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| Ministerial Review Victorian Public Sector Medical Staff Workplace Systems and Employment Arrangements |
| Executive summary and recommendations |
| The panel G R Smith AM Chair  Professor R Aldrich Panel member  Dr T Kambourakis Panel member |

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# Executive summary and recommendations

The Panel met with some 72 participants and received 78 written submissions from doctors, doctors in training and specialist staff associations, craft group peak bodies, directors of medical services and health service senior executives, specialist medical colleges, universities, employer organisations, government agencies and unions.

Analysis of information provided during consultations revealed 14 key themes. Regarding each, participants identified problems and proposed solutions. This information has of course informed the panels consideration and development of recommendations. The themes can be distilled as follows:

* recruitment and retention of medical staff to rural and regional areas is challenging;
* rostering practices, overtime, out of hours work and on-call work have a significant impact on the work-life balance and wellbeing of medical staff;
* reliance on International medical graduates (IMG) medical staff is not sustainable while recruitment practices and support of IMGs could be improved;
* bullying, harassment, discrimination, and other aspects of workplace culture need to be addressed, including by improving job security. Access to speciality training to support complaint resolution needs to be strengthened;
* greater diversity and improvements to inclusion and cultural safety would benefit public health services and medical staff;
* practices that determine numbers of trainee, selection of trainees, accreditation of hospitals for specialist training teams, and administration of supervision are limiting the extent to which specialist training meets community needs;
* recruitment and retention of part-time and full-time medical specialists is impacted by pay scales and above agreement payments and the sector would benefit from changes that increased the proportion of specialists who work full time or at higher fraction at single health services;
* the sector would benefit from changes to improve supply of, and better utilise of, general practitioners, rural generalists, and Career Medical Officers in hospitals;
* technology, and use of allied health workers, nurse practitioners and other new categories of workers (such as an Assistant in Medicine) could reduce medical staff workload, have medical practitioners working closer to full scope and reduce overtime and costs;
* doctors in leadership and management roles, and executive leadership could be better supported;
* doctors could benefit from greater autonomy in rostering, taking leave, and work design;
* the medical profession, health services and specialist training programs need to better accommodate flexibility for a changing workforce and to improve gender equality; and
* systems governing recognition and compensation for on-call and recall are a cause of frustration and impact morale.

Against this background we now provide our recommendations and a summary of the context that informs them. Some of the recommendations are elaborated and supplemented in the body of the report.

## Recommendation one

**Context:** The significant difference in fractional remuneration and full-time remuneration in the current Agreement (where for example a year 9 specialist working fractionally for 31.33 hours per week earns the same weekly amount as a full-time year 9 specialist working 38 hours per week) creates a disincentive for full-time or higher-fractional employment with the consequent staffing and rostering issues. This presents consequent challenges to continuity of care and means that it is possible to have two medical officers of equivalent experience doing the same job yet paid unequally. Additionally, in the current Agreement, specialists of the same level of experience working fewer than 17.6 hours per week are paid less than someone of the same level of experience working 17.6 to 35 hours per week, which the Panel has heard can have a gender impact for specialists with caring responsibilities.

We do not recommend any restriction on fractional employment as that is within the control of the Health Service and fractional employment may also assist in achieving a work-life balance, particularly given the changing demographics and aspirations of people in the workforce seeking flexible work arrangements. Whilst we would encourage higher fractional employment some of the underlying supply issues need to be addressed which may overcome using small fractional employment as a cost control measure

**Recommendation:** *The Industrial Parties move in bargaining to create, between medical staff of similar experience, parity between hourly remuneration rates of full time and fractional and amongst fractional medical staff, with the support of Government, over a period of 5 years.*

## Recommendation two

**Context:** Because of the devolved nature of the Victorian public health system, there are inconsistent and competitive approaches to recruitment of doctors in training, creating a burden and employment insecurity. Given that the Victorian Department of Health does not employ medical staff in public hospitals (unlike other states), steps should be taken to remove administrative barriers and make selection of doctors in training by hospitals more transparent.

**Recommendation:** *Consideration should be given to training networks comprising multiple health services which can help remove the administrative burden for doctors in training having to apply to each hospital for employment.*

## Recommendation three

**Context:** Specialists Colleges and societies control the selection, training, accreditation of training sites, and work practices of doctors in training.

