Special Commission of Inquiry into Healthcare Funding

Statement of Melissa Collins

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Occupation:	A/Executive Director, Workplace Relations

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Inquiry**). The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. I am the acting Executive Director of Workplace Relations of NSW Health. I have acted in the role since 5 February 2024 and the role will shortly be advertised via a formal recruitment process on the open job market.

3. My substantive position is Director, Industrial Relations (Medical) and Policy in the Workplace Relations Branch of NSW Ministry of Health (**MOH**) and I have held this position since January 2019. Prior to this position, I was the Deputy Director of Workforce at Northern Sydney Local Health District. I also previously worked in the Workplace Relations Branch of the MOH between 2009 and 2013.

4. I hold a Bachelor of Laws and a Bachelor of Social Science (Industrial Relations).

5. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0142.0001**).

6. As acting Executive Director, I am responsible for state-wide decision-making for industrial relations, general workforce and policy matters across NSW Health. A copy of my position description is exhibited to this statement (**MOH.0010.0145.0001**).

B. SCOPE OF STATEMENT

7. This statement addresses Term of Reference F concerning the current capacity and capability of the NSW Health Workforce to meet the needs of patients and Issues Paper 1/2024 issued by the Inquiry.

8. In this statement, where I use the term 'Health Agency' I am referring to Local Health Districts (**LHDs**), Speciality Health Networks (**SHNs**) as well as the divisions and units of the Health Administration Corporation (**HAC**). Accordingly, unless otherwise indicated, my use of that term in this statement includes:

a. the 15 LHDs;

b. two SHNs;

c. five Pillar organisations; and

d. six health system support or statewide health services (namely, NSW Ambulance, Health Infrastructure, HealthShare NSW, NSW Health Pathology, eHealth NSW and Health Protection NSW).

9. I have reviewed the data report of Rian Thompson dated 16 July 2024 and the data contained in that report has been used as a source for this statement.

C. EMPLOYMENT WITHIN NSW HEALTH

(i) NSW Health, Non-Executive

10. NSW Health employees are engaged under Chapter 9, Part 1 of the *Health Services Act 1997*.

11. Section 115 of the *Health Services Act 1997* provides that the NSW Health Service consists of those persons employed under Chapter 9, Part 1 of the Act by the Government of New South Wales in the service of the Crown.

12. Pursuant to s 116(3) of the *Health Services Act 1997*, the Health Secretary exercises the employer functions on behalf of the Government of New South Wales in relation to the staff employed in the NSW Health Service, subject to exceptions relating to certain NSW Health senior executives.

(ii) NSW Health, Executive

13. NSW Health Service senior executives (**Health Executives**) are engaged under Chapter 9, Parts 1 and 3 of the *Health Services Act 1997*.

14. The employer functions on behalf of the Government of New South Wales for Chief Executives employed in LHDs and SHNs reside with the Board of each LHD or SHN (s 116(3A) and 116(3C) of the *Heath Services Act 1997*).

15. The appointment and termination of the employment of a Health Executive, where the appointment or termination is not made by the Secretary, requires the concurrence of the Secretary (*Health Services Act 1997* ss 23(1), 52G(1), 121H(5); *Government Sector*

Employment Act 2013 s68(2); *Government Sector Employment (Health Service Senior Executives) Rules 2014* r 32).

16. The Chief Executive of a LHD or SHN exercises employer functions in relation to other Health Executives of the LHD or SHN on behalf of the Government of New South Wales (s 116(3B) and 116(3D) of the *Health Services Act 1997*).

17. The Secretary may terminate the employment of a Health Executive (including a Chief Executive) at any time, for any or no stated reason and without notice (s 121H(1) *Health Services Act 1997*).

18. Employer functions for Health Executives not employed in LHDs and SHNs reside with the Secretary, who exercises the employer functions for Health Executives in all other NSW Health organisations, such as Pillars and HAC entities (*Health Services Act 1997* s 116(3)).

(iii) MOH

19. MOH employees are public servants employed under the *Government Sector Employment Act 2013*. The MOH is a Department of the Public Service listed in Schedule 1 of the *Government Sector Employment Act 2013.*

D. DELINEATION BETWEEN HEALTH AGENCIES AND THE MINISTRY

20. Governance structures within NSW Health are summarised in *The Corporate Governance and Accountability Compendium*, a copy of which is exhibited to this statement (**MOH.0010.0256.0001**).

21. The MOH supports the executive and statutory roles of the Minister for Health and Minister for Regional Health, Minister for Mental Health and Minister for Medical Research.

22. LHDs (and their predecessor Area Health Services) and SHNs are distinct entities from the Secretary and the HAC: they are bodies corporate separately constituted under the *Health Services Act 1997* (ss 17 and 41) with separate governance, management and functions. The *Health Services Act 1997* states expressly that LHDs and SHNs do not represent the Crown (ss 22 and 45).

