



AMA/TSMPS CLAIM FOR A NEW INDUSTRIAL AGREEMENT

WITHOUT PREJUDICE

INTRODUCTION

This claim is lodged on behalf of the Tasmanian Salaried Medical Practitioners Society (TSMPS) in conjunction with the Australian Medical Association Tasmania (AMA Tasmania) and reflects the views of members of both organizations as extensively canvassed over the past 6 months.

In formulating this claim we recognize that the world economic system is in difficult circumstances but also that the ongoing national shortfall of qualified and experienced medical practitioners remains. Tasmania competes with the rest of Australia for scarce medical resources and this demands an overriding imperative that we remain competitive in the terms and conditions of employment for doctors.

In recent years there has been an emphasis on recruiting international medical graduates (IMG's) in an effort to close the numbers gap. This is a shortsighted and negative policy for several reasons two of which include:

- A proportion of those practitioners, recruited at considerable expense, leave Tasmania once their initial contract obligations are met and the cycle of recruitment must be repeated, with the attendant costs and the disruption to the treatment of vulnerable Tasmanians, until the gap is filled.
- Some of the IMG's are recruited (often indirectly) from countries where the need for medical expertise is even greater than here and the

issue of us drawing valuable resources from communities poorer than our own is simply not morally sustainable.

We recognise there is a place for overseas trained doctors in our system but the reliance that has developed in some places is neither good for the health of the system nor sustainable in the long term.

Tasmania must be competitive to attract and retain practitioners in an Australia wide context.

Our claims are modest, reflect general Australian mores in terms of medical employment, and will enhance the ongoing provision of quality medical services provided to Tasmanians by our public hospital system.

OUR CLAIMS

1. SALARIES

- 1.1. Subject to the following matters we believe that the nexus arrangement adopted in the 2006 Agreement has worked and should be retained, with modifications
- 1.2. The elements included in the nexus datum points require revision to ensure they provide an accurate reflection of the real value of the nexus point in each jurisdiction. For example the Victorian “Senior Specialist 9th year”. The actual rate payable at this level in Victoria includes a 20% all purpose allowance (not including the current 20% allowance in lieu of private practice). We need to reach agreement on the real datum points to be included in the nexus formula.
- 1.3. Our claims are detailed in Schedule 1
- 1.4. Additionally the current agreement specifies the calculation date as 31 March each year. We say that for 2009 the calculation should occur at 30 June 2009 (to incorporate increases that are pending interstate but not yet processed). The date of 31 March is acceptable for subsequent adjustments during the life of the agreement.

1.5. Within the salary scales there is a need to review the progression arrangements. Tasmania is the only state that mandates 4 separate levels for Consultants. In states where there are levels specified they are automatic progressions based on years of service.

1.6. Our claims are detailed in Schedule 2

1.7. A number of junior doctors have informed us that notwithstanding that they have the requisite years of service and meet the specified duties requirements they are classified and paid at rates lower than those listed in the current agreement. We seek a review of the classification criteria for junior doctors to ensure their years of experience and duties undertaken are properly reflected in the payments they are entitled to and paid.

1.8. Our claims are detailed in Schedule 3

2. PROFESSIONAL DEVELOPMENT

2.1. Current professional development entitlements for both Consultants and junior doctors fall below national and emerging standards in payment support, and the administrative arrangements applicable. Our claims address these issues and, when adopted, will provide an environment to enable best practice medicine to flourish in Tasmania.

2.2. Currently all medical practitioners can apply for up to 10 days leave each year for professional development purposes. This is cumulative for two years where suitable professional development opportunities are not accessible in the first 12 months. However, we have been informed that some hospital divisions do not permit accumulation. This must be administratively rectified immediately.

2.3. Consultants can access TERF entitlements to a current value of approx. \$13,500 pa. This amount falls well short of the emerging national rate of at least \$20,000 pa. The available entitlement is cumulative in some places. Accordingly we claim that TERF be increased to \$20,000 pa.

2.4. Doctors other than Consultants currently have no entitlement to financial support for professional development. This is not in accord

with developments elsewhere, especially South Australia, where up to \$7,000 pa, and Victoria, which provides for up to \$2,500 pa to be available for professional development support. Accordingly we require \$3,000 pa, be payable to all doctors below the level of Consultant.

2.5. The processes surrounding the application of the existing TERF system is complex and variable between employing units. Some managers facilitate a smooth application process while others seem intent on creating barriers and difficulties where none need exist. Accordingly we require that agreed professional development support be paid as an allowance fortnightly.

3. LOCUMS

3.1. In many medical disciplines in Tasmania's public hospitals only small numbers of practitioners are engaged. Small numbers mean that the ratio of "on call" duty is high and that the workload of any individual practitioner increases whenever other members of the group are unavailable. In the interests of not increasing the workload on colleagues some practitioners do not access all their leave entitlements, sometimes to the potential detriment of their own health or to their professional development.

3.2. Accordingly we require the provision by the employer of suitably qualified locums whenever an incumbent is accessing a leave entitlement.

