Policy Document

International Students

Position Statement

AMSA believes that:

1. All Foreign Graduates of Australian Medical Schools (FGAMS) should have the opportunity to complete their internship in Australia to achieve full medical registration;
2. All FGAMS should be supported in their pathway to apply for and attain a visa and permanent residency;
3. Where possible, FGAMS should be given the opportunity to undertake rural placements;
4. International medical students are an under-investigated resource in the rural health workforce distribution;
5. The cost of a full-fee paying medical degree places a significant financial burden on many international medical students and their families;
6. All prospective medical students deserve open and transparent communication about all aspects of studying in Australia;
7. All international medical students should receive necessary support to return to their home country to practise medicine;
8. During times of crisis, international students require additional consideration to protect their wellbeing and the progression of their medical degree;
9. International medical students should be provided with supports for their physical and mental health.

Policy

AMSA calls upon:

1. Australian Federal Government, State and Territory Governments to:
    a. Provide all FGAMS who wish to complete their internship in Australia with the opportunity to complete a supervised internship in Australia;
    b. Conduct research into the outcomes of utilising international students and FGAMS as a resource in the rural health workforce;
    c. Support the provision of concessional transport to all international students;
    d. To regulate private insurers providing Overseas Student Health Cover (OSHC) by:
        i. Waiving the requirement for full fee upfront payment in public hospitals;
        ii. Providing adequate pharmaceutical reimbursement;
        iii. Reducing the waiting time for international students after arriving in Australia to access insured medical care;
2. Australian Government, Department of Home Affairs (DHA) to:
    a. Recognise all FGAMS as having met English language requirements upon graduation for AHPRA registration and visa application;
    b. Remove the work restriction attachment on the spouses and dependents of international medical students studying under the subclass 500/573 student visa;
    c. Revise current visas to provide FGAMS lawful stay and work in Australia, for at least the duration of their postgraduate clinical training;

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d. Create an accelerated pathway for FGAMS to obtain permanent residency after graduation;

3. Australian Government Department of Education, Skills and Employment to:
   a. Enforce *the National Code of Practice for Providers of Education and Training of Overseas Students* (2018) through ongoing monitoring;
4. Australian medical schools and universities to:
   a. Where practicable, be transparent regarding:
      i. The total financial cost of studying and living in Australia;
      ii. Admission requirements for medicine;
      iii. The availability and distribution of medical internship positions in Australia;
      iv. The likelihood of returning to their home country to practise after graduation;
      v. The number of international medical students recruited annually;
   b. Conduct ethical recruitment of international students in line with *The National Code of Practice for Providers of Education and Training to Overseas Students* (2018);
   c. Advertise the Junior Doctor Training Program to graduating international medical students;
   d. Accept the UCAT from international undergraduate applicants as an alternative to the ISAT;
   e. Empower international student representatives of Australian medical schools and ensure open communication channels with them;
   f. Create emergency response planning specific to international medical students for future states of emergencies;
   g. Provide resources for international medical students to electively complete foreign licensing;
   h. Allow leave for students undertaking travel for foreign licensing processes, internship applications, and exams;
   i. Facilitate away rotations for international medical students to create a competitive application for foreign post graduate training;
   j. Conduct and facilitate research regarding the mental health of international students, including international medical students;
   k. Provide financially accessible and culturally appropriate health and mental health services for international medical students;
   l. Provide financial support to international students on rural placement similar to their domestic student counterparts;
   m. Once Commonwealth requirements have been met for domestic quotas for rural placements, offer both domestic and international students equal access to remaining places;
   n. Provide information in regard to the 10-year moratorium and its effect on future training and practice prior to enrolment;
5. Australian specialist colleges to:
   a. Recognise applicants for specialist training by their university accreditations and clinical experience, rather than their nationality or permanent residency status;
   b. Remove permanent residency requirements when applying for all specialist training programmes;
6. Australian Hospitals to:
   a. Ensure that FGAMS will continue being sponsored for their visa for the entire duration of their training, unless otherwise deemed unfit to remain employed.

7. Prospective and current international medical students to:
   a. Seek information about internships and visas from credible sources, including universities, AMSA, state medical student councils and registered migration lawyers;
   b. Consider all internship opportunities beyond the state of their graduation, such as interstate applications, Junior Doctor Training Programme and overseas job opportunities;
8. AMSA, AMSA International Student Network (ISN) and Australian Medical Student Societies to:
   a. Research the mental health burden of international medical students in Australia and the associated risk factors;
   b. Advocate for the continual review of the Junior Doctor Training Program in keeping with workforce demand and international student numbers and admissions;
   c. Provide up-to-date information on post-graduate visas to international medical students, and clearly explain how these changes might affect them;
   d. Provide open feedback channels with international representatives of Australian medical schools;
   e. Communicate openly during times of crisis to better escalate international student advocacy;
   f. Support the international student representative role in terms of advocacy of international students.
   g. Provide international medical students with contacts to migration lawyers and other services relevant to acquiring visas after graduation.

