SENATE FOREIGN AFFAIRS, DEFENCE AND TRADE REFERENCES COMMITTEE

INQUIRY INTO RECRUITMENT & RETENTION OF DEFENCE PERSONNEL

SUBMISSION

Submission No: 68

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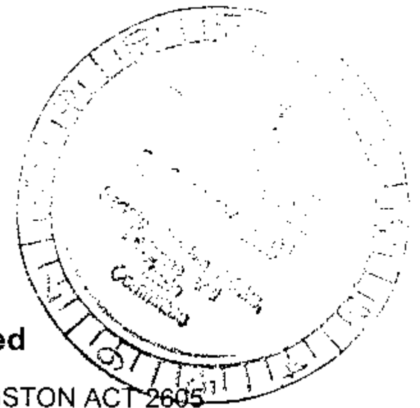

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The Secretary
Senate Foreign Affairs, Defence and Trade References Committee
Parliament House
CANBERRA ACT 2600

Inquiry into Recruitment and Retention of Defence Personnel

The AMA welcomes this Inquiry and the opportunity to lodge a submission on the recruitment and retention of Medical Officers, including those in the ADF Reserve.

In 1999 there was mounting evidence that the ADF could not attract sufficient doctors to meet its operational requirements. I refer, for example, to:

- the article in *The Bulletin* of 10 August 1999, quoting ADF documents on a critical shortage of qualified medical personnel for the Army and the need to start compensating Reserve specialists for time away from their busy practices if critical ADF needs were to be met;
- an article in *The Australian* of 5 August 1999, in which an ADF spokesman admitted a serious shortage of medical specialists and referred to ADF initiatives to indemnify practice income and improve base salary for Reservists.

The AMA, on behalf of its members and in support of adequate medical services for the ADF, has made representations to the ADF on these and other issues for some time. These issues affect the provision of medical support, which in turn has a significant impact on the ADF's capacity for operational deployments and the effectiveness of those deployments.

Issues

Since the time of the Gulf War in 1991, the AMA has been pressing the ADF to resolve identified problems in the recruitment, retention and deployment of Reserve medical specialists, particularly those in private practice. The AMA's representations have centred on three components in relation to Reserve Medical Officers:

- improved salaries for all military doctors through recognition of specialist skills and regard to market rates, not just rank;
- reimbursement of private practice costs for Reserve medical officers on ADF deployments;
- compensation and insurance arrangements to protect the families of Reserve doctors in private practice by guaranteeing their private levels of insurance for death, disability and income protection.

Another theme has been the need for ADF Medical Officers to have access to accredited training pathways to the award of a Fellowship by one of the medical Colleges.

Salaries

On the issue of salaries for ADF Medical Officers, it has been clear to the AMA that salaries must have regard to the remuneration of doctors in civilian life, meaning that salaries would have to be based to some extent on professional competencies and market rates, not just rank. This meant acceptance of the concept that a Captain may be paid more than a Major. The second clear point was that additional funding would be required to address this part of the problem.

The concept of a Specialist Officer Career Structure (SOCS) with a Specialist Officer Salary Structure (SOSS) was approved by the Joint Chiefs of Staff in April 1998. A firm undertaking was given to the AMA in December 1998 to implement a new medical officer career and salary structure via a Defence Force Remuneration Tribunal (DFRT) hearing scheduled for July 1999. In March 1999 the ADF gave an assurance in writing that the SOSS project was on track for the scheduled mid-year implementation. Yet late in 1999 the AMA was advised that no bid had been made for funding in the 1999/2000 ADF budget and there was no possibility of implementing the specialist salary structure before 2000/2001.

The DFRT hearing planned for July 1999 slipped back to August, then to September 1999 and then into limbo. Later advice was that the ADF may be ready to present a case to the DFRT in mid-2000. Still nothing has happened. The AMA understands that there have been two reasons for the lack of any outcome:

- directives that the outcome must be cost-neutral;
- rejection of the notion that an officer may be paid more than a higher rank.

Pay is not the only factor in the recruitment and retention of ADF Medical Officers, but it is an important one. Any improvement would flow through to Reservists, on whom the ADF relies heavily for operational deployments and who in many cases lose significant amounts of income when on ADF deployments. The ADF must come to grips with these two points before any progress can be expected.

Professional Development

A critical factor for the ADF in the recruitment and retention of Medical Officers is access to professional development, particularly the attainment of postgraduate medical qualifications which are required for unrestricted medical practice in civilian life.

The move towards formal postgraduate qualifications for unsupervised medical practice in Australia had been developing since the 1980s and affecting the career choices of young doctors. When the *Health Insurance Act 1973* was amended in 1996 to impose restrictions on access to Medicare provider numbers, completion of a College Fellowship in General Practice or one of the medical specialties became a necessity for doctors who wanted to undertake clinical practice outside a supervised work environment in the public hospital system. The ADF has made moves to enable some military medical practice to be recognised for general practice training, but on the whole has failed to come to grips with the need for access to postgraduate medical training pathways.

