a different trend regarding the passing rates of candidates from the mentioned countries (Birrell, 2004). 91% of candidates from South Africa passed the clinical examination on their first attempt. 88% of candidates from the UK have achieved the same result. Only 48% of candidates from Bangladesh (despite their very impressive performance on the MCQ test) passed the clinical examination on their first attempt. The candidates' performance from Iraq (66%), Pakistan (53%), Sri Lanka (65%) is definitely not to par to their results on the MCQ examination. However, candidates from India whose passing rates on the MCQ examination were 47%, demonstrated significant improvement on the second part of the AMC examination. 63% of candidates from India passed successfully the clinical examination on their first attempt (Birrell, 2004).

It has been proposed that unsatisfactory performance on clinical examination demonstrated by many IMGs is due to the particular design of this part of the AMC examination. Many IMGs are experienced clinicians who completed their medical education years ago. It has been outlined that because of an encapsulation process, the clinical expertise of IMGs have increased, basic knowledge has integrated into IMGs' knowledge base, and, consequently, after some time, experienced clinicians have difficulties recalling some specific details (Douglas, 2008). Considering that IMGs who currently attempt to take the clinical examination have to go through 16 stations during their clinical assessment and they have only a 10-minute time frame to perform a number of clinical tasks, it is not a revelation that the clinical examination might be very stressful and demanding for many IMGs which evidently have a negative effect on their performance during this particular test. This test might be appropriate for the assessment

of young Australian medical school graduates, but it is rather debatable whether it adequately accesses IMGs many of whom might be middle-aged experienced clinicians. The design of this particular test may not allow those IMGs to appropriately demonstrate their clinical abilities.

There is an opportunity for IMGs to take the AMC MCQ examination at one of 29 examination venues which are located in 23 countries. If the examination venue for this test is located in the country of origin of an IMG, it might positively correlate with his or her performance on this test. Some IMGs reported that it was beneficial for them to take this exam in their country of origin, and they were able to pass the exam on their first attempt. IMGs have also highlighted the shortening of the examination process without enduring travelling expenses (McGrath, Henderson, Holewa, Henderson, Tamargo, 2012).

It has been emphasized that IMGs might have to wait from 18 months to 2 years for the clinical part of the AMC examination. Such a long waiting period to sit for this examination might limit employment opportunities for many IMGs (Han, 2010; Zubaran & Douglas, 2014).

IMGs specialists also experience problems with the passing of the required examination. According to the data provided by the College of Surgeons, only 48% of IMG surgeons had been able to pass the required Fellowship exam. At the same time, the passing rate for this exam of their Australian and New Zealand-trained counterparts was 70% (Webster & Ellison, 2009). IMGs surgeons who took this examination commented that the clinical part of this exam was the most challenging for them. IMG candidates emphasized that they had experienced difficulties (due to the required communication

style) in examining patients, discussing pathology and treatment with the patients during this examination and, concurrently, answering questions from an examiner. It is important to mention that absolute majority of the IMGs surgeons (about 90%) who described their difficulties during clinical examination already resided in Australia for a number of years. Nevertheless, they define the communication style of the examination as quiet different from their previous assessments (Webster & Ellison, 2009).

Assessment of Temporary Residents IMGs

It has been proposed that the skills of temporary residents IMGs are not thoroughly examined before they start practicing medicine in Australia (Birrell & Hawthorne, 2004; McGrath, 2004; Van Der Weyden & Chew, 2004). Some critics even suggest that temporary residents IMGs start working in Australian hospitals without a proper evaluation of their qualifications, English language abilities, or clinical skills (Spike, 2006). These concerns might seem legitimate especially considering the noticeable increase in the temporary medical migration in Australia (Iredale, 2009). From 2005 to 2010, 34,780 temporary skilled migrants versus 15,940 permanent skilled migrants as part of the health workforce migration arrived in Australia. 15,490 temporary 457 visas have been granted to foreign trained doctors in the same time period (Hawthorne, 2011a).