Background

The Australian Medical Students' Association (AMSA) is the peak representative body for medical students in Australia. Accordingly, AMSA is uniquely placed to advocate on issues relevant to international medical students in Australia.

International Medical Students (IMS) are defined by their temporary residency status in Australia with a Higher Education Sector Visa (subclass 500 or 573) at the time of commencement of their degree, allowing them to complete an accredited medical degree in an Australian University [1,2]. It is important to note that IMS refer to those who are enrolled in onshore Australian medical schools. Once graduated, IMS become Foreign Graduates of Australian Medical Schools (FGAMS). In Australia, the export of international education was worth $30.3 billion AUD in 2017 [3].

IMS in Australian medical schools face a number of unique challenges. These challenges may occur before, during and after the medical degree and encompass every aspect of international student wellbeing. Logistic problems such as difficulty obtaining internships and appropriate visas with pathways to permanent residence are well documented and historic problems for IMS. Rural health placements are largely inaccessible to IMS; and the physical, mental and financial health of IMS are more likely to be at risk during times of national and global strife.

Internships for international students

Current Internship Situation

Internship is an essential component of medical training. The Medical Board of Australia (MBA) clearly stipulates that all Australian and New Zealand medical school

graduates, including IMS, are not eligible for general registration unless they undertake a period of approved intern training [4].

The number of medical students in Australia has increased over the past two decades. However the number of state and territory funded intern positions has failed to keep up, resulting in a shortfall in internship places since 2010 [5]. In 2018 there were 3475 graduates and only 3365 intern positions, leaving a shortfall of 110. In the past, the State and Territory Governments introduced priority lists for internships based on either Commonwealth Supported Placements (CSP) status, residency status or merit. Currently, all students with a CSP are guaranteed an intern position, whereas IMS are not.

In all states and territories, IMS are allocated positions after CSP students who have graduated from medical school in the state or territory [6-11]. Lower preference applicants are left to a merit based system for the few remaining spots after allocating internship positions to domestic students [6-11]. This is further strained by Commonwealth initiatives, such as the *Stronger Rural Health Strategy*, that is already in motion. This program will take away positions from the current internship pool and redistribute them towards new rural focused medical schools [12]. Initiatives like this aim to provide better distribution of health service professionals to rural areas, but do so at the cost of shrinking the pool of internships for FGAMS. The creation of these schools that will receive exclusive internship positions taken from the current internship pool via the *Stronger Rural Health Strategy* will also increase the number of students competing for internships, both domestic and international students alike to exacerbate the internship strain [12].

Furthermore, the establishment of the Macquarie Medical School will see a net increase of 60 medical students per year in Australia, including 40 domestic and 20 international, from 2018. The opening of the Sunshine Coast University Hospital will see a net increase of 50 medical students from 2019, with a concomitant expansion in international student numbers by 15. The Murray Darling Medical School proposal is set to further exacerbate the rise.

FGAMS who are unable to secure an intern position in Australia will be forced to either access prevocational training overseas, or wait another year for an opportunity to obtain an internship. However, there is a limit of three years after graduation from medical school to be eligible for general registration, and many countries outside of Australia and New Zealand, such as Thailand, have moved to only accredit graduates from Australia who have obtained full accreditation as medical practitioners after internship.

The chokepoint of an internship is unique. After obtaining general registration, FGAMS rise to equal footing with their domestic counterpoints when applying for resident and registrar positions [13]. The probability of obtaining general registration for FGAMS is not well communicated to international medical applicants before starting medical school. Internship availability is one of the few remaining obstacles IMS face before being considered equal to domestic counterparts.

Junior Doctor Training Program (JDTP)

In response to the national internship crisis and pressure from medical students, the Federal Government introduced the Commonwealth Medical Internship (CMI) which has been converted to the JDTP in 2018 [14]. This program now funds 115 additional internships per year for international full-fee paying graduates of on-shore Australian medical schools [15]. These internships must be completed in private hospitals and other non-traditional primary care settings outside major metropolitan areas [15]. This program is further detailed in the AMSA Policy: Internships for International Students 2019 [16]. This program has acted as a safeguard for FGAMS who were unsuccessful in securing a state internship and has provided relief in addressing the shortfall in intern positions. As of June 2020, the JDTP has been sufficient to address the shortfall of

FGAMS without internships and that are agreeable to private stream internship. Expansion of medical schools and creation of programs that take CSPs away from state internship pools, reducing the supply of state internships. This generates downstream effects on FGAMS internships, which will shuttle increasing numbers of IMS towards JDTP and will threaten the long term viability of the JDTP. Furthermore, IMS typically wait months longer to receive offers for state internships which presents a significant mental health strain and is only exacerbated by the late application window of JDTP starting in September of each year.

English Requirements for Visas, Internship and General Registration

Currently, IMS applying for temporary visas (subclass 482 and 485) and permanent residencies (subclass 189 and 190) are subject to a minimum English Language proficiency requirement. While exemptions are given to IMS holding passports from certain recognised countries, many applicants are required to sit the International English Language Testing System (IELTS) and score a certain grade to be certified competent [17].

