Defence Force Remuneration Tribunal

DECISION

Defence Act 1903
s.58H—Functions and powers of Tribunal

AUSTRALIAN DEFENCE FORCE: TRI-SERVICE MEDICAL OFFICERS
(Matter 17 of 2020)

MS I. ASBURY, PRESIDENT

MR A. MORRIS, MEMBER

CANBERRA, 7 APRIL 2021

MAJGEN G. FOGARTY AO RETD, MEMBER

[1] This decision arises from a listing application[1] made by the Australian Defence Force (ADF) for a determination to be made under Section 58H of the *Defence Act 1903* (the Act) to modify the training prerequisites for medical level advancements; set remuneration increases for medical levels experiencing workforce 'hollowness'; and to develop career and professional pathways that align with the ADF's clinical capability requirements.

[2] This matter was considered in hearing on 4 March 2021 when Mr J. Phillips SC appeared for the ADF and Mr P. Hoang for the Commonwealth. Rear Admiral S. Sharkey AM RAN, Commander Joint Health and Surgeon General ADF, appeared as a witness for the ADF.

Background

[3] The ADF Medical Officers Specialist Officer Structure was last considered by this Tribunal in Matter 3 of 2010 when a career structure was established for ADF medical officers based on undergraduate qualifications, internship and residency, and four levels of competency for Permanent Force medical officers (with a fifth for Reserve medical procedural specialists).[2]

Submissions

ADF

[4] The ADF submits that it principally intends to address the current recruitment, retention and remuneration challenges of the workforce by establishing a "*Human Resource (HR) Management strategy so that the ADF can develop and implement a long-term sustainable medical officer workforce that delivers both general and specialist medical support that meets the ADF's capability needs*".[3]

[5] In implementing this approach the ADF proposes to address four broad elements of the workforce: an improved multi-pathway career structure; improved mentoring; improved clinical and professional development; and targeted remuneration.

[6] Specifically, and with a remuneration focus, the ADF intends to:

a. change the terminology from Medical Level (ML) to Military Medical Level (MML) to remove the confusion around the meaning and requirements to the term "medical level" in the civilian medical sector and provide a distinction between them;

b. introduce a senior resident increment rate and include both residency increments into ML1;

c. roll an amount of the medical officers professional development financial support scheme of up to a maximum of $10 000 *per annum* (provided under s.58B of the Act) into the rates of salary for MML1-4 to MML4;

d. increase the medical officers professional development financial support scheme (under s,58B of the Act) by an additional $10 000 *per annum* for medical procedural specialists, and roll the full $20 000 into the rates of salary for military medicine trauma specialists;

e. remove the last three increments in ML2 to establish an MML2B career pathway with two salary increments;

f. introduce a MML3(A) career pathway with four increments;

g. increase the remuneration for MML3/3(A) increments (approximately $60 000 which includes the medical officers professional development financial support scheme);

h. remove the last ML4 increment with an increase in the remuneration for the remaining MML4 increments (approximately $45 000 to $50 000, which includes an amount for the medical officers professional development financial support scheme); and

i. remove medical levels from the Star Rank medical officers remuneration and replacement with two salary increments for each rank, with an increase in remuneration (approximately $38 000 to $67 000 which again includes the medical officers

professional development financial support scheme and to which they were previously entitled as an ML3 and ML4).

[7] The non-remunerative elements proposed are:

a. the establishment of clear professional pathways that align with the ADF's clinical capability requirements, and balance the needs of the organisation and individual aspirations;

b. improved sustainability by targeted remuneration/professional development opportunities (that develop ADF specific capability needs) at career decision points;

c. creation of retention conditions to increase the tenure of ADF medical officers within the garrison environment,[4] which should reduce the number of contracted doctors used to supplement ADF medical officer positions (with consequential savings attached);

d. increased capability and quality of care to ADF members by increasing numbers at critical capability levels of deployable medical officers who do not require supervision, and increasing experience levels prior to the commencement of clinical service with the ADF;

e. increased footprint of military medical officers which will strengthen the linkage between the ADF medical system and the command chain; and

f. the recognition that the three Services provide specialist clinical capability specific to each Service, specific to capability and to common clinical capabilities.[5]