23. The functions of the MOH and the public servants who are employed in it include:

a. supporting the relevant health portfolio Ministers and the Secretary to exercise their statutory functions;

b. undertaking regulatory and public health functions (disease surveillance, control and prevention) under relevant health portfolio legislation; and

c. undertaking Health system manager functions such as statewide planning, purchasing and performance monitoring of health services.

24. Compared to previous structures, including under the (then) Department of Health, the MOH's responsibility is reduced in size, consistent with its core functions.

25. The Secretary's statutory role in exercising employer functions in respect of NSW Health Service staff means the MOH retains a substantial degree of centralised administration of certain key employment functions regarding policy, and strategy, which provides the capability to ensure the workforce and its associated labour cost is sustainable. The employer functions are otherwise largely delegated by the Secretary to individual NSW Health Agencies. A copy of NSW Health's *Combined Delegations Manual* is exhibited to this statement (**MOH.9999.0817.0001**).

26. The Workplace Relations Branch leads system-wide industrial relations for the NSW Health system, including negotiating and determining wages and employment conditions for the NSW health service within the prescribed framework of Government and the conduct of industrial cases in the NSW Industrial Relation Commission (**NSW IRC**).

27. The role of the Workplace Relations Branch also includes:

a. responsibility for human resource and workplace health and safety policy for the NSW Health system;

b. administering the Health Executive Service;

c. managing the MOH's human resources strategy; and

d. providing information and advice to managers and employees on all employment issues.

E. DIRECTION TO HEALTH AGENCIES

28. The MOH retains a substantial degree of centralised administration of certain key employment functions, policy, and strategy.

29. NSW Health operates under a mainly devolved structure using a tight-loose-tight governance framework, by which I mean that some functions are centrally managed, some are devolved and others are shared. This governance framework seeks to ensure that high quality patient-centred care is available in a timely and equitable way.

30. Health Agencies decide on the composition of their workforce to meet their activity targets, relevant to their population and health care needs. Decisions on the development and implementation of workforce models are multifactorial and are focused on providing high quality, value-based health care.

31. Health Agencies:

    a. use the strategic and operational guidance provided by the MOH to inform their own workforce plans and strategies, ensuring they are tailored and responsive to local needs;

    b. prioritise implementation of activities that are most important and relevant to their local needs;

    c. contribute to broader system level workforce approaches where they have expertise or interest; and

    d. actively share learnings and experiences with other Health Agencies as well as other organisations to help to leverage experiences, accelerate progress, and avoid duplication.

32. NSW Health uses a combination of staffing arrangements which are an important feature of the health system to remain agile and scale up and down when needed.

33. NSW Health aims to secure a stable workforce with an optimal balance of permanent, temporary, casual, and Visiting Medical Officer (**VMO**) staff (including via quinquennium contracts) with an ability to surge workforce capacity according to demand for health services as required.

34. Payroll data extracted in June 2024 showed the following Full Time Equivalent breakdown through the NSW Health payroll system (i.e. excluding VMOs):

    a. 78.6% permanent full/ part time;

    b. 15.9% temporary (this includes Staff Specialists on temporary contracts); and

c. 5.5% casual / agency.

Included in the above Full Time Equivalent is approximately 3% overtime.
(Source: NSW Health Corporate Data Warehouse, note that figures are rounded and amended slightly as overtime isn't its own employment category)

F. INDUSTRIAL FRAMEWORK

35. The terms and conditions of employment of staff within the NSW Health Service and the extent of authority of NSW Health representatives in this regard are regulated by legislation, industrial instruments, NSW Health policy, delegations and determinations.

36. NSW Health currently administers over 40 industrial awards and over 100 other instruments, including policy directives and determinations, which set the conditions of employment for NSW Health employees. All awards and determinations are available on the NSW Health website, currently via the https://www.health.nsw.gov.au/careers/conditions/Pages/default.aspx webpage.

37. Pursuant to s 116A(1) of the *Health Services Act 1997*, the Health Secretary may fix the salary, wages and conditions of employment of staff employed under this Part in so far as they are not fixed by or under any other law. The exercise of this power to fix the salary, wages and conditions of employment is through the making of and variation to awards and is described in NSW Health as the making of a "Determination".

38. The Health Secretary may delegate this power by an instrument in writing pursuant to s 21(1) of the *Health Administration Act 1982*.

39. The Health Secretary has delegated the power to make a Determination under s116A(1) to fix the salary, wages and conditions of employment of staff to certain senior officers of the MOH only (see the MOH's 'Combined Delegations Manual'). This power is not delegated to staff of Health Agencies. This is to ensure both consistency of approach across NSW Health and compliance with Government policy and direction.