Under the AHPRA English requirements, English proficiency can be proven using either the visa English requirement or other alternatives. Notably, previous education in a recognized English speaking country is sufficient under one of three criteria: 1) completion of primary, secondary and tertiary education in a recognised country, 2) two years of secondary and tertiary education in a recognised country or 3) six years of continuous study in a recognised country (including Australia, Canada, New Zealand, Ireland, United Kingdom, United States and South Africa) [18]. Failing to meet any of these three options dictates the need for additional English proficiency examinations.

However, the current process leaves out students from non-recognised countries who, together with those from recognised countries, would have been expected to write and converse in fluent English during their four to six years of medical education in Australia. Furthermore, many IMS in general would have prior secondary education qualifications that more than satisfy the aforementioned English requirements. For instance, international students from Singapore are often required to take either the General Paper in the Singapore-Cambridge GCE A-Levels, English Language in the Singapore-Cambridge GCE O-Levels, or English as a Group 1 language subject in the International Baccalaureate.
Furthermore, there are costs associated with taking an English proficiency exam; as an example, IELTS was $355 AUD in 2020 [19].

Visas

Note: Migration law is extremely complex. The visa pathways that one can take are highly specific to one's individual circumstances, and change frequently with time. This section offers an overview of the visa issues faced by IMS, as of July 2020.

Current Visa Situation

Prior to March 2018, most graduating IMS would apply for the subclass 457 visa, which allowed for work and stay in Australia for up to 4 years under an employer's nomination and sponsorship. After obtaining AHPRA registration, FGAMS were then eligible to apply for sponsored permanent residency (PR) [20].

However, as of March 2018, the subclass 457 visa was abolished and replaced by the new Temporary Skills Shortage (TSS) subclass 482 visa [21]. This new TSS visa consists of two occupation lists: the Short-Term Skilled Occupations List (STSOL) valid up to 2 years and Medium and Long-term Strategic Skills List (MLTSSL) valid up to 4 years [22].

For IMS who were granted their first student visa before 5th November 2011, the Department of Home Affairs has made the following recommendations [23]:

1) Before commencing internship, apply for STSOL under "Resident Medical Officer".
2) Upon obtaining full AHPRA registration (typically after PGY1), convert the STSOL visa to the MLTSSL under "Medical Practitioners Not Elsewhere Classified (NEC)". This MLTSSL will be valid for 3 more years.
3) With the MLTSSL visa and full AHPRA registration, doctors can then begin applying for permanent residency (PR). Applicants under STSOL cannot apply for PR.
4) If PR is not obtained by end of the first MLTSSL visa (usually PGY4), FGAMS can renew their MLTSSL visa multiple times onshore.

For IMS who were granted their first student visa on or after 5th November 2011 (most current IMS), the Temporary Graduate (TG) subclass 485 visa is a popular option. Unlike the TSS visa, this TG visa does not require nomination or sponsorship by an employer [24].

The TG visa has two available streams, the more relevant being the Post-Study Stream valid for 2-4 years depending on one's qualifications. Students who have received their student visa before 5th November 2011 are not eligible for the TG visa. Only the TSS visa is available for them [23].

After obtaining full AHPRA registration, doctors under the TG visa can either:

1) Submit an Expression of Interest (EOI) for PR directly (via the Skilled Independent Visa (subclass 189) [25], Skilled Nominated Visa (subclass 190) [26], or Skilled Work Regional Visa (subclass 491) [27]; or
2) If PR is not obtained by the end of the TG visa, FGAMS can apply for the MLTSSL under 'Medical Practitioners NEC' [18] and renew multiple times onshore. The TG visa is not renewable [24].

A summary of this process can be found in Appendix 1.

<u>Eligibility for the MLTSSL stream in the TSS Visa</u>

Currently, the 'Medical Practitioners NEC' under MLTSSL covers anyone with an AHPRA registration. However, this is with the exception of anaesthetics, which is listed under the Regional Occupation's List [28]. This may restrict the range of visas that IMS pursuing anaesthetics can apply for in the future, should they remain unable to obtain PR.

Additionally, the MLTSSL list is reviewed by The Australian Department of Home Affairs every 6 months and can change according to the occupational demands in Australia. This leaves FGAMS vulnerable to exclusion from the TSS visa in the future.

<u>Implications on Permanent Residency</u>

Under the former 457 visa, FGAMS could express interest in sponsored PR after obtaining full AHPRA registration (usually after PGY1). Currently, the hurdle for FGAMS under the TG visa (most graduates) for PR EOI application is obtaining full AHPRA registration. This usually occurs after PGT1. However, for FGAMS who take up the TSS visa after graduation, the hurdle for PR EOI application is the conversion from the STSOL stream to the MLTSSL stream, which usually happens after PGY2, after a year on STSOL. Thus, in terms of qualifications, most FGAMS are not disadvantaged when submitting an PR EOI application. The few disadvantaged students (TSS visa holders) only face an additional year of waiting time.