3.3. In those instances where locums are not available despite reasonable attempts to engage them we require that colleagues accepting the onerous role of "filling the gap" be paid at locum rates for the time they provide the additional cover

4. PRIVATE PRACTICE

4.1. One way to enhance Consultants total remuneration package, and thus ensure that such packages remain competitive, is via the granting of the right to private practice. Such entitlements exist in all states and territories. In Tasmania the right is granted to eligible Consultants through a "Private Practice Plan Agreement" which

provides for a minimum payment of 35% with fund distributions specifically stated.

4.2. During 2008 collections due to the plan were disrupted by industrial action and the benefits owing to participating Consultants were seen to be in jeopardy. Thus the operation and scope of the plan came under the spotlight as Tasmanian Consultants require private practice income to remain competitive with their interstate counterparts.

4.3. Accordingly, as part of the next agreement we require a guarantee that a minimum of 45% of “Base Salary” (as defined in the Private Practice Plan Agreement) will be paid to all Consultants and the right to private practice formally addressed in the Industrial Agreement.

5. CONTRACT COMPLETION BONUS

5.1. The traditional practice of engaging junior doctors on short term contracts creates a range of problems, including uncertainty for the doctor concerned, and the issues associated with obtaining another position and relocating. As the term of service at a location draws to a close the doctor naturally begins to disengage and to turn attention to the forthcoming relocation. Sometimes doctors resign prior to the notional contract completion date. The early termination of contracts impacts on remaining staff. The solution lies in greater long term employment certainty for junior doctors, but this, in turn, is sometimes governed by the requirements of medical colleges.

5.2. Currently, to address this issue contract completion bonuses are available in various locations. To better address this problem we require, as a standard provision for junior medical staff, a bonus payment of 2 weeks pay for the successful completion of a 1 year contract and 4 weeks pay for the completion of a 2 year contract.

6. PAID MEAL BREAKS/SNACK PROVISION

6.1. Current arrangements provide for doctors to take an unpaid meal break of 60 but not less than 30 minutes within certain parameters. Generally these rules are supported on health and safety and normal amenity grounds. The reality, in a busy ward or department, is that often a break is not able to be taken or, if it is, it will be subject to

constant interruptions and recall to duty. Nevertheless the mandated break is deducted from time worked even if it has in fact been worked. This is clearly an unjust and unintended consequence of applying a mandatory unpaid meal break.

6.2. Accordingly we reiterate our support for a break free of duty but claim that where a doctor is unable to be relieved of all duty to permit a “duty free meal break” that the time be credited as time worked.

6.3. Working through, or during, break periods is especially prevalent after normal daytime hours. This coincides with the down time of hospital food outlets such as cafeterias. To meet the need for access to snacks after hours we require the provision of basic supplies at accessible points in each hospital. This includes items such as hot and cold drinks, bread, butter, cheese, spreads and biscuits as a minimum requirement. Where such supplies are not provided a meal allowance shall be paid.

7. CALLS WITHOUT CALLBACK

7.1. Doctors recalled to the hospital after hours are entitled to additional payments in recognition of the interruption to their own time to meet the needs of patients and their employer. Doctors able to deal with problems after hours by giving telephone orders or by telemedicine do not currently have an entitlement to payment. This is despite the fact that they suffer an interruption, often in the middle of the night, and often on multiple occasions.

7.2. Accordingly we require that payment be made at the hourly callback rate applicable to the employee, for 15 minutes, for each hospital initiated call received which does not result in a callback.

8. HIGHER DUTIES ALLOWANCE

8.1. Doctors are classified on the basis of their qualifications and experience and are appointed to undertake specified duties within the parameters of their accreditation by the employing hospital. Sometimes doctors are required to undertake additional duties for a period of time (not on an ongoing basis).

8.2. The entitlements due to doctors in such circumstances are not clear and this can be a cause of friction. We therefore claim that any doctor required to undertake duties that attract a higher rate or an additional allowance shall be entitled to be paid that higher rate or allowance for all time such additional duties are performed.

9. REASONABLE NOTICE OF ROSTER

9.1. Under current arrangements doctors required to work... “outside the spread of hours on weekdays or on weekends...” Are entitled to 4 weeks advance notice of roster. Our members report that this requirement is often not met, seemingly as a result of bureaucratic indolence.

9.2. Accordingly we require that the notice period be enforced. To ensure this happens we require the provision in the agreement of payment at the rate of double time (200%) for all hours worked without the necessary 4 weeks notice having been given (except where the later notification occurs within the provisions in the current agreement e.g. in an emergency or by agreement between the parties)

10. CONSULTANTS WORKLOAD

10.1. Members employed as Consultants consistently report on the additional burden placed on them by the requirement to facilitate undergraduate training. This is an accepted part of their role and is an element Consultants generally enjoy. However, the number of Consultants in some disciplines in Tasmania is quite small and the teaching load is disproportionate to that required in states where the numbers in each medical discipline is much larger.

10.2. With the current expansion of medical undergraduate numbers we believe we need to examine this matter, as a workload issue, and require the establishment of a joint committee comprised of equal numbers of nominees of TSMPS/AMA and DHHS to review the existing arrangements and recommend ways in which the impact on Consultants can be ameliorated.