Commonwealth

[8] The Commonwealth submission supports the intent of the ADF's proposal and all of the non-remunerative measures and agrees "*an increase in salary should form part of the approach to address the current shortfalls*". However, the Commonwealth *"does not believe the significant quantum has been appropriately justified".*[6]

[9] The concerns of the Commonwealth are summarised as being:

a. supportive of the targeted salary increases at MML3, 3A and MML4, but not at the MML1 2A and 2B levels;

b. the significantly large salary increases proposed have not been appropriately justified and non-monetary reforms will likely have a larger impact;

c. the effect of significant salary increases for medical officers on other specialist workforces;

d. the timing of the increase in the context of the Military Salary and Workplace Remuneration Arrangement operating two weeks after the proposed implementation date;

e. a perceived lack of alternate options to salary increases such a retention incentive bonus;

f. the temporary incursion into Star Ranks salary due to the pause in senior executive salary increases instigated by the Government in response to COVID-19; and

g. accountability for improvement.[7]

Evidence

[10] Evidence was presented in written affidavits by four medical officers spanning the three Services who provided evidence specific to each Service and to their specific roles. They were:

a. Rear Admiral S. Sharkey (RADM) AM CSC RAN, Commander Joint Health and Surgeon General ADF;[8]

b. Group Captain (GPCAPT) G Hampson, Regional Senior Aviation Medical Officer, RAAF Institute of Aviation Medicine, RAAF Base Amberley;[9]

c. Commander (CMDR) C Ryan RAN, Staff Officer 1 Military Medicine;[10] and

d. Captain (CAPT) P Zimmerman, Medical Officer, 8 Close Health Company. 1st Close Health Battalion, Robertson Barracks.[11]

Of these four, RADM Sharkey also appeared as a witness in the hearing. Their evidence is summarised below.

[11] RADM S Sharkey AM CSC RAN. RADM Sharkey stated that "*the ADF has not done a great job of making it obvious to junior medical officers as to what their career pathway might look like. It's a little bit of 'design your own future' rather than a member being given a mapped out, formalised, tangible vision of their medical career that includes a range of jobs/positions and career projection*". This was coupled with her evidence that "*the ADF has not been good at mentoring (in general) and regularly staying in contact with undergraduate medical students, interns and residents. As a result an ADF trainee is getting the bulk of their support, advice, guidance and views from their civilian peers in their cohort*". [12]

[12] We accept her evidence that "*the intent is to re-establish strong mentoring and coaching programmes from undergraduate service through to various stages of their respective careers. We have established webinar programmes for undergraduates/residents as well as introducing regional mentoring networks*".[13]

[13] In part, RADM Sharkey addressed recruiting and recruitment marketing which is primarily focussed on experiences that do not reflect the medical officers' career causing dissatisfaction and leading them to leave the ADF after their Return of Service Obligation (ROSO). To remediate this she highlighted a targeted open media campaign commencing in May 2021 which will be "*capitalising on professional body networks/communications including podcasts and professional forums"* and which will ensure that *"messaging better reflects what the ADF can realistically offer*". [14]

[14] **GPCAPT G Hampson.** We accept the evidence of GPCAPT Hampson that "*Air Force continues to experience difficulty in filling all of its aviation medical officer positions which has a flow-on effect across the aviation community*"[15] resulting in the "*potential for compromise in aircrew fitness for aviation duty, health (short and long term) and organisational risk with regards to human performance and safety in ADF aviation operations*".[16]

[15] GPCAPT Hampson also detailed requirements whereby "*aircrew capability (command and individual) require specialised care, clinical governance, system integration support and responsive, flexible subject matter expert aviation medicine support (with appropriate security clearances)*" which is "*not available in the civilian sector and not available from the basic aviation medical officer workforce*".[17]

[16] In conclusion GPAPT Hampson said that "*the expectation is that the aims will support the ADF in its efforts to force generate a self-sustaining aviation medicine workforce that have desirable career pathways available to junior aviation medical officers as they progress through their medical officer career*".[18]

[17] **CMDR C Ryan RAN.** CMDR Ryan gave evidence in part specific to her qualifications in diving and underwater medicine and the time taken to achieve those specialisations above general practice noting "*these critical skill sets are required for the ADF to meet capability requirements and as such medical officers need an incentive to undertake such training and consolidate those skills to develop deep expertise*".[19] She also highlighted the skills that ADF medical officers attain such as *"the ability to think strategically, make decisions with limited information and limited evidence, develop plans quickly, implement plans rapidly and to develop the workforce to satisfy the capability need*" and which are "*not generally a skill set that is developed in or available from doctors in the public sector*". CMDR Ryan also confirmed the attraction of these skills to external workforces when, at the completion of a secondment to the Department of Health in support of COVID-19, she had received six job offers.[20]