Being successful in one's PR EOI application will depend heavily upon individual circumstances. For instance, applicants for the points-tested subclass 189 visa only require 65 points (comprising of age, qualifications, training time etc. [25]) to submit an EOI, but require 90 points to be invited for a PR application [25]. Realistically, this 90-point requirement makes it difficult for some FGAMS to receive PR invitations on their first attempt, forcing them to submit multiple EOI attempts. This delays the PR status for these students and carries significant financial costs for the applicant (each application costs AUD 4045, excluding extra costs from various checks and additional family members) [25].

Implications for Specialist Training Programs

Currently, several specialist colleges require FGAMS to obtain PR status before applying for an accredited registrar position [16]. Some examples include the Surgical Education and Training (SET) programmes [29], Obstetrics and Gynaecology [30], Ophthalmology [31]. For the minority of FGAMS who require multiple attempts at obtaining PR, these PR prerequisites place them at greater risk of being ineligible for these specialist training programmes at the same time as their domestic counterparts. Additionally, the delay in obtaining PR could make colleges without PR prerequisites more competitive for domestic students. Some of these colleges include the Australian College of Rural and Remote Medicine (ACRRM) [32], Royal College of Pathologists of Australasia (RCPA) [33], and Royal Australian College of Physicians (RACP) [34]. Even though these colleges do not have any specific residential requirements for trainee selection, employing Health Services may have citizenship / residency requirements that need consideration in appointment decisions [33]. This further exacerbates the aforementioned delay for some FGAMS in getting on to specialist training programmes.

Coverage of Visas for Duration of Training

All TG visas and most TSS visas for FGAMS are valid for a period of 2 years, depending on one's qualifications and individual circumstances [35]. Thus, FGAMS under these conditions are required to renew their visas every 2 years in order to continue living and working in Australia. Not only does this increase total costs (each application costs approximately AUD 1265 - AUD 2645) [17], it creates unnecessary worry amongst FGAMS who may be forced out of Australia mid-training due to expired or rejected visas. This is in comparison with the US system, where all medical graduates from non-US medical schools will apply for visas which guarantee coverage for the full duration of their training [36 - 38]. Therefore, there is a strong case for restructuring Australia's visa programme to ensure that FGAMS are guaranteed a visa for the entire duration of their training programme.

Hospital Sponsorship for Visas

As of 12 August 2018, the Department of Home Affairs has implemented the new Skilling Australians Fund (SAF) levy, where all employers are required to pay an additional sum for each nominated overseas worker (e.g. doctors holding TSS visas). The total amount payable ranges from $2400 to $7200 AUD per person, depending on the visa and the hospital's annual turnover [39]. Because of this additional financial burden, hospitals may be reluctant to nominate and sponsor FGAMS for the TSS visa forcing them to seek other visa options. This affects the job prospects of future FGAMS.

Rural health placements

The Rural Paradox

There is a lack of opportunity for IMS to complete rural placements during medical school. The Rural Health Multidisciplinary Training Program (RHMTP) funds University Departments for Rural Health (UDRH) across Australia. These departments are

mandated to provide rural clinical placements for health students, and increase student exposure to rural practice [40]. However, the funding for UDRH is preferentially aimed towards CSP students. A clear example is the John Flynn Placement Program (JFPP), an initiative of the Australian Department of Health available only to domestic students and designed to attract the future medical workforce to a rural career [41]. As it stands, the Rural Clinical Training and Support (RCTS) program has contracts with 18 medicals schools as of 2019 [42], with the following target requirements:

- 25% of Australian medical students are to undertake a minimum of one year of their clinical training in a rural area (defined as ASGC-RA 2–5) by the time they graduate;
- 25% of CSP medical students are to be recruited from a rural background; and
- All CSP medical students must undertake at least four weeks of structured residential rural placement in an ASGC-RA 2–5 region. [43]

Many of these programs were founded with the intent to promote doctors joining the rural workforce and reducing health inequity. Current literature states that there may be scope for including FGAMS as an avenue to remediate the rural workforce shortage [40, 44, 45, 46], but there is no evidence as of 2020 that definitely proves or disproves this. Given the purpose of the aforementioned programs, there may be a tangible benefit to the workforce distribution in providing international students with opportunities to participate, on an opt-in basis. Medical schools provide those opportunities at their discretion, often with drawbacks. These can include lack of financial support for IMS [47, 48, 49] or charging higher accommodation costs compared to domestic students [48]. This situation creates a paradox in which international students are commonly placed rurally during junior doctor years without prior rural experience during medical school. IMS are also not provided with targeted support or access to the support provided to domestic medical graduates.

Rural Workforce Retention Strategies

The literature on rural health workforce retention strategies fails to distinguish between international and domestic medical students [50]. FGAMS are lower priority than domestic students for internships in all states but one, and therefore often work in rural areas as these are the least favoured by domestic medical graduates. Retention of health professionals in rural areas is a priority for the Australian health system, and research shows that this is a multifaceted challenge [40, 51]. Factors that increase the likelihood that a medical graduate will work rurally in the future include: having an interest in rural health, rural exposure in medical school, and support provisions such as accommodation [47, 50, 52, 53, 54]. It has been demonstrated that completing rural clinical placements in medical school is more positively correlated with accepting a rural internship than originating from a rural area [47, 55]. Further studies show that place-based processes, or the social and educational landscape available to students, are the most important factors in fostering retention [56], and this is supported by the National Rural Health Student Network (NRHSN) guidelines for optimising rural placements [57]. These call for the supply of affordable accommodation to all students, a reduction in the financial barriers to going rural, and equitable access to rural placements.