The answer appears to lie first in full recognition of the issue by the ADF, then in working much closer with the public hospital sector and medical Colleges to develop career structures with training pathways to the award of College Fellowships. It is recognised that the ADF has difficulty providing a full time clinical load for some disciplines and that there are military medical requirements which the civilian hospital system and Colleges do not have to grapple with, but the ADF must find a way to resolve this issue. Otherwise the ADF will

become a decreasingly attractive option for medical students and those full time military doctors who have completed their Return of Service Obligation after graduation and are considering their longer term career options in medicine.

Practice Costs for Reservists

The ADF relies to a large extent on Reservists to provide specialist medical services for deployments. Many of these Reserve specialists are in private practice.

The Practice Costs Study undertaken by PricewaterhouseCoopers as part of the Relative Value Study (commissioned by the federal Government into medical practitioners' remuneration) demonstrated that doctors in private practice incur very substantial practice costs, many of which are fixed and continue even when the doctor is not present e.g. during ADF deployments. For specialists, as distinct from General Practitioners, it is uncommon for locums to operate the private practice in the absence of the principal. Therefore a loss of business is likely to result from prolonged absences on ADF deployments. Any absence longer than two weeks falls into this category.

Having campaigned for years for recognition of private practice costs for Reserve medical specialists on ADF deployments, the AMA welcomed the new Civil Practice Support Allowance that was approved by the ADF on 16 September 1999 for Reserve medical officers deployed to East Timor and Bougainville. This was not a complete ADF response, but a very encouraging sign of recognition of the issue, plus the willingness and capacity to do something practical about it.

Initially there were differential rates set for GPs and different specialist disciplines, with complaints that the rates for some groups were too low. Also, the allowance was only payable for deployments to East Timor and Bougainville and then only for a minimum deployment of 4 weeks and a maximum total period of 8 weeks. The rate has now been standardised at $1,600 per week, which apparently represents 60% of average practice costs across a range of medical disciplines. The AMA is pleased to note that the minimum deployment is now 2 weeks and the 8 week maximum has been removed. There is still work required to get this right, but good progress has been made on a critical issue for Reserve medical specialists in private practice. This will have a positive effect on ADF efforts to recruit and retain suitably qualified Reserve specialists.

Insurance/Compensation

Compensation and insurance for Reserve medical officers is one area where the AMA's representations have been acknowledged, through the Review of the Military Compensation Scheme headed by Mr Noel Tanzer. His report acknowledged the problem and recommended that the ADF guarantee and fund the gap between military compensation payments and private insurance cover for death or incapacity on ADF deployments. Mr Tanzer's report was presented to the Minister Assisting the Minister for Defence in March 1999. Once again, no implementation has commenced.

Discussions with ADF officers indicated that some private insurance products had been organised through a broker. These cover death or loss of body parts while on ADF deployments, but have to be arranged and paid for by individual Reserve officers through nominated insurance companies. There is apparently no income protection insurance available under these arrangements, despite this often being the main concern. These ad hoc

insurance arrangements are unsatisfactory; they need to be formalised and expanded if they are to be a reasonable interim solution.

Much more important is implementation of the Tanzer report. This would address one of the factors which make it increasingly difficult for Reserve specialists in private practice to commit to further ADF deployments. Similarly, it affects the willingness of younger specialists with dependent families to join the Reserve.

Compulsory Service

The AMA has expressed to the Minister Assisting the Minister for Defence its concern about the legislation passed in 2000 enabling the call-out of Reserves for periods up to3 months in situations short of declared war. This occurred when the above issues affecting Reserve medical specialists' ability to deploy had not been resolved. The liability to lengthy call-ups added another disincentive to Reserve service by medical specialists in private practice.

General

The AMA has provided input over a number of years to various ADF projects relating to the career structure, professional development and salaries of ADF Medical Officers. There has been a frustrating lack of results and we can only conclude that the matter does not command a high priority in the ADF. This seems odd, given the structural difficulties with ADF Medical Officers and the well publicised problems in arranging medical support capability even for exercises in Australia, much less for longer term operational deployments outside Australia.

Recently the AMA has been consulted by officers of the Medical Officer Career and Remuneration Structure (MOCRS) Group. This group is preparing a comprehensive report on training, career structures, professional development and remuneration of ADF Medical Officers and, with AMA input, appears to be addressing a number of the key issues in recruitment and retention of full time military doctors as well as Reservists. The AMA's concern is that this exercise, like others before it, will be consigned to the dustbin when the ADF decides that the issue is too hard, costs money or simply is not a high enough priority to warrant pressing forward with implementation.

The AMA believes that the issue of recruitment and retention of ADF Medical Officers *is* important, the problems have been identified, the solutions can be found and they can be implemented. It is a question of will.

The AMA would be pleased to appear before your committee to elaborate on our submission.

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