SUBMISSION – AGE BARRIERS TO WORK, GREY AREAS

The National Registration and Accreditation system set up in 2009-10, under The Health Practitioner National Law Act 2009, created a registration category for 1800 senior doctors, entitled Limited Registration Public Interest Occasional Practice (LRPIOP) . Legislation has determined that this category will be abolished on 1 July 2013; it was closed to new entrants from 1 July 2010. Effectively, only doctors in NSW, Queensland, Tasmania and the ACT were "grandfathered " into the new scheme, retaining their limited privileges to prescribe and refer, and undertake other pro bono medical activities (such a services to community groups), drawing on professional expertise.

Senior doctors from the other states and territories were excluded from this limited category in September 2010, although it had formerly existed in these jurisdictions. As of 1 July 2013, this group of 1800 doctors will also no longer be able to participate effectively in the profession, in a category similar to the long-standing one that has proven both useful to the community, as well as safe.

It has been estimated that significant cost savings to Medicare have arisen from the ability of senior doctors to issue repeat prescriptions and referrals for ongoing care of established medical conditions. Such practice also helps alleviate pressures on General Practice, which recent medical and general press has suggested contribute to nationwide overcrowding of Emergency Departments, with patients with acute illnesses that could be managed by General Practitioners, but who are unable to obtain timely GP appointments. Senior doctors who remain registered, under an appropriate fee structure, will provide additional income for the Australian Health Practitioner Regulation Agency (AHPRA). In addition, senior doctors could provide a valuable resource in the event of national emergency.

Doctors registered in LRPIOP would continue to be subject to all the safeguards inherent in the legislation for a registered doctor, including medical indemnity, continuing professional development (both at a level commensurate with the category), mandatory reporting, and disciplinary procedures.

The LRPIOP category provides an appropriate transition to full retirement from the profession. Its continuation should be an essential element of any progressive policy which takes account of the way professionals work, and would provide for dignified exit from professional life.

AHPRA asserts that there is no impediment to senior doctors remaining on the medical register. However, once retired from active practice, it is impossible to meet the mandatory 'recency' of practice requirement, and this automatically excludes a doctor from continuing registration. Once off the medical register, it becomes impossible to obtain medical indemnity from any insurer, thus precluding any pro bono professional community contribution. Even lecturing to community groups on medical matters is precluded. Under the legislation, use of the title 'doctor' is permitted in retirement, although there have been cautions about 'misrepresentation'.

Australia should use its senior doctors and their knowledge in a productive way, as has occurred formerly. Bureaucratic systems should not work against stated public policy of all political parties, which encourages older Australians to remain engaged in the workforce. Senior doctors are well placed to continue to contribute positively to the health and welfare of the community. I understand that this group of doctors has generated the lowest rate of referrals to Medical Boards or insurers, so it is hard to argue that this change has been necessary to protect the public.

It is difficult to avoid the conclusion that The Health Practitioner National Law Act 2009 , and its enactment by AHPRA, reflects both current ageist attitudes in sections of the broader community, as well as evolving inter-generational tensions. Meredith KAESEHAGEN 14 June 2012