KPMG

Final Report

Employee Entitlement Portability for GP Registrars

Department of Health and Aged Care

FINAL

October 2023

At KPMG, we recognise Aboriginal and Torres Strait Islander peoples as First Peoples of this nation.

We recognise that Aboriginal and Torres Strait Islander history and cultures are inseparable from Australia's collective history and culture and are something we can all be proud of and celebrate.

We acknowledge Elders past, present and emerging as Traditional Custodians of the land on which we live and work. We recognise their continuing connection to the land and waters, and thank them for protecting this land, waterways, coastline and its ecosystems.

We are proud that we live in the country with the world's oldest continuous living cultures, and we are playing our part to support Indigenous people to keep these cultures alive and vibrant.

gilimbaa™

In 2013, we commissioned Gilimbaa, a certified Indigenous creative agency, to design an artwork that reflects the diversity of Aboriginal and Torres Strait Islander cultures and KPMG's commitment to reconciliation, which is shown on this page.

This Final Report has been prepared as outlined by KPMG for the Department of Health and Aged Care in the Detailed Statement of Work section of the engagement contract dated 10 February 2023. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently, no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, the Department of Health and Aged Care management and personnel / stakeholders consulted as part of the process.

KPMG has indicated within this document the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update Final Report, in either oral or written form, for events occurring after the report has been issued in final form.

This document has been prepared at the request of the Department of Health and Aged Care in accordance with the terms of KPMG's engagement contract. Other than our responsibility to the Department of Health and Aged Care, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this document. Any reliance placed is that party's sole responsibility.

Contents

Acronyms and Abbreviations

Acronym/ Abbreviation	Definition
ACCHOs	Aboriginal Community Controlled Health Organisations
ACCHSs	Aboriginal Community Controlled Health Services
ACRRM	Australian College of Rural and Remote Medicine
AGPT	Australian General Practice Training
AMA	Australian Medical Association
AMSs	Aboriginal Medical Services
Cth	Commonwealth (referred to for Commonwealth legislation)
the Department	The Department of Health and Aged Care
EA	Enterprise Agreement
FARGP	Fellowship in Advanced Rural General Practice
FDVL	Family and Domestic Violence Leave
FSP*	Fellowship Support Program
FWC	Fair Work Commission
FWO	Fair Work Ombudsman
GP	General Practitioner
GP registrar	General Practice registrar
GPTAC	General Practice Training Advisory Committee
HPOS	Health Professional Online Services
IMGs	International Medical Graduates
IP	Independent Pathway (ACRRM Fellowship pathway option)
LHN	Local Health Network
LSL	Long Service Leave
MBS	Medicare Benefits Schedule
NCP	National Consistent Payments
NES	National Employment Standards
NHS	National Health Service (United Kingdom)
NPP	New Policy Proposal
NTCER	National Terms and Conditions for the Employment of Registrars
PEP	RACGP Practice Experience Program (discontinued)
Personal Leave	Leave entitlement including sick and carers leave
PHN	Primary Health Network
PLSP	Parental leave Support Payment
PPL	Paid Parental Leave
RACGP	Royal Australian College of General Practitioners
the Report	The Policy Options Report
RGTS	Rural Generalist Training Scheme
RMCLHN	Riverland Mallee Coorong Local Health Network
RMO	Resident Medical Officer
RTO	Regional Training Organisation
RVTS	Remote Vocational Training Scheme
the Scheme	A portability scheme for GP registrars
SEM	Single Employer Model
WHS	Workplace Health and Safety
WIP	Workforce Incentive Program

**Note: Until 2022, the non-Vocationally Registered Fellowship Support Program (FSP) was the Department's program and called PEP and IP by the colleges. From 2023, this is also the name of the RACGP program, formerly PEP.*

Executive Summary

The Employee Entitlement Portability Project

The purpose of the Employee Entitlement Portability Project has been to explore options to reform the leave employment arrangements for General Practice (GP) registrars. This reform is intended to boost the attractiveness of the training pathway and the supply of General Practitioners, by addressing one of the key concerns that have been raised by the sector.

Purpose of this Final Report

The Department of Health and Aged Care (the Department) engaged KPMG to support the development of policy reform of leave employment arrangements for all GP registrars across Australia. The purpose of this Final Report is to present the recommended model for the sector.

This Final Report outlines the recommended reform approach, and has been informed by a series of reports including a Literature Review, Stakeholder Insights Report and Policy Options Paper. This Final Report should be read in conjunction with these reports, particularly regarding the policy design of options outlined in the Policy Options Paper (which is provided in Appendix B).

Why immediate action is required

The last 10 years has seen a continued decline in the proportion of medical students choosing a GP specialist pathway (from approximately 30 percent of all medical registrars in 2015 to 13 per cent in 2022).[1]

While it is acknowledged that this decline is not attributable to a single factor, one of the regularly cited reasons impacting the attractiveness of General Practice is the inequity in leave entitlements when compared with leave available for other medical specialties. The sector is seeking that leave reform occur as part of a wider series of changes aimed at supporting the sustainability of General Practice and primary care in Australia.

There is an urgency in addressing this concern due to workforce pressures being felt across the General Practitioner workforce. These workforce pressures are already impacting on the health outcomes of Australians, including health access in rural and remote communities and unnecessary presentations to Emergency Departments in hospitals across Australia. If the future supply of General Practitioners is not addressed, this will have implications for future health service delivery of primary care across Australia.

1. Medical Schools Outcomes Database, *National Data Report 2023* (Report, July 2023) https://medicaldeans.org.au/md/2023/08/MSOD-National-Data-Report-2023-July.pdf

Current State

Complexity in current employment arrangements

Current employment arrangements for GP registrars are determined by different Commonwealth and jurisdictional industrial relations environments due to variations in the employment arrangements of GP registrars. This means a range of different legislation, enterprise agreements, awards and individual contracts currently determine the salary and entitlements (including for leave) of GP registrars.

The range of different employment arrangements, which include individual employment contracts with GP practices, do not allow for a system wide view of GP registrar conditions. These arrangements also do not support system based levers around workforce except through additional salary or incentive payments.

Inequity in comparable entitlements with other medical specialities

Currently there is inequity in the leave provided to GP registrars compared with other medical specialities due to the impact of:

- breaks in service where leave is paid out;
- losing continuity of service and eligibility for certain leave, and
- more generous entitlements in state and territory based enterprise agreements and awards than the private sector (this includes for leave entitlements like exam/study leave, professional development leave and cultural leave).

A need to better support diversity in the GP workforce

Demographic data shows GP registrars have an average age at enrolment of around 33-34 years and over 60 percent of the cohort has been female over the five years to 2022. Paid parental leave is a priority for this cohort, and will be required to maintain the female representation of this workforce (noting males are also eligible).

Improving the number of First Nations GP registrars is important to closing the gap in primary care. Stakeholder consultation suggests providing access to cultural leave may improve attractiveness.

A need to better address workforce distribution into areas of need

Currently there are workforce shortages for GP registrars (and GPs) across the country, which are generally focused on areas which are more rural and remote (and have higher Modified Monash Model ratings) but also exist in some outer urban areas. There is also a shortage of GPs with advanced practice training in key areas such as obstetrics and paediatrics. Some incentives currently exist to address areas of workforce need (such as the Salaried Support Program).

Inequitable access to leave entitlements

Currently there is inequity in the access to, and accrual of, leave. This depends on whether GP registrars work in a GP practice or AMS setting where entitlements are generally determined by the National Terms and Conditions for the Employment of Registrars (NTCER) and individual employment contracts, compared with those who may be undertaking training in the public health system, where entitlements are determined by the jurisdiction's relevant enterprise agreement or award.

Limiting attractiveness to a career in General Practice

GP registrars are not currently guaranteed paid parental leave or exam leave which is offered to medical specialty trainees in hospital-based settings under enterprise agreements and awards. If they remain in placements within jurisdictions they will receive these entitlements, but in other cases will not be paid these entitlements by their employer. Limited access to paid parental leave and exam leave has been noted as a barrier to the attractiveness of General Practice training, as well as losing continuity of service for some leave entitlements.

Support General Practice training

Any reform to GP registrar entitlements needs to continue to support GP practices, AMS ACCHOS and other GP employers in supervising GP registrar training. Current concerns amongst the sector include that GPs are working longer hours, experiencing burnout, are under increasing financial pressure, and have a high administrative burden.

Stakeholder Perspectives

No uniformly agreed way forward from stakeholders

Consultation with the sector following the development of the Policy Options Paper has shown that there are some strongly held and divergent views from GP stakeholders regarding the approach that would work best for the sector.

It is recommended that **further consultation and options refinement occur in order to provide a way forward that will be supported by all parts of the sector,** even if it is not their preferred model. The key points of discussion requiring further detailed design are discussed in Chapter 5 of this Report.

Reforms that continue to occur alongside this implementation journey may also impact on detailed design considerations, such as the evaluation of the place-based SEM trials. Legal advice is also required to ensure that the construct of the selected option(s) will operate as intended, taking into account the regulatory environment and legislative reform necessary for enactment.

GP peak body perspectives are not aligned across the options based on GPTAC and one-on-one discussions with stakeholders in June and July 2023. While some consultation has occurred with the jurisdictions, practice managers, GP supervisors, GP practice owners, AMS/ACCHOs, GP registrars and medical students, it is noted this has been relatively limited and could be further expanded to ensure the views of those most impacted are reflected in the final approach and design considerations.

Figure E.1. Three options explored for leave entitlement portability

Option 1:
GP Portability Scheme for GP registrars

Option 2:
Incentive and Parental Leave Support Payment

Option 3:
Single Employer Model

The Recommended Reform

Based on consultation to date, the recommended reform involves a two stage process, to 1) implement an incentive and parental leave support payment in the short-term, and 2) to implement a national Single Employer Model over the longer term. It is noted this view is based on high level policy discussions, and that more detailed consultation & analysis will be required to confirm this as the preferred approach, and resolve a concerns raised by stakeholders.

Stage 1

Incentive and Parental Leave Support Payment

Given the pressing need to improve entitlements for GP registrars, it is proposed that in the **short term** the sector is supported through the **implementation of an incentive payment, and a parental leave support payment** for those eligible for statutory parental leave.

Stage 2

National Single Employer Model

The establishment of a **national Single Employer Model (SEM)** for GP registrars across Australia is proposed over the **longer term**.

This option establishes a national single employer arrangement for the GP registrar throughout their training experience. The single employer would have overall responsibility for the determination of salary and entitlements for GP registrars including leave arrangements, ensuring ongoing continuity of service.

Next Steps

The next steps to build consensus amongst stakeholders regarding the recommended reform are to:

- Seek broader stakeholder feedback from the sector (including GP registrars, practice owners and supervisors, and practice managers) on the proposed reforms;
- Work to resolve the stakeholder considerations raised in this Final Report where possible (and noting that further detailed design of the recommended options will be undertaken on the preferred model(s));
- Seek endorsement of the recommended reform approach from GPTAC;
- Seek wider government endorsement of the recommended reform and implementation plan; and
- Staged implementation (assuming the stages recommended are adopted as the agreed reform for the sector).

Stage 1: Incentive and Parental Leave Support Payment

Key features

- Provides an incentive payment of $30,000 for all GP registrars to compensate for any leave entitlements paid to other medical specialities. This is designed to be paid at two intervals, at the end of the first full time year and on attainment of Fellowship.
- Provides a Parental Leave Support Payment offered as a single, lump sum payment to any GP registrar who qualifies for statutory paid parental leave (PPL). This will be paid at a rate of 14 weeks of leave for the primary carer, and a rate for the secondary carer. It would be paid via the employing entity (e.g. GP practice) to the GP registrar.
- These payments would be governed by the Department of Health and Aged Care and administered by Services Australia in a similar way to other health workforce incentive payment programs.