40. Requests from Health Agencies for Determinations for a variation of award conditions must be advanced consistent with part 3 of NSW Health Policy Directive, *Non-Standard Remuneration or Conditions of Employment* (PD2018_040), a copy of which is exhibited to this statement (**MOH.0010.0144.0001**). Workplace Relation's records indicate that approximately 500 Determinations have been approved since 2005.

41. In my experience, the primary consideration for the relevant delegate in deciding whether or not to approve a Determination is the potential for approval to lead to pressure to flow-on the same or similar arrangements to other staff in the health organisation or more broadly in the NSW Health Service. This has particular importance given the requirements of the Government's Wages Policy, which is discussed below.

G. GOVERNMENT'S WAGES POLICY

42. The *NSW Government Fair Pay and Bargaining Policy 2023* (**the Wages Policy**) applies to the government sector as defined in the *Government Sector Employment Act 2013*, including Public Service agencies, departments, executive agencies, independent statutory bodies, and the NSW Health Service. A copy of the Wages Policy is exhibited to this statement (**MOH.0010.0143.0001**). A copy of the associated commentary to Unions is also exhibited to this statement (**MOH.0010.0150.0001**).

43. The Wages Policy applies to any negotiations, variations, claims or offers by agencies that impact on remuneration or other conditions of employment, whether or not they are formalised in an industrial instrument.

H. ADVANTAGES AND LIMITATIONS OF THE CURRENT INDUSTRIAL ARRANGEMENTS

(i) Suitability of current conditions for future Health workforce

44. Ongoing work is required to assess the suitability of the current conditions in enabling the relevant objectives of the *NSW Health Workforce Plan 2022- 2032*, a copy of which is exhibited to this statement (**SCI.0001.0043.0001**). For example, those relating to the introduction of new positions and modernising employment arrangements to enable delivery of new care models and new ways of working.

45. Awards are a product of history, particular to the parties involved. They are made in the light of the customs and working conditions of each industry or professional occupation, and they frequently result from an agreement between the parties. These agreements are often couched in terms intelligible between the parties but tend to be framed without the careful attention for legal form and draughtsmanship that is expected of legislation.

46. As legal formality and technicality are not required, the parties have enough flexibility to arrive at agreements to address or settle industrial disputes.

47. However, given the strong and often competing industrial interests, parties to an award can find it challenging to reach agreement. In some cases, disputes can span over a few years before these are resolved (and sometimes it is not practical to do so).

48. Consequently, industrial matters can sometimes remain open and unresolved for an extensive period of time while the issues that gave rise to them continue to persist at the operational or system level. Additionally, community expectations are that hospitals provide a 24/7 medical service. In order to meet those expectations, the hospital system is reliant on the junior medical workforce to provide overnight medical coverage, who manage the bulk of overnight shiftwork and on-call duty. Junior Medical Officers (**JMOs**) must combine their ongoing study with work commitments, including overtime and on-call obligations.

49. Current JMOs rotate frequently throughout their training, from their intern year continuing through to their time as a registrar. They have limited control over their locations of work. The academic pathway, training and work patterns for doctors in training have all changed since the *Public Hospital Medical Officers (State) Award* was drafted.

50. The culture and work schedule for senior medical (VMOs and Staff Specialist) staff impacts directly on the way JMOs work. Historically, senior medical staff expect to work Monday – Friday business hours, providing remote phone advice after hours. The expectation for hospitals to run 24/7 has increased. Consequently, JMOs are increasingly rostered as first on-call and more afterhours/overnight shifts.

51. College accreditation standards also often contrast with the need to deliver clinical services. Trainee doctors require differing levels of supervision from Staff Specialists and VMOs and broad experience across their speciality work. This has driven colleges to set standards that restrict where and when a trainee doctor can work. This includes limiting time in regional, country or unaccredited locations as well restricting the number of night shifts. This results in the need for unaccredited trainees and/or locums being engaged to provide clinically required services.

52. To manage the challenges of running a 24/7 Service, NSW Health requires senior medical practitioners to work broader hours, which is reflected in the Award Variation submitted to the NSW IRC in June 2023 (see below).

53. Tracking of time worked is a present and ongoing challenge across all levels and introduction of a statewide time recording system is seen by the MOH as a way to track

and pay workforce accurately and also to guide future award variations and ensure that Awards remain reflective of the present workforce requirements.

(ii) NSW Health awards are generally outdated

54. It has been my experience in working with and applying the various awards applicable to NSW Health staff that they are outdated, ambiguous, overly prescriptive and can place limits on the ability to engage and retain an agile and contemporary workforce.