FGAMS in the Rural Workforce

There is little research on the retention of FGAMS in the rural workforce. Approximately 70% of FGAMS stay in Australia following graduation [58]; according to the Department of Health, FGAMS make up approximately 10% of PGY1-2 doctors [51, 59], and as of 2015, FGAMS occupied 7.7% of PGY2 positions [60]. As previously mentioned, the JDTP helps address the internship shortfall for FGAMS by offering employment to junior doctors in early post-graduate years (PGY1-3). This employment takes place outside of major metropolitan areas, and all doctors participating are obligated to complete a minimum of one rural rotation per year [61]. This means FGAMS are more

likely to work rurally in junior doctor years than their domestic counterparts [44, 59]. Furthermore, under section 19AB of the Health Insurance Act, there is a 10 year restriction, known as a moratorium, on the provision of Medicare provider numbers to FGAMS [44, 62]. If an individual was to achieve college accreditation before the 10 years have elapsed, they would be unable to work in metropolitan areas until the moratorium expires. In order to access Medicare benefits in the first decade of an FGAMS career, the individual is required to apply for an exemption, which is only granted on the basis of practising in a distribution priority area for GPs or a district of workforce shortage (DWS) for specialists. These terms are the same as those that IMGs are subject to. This restriction leads to higher likelihood of FGAMS into rural practice, with doctors practising in remote areas afforded a larger scaling bonus for exemptions. There is insufficient research on the retention of FGAMS beyond PGY3 to adequately comment on the success of the current strategies.

Vocational Training Challenges

The rural training pipeline of FGAMS brings its own set of challenges. Vocational training is generally urban centric, which impacts the ability and willingness of FGAMS to relocate rurally [45, 51, 58]. There has been a recent push by the Australian Department of Health to provide vocational opportunities in regional areas, but with the financial stress of hefty loan repayment for international full fee paying students, and the expected lack of income growth in rural spaces, the likely placement of FGAMS into those areas may directly impact career progression [58]. This suggests that the current health infrastructure is not able to adequately balance the needs of its FGAMS workforce with the needs of its rural health consumer base, and requires further investigation into solutions that best serve both of these populations [44, 58].

Health of international students

Overseas Student Health Cover (OSHC)

OSHC is a type of private health insurance for IMS and their dependents, offered by private health insurers. As a condition of their student visa, IMS must purchase OSHC that covers the entire length of their studies. Most IMS are not eligible for medicare [63], while students from 11 eligible countries (the United Kingdom, New Zealand, Ireland, Sweden, Finland, the Netherlands, Norway, Italy, Malta, Belgium and Slovenia) are able to obtain Medicare under a Reciprocal Health Care Agreement (RHCA) [64]. Students from these countries are still required to purchase OSHC unless exempt [64]. For a 4-year medical degree, OSHC costs at least $2100 AUD for a single student [65].

OSHC aims to ensure “adequate and affordable healthcare” for IMS while studying in Australia. The coverage of OSHC is similar to Medicare for in-patient treatments, as the minimum level of OSHC coverage for in-patient services must include 100% of the cost subsidised by the Medicare Benefits Schedule (MBS). However, as an outpatient, only 85% of MBS benefits are available for most services not provided by a general practitioner, such as pathology and radiology. If students with OSHC are admitted into a public hospital, a full upfront payment is expected to be made. The amount refundable is then determined at the discretion of individual state, territory and health services, and it may not be fully covered [64, 66].Some out-of-pocket expenses can also incur for private hospital visits, depending on the contractual arrangements the insurers have in place with the hospitals. Furthermore, OSHC coverage does not include subsidised pricing for medications under the Pharmaceutical Benefit Scheme (PBS). For expenses exceeding the equivalent of the PBS, a maximum of $300 AUD per person per year is refundable. IMS must pay for the pharmaceuticals and submit a claim to their health insurer for reimbursement. The amount of reimbursement may vary between health insurers [64].

For IMS with pre-existing conditions, waiting periods apply before they can benefit from their health cover. The waiting period is 2 months for pre-existing psychiatric conditions, and 12 months for all other pre-existing medical conditions, including pregnancy related services. The waiting period starts from the date the student arrives in Australia, or the date their student visa is granted, whichever is later [64]. This means IMS with pre-existing medical conditions, or are pregnant when they arrive in Australia, need to pay the full costs of their medical treatments before the waiting period passes. Although the waiting period does not apply in emergency situations, it can still deter IMS from accessing health care and inflict additional financial burden on IMS.

Fees and Work Restrictions

In 2018, IMS occupied 17% of medical student places in Australia [67]. These students study as private students on an upfront full–fee paying basis, and can be expected to pay over $350,000 AUD in university fees alone, depending on the duration of their course [68, 69]. The tuition fee is subject to an annual review, and an increase is commonly seen from year to year.