[18] We accept CMDR Ryan's evidence that "*this pay proposition is trying to provide a multi-pathway career continuum from which medical officers and their advisors can formulate a clear, defined career pathway from residency right through to the end of their clinical career. With this a medical officer can see how they can develop, grow, continue to learn, and continue to contribute to capability*".[21]

[19] **CAPT P Zimmermann.** CAPT Zimmermann highlighted the impact of the retention issue at the MML3 level stating that "*Army has been unable to 'force generate' rural generalists to meet the capability demand. There are only two MML3 medical officers in the Permanent Army who may be considered Rural Generalist doctors. No Army medical officer has achieved this without previous experience (prior to joining the ADF) or taking extended periods of leave (i.e greater than 12 months)".*[22]

[20] CAPT Zimmermann confirmed that "*these changes proposed in the ADF submission will have a positive impact on both force generation and retention of MML3 medical officers*". His evidence also states that "*the proposed remuneration improves the parity with our civilian counterparts*".[23]

Consideration

[21] Within the context of this matter we note the submissions in relation to the ADF garrison health contract which offers "*an integrated workforce of public servants and contracted health care providers working alongside uniformed strength to prepare, in a health sense the medical fitness of our forces for training and for deployment and has the ability surge and fluctuate in terms of the workforce size and capacity*". We accept that this contract provides a "*public service workforce that is more consistent and a surging workforce of contractors and supported also by uniformed clinicians, that is a sort of deliberately designed model*".[24] The contract requirements are outside our jurisdiction and we do not comment other than to note their relevance to this matter.

[22] Throughout our deliberations, and in the context of the garrison health environment, we were cognisant that the ADF has, for some time, been unable to retain medical officers in the numbers necessary to meet its uniformed capability requirements. We accept that all three Services are experiencing shortfalls in the number of medical officers who remain once they have passed their ROSO date - and agree that the most critical medical officer workforce shortfall is at the MML3 level.[25]

[23] We note the evidence of RADM Sharkey that MML3 officers "*happen to be the core group responsible for delivery of ADF health services*", that they are the cohort "*crucial to the success of capability delivery"* who are *"clinically competent, skilled and qualified,* and that "*the time they have spent in uniform to get to MML3 equips them with a level of understanding of the military environment that is invaluable*".[26] Additionally we considered her evidence that "*they are key personnel in terms of mentoring and leadership to the more junior medical officers that are coming through. They are also key at providing trusted, comprehensive advice to commanders as it relates to the inherent health risk of the forces that commanders command, and so they provide really an essential and critical contribution to the risk management framework inherent in our health system and how we support commanders in managing risks of deployed forces*".[27]

[24] We also considered the issues raised by the Commonwealth which are summarised in the following paragraphs.

[25] With regard to the implications of Return of Service Obligation (ROSO) we note the evidence of CMDR Ryan that *"when a medical officer has fulfilled their ROSO they happen to also be at the point at which they become qualified, or are about to be qualified, as a general practitioner. When those two events coincide, employment opportunities in the civilian medical sector become available and this becomes a defined position point at which individuals might make a decision to leave. The lure of a work-life balance, stability of location and financial returns often draws medical officers from service in the Navy at this point".[28]* We considered the option of simply forcing extended ROSO provisions and concluded, based on the evidence before us, that while it would lengthen the period of service it is likely to become a disincentive and simply defers career decision points and therefore is unlikely to resolve the retention issues.