55. A working example of this is the *Public Hospital Medical Officers (State) Award*, a copy of which is exhibited to this statement (**MOH.0010.0122.0001**). This was drafted some 40 years ago, at a time when trainee medical officers were primarily based in Sydney, working Monday – Friday during the day. Today the junior medical workforce works on a rotational basis and doctors are expected to work nights on Monday to Friday and on weekend to support an increasingly 24/7 health system. They are also required to rotate between facilities across NSW including regional, rural and remote facilities for periods of between 3 and 12 months.

56. There is an opportunity for NSW Health and the public health unions to work collaboratively to modernise the industrial instruments that establish wages and conditions for the workforce through bargaining, including Mutual Gains Bargaining (**MGB**) under the new framework within the *Industrial Relations Act 1996*. However, this framework is not without its own challenges.

57. The NSW Government's *Fair Pay and Bargaining Policy* places a positive obligation on government agencies to engage in MGB; an interest-based approach that has a focus on finding a solution that provides mutual gains for both employees and employers. Additional increases to remuneration may be provided where substantial efficiency improvements are identified. Where these improvements have been identified, approval of the Expenditure Review Committee of Cabinet (**ERC**) must be sought. Such proposals must be submitted for consideration by Senior Officials Wages Advisory Committee for assessment before proceeding to ERC.

58. An example of Health's outdated awards are incidental award allowances (such as infectious cleaning and nauseous linen allowances). These have been enshrined in Health awards for decades, and at times are not consistent with contemporary health work practices. They are also a cause of significant disputation across the health system and are often cumbersome and inefficient to administer. The *Health Employees'*

Conditions of Employment (State) Award has up to 70 incidental allowances. A copy of that Award is exhibited to this statement (**MOH.0010.0126.0001**).

59. There is an opportunity to assess the ongoing applicability of these allowances, and potential efficiencies through consolidation and rolling up where appropriate; however, the opportunities of achieving this within the MGB framework in terms of offsetting via substantial efficiency improvements and/or savings are limited.

(iii) Challenges in seeking variations to modern awards through bargaining

60. A key challenge for such modernisation under MGB is that efficiency gains are more readily achieved over an extended period of time. It is difficult for NSW Health to identify efficiency improvements that can be realised in the short term necessary to deliver the remuneration increases expected by, and acceptable to, the unions for consenting to modernisation of awards.

61. Employee wages and associated costs (excluding redundancies and workers compensation) account for 57.04 per cent of the overall NSW Health expenditure ($16.84 billion of $29.53 billion). There is also approximately $1.04 billion of expenditure on VMOs; separate to employee wages and associated costs. Therefore, any material change to the terms and conditions of employment will impact the budget position of NSW Health.

62. Another key challenge is that there is little incentive to modernise award provisions. Unions are understandably reluctant to agree to any changes, including to modernise provisions, unless there is a significant benefit provided for them to do so. Any agreement is likely to incur direct and recurrent costs, with deferred efficiency benefits.

(iv) Interrelationship with other health systems and sectors

63. I observe that the workforce shortage issues impacting the health sector are universal and not restricted to NSW Health. Some of the workforce issues are more acute in other States. As a result, NSW Health remains mindful that any significant changes to remuneration and employment arrangements will likely impact other public health systems (and potentially the private sector) as they have structured their terms and conditions of employment to compete with NSW Health.

64. I set out below some other examples of specific awards that present challenges to NSW Health.

(v) Nurses

65. Most nurses are engaged by Health Agencies and covered by the *Public Health System Nurses' and Midwives' (State) Award* (**the Nurses Award**). A copy of the Nurses Award is exhibited to this statement (**MOH.0010.0129.0001**).

66. The Nurses Award provides the terms and conditions for all nurses and midwives who are directly employed by Health Agencies or anywhere else within NSW Health and recognises the NSW Nurses' and Midwives' Association as the representative party for employees.

67. Due to historical agreements between the parties, the Nurses Award is considered to be 'modernised' compared to other Awards across NSW Health and does not have many provisions left that would result in a significant cost-saving if changed or removed.

68. There are also workplace practices that limit flexibility, workforce pipelines, and contemporary workforce models. Such models can provide more cost-effective patient care and assist in building workforce pipelines and supply.

69. For example, health care teams can include Assistants in Nursing (**AINs**) and Assistants in Midwifery (**AIMs**) working alongside Registered Nurses, where AINs work within a defined scope of practice and performing functions such as assisting patients with activities of daily living, making beds and attending to personal care. This allows Registered Nurses and Midwives to focus on the more complex care requirements.

70. The engagement of AINs / AIMs can assist in providing patient care in areas where nursing workforce shortages exist. They are also often a workforce pipeline towards Registered Nurse positions as often an AINs / AIMs are working to become a Registered Nurse.