The financial burden experienced by IMS is compounded by the restrictions placed on their earning capacity. IMS (both undergraduate and postgraduate) are subjected to the regulations of the subclass 500/573 visa. IMS are limited to 40 hours of work per fortnight. Spouses and dependents of the international student are restricted to working no more than 40 hours per fortnight throughout the year [70]. The Department of Immigration and Border Protection (DIBP) stated that the estimated cost of living for an international student in Australia as of October 2019 is $21,041 AUD per 12 months [71]. With a work restriction in place, IMS may not have an income that is sufficient to support their cost of living. This is in direct contrast to students enrolled in a postgraduate Masters by research or Doctoral degree, or who are sponsored by Foreign Affairs or defence. Family members of these students can work unlimited hours [70]. On the other hand, FGAMS often face hefty fees when applying for visas and residencies and greater uncertainty with regards to their future. This significantly increases the financial burden and psychological stress of medical graduates who are navigating this system.

Travel Concessions

Travel concessions help to alleviate daily transport costs associated with education, and they are an important part of student welfare. Currently, IMS enjoy similar tertiary student transport concessions to their domestic counterparts in all Australian states and territories, except Victoria and New South Wales. This adds another layer of financial stress as travel to placement sites is a requirement for course participation and ultimately graduation.

In Victoria, all international students pursuing an undergraduate degree are eligible for an international Undergraduate Student Education pass (iUSEpass). This concession card is purchased at 50% of the cost of an annual myki pass, which amounts to $877.50 AUD for travelling in metropolitan Melbourne. However, this payment must be made upfront, and a new payment needs to be made after 12 months if the student wishes to continue using iUSEpass [72]. In comparison, domestic undergraduate students in Victoria pay a 50% concession fare each time they travel, with no upfront payment needed [73]. International postgraduate medical students on the other hand, are not eligible and need to pay over $1600 AUD per year for travelling on public transport. Similarly, in New South Wales, IMS are not eligible for travel concessions, unless their studies are fully funded by specific Australian Government scholarships [74]. Of all international students in Australia, 68% reside in NSW or Victoria [63]. Hence, this places the majority of IMS at a more vulnerable position to financial stress than their domestic counterparts.

Mental Health

Many IMS must learn to adapt and adjust to a new environment which can be challenging and confronting. Health is defined as a state of complete physical, mental and social well being [75]. Hence, while much emphasis is often put on physical health, an equivocal focus should be placed on mental health given its close relationship to physical health.

Risk factors found to be associated with an increased risk of mental disorders amongst immigrants include separated cultural identity, loss of close family ties and stress associated with adjusting to a new country [76, 77, 78]. IMS are similar to immigrants in many ways as they are settling into Australia as well.

In addition to these risk factors, the emotional and mental stress of being a medical student should not be overlooked as the psychological distress, burnout and the prevalence of mental health disease is significantly greater in medical students compared to the general population [79]. A BeyondBlue study in 2013 revealed medical students experience very high rates of depression and psychological distress compared to the general population, with approximately one in five reporting suicidal ideation in the last 12 months [79]. A study showed that a sense of belonging to the community coupled with perceived social support has been found to be positively associated with better mental health amongst immigrants [80]. While many universities offer general mental health support services, options catered specifically for IMS are unclear. This represents a potential looming problem as IMS display multiple risk factors for mental health issues and is relatively unstudied as a potential group at risk.

Ethical recruitment and admissions

International Medical Student (IMS) Recruitment

Education agents play a key role in the recruitment and enrolment of IMS in Australia, with over 70% of all enrolments in Australian education institutions attributable to their work [81]. These agents have a formal contract with the education institutions they work with, establishing a transactional relationship in which agents are paid a commission fee for every student enrolled. As such, the fees for employing an agent are not charged to the student, but rather to the educational institution.

The *National Code of Practice for Providers of Education and Training to Overseas Students* was commenced in 2018 in Australia, adopting ideas from the “London Statement” and outlining that educational institutions were to be responsible for ensuring the quality of the education agents employed. [82]. The *London Statement* is a document outlining an ethical framework and principles that agents are recommended to adhere to in an attempt to ensure information provided to students is accurate and honest [83].

Outside of this code, there is little information regarding how often agents should be followed up by institutions, and the information that agents should be providing prospective students. This is particularly important in the recruitment of IMS for medical courses in Australia - who face unique issues in terms of medicine being a significant financial burden, medical graduates needing to undertake an accredited internship before becoming eligible for general registration [84], and Australian medical degree eligibility for practice in other countries. These are all significant factors which can greatly influence a student’s decision on whether they wish to undertake medical training in Australia as an international student, and it should be every educational institution’s responsibility to ensure that agents are providing students with up to date and realistic information before making their decision to study in Australia.

International Medical Student Admissions

There is currently no standardised format for which data needs to be reported for international student admissions. For domestic students, the *Improving the transparency of higher education admissions* report released in 2016 outlined recommendations for education providers with an intent to increase information accessibility and transparency regarding admissions for prospective students.[85] However, these 'information sets', which constitute course and institutional admissions information, have yet to include international admissions statistics [86].

