AMA Submission - Australian Government seeking input to improving protections of employees' wages and entitlements: further strengthening the civil compliance and enforcement framework

The AMA submission responds to the Commonwealth Attorney General's call for community input, in capacity as the Minster of Industrial Relations, about the operation of the current employment compliance and enforcement framework. The AMA submission aims to inform about public hospital registered collective doctor employment agreement / award non-compliance, the challenges faced to enforce those entitlements and what needs to change.

About the Australian Medical Association (AMA)

The Australian Medical Association (AMA) is the most influential membership organisation representing registered medical practitioners and medical students of Australia. The AMA exists to promote and protect the professional interests of doctors and the health care needs of patients and communities. The AMA improves patient care by supporting the medical profession through a range of essential services, which, amongst other things, relevantly includes:

- protecting the wellbeing of medical practitioners;
- promoting and advancing ethical behaviour of the medical profession; and
- preserving and protecting the political, legal and industrial interests of medical practitioners.

About the Doctors most affected by employment entitlement non-compliance

The AMA's submission is about Doctors-in-Training (DIT) employees who are most affected by public hospital non-compliance with registered enterprise agreement / award terms and conditions. A DIT is a non-specialist doctor who may or may not be engaged in formal accredited training to become a specialist. Accredited training is in addition to DITs' employment but occurs in the workplace and is supported by specific industrial entitlements. Nationally, around 25,000 DITs[1] are covered by an AMA and / or Australian Salaried Medical Officer's Federation (ASMOF[2]) negotiated public hospital enterprise agreement.

Generally, a DIT would anticipate working a rostered span of hours (ordinary and overtime hours) within a 24/7 fortnightly cycle and also contribute to an out of hours (On call / Re call) roster. While AMA/ASMOF jurisdictions will differ in their entitlements (i.e. description, application and calculation), a DIT will typically enliven enforceable employment entitlements to the following (some elements being point of career dependant):

[1] Fig.2, Australian Institute of Health and Welfare - Medical Practitioners Workforce 2015

[2] The ASMOF is the registered medical practitioner trade union.

- a classification rate or pay (typically an increment or title related to years of experience or point in training);
- overtime;
- On call / Re call penalties (telephone consultation and/or return to work);
- shift / night / weekend penalties;
- (usually) for accredited DITs, free from duty training / education / study time (as paid and rostered additional work hours);
- fatigue management; and
- rosters being published within a specified period prior to operation (vital to manage planning of continuing education and out of work family/personal obligations).

AMA Data - National DIT workforce experience

For the past four years, a number of state AMAs (with the co-operation of the ASMOF in some jurisdictions) have conducted workplace surveys amongst our DIT AMA members. While, survey questions differ between jurisdictions, the AMA asserts all jurisdictions would report very similar results if surveyed identically.

> "One (DIT) described a toxic and intimidating culture in which trainees were pressured to fudge their overtime hours. *'Not being able to receive critical training is symbolic of a hospital where a workload is out of control and you're staying back just to make sure patients are safe,'* the doctor said. *'But they often question why you can't get everything done in your shift and blame you for it. It makes you feel powerless, embarrassed and frustrated'."*[3]

The following outlines the most recent and relevant AMA survey results from various jurisdictions:

New South Wales[4]

Arising from NSW DIT survey respondents (about overtime and roster posting compliance):

- 37 percent received less than, or zero, payment for their eligible overtime claims.
- 69 percent sometimes, or almost never, worked to their published rosters (roster design did not match expectations; more was worked).
- 32 percent claimed zero overtime despite eligibility.

[3] *The Age*, 6 August 2019
[4] *AMA New South Wales Hospital Health Check 2019*

Victoria[5]

Arising from Victorian DIT survey respondents (about compliance generally and overtime):

- 48 percent report "ongoing breaches" of the Fair Work Act registered enterprise agreement.
- 76 percent are paid for less than one quarter of the overtime worked (nine hours of unrostered work on average).
- 71 percent often, or very often, involuntarily work through rostered lunch break.

Queensland[6]

Arising from QLD DIT survey respondents (about overtime compliance and culture):

- 21 percent (averaged) where not paid eligible un-rostered overtime.
- 9 percent (averaged; one public hospital 41 percent) were advised by management to not claim their eligible overtime.
- 20 percent (averaged) reported concern about negative career implications for claiming overtime.