The analysis of the current immigration requirements regarding temporary 457 visa migrants does not support the claims that the skills of temporary residents IMGs are not thoroughly examined. In order to receive the mentioned visa, temporary residents IMGs have to be already registered by the Medical Board of Australia (http://www.border.gov.au). Their medical schools should be listed in the International

Medical Education Directory (IMED). The medical curriculum of these schools is evaluated. The IMGs' educational credentials are verified using the ESFMG. IMGs have to meet many approved by the Board registration standards such as English language proficiency, recency of practice, professional indemnity insurance, and continued professional development. In order to satisfy English language proficiency standards IMGs have to reach a required score in one of the English language tests, such as International English Language System (IELS) or Occupational English Test (OET) (http://www.ahpra.gov.au; http://www.amc.org.au; http://www.doctorconnect.gov.au; http://www.medicalboard.gov.au). One of the requirements of a temporary 457 visa is that an IMG has to have a confirmed offer of employment. The prospective employer of an IMG has to be approved by the government authorities and the compliance with the sponsorship agreement will be monitored by the Australian immigration authorities during and even after the sponsorship ends. Non-compliance with sponsorship agreement by the employer will result in losing the approved status. Consequently, the employer will not be able to sponsor any more IMGs (http://www.border.gov.au). Considering the mentioned requirements, the prospective employers are probably very selective when it comes to hiring overseas-trained workers. An IMG with questionable qualifications / training / clinical experience will not be considered as a potential employee by any reputable health care organization (which in many cases is a state-run health care provider such as hospitals, for example). Temporary residents IMGs are also supervised during their sponsorship period (http://www.medicalboard.gov.au). It has been claimed though that IMGs are supervised differently or experience limited supervision compared to the Australian trained medical graduates. Australian trained medical graduates are

supervised by the accredited GP trainers who can supervise only 2 individuals at the time. IMGs are not supervised by accredited trainers and their supervisors are allowed to work with 4 IMGs concurrently (Birrell, 2011; Douglas, 2008; McGrath, 2004). Adequacy of supervision might be a legitimate concern, but the critics of the approach to supervision of IMGs should consider that they are medical professionals who, probably, have been practicing medicine for many years (in contrast to the Australian trained medical graduates). Temporary residents IMGs will also have to demonstrate satisfactory work performance and their involvement in continuous professional development each time before they renew their limited registration. Unsatisfactory work performance might lead to the cancellation of their registration. IMGs might also have to complete an examination or go through an additional assessment to demonstrate their satisfactory work performance to the Board. Some critics of the Australian approach to licensing and registration of IMGs argue that temporary residents IMGs are exploited by their employers and experience a two-tier medical system in Australia. Those critics believe that the Australian licensing and accreditation policies discriminate against temporary residents IMGs (Zubaran & Douglas, 2014). Taking into consideration that the IMGs' employers have to provide them with the same working conditions as their Australian counterparts (including the wages and the number of hours they have to work each week) and these employers are monitored by immigration authorities, it is doubtful that temporary residents IMGs are completely powerless in negotiating their schedule with their sponsors. Temporary residents IMGs are also strongly encouraged to apply for general or specialist registration which leads to a permanent resident status and also

allows them to practice medicine anywhere in Australia without any restrictions (http://www.medicalboard.gov.au).

Permanent Residents IMGs: Registration Issues

Permanent residents IMGs can enter Australia as skilled workers, or as dependents of GSM migrants, or using family and humanitarian streams of permanent immigration to Australia (http://www.border.gov.au; Hawthorne, 2011a). IMGs who have been trained in the UK, Ireland, USA, Canada, or New Zealand can utilize the so-called Competent Authority Pathway to registration (http://www.medicalboard.gov.au). It is open to discussion why only the listed above countries are considered as competent authorities by the Australian licensing and registration bodies. The standards of medical education and training as well as the regulations and ethics of practicing medicine in France, Germany, Switzerland, the Netherlands, or Scandinavian countries are rather high and should be comparable with Australian requirements. Medical practitioners in the mentioned countries also do not have any difficulties communicating in English (as well as the majority of residents of these countries with post-secondary education). Nevertheless, IMGs from the countries of the European Union (except the UK and Ireland) are not entitled to use this particular pathway to registration.

It has been reported that IMGs who arrived in Australia as family members or refugees and, therefore, did not go through the current process of the selection of skilled migrants experience difficulties regarding licensing and registration. Many of those IMGs are not employed as medical practitioners even after residing in Australia for many years (Hawthorne, 2011b; McGrath, Henderson, & Philips, 2009). However, it has been suggested that these permanent residents IMGs can utilize the scheme for temporary

IMGs and, consequently, gain access to employment in their professional field (Birrell & Hawthorne, 2004). Taking into consideration that the absolute majority of IMGs currently enter Australia as temporary residents or use one of the skilled migration streams, problems with registration faced by some permanent residents IMGs might not be indicative of success or failure of the Australian approach to migration of health care professionals.

