Australian Medical Association (WA)

Inquiry into Wage Theft In Western Australia

The Australian Medical Association (Western Australia)

The Australian Medical Association (WA) is the largest independent professional organisation for medical practitioners and medical students in Western Australia.

The AMA (WA) has industrial representative powers before the Western Australian Industrial Relations Commission (**WAIRC**) under Section 72B of the *Industrial Relations Act 1979 (WA)* (IR Act) and has enterprise industrial agreements pursuant to section 41 of the IR Act, which govern the terms and conditions of employment of both Senior Doctors and Doctors in Training operating in WA's public health system.

The AMA (WA) represents doctors across WA and works to promote and protect the professional interests of the medical profession and the health care needs of patients and communities in Western Australia.

This submission relates to the experience of medical practitioners employed in the [redacted]

The Agreement is a registered industrial agreement, pursuant to the IR Act, negotiated by the AMA (WA) extending and binding all medical practitioners employed [redacted] There are approximately 5,225 employees covered by the Agreement. These employees are divided into two categories, Doctors in Training and Senior Practitioners. There are a number of general provisions in the Agreement that apply to both cohorts, in addition to provisions that apply exclusively to each.

As a general comment relating to the medical profession:

- The public health system operates 24 hours a day, all year. Doctors can reasonably expect to be rostered any time over a 24 hour period. Accordingly, shift penalties may be applicable depending on the hour of the day worked.
- Doctors in Training are regularly required to work hours beyond their contracted hours. Accordingly, overtime provisions exist and penalties for overtime are applicable.
- There are prescriptive rostering provisions for Doctors in Training, recognising that clinical expectations, their role as shift workers and their training requirements, places a significant burden on them.
- The medical profession is hierarchical. Clinical responsibility and accountability depends on a combination of years of experience and post graduate qualifications.

- Health Service Providers established pursuant to section 32(1)(b) of *the Health Services Act 2016 (WA)* have a legally prescribed role in teaching and training.[1]
- The medical profession is a regulated profession that requires practitioners to engage in continual professional development and accreditation.
- Medical practitioners are primarily responsible for the health, wellbeing and lives of patients in WA's public health system.

1. Whether there is evidence of wage theft occurring in Western Australia, and the various forms wage theft may take.

AMA (WA) can only comment on evidence of wage theft occurring in Western Australia as it relates to medical practitioners. AMA (WA) asserts that wage theft amongst medical practitioners [redacted]

Given the complexity of industrial entitlements that apply to medical practitioners, wage theft manifests in multiple ways.

Doctors in Training and Unrostered Overtime

DiTs are regularly required to work additional hours beyond their contracted hours. A 2019 AMA (WA) survey[2] identified 61% of DiTs employed by [redacted] had worked 81 hours or more in the previous fortnight. The Agreement has express provisions that relate to rosters, overtime and **unrostered overtime**, those are:

- Clause 15(1) - A full time DiT's ordinary hours of duty shall be an average of 40 hours per week.
- Clause 16(1) - Rosters must take account of all clinical and non-clinical duties regularly required to be worked.
- Clause 17(2) - Paid hours in any two week pay cycle in excess of 80 hours shall be paid at the rate of 150% of the practitioner's base ordinary rate of pay.
- Clause 17(3) - Paid hours in any two week pay cycle in excess of 120 hours shall be paid at the rate of 200% of the practitioner's base ordinary rate of pay.
- Clause 17(1) - Un-rostered overtime shall be authorised and authorisation shall not be unreasonably refused.

Accordingly, rosters can account for hours that extend beyond 80 hours in a two week pay period, these hours attract overtime penalties. Further, there are specific Agreement provisions negotiated to facilitate authorisation and payment for **unrostered overtime**. An estimated 89% of DiTs are regularly required to work **unrostered overtime**[3] and collectively DiTs report working between one hour and 25 hours of **unrostered overtime** per fortnight. The amount of **unrostered overtime** required to be worked will depend on a number of variables, including a DiT's area of clinical practice.

Based on data collected over a number of AMA (WA) surveys, it is estimated on average a DiT employed by a [redacted] is typically required to work between 7 and 10 hours of **unrostered overtime** per fortnight. This should be authorised and paid according to the provisions of

[1] The Health Services Act 2016 (WA), section 34
[2] Australian Medical Association (WA), *"WA Hospital Health Check Survey 2019"*, Results at: 03/04/2019
[3] Australian Medical Association (WA), *"2019 Industrial Agreement Survey (Doctors in Training)"*, August 2018, *n*=326

the Agreement. However, survey[4] data indicates that only 7% of DiTs 'always' claim payment for **unrostered overtime.**

AMA (WA) believes that these unpaid hours qualify as wage theft. Survey data shows that while only 3% of survey respondents were unware that claiming **unrostered overtime** was possible, 57% point to workplace cultural expectations as the reason they do not claim **unrostered overtime**. Survey data indicates that approximately 18,480 hours of unpaid **unrostered overtime** are worked by DiTs employed by [redacted], per fortnight. This is equivalent to 231 full time employee positions, per annum.