**Recommendation 3.1:** *The Minister raise with State Ministers for Health at a Federal level the factors which impact adversely upon the efficient training and supply of medical specialists including reducing the limitations (such as accrediting night and after-hours) on the use of specialist trainees in Public Hospital settings.*

**Recommendation 3.2:** *To better support health services while responding to the community’s current and future healthcare and workforce needs, the Australian Medical Council develop and oversee implementation of consistent and transparent standards for accreditation of health services to deliver specialist training programs.*

## Recommendation four

**Context:** Universities have a greater role to play in providing medical graduates for the system, particularly in admitting and training students from rural and regional backgrounds. It is said that those attending University from rural or regional areas are more likely to return to rural and regional practice.

**Recommendation:** *The Minister take whatever steps are available either at a State or Federal Level, to enable Universities to take special measures[[1]](#footnote-1) to facilitate the enrolment and education of students from rural and regional areas.*

## Recommendation five

**Context:** It was submitted that Medical Staff appear, in part, reluctant to move to rural or regional locations because of difficulties in local opportunity and infrastructure.

**Recommendation:** *The Department of Health establish a support service that understands the services in regional and rural areas to assist with “on boarding” to find housing, schools, childcare, partner employment, community support etc. The person/s selected must have local knowledge. International Medical Graduates must be provided with information about the community in which they are going to live; the industrial instruments relevant to them; the industrial organisations and how to deal with matters which may be of concern. Following engagement, they may also require additional information in accessing community support.*

*This might be achieved administratively by combining/coordinating activity across a number of Health Services.*

## Recommendation six

**Context:** There is a greater role for Safer Care Victoria or the Department of Health in dealing with issues which ultimately impact upon patient care.

**Recommendation:** *Safer Care Victoria or the Department of Health should:*

*a) Chair a task force to determine safe rostering practices for all Victorian Public Hospitals with emphasis on fatigue management, safe working hours and ensuring role responsibilities align with rostered hours;*

*b) Chair a task force to review the models of care for Victorian public hospitals which will examine the relationship between hospital care and out of hospital care against the background of greater use of registered nurses and allied health professionals working to their full scope of practice, with modern models of care enabled by technological advances;*

*c) In the context of Safer Care Victoria examining ways of working, consideration to be given to greater use of multidisciplinary teams to relieve doctors from some functions which might be performed by others working up to their scope of practice. It appears that greater use could be made of teams comprising doctors, nurses and allied health professionals all working up to their scope of practice; and*

*Opportunities might exist for some duties to be undertaken by, allied health professionals and registered nurses, as well as a new staff category of Assistants in Medicine, and administrative staff. The greater role of nurse practitioners and advanced practice nurses should also be considered.*

## Recommendation seven

**Context:** There appears to be a need to fully understand workforce data as it relates to attraction and retention of medical staff:

**Recommendation:** *The Minister in the annual Statement of Expectations require hospital to provide on a six-monthly basis:*

*a) Workforce data which details the percentages of all contracts of employment (including details of fractions), contractor arrangements and gender distribution within the workforce;[[2]](#footnote-2)*

*b) Data revealing the extent that the total cost of medical staff employment entitlements exceeds the amount that would be payable were entitlements provided in accordance with enterprise agreements only; and*

*c) Information about the impacts of measures the health service or hospital has undertaken to reduce the number of arrangements it has with medical staff according to which the hospital or health service provides terms and conditions that are more beneficial than terms and conditions contained in relevant enterprise agreements.*

## Recommendation eight

**Context:** Doctors in training have expressed great concern over the use of fixed term contracts. Those concerns are both financial (financial institutions are reluctant to lend money to a person on a fixed term contract) and concern about job security. Concern was also expressed that there was a lack of performance feedback. The lack of job security was also a factor in a reluctance to raise any grievances.

**Recommendation 8.1:** *Hospitals should review the need for fixed term contracts and the duration of fixed term contracts offered to doctors in training. Reviews undertaken by hospitals should provide options to increase job security for doctors in training.*

**Recommendation 8.2:** *Parties in bargaining for a replacement enterprise agreement to cover doctors in training should use outcomes of reviews conducted by hospitals per a) above to craft terms to improve job security for doctors in training.*

**Recommendation 8.3:** *At the time doctors in training are appointed, hospitals should discuss with the doctor options to improve job security, including whether a longer contract term or ongoing employment can or may later be provided to the doctor.*

## Recommendation nine

**Context:** It is clear that there are many avenues for doctors in training to raise concerns about unprofessional behaviour, bullying, harassment and discrimination, (including through the colleges) but the Panel has been told that many believe that these are ineffective because many doctors in training genuinely believe that to raise an issue about a senior doctor can impact seriously upon a career, or reappointment to a position, or selection onto a specialist training program. Our consultation leads us to believe that this is not an unreasonable apprehension and examples have been shared. The view that “because I went though it you should see it as a part of resilience training” has no place in a modern workplace. It would not be unreasonable to link poor workplace culture to less than optimal patient outcomes.