10.3. As a starting point we require the adoption of the minimum standard applicable in Victoria, namely the 80:20 rule whereby 80%

of work time is allocated to patient care and teaching and 20% is available for related paperwork, research etc.

11.RECOGNITION OF INTERSTATE SERVICE

11.1. Recognizing the mobility of doctors, and the need to continue to attract and retain doctors in Tasmania, we require the proposed Agreement to specify the right of staff moving from interstate to have their long service leave entitlements, accrued in public health systems in any Australian state or territory, accepted as a long service leave credit in the Tasmanian public health system.

12.MEDICAL ENGAGEMENT

12.1. We require the that the proposed agreement include the establishment of formal processes to ensure senior medical engagement in decision making.

13.LEAVE LOADING

13.1. We require that all employees when proceeding on annual recreational leave shall be paid an additional 17.5% on their ordinary time earnings as a leave loading.

14.LATE THEATRE PENALTIES

14.1. To meet medical or hospital needs operating theatres often continue beyond the span of normal working hours and Consultants remaining on duty notionally have access to TOIL for such extra hours . In practice organizational demands often preclude the ability to take TOIL.

14.2. Accordingly we require that where theatres continue beyond 7 pm, in situations where call back payments are not currently made, all time worked beyond 7pm shall be paid at call back rates.

15.CONULTANT CALL BACK RATES

15.1. A major anomaly has been identified in the entitlements of employees in the payment of call back. Salaried staff and employees

engaged as VMO's have the same professional training and responsibilities and share responsibility for staffing after hours rosters. Two members of the same discipline can share the roster, and work concurrently, yet receive different remuneration for performing the same work, after hours.

- 15.2. Accordingly we require that a salaried consultant on call back duties, after normal hours, shall be paid shall be paid an amount not less that that paid to a Visiting Medical Officer performing the same duties

16.MATERNITY/PARTNER LEAVE

- 16.1. The current parental leave entitlements need to be extended to keep up with general Australian standards.
- 16.2. We require paid maternity leave to be increased from 12 weeks to 14 weeks.
- 16.3. We require paid partner leave to be available at the time of the birth of a child /children to his /her partner for one week.

17.SAVINGS

- 17.1. We require that all entitlements received by a doctor prior to the implementation of the proposed agreement, which are over and above the provisions of the new agreement, will continue.

AMA Tasmania, 20th March 2009.

SCHEDULE 1

NEXUS DATUM POINTS

1.1 VICTORIA

Senior Specialist 10th year (adopting the new Victorian top of range classification), Salary to be published rate plus 20% all purpose allowance paid to all Specialists.

1.2 WESTERN AUSTRALIA

Consultant Year 9 (pay point 24)

1.3 SOUTH AUSTRALIA

Senior Consultant Step 9

1.4 NORTHERN TERRITORY

Medical Officer Level 25

1.5 QUEENSLAND

Senior Medical Officer Level 25

1.6 NEW SOUTH WALES

Staff Specialist Senior

Nexus Salary to be published rate plus 17.4% Special Allowance

1.7 ACT

Senior Specialist

ACT has a nexus with NSW

SCHEDULE 2

2.1 CONSULTANT INCREMENTAL LEVELS

<u>Current</u>	<u>Proposed</u>
Level 1 \$120,738	Year 1 \$120,738
\$126,009	2 \$126,009
	3 \$135,000
2 years standstill	4 \$139,723
	5 \$145,398
Level 2 \$139,723	6 \$150,000
\$145,389	7 \$ 158,133
	8 \$160,000
2 Years standstill	9 \$163,021
Level 3 \$158,133	
2 years standstill	
Level 4 \$163,012	

2.2 Classification descriptors to be reviewed as follows:

2.2.1 Specialist Medical Practitioner Level 1 to be automatic annual increments 1, 2 and 3

2.2.2 Specialist Medical Practitioner Level 2 to be by automatic annual progression to increments 4, 5 and 6

2.2.3 Specialist Medical Practitioner Level 3 to be by automatic annual progression to increments 7 and 8

2.2.4 Specialist Medical Practitioner Level 4 to be by automatic annual progression to increment 9.

SCHEDULE 3

DOCTORS IN TRAINING (DiT's) SALARY CLASSIFICATION

3.1 Practitioner in Training Level 1 (Intern). Unchanged salary point 1

3.2 Medical Practitioner in Training Level 2 (Resident). Automatic annual progression through salary points 2, 3 and 4.

To be paid at the relevant annual increment point.

3.3 Specialist Medical Practitioner in Training Level 1 (Registrar). Any medical practitioner with at least two years post graduate experience must be paid at salary point 5 (currently \$74,808) if they are:

3.3.1 Employed in a recognized Registrar position, or

3.3.2 If they are employed to undertake the duties required in a Registrar position.

3.4 Specialist Medical Practitioner in Training Level 2 (Senior Registrar) to be paid at salary point 9 (currently \$99,546) unchanged.