Western Australia[7]

Arising from WA DIT survey respondents (about culture and administration):

- 50 percent of the time payslips are not accurate.
- 35 percent (roster start) and 59 percent (roster end) respectively of published rosters do not reflected the expected (more) work.
- 17 percent claim their eligible unrostered overtime (only 3, 4, 6 percent respectively claim in three public hospitals).

About public hospitals (as employers)

In the public hospital setting, the incentives to challenge wrong behaviour or question / make a complaint about non-compliance can be outweighed by incentives to remain silent (claiming tension). There are clear power structures operating and therefore incidences of industrial non-compliance can be high, while the reporting of concerns can be low. The imbalance arises, and the failure to report occurs, because of the following public hospital cultural and environmental experience:

[5] 2018 Hospital Health Check - AMA Victoria
[6] AMA Queensland's Resident Hospital Health Check 2018
[7] 2019 Hospital Health Check – AMA (WA) Doctors-in-Training Committee

- management of doctors (entitlement compliance) is a second / third order consideration compared to the important patient care focus and mission;
- the sector is resource poor (and there are often assertions that government does not adequately fund hospitals to deliver on their bargained and agreed outcomes);
- leadership tends to not challenge norms and tends to not legitimising advocacy about seeking change / compliance with entitlements;
- the normed offering of fixed term employment contracts and less than transparent assessment / recruitment practices cause uncertainty / lack of security and reinforces the need to keep decision makers 'on-side' which limits preparedness to challenge norms;
- a knowledge, or at least feeling or belief, that complaints will not be taken seriously; and
- unclear, difficult and/or unsafe (for career et al) reporting processes.

The management of the above falls to public hospital administrative units such as: human resources / people & culture, industrial / employee relations and medical workforce management (HR). Within public hospitals, where patient priority usually trumps resourcing of other organisational components, HR tends to lack capability, has limited internal influence and limited capacity to act proactively. These features, combined with doctors being a small fraction of a public hospital's total workforce means a nuanced understanding of the features, terms and conditions of doctors is limited and deprioritised.

Those employed in DIT Medical administration/management are often not formally trained / qualified to manage and pay a DIT according to a registered agreement / award. It is not uncommon for medical administration personnel to:

- not know DIT entitlements have legally enforceable standing in State or Federal law and instead treat entitlements as 'guidelines';
- not understand there is a duty to proactively intervene where there is foreseeable risk to doctor health and safety even though there may not be formal complaint. That is, managing risks associated with fatigue inducing workloads and inappropriate workplace behaviours;
- rely on norms rather than the actual words of an entitlements to determine rights and obligations;
- have no initiative or incentive and no internal authority to advocate for a DIT even where the DIT claim is inconsistent with norms despite being obviously correct; and
- not uncommonly, unilaterally change a DIT's penalty and allowance claim form without their knowledge (often blatantly with "white out" or a 'red pen').

Barriers to Change

Public hospital settings can demonstrate the hallmarks of what has been termed "institutional betrayal". The term's meaning and implications are very close to those associated with personal betrayal. Such institutions do not just operate on power and fear but also on trust and dependency. The latter elements create an inherent conflict for a doctor not being paid correctly between them staying and receiving more of the same or reporting then potentially losing critical relationships.

There is a culture within public hospitals which discourages discussion that would highlight links between (so called) 'one-off-events' and what are actually 'bad' ongoing themes. (As example: a fair days pay for a fair days work according to agreed legal entitlements can be twisted to become, 'stop taking money away from patients, you are supposed to work hard and do long hours').

Where the public hospital is itself traumatised through a lack of resources it can responded through a culture of punitive decisions, unfairness and accusations. Protective mechanisms will spring up that discourage, refuse to act and refuse to acknowledge.

The DIT overtime payment compliance problem

Un-rostered overtime payment entitlement non-compliance can be misconceived by public hospitals. The AMA advises, for the large majority of non-compliance (related to pay for hours worked), breach of roster design obligations (job size) or breach of occupational health and safety law (fatigue) is the root problem to address.

Where rosters are not designed to accommodate true, required in reality, work time (including handover and administrative work) there is then heavy reliance on the claiming of "unrostered overtime". Proper public hospital entitlement compliance requires published rosters to genuinely reflect hours of work. This removes claiming tension (as it is 'auto paid' according to roster) and budgets are forced to accommodate the visible, objective and planned workforce cost.