(vi) Allied Health and Other Professions or Employees

71. Most Allied Health Practitioners are engaged by Health Agencies and covered by the *Health Professional and Medical Salaries (State) Award* for salaries, a copy of which is exhibited to this statement (**MOH.0010.0110.0001**) and the *Public Hospitals (Professional and Associated Staff) Conditions of Employment (State) Award*, a copy of which is exhibited to this statement (**MOH.0010.0126.0001**), for their conditions. There are some professions that have specific awards for their salaries including for example

Medical Radiation Scientists (Radiographers, Nuclear Medicine Technologists and Radiation Therapists), Psychologists and Pharmacists.

72. NSW Health has recently made the Allied Health Assistants Determination to create a pathway for university students and others into the Allied Health positions to improve the capacity to attract and retain staff.

73. *The Health Professional and Medical Salaries (State) Award* was made in 2007 providing a new eight-level, integrated structure for health professionals. The Award provides career progression for senior roles, including senior clinicians, education roles, team / unit leaders, department heads and discipline specific area directors.

74. The *Health Professional and Medical Salaries (State) Award* proposes utilising this structure for additional health professions across NSW Health.

75. The main competitors for Allied Health practitioners are the private sector and other States (mainly Victoria and Queensland).

76. While the *NSW Health Service Health Professionals (State) Award* has a modern and simple structure, the career pathways for Senior Allied Health roles are limited due to the number of senior classifications within the Awards. This has resulted in LHDs using the *Health Managers (State) Award*, a copy of which is exhibited to this statement (**MOH.0010.0109.0001**), as an alternative to be able to attract senior management and clinical expertise. The *Health Managers (State) Award* does not allow for weekend work or rostered shifts making it difficult to roster senior professionals after hours.

77. Additionally, the *Health Professional and Medical Salaries (State) Award* does not meet the needs of a 24/7 health service as I have set out above, with on-call provisions only applying to some classifications.

(vii) Medical Officers

78. JMOs are those doctors employed by NSW Health during their post-graduate training from intern year, through to resident medical officers and registrars, until they complete their specialist training.

79. Key challenges for JMOs (also known as medical officers, non-specialist doctors, or doctors in training) include the current *Public Hospital Medical Officers (State) Award*, which no longer reflects workforce nor work patterns of doctors. A copy of that *Award* is exhibited (**MOH.0010.0122.0001**). The *Public Hospital Medical Officers (State) Award*

has not been updated in any fulsome way since 1989 and, as a result, it is complex and burdensome to administer, hard to interpret and no longer reflects the way in which JMOs train and work. This has led to challenges for NSW Health including award interpretation issues and inconsistency of practice across the state. The Award requires comprehensive review so that it reflects the way in which junior doctors now work.

80. An example of the complexity of interpretation and application of the *Public Hospital Medical Officers (State) Award* was highlighted in a recently settled class action that included a dispute regarding the provisions of the Award applying to meal breaks for non-day shifts. The Award stated that meal breaks are to be paid on shifts other than a "day" shift, but the term "day' shift was not defined in the Award. Rather the Award referred to a Circular from 1988 which then referred to a Circular from 1982. Neither circular was updated in line with minor variations to the Award nor was the definition included in the Award.

(viii) Staff Specialists

81. Staff Specialists are salaried employees, which is inclusive of overtime. An overview of the Staff Specialist employment arrangement is exhibited to this statement (**MOH.0010.0136.0001**).

82. There are issues linked to the *Staff Specialists (State) Award*, but I firmly believe that those Award matters should be resolved within the relevant industrial framework due to the history of these issues as explained below.

83. On 2 November 2022, NSW Health received an unpublished statement from the NSW IRC pertaining to the *Staff Specialists (State) Award*, a copy of which is exhibited to this statement (**MOH.0010.0149.0001**). In short, the NSW IRC invited a variation to address deficiencies with the Award, including:

    a. the scope of hours which may be worked; and

    b. address overtime requirements, including via recall.

84. This matter commenced as an industrial dispute at The Sydney Children's Hospitals Network (**SCHN**) around the working hours of paediatric intensive care and anaesthetic Staff Specialists at the Children's Hospital Westmead. The Australian Salaried Medical Officers Federation (**ASMOF**) requested a significant wage increase, including a 40% recruitment and retention allowance, for these SCHN Staff Specialists, which doubled

projected wage costs. A copy of this request is exhibited to this statement (**MOH.0010.0148.0001**). ASMOF and the relevant Staff Specialists advocated remuneration is not competitive to attract and retain staff. They also contend their afterhours commitment is onerous.

85. When ASMOF's demands were not accommodated, it lodged a dispute with the NSW IRC to restrict hours worked. A copy of ASMOF's proposed orders and recommendations is exhibited to this statement (**MOH.0010.0134.0001**).