Key benefits

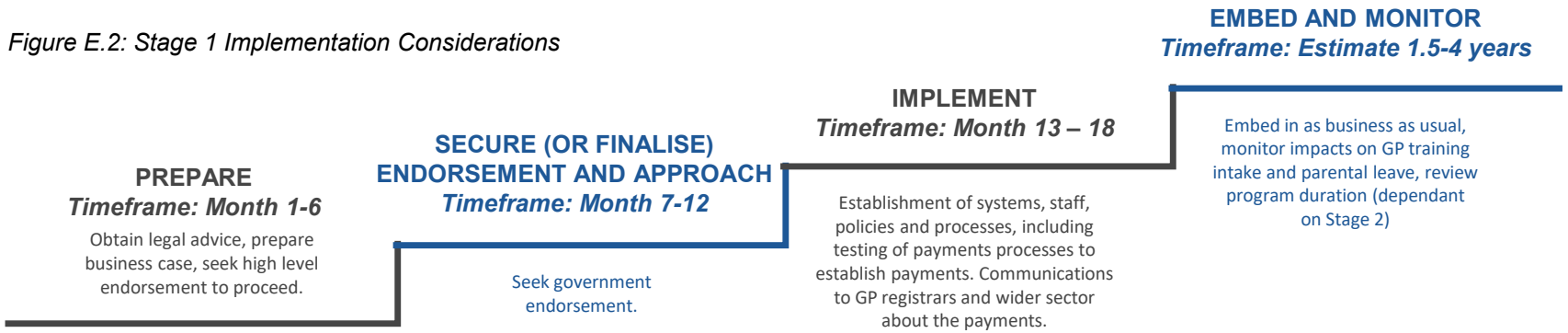
- The time taken to operationalise is significantly less than other proposed options that have been explored with an expected time to implementation once endorsed of 6-9 months.
- This model helps to address GP registrar concerns in relation to eligibility for employer based paid parental leave, and also helps to address the comparability of entitlements with other medical specialities through providing financial compensation. It is expected to alleviate some of the financial burden on GP registrars.
- This option seeks to provide additional financial incentives based on areas of need and advanced practice training priorities.
- This model has a lower administrative burden compared with other policy options explored. It also features infrequent payments which minimises burden borne by GP registrars in receiving the payment.

Design considerations

- This option is designed so that coverage applies to all GP registrars for the incentive payment, and all GP registrars who meet parental leave eligibility under the Commonwealth's Parental Leave Pay scheme. This design helps to removes any requirement for assessment of eligibility for the Parental Leave Support Payment.
- The incentive payment value of $30,000 has been determined based on a more generous entitlement than the GP registrar would have been entitled to for any portable personal leave, paid exam and study leave, paid professional development leave, cultural leave and long service leave. It is also assumed a age indexation rate would be applied to reflect the increase in the value of leave salaries over time. A higher rate will be paid to GP registrars in areas of workforce need to incentivise these areas of priority.
- The value of Parental Leave Support payment has been determined at 14 weeks for the primary carer as this is consistent with six of the seven entitlements currently provided under jurisdictional enterprise agreements or awards. An amount will also need to be determined for the secondary carer.
- The design feature to pay an instalment at the end of the first year of training has been made to seek to influence medical trainee decision making at the time of choosing their medical speciality. The last payment on attainment of Fellowship is designed to ensure that the incentive encourages completion of the GP training program, thereby increasing the General Practice workforce.
- To align with existing similar arrangements, it is proposed these payments are made by Service Australia, with policy oversight from the Department of Health and Aged Care. These payments will be made via the employer, in keeping with the Commonwealth Parental Leave Pay scheme.

Stage 1: High level implementation plan

Figure E.2: Stage 1 Implementation Considerations



KEY ACTIONS

Month 1-6	*Month 7 – 18*		*Ongoing*

• Obtain legal advice in relation to the proposed design, including in relation to:
  • Whether this would constitute a grant or incentive payment;
  • Legislative power and construct.
• Wider government endorsement and policy approval.
• Undertake stakeholder engagement to clarify/modify any features based on design concerns and challenges.
• Define accountabilities and responsibilities for each entity, taking into account required funding and information flows.
• Seek high level endorsement at GPTAC.
	• Preparation of any legislative amendments, draft materials including guidelines.
	• Discussions with Services Australia around administration of the payments, system requirements and set-up, governance, resourcing requirements.
	• Modification of any of the detailed elements of design based on stakeholder feedback, legal advice and funding allocations.
	• Determination any transitional arrangements that need to be considered (including for GP registrars part-way through training).
		• Recruitment of staff to oversee program through the Department of Health and Aged Care and Services Australia.
		• Modifications to systems and testing to process payment through Services Australia.
		• Embed process changes for information flows, including from RACGP and ACCRM (e.g. for those GP registrars who attain Fellowship). This will include privacy considerations.
		• Legislative or regulatory amendments if required (noting this is not anticipated).
		• Publication of policy guidelines.
		• Communication to GP registrars and wider GP sector about the incentive and Parental Leave Support Payments.
			• Regular review and evaluation of the acquittal of funds to ensure public funds are subject to appropriate governance and oversight.
			• Link with internal governance structures to ensure compliance issues are managed, as well as management of any unintended consequences.
			• Monitor the Stage 2 implementation pathway for the SEM, and if required seek an extension (or shorten) the duration of the program.
			• Collect information on the impact of the payments on the attractiveness of General Practice to medical registrars, and the utilisation of the Parental Leave Support Payment by GP registrars. Report on realised benefits.

Stage 2: Single Employer Model (SEM)

Key features

- Establishes a national single employer arrangement for the GP registrar throughout their training experience. The single employer has overall responsibility for salary and entitlements including leave arrangements.
- Salary arrangements are expected to include both a higher fixed salary arrangement, and a base salary with additional payment linked to Medicare billings. Leave entitlements are expected to include exam/ study leave, paid parental leave, professional development leave and other leave as per the National Employment Standard. These would be set through a national enterprise agreement, no longer requiring the NTCER.
- Secondment arrangements would be established with the service provider (including GP practice, AMS, and LHN or equivalent). Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) would maintain responsibility for leading GP registrar training.

Key benefits

- This option provides the greatest capacity to use levers to support the attraction and improved workforce distribution of GP registrars and reduce fragmentation in the employment arrangements that currently exist. This includes the ability to determine salary and leave entitlements, incentivise area of need, pay for relocation expenses, system-wide view of GP registrar places, training experience and pastoral care, and greater visibility of GP registrar billings.
- It is noted that this option helps to provide support for all GP registrars and not just support for rural generalists under place based SEM models.
- This option removes some current administrative burden for GP practices and supervisors, including contract negotiation for GP registrars and leave and salary payments and management. The establishment of a SEM will help ensure compliance as it will control payments, auditing and the collection of Medicare billing profits.

Design considerations

- This option is designed so that coverage applies to all GP registrars and address leave comparability by providing a single employer for the training journey. A national model has been adopted to provide national consistency, and ensure oversight of general practice and primary care remains with the Commonwealth. This option also remove complexity in jurisdictional models requiring mirroring of jurisdictional arrangements to those provided to other medical specialities.
- National oversight will provide a system wide view of GP registrars, including their placements and management, and therefore supports increased workforce mobility across jurisdictional borders.
- The leave entitlements to be included in scope match those outlined through consultation, and include paid parental leave, exam/ study leave, professional development leave and cultural leave in addition to other leave entitlements under the National Employment Standard (NES). This is consistent with leave entitlements offered to other medical specialities under jurisdictional enterprise agreements.
- This model will require the setting of salary arrangements. It is recognised that this will require the design of two arrangements that GP registrars may select; 1) those paid under a higher salary arrangements, and 2) those paid under a base salary, who are also paid a percentage of their Medicare billings.
- A range of wider employee entitlements would also need to be negotiated in an Enterprise Agreement, and it is proposed the NTCER be used as the basis for these arrangements.
- Given the national employer will pay for the salary and entitlements for GP registrars, it is assumed that a proposition of the Medicare billing will go to the single employer. A proportion may still remain with the service provider providing supervision and oversight of the GP registrar during placement.

Stage 2: High level implementation plan

Figure E.3 (part 1): Stage 2 Implementation Considerations

PREPARE
Timeframe: 12-18 Months

Obtain legal advice, prepare business case, seek high level endorsement to proceed.

SECURE (OR FINALISE) ENDORSEMENT AND APPROACH
Timeframe: 18 Months- 2 years

Seek government endorsement and continue planning regulatory and legislative changes and determine detailed transitional arrangements.

KEY ACTIONS

12-18 months

- Obtain legal advice in relation to the proposed design, including in relation to:
  - Legislative power and construct;
  - Secondment arrangement and enforceability including insurance and WHS arrangements;
  - Mutual recognition;
  - Medicare billing arrangements and exemptions as well as other financial and tax requirements;
  - Single Employer construct, including whether this is a Commonwealth entity, and its set-up and design.
- Undertake stakeholder engagement tour and written submissions to clarify/modify any features based on design concerns and challenges. This is expected in relation to:
  - Transition of existing regional SEM pilots;
  - Medicare billing arrangements;
  - Local discretion and transition of employment arrangements including from jurisdictions, GP practices and AMS/ ACCHOs;
  - National single employment entity (i.e Commonwealth);
  - Transitional arrangements, including from regional SEM trials;
  - Design features including proposed eligibility, leave coverage, and wider employment arrangements, using the NTCER as the basis;
  - Salary rate at which leave its to be paid given the different ways in which GP registrars can be paid.
- Seek high level endorsement for Stage 2 at GPTAC
- Seek wider government support and endorsement of the reform and policy pathway.
- Monitor reform context for impacts on design, including evaluation of regional SEM pilots.

18 months – 2 years

- Modification of any of the detailed elements of design based on stakeholder feedback, legal advice, funding allocations and evaluation of the regional SEM trials.
- National entity set-up of single employer (depending on the selected model) including administration of the payments, system requirements and set-up, governance, staff resourcing requirements. This may involve recruitment of skeleton staff for planning and establishment.
- Determination of any transitional arrangements that require design, detailed legislative advice and stakeholder input including:
  - MOUs with local service providers, detailing areas of local discretion and secondment arrangements;
  - Transfer of information from RACGP and ACRRM regarding GP registrar cohorts, placement and attainment of Fellowship;
  - Transfer of employment arrangements from the current arrangements (jurisdictions, GP practices, AMSs/ ACCHOs, regional SEMs) to the national SEM;
  - Greenfields negotiation of a new enterprise agreement for GP registrars. Transitional arrangements including consideration of grandfathering, no disadvantage and abolition of NTCER.
- Determination of any transitional arrangements that need to be considered (including for GP registrars part-way through training).

Figure E.3 (part 2): Stage 2 Implementation Considerations

IMPLEMENT
Timeframe: Years 3 to 4

Establishment of systems, staff, policies and processes, including testing of payments processes to establish payments. Communications to GP registrars and wider sector about the payments.

EMBED AND MONITOR
Timeframe: Ongoing

Embed in as business as usual, monitor impacts on GP training intake and parental leave, review program duration (dependant on Stage 2)

KEY ACTIONS

Year 3	*Year 4*	*Ongoing*
• Recruitment of staff for the Single Employer. This is expected to include but would not be limited to finance, human resources (including payroll) and technology. Establishment of new systems, processes, governance, and if applicable, legislative construct. • Modifications to systems and processes through Services Australia (including testing, go-live, and post systems implementation support). • Embed process changes for information flows, including from RACGP and ACRRM (e.g. for new GP registrars intake, for GP registrars who attain Fellowship, for placements). This will include privacy considerations. • Legislative or regulatory amendments. It is expected this will include changes to the Medicare billing revenue of GP registrars, and may also require other legislative and regulatory amendments. • Communication to GP registrars and wider GP sector about the transition to the Single Employer Model, including timing and transitional arrangements. • GP registrars transfer into SEM, with secondment arrangements taking effect while on training rotations.		• Regular review and evaluation of the employment arrangements, particularly the operation of the secondment model, including appropriateness of local discretion (e.g. on leave approvals), WHS and the interplay between the Colleges (ACRRM and RACGP). • Link with internal governance structures to ensure compliance issues are managed, as well as management of any unintended consequences. • Collect information on the impact of the Single Employer Model on the attractiveness of General Practice to medical registrars, and the utilisation of leave entitlements by GP registrars. Report on realised benefits.

Chapter 01:

Introduction to the Report

Purpose and scope

Purpose of this Report

This Final Report (the Report) seeks to outline the recommended reform approach to addressing leave entitlement challenges which are being faced by GP registrars as a result of the employment arrangements that currently apply.

This Report forms part of a wider scope of work which has included a Literature Review, Stakeholder Insights Report, and Policy Options Paper and has been developed following consultation with the sector over a 13 month period (July 2022- July 2023).

Evidence basis

The Report has been informed by insights from previous phases of work and deliverables, including:

- Literature Review of comparable schemes in Australia, and the GP training context (Phase 2);
- An analysis of previous submissions from GP stakeholder groups summarised in the Stakeholder Insights Report (Phase 2);
- 31 stakeholder engagement activities, including interviews, focus groups and submissions described in the Stakeholder Insights Report (Phase 3);
- Nine stakeholder interviews, four workshops, and three focus groups to inform the Policy Options Report (Phase 4); and
- Nine stakeholder interviews, two focus groups and written submissions providing feedback on the Policy Options Paper (Phase 5).