[26] We considered the flow-on effects to other specialist workforces raised by the Commonwealth and accept the evidence of RADM Sharkey that "*medical officers are a far and greater risky category than any of our other health primary qualifications like dentistry or nurses*" and accept that the same tensions do not occur in those workforces.[29]

[27] We evaluated the option of substitute solutions such as targeted bonus payments or a form of retention bonus. We note the Commonwealth reference to other similar bonuses which we have previously introduced on the premise that they would extend the length of service for a specific cohort.[30] In this matter we accept the evidence that it "*does not remediate the ever-increasing gap between the salary for ADF members and their civilian counterparts*" and would not address the structural and workforce HR issues included in this proposal.[31]

[28] In regards to the proposed quanta of the remuneration proposed we were conscious that while the Commonwealth had not agreed with the submitted methodology to reach the amounts proposed, it had chosen not to provide alternative research nor quanta. In the hearing RADM Sharkey gave evidence that the amount had been identified as being "*the appropriate amount to bring changes*" and that "*the team did quite a significant body of work in benchmarking and engaging with stakeholders in regards to the range of factors that were impending our ability to recruit and retain our medical officers*". We accept that "*the $50 000 does not seek to match the gap between the serving ADF salaries and civilian counterparts in the Australian Public Service (APS) or in the contracted workforce but what it does seek to do is significantly neutralise or lessen the degree to which those medical officers would make a choice based on the remuneration choices that they had at that time*".[32] We sought further feedback in the hearing as to the research undertaken by the ADF and quanta proposed. In reply, the Commonwealth queried the lack of analytical data provided in the ADF submission but did not seek to provide further evidence or research in support of a lesser amount.[33]

[29] In relation to the impact of the ADF Workplace Remuneration Arrangement (WRA) 2020-2023,[34] we note the concerns of the Commonwealth that the WRA 2 per cent salary and allowance increase due to take effect on 13 May 2021 will have further financial impact as will the amendments to Military Salary structure which commence on the same date.[35] We consider the timing is coincidental and that had the matter been considered at any earlier date the increase would still have been applied. We note the present embargo placed on Senior Executive/Star Ranks salary increases by Government and the Secretary of Defence and the Chief of Defence Force during COVID-19 restrictions. We acknowledge that increases provided in this submission and in the WRA will mean that some O6 medical officers' salaries will be higher than those of O7 medical officers. While this is undesirable we are confident that it will be temporary.

Conclusion

[30] In conclusion we accept that the existing salary structure has not kept pace with contemporary issues and market forces. We agree with RADM Sharkey that this submission is "*but one component of a package of medical officer workforce reforms being actioned by the ADF to address the challenges*". We consider this presents a core difference since the application of Matter 3 of 2010 and agree this proposal offers a "*holistic package of targeted remuneration, professionalism and enhanced workforce engagement/career management*".[36]

[31] We accept that the ADF is essentially aiming to extend the average length of service for medical officers by approximately two years to provide critical mass at MML3. We accept that the MML3 cohort is at a decisive career point which, at the same time, provides the ADF with a critical capability enabler. We agree that modifications to the structure should specifically target this cohort and must focus on remuneration coupled with career opportunities to incentivise their retention past ROSO.

[32] We concur with the concerns raised by the Commonwealth in regard to previous attempts to address workforce issues with medical officers. For example, we accept that "*following Matter 3 of 2010 there was slight improvement in retention; however, this was short lived as the remuneration within the public/private sectors increased following the ADF's increases,*[37] *restoring the previous salary gap that was being remediated*".[38] We gave consideration to the risk of reoccurrence of this issue and accept that "*this proposition is but one component of a whole package of reforms that are focused on fundamentally remediating medical officer retention, establishing a joint workforce sponsorship and centralising the governance and management of a sustainable medical officer workforce*".[39]

[33] We note the non-financial remediation items that are being implemented alongside the remuneration increases and accept that these should allow the ADF to sustain clear professional pathways that align with capability requirements and will balance the needs of the ADF with individual choices and aspirations.[40] We agree that "*the proposition introduces financial recognition for obtaining education and expertise in specific military medicine fields, such diving, submarine and aviation medicine, by remunerating medical officers with specific qualifications at a higher pay point*".[41]

[34] We agree that in order to have a robust workforce, a flexible career pathway with improved remuneration is required. We consider that this, coupled with the changes to the career management structure and training and the HR components is more likely than not to improve the situation. In this regard, we note the creation of a "*deliberate framework and mechanisms through which we have embedded a more permanent structure*" with "*a requirement for newly recruited medical students and junior medical officers to maintain a more formal relationship with mentors and with serving officers through the conduct of programs, webinars, programmed workshops and meetings so that it is a far more structured arrangement with governance processes over that, centrally managed from Joint Health Command, working closely with our single Service personnel*".[42]

[35] We agree that the disestablishment of some increments will require the application of non-reduction provisions and that these will be for a specified period. We ask the ADF to return to us on the progress of those provisions in the annual review of this matter due in 2023. Additionally in hearing we sought feedback from the ADF on any data and attrition rates that will be relevant to this matter and ask that those outcomes be provided to us annually each March for a period of three years.

