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AMA submission on opportunities for reform of GP training employment arrangements

The AMA welcomes the opportunity to provide feedback on the Discussion Paper about the reform of GP training employment arrangements.

The paper from the General Practice Training Advisory Committee is timely, as there has been an alarming decline in the number of doctors interested in pursuing general practice training during the last several years. This is, in part, due to the inequitable employment conditions between General Practitioners in Training (GPiTs), and their hospital-based counterparts.

GP stakeholders at the AMA Single Employer Model for GPiTs Planning Day agreed that the National Terms and Conditions for the Employment of Registrars (NTCER) has outlived its purpose as an employment tool, and that a new GPiT employment model should create:

- A fairer model for the employment of GPiTs in Australia that delivers pay and conditions comparable to non-GPiTs, which improve the standards of employment for GPiTs and promotes General Practice as an attractive vocational pathway for prevocational doctors.
- An employment model that allows GPiTs and supervisors to focus on the learning experience rather than being influenced by service delivery and business arrangements.

The AMA has been advocating for a single employer model for GPiTs, as this is the only model that can deliver GPiTs equitable remuneration and employment conditions compared to hospital-based trainees while meeting the needs of supervising practices. By our definition, a single employer would be either State/Territory Health Services or a Commonwealth funded entity(s) (new or existing).

The AMA would like to see a single employer model in place for all GPiTs (not limited to rural generalists or geographical locations) for the duration of their training. Under this model, there must also be assurances that practices and supervisors are no worse off than current arrangements and are adequately renumerated for supervision and teaching time as they train the next generation of GPs.

The AMA is looking forward to working with the General Practice Training Advisory Committee and the Department of Health on the reform of GPiT employment arrangements to ensure that the new model is profession-led, sustainable and adequately funded.

1. Are there other issues that GPTAC members believe are contributing to declining GP application/vacant training positions that could be addressed through reform of GP Registrar employment arrangements?

There is a notable absence of prevocational exposure to general practice and other forms of community-based medical care. This was previously accessible via the Prevocational General Practice Placements Program (PGPPP). The subsequent policy efforts to encourage prevocational GP experience including the Rural Junior Doctor Training Innovation Fund and the More Doctors for Rural Australia Program have not been able to generate the same level of interest or participation and have failed to foster an adequate pipeline of doctors in training seeking entry into the GP training program. The flow on effect is a decreased interest in GP training more broadly, and difficulty attracting high-quality trainees to GP specialty training programs. The AMA has called for the PGPPP or similar to be reinstated. The AMA has proposed a Community Residency Program to provide a high-quality general practice experience delivered more cost effectively than the former PGPPP.

2. What are the views of members around incremental reform of employment arrangements during the current period of broader sector reform?

It is important GPs in Training (GPiTs) are included in the consultation process when reform of employment arrangements commences.

If employment reform arrangements were to proceed incrementally, it should not create a two-tiered system of employment and/or an 'us and them' mentality between GPiTs in urban and rural settings. There is a risk of this occurring if the Rural Generalist Single Employer Model is implemented without this being extended to non-Rural Generalist GPiTs.

The AMA could support incremental reform of employment arrangements provided there was a clear end point that ensured coverage of all GPiTs and timely milestones built into reform plans. This period of transition would need to be clearly communicated with trainees and supervising practices.

It should also be noted that no reform is not an option. All stakeholders must work to find a way through the current problems with GP training employment arrangements to deliver tangible support to GPiTs and generate more interest in GP training. In the past, stakeholders have struggled to reach agreement on a way forward and this has clearly been to the detriment of GPiTs, supervising practices and the GP training program. This process must work through these issues carefully and arrive at an arrangement that ultimately seeks to delivery parity of conditions.

3. Are members supportive of new employment arrangements being targeted or should they be applied to all participating registrars?

The AMA has strong preference for new employment arrangements to apply to all GPiTs regardless of training location.

4. What are the impediments to reviewing and updating the NTCER?

The AMA believes that the NTCER has outlived its usefulness, and is unlikely to be modified for either party's benefit or to address unpredicted imperatives (other than automatic rate of pay indexation aligned to MBS indexation) into the future. Stakeholders at the AMA Single Employer Model for GPiTs Planning Day agreed with this view. Indeed, the problems with the NTCER go well beyond the nature of the document itself, but extend to the current employment model for GP registrars itself.

Limitations of a NTCER include:

- The NTCER is essentially a goodwill document that in the true industrial sense is completely unenforceable.
- The NTCER has largely remained unchanged for many years despite the dissatisfaction of stakeholders.
- There is a high degree of ambiguity, and practical inability to enforce and limited scope of terms and conditions of employment using the NTCER compared to a public hospital enterprise agreement.
- Updating the NTCER does not address other inequities for GPiTs including loss of entitlements (e.g. sick leave, parental leave, carers leave) when transitioning into community practice.
- In some circumstances, it creates an environment where it may be difficult to negotiate satisfactory employment arrangements for all parties, and to separate learning from quantity of service provision.

5. What are the strengths and weaknesses of such a model? What issues does it resolve? What risks does it create?

It is worth noting that New Zealand has a different health system/primary care environment to Australia, so consideration should be made to the extent to which that model is transferable.