Limitations

- This Final Report provides a recommendation which is based on the materials that have been developed throughout this journey.
- Further legal advice will need to be obtained to consider the details of the reform agenda. This includes noting that any constitutional legal advice would need to be obtained from the Australian Government Solicitor.

Project Scope - Options for Reform

This project has included the design and feasibility of three options to reform employment entitlements for GP registrars. The options which have been explored include:

Option 1: Portability Scheme for GP registrars

A portability of leave entitlements scheme for all GP registrars in Australia to enable accrual and portability of leave for the duration of their GP training program. While a Portability Scheme for GP registrars is comparable to other portability schemes that currently exist, this would be the first portability scheme in Australia to cover leave types beyond Long Service Leave.

Option 2: Incentive and Paid Parental Leave Payment

This option seeks to incentivise the selection of General Practice as the medical speciality of choice by providing incentive payments to GP registrars that is equivalent to the cash value of leave they would otherwise have received in a hospital-based medical speciality. This also includes a Parental Leave Support Payment that would be offered as a single, lump sum payment to any GP registrar who qualifies for unpaid parental leave.

Option 3: National Single Employer Model

This option would establish a national single employer arrangement for the GP registrar throughout their training experience. This would be a secondment-type arrangement and allow for movement between GP practices, Aboriginal Medical Services (AMS)/Aboriginal Community Controlled Health Organisations (ACCHOs), and public hospitals for GP training rotations. In this arrangement, the single employer has overall responsibility for salary and entitlements including leave arrangements. Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) would maintain responsibility for leading registrar training.

Report structure

This Report has been structured as per Figure 1.2 to meet the primary goals of policy design of the three options, and a comparative assessment of the options.

Figure 1.2: Report structure

01

Introduction to the Report

Provides the overarching purpose of this Report, outlines the scope and limitations, identifies the overarching policy objectives of each of the three explored options, and outlines the Final Report structure.

02

Reform Context

Provides an overview of the background and context, including the complexity of the GP training employment landscape, and recent and relevant programs of work being undertaken, such as the Regional SEM trials and NTCER Review.

03

Three Options In Summary

Discusses policy design considerations including legislative framework, eligibility and coverage, governance, operational design, user centred design, benefits, and risks and limitations for each of the three proposed policy options.

04

Stakeholder feedback

Summarises feedback on the three policy options presented to a range of stakeholders, including preferences, and suggestions. Further detailed feedback and quotes are included in Chapter 5.

05

Further Detailed Design Considerations

Identifies key considerations for further design consideration with the sector, taking into account a range of stakeholder perspectives and views. These are proposed as areas for further exploration to help ensure reform pathway that is supported by the sector.

06

Comparative Assessment of Reform Options

Compares each of the three options against the seven policy objectives as well as five further criteria covering legislative complexity, benefits, risks and time to deploy.

07

The Pathway to Reform

Recommends implementation steps across two stages, providing considerations across the implementation timeline.

08

Appendices

A: Stakeholders Consulted (in this phase of work)

B: Policy Options Paper

Chapter 02:

Reform Context

Shaping the future of General Practice

Strategic context

The key strategic driver behind the need for reform of GP registrar employment arrangements is the need to address the barriers impacting the speciality's attractiveness to RMOs. If addressed, this seeks to boost the attractiveness of the GP training pathway and the supply of future GPs across Australia. This is required to support significant workforce challenges in General Practice and primary care across Australia.

The last 10 years has seen a continued decline in the proportion of medical students choosing a GP specialist pathway (from approximately 30 percent of all medical registrars in 2015 to 13 per cent in 2022).1

These workforce challenges occur in an environment of significant reform across the GP training sector. In February 2023, the education and training of GPs transitioned to profession-led-training, delivered by the two GP colleges in Australia – the RACGP and the ACRRM. This provides an ideal environment in which to examine GP registrar employment arrangements that better supports the sector, responds to GP registrar concerns, and applies regardless of training location in Australia. Additionally, a review of the National Terms and Conditions for the Employment of Registrars (NTCER) was completed in late 2022.

Other reforms that are occurring that may impact GP stakeholders and the attractiveness of General Practice include:

- A review of GP supervisor and accredited practice payments for those supervising GP registrars under the National Consistent Payments Framework (NCP);
- Place-based SEM pilots for GP registrars across 22 sites;
- Victorian Government incentive payment to boost the attractiveness of General Practice training pathway; and
- The development of a national GP Attraction Strategy.

Exploration of a Scheme

One of the reasons cited for the decline in the proportion of medical students choosing a GP specialist pathway is the differences in the employment entitlements offered to GP registrars compared with hospital-based registrars.[2] This is because GP registrars are required to undertake multiple training rotations as part of the education and training experience, resulting in GP registrars being employed by multiple small business employers throughout their training journey.

Current and historical arrangements have inconsistently supported the portability of employment entitlements or salaried arrangements for rural and remote GP registrars, or have supported limited portability in some states or territories. This has created different models and arrangements across Australia, depending on the location and setting of the GP registrar placements.

The journey to date

In November 2020, the General Practice Training Advisory Committee (GPTAC) and the Department of Health and Aged Care (the Department) released a discussion paper on opportunities to reform the portability of employment arrangements for GPs in training (GP registrars).

This included analysis of Australian portability schemes (including for the black coal, construction and cleaning industries), as well as arrangements in place for GP registrars internationally (such as in New Zealand). This discussion paper was provided to GP stakeholders, who were invited to provide submissions.

Prior to the exploration of this project, the Department also explored the feasibility of paid parental leave for GP registrars noting the employment complexity across the sector.

1. Medical Schools Outcomes Database, *National Data Report 2023* (Report, July 2023) https://medicaldeans.org.au/md/2023/08/MSOD-National-Data-Report-2023-July.pdf
2. Australian Medical Association, *AMA submission on opportunities for reform of GP training employment arrangement* (Submission, 2020).

GP training intake

There has been a reduction in the number of filled training places since 2017, with some jurisdictions finding it more difficult to fill GP registrar places than others.

Across Australia, attracting GP registrars into rural areas remains a key issue. 31.2% of RACGP Rural and ACRRM training places remained unfilled in the 2023 intake, compared to 6.3% of RACGP General training places.[3]

The exploration of reforming leave entitlements for GP registrars seeks to address one of many factors that have been noted as reasons for this reduction in intake.

It is noted that reform of leave entitlements must be considered alongside a wider suite of policies aimed at strengthening the attractiveness of General Practice in Australia.

GP registrar training pathways

Current GP registrar employment arrangements are complex, with differences based on the training program and College, employer context and setting, and rotation options which may lead to breaks in continuity of service.

At present, the majority of GP registrars are engaged under the Australian General Practice Training (AGPT) pathway, either through the RACGP or ACRRM. The current pathway provides a number of breaks in service that may occur at the completion of training placements. These will not occur in every instance but are important to understand in leave entitlements reform.

Place-based Single Employer Model (SEM) trials

Regional SEMs for GP registrars are currently being trialled, aimed at increasing the number of GPs living and working in rural communities, and attracting more trainees to General Practice. The Commonwealth has committed to 22 place-based SEM trials.

This model establishes a regional entity (usually a LHN or equivalent) as the single employer, who has overall responsibility for salary and entitlements including leave arrangements and includes participating GP practices and AMSs within its remit. The GP registrar then works under a secondment-type arrangement between the participating GP practices, AMSs and public hospitals for GP training rotations.

Each model is designed as a place-based model, and this means that salary, entitlements, administrative and financial arrangements can be established in different ways that best suit the local stakeholders. These trials will be evaluated over the medium term, and will generate lessons to be incorporated into the design features proposed for the national Single Employer Model.

The National Terms and Conditions for the Employment of Registrars

The NCTER is a good faith agreement that sets out the minimum conditions relating to remuneration, leave entitlements and other employment entitlements for GP registrars across Australia.

The arrangements are negotiated between General Practice Registrars Australia (GPRA) and General Practice Supervisors Australia (GPSA). The entitlements were last updated in 2022, noting there is annual adjustment to wages aligned with indexation applied to the Medicare Benefits Scheme (MBS).

Engagement with key stakeholders from GPRA and GPSA indicated an openness to future out-of-cycle amendments to the NTCER, should it be required as a vehicle for entitlement reform.

3. Department of Health and Aged Care, May 2022 AGPT – GP training figures information supplied by the Department of Health and Aged Care (not publicly available); Department of Health and Aged Care, May 2023 AGPT – GP training figures information supplied by the Department of Health and Aged Care (not publicly available)

Chapter 03:

Three Options In Summary

Three Policy Options

The Options

This project initially focused on testing the feasibility of a Portability Scheme to support the portability of employment entitlements for GP registrars. Stakeholder consultation in late 2022 underscored the need to consider two further reform options: an incentive and paid parental leave payment; and a national single employer model.

These three options form the basis of the policy design discussion in the Policy Options Paper (Appendix B) and in this Final Report. The aim of exploring these options has been to explore high level design considerations across the areas of:

- legal and legislative requirements and limitations;
- coverage and eligibility (including in scope leave entitlements);
- Governance;
- operational considerations;
- user centred design;
- costs to establish and implement (provided to the Department only);
- benefits and features; and
- risks and limitations.

While each option is different and has different advantages and disadvantages, policy design against these common elements allows the policy options to be discussed in more detail with stakeholders.

Following consultation, some updates have been made to the draft Policy Options Paper (Appendix B). These include but are not limited to: further explanation of how rural GP registrars with more than one employer currently would operate under the national SEM, updates to reflect the secondary carer for parental leave, and updates to superannuation given recent legislative changes.

Option 1: Portability Scheme for GP registrars (Scheme)

Summary

The Scheme proposes the establishment of a national entity and Scheme to enable the portability of accrued leave for GP Registrars, regardless of changes to employer or employment arrangement during training.

It would seek to recognise continuous service during medical training, and cover nine leave entitlements. Any net new leave costs would be paid for by the Scheme (Commonwealth).

Key Features

Legal Considerations

The model design would permit transfer of service-based entitlements to provide continuity of entitlements. It would (likely) require the establishment of a Scheme entity to lawfully collect, store, invest and distribute entitlements to GP registrars. This would be underpinned by legislative reform including new enabling legislation.

Scope

Coverage and Eligibility: Inclusion of all GP registrars in Australia, regardless of training program or training college.
National Proposed Entitlements: To provide leave portability for annual leave, compassionate leave, family and domestic violence leave, personal leave, long service leave, paid parental leave, cultural leave, exam/study leave, and professional development leave.

Governance

Entity Establishment: National Scheme, with a Governing Board and CEO/Registrar. Functions and role are matched to other portability schemes.
Compliance and Enforcement: Provisions required in relation to recordkeeping, leave payments and leave balances to ensure operational effectiveness.

Operation

Recognition of Service: To recognise prior service for medical graduates.
Payments and Drawing Down: Proposes proactive payment of long service leave and paid parental leave and retrospective payment for other leave types. To be reconciled monthly or every three months with employers of GP registrars.

User Centred Design

GP registrar Journey and Key Moments: Needs to be accessible, integrated with other systems, convenient and easy to access. Should provide real-time leave balances.
User Experience: Needs to address concerns about administrative burden and financial liability. Needs to consider impact of increased leave taking on training terms and timing.

Benefits and Risks

Features and Benefits: This option provides a range of benefits linked to the intent. Unique to this option are recognition of prior service, and maintaining current employment and salary arrangements.
Risks and Limitations: These include any impact of additional leave taking on training terms, administrative burden on practices, good faith reporting of salary and to inform net costs borne by the Commonwealth Government. Cost per participant is high relative to other leave portability schemes in Australia.

Option 2: Incentive and Parental Leave Support Payment

Summary

This program would provide an incentive payment broadly aligned to the difference in the value of leave available to hospital-based medical specialist trainees. This incentive will also be linked to areas of workforce priority so that larger incentives are offered in areas of greatest need. It would be paid at two intervals, at the end of the first full time year and on attainment of Fellowship.

The Parental Leave Support Payment would be paid by the Commonwealth as a single, lump sum payment to any GP registrar who qualifies for statutory paid parental leave (PPL).

It is anticipated that the payment would be governed by the Department of Health and Aged Care and administered by Services Australia in a similar way to other health workforce incentive payment programs.

Key Features

Legal Considerations

Designed as an incentive payment which will compensate GP registrars at a level comparable to those engaged in hospitals.
Threshold questions concerning powers to distribute funds and how to appropriately quantify leave types will need to be considered carefully.

Scope

Coverage and Eligibility: All GP registrars in Australia, regardless of training program or training college, would be eligible.
Payment Value: The incentive payment value would be at least equal to the entitlement value offered to hospital-based registrars. It is assumed it would be indexed. The parental leave support payment is assumed to be 14 weeks for the primary carer. The secondary carer payment amount would need to be determined, noting a high level of variability in this amount across jurisdictional enterprise agreements and awards.