86. This appeared to be a test case for ASMOF, as the circumstances (including hours worked and ongoing recruitment and retention difficulties) were not limited to the specialists in dispute. More importantly, this dispute placed NSW Health at operational risk as it requires a range of specialists to work outside standard work hours, including but not limited to, the following specialities:

    a. emergency;

    b. intensive care;

    c. trauma, retrieval;

    d. surgery, anaesthetics;

    e. radiology;

    f. pathology;

    g. interventional cardiology;

    h. sexual assault; and

    i. obstetrics.

87. The dispute before the NSW IRC focused on what 'work' is contemplated and permitted by the Award, despite the relevant specialists working outside standard work hours regularly for 15 plus years consistent with service demands.

88. Whilst the NSW IRC's unpublished statement highlighted issues with the current drafting of the Award, the NSW IRC did not make the orders or recommendations sought by ASMOF and provided NSW Health with the opportunity to address the deficiencies to avoid service risk or patient harm.

89. It was agreed that the Health Secretary would file and serve an application to vary the Award, which she did on 26 June 2023 after a period of internal consultation. A copy of that application is exhibited to this statement (**MOH.0010.0147.0001**).

90. Since that time, ASMOF has delayed the matter, advising the NSW IRC during verbal report backs that it would lodge a counter Award variation on multiple occasions. A counter variation was not submitted.

91. In February 2024, NSW Health asked ASMOF as to whether it would agree to mutual gains bargaining as an alternative approach to a counter Award variation given the inaction.

92. ASMOF advised it would only agree if two demands were met:

    a. NSW Health withdraw its Award variation application; and

    b. NSW Health agree to a special interim deal for the paediatric intensive care and anaesthetic Staff Specialists at the Children's Hospital Westmead.

93. NSW Health did not agree and formally suggested to the NSW IRC in a report back that the Award matters be stood over subject to bargaining. NSW Health sought a formal recommendation to this effect to encourage ASMOF to agree.

94. On 18 March 2024, the NSW IRC agreed with NSW Health's approach and made a formal recommendation to ASMOF, a copy of which is exhibited to this statement (**MOH.0010.0141.0001**), that it agree to mutual gains bargaining in respect to all matters arising (i.e. no preliminary deal for the SCHN specialists as sought by ASMOF) prior to progressing the Award variation in the usual manner.

95. On 19 April 2024, ASMOF advised it agreed in principle to mutual gains bargaining. As a result, the respective proceedings have been stood over pending the mutual gains bargaining process (or an alternative bargaining process as determined by the parties), with both ASMOF and NSW Health granted liberty to relist at any time.

96. ASMOF and NSW Health have yet to agree to the terms / framework for mutual gains bargaining as ASMOF seeks to develop its draft log of claims first. I understand ASMOF is still consulting its membership at the time of drafting this statement.

97. NSW Health intends to address three primary objectives during bargaining:

a. Award flexibility to support service needs;

b. financial sustainability of arrangements; and

c. improved governance (including non-standard arrangements, records for time in attendance, working from home arrangements, non-clinical time, and simplified private practice arrangements).

98. Depending on ASMOF's demands and NSW Health's correlating instructions, the parties will either:

a. engage in mutual gains bargaining; or

b. the matter will be relisted in the NSW IRC, for the variation (and any ASMOF counter variation) to be timetabled in the usual manner.

(ix) Visiting Medical Officers (VMOs)

99. NSW Health engages specialist doctors either as Staff Specialists (employees) or VMOs (independent contractors) depending on the needs of the Health Agencies and preference of the specialist doctors. There is little difference between Staff Specialists and VMOs in day-to-day delivery of services.

100. From an industrial relations viewpoint, MOH considers that it is preferrable for Health Agencies to employ or engage a mix of Staff Specialists and VMOs so that there is not a reliance on one employment or engagement model over another, including in metropolitan Sydney, as VMO arrangements provide greater flexibility to scale services up or down. Notwithstanding this, the choice of appointment often comes down to preference of the Health Agency and market power of individual specialists based on location and speciality.

101. The use of VMOs in the NSW public hospital system predates Workplace Relations Branch's records. These positions were originally unpaid, honorary positions, which gave the practitioner access to public hospitals for use for their private services, and in return the VMO would provide 'public' services free of charge; referred to as the "the Robin Hood principle".

102. Paid VMO arrangements were sporadic up until the 1970s and were often developed locally. With the introduction of the Medibank legislation in around 1974/1975 and tripartite agreement between the Commonwealth, the NSW Government and the

Australian Medical Association (**AMA**), a paid model was introduced in 1976, with the arrangement determined in private arbitration by Justice Rogers.