The issue was identified in the 2017 *Review of the morale and engagement of clinical staff at Princess Margaret Hospital,*[5] which found that a consistent approach to management of overtime should be implemented immediately and that all legitimate claims should be paid. However, AMA (WA) members continue to cite unpaid unrostered overtime as a contentious issue. AMA (WA) asserts that WA Health System Employers continue to wilfully ignore the practice of unrostered overtime not being claimed, or in some cases actively discourage DiTs from claiming payment for **unrostered overtime.**

AMA (WA) believes that [redacted] should actively encourage DiTs to claim all **unrostered overtime**, not just as part of their legal obligation to keep employment records, but:

- in recognition of DiTs industrial entitlement to be paid for these unrostered hours;
- to protect the occupational safety, health and wellbeing of their employees, as unclaimed hours worked are not recorded by the Employer; and
- to ensure appropriate staffing levels.

Doctors in Training and Commencement of Duty

DiT rosters must take account of all clinical and non-clinical duties regularly required to be worked, however, AMA (WA) is aware that many DiTs are instructed to commence work prior to their officially rostered start time.

AMA (WA) survey data[6] indicates that DiTs are regularly directed to commence work prior to their rostered start time. Survey data shows that over 21% of DiT survey respondents were 'always' expected to commence work prior to their rostered start time and of those, 87% were required to start at least 30 minutes prior to their rostered start time. Quantifying and extrapolating the impact of this practice on the entire WA health system is difficult, as the number of rostered shifts per week, worked by DiTs will vary significantly.

AMA (WA) notes that these hours are not recorded by the Employer, DiTs are not remunerated for these additional hours and they are not paid any applicable overtime, shift or roster breach penalties that may apply to the hours worked.

The requirement to work unpaid hours prior to the official commencement of rostered duty is premediated and comes at the express direction of [redacted] Consequently, it is wage theft. AMA (WA) maintains that if DiTs are required to commence work at a given time, then the roster must reflect this and the hours must be paid.

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[4] *Ibid.*

[5] WA Health - Child and Adolescent Health Service, *"Review of the morale and engagement of clinical staff at Princess Margaret Hospital (PMH)",* May 2017

[6] Australian Medical Association (WA), *"WA Hospital Health Check Survey 2019"*, Results at: 03/04/2019

Doctors in Training and Roster Breach Penalty

DiTs rosters should provide for at least an 8 hour break between periods of rostered duty. In the event that a DiT is required to resume rostered duty before having eight consecutive hours free from all duty (including call back requiring attendance at the workplace), the subsequent hours worked shall attract a 50% loading.[7]

Given that the roster breach penalty is prescribed by the Agreement, AMA (WA) considers any failure to pay the 50% roster breach penalty as wage theft. Since 2016, AMA (WA) has assisted members in recovering over $1.6 million in unpaid wages as a result of [redacted] failing to pay the 50% roster breach penalty.

Despite AMA (WA) raising individual claims for unpaid penalties, which in turn should create an understanding that the penalty has been withheld in some instances and remedial action, a 2018 AMA (WA) survey found that of those DiTs who do not have an 8 hour break prior to commencing rostered duty, 32% continue to never receive the prescribed penalty. In this regard, AMA (WA) questions [redacted] commitment to pay DiTs in accordance with the Agreement.

Misclassification of Doctors

The Agreement prescribes over 15 classifications for medical practitioners and practitioners are paid the relevant annual salary in Schedule 1 or 3 of the Agreement. The Agreement has express definitions which define which classification a practitioner should be appointed to. Remuneration for each classification varies, as each classification represents as distinct level of clinical accountability, qualification and required skillset.

AMA (WA) considers the misclassification of medical practitioners as wage theft, as AMA (WA) believes that such misclassification occurs to expressly avoid paying practitioners a higher salary rate.

Remuneration that is not reflected in the Agreement

AMA (WA) has identified WA Health System Employers advertising positions for medical practitioners with remuneration packages that are not reflective of their legal entitlements under the Agreement.

By way of example, Position Number [redacted] advertises a position that can only be filled by a DiT with experience that is commensurate with Registrar Year 3 classification. Registrar Year 3 classification has a salary of $123,800 per annum. Not only does the advertised position's remuneration of $80,000 per annum represent a significant reduction in the prescribed salary of a Registrar Year 3, the remuneration offered does not correspond with any position or classification outlined in the Agreement. It is an aberration which AMA (WA) believes may an attempt to exploit the training requirements of a small number of DiTs who require selective experience to progress in their career.

Where the AMA (WA) has identified erroneous position advertisements and notified the relevant authority, advertisements have been amended. However, AMA (WA) is unaware if appointments have made been made contrary to the terms of the Agreement as a result of other erroneous advertisements.

Again, AMA (WA) questions the need for a representative organisation to advocate on such issues to ensure compliance with a registered industrial agreement.

[7] WA Health System – Medical Practitioner – AMA Industrial Agreement 2016, Clause 15(4)(a) & 15(4)(b)

Specialists and Non-Specialists

Senior Practitioners practice without clinical supervision. The majority are Senior Practitioners by virtue of their training and recognised specialist qualifications (and specialist registration with the Medical Board of Australia), however, a number are non-specialist qualified and are appointed on the basis of their experience and skills. Specialist qualified Senior Practitioners command higher remuneration in recognition of their accredited knowledge and skills in a specialist area recognised by the Australian Medical Council. AMA (WA) has identified a number of job adverts that advertise positions as non-specialist positions, yet require specialist qualifications. AMA (WA) asserts that [redacted] are seeking to employ a specialist qualified Senior Practitioner at non-specialist rates, despite the Agreement prescribing specialist classification and remuneration for specialist qualified practitioners.

Recent examples include:

[redacted] *– Senior Medical Practitioner (Attachment 3)*

[redacted] *– Senior Medical Practitioner – Emergency Medicine (Attachment 4)*