The medicine admissions process is composed of a number of entry requirements unique to medicine. This may include an admissions interview, and/or completion of a medical school admissions test. In assessing these various components, domestic and international admissions processes for undergraduate medicine appear to be quite distinct.

For domestic students, the UCAT (Undergraduate Clinical Aptitude Test), a replacement of the former UMAT as of 2019, is the only admissions test required for domestic undergraduate medicine admissions in Australia - accepted by a total of 11 universities in Australia, 2 universities in New Zealand, and most medical schools in the UK [87,88]. International applicants, however, are required to sit the ISAT (International Student Admissions Test), applicable for only some medical schools in Australia, with the remaining medical schools requiring a UCAT score [89]. Postgraduate medical courses in Australia accept either the GAMSAT (Graduate Australian Medical School Admissions Test) or the MCAT (Medical College Admission Test) from international applicants - with the latter being a standardised examination also used in the US, Canada and Caribbean Islands [90].

International postgraduate applicants have been afforded flexibility in admission test requirements, yet there has been little to no justification given for the disparity in testing requirements between domestic and international undergraduate applicants. The ISAT also represents an additional financial burden on IMS, with registration costing $320 USD [91].

International student support for returning to practice in home country

<u>International Medical Placements in Home Country</u>

Overseas elective medical placements are a large part of many medical school programs across Australia, with 53% of graduate entry (GE) and 35% of high school entry (HSE) students taking part in an overseas placement in 2013 [92]. This provides an important opportunity for students to explore a new setting of clinical medicine, and broaden their understanding of overseas healthcare. These placements, usually undertaken by seniors in their clinical years, are most of the time taken in low-resource settings in places like Nepal, Cambodia, and the Philippines – 59% and 56% in GE and HSE programs respectively [93].

Australia is fortunate to host many IMS at its medical schools every year. In 2019, there were 2,870 IMS studying in Australia, just over 17% of all medical students. [94] While placements are an important part to every medical student's education, these placements can be especially vital to IMS who plan to return to their home country for post graduate training and the application for.

In countries where there are very strict and specific requirements for FGAMS returning for residencies, such as the U.S. and Canada, not undertaking a placement in a student's home country can have adverse effects on their chances of matching into a post graduate training program. Research shows that for the U.S. match in 2018, the number of relevant work experiences undertaken by U.S. FGAMS that matched to a training program was on average 4 [95]. There is a similar trend in Canada. In 2019 just 15% of students without any local placement experience matched to a program [96].

Support for International Licensing Exams & Vocational Training Program

In addition to placements, there are many other hurdles that IMS must overcome when planning to go back to their home country to practice. These additional hurdles include the necessity of additional study time for international licensing exams, as well as both the time and financial burden of international travel for taking the licensing exams. One study estimated the financial burden associated with USMLE (United States Medical Licensing Exam) testing, application fees, interview travel costs, ECFMG (Educational Commission for Foreign Medical Graduates) certification, etc. for some foreign medical graduates undertaking a residency in the U.S. to be $25,000 USD. [97] While this may not be representative of every IMG, it does clearly illustrate that there are undoubtedly additional costs, be they financial, stress-related, time-related or otherwise, for IMS seeking licensure outside of Australia.

With the obvious need for IMS to return to their home countries for placements to ensure positive post-graduate training program match results, it then behooves Australian universities to facilitate such placements, give support in the way of resources for licensing and/or recognition of the necessary time away for licensing exams.

Emergency response planning and advocacy

As seen through the COVID-19 pandemic, IMS can be disproportionately affected by states of emergency, due to the many hurdles of studying abroad. Most notably, IMS felt increased financial pressures due to a halting economy, threatened course progression, restricted travel and further strain on their mental and physical health [98 - 100]. Any of these factors individually can place the huge financial and personal investment of studying in Australia at huge risk. This policy is intended to be an addition to previous AMSA policies such as COVID-19 and the Pandemics policy with special consideration for IMS [101].

Financial Burden and Disruption in Funding

Emergencies that threaten the supply chain of funding for IMS can cause financial vulnerability [102]. Commonwealth initiatives such as jobkeeper payments and student support were readily offered to domestic students in 2020, but not IMS [103]. With a considerable proportion of Australia's GDP derived from the export of international education, a strain on IMS' finances can heavily impact the higher education sector and economy as a whole, and in turn will affect the quality of education for all students [104].

Travel Restrictions

Travel restrictions imposed due to COVID-19 caused problems to the progression of IMS. This particularly impacted some IMS who have decided to pursue post-graduate training in their home country, as they are typically required to complete numerous rotations in their home country prior to graduation [96]. During COVID-19, many IMS who returned back to their country of origin were later trapped overseas due to travel restrictions. This can result in serious delays to their medical progression as many were unable to return back to Australia for clinical placements [105]. IMS are particularly vulnerable to this, as attendance at clinical placements is a requirement for progression through medical courses.