Australian authorities offer different pathways to registration which can be utilized by permanent residents IMGs. If an IMG is required to take the AMC examination, he or she can take the first part of this examination using some overseas examination venues. It should be noticed that MCQ examination venues are not located in any of the African countries and only 2 examination venues are available for IMGs in Latin America (http://www.amc.org.au). Considering that medical practitioners in developing countries do not earn the same wages as their counterparts in Europe, for instance, it might be problematic for IMGs from the mentioned states to travel to other countries in order to utilize MCQ examination venues. Travel costs, such as airfares, visas, accommodations, and some other related expenses might present a significant obstacle for IMGs from these particular countries. Other financial aspects of the examinations might also be quite challenging for many IMGs from the developing countries. The CAT MCQ examination costs $2,720 AUD and the AMC clinical examination costs $3,530 AUD (http://www.amc.org.au). Not every medical practitioner in a developing country can afford to pay $6,250 AUD especially considering the low passing rates for both parts of the examination. The expenses related to the immigration process itself might also be testing for many IMGs from developing countries. Potential

permanent residents IMGs have to pay for visas for themselves and their family members (skilled-independent / skilled-nominated / skilled-regional visas: the base application charge is $3,600 AUD, each additional applicant 18 years old or over is charged $1,800 AUD, and each additional applicant who is under 18 years of age is charged $900 AUD), for mandatory English language test, for their health examination, and for police certificates from each country they have lived in for 12 months or more over the last 10 years since they reached the age of 16 as well as for the translation and notarization of the required documents (http://www.border.gov.au). All relevant travel expenses, such as tickets to Australia, for instance, should also be included in the calculation. The burden of compulsory expenses might actually prevent otherwise qualified candidates from immigrating to Australia as medical practitioners.

IMGs might be required to go through a pre-employment structured clinical interview (PESCI) before they apply for provisional registration. The Medical Board of Australia claims that accredited by the AMC PESCI interviewers can objectively assess IMGs' skills and clinical experience in regards to a specific position (http://www.medicalboard.gov.au). It seems that PESCI providers are quite powerful: they actually decide whether a candidate is suitable for a particular position or requires some additional training. The review of the existing literature and the official website of Australian licensing and accreditation authorities does not allow concluding how the PESCI panel is supervised, who chooses members for this panel (what criteria is applied in choosing PESCI interviewers). There is also lack of information if a candidate can appeal the PESCI panel decision and what grounds are sufficient for their appeal.

Discussion and Conclusions

Canadian and Australian licensing and registration policies in regards to IMGs display some noticeable similarities and differences. It should be stated that selection of skilled migrants and licensing and registration policies of both studied states are rather intertwined and have to be analyzed and evaluated concurrently.

For instance, Canadian and Australian selection systems of permanent residents IMGs have demonstrated some convergence since January 2015 when the developed by the Canadian federal Conservative government Express Entry selection system of skilled migrants came into force. For the last year and a half IMGs who intend to enter Canada as permanent residents and principal applicants have to submit such required information as educational credentials, professional experience, personal demographic information as well as evidence of their English language fluency to the pool of candidates. For each selection criteria, Canadian-bound IMGs receive a specific number of points. IMGs who already have a verifiable offer of employment are also granted points for that essential selection factor. Candidates with a maximum number of points are selected by Canadian immigration officials and are invited to apply for a permanent resident visa. Some other requirements, such as security clearance and medical examination, also have to be met by applicants in order to be granted this type of visa.

This selection system is almost identical to the selection system of permanent residents IMGs which is utilized by the Australian immigration authorities. However, IMGs who currently intend to enter Canada as permanent residents and use the Express Entry option are not required to obtain any type of registration from Canadian licensing bodies before they are granted this type of visa by the Citizenship and Immigration

Canada. IMGs' educational credentials, work experience and clinical skills are not assessed in advance, before their arrival in Canada. Consequently, IMGs who enter Canada as permanent residents have to start the rather stretched and expensive process of registration and licensing after they arrive in this country. Evidently, those IMGs are not going to practice medicine in Canada before they successfully complete the licensing process which includes two or three years of residency training.