103. Between 1982-1988, formal structures were introduced in NSW Hospitals and rights created via amendment to the *Public Hospitals Act 1929*, the enactment/amendment of the *Health Administration Act 1982*, and the enactment/amendment of the *Area Health Services Act 1986.*

104. VMO structures are currently delineated within the *Health Services Act 1997*. VMOs are engaged under Chapter 8 of the *Health Services Act 1997* on terms consistent with Determinations made under Chapter 8 which have similar construction and effect (conditions and rates) to that of the employee Awards.

105. Section 92(2) of the *Health Services Act 1997* states that:

> *In making a determination under this Part, the arbitrator is to give effect to the same policies on increases in remuneration as those that the Industrial Relations Commission is required to give effect to under section 146C of the Industrial Relations Act 1996 when making or varying awards or orders relating to the conditions of employment of public sector employees.*

106. VMO arrangements were historically arbitrated by the Industrial Court. This was converted to private arbitration when the Industrial Court was dissolved in 2016 and its jurisdiction was transferred to the Supreme Court of NSW. There has been no change to this process as a result of the re-establishment of the Industrial Court as at the time of drafting this statement.

107. There are three types of remuneration arrangements for VMOs:

    a. Sessional (paid an hourly rate): Sessional VMOs are paid hourly and receive between $168 to $262 per hour (plus background practice costs and call-back payments). The terms of sessional arrangements are outlined in the *Public Hospitals (Visiting Medical Officers - Sessional Contracts) Determination 2014*, a copy of which is exhibited to this statement (**MOH.0010.0100.0001**).

    b. Fee-for-service (paid per treatment delivered): Fee-for-Service VMOs receive rates based on the fees within the Medicare Benefits Schedule (at 113.4% of the 2018 MBS Schedule), which generally prove more lucrative than sessional arrangements for the procedural specialities. The terms of fee-for-service

arrangements are outlined in the *Public Hospitals (Visiting Medical Officers - Fee-for-Service Contracts) Determination 2014*, a copy of which is exhibited to this statement (**MOH.0010.0090.0001**).

c. Rural Doctors Settlement Package (paid for services provided in 120 small hospitals in rural NSW): VMOs receive 140% of the Medicare Benefits Schedule or per an agreed fee under the Rural Doctor Settlement Package (**RDSP**). The terms for the RDSP are outlined in NSW Health Information Bulletin, IB2023_036 *Rural Doctors' Settlement Package Hospitals Indexation of Fees – Visiting Medical Officers* (as amended), a copy of which is exhibited to this statement (**MOH.0010.0140.0001**).

108. The relevant service contract to be issued is determined via NSW Health Policy Directive, *Visiting Practitioner Appointments in the NSW Public Health System* (PD2016_052 - Part 15.3), a copy of which is exhibited to this statement (**MOH.0011.0004.0001**), specifically:

a. all principal referral hospitals (peer group A) facilities are sessional only;

b. all major hospitals (peer group B) and larger district hospitals (C1 facilities) are election of choice (sessional or fee-for-service), plus those facilities listed in document titled Additional Election of Choice Hospitals to Peer Group B or C1;

c. all other facilities are fee-for-service;

d. dual fee-for-service and sessional contracts are permitted at facilities at which RDSP arrangements apply; and

e. the list of facilities showing peer groups is contained within NSW Health Information Bulletin, *IB2016_013 NSW Hospital Peer Groups 2016*, a copy of which is exhibited to this statement (**MOH.0011.0003.0001**).

109. The importance of services provided by VMOs cannot be overstated. Without VMOs there would not be a functioning health service, and rural and remote services could collapse.

110. VMO appointments make up approximately 50% of the current specialist medical workforce. There are approximately 6,732 VMOs on headcount. The total VMO expenditure for the 2022 - 2023 financial year was approximately $1.042 billion. *(Source: NSW Health Corporate Data Warehouse)*

111. For context, there were 4275.85 full-time equivalent Senior Medical Officer appointments across NSW Health in 2022/2023. The total payroll expenditure for Staff Specialists in the 2022 - 2023 financial year was approximately $1.388 billion.
(Source: NSW Health Corporate Data Warehouse)

112. The percentage mix has not materially changed since 2009, when last reported on in the *NSW Health Auditor-General's Report into Visiting Medical Officer and Staff Specialists*, a copy of which is exhibited to this statement (**MOH.0010.0133.0001**).

113. The difference in remuneration between what a staff specialist receives and a VMO (as an independent contractor) receives is somewhat ambiguous as there are direct and indirect benefits received in the model. Many specialists choose to be staff specialists despite VMO opportunities available in the current market due to these ancillary benefits of an employment relationship.