At present, the lack of workload visibility via accurate compliant rosters means the true cost of doing business is invisible / unaccounted for and there is therefore constant pressure to not pay overtime because of unaffordability / absence of budget. Further, risk assessment related to public safety interest is unlikely to be accurate where job size related to patient flows and admission spikes is in an unknown due to invisible service hours.

When the roster design non-compliance occurs, a DIT confronts substantial complexity and evidentiary hurdles to show eligibility for unrostered overtime. HR can use the following concepts to resist payment by shifting onus to the DIT even though clinical need, true job size or cultural expectation would oblige the DIT to do the work:

- whether the DIT is volunteering or was directed;
- whether the DIT has breached their own duty to maintain a safe system of work;
- whether the DIT should / would have been directed to not perform the work had HR been aware in advance it was about to be performed;
- whether the DIT should have actively sought authorisation prior to performing the work;

- whether the patient / general workload and availability of other doctors meant there was genuinely no reasonable alternative but to perform the work (therefore the DIT is "required" and therefore, in fact, directed despite absence of hospital initiative) (or the converse that patient requirements or administrative load are said to not need the additional hours);
- whether there is, or is not, a breach of roster design rules by the public hospital; and
- whether alternatives existed (regarding fatigue management and the model workplace safety laws safety "as far as practicable obligation") and how that may interface with an industrial instrument safe hour requirements).

Overtime and DIT non-clinical (free from service) time

As the numbers of DITs on the wards, clinics and in theatre increases, so too does the demand for teaching. Doctors need dedicated rostered and paid time set aside for teaching or study. Routinely (particularly in some craft areas of medicine) this important entitlement is inadequately valued and is encroached on by the ever-increasing pressures of service delivery. Public hospitals have been is denial about their non-compliance because of their belief that they support medical education (likely correct but not necessarily relevant to precise entitlement compliance). Apart from the lost training benefits, the implication of not providing, "training time"[8] means there is extra service being compulsory worked paid at ordinary time that instead should be paid as overtime (that is, two entitlement breaches).

Other compliance problems

In summary, other entitlements to the above consistently reported to AMA as being ignored or not properly implemented include:

- Annualised salaries – these arrangements shift risk to doctors as once there is an 'agreed' sum, the work value contribution is no longer (in practice, not in law) regulated via specific entitlements; the DIT is just required to work. Typically, there is no genuine method to calculate or predict work contribution against entitlements, the offer is typically impossible to turn down for want of alternative opportunity and is based around funding stream or history.
- Higher duties – a DIT asked to fill in for an otherwise more senior role (or does that role because there is no alternative for patient care) is often refused eligibility to the higher classification's rate of pay (as otherwise entitled). Refusal is based on the idea that a more junior doctor is not experienced enough to perform the higher duties. This normed belief does not consider the objective reality that while the more junior doctor may be less efficient or not as good, doing the work creates eligibility for the payment.

[8] For example, five hours per week of paid, rostered, free from service time, as required in Victoria for DITs classified as "Registrar").

- 2nd On call – as a general rule, being On call attracts additional payment for rostered availability after hours to cover absence, provide clinical advice by telephone or return to work for clinical care. Public hospitals are known to establish On call rosters only for unexpected absence (i.e. for 'cover' and known as 2nd On call). Simply by virtue of a name ("2nd") being given to this 2nd roster there is refusal to recognise eligibility for "On call" pay. It is wrongly stated 2nd On call is somehow not On call.

Reasons behind public hospital employment entitlement non-compliance

The following summarises, from the AMA's experience, the reasons (often in combination) that public hospitals do not pay and manage DITs according to their lawful and agreed entitlements:

- provisions in the registered agreement / award are misinterpreted;
- annualised salaries are incorrectly calculated (salaries are based on estimated or historically offered rather than auditable analysis of all enforceable entitlements);
- normed behaviours trump enforceable employment entitlements;
- a DIT raising non-compliance can mean being identified as a troublemaker because "no one else has complained" (not leading to broader investigation to deal with systemic, broad, cultural problems);
- patient unit budgets are often designed around incorrect data and/or historical, assumptions rather than workflow / job size analysis. As a consequence, the true cost of 'business' is never accounted meaning the budget is never sized to ensure there is capacity to pay consistent with entitlement compliance obligations;
- professionalism includes a perceived legitimacy in the idea that claiming an entitlement is "taking money away from patient care";
- blame the 'slowness' of the DIT rather than understand the obligation to pay for work performed irrespective of comparisons to others or assumed workloads (procedural fairness when considering circumstances is often ignored);
- the DIT who expects to be paid according to entitlements is perceived as 'taking money away from patients' / 'gaming the system' / 'ripping the system off';
- leadership culture does not identify DITs as employees but instead identifies them as doctors who have professional / vocational obligations (not employment rights);
- time / energy is not available to doctors to be vigilant about their terms and conditions of employment or pursue unpaid eligible claims (particularly if administrative or cultural barriers are present);
- pay slips are typically opaque / convoluted in their presentation of what has been paid and for what specific work pattern. It is rarely possible to use a pay slip to determine whether compliant payment has occurred (this includes determining the accuracy of pay adjustments intended to reconcile previous underpayment error); and
- management of claims is geared around the majority of employees rather than unique doctor entitlements (doctors are a comparatively small number of the public hospital workforce).

Improving Protections - what public hospitals need to agree to do

Improve confidence in systems dealing with claims & disputes

Collecting data, analysis, developing evidence based change management plans and measuring outcomes against the achievement of goals is fundamental to entitlement compliance (which is a cultural change agenda).

> *"There was no clear pathway for managing my concerns and I had to present to the head of department, which was highly intimidating. These concerns were downplayed, despite reports from multiple individuals, and inadequately handled"*[9]
>
> 38 percent of DIT AMA survey respondents reported poor or very poor understanding of policy, protocols and frameworks[10]

It is unrealistic to expect a doctor to navigate employment law and HR complexity particularly when there is usually a lack of trust in the process. This is because there can be a basic lack of understanding that might be 'obvious' to those familiar with HR practice but will likely be 'foreign' to a doctor. It should not be assumed doctors:

- understand what is fair and legally required entitlement treatment is (includes timeliness of actions);
- can trust, unpack and navigate redress schemes;
- knows when procedural fairness is not being applied; and
- can properly define then express what the problem is.

Doctors do not naturally seek professional advice and representation and instead have preference for seeking out support from informal sources (colleagues / family). The AMA's advice / representation (ASMOF in some jurisdictions) has a variety of important benefits for all parties associated with a complaint and this should be encouraged as a first primary step by public hospitals.

The benefits of the AMA (and ASMOF) representation drawn from the experience of the AMA workplace advisers representing doctor members include:

- the inherent efficiencies and fairness that arise where there is accurate definition of the issues after forensic consideration of fact and law. Understanding the problem is not 'common sense'. A false premise, taken to its logical conclusion, inevitably forms the wrong answer;

[9] AMA Victoria survey 2015

[10] ACT Health's *Review of Clinical Training Culture – TCH and HS* [September 2015] p21

- making a claim that is controversial because of ambiguity or norms can be serious step. Therefore, expert intervention is required to avoid potential of being perceived as vexatious and presenting in a way capable of being upheld rather than being undermined because of unintended exaggeration, inaccuracy, ambiguity or dominated by emotion and perception rather than objectivity;
- ensuring expert navigation and explanation of often complex and unfamiliar policy and enforceable workplace rights avoids inefficiency and unreasonableness. This also acts as confidence builder and a cross check about the safety of the claim / dispute process and the maintenance of procedural fairness; and
- providing effective pastoral care and ensures the doctor understand the choices, implications and risks at any point.

Measurable goals

Public hospitals' commitment to revise and strengthen their claims management and general entitlement compliance process must include increased external scrutiny and best practice featuring transparency, clarity and fairness. Key public hospital actions include:

- revise Code of Conduct and sanctions policy to incorporate clear expectations about the management of claims, including clear consequences for findings of managerial unprofessionalism;
- incorporate principles helping prevent victimisation and increase / ensure protection for those who want to exercise their right to compliance through making claims or raising dispute; and
- establish, in consultation with AMA (and ASMOF in some jurisdictions) expert and independent audit review and oversight of claim processes including recommendations when processes are not followed or are inconsistent with entitlement compliance obligations.

Public hospital self-reporting

Robust annual and public reporting on entitlement compliance performance and underpayment complaints should occur. This creates visibility and builds confidence in the legitimacy of raising issues and confidence that public hospital will make change through their honest acknowledgement of the issues.