**Recommendation 9.1:** *The Minister in the statement of expectations require Health Services Boards to report annually on what steps it has taken to implement a positive duty to eliminate bullying, harassment, and discrimination at the health service and to report on those measures.*

**Recommendation 9.2:** *The Minister establish a Doctors’ Advocate. The following should be the criteria for the work of such a person. The person should:*

*a) Report to the Minister;*

*b) Be independent of the Department of Health;*

*c) Have protections and not be subject to FOI;*

*d) Have sufficient administrate support;*

*e) Have skills in conciliation and mediation;*

*f) Have the power to act on a complaint or “on their own motion”;*

*g) Have the power to enter any Hospital facility for the purpose of investigating a complaint; and*

*h) Have the power to refer the matter back to the hospital and/or other mechanisms for review.*

*We do not support, at this stage, the Advocate having any coercive powers to compel the production of documents or to take evidence.*

## Recommendation ten

**Context:** The current Medical Practitioners Award 2020 and industrial instruments do not sufficiently cater for the needs of doctors, hospitals and sometimes the communities they serve, including in public health services not covered by Agreements (usually for which skilled general practitioners are critical to their core medical workforce). Additionally, there are opportunities to both expand and improve retention of the medical workforce in the public health sector. There needs to be:

* scope for doctors who do not wish to undertake specialist training to have a varied career path with the public health system;
* consideration given to introducing the new remunerated role of Assistants in Medicine (AIMD). International medical graduates (IMGs) who possess their Australian Medical Council (AMC) Part One qualification and who are yet to obtain the AMC Part Two accreditation necessary for AHPRA provisional registration could work under supervision to assist hospital medical officers and medical teams as a workplace-based route to obtaining their AMC Part Two. This would address two critical imperatives: alleviating somewhat the burden of administrative tasks on hospital medical officers and increasing the supply of registered medical officers. Final year medical students would also meet the key criterion for employment as AIMDs;
* consideration given to making provision in Agreements to recognise the role that specialist general practitioners do, and may have, in current and future public hospital systems; and
* scope to expand programs of skills training across metropolitan, regional, and rural hospitals for doctors who are training to become rural generalists in general practice.

**Recommendation:** *The relevant industrial parties should negotiate a new multi-employer agreement (or amend an existing one) with all public hospitals which provides a career path for doctors who wish a career path within a hospital as a generalist hospital doctor (termed Career Medical Officer in other jurisdictions).*

*Attention should be given to remuneration and working conditions (such as training time Continuing Medical Education (CME) support, leave, out of hours and on call to name a few) of accredited registrars and non-accredited registrars where the work value is identical.*

*Further there should be a classification for Assistants in Medicine for individuals within 12 months of obtaining Ahpra provisional registration as a medical practitioner. The new agreement should provide that an individual eligible to be employed as Assistants in Medicine be paid accordingly, and that any necessary work is undertaken:*

* *to ensure a framework is developed to enable medical students to perform work as an Assistant in Medicine; and*
* *to support health services to gain AMC Accreditation to provide workplace-based assessment requirements of eligible IMGs working as Assistants in Medicine.*

*Additionally training opportunities in metropolitan and regional health services in specialty areas such as paediatrics, palliative care, mental health, and emergency medicine should be expanded and designed to equip general practitioners with skills they need to support skilled hospital practice by general practitioners and development of the rural generalist workforce. Attention should be directed to ensuring fair and appropriate recognition of general practitioners and rural generalists, including those in training, to encourage take up of training opportunities.*

## Recommendation eleven

**Context:** The industrial regulation of health services is fragmented as not all hospitals are party to Agreements covering doctors. Hospitals that are not party to relevant enterprise agreements are bound by applicable modern awards, but this is not sufficient to create synergies in the sector.

**Recommendation:** *That steps be taken by those health services that are not party to the relevant enterprise agreements to explore options under s.216D of the Fair Work Act 2009.*

## Recommendation twelve

**Context:** It is the case that doctors are performing too many non-clinical tasks which take time that could be spent on direct patient care.

