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Health Checks for late career doctors

CONSULTATION REGULATION IMPACT STATEMENT

MEDICAL BOARD OF AUSTRALIA

College Submission
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About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***healthy rural, remote and First Nations communities through excellence, social accountability and innovation***.

The College works to *define, promote and deliver quality standards of medical practice for rural, remote and First Nations communities through a skilled and dedicated Rural Generalist profession*. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM has more than 5000 rural doctor members including 1000 registrars, living and working in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia and further afield. College members deliver expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

General Comments

ACRRM welcomes the opportunity to respond to this proposal that late career doctors (aged 70 and older) have regular health checks to support their health and wellbeing and to prevent patient harm. The proposal has generated a great deal of interest amongst College members.

The College acknowledges that medical practitioners are the cornerstone of Australia's health care system. This is particularly the case for the medical practitioners living and working in rural, remote and First Nations communities. We welcome the Medical Board of Australia (MBA) recognition that *any process that routinely screens older doctors in Australia needs to balance the responsibility to protect patients from harm form undetected poor performance, with the costs and benefits;* together with the acknowledgement that the process *must be fair to all doctors, including those who have no performance concerns, and avoid unnecessary loss of workforce.*

ACRRM actively encourages and supports its members to prioritise their own mental and physical health and wellbeing. This includes having regular checkups with their regular GP. However College members who live and work in rural, remote and First Nations communities do face additional barriers in terms of access to a regular GP and associated health checks. This is the case particularly for doctors working in solo or very small practices or facilities and in situations where they would prefer to consult with a practitioner with whom they do not have any other relationship.

It is equally important that other health professionals also prioritise their own mental and physical health and wellbeing.

The Rural and Remote Context

There is a clear and well evidenced link in Australia between levels of remoteness to healthcare services and worsened health and mortality outcomes. The burden of disease increases with remoteness and for people in very remote areas is 1.4 times that of people in cities.[1] In remote areas, fatal disease burden

[1] Australian Institute of Health and Welfare. (2018). A*ustralian Burden of Disease Study: Impact and causes of illness and death in Australia.* https://www.aihw.gov.au/getmedia/5ef18dc9-414f-4899-bb35-08e239417694/aihw-bod-29.pdf?v=20230605164208&inline=true

rates were 1.7 times as high as in major cities, while non-fatal burden rates were 1.2 times as high.[2] The median age at death for Aboriginal and Torres Strait Islander people is 62 years, compared to 82 years for non-Indigenous people.[3] Rural and remote populations experience substantial health disparities, including poorer health outcomes among Indigenous people compared to their non-Indigenous counterparts.[4]

In the view of the College, these poorer health outcomes can largely be attributed to lack of access to medical services, and in particular, the distribution and services provided face-to-face by a Rural Generalist or specialist General Practitioner.

While there are promising signs in terms of higher levels of interest in rural practice from medical students, junior doctors and registrars, the current maldistribution (both in terms of geographic distribution and skill sets) remains. Given the length of time required to train a Rural Generalist practitioner and the need for experienced supervisors to train and mentor the next generation, it will continue to be important to retain as many doctors as possible in rural practice for the foreseeable future.

There is considerable evidence that Australia's rural doctor workforce is ageing and has heavier workloads than their urban-based counterparts. There is need for urgent and significant action to support the nations rural and remote health services given the general practice workforce is ageing, and a large proportion is approaching retirement with 15% aged over 65.[5] It is also not unusual for late-career doctors, particularly those working as solo practitioners, to face difficulties in selling their practice or recruiting new doctors due to a lack of interest. As a result, these practitioners often remain to continue to provide essential services to their communities.