Governance

The type of payment: It is anticipated that both payments would operate following a similar premise to the current Workforce Incentive Program.
Oversight and Administration: Both payments could be administered by the Department of Health and Aged Care, with funds distributed through Services Australia.
Guidelines: Clear guidelines need to be established for both payments.

Operation

Calculating and Making Payments: Proposes a smaller incentive payment upon completion of year one, and a larger incentive payment upon attainment of Fellowship. An application to confirm eligibility will be required for the parental leave support payment.

User Centred Design

GP registrar Journey and Key Moments: Must provide sufficient incentive to make the GP a more attractive training pathway, and ensure no disadvantage to those already in GP training.
User Experience: Must provide clear and accessible guidelines, and streamlined processes that minimise administrative burden.

Benefits and Risks

Features and Benefits: This option provides a range of benefits linked to the intent. Unique to this option are accelerated time to delivery, low administrative burden, and support for workforce distribution into areas of need.
Risks and Limitations: These include the lack of legislative protection, payment not sufficient to attract Resident Medical Officers (RMOs) to GP, and not addressing burnout and fatigue reported across the system.

Option 3: National or Jurisdictional Single Employer Model

Summary

This option establishes a single employer arrangement for the GP registrar throughout their training experience. This would be a secondment-type arrangement and allow for movement between GP practices, AMS/ACCHOs, and public hospitals for GP training rotations. The single employer has overall responsibility for salary and entitlements including leave arrangements. Royal Australian College of General Practitioners (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) would maintain responsibility for leading GP registrar training.

Both a national and jurisdictional way of achieving comparable salary and leave conditions for those in hospital-based training programs are outlined. It is assumed the Commonwealth would fund net new costs for the Single Employer.

Key Features

Legal Considerations

Legislative complexity may arise in the determination of the secondment arrangement, and in ensuring training oversight of the Colleges (ACRRM and RACGP).

Scope

Coverage and Eligibility: Mandatory inclusion of all GP registrars in Australia, regardless of training program or college.
Leave Entitlements: Annual leave, compassionate leave, family and domestic violence leave, personal leave, long service leave, paid parental leave, cultural leave, exam/study leave, and professional development leave included.
Wider Employment Entitlements: To ensure consistency with other EAs and Awards.
Salary Considerations: Consider existing models and arrangements to set salary.

Governance

Employer Considerations: It is expected an established entity to employ GP registrars, requiring new governance arrangements.
Training Relationship with the Colleges: Relationship between the entity, GP practices, and the Colleges must be clearly understood.
Disputes and Compliance: To be defined in enterprise agreement.
Local Discretion: Must define the nature of local decision-making power regarding leave.

Operation

Recognition of Prior Service: Not necessarily be required.
Human Resources & Administrative Requirements: Likely to be significant, to support an employee base of 4,500 to 6,000 nationally.
Employment Separation: Upon transition out of training pathway.
Medicare Billing: Employing entity would require access to billing.
Transitional Arrangements: Need to consider transition from regional SEM trials.

User Centred Design

GP registrar Journey and Key Moments: Need to communicate expectations for leave taking, to minimise impact on training timelines and eligibility.
User Experience Considerations: Will need a technology solution that is accessible, convenient, real-time and limits administrative burden.

Benefits and Risks

Features and Benefits of this Option: The benefits of this model align closely with the policy objectives identified by stakeholders.
Risks and Limitations of this Option: The establishment of a national SEM is expected to lead to some risks and limitations, however mitigations for these have been considered.

Chapter 04:

Stakeholder Feedback

Stakeholder Views On Options

Distilled feedback on the policy options from stakeholder interviews is provided in summary below, noting more detailed concerns have been outlined for further consideration in Chapter 5 of this Report.

Across all three options, there is practical concern around the impact of paid parental leave on both training terms and the duration of training. It was also flagged that this could lead to increased discriminatory practice against females of child bearing age which would need to be monitored.

1 OPTION 1: PORTABILITY SCHEME FOR GP REGISTRARS

- Stakeholders acknowledge this option may not be viable if the cohort size is limited only to GP Registrars, but discussed widening scope to provide this across the whole General Practice and/or wider medical workforce/ health professionals for those who wish to opt-in. This would support private practice arrangements across the sector. GP registrars could be the first stage of this reform. Such a change would be substantial and would require extensive consultation across all medical specialities but would provide greater efficiency through economies of scale.
- One of the key challenges raised is the salary rate at which leave would be paid. If no change is made to current salary arrangements this will be paid for some GP registrars at a base rate of pay, and for others at a higher fixed salary.

2 OPTION 2: INCENTIVE AND PARENTAL LEAVE SUPPORT PAYMENT

- Most stakeholders agreed that an interim option required to promptly increase the attractiveness of medical trainees choosing General Practice over the short term. This option reduces financial pressure associated with GP training.
- Concerns were raised regarding tax implications of lump sum payments as well as the inability of this option to address burnout as doesn't increase leave entitlements.
- Concerns were also raised about introducing an incentive payment which is later removed, and messaging would need ensure GP registrars understood this would not be a permanent payment, with the final option providing access to additional paid leave.
- Need for an interim option was supported by AMSA, AMACDT with option 2 discussed as the preferred model. ACRRM discussed an interim model that just provides support for paid parental leave.
- This was the preferred long term option in discussion with GP supervisors and practice owners.

3 OPTION 3: SINGLE EMPLOYER MODEL

- Most stakeholders agreed that a Single Employer Model (in some form) is the preferred long-term option. There was support for a national SEM and an interest in evaluation of the place-based SEM trials to guide this option and ensure no unintended consequences.
- Concerns were raised regarding whether GP registrars had a choice to opt-in of the SEM. Much of this discussion is driven by an underpinning concern that GP registrars need to be able to chose between a higher fixed salary or share-of-billings arrangement.
- Stakeholders also expressed concern about impacts on smaller practices' business models and for the lack of bargaining power in a jurisdictional model.
- The AMA prefers a single employer model either a national SEM or a model where jurisdictions employ all GP registrars (different to the model proposed in the Policy Options Paper). The RDAA prefers a hybrid model where Rural Generalist trainees are covered by a jurisdictional single employer and general trainees are covered by a national single employer.
- This option was identified as being the preferred future state by AMSA, AMA, RDAA. Most jurisdictions were also supportive of this approach.

Chapter 05:

Detailed Design Considerations

Detailed Design

Areas requiring further detailed design

At present, consultation suggests there isn't uniform consensus on the overall reform approach to supporting the leave entitlements of GP registrars. There are a number of areas where it is suggested there is further engagement, research, and refinements in detailed design of the proposed option(s) to ensure effective operation, and ensure stakeholder support and buy-in. This will also need to be balanced with wider reforms and evaluations, including the place-based SEM trials.

It is noted this Chapter been informed buy a range of consultations and written submissions aimed at assisting in next step policy design. This Chapter does not provide the detail of each stakeholder's preferred position.

The future of General Practice

Strategic Vision

Many stakeholders have raised questions about the future vision for General Practice in Australia as being integral to how this reform should be positioned. This has included:

- The extent to which primary care and General Practice will remain solely in the Commonwealth purview, or is supported by both jurisdictions and the Commonwealth;
- The desired distribution of the GP workforce, including the ideal workforce distribution across regions aligned to community need;
- The service provider profile, including the role, number and workforce expected in private practices, AMS/ ACCHOs, hospitals (especially rural hospitals), Urgent Care Clinics and regional SEMs;
- The desired future state of the place-based SEMs, including whether these remain place based with divergent approaches to governance, funding and oversight; and
- Medicare and funding reform including any changes to current arrangements and practices, including the 19(2) exemption.

Each of these factors may influence the policy option and design that is best for the sector.

Overall objectives

Questions also arose regarding the overarching policy objectives of these options. Stakeholders expressed the following views:

On intent:

"This (leave portability) is one of a few concerns that are being reported as making General Practice less attractive as a medical speciality. I think it will be important to understand how much this will impact the choices of medical students and whether the selected option actually results in increased attractiveness of the speciality."

On workforce mobility:

"When states employ a GP registrar they effectively lock them into their jurisdiction for the duration of their training, preventing workforce mobility."

" Any model would need to be national to help address some of the challenges our jurisdiction faces in GP registrar enrolments. Without this, there will continue to be GP registrars oversubscribed in some jurisdictions, without incentives into places that need them most."

On key areas of focus:

" While GP registrars and medical students may have a preference to address the paid parental leave and exam/ study leave as a priority now, long service leave may become more important to them at the end of their training when they see some of their other medical colleagues access long service leave, when they do not have that same entitlement."

"A GPRA survey has highlighted that exam/study leave and Paid Parental Leave are the highest priorities."

Wider scope

In addition, stakeholders have raised that while the scope of this work has been limited to GP registrars, further decisions to expand the scope of those covered, may also influence the preferred option.

"Consideration needs to be given to whether leave entitlements will also be something considered in the next few years for Fellowed GPs. This may change the preferred long term option that is adopted."

"It is possible that option 1 is expanded to apply to all medical specialities in Australia as an opt-in arrangement. This would demonstrate stronger support for private practice for all medical specialities and would increase the coverage of the Scheme to make it more efficient and viable."

Paid Parental Leave and Fellowed GPs

While discussion on widened scope in some cases refers to access to all leave entitlements, it is noted there is particular concern about Fellowed GP access to paid parental leave. While outside of the scope of this body of work, discussion are occurring about this across the sector and need to be considered alongside these discussions.

" [We have concern about the ending of paid parental leave on Fellowship..] The exception to this was raised in a discussion with advisors to [a jurisdiction] who noted that they are working to tie in their SEM pilots with ongoing accrual of and access to entitlements post-fellowship under new VMO arrangements: ….this was a very encouraging discussion and echoed a lot of the comments we have heard from our members about the importance of making general practice more attractive as a profession in order to attract more doctors to GP training."

Place-based SEM considerations

Jurisdictional leaders have outlined the complexity that they have faced in seeking the establishment of place-based SEM trials and the employment model that would work effectively with local stakeholders. These concerns may not have been universal, but highlight the need for detailed design and discussion with stakeholders should a national SEM model be introduced across the following issues:

- Local requirements in relation to occupational health and safety. Service provider obligations around Workplace Health and Safety (WHS) have been raised as a concern, and may limit the attractiveness of SEMs for local practices. Given differences in state WHS legislation this may require a tailored approach;
- The ability for the place-based SEM to recoup costs for salary and entitlements through the GP registrar's billing. This arrangement will be determined differently for each place based model, but remained an area of stakeholder sensitivity;
- Ensuring compliance with tax, financial and legislative considerations including at a Commonwealth and jurisdictional level. Some complexity in this has been reported by some stakeholders in establishing the place-based SEM trials, and these may materially impact the way in which the national SEM model is designed- for example whether a billing based salary arrangement would be possible as part of the national SEM;
- Opting out of the SEM based arrangement to pursue a billing option. Stakeholders reported that GP registrars are asking about whether they are able to step away from the SEM pilots, should they wish to later pursue a billing arrangement. This is consistent with stakeholder feedback which has always strongly suggested that both a higher fixed salary arrangement and billing arrangement need to be available to provide choice to GP registrars;
- Flexibility and adaptability in the model to meet the requirements of certain jurisdictions, such as those of rural workforces. Some stakeholders noted the importance of flexibility to support areas of workforce shortage by incentivising rural work; and
- Transparent processes for payment flows and negotiations with practices. Determining on-cost responsibility is complex:

"There needs to be a longer term view on what the GP landscape in Australia will look like when considering these options, including support for private GP practices.

There is significant focus on the regional SEM trials but these support small numbers of rural GPs.

Thought needs to be given to the urban centres, and the composition of private practices, hospital based GPs and Emergency Care Clinics, noting the latter will be employed by the state health systems and will not be small business employers."

Key Considerations- Portability Scheme

Cohort size

Stakeholders agree that the current cohort size limits the desirability of the Scheme as a sustainable option over the longer term. It is noted this could change should the scope be expanded to allowing an opt-in arrangement for all GPs, all medical specialities, or widen to include practice nurses and allied health staff.

If either of these occur, the scope of the Scheme could expand significantly. Figure 5.1 shows current workforce levels across GP Registrars, GPs and other medical specialities based on recent registration data from the Medical Board of Australia. If scope were widened, any modelling of costs per covered person are expected to improve based on efficiency, but would require significant additional funding to cover net new leave costs (if this were to remain borne by the Commonwealth).

