RURAL DOCTORS ASSOCIATION OF AUSTRALIA

# POSITION PAPER
# SINGLE EMPLOYER MODEL

## RDAA position on reform of GP and RG employment arrangements

## About RDAA

**The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and the patients and communities they serve.**

RDAA's vision for rural[1] and remote communities is simple – excellent medical care. This means high quality health services that are: patient-centred; continuous; comprehensive; collaborative; coordinated; cohesive; and accessible, and are provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their communities.

## Need for reform

It has been recognised for a number of years that general practice is declining in popularity as a career choice for junior doctors. Applications for general practice training have been undersubscribed for at least the last 7 years. While there are programs and incentives currently in place which have assisted to make improvements in pockets, there needs to be a suite of coordinated reforms, including innovative employment arrangements. These innovative arrangements should address the medical workforce shortages in rural areas and improve the attractiveness of a career in general practice.

The maldistribution of the medical workforce is an ongoing problem for rural and remote communities. While this affects most Specialties of medicine, the vast majority of medical services in rural and remote areas are provided by General Practitioners (GPs) and Rural Generalists (RGs). Thus, the ongoing undersubscription of general practice and rural generalist training programs is disproportionately felt in rural and remote areas.

RDAA has received strong feedback from doctor-in-training and recently Fellowed members indicating that the complexity of employment arrangements, the challenges around contract negotiations and the loss of entitlements gained during their time working in the hospital sector are all significant barriers to choosing Rural Generalism as an attractive career.

Similar concerns have been raised regarding GP training and the resulting loss of entitlements and income certainty.

In response to this feedback, RDAA has strongly advocated for the implementation of a Single Employer Model (SEM) for RG trainees , as well as employment reform more broadly for GP registrars and fellows. RDAA believes significant reform is needed to re-establish General Practice and Rural Generalism as a career of choice with junior doctors.

## Single Employer Model for Rural Generalist trainees

SEM is particularly relevant to RG registrars as many maintain continuous work within the hospital system from their PGY1 and PGY2 years, through their training and beyond, under a GP Visiting

[1] Within this document the term 'rural' is used to encompass locations described by Modified Monash Model (MMM) levels 3-7. Rural doctors are rural GPs, Rural Generalists and consultant specialists (resident and visiting) who provide ongoing medical services in these areas.

Medical Officer (VMO) fee-for-service arrangement. This is particularly relevant to NSW, Victoria, Tasmania and South Australia.

However, as a GP VMO, they have no mechanism for this continuity of remuneration, certainty or leave to be maintained. Instead, they are forced to relinquish their hospital employment and contract back as a Visiting Medical Officer arrangement while working as a registrar in General Practice. This is inequitable with their peers who choose hospital-based speciality training pathways, who maintain and continue their leave accruements and ongoing entitlements under the state award provisions.

There is unnecessary complexity in employment arrangements for RG registrars particularly. RG Registrars experience greater complexity as they are working in community based general practice, or an Aboriginal Medical Service (AMS), as well as providing services in the hospital for emergency care and/or area of advanced skill. Often this translates into multiple work contracts, with two employers, resulting in significant additional administration burden and income uncertainty, with the rate of pay to the registrar or VMO being practice and/or district specific in many states.

In other states such as Queensland or Northern Territory, where the state health system has invested in the rural generalist medical model, there are concerns that these have created 'hospitalists'. Due to the generous hospital remuneration, these models are not incentivising community based general practice or other community based primary care services.

A rural and remote health service at its core needs an integrated medical workforce with the skills to align with community need. A rural generalist workforce working in both hospital and primary care settings, alongside rural GPs and a suite of health care professionals is the ideal way to meet that need.

Additionally, rural generalists often need to access clinical placements in the state system to maintain credentials in emergency and advance clinical skill areas at a rural hospital, as well as maintain competence and confidence in the clinical services they provide. Accessing a supportive and productive clinical placement, with an understanding of the scope of practice of that individual, for a medical practitioner working outside of the state health employment system is problematic in relation to indemnity, credentialing and network connections.

## Single Employer Model for Rural Generalist Fellows

RDAA also supports a single employer model extending beyond the attainment of Fellowship. This will prevent registrars delaying completion of training in an effort to maintain access to entitlements to suit their personal circumstances. RG Fellows should be able to make a decision based on their own circumstances as to whether they would like to continue working under an SEM, or transition to a fee-for-service model. RDAA recognises that not all rural generalists will want to continue on a salary arrangement, and that a choice will be important, as many consultants enjoy choice in the city.