- In 2022, medical practitioners constituted the largest percentage of health professionals within the 65–74 age range, accounting for 8% of the health workforce. In very remote areas, there were 205 full-time equivalent (FTE) clinical medical practitioners per 100,000 people, while major cities had a significantly higher rate of 427 FTE per 100,000 people.[6]

- Research consistently shows that rural and remote clinical environments often experience staff turnover and instability, which is contributing to low practitioner retention and challenges with maintaining quality and continuity of care.[7]

- National surveys have found that the longer the time since graduation the more likely a doctor was to be rurally based. They found for example that 21% of Australian medical graduate doctors who graduated in the 1970s and 1980s were rurally based compared to 17% of doctors who graduated in the 1990s and 2000s.[8]

- The number of registered doctors increased from 82,408 in 2013 to 111,908 in 2022. However, the average number of hours worked per week decreased from 41 to 39 up to 2020. While both the

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[2] Australian Institute of Health and Welfare. (2022). *Australia's health 2022: In brief.* https://www.aihw.gov.au/reports/australias-health/australias-health-2022-in-brief

[3] Australian Bureau of Statistics (2024). *Deaths, Australia: Latest release.* Deaths, Australia, 2022 | Australian Bureau of Statistics (abs.gov.au)

[4] Azzopardi, P. S., Sawyer, S. M., Carlin, J. B., Degenhardt, L., Brown, N., Brown, A. D., & Patton, G. C. (2018). Health and wellbeing of Indigenous adolescents in Australia: a systematic synthesis of population data. *The Lancet*, 391(10122), 766-782. https://doi.org/10.1016/S0140-6736(17)32141-4

[5] Cth Dept of Health (2021) *General Practice Workforce providing Primary Care services in Australia*: 27 Sept. 2021. Based on the National Medical Workforce Data Set.

[6] Australian Institute of Health and Welfare (2024). *Health workforce*. Retrieved from https://www.aihw.gov.au/reports/workforce/health-workforce

[7] Wakerman, J., Humphreys, J., Russell, D., Guthridge, S., Bourke, L., Dunbar, T., ... & Jones, M. P. (2019). Remote health workforce turnover and retention: what are the policy and practice priorities?. *Human resources for health*, 17, 1-8. https://doi.org/10.1186/s12960-019-0432-y

[8] O'Sullivan, B., Russell, D. J., McGrail, M. R., & Scott, A. (2019). Reviewing reliance on overseas-trained doctors in rural Australia and planning for self-sufficiency: applying 10 years' MABEL evidence. *Human resources for health,* 17, 1-9. https://doi.org/10.1186/s12960-018-0339-z

number of registrations and total full-time equivalent (FTE) outcomes have grown consistently in metropolitan (MM1) and rural (MM2–5) regions, there has been no increase in remote and very remote (MM6–7) regions.[9]

There is a danger that, if the nature and frequency of compulsory health checks become too costly or onerous, this may provide a catalyst for late-career rural doctors to leave practice altogether.

The consequences of this scenario could be significant, as the areas that already have the poorest access to medical care will be disproportionately vulnerable to an exodus of doctors.

Within the margins of overall quality and safety, in these contexts, there needs to be a balance between the level of community benefit and safety provided by a later-career doctor as opposed to no service at all.

While recent and detailed national figures are not available to the College, we would recommend further analysis of these scenarios and their implications for rural, remote and First Nations communities incorporated into the Medical Board's planning.

Health Checks from Rural and Remote Locations

As outlined above, many of the doctors that will be required to undertake health checks are working long hours and are based in rural, remote and First Nations communities. Depending on the nature of any required health checks, these doctors may need to invest considerable money and travel time (which is also loss of potential income and time away from their medical practice and communities) to comply with the requirements.

While relatively easy to access in cities, consultant specialists and many allied health specialist staff and facilities are typically not located in rural and remote Australia.

Furthermore, if health checks are classified as occupational medicine, they will not attract any MBS rebate.

Response to MBA proposals

ACRRM notes the options outlined in the MBS Consultation paper:

- Option 1: Rely on **existing guidance**, including *Good medical practice: a code of conduct for doctors in Australia* (Status quo).
- Option 2: Require a **detailed health assessment** of the 'fitness to practise' of doctors aged 70 years and older every three years for doctors from the age of 70 and annually for doctors from the age of 80.

[9] Cortie, C. H., Garne, D., Parker-Newlyn, L., Ivers, R. G., Mullan, J., Mansfield, K. J., & Bonney, A. (2024). Australian medical practitioners: trends in demographics and regions of work 2013–2022. *Australian Health Review*. https://doi.org/10.1071/AH24101

These health assessments are undertaken by a specialist occupational and environmental physician and include an independent clinical assessment of the current and future capacity of the doctor to practise in their particular area of medicine.