[36] In summary, we agree that the proposed HR strategy, supported by a targeted remuneration structure and combined with whole of career progression points is expected to resolve most, if not all, of the workforce challenges presently facing the ADF medical officer workforce.

[37] Determination 3 of 2021 will give effect to this decision from 29 April 2021.

MS I. ASBURY, PRESIDENT
MR A. MORRIS, MEMBER
MAJGEN G. FOGARTY AO RETD, MEMBER

Appearances:

Mr J Phillips SC assisted by Mr P Blady for the ADF.

Mr P Hoang assisted by Ms E. Beresford-Jones for the Commonwealth.

Witness:

Rear Admiral S Sharkey AM CSC RAN Commander Joint Health and Surgeon General ADF.

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[1] DMR/OUT/202/35 *Listing Application – ADF Tri-Service Medical Officers* dated 30 October 2020.
[2] https://dfrt.govcms.gov.au/sites/default/files/Medical-Officer-Reason-for-Decision-16-Aug-2010.pdf
[3] ADF Submission *ADF Medical Officers Matter 17 of 2020* undated (ADF1) 1 page 1 paragraph 1.4.
[4] The garrison environment is an ADF base on which units, squadrons, battalions and the like are stationed. The garrison environment will often have ancillary facilities such as messes, gyms, dental and medical facilities.
[5] ADF1 pages 2 and 3 paragraphs 1.7 and 1.9.
[6] Commonwealth Submission Matter 17 of 2020 ADF Medical Officers dated 22 February 2021 (CWLTH1) page 8 paragraphs 35 to 37.
[7] CWLTH1 pages 8 to 10 paragraphs 36 to 52.
[8] Affidavit of RADM S E Sharkey AM CSC RAN dated March 2021 (ADF 6).
[9] Affidavit of Group Captain G V Hampson dated 1 March 2021 (ADF5).
[10] Affidavit of Commander C Ryan dated 02 March 2021 (ADF 3)
[11] Affidavit of Captain P K Zimmermann dated 1 March 2021 (ADF 4)
[12] ADF6 page 4 paragraphs 24 and 25.
[13] ADF6 page 5 paragraph 26.
[14] ADF6 page 5 paragraphs 27 and 28.
[15] ADF5 page 3 paragraphs 13 to 15.
[16] ADF5 page 4 paragraph 16.
[17] ADF5 page 12 paragraph 41.
[18] ADF5 page 13 paragraph 44.
[19] ADF3 page 10 paragraph 32.
[20] ADF3 page 7 paragraphs 21 and 22.
[21] ADF3 page 10 paragraph 33.
[22] ADF4 page 4 paragraph 16.
[23] ADF4 page 13 paragraphs 48 and 49.
[24] Transcript 4 March 2021 page 7 lines 32 to 34.
[25] ADF1 page 20 paragraph 4.8.
[26] ADF6 page 11 paragraphs 57 and 58.

[27] Transcript page 8 lines 33 to 39.
[28] ADF3 page 4 paragraph 12.
[29] Transcript page 15 lines 9 to 20.
[30] CWLTH1 page 9 paragraph 44
[31] Transcript pages 10 and 11 lines 44 to 62.
[32] Transcript page 10 lines 5 to 19.
[33] Transcript pages 29 to 30 lines 25 to 27.
[34] https://www.dfrt.gov.au/matters/adf-workplace-remuneration-arrangement-2020-2023
[35] https://www.dfrt.gov.au/matters/adf-allowances-modernisation-tranche-1
[36] ADF6 page 8 paragraph 41.
[37] ADF1 page 7 paragraph 2.9(b) *"the structure has only increased with annual Workplace Remuneration Arrangement increases of 2 per cent and the gap in market salaries has increased from 2013 to 2018 by 6.5 percent p.a".*
[38] ADF1 page 6 paragraph 2.8.
[39] ADF6 page 18 paragraph 89.
[40] ADF1 page 3 paragraph 1.9.
[41] ADF3 page 10 paragraph 34.
[42] Transcript page 14 lines 1 to 9.