In contrast, IMGs who decide to enter Australia as permanent residents through the skilled immigration stream are assessed by the Medical Board of Australia before they are granted this type of visa. The applicants for this visa are required to get registered with the Medical Board of Australia well before they might be granted a permanent visa by the Australian Department of Immigration. Being registered with the Medical Board of Australia, permanent residents IMGs can utilize various employment opportunities and are not out of the health care workforce for a significant period of time as their Canadian counterparts.

Lack of well developed federal or provincial programs prevents IMGs from entering Canada as temporary skilled migrants. On the contrary, the majority of IMGs immigrating to Australia enter this receiving country utilizing temporary work visas. Temporary residents IMGs are required to register with the Medical Board of Australia, therefore, their skills and credentials are evaluated and verified prior they are granted this type of visa. One of the requirements for temporary work visa is a verifiable and approved offer of employment which should be submitted by IMGs to the Australian immigration authorities. The perspective employers of temporary residents IMGs are approved and constantly monitored by the Australian immigration authorities. It is

important to mention that the Australian government funds employment agencies which help IMGs get connected to their prospective employers in Australia. Hence, temporary residents IMGs start practicing medicine immediately after their arrival in Australia.

There are some other common features in regards to the licensing and registration of IMGs by relevant Canadian and Australian authorities. Both groups of IMGs are required to possess medical degrees from educational institutions which are recognized by the licensing / registration bodies of the receiving countries. Both groups of IMGs can use some online tools to find out whether their medical schools are recognized by the MCC and the AMC. Nevertheless, only IMGs who intend to work as medical practitioners in Australia have to verify their medical qualifications using the ECFMG electronic portfolio of international credentials which is used later by the Medical Board of Australia as a part of their registration procedure. The Australian specialist colleges also use the evidence of the verification of credentials of IMGs during their assessment process.

Both groups of IMGs can take some required examinations at a rather limited number of venues overseas before their arrival in the receiving country. However, almost all examinations, including clinical examinations, are administered only in Canada or Australia respectively. The complexity of the required examinations, the costs associated with these exams, and rather low passing rates demonstrated by IMGs are common characteristics of the licensing and registration process in both countries. Still, unlike Canada, Australia offers various registration options for IMGs. Australia-bound IMGs have the opportunity to choose a registration option which does not require taking any examination at all. Australia does not require permanent or temporary residents IMGs to

complete a postgraduate medical training before they can start practicing medicine. It does not mean that Australian registration bodies are not concerned with safety and quality of health care services provided by IMGs. IMGs might be required to attend the structured pre-employment interview specifically designed for a particular position. The renewal of limited registration by IMGs includes numerous requirements such as mandatory supervision, satisfactory work performance and continuous professional development. Their Canadian counterparts (after they have successfully completed all the required examinations) have to secure a residency space which in many cases seems quite problematic considering the lack of residency placements in this country. Canadian IMGs have to sign a Return of Service Agreement as a condition of being offered a space in a residency program and work in underserviced areas for a specified number of years after they complete their residency training. The Return of Service program might seem similar to the Australian Area of Need or District of Workforce Shortage programs. All these programs intend to place IMGs in locations in which there is a shortage of medical practitioners. However, temporary residents IMGs in Australia (as well as permanent IMGs who want to use this option) are allowed to practice medicine immediately after their arrival in Australia or, in case of permanent residents IMGs who might already be in the country, as soon as they meet the requirements for a limited registration. Temporary residents IMGs are encouraged by the Australian registration authorities to apply for standard or specialist registration which leads to unrestricted employment anywhere in Australia. Some Canadian permanent residents IMGs who receive their medical education and training in such countries as Australia, Hong Kong, Singapore, Ireland, the US, New Zealand, or South Africa might not be required to go through any additional

postgraduate medical training in Canada. This part of the Canadian approach to licensing of IMGs is comparable with the Australia Competent Authority Pathway to registration. However, since 2014, IMGs who chose the mentioned Australian pathway to registration must secure employment before they are granted a provisional registration by the Medical Board of Australia. It is rather telling that all Australian pathways to registration have a positive correlation with the prearranged employment for all categories of IMGs. The current Canadian licensing approach to IMGs fails to demonstrate its commitment to the employment of this group of foreign trained health care professionals.