- Option 3: Require **general health checks** for late career doctors aged 70 years and older every three years for doctors from the age of 70 and annually for doctors from the age of 80.

  The health check would be conducted by the late career doctor's regular GP, or other registered doctor when this is more appropriate, with some elements of the check able to be conducted by other health practitioners with relevant skills, e.g., hearing, vision, height, weight, blood pressure, etc.

The College does not support Option 2. Within the context of the issues outlined in the previous section, in the view of the College any potential benefits this option would be significantly outweighed by the potential disadvantages in terms of access and cost for rural, remote and First Nations practitioners and possible loss of medical services in their communities, particularly if these requirements resulted in an exodus of later-career doctors from the rural, remote and First Nations medical workforce.

It should be noted that a requirement to have health assessments undertaken by specialist occupational and environmental physicians could result in a cost impost of many thousands of dollars in travel and lost work time, especially for practitioners living and working in rural, remote and First Nations communities. Under these circumstances it is likely that these practitioners would cease work altogether.

Given that medical practitioners (along with other health professionals) are not immune to health problems, the College considers that it is not unreasonable to require health checks as outlined in either Options 1 or 3. However, it should be noted that, while undergoing regular medical screening by a regular GP with whom a practitioner has a clinical relationship has merit, this is a nuanced and complex issue where there are a number of factors to be considered, including weighing up costs and benefits and how any proposal can be practically implemented.

If either Option 1 or 3 is introduced, ACRRM recommends that that any process is designed to enable the health checks to be undertaken in their entirety in the local practice location. Given the considerable opportunities available through digital health together with the utilisation of local medical, nursing and allied health practitioners for specific activities requiring physical contact we consider this as a reasonable and achievable outcome.

The College would also specifically request that the option of having GP health checks via telehealth is enabled in any program design. Even where local doctors are available rural doctors may prefer the confidentiality afforded through a telehealth consultation. Typically doctors in rural and remote areas have a personal relationship with all the doctors in their local and surrounding communities and should have the option of the relative personal privacy possible through a telehealth consult.

ACRRM also recommends that initiatives such as the GPS4RuralDocs service be promoted by the Medical Board to balance the perceived regulatory and punitive approach to this issue.

These arrangements would not only contribute to equity but will also send an important message to rural doctors that the Medical Board acknowledges their time and their services in their community.

Summary

ACRRM recognises and supports the goal of the initiative to ensure registration systems are actively working to protect patient safety. Access to medical care is a critical aspect of patient safety and quality care and this is especially the case for people in rural and remote areas. It is imperative therefore that this initiative does not have the perverse outcome of worsening patient safety by triggering the loss of the services of competent doctors in rural, remote and First Nations communities.

The College strongly encourages and supports all its members to prioritise their mental and physical health and wellbeing and to undergo regular checkups and to have a regular General Practitioner or Rural Generalist.

We request that any options under this initiative are progressed at all levels with the explicit goal of minimising the practical hurdles and any perceived intimidation to affected doctors that it may engender.

We also ask that any mandatory activities associated with the health check are able to be easily and inexpensively undertaken by doctors based in rural and remote locations.

Any health checks should be designed to enable doctors to complete the process in their local practice location. Given the considerable opportunities available through digital health together with the utilisation of local medical, nursing, and allied health practitioners for specific activities requiring physical contact we consider this as a reasonable and achievable outcome. We consider this will not only contribute to equity but will also send an important message to rural doctors of the Medical Board's valuing of their time and their services in their community.

The College recommends that current practising rural doctors be included on any Steering Committees and Advisory Groups which might be convened to progress this proposal. As outlined rural doctors are over-represented under the proposal and will face a range of distinctive issues in endeavouring to comply with it. There would be considerable benefit in matters as they progress being considered by a doctor who has a direct understanding of how the proposed arrangements will affect their continuing practice and the options available to ensure the most effective possible design. Likewise, the impacts on rural, remote and First Nations communities must be fully considered at all stages of the design, implementation and evaluation of any initiative.

ACRRM looks forward to further opportunities to share its experience and expertise and contribute to further discussion of this important issue.

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.