Such an expansion may lead to further complexity- for example it would be more difficult to accurately determine the size of the Scheme if it is opt-in, and may lead to definitional issues on coverage which have occurred for some other portability schemes across Australia. It would also raise concerns on payment for the leave, and whether the private sector Fellowed medical workforce would need to contribute to the Scheme (as with other portability schemes which are usually established on an employer levy basis).

Figure 5.1 Current workforce headcount of areas which may be selected for wider application of the policy options.[1,2]

Workforce segment	Current headcount (based on registration data, March 2023)[1]
GP registrars	7,470
GPs	34,701
Other medical specialities	50,905

Commonwealth to only pay net new costs

Stakeholder concerns were raised around the Scheme costs to be paid for by current service providers including the jurisdictions:

"I would be concerned if jurisdictions were asked to contribute to leave entitlements that otherwise get lost on termination of employment at present."

This is particularly applicable at the "porting in" period where any outstanding personal leave and any length of service towards long service leave are lost on termination of employment. Further investigation of accounting accruals that determine what is costed currently are important to determining jurisdictional costs and net costs to be paid by the Commonwealth for Scheme operation.

However other views on jurisdictional obligations (outside the scope of porting in) were made including:

"I'm surprised that none of the options seem to include the last employing public hospital to take on the role of paying out the accrued long service leave before registrar leaves hospital."

1.Medical Board of Australia. March 2023. Statistics.
2. Department of Health and Aged Care, May 2022 AGPT – GP training figures information supplied by the Department of Health and Aged Care (not publicly available); Department of Health and Aged Care, May 2023 AGPT – GP training figures information supplied by the Department of Health and Aged Care (not publicly available)

Administrative arrangement

Stakeholders discussed the design of Option 1, particularly the administration of leave obligations being managed at the local employer level. From and administrative perspective some raised that a relationship between the Scheme and GP Registrar may be administratively easier. If such an approach was adopted, key design considerations would include:

- How this model accounts for and requires employers to pay for the leave they currently are required to pay, with the Commonwealth only paying for net new leave;
- Whether an information technology system could apply to enable a smooth and seamless relationship between the Scheme and GP Registrar and have interoperability with all employer payroll systems;
- How certain types of leave that tend to be taken with very little notice, and which may require approval (such as personal leave) would be administered, whether local discretion would be factored in, and whether compliance mechanisms need to be introduced to prevent misuse.

Disadvantages on salary rate for leave

GP registrars have noted there would need to be exploration of what will occur where they accrue leave (such as annual leave) at a higher salary (for example in the hospital based system) and then move to a billing arrangement and want to take the leave, but this is paid at a lower rate of base pay. This may require GP registrars to elect to cash out their annual leave at the end of their hospital based training in order to preserve the higher rate of pay.

"I'd feel pretty ripped off if the leave I'd accrued as a for example PGY6 hospital doctor, being paid base salary of $58/h, is then paid out to me at a base rate of $38/h if taken in GPT1."

The impact of ported leave entitlements was also raised in terms of attractiveness to GP practices:

"Option 1 would put practices off GP registrars....I worry that if you had leave accrued from hospital years, its unfair on the practices to have to honour that leave (irrespective of who's paying the leave)."

Scheme entity

It was noted in discussions with the sector that there is significant mistrust from GP practices and supervisors towards government based on historical reforms. This may require adjacent work on developing trust across the sector, but also led to feedback on the Scheme entity (and is also a key consideration in any national entity selected should the national SEM be adopted):

"To counteract the mistrust in the sector, this [entity] would need to be developed independent of state / Commonwealth (so much talk about GPs as employees is not going down well out there) and without interference or oversight by specialty Colleges or AMA or the PHNs."

Key Considerations- Incentive Payment

The need for an interim solution

Stakeholders representing the view of doctors in training and GP registrars (including AMSA, AMACDT and RACGP) all advocated for an interim solution.

"There needs to be an interim solution provided now to entice people into General Practice."

"While there is a need for an interim solution, it could be limited to the paid parental leave option developed two years ago."

"There is a need for any incentive to be broader than paid parental leave, noting that exam and study leave was raised as the highest issue faced by GP registrars."

Some stakeholders have raised concerns that the incentive amount may not be sufficient to influence decision making around the medical specialty, however this could be monitored for the interim period, and adjusted if needed.

Linked to this however, was some concern that if this option were implemented in the interim, the sector may lose momentum around implementing options 1 or 3 which provide the leave equivalency which is not available under option 2.

"Option 2 would need to be announced with a longer-term option so that the expectation is set across the sector, and so that momentum is not lost for a solution that provides leave and addresses the underlying issues."

"There is risk in that things that are meant to be short-term often aren't and it is hard to take things away"

"I view this as not an option long term, however acknowledge it may have a role as an interim measure... framed as an incentive."

"Option 2 could work as a short-term or interim solution leading to (and potentially absorbed into) something more comprehensive and permanent"

Taxation and payment milestones

Some stakeholders raised that the proposed two larger payments would not be well received by GP registrars because of the tax rate implications. While some stakeholders note it would be preferable to receive an ongoing payment in line with salary arrangements, this needs to be balanced with the risk that the reason for the payment is lost in a salary package arrangement.

"I don't believe GP registrars will agree to lump sum payments as they will get taxed at approximately 50 percent."

Other stakeholders noted there could be some undesirable consequences through payment on Fellowship.

"My one concern with option 2, [is that it will] stream people towards the three year training pathway [without the Advanced Practice training year] which is not necessarily what the country wants."

"... [the] main downside [to this option] is having to wait until completion of training to receive the second larger payment, so you're not actually receiving that money when you need it the most."

Continued industrial relations obligations

Stakeholders noted that for clarity, it needs to be understood that current leave entitlements will continue, and that this payment occurs over and above the current leave entitlements. All employers of GP registrars will continue to have industrial relations obligations to adhere to either national or jurisdictional arrangements, including any applicable enterprise agreements and awards, and the NES.

" We will need to make clear to stakeholders that this will not change their industrial relations leave obligations, including under the NES for things like annual leave and personal leave. The incentive is to cover leave equivalency for exam/ study leave, professional development leave, cultural leave, portable personal leave, and long service leave accrual. The payment for parental leave is over and above this payment and will only apply to those eligible for parental leave."

Intersection with Victorian GP registrar commitment

It was noted by some stakeholders that $30,000 is also the amount provided under the Victorian Government announcement to entice medical students into General Practice.[3] This payment is yet to be introduced, but if offered, would provide a further incentive in Victoria. Clarification on whether this would impact the incentive payment provided nationally may need to be determined, and clarity would need to be provided to medical students about the differences between these incentives.

"There may be some confusion from GP registrars in Victoria about this payment an the Victorian Government commitment. However if this [Victorian commitment] is implemented first, its behavioural impact on attraction into General Practice training will be better understood."

Paying back Incentives

Stakeholders noted that other incentive payments made to GP registrars historically required paying back the incentive where the GP registrars did not meet certain obligations. Therefore while the model makes clear there is not expectation that a GP registrar who does not complete training would need to pay back the partial payment, it was flagged that this would need to be communicated clearly to GP registrars.

"You could get people gaming the system to get the payment without intending to go through the training pathway"

"I think GP registrars would need to complete both years to be eligible for the payment, but the incentive also needs to be distributed throughout the training period so that it is actually functional"

"Reference to how historical incentives have played our across the medical profession, including bonded scholarships, needs to be considered from a lessons learned perspective."

Transition of this program

Some concerns have been raised about providing the incentive payment of $30,000 to cover leave equivalence for the medical specialities in hospitals, and then removing this when the final option is implemented. It will be important that stakeholders understand that this financial incentive is to help cover differences in entitlements between GP registrars compared with other medical specialities- including for exam/ study leave, professional development leave, and long service leave (with a separate payment for paid parental leave).

"If option 2 is only implemented for a short period of time (like 2 years) it may be easier to revoke than if this is provided for a longer period such as 4-5 years where people will forget the reason they are receiving the payment."

"No one will object to receiving further incentives, but what will be important to see is whether this actually achieves the intended objectives."

If this is selected as the interim option, careful consideration will need to be given to how this is communicated, including how transition will occur for those who may be part-way through their training when another option is implemented.

Eligibility for parental leave

As is noted in the Policy options paper, more work will need to be undertaken to ensure eligibility for parental leave. Stakeholders also noted a concern for International Medical Graduates (IMGs):

While it is noted in the Policy Options Paper, waiving the 12 months eligibility to access parental leave will be important."

"There is little consideration of how IMGs who have not spent time in the Australian public hospital system will qualify for provisions such as paid parental leave.

3.RACGP. November 2022.News Media Release.

A need to provide leave

While a noted concern in the Policy Options paper, stakeholders reiterated some concern that the incentive payment would not provide access to the additional leave that is of concern to GP registrars.

"A key issue which registrars identified through the consultation it is often not only the payment but also the access to their leave provisions. For example, many GP registrars have annual leave entitlements paid out at the end of a rotation and are rostered to work the following week, so no actual break from duty."

Key Considerations- National SEM

Salary determination

All stakeholders acknowledge that consideration needs to be given to the two different salary options which are currently utilised across the GP registrar workforce under the national Single Employer Model. These salary arrangements are:

- 1. A higher fixed salary rate, and
- 2. A base rate where additional pay is determined by the proportion of Medicare billings the GP registrar provides.

Under the second arrangement, GP registrars are currently only paid the base rate of pay while on leave. It is understood many GP registrars prefer this second option even with the lower leave rate as it is more lucrative over their training term (although this is not always the case).

Salary information showing how these arrangements are currently utilised for all GP registrars has not been available for this report. While individual employment contracts will be subject to privacy considerations, data available from Medicare billings may help to provide greater clarity on the number of GP registrars under a base salary arrangement, and the variability in the final salary amounts (including based on PGY year, setting, and level of remoteness). This may help to determine a more comprehensive picture around GP registrar salaries, where incentives may be needed, and GP registrar preferences around their employment package including both salary and leave entitlements.

Anecdotal information from stakeholders states:

"..evidence [is needed] around GP registrar salaries and how they compare to hospital salaries in the long term – not just in the first 6 months when they leave the hospital and go into General Practice. All these options are not helpful without knowing the facts around GP registrar actual take home pay."

"Most of them [GP registrars] after working for one year prefer to have the percentage rate of pay rather than a salary as it is so much more."

Employment security benefits

Stakeholders noted that employment security has been a key issue amongst GP registrars, particularly as they seek financial security for housing purchases, and is a key benefit to a SEM model. The other options will not provide for this benefit, as these models will continue to provide breaks in service form employer changes during their training journey.

"Employment stability is much bigger than just maintaining leave entitlements and the benefits of this should be emphasised."

Housing, childcare and relocation benefits

One stakeholder noted that some of the issues around improvement in workforce distribution of GPs in rural and remote areas are better supported by housing and childcare related supports which may be able to be offered under a SEM model, but would not be available in the other options.

Lack of business model training

Many stakeholders noted that the way in which salaries are established should also consider the teaching of business viability and billing to ensure GP registrars learn the business model of general practice upon Fellowship.

"If it takes the form of the registrar not receiving a top-up payment for percentage of billings, then this could have implications for learning the Medicare billing system and removes the incentive to learn how to bill optimally."

Opting in to a National SEM

While the model for a national SEM is designed to accommodate both of the salary based arrangements and still provide GP registrars with choice in their salary, some stakeholders felt providing the ability to opt in to a national single employer model may be the most effective approach.

"Opt-in arrangements may be needed as not all GP registrars would want increased leave entitlements if this changes their current salary arrangements."

"In terms of attraction, having a choice is really desirable. My concern is that in giving GP registrars lots of choice, things may get too complicated and they would get nothing."

"Autonomy needs to exist to allow for billing arrangements to apply. There is power in negotiating billing arrangements, and GP registrars may be disadvantaged under new arrangements."

What is important to determine in any opt-in arrangement is what the GP registrar is opting in to (or out of). That is, if everything they currently receive can be provided to them under the national SEM, with the only aspect changing being their employer, the better policy outcome would mandate the inclusion of all GP registrars to prevent fragmentation in the employment arrangements that currently exist. However to achieve this, it will be important that there is no disadvantage applied to any GP registrar's current employment arrangement.

In addition stakeholders in some jurisdictions have reported complexity in tax, financial and regulatory obligations in how their place-based SEM pilots could be established, including noting that they were not able to offer a billing arrangement within the place-based model because of regulatory constraints.

This raises some concern that the national SEM model proposed (to include billing) may not be possible, and that jurisdictional legislative differences will need to be considered (which may negate some of the benefits of a uniform national model).