**Recommendation 12.1:** *Appropriate administrative support for clinical staff and doctors in management roles needs to be provided and sufficiently resourced. It is envisaged that the new role of Assistants in Medicine would assist also with clinical administrative tasks. Such tasks might include managing communications/emails correspondence, scheduling, etc.*

**Recommendation 12.2:** *A single state-wide record of mandatory training should be established to reduce and or avoid duplication between individual health services.*

## Recommendation thirteen

**Context:** Submissions have led to the conclusion that professional development of senior medical staff responsible for unit or departmental management or supervision of prevocational employment for doctors in training may be inadequate. Therefore, the necessary professional development to manage general requirements of management or supervisory position should be implemented. This is not a criticism of medical expertise but a need to provide support for managerial functions.

**Recommendation:** *Government provide funding for the delivery of managerial professional development for senior medical staff who have relevant responsibility. Completion of managerial professional development work to be a key selection criterion in the appointment of medical staff to such positions which could take place before appointment or as a part or orientation. We are not prescriptive about the delivery of this training be it through professional associations or tertiary institutions. An important ingredient is sufficient time allocated to undertake this professional development in addition to a specialist medical officer’s CME entitlement.*

## Recommendation fourteen

**Context:** The Review Panel has heard that there is, across Victoria, a mismatch between population needs for public sector medical care and the distribution and location of public sector medical officers, including:

* the numbers of public sector medical officers (doctors in training and specialists) in a health service;
* number and discipline and location of specialist training positions;
* number of specialists available for supervision of doctors in training;
* number of training positions accredited by specialist colleges;
* nature of training term rotations accredited by specialist Colleges; and
* incentives provided to attract public sector medical officers to rural and regional practice.

This mismatch appears due to a lack of co-ordination in planning, recruitment, and opportunity together with long-standing conventions regarding patterns of work and models of care. These entrenched inequities between health services’ medical officer numbers and capacity, and the consequent impacts on population health and well-being outcomes among the people they serve, undermine progress towards [Victoria’s vision that Victorians are the healthiest people in the world](https://www.health.vic.gov.au/our-strategic-plan-2023-27/our-vision-and-values). <https://www.health.vic.gov.au/our-strategic-plan-2023-27/our-vision-and-values>

Distribution and numbers should be based on a whole-of-Victoria assessment of needs for public sector medical care.

**Recommendation:** *That the Department of Health undertake a comprehensive, population health needs-informed medical workforce 10-year plan, and which:*

* *articulates its assumptions regarding rostered workloads;*
* *acknowledges the role of specialist Colleges in training specialists and the need for distribution of training positions to match local population needs for public sector medical care;*
* *envisions contributions from new classifications of Career Medical Officer and Assistants in Medicine as proposed and if accepted;*
* *envisions the contribution of new technologies for health service delivery;*
* *envisions new models of care (and staffing numbers) required to provide continuity of care across seven days, either in a hospital, at home or using technology to provide that care as close as safely possible to where Victorians live; and*
* *ensures that medical officers are enabled to work to the top of their scope with advances in scopes of other health professionals also.*

## Recommendation fifteen

**Context:** There appears to be variability and inconsistency in conditions of employment and provision of certain entitlements within the sector. This may arise from saving clauses from earlier agreements and includes variation in methods of recognition of fractional specialists for on-call periods, for recall to duty out of normal hours, and for conduct of routine rounds outside normal hours.

**Recommendation:** *Between now and the next round of bargaining the Industrial Parties should examine these issues and agree to rationalise and standardise these issues to create equity and consistency of treatment. Savings clauses should be closely examined rather than rolled over. Remedies might include:*

* *A medical specialist is paid one hour’s pay for each and every on-call period, regardless of full-time or fractional status;*
* *An hourly amount should be paid when a medical officer is recalled to duty, regardless of where that duty is performed (recognising that technological advances and regionalisation of some roles will mean that some responsible consulting actions taken while on-call after hours are conducted via telephone or on-line meetings or from their home or other offsite location); and*
* *Scheduled ward rounds and other clinical activities conducted by a team’s on-call consultant on weekends should either be rostered as working hours (subject to other shift and day compensations) or be considered as recall to duty.*

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1. Special measure may not constitute a discriminatory practice. [↑](#footnote-ref-1)
2. to the extent that the Workforce Gender Equality Agency collects relevant data this may not be necessary. [↑](#footnote-ref-2)