A first action is to understand what problems exist. The purpose of public hospitals collecting data about incidents and complaints is to collect information that is objective and can be used to identify recurring issues or trends, make improvements to systems and enable improvement to their reputation. Analysis should be done regularly and reported on with the following fields in mind[11]:

[11] Whole of government commitments to effective complaints handling, NSW Ombudsman [2015]

- volumes and trends over time;
- the types of issues being raised and their impact;
- dispute outcomes;
- the managerial actions taken in response; and
- the systemic issues identified.

There is inherent positive competition arising from reporting (intra and inter public hospital). Those willing to report their wins and acknowledge their short comings enhance trust, have a reference for continuous improvement and have evidence to design positive strategies. Those that prefer not to report will still have an incentive to match their competitors by doing so and are likely to perceived with a degree of suspicion if they remain 'out of step'. In public hospitals, these perceptions relate not just to employer of choice characteristics but also to community trust and confidence in the quality and safety of care provided. (Whether doctors are treated properly or badly will influence public perception).

HR Staff (and doctor) Training

A degree of crafted management is required to avoid unfair (nay illegal) outcomes or to harness HR's positive potential to lead change. This raises the questions as to whether there are appropriate levels of investment to ensure HR professionals are equipped with the competency, knowledge and skill to ensure there is both the capability and time to manage issues related to doctors.

HR staff training (potentially also offered to doctor employees) should focus on:

- principles about understanding, interpreting and applying often complex industrial agreements that apply to doctors;
- understanding that risk management requires proactive response (being reactive is the most common approach);
- dispute management (that is not designed to frustrate or delegitimise);
- understanding impacts of unconscious bias, learned / normed (unfair) behaviours that prevent open consideration of eligible claims;
- principle about 'managing up' to encourage improved internal influence and advocacy for doctors employment entitlement compliance interests; and
- principles about capacity building and strategy to increase leadership competency and aptitude to manage cultural change.

Strengthening the enforcement framework - AMA National Bargaining Framework

The AMA has designed a National Bargaining Framework (model clauses) as a resource / reference tool for all AMA jurisdictions when engaged in enterprise bargaining on behalf of doctor members (the framework is for ASMOF use also).

The AMA believes that it is important for there to be easily enforceable, comprehensive and express (unambiguous) workplace rights, duties and obligations that encourage equity, fairness and management accountability. When bargaining, drafting agreement and then implementing, public hospitals should be committed to these same principles.

Enforceable workplace entitlements that promote the AMA principles will have active inducement potential to change behaviour and demonstrate a public hospital's willingness to require change (because in the main, new entitlements require employer agreement). Enforceable entitlements change expectations and enhance respect & understanding which in turn reduce improper behaviours as a respectful (fully entitlement compliant) culture evolves.

Summarised below are the AMA's general model registered collective agreement clause design approach / principles (applies equally to common law contract, workplace instrument, workplace educational systems and workplace policy):

i) maximise regulation judged against fairness, justice, current deficits / needs gaps and emerging community trends / expectations;
ii) educate both hospital and doctors (partly by saying what is intended in straight forward language - i.e. through: the use of headings as a guide to intent, the use of the word "must", being prescriptive about action steps, requiring consultation & policy promulgation and in-built clause compliance mechanisms);
iii) shift culture, in some cases there should be agreed party statements as to 'why' the clause exists;
iv) enshrine expression that provides clear / express rights, process steps, responsibilities, accountabilities and consequences and / or explanations (i.e. easy steps to follow / easy understanding of decision justification or what is in dispute);
v) encourage managerial / leadership competency and skills; leaving no doubt as to what steps to take to ensure compliance (this to counter the common styles / approaches to entitlement delivery; i.e. 'see one, do one, teach one' / act through experience / 'only do what I think is fair' need to instead become: 'just read the Agreement then do that');
vi) enhance prospect of compliance and/or enforcement through a *'belts & braces'* / comprehensive clause drafting approach (closing off as many predictable gates and ambiguity arguments as are reasonably foreseeable);
vii) enshrine within entitlements penalties triggered by the public hospital having done, or not done something otherwise required by the registered agreement entitlements; and / or
viii) streamline access to conciliation then arbitration conducted in a formal settings (Tribunal) because clause procedural requirements already 'flesh out' the issues in dispute or there are practical reasons to encourage quick settlement.

END OF AMA SUBMISSION