"The financial auditing becomes quite circular, and the options that are actually feasible to implement get narrowed down"

Blended models – national and jurisdictional SEM

Some stakeholders raised the concept of a blended SEM model, combining a national and place-based approach (subject to the place-based SEM trials evaluation). The possible advantage of this is that a place-based model may work better for a small but critical cohorts of GP registrars who undertake their training in hospital settings (such as Rural Generalists), while the national model may be much more suited to GP registrars undertaking training in GP practice settings, who are also subject to national industrial relations arrangements already.

It will be important to consider the viability of SEM blended options following the findings from the evaluation of the place-based SEM pilots to ensure suitability for key cohorts, efficiency and user centred design are all considered in the long term reform that is adopted for Australia.

Medicare billing

The model proposed would shift some of the revenue GP practices, AMSs and other service providers currently receive for GP registrar billing to the single employer. This revenue would be used to pay for leave and overheads in employer administration and remove this leave and salary cost from service providers.

Stakeholders noted that this is expected to be strongly opposed by GP practices as they are already under significant financial pressure and it would make supervision much less attractive. This would be occurring at a time when profits have already been impacted by payroll tax changes which recently came into effect. Discussions with one AMS noted that the revenue from GP registrar Medicare billings are currently used to help support wider allied health professionals and provide more holistic models of care, and that this would compromise their ability to provide these models of care.

"Any reduction in Medicare revenue is likely to be seen as an attack on the viability of GP private practices, particularly given the low current profit levels and impact of recent changes such as payroll tax."

"Practices will be getting less than they have now, and they are already scraping by"

"Further work needs to be undertaken to understand the current Medicare revenue arrangements, and differences depending on the setting (e.g. GP practice or rural hospital), and location (taking into account rural and remoteness)."

Some concerns were raised regarding changing the billing arrangements under option 3, and while the following was a noted concern, consideration also needs to be given to the way in which current practices already operate.

"[there needs to be] serious consideration on how to ensure practices are well supported without reverting to a system where their earning are dependent on how productive a GP trainee is."

"SEM also risks disincentivizing practices to take on registrars (due to lower practice payments), which could limit placement options and create more competition amongst registrars."

Further analysis may need to be undertaken on the current revenue distribution across different GP registrar models to better inform the impact of any re-allocation of revenue. This should include analysis across the following models:

- GP practices (including those where GP registrars operate under a fixed salary or base salary arrangement);
- AMS and ACCHOs;
- Regional SEMs (noting the way in which revenue is allocated may be different across different SEM models);
- Hospital and primary health care models (noting that in some cases they do not utilise Medicare billing, and therefore there may be question as to what revenue will be provided to the national SEM, in other cases section 19(2) exemptions apply which allow the claiming of Medicare benefits to support primary care services).

It should also consider:

- How revenue changes would impact taxation, including payroll tax;
- The differences in revenue, noting this is expected to be very different depending on the year of training on the pathway.
- The different options for revenue distribution, including the proportion that remains with GP practices.

Wider entitlements

The policy option around a SEM (either national or jurisdictional), notes that it allows for consideration of a wider suite of entitlements under a national agreement, and could simplify a range of current additional employment based payments which are made. However some concern has been raised about utilising this mechanism for wider system benefits.

"it [workforce incentives] must remain independent from existing workforce incentive payments. SEM is a model of employment to improve the attractiveness of GP training, not a workforce solution. Having separate workforce incentives maintains that distinction and allows for workforce incentives to be applied, adapted, and changed as the needs of the community change."

"A national SEM should have no impact on how GP trainees are allocated into placements… This role belongs to the Colleges."

However, this was balanced with some other views that the SEM provides a number of benefits significantly wider than those possible under a portability of entitlements scheme For example:

"If a National SEM is established, it would be advantageous to have mechanisms that can be more targeted, such as incentivising rural work."
"Consideration may need to be given to workforce incentives that are wider than rural and remoteness, for example in supporting community GP practice rotations."

Greenfields negotiation

It is noted that under the initial establishment of a national SEM model, it is proposed that a greenfields enterprise agreement would need to be established, prior to the employment of all GP registrars. Some stakeholders raised concerns about this initial agreement stating:

"[We are] concerned, due to the nature of a greenfields agreement (where an agreement is struck within a power imbalanced weighted towards the new entity employer) that the entitlement package will be limited by what the government is willing to fund. One would assume that if the SEM policy is to deliver significant employment reform and incentivise increased GP workforce supply, funding must match what is necessary to establish attractive salary and conditions. That is, equitable conditions to those in public hospitals.

Key Considerations- Jurisdictional SEM

Jurisdictional model should consider State employment models

There were a number of discussions in relation to the jurisdictional model put forward in the Policy options Paper, noting that it was designed in a way that would not require the jurisdictions to become the employers of all GP registrars. While most jurisdictions agreed with this, subject to further discussions, it was noted this needs to be formally tested:

"While State Health Departments may not wish to employ all GP registrars,… there is definitely an appetite by various State Health bodies to employ Rural Generalist and Rural GP registrars where they provide service to the local hospital. The option of employer of state health must be one of the options available for registrars to select."

The AMA, in particular note concerns about the model proposed:

"The AMA does not believe that a jurisdictional SEM, as presented in the policy options paper, is a viable solution. …If a jurisdictional SEM is considered by governments as the most viable option for employment reform, the AMA strongly recommends that the model being used by existing SEM trials, where GP trainees are employed directly by the state, is the employment mechanism used."

However this is countered by other views:

"[a move to a jurisdictional SEM would be] the death knell for independent community general practice and a state-grab for primary healthcare funding."

Rural Generalists

It was noted Rural Generalists, who are often employed by both GP practices and jurisdictions, are most seeking comparable entitlements with the jurisdiction based enterprise agreement or award. This may be influencing their training pathways.

"many rural generalists are not choosing between a GP training pathway and Rural Generalist pathway, they are choosing between a non-GP specialty and rural generalist"

Inconsistency of entitlements

Some stakeholders noted concerns with the jurisdictional model around equity in entitlements for GP registrars, and provided this as one of the key reason why a national model is preferred.

"The Jurisdictional model mirrors state awards which could cause industrial relations problems and wouldn't provide national equity. Trainees would not have any bargaining power as their Enterprise Agreements (EAs) would be negotiated by states. The profession would need a way to influence this."

Blended models

One key stakeholder suggest a combination of allowing a billing arrangement, national SEM (fixed salary) and jurisdictional SEM (state employed) may provide the best combination of outcomes. Such blended models would be subject to further consultation as these have not been a key focus of the stakeholder engagement to date.

"[We] recommend that there are three options available to [GP] registrars:

- *Status quo – billing of Medicare as per current arrangements under NTCER*
- *National Single Employer Model*
- *Jurisdiction (state health) employer option for Rural Generalist Registrars and rural GP registrars who undertake hospital work.*

For each of these models, Medicare billing will still be required, and therefore 19(2) exemptions will be needed, as it provides the mechanism for the practice to be paid for the practice overheads associated with registrars provide patient care such as medical consumables, administration and practice nurse time, consultation room costs such as power, computer licenses etc."

Chapter 06:

Comparative Assessment Of Reform Options

Comparative Assessment

Assessment criteria

A comparative assessment of each of the options has been undertaken in the **Policy Options Paper**, to help allow comparison of the advantages and disadvantages of each option as per Table 6.1.

The first seven assessment criteria are aligned to the policy objectives and reform goals of improving leave comparability for GP registrars in Australia and were agreed by stakeholders at GPTAC and in a policy reform context discussions with stakeholders. A further five criteria have been included which help to assess the practical features, risks, timing, and legislative complexity of each option.

Each policy option has its own advantages, disadvantages and complexity in implementation.

As further detailed design discussions occur, some of these criteria may need to be amended or added to ensure the comparison reflects the complexity of the proposed options.

Table 6.1: The comparative assessment criteria discussed in the Policy Options Paper

Assessment Criteria	Definition
1. Improve attraction to a career in General Practice	The extent the option addresses the key concerns raised by GP registrars regarding leave equivalency, particularly paid parental leave; continuity of service; and certainty in employment conditions.
2. Provides comparable benefits and entitlements to other medical specialties	The extent the option addresses the inequity in leave provided to GP registrars compared with other hospital-based medical specialities.
3. Supports retention of existing GPs and sustainability of General Practice	The extent the option supports (or does not disincentivise) current GPs and practices from taking on supervision, and/or supporting the proposed option.
4. Improved workforce distribution into areas of need	The extent the option seeks to improve the workforce distribution of GP registrars into areas of need.
5. Increases the number of GP registrars that can access entitlements	The extent the option supports all GP registrars regardless of their placement to access leave entitlements (or incentives).
6. Increases GP registrar mobility and transferability across GP practices and settings	The extent the option supports the movement of GP registrars across Australia, including across practices and settings.
7. Strengthens diversity in the GP workforce	The extent the option supports diversity in the GP registrar workforce, including the proportion of females and First Nations representation.
8. Reduces legal and or legislative complexity on order to be operationalised	The extent to which the option can be operationalised with minimal legal or legislative complexity. That is, for the purposes of this criteria, a **low rating indicates** the option requires significant legislative reform to operate effectively.
9. Can be deployed quickly, with minimal time to establish and implement	The extent the option limits the expected time to deployment in order to support GP registrars as soon as possible.
10. Provides a framework which supports sustainable health system design and control	The extent the option provides stability and sustainability across primary care, and supports levers which can be deployed to assist with workforce attraction, distribution, and financial management.
11. Provides additional benefits and features (compared to other options)	The extent the option provides additional benefits when compared with other options that need to be considered in the assessment of qualitative value.
12. Minimises unintended consequences and/or limitations (compared with other options)	The extent the option provides unintentional limitations when compared with other options that need to be considered in the assessment of qualitative value.

Comparative assessment

In order to inform the recommended option for reform, KPMG have assessed each of the options against the criteria as shown in Table 6.2. Each option is assessed against a Likert Scale based on a qualitative assessment, with value attributed based on strength of alignment of each option to each criteria.

Assessment of each of the model options is based on a qualitative assessment using a Likert scale based on inputs from a range of sources including stakeholder consultations and workshops, a detailed literature review, and consideration of the design and proposed implementation features associated with each option.

It is noted these criteria have not been weighted based on importance, and the assessment is shown to allow relative comparison across each assessment criteria.

Based on this comparative assessment, the Single Employer Model (Option 3) has been assessed as the most desirable for the sector.

Table 6.2: The comparative assessment ranking summary based on the assessment in Chapter 6.

Assessment Criteria *(Each criteria has a maximum score of 7)*	**Current State**	**Option 1: Scheme**	**Option 2: Incentive Payment and PLSP**	**Option 3: Single Employer Model**
1. Improve attraction to a career in General Practice	●●●○○○○	●●●●●●●	●●●●●○○	●●●●●●○
2. Provides comparable benefits and entitlements to other medical specialties	●○○○○○○	●●●●●●○	●●●●○○○	●●●●●●●
3. Supports retention of existing GPs and sustainability of General Practice	●●●○○○○	●●●●●○○	●●●●○○○	●●●○○○○
4. Improved workforce distribution into areas of need	●●●●○○○	●○○○○○○	●●●●○○○	●●●●●○○
5. Increases the number of GP registrars that can access entitlements	●●○○○○○	●●●●●●○	●●●○○○○	●●●●●●○
6. Increases GP registrar mobility and transferability across GP practices and settings	●●○○○○○	●●●●○○○	●●●●○○○	●●●●●●○
7. Strengthens diversity in the GP workforce	●●●○○○○	●●●●●○○	●●●○○○○	●●●●●○○
8. Reduces legal and or legislative complexity on order to be operationalised	N/A already implemented	●●○○○○○	●●●●●○○	●●●○○○○
9. Can be deployed quickly, with minimal time to establish and implement	N/A already implemented	●●●○○○○	●●●●●○○	●●●○○○○
10. Provides a framework which supports sustainable health system design and control	●●○○○○○	●○○○○○○	●●●○○○○	●●●●●●○
11. Provides additional benefits and features (compared to other options)	N/A already implemented	●●●●○○○	●●●○○○○	●●●●●○○
12. Minimises unintended consequences and/or limitations (compared with other options)	N/A already implemented	●●●●○○○	●●●○○○○	●●○○○○○

Chapter 07:

The Pathway to Reform

A sustainable solution to leave entitlements

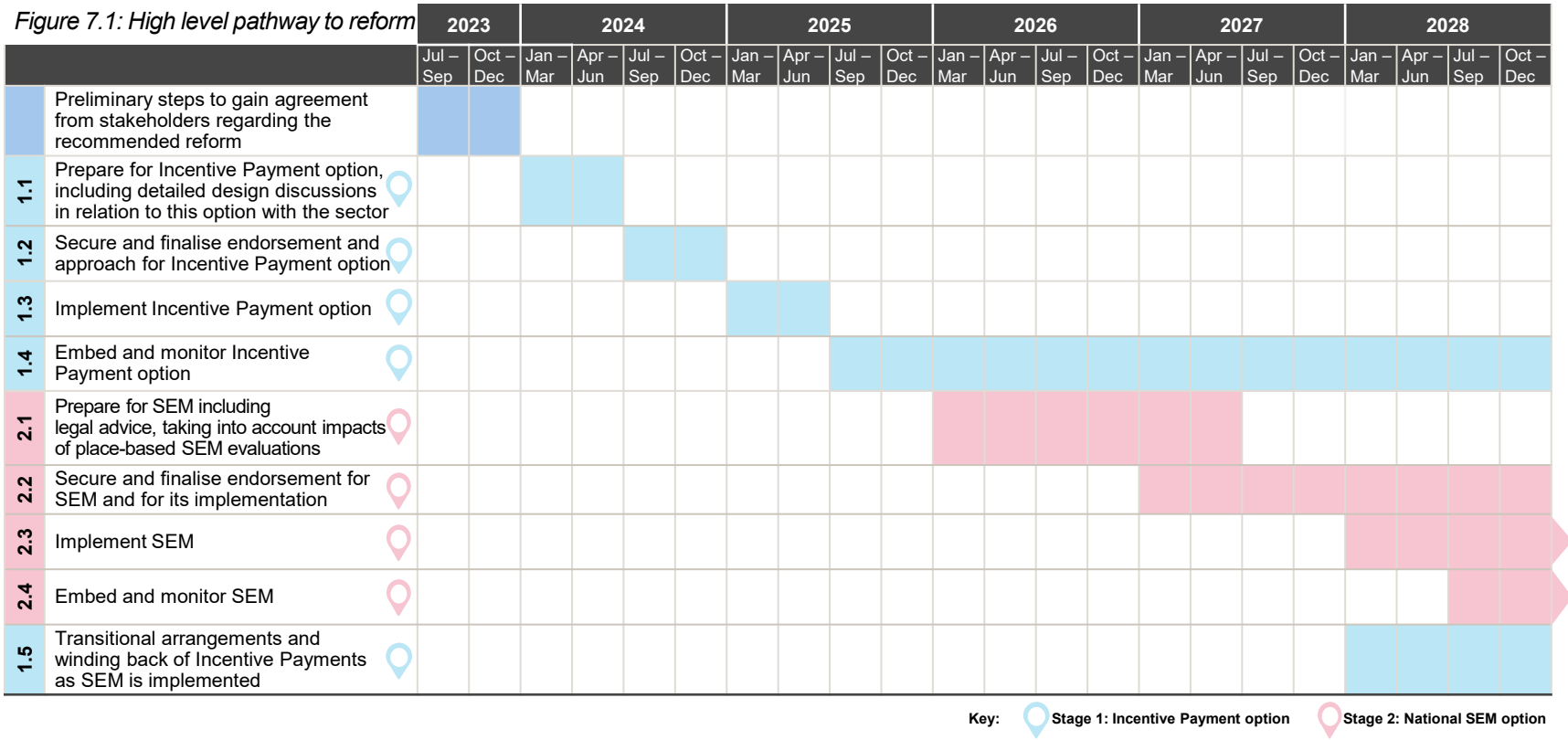
The recommended pathway to reforming leave entitlements for GP registrars to ensure their comparability with those in other hospital based specialities, is to move to a national Single Employer Model. This is because of the benefits it provides in terms of attraction to a career in General Practice, provision of comparable leave benefits to other medical specialities, the ability to address workforce distribution challenges and mobility, and providing a framework which supports sustainable health system design and control.

However given the time to establish, it is recommended that in the short-term an incentive payment and a payment for parental leave be implemented to help address GP registrar concerns.

There are a number of key steps which will need to be achieved to implement both options which are summarised in Figure 7.1, and described in more detail in this Chapter. It is expected the both options be pursued concurrently to accelerate the reform pathway.

There will need to be further consultation with the sector around detailed design considerations which will be further informed by the place-based SEM pilot evaluation.

Figure 7.1: High level pathway to reform



1. MSH supplied information from the Request for Quote information provided for the Project.
Note: These reviews and their recommendations were not provided for analysis, and any evaluation or progress repotting against key recommendations have not been provided for analysis

Stage 1: Incentive and Parental Leave Support Payment

Objectives

The design and establishment of an Incentive Payment and Parental Leave Support Payment as Stage 1 of Entitlement Reform for GP registrars seeks to:

- Improve attraction to a career in General Practice, including specific payments to support parental leave;
- Improve workforce distribution into areas of need;
- Maintain and strengthen diversity in the GP workforce;
- Ensure national coverage, including eligibility for all GP registrars regardless of training program;
- Provide an incentive equal to any difference in leave compared with those in hospital based training programs; and
- Operate in a way which is agnostic to the training program and college (where possible).

High level design of this approach has been discussed in further detail in the **Policy Options Paper (Appendix B)**, and is summarised in this Final Report against the nine areas shown in Figure 7.2.

Figure 7.2: Analysis areas

Legal Considerations

This option is designed to require the establishment of governance arrangements to allow for the incentive payments to be paid by the Commonwealth. Legal consideration needs to be given to:

- **Ministerial powers to distribute funds to GP registrars:** Legislative powers need to exist to allow for the distribution of funds to GP registrars via their employers for incentive payments. If this does not exist under current legislative arrangements then this may require legislative reform.
- **Clarity on the purpose of the payments (what are these seeking to remedy, and how were these quantified?):** It is important these factors are clearly defined in order to ensure they operate as intended, including eligibility, payment quantum and whether individual circumstances need to be considered.

Scope

Scope considerations are different based on the two payment types.

Incentive Payment: Designed to:

- Apply to all GP registrars regardless of training program;
- Have a payment value set to be great than the sum of hospital based leave entitlements for paid exam and study leave, portable personal leave (with continuity of service), paid professional development leave, cultural leave, and long service leave;
- It is expected the payment amount will be increased to incentivise placements in areas of workforce need. This may be based on Modified Monash Model ratings.

Parental Leave Support Payment: Designed to:

- Apply to GP registrars eligible for Commonwealth Paid Parental Leave;
- Have a payment value set at a comparable rate to that offered in jurisdictional EAs and awards..

Governance

Public funds utilised to provide incentive payments to GP registrars will need appropriate governance to withstand public scrutiny. This includes:

- **The type of payment:** This has been designed to operate as an incentive payment (not a grant payment). This distinction is important to its legislative arrangement and rules for operation.
- **Oversight and administration:** It is anticipated these payments would be administered by the Department of Health and Aged Care and distributed by Services Australia. This approach is consistent with similar existing payments and governance.
- **Guidelines**: To ensure consistency in administration, guidelines for these payments will need to be developed. This will include consideration of eligibility, indexation, dispute resolution, processes for under and over payments, and auditing.

Operation

The way in which payments are calculated and made are important in ensuring effective operation. Key considerations in design include:

- **The wage rate at which paid parental leave will be paid.** It is noted that at present, GP registrars can be paid against a base rate of pay and a proportion of Medicare Billing, or at a higher salary rate. To ensure equity in paid parental leave across the sector, clarity will need to be provided regarding the salary rate to be used to determine the Parental Leave Support Payment.
- **The payment pathway.** It will need to be determined whether the payments (both the Incentive and Parental leave Support payment) are paid directly to the GP registrar or via the employer. This determination may impact on data collection and privacy considerations.

User-Centred Design

GP registrars consulted around the design of option discussed the need for a payments model that is:

- **Accessible** – without complex eligibility or application processes, available to all GP registrars (for the incentive payment);
- **Streamlined** – reducing administrative burden to practices, GP registrars and utilising existing processes and mechanisms where possible;
- **Equitable** – providing for comparable benefits to those provided to other medical specialities;
- **Convenient** – Preferably allowing for application and payments to be visible on mobile devices;
- **Transparent** – Providing for transparency in how payments are calculated and paid s they can be easily understood by stakeholders.

Funding and Information Flows

This option does not seek to change any of the current funding arrangements or payments.

Under this option, new **funding flows** exist between Commonwealth (Services Australia) and GP Registrars (for both incentive payments and the parental leave support payment).

New **information flows** exist between GP registrars and the Commonwealth, particularly in requesting the parental leave support payment and demonstrating eligibility.

New information flows exist between the Colleges and Commonwealth in determining fellowship attainment of GP Registrars, triggering the final incentive payment.

Benefits

This option provides a number of key benefits compared with the current arrangements and other policy options. It includes:

- **Accelerated time to delivery.** Relatively straightforward to set up and not set through legislation or an enterprise agreement.
- **Comparable benefits.** This option provides comparable leave and payments to provisions for hospital-based medical specialities.
- **Provides national consistency and coverage.** The design of the Scheme seeks to promote inclusion of all GP registrars regardless of their training program. This helps to promote equality in leave entitlements across the GP registrar workforce.
- **Low administrative burden.** The Scheme is designed to simplify administrative processes and reduce complexity.

Risks

This option provides a number of key risks and limitations. These include:

- **Lack of legislative protection.** Lack of legislative constructs means this may not be as durable as required.
- **Limited boost for GP training pathway attractiveness.** This option may not be sufficient enough to influence RMOs to select General Practice.
- **Compliance mechanisms.** In keeping with good governance, consideration needs to be given to guidelines and mechanisms which minimise misuse.

Unintended Consequences

Under this option, there are potential outcomes that may arise different to the initial purpose in mind. This includes:

- **No change in leave taking practices.** By providing an incentive payment only, reform does not address the fatigue and burnout reported in the system.
- **Behavioural change.** The incentive payment may not be sufficient to increase attractiveness into General Practice.
- **Taxation applied to incentive.** In the way this model is currently designed, it may limit impact due to the taxation made to lump sum payments.

Stage 1: High level implementation plan

Figure 7.3: Stage 1 Implementation Considerations

PREPARE
Timeframe: Month 1-6
Obtain legal advice, prepare business case, seek high level endorsement to proceed.

SECURE (OR FINALISE) ENDORSEMENT AND APPROACH
Timeframe: Month 7-12
Seek government endorsement.

IMPLEMENT
Timeframe: Month 13 – 18
Establishment of systems, staff, policies and processes, including testing of payments processes to establish payments. Communications to GP registrars and wider sector about the payments.

EMBED AND MONITOR
Timeframe: Estimate 1.5-4 years
Embed in as business as usual, monitor impacts on GP training intake and parental leave, review program duration (dependant on Stage 2)

KEY ACTIONS

Month 1-6	*Month 7 – 18*		*Ongoing*

• Obtain legal advice in relation to the proposed design, including in relation to:
  • Whether this would constitute a grant or incentive payment;
  • Legislative power and construct.
• Wider government endorsement and policy approval.
• Undertake stakeholder engagement to clarify/modify any features based on design concerns and challenges.
• Define accountabilities and responsibilities for each entity, taking into account required funding and information flows.
• Seek high level endorsement at GPTAC.
	• Preparation of any legislative amendments, draft materials including guidelines.
	• Discussions with Services Australia around administration of the payments, system requirements and set-up, governance, resourcing requirements.
	• Modification of any of the detailed elements of design based on stakeholder feedback, legal advice and funding allocations.
	• Determination any transitional arrangements that need to be considered (including for GP registrars part-way through training).
		• Recruitment of staff to oversee program through the Department of Health and Aged Care and Services Australia.
		• Modifications to systems and testing to process payment through Services Australia.
		• Embed process changes for information flows, including from RACGP and ACCRM (e.g. for those GP registrars who attain Fellowship). This will include privacy considerations.
		• Legislative or regulatory amendments if required (noting this is not anticipated).
		• Publication of policy guidelines.
		• Communication to GP registrars and wider GP sector about the incentive and Parental Leave Support Payments.
			• Regular review and evaluation of the acquittal of funds to ensure public funds are subject to appropriate governance and oversight.
			• Link with internal governance structures to ensure compliance and issues are managed, as well as management of any unintended consequences.
			• Monitor the Stage 2 implementation pathway for the SEM, and if required seek an extension (or shorten) the duration of the program.
			• Collect information on the impact of the payments on the attractiveness of General Practice to medical registrars, and the utilisation of the Parental Leave Support Payment by GP registrars. Report on realised benefits.

Stage 2: National Single Employer Model

Objectives

This option would establish a single employer arrangement for the GP registrar throughout their training experience. This would be a secondment-type arrangement and allow for movement between GP practices, AMSs/ACCHOs, and public hospitals for GP training rotations.