Obstacles for Registration

With a nationwide shutdown of non-essential services, many final year IMS faced additional barriers in securing internship, visas and AHPRA registration. Delays were seen with regards to certifying application documents, sitting required English examinations, and accessing immigration services. While the application requirements for referees were loosened in several states, some states still required clinical references for applications. For IMS who are stuck overseas and hence unable to

attend placements, they encounter barriers in obtaining referees needed for application. During crises, IMS often face more challenges in providing a competitive application. Accommodations should be made that acknowledge these challenges in times of crisis.

Appendix

Appendix 1: PR Progression Pathways for International Medical Students

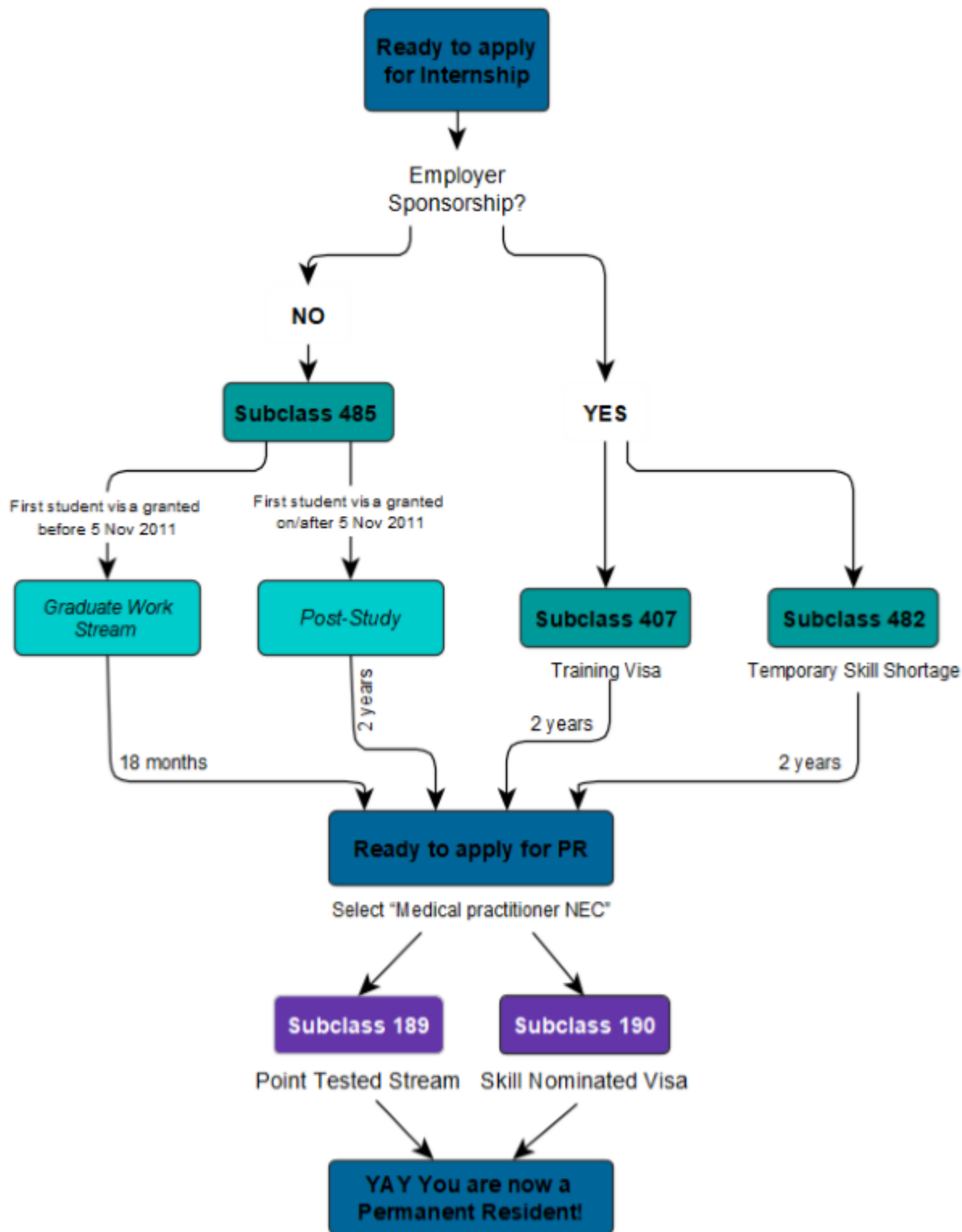

Figure 1: Potential visa application pathways taken from the 2020 International Students Network Internship Guide [17].

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Policy Details

Name: International Students

Category: C – Supporting Students

History: Reviewed, Council 2, 2020
Nicolas Sieben, Yufei Xu, Zhi Shyuan Choong (Seraphina), Anne Lehmann, Ines Portella, Jessica Yu, Tay Zhi Yu Ernest, Travis Lines (National Policy Officer)
Reviewed by amalgamation of *International Students* and *Ethical Recruitment of International Students*, Council 3, 2017
Z. Abidin bin Azhar, S. Kim, V. Lin
Adopted, Council 2, 2016

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