Since July 2010, 14 health professions (including doctors) are regulated in accordance with the Health Practitioner Regulation National Law by the Australian Health Practitioner Regulation Agency. The National Registration and Accreditation Scheme is delivered by the AHPRA and 14 national boards (including the Medical Board of Australia). Therefore, the national approach to registration of all medical practitioners, including IMGs, has been established. In contrast, Canada still does not have a nationally consistent approach to licensing of IMGs.

Canadian and Australian licensing and registration policies in regards to IMGs have experienced adjustments in accordance with the perceived oversupply or shortage of medical practitioners in the studied countries. In the times of perceived oversupply of medical professionals both countries applied similar restrictions and developed some rather hard to meet requirements for registration in order to limit the entry of foreign trained doctors. Currently both countries do not employ fundamentals of the human capital model to the selection process of immigrant professionals. However, since 2010, Australia started to implement the national approach to registration of IMGs. Besides the

national regulations concerning the registration of foreign trained health care professionals, there is a variety of registration options which might be utilized by that group of immigrant doctors in order to be employed in their intended occupation. Multiple ways to registration as well as the pragmatic approach to immigration of medical practitioners which requires them to verify their educational credentials, get registered with the Medical Board of Australia, and to secure an approved and verified employment offer before they are granted visas by the Australian immigration authorities positively affects labour market participation of IMGs in that country. The much criticized neo-corporatist model of selection of highly skilled migrants provides IMGs with the opportunity to practice medicine without delay after their arrival in Australia which is essential for successful economic integration of this group of professional migrants. It also addresses adequately (at least to a certain degree) the explicit objectives of the Australian health care strategy concerning the provision of health care services in underserviced areas. Applying mandatory registration as a prerequisite to issuing visas, Australian policy makers (one way or another) put forward a meaningful and coherent solution to the issue of non-recognition of foreign educational credentials. It is important to emphasize that Australian registration bodies developed clearly outlined policy instruments and support temporary residents IMGs in their efforts to apply for general / specialist registration which leads to unrestricted practice anywhere in Australia and, consequently, grants permanent residency.

On the contrary, IMGs immigrating to Canada have very few options to choose from. They are still subjected to the challenges of the lengthy and expensive licensing process with rather unknown outcome. Lack of residency places does not allow foreign

trained doctors (who did succeed in the examination segment of the licensing process) to practice medicine and make a valuable contribution to the Canadian health care system. There is a noticeable disconnect between Canadian licensing policies of IMGs and recently introduced immigration approach to the selection of professional immigrants. As skilled migrants, foreign trained doctors receive required selection points if they have a verifiable offer of employment. However, foreign trained doctors can not be employed as medical practitioners in Canada (except for very rare exemptions) before they complete their licensing process. The recently introduced Express Entry system basically prevents foreign trained medical professionals from receiving the required number of points needed to become a suitable candidate for permanent residency.

Canadian licensing and immigration policies do need some rather urgent modification. At the very least, they need to be in-tune and should not contradict one another. There is also the time to develop and implement a nationally consistent approach to licensing of IMGs in this country. The current Australian model of registration of foreign trained medical professionals might be looked at as quite a pragmatic, consistent, and rather efficient approach which undoubtedly has been beneficial to IMGs and to the Australian society at large. The current Canadian licensing approach is inflexible and does not correspond with the realities of globalized health care workforce trends. Canadian IMGs who are mostly not employed in their intended occupation for years and who do not have options to complete their licensing process in a reasonable time and with a successful outcome, might choose other jurisdictions which are more creative in their efforts to utilize the expertise of foreign trained medical practitioners.

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Glossary

AHPRA – Australian Health Practitioner Regulation Agency

AMA – Australian Medical Association

AMC – Australian Medical Council

AMC MCQ Examination – Australian Medical Council Multiple Choice Question Examination

CFPC – College of Family Physicians of Canada

IMG – International Medical Graduates

MCC – Medical Council of Canada

MCCEE – Medical Council of Canada Evaluating Examination

MCCQE– Medical Council of Canada Qualifying Examination

NAC Examination – National Assessment Collaboration Examination

PESCI – Pre-Employment Structured Clinical Interview

RCPSC – Royal College of Physicians and Surgeons of Canada