While this model resolves the large difference in salary between GPiTs and hospital-based trainees in first year of GP training, and retains the ability for GPiTs to learn and use the billing system of their training location, it fails to address the loss of entitlements, including the lack of parental leave eligibility and other forms of leave not accruing at a beneficial rate, when GPiTs commence training in community settings. Moreover, once the arrangement ends after 12-months, GPiTs will need to return to the NTCER for the remainder of their training, which as described above, has outlived its usefulness.

The AMA acknowledges that GPiTs in the later stages of training are more likely to earn higher salaries as their skillset develops, and can see more patients per day, thus making a New Zealand-style model less useful to retain over the entire 3-4 years of training.

The AMA does not support opt-in models of employment. For clarity, all new trainees on the pathway should be employed under the new model, and trainees already on the training pathway should be grandfathered under their existing employment arrangements. This will help to streamline the introduction of new employment arrangements, and to keep the transition seamless for both GPiTs, supervisors and practices.

As presented in the Discussion Paper, this model does not explicitly state that there is appropriate remuneration for the host-practice or supervisor. Any "on costs" should ensure that practices and supervisors are adequately renumerated for supervision and teaching time as they train the next generation of GPs. This must be new funding and should not be redirected from elsewhere.

While in theory, a 'flagged Medicare provider number' is a good solution to supports GPiTs billing Medicare while salaried, it is unclear what happens to the gap payment in a private billing practice. The AMA would like assurance that GPiTs using a flagged Medicare provider number are able to continue billing gap payments, and that these payments are retained by the supervisor/practice.

6. Who would be the most appropriate fund holder(s)?

The AMA would support Regional Training Organisations, or other Commonwealth funded entity(s) being used as a potential fund holder(s) for GPiT employment arrangements. Given their role in training and education, the AMA does not support the Colleges taking on this role either directly or through a related party.

7. What are the strengths and weaknesses of this model? What issues does it resolve? What risks does it create?

Employment under a 'single employer' with a 19(2) exemption is the AMA's preferred employment model for GPiTs. This is the only model that can deliver GPiTs equitable remuneration and employment conditions compared to hospital-based trainees while meeting the needs of supervising practices. A summary table outlining why this is the AMA's preferred model compared to other possible solutions (like a revised NTCER, a portability leave scheme or a salary supplement) is attached (Appendix 1).

The AMA has been exploring how a single employer model would work in practice, and recently held a Single Employer Model for GPiTs Planning Day to leverage the collective expertise from principal stakeholders including GPiTs and supervisors, and advocacy, education and training organisations, to build an agreed model of employment that is fit-for-purpose for GPiTs, supervisors and practices in Australia.

The AMA Single Employer Model for GPiTs Discussion Paper is attached for reference (Appendix 2). Two additional documents outlining the summary and outcomes of the meeting, and a SWOT and solutions summary are also attached (Appendices 3 and 4).

Briefly, the AMA asked stakeholders to consider the strengths, weaknesses, opportunities and threats of two single employer models: a State-based model and a Commonwealth-based model.

Attendees agreed that a State-based model could leverage off existing employment arrangements for doctors to provide GPiTs with equal treatment, remuneration and conditions to public hospital registrars, but would not offer national consistency.

The Commonwealth model would see the Commonwealth put in place national employment arrangements for GPiTs, with a Commonwealth agency or one or more bodies funded by the Commonwealth being the employing entity. GPiTs would have access to more equitable treatment,

remuneration and conditions, noting that a first-round collective agreement(s) would have to be developed. It was also noted that the Commonwealth has little experience in employing for direct service delivery.

There was general agreement that a single employer model was achievable. Of critical importance to counteract threats to the success of each model was to ensure that the process is profession-led and adequately funded.

The AMA would like to see a single employer model in place for all GPiTs (not limited to rural generalists or geographical locations) for the duration of their training. Under this model, there must also be assurances that practices and supervisors are no worse off than current arrangements and are adequately renumerated for supervision and teaching time as they train the next generation of GPs. This must be new funding and should not be redirected from elsewhere.

8. Are there additional options or certain elements that should be investigated further?

No further comment here.

9. Are any of these options more favourable than others or should any be ruled out for further consideration?

The purpose of GPiT employment reform is to achieve meaningful change. Options A, B and D presented in the lead to this question are all fractional adaptions to singular issues facing GPiTs. In essence, they are bandaids to a single issue without addressing the underlying causes (outlined in the AMA Single Employer Model Paper – See appendices 1 and 2).

Option C addresses almost all GPiTs concerns and is effectively a State-based single employer as per the AMA's preferred model outlined in our response to Question 7. To achieve the same outcome through other options may require a combination of policy options.

Regarding the creating of a Portability Fund, there are several issues to consider, including:

- The achievement of parity with public hospital registrars and the lack of genuine employment continuity/job security remains unresolved.
- In respect of parental leave, the national standard is unpaid leave release after 12-months service with the one employer. It is a new concept for any class of general practice employee to receive paid parental leave by right (as opposed to local policy or agreement).
- It is unclear how to compensate the general practice for the cost where they have received a GPiT but who is then (potentially immediately) absent on leave for a full quantum of an accrual that has been accrued elsewhere. This means the general practice gains no service while still having on-costs/cover cost. A mechanism that forces the general practice to release a GPiT who is eligible to access the fund would have to be newly created.
- The tracking of individual accruals that would enable access to funding is a burdensome administrative exercise that would have to be managed by the fund controller along with (probably) an evidence onus for the GPiT.

The AMA does not support the Colleges acting as an employer of GPiTs under any circumstances. There should not be any link between a GPiTs training and their employment.