114. Depending on the circumstances, VMOs can be more cost effective under the current activity-based funding model as the VMO arrangements incentivise output and there are no patient activity down periods associated with paid leave and non-clinical time. The VMOs arrangements also allow NSW Health to scale up and down contracted services based on patient activity/demand as mentioned.

115. Similar to other cohorts, the AMA is advocating that remuneration for VMOs is not competitive and seeks considerable increases, including but not limited to base rates and separate payment for afterhours remote clinical work (which currently forms part of the on-call allowance payment). These demands place both industrial and financial pressures on NSW Health.

I. RURAL DOCTORS

116. A senior medical workforce model used within rural hospitals is VMOs engaged under the RDSP. This model typically relies on General Practitioners (**GPs**) within local communities to provide services to the hospital on a recall basis often because there is insufficient volume of patients to warrant full-time presence, although in the largest RDSP facilities there is often a requirement for a full day's work onsite.

117. The RDSP contracts were introduced in 1988 to better remunerate rural GPs who shared their time between the local hospital and their private practice. The RDSP is a schedule of fees paid by rural hospitals for public services rendered at rural hospitals. The RDSP is a fee-for-service contract offering increased remuneration for procedures as outlined

in the Fee Schedule for the RDSP (typically higher than the Commonwealth Medicare Benefits Schedule), and an hourly payment for on-call services.

118. The key advantages of the existing RDSP fee-for-service model are:

a. built-in flexibility for offsite private practice work;

b. enhanced remuneration for services performed; and

c. an on-call allowance plus enhanced recall payments.

119. The model faces sustainability challenges in an evolving workforce:

a. Doctors are seeking a greater work/life balance by reducing their on-call burden and moving to part-time work (in particular GP Obstetrics).

b. Doctors are preferring a salaried model for security and a predictable income stream, rather than running their own business.

c. The model is expensive for LHDs at the busier RDSP sites.

d. The more remote communities can be less attractive for doctors due to these sites having less income-earning opportunity under a fee-for-service model owing to fewer patient presentations..

e. There is less interest from junior doctors in pursuing the GP pathway, with only about 11% of medical graduates planning to pursue a career in general practice, down from 14% in 2019.
(Source: Medical Schools Outcomes. Database National Data Report 2024)

Locum doctors

120. Locum doctors are an essential part of the broader workforce. Locum doctors provide coverage where there is a vacancy, particularly the unattractive shifts such as nights, weekends and public holidays in regional and rural emergency departments.

121. The employment and management of Locum Medical Officers through Medical Locum Agencies is governed by NSW Health Policy Directive PD2019_006 *Employment and Management of Locum Medical Officers by NSW Public Health Organisations*, a copy of which is exhibited to this statement (**MOH.0011.0005.0001**). This Policy Directive relates to the engagement of non-specialist, JMOs providing cover for Residents, Registrars or

Career Medical Officers. It also outlines the roles, responsibilities and processes to be applied by NSW Public Health Organisations in NSW Health.

122. This policy does not apply to VMOs, Dentists, Staff Specialists or any medical professional whose engagement must be confirmed by the Medical and Dental Appointments Advisory Committee. Short term VMO contracts are used to offer an option for leave cover that supports service delivery for senior medical vacancies.

J. INTERJURISDICTIONAL BASE WAGE COMPARISON

123. NSW Health undertakes comparative assessment of base wages for staff as against other Australian jurisdictions. It is accepted that base rate comparative assessments indicate that NSW Health is unfavourable on many award categories compared to other jurisdictions.

124. It is important to note that base wages are only part of the picture when considering remuneration. Interjurisdictional comparison of salary and wages can be misleading due to the varying State and Territory industrial instruments, and the conditional and incentive payments within. It is somewhat like comparing apples with oranges.

125. For example, comparing a staff specialist's total remuneration package is challenging as the structure of entitlements and private practice arrangements differ greatly across jurisdictions, and are often difficult to identify and match because:

    a. NSW Health pays a 17.4% 'special allowance' to staff specialists via the *Staff Specialists Determination 2015* to compensate, on top of the *Award* salary, for on-call, recall and additional hours. It also pays an additional 20% allowance for assignment of private practice income where the practitioner so elects.

    b. All other States and Territories except ACT pay for overtime separately for staff specialists, whereas NSW Health's salary in all inclusive.

126. There are a range of factors which should also be considered when comparing NSW wages to other jurisdictions including:

    a. the need for other jurisdictions to compete with NSW and use increased wages to attract NSW health workers to move interstate;

    b. the bargaining cycles of each State and the respective Government policies; and

c. the public interest and impact of states leapfrogging each other. A bidding war between states is counterproductive and not within the broader public interest of keeping the public health system sustainable.

Melissa Collins

Melissa Collins

Witness:

17/07/2024

Date

17/7/2024

Date