In this arrangement, the single employer would assume all employer obligations including responsibility for salary and leave entitlements. RACGP and ACRRM would maintain responsibility for leading GP registrar training.

The SEM is being discussed across national, jurisdictional and place-based levels as described overleaf, and it is important to understand the differences across these models.

High level design of this approach has been discussed in further detail in the **Policy Options Paper (Appendix B)**, and is summarised in this Final Report against the nine areas shown in Figure 7.3. The Policy Options paper provides more detail on the differences between the national and jurisdictional models proposed.

Figure 7.4: Analysis areas

Legal Considerations

This option will be underpinned by a secondment-style arrangement where GP practices will enter into an arrangement with the employer to 'host' GP registrars. Various legal considerations are relevant, including:

- The selection of the most appropriate **entity** to become the employer of GP registrars, and by extension, who assumes all employer obligations;
- The **legal structure** that underpins the secondment arrangement between the SEM and host employer including considerations of work health and safety obligations;
- The potential need for development of an **enterprise agreement** to underpin terms and conditions of employment; and
- Constitutional arrangements and specifically the **operation of industrial relations powers** that have been referred (and not referred) from the States to the Commonwealth.

Scope

Under a SEM, definition of the included employees, and the salary and entitlements to be considered are:

- **Coverage and Eligibility:** Defining who the arrangement should apply to, and ensuring it removes coverage when GP registrars leave the training program (for any reason).
- **Leave Entitlements:** Determining consistent leave entitlements for employees noting accrual, eligibility, evidence requirements and any other factors which need to be defined.
- **Wider Employment Entitlements:** Determining any other employment entitlements which need to be defined which are typical to an enterprise agreement.
- **Salary Considerations:** Under a SEM, the employer will set salary arrangements for GP registrars and will need to consider the different existing models and arrangements, including salary support and Medicare billing.

Governance

The key considerations in the governance of this model differ from other options. They include:

- **Employer Considerations:** Clarity in who the employing entity is, including how that entity is governed, is important to the SEM establishment.
- **Training Relationship with the Colleges:** It will be important to articulate and document the relationship between the employer and the Colleges as the training provider and the roles and responsibilities of each entity.
- **Disputes and Compliance:** This includes defining how disputes will be resolved should they arise.
- **Local Discretion:** It will be important to define what can be determined locally (i.e. at a practice level as the accredited training provider and supervisor), and what will be within the remit of the SEM employer.

Operation

The National or Jurisdictional Single Employer Model has range of different operational considerations. These include:

- **Recognition of Prior Service:** Determining any recognition of service prior to being employed as a GP registrar nationally, under a national or jurisdictional agreement;
- **Human Resources and Administrative Requirements:** Outlining the requirements to support the operational effectiveness of the SEM with human resources and administrative personnel;
- **Termination of Employment:** How termination of employment will be determined by the employer;
- **Medicare Billing:** How collection of profits for all GP registrar billings will be established; and
- **Transitional Arrangements:** How the jurisdictional or national SEM would be created given the current regional SEMs.

User-Centred Design

GP registrars consulted around the design of a National or Jurisdictional Single Employer Model discussed the need for an operating model that considers:

- **"Host employers".** To provide the ability to access and amend leave balances, streamline approvals, and provide access to Medicare billing information.
- **GP registrars.** To give visibility of accurate leave balances, prompt payments, and the ability to request and cancel leave.
- **RACGP and ACRRM.** To ensure the model aligns with, and has no negative impact on, the training goals, policies and procedures.

Funding and Information Flows

Under a National or Jurisdictional Single Employer Model, there would be substantial change to current arrangements, by providing a single point of oversight and control.

Under this option, new **funding flows** exist between the SEM and the GP registrar.

New **information flows** exist between GP practises and Jurisdictions (at LHN) level and the Single Employer in relation to the secondment arrangement. There would be an information flow around billing from the service providers to the Commonwealth.

Service-based funding through the Medicare Benefits Schedule would be paid directly to the single employer and GP registrar.

Benefits

The SEM has a range of key policy benefits which differ slightly depending on whether a national or jurisdictional model is chosen. These include:

- **Provide national consistency and coverage.** The SEM will leverage the NTCER to further standardise the employment conditions of registrars. *National SEM will provide national consistency (jurisdictional model will not).*
- **Comparable leave entitlements.** This option allows for entitlements and rates of pay to be set to an equivalent level to hospital-based registrars.
- **Incentivise workforce areas of need and support mobility.** The secondment arrangement will enable greater workforce mobility. Through the single employer, additional salary payments into areas of need are expected to improve workforce mobility.

Risks

The SEM has a range of key policy risks which differ slightly depending on whether a national or jurisdictional model is chosen. These include:

- **Consideration of compliance mechanisms.** There are existing mechanisms in place to prevent mismanagement that would apply to the national single employer.
- **Secondment arrangement burden.** The responsibility of practices, jurisdictions and AMS/ACCHOs as host employers will be clearly defined. Minimising any local administrative burden in reporting Medicare billing will be important.
- **Salary escalation.** The national single employer will have to go through a bargaining process to set wages and entitlements which may result in wage escalation in some jurisdictions (to ensure that no GP registrar is worse off)

Unintended Consequences

Under this option, there are potential outcomes that may arise different to the initial purpose in mind. This includes:

- **Increased leave taking.** Through providing improved accrual and transfer of leave arrangements, it is expected leave taking will increase which may impact training terms, timing and practices.
- **Loss of GP practice and AMS/ACCHO discretion.** Local discretion on leave and employment arrangements may seen to be undermined under a SEM. This may impact on desirability to support supervision of GP registrars by GP practices and AMSs.
- **Medicare billing distribution assumptions.** The assumption that the SEM will receive Medicare billing profits may disincentivise practices from supervising GP registrars.

Stage 2: High level implementation plan

Figure 7.5 (part 1): Stage 2 Implementation Considerations

PREPARE
Timeframe: 12-18 Months

Obtain legal advice, prepare business case, seek high level endorsement to proceed.

SECURE (OR FINALISE) ENDORSEMENT AND APPROACH
Timeframe: 18 Months- 2 years

Seek government endorsement and continue planning regulatory and legislative changes and determine detailed transitional arrangements.

KEY ACTIONS

12-18 months

- Obtain legal advice in relation to the proposed design, including in relation to:
  - Legislative power and construct;
  - Secondment arrangement and enforceability including insurance and WHS arrangements;
  - Mutual recognition;
  - Medicare billing arrangements and exemptions as well as other financial and tax requirements;
  - Single Employer construct, including whether this is a Commonwealth entity, and its set-up and design.
- Undertake stakeholder engagement tour and written submissions to clarify/modify any features based on design concerns and challenges. This is expected in relation to:
  - Transition of existing regional SEM pilots;
  - Medicare billing arrangements;
  - Local discretion and transition of employment arrangements including from jurisdictions, GP practices and AMS/ ACCHOs;
  - National single employment entity (i.e Commonwealth);
  - Transitional arrangements, including from regional SEM trials;
  - Design features including proposed eligibility, leave coverage, and wider employment arrangements, using the NTCER as the basis;
  - Salary rate at which leave its to be paid given the different ways in which GP registrars can be paid.
- Seek high level endorsement for Stage 2 at GPTAC.
- Seek wider government support and endorsement of the reform and policy pathway.
- Monitor reform context for impacts on design, including evaluation of regional SEM pilots.

18 months – 2 years

- Modification of any of the detailed elements of design based on stakeholder feedback, legal advice, funding allocations and evaluation of the regional SEM trials.
- National entity set-up of single employer (depending on the selected model) including administration of the payments, system requirements and set-up, governance, staff resourcing requirements. This may involve recruitment of skeleton staff for planning and establishment.
- Determination of any transitional arrangements that require design, detailed legislative advice and stakeholder input including:
  - MOUs with local service providers, detailing areas of local discretion and secondment arrangements;
  - Transfer of information from RACGP and ACRRM regarding GP registrar cohorts, placement and attainment of Fellowship;
  - Transfer of employment arrangements from the current arrangements (jurisdictions, GP practices, AMSs/ ACCHOs, regional SEMs) to the national SEM;
  - Greenfields negotiation of a new enterprise agreement for GP registrars. Transitional arrangements including consideration of grandfathering, no disadvantage and abolition of NTCER.
- Determination of any transitional arrangements that need to be considered (including for GP registrars part-way through training).

Figure 7.5 (part 2): Stage 2 Implementation Considerations

IMPLEMENT
Timeframe: Years 3 to 4

Establishment of systems, staff, policies and processes, including testing of payments processes to establish payments. Communications to GP registrars and wider sector about the payments.

EMBED AND MONITOR
Timeframe: Ongoing

Embed in as business as usual, monitor impacts on GP training intake and parental leave, review program duration (dependant on Stage 2)

KEY ACTIONS

Year 3	*Year 4*	*Ongoing*
• Recruitment of staff for the Single Employer. This is expected to include but would not be limited to finance, human resources (including payroll) and technology. Establishment of new systems, processes, governance, and if applicable, legislative construct. • Modifications to systems and processes through Services Australia (including testing, go-live, and post systems implementation support). • Embed process changes for information flows, including from RACGP and ACRRM (e.g. for new GP registrars intake, for GP registrars who attain Fellowship, for placements). This will include privacy considerations. • Legislative or regulatory amendments. It is expected this will include changes to the Medicare billing revenue of GP registrars, and may also require other legislative and regulatory amendments. • Communication to GP registrars and wider GP sector about the transition to the Single Employer Model, including timing and transitional arrangements. • GP registrars transfer into SEM, with secondment arrangements taking effect while on training rotations.		• Regular review and evaluation of the employment arrangements, particularly the operation of the secondment model, including appropriateness of local discretion (e.g. on leave approvals), WHS and the interplay between the Colleges (ACRRM and RACGP). • Link with internal governance structures to ensure compliance issues are managed, as well as management of any unintended consequences. • Collect information on the impact of the Single Employer Model on the attractiveness of General Practice to medical registrars, and the utilisation of leave entitlements by GP registrars. Report on realised benefits.

Appendix A: Stakeholders Consulted

Stakeholders Consulted

Table A.1 lists the stakeholders consulted in relation to the Report through stakeholder workshops and individual consultation and interviews. This list expands on consultation already undertaken to inform the Stakeholder Insights Report.

Table A.1: Stakeholders Consulted

Name	Organisation
Adam Chapman	Victorian Department of Health
Ajitha Nair	Western Australia Department of Health
Allison Turnock	Tasmanian Department of Health
Andrew Lewis	Australian Medical Association
Andrew Stafford	ACT Department of Health
Ann Chipperfield	South Australian Department of Health
Anusha Philips	Western Australia Department of Health
Carla Taylor	General Practice Supervisors Australia
Chantal Stewart	Queensland Health
Daniel Halliday	Australian College of Rural and Remote Medicine
Daniel Wilson	Australian College of Rural and Remote Medicine
Danielle McMullen	Australian Medical Association
Danny Coombes	Northern Territory Government
Georgina van de Water	Royal Australian College of General Practitioners
Gerard O'Gorman	Queensland Health
Gerlinda Williamson	Northern Territory Government
James Brown	Royal Australian College of General Practitioners
James McNulty	Queensland Health
Jo-anne Chapman	General Practice Registrars Australia
Justine Harris	New South Wales Ministry of Health
Karen Stringer	Northern Territory Government
Karyn Matterson	General Practice Registrars Australia
Katrina Anderson	ACT Department of Health
Kristen Farrell	Australian Medical Association
Linda Macpherson	New South Wales Ministry of Health
Luke Martyr	Western Australia Department of Health
Megan Crawford	Queensland Health
Melanie Smith	South Australian Department of Health
Melissa Collins	New South Wales Ministry of Health
Miranda Grace	Australian Association of Practice Management
Patty Shih	Northern Territory Government
Paul Worley	Riverland Mallee Coorong Local Health Network
Peta Rutherford	Rural Doctors Association Australia
Rachel Howden	Western Australia Department of Health
Renea Desfontaines	ACT Department of Health
Russell Bancroft	Department of Premier and Cabinet (Victoria)
Simon Towler	Western Australia Department of Health
Stephany Saban	Australian Association of Practice Managers
Tess van Duren	Royal Australian College of General Practitioners
Tessa Pascoe	Department of Health and Aged Care
Tess van Duuren	Royal Australian College of General Practitioners
Thomas Duong	Western Australia Department of Health
Thomas Kennedy	New South Wales Ministry of Health
Tish Sivangnanan	Australian Medical Students Association
Tony Robins	Western Australia Department of Health
Trang Nguyen	Victorian Department of Health

Note: GP Registrars, Supervisors and Practice Managers have also been consulted in Workshops and these participants are not listed individually.