## Jurisdictional Model

The jurisdictional model is where a medical practitioner, is employed by a State Health Service under the provisions of the state medical practitioners certified agreement and award. The employment arrangement includes the time worked in community based general practice as well as

the hospital setting. A formal agreement or Memorandum of Understand (MOU) is in place between state health or its delegate, such as a Local Health District, and the general practice to outline the specifics of the general practice placement. The jurisdiction model facilitates continuity of employment under a salaried model, accrual of entitlements and the industrial protections equivalent to all other non GP registrars and senior medical staff who work in the public hospital system.

Establishment of SEMs under a jurisdictional model will ensure that RGs are able to work between hospital and community based general practice or AMS's, rather than states creating a hospitalist workforce from the RG programs. These models will provide greater opportunity for the registrars to work in community based general practice and not feel financially disadvantaged, or penalised in some way as a result of the placement.

Based on early feedback from initial SEM pilots, RDAA recommends that additional investment is needed to support the provision of supervision in SEM sites, and 19(2) exemptions for the practice to cover the practice overheads. RDAA currently recommends the practice to be paid 50 per cent of the private billings, with the other 50 per cent payable to the state jurisdiction to offset the salary of the registrar or Fellow RG.

The financial impact on general practices and supervisors must continue to be monitored, evaluated and adapted accordingly.

There are some key principles that should apply to jurisdictional employment models of an SEM:

- The participation in SEM arrangements must remain opt-in for both registrars and practices.
- A single employer model 19(2) exemption should only be granted where the registrar or RG is providing services in community based general practice or an AMS. Primary care clinics owned and managed by the state should only be eligible for SEM 19(2) exemption in locations where there is no general practice or AMS in operation.
- SEM 19(2) exemptions should be regularly reviewed and any non-compliance with the MOU should result in withdrawal of the exemption and a penalty applied to the State Health.
- There needs to be provision for local input and flexibility within the model to tailor arrangements to align with the local context within the MOU.
- Responsibilities of hospital and general practice need to be explicitly outlined in a MOU and include such provisions as:
    - Hospitals cannot recall SEM medical practitioners to the hospital outside of their scheduled roster to cover workforce shortages in short, medium or long term, other than exceptional circumstances.
    - In exceptional circumstances the hospital may request workforce support from the general practice, however the practice has the right to refuse the request.
    - The salary offset payable by the practice should be capped at the salary proportionate for the time worked in general practice over a 12 month period for a Fellow or over two years for a rural generalist trainee. State health should not be making a profit from SEM arrangements.
    - The state health employer should provide ongoing support for clinical upskilling or skills maintenance.
    - The state health employer hospital rosters should be developed to minimise the impact of overtime and recall on the general practice, due to fatigue leave

provisions. Any costs incurred as a result of fatigue penalties should be incurred by the state health employer, if payable due to hospital work.

- Contracts covering the entire duration of training should be an option, ie where possible intern to completion of college training.
- Models must be designed to align with registrars' college training requirements, such as pre-requiste college terms and clinical experience, mandatory requirements, as well as consolidation of clinical skill support. This provision should also be linked to continued approval of 19(2) exemptions.

RDAA acknowledges there is a potential risk, in that there may be a reduction in productivity of rural generalists participating in an SEM as opposed to the fee for service model. This needs to be monitoried closely in the pilots and in early years of implementation, and additional investment may be required to ensure the costs associated with practice overheads are met and the long term viability of general practice is not compromised as a a result of participation in an SEM. This investment could be managed through additional practice payments utilising the Flexible Payments model administered by ACRRM and RACGP.

## GP employment reform

RDAA is supportive of the work led by the Australian Medical Association (AMA) regarding broader GP employment reform. RDAA strongly endorses significant reform for GP registrars and senior GPs, however, the jurisdictional model is ready to implement as an opt-in program, in sites where there is the local leadership to establish the model.

In discussions there has been a cash payment in lieu of entitlements concept tabled for GP registrars, RDAA does not support this as an alternative to systematic reform. RDAA doctor in training members have consistently flagged a need for significant employment reform, and there is risk that a cash out model, will be a temporary fix and would certainly not address the issues for continuation of entitlements beyond Fellowship. RDAA would not accept this model for RG registrars or Fellows.

The jurisdiction model has all the elements available to facilitate further expansion now, and RDAA would strongly recommend that this is supported by Government policy and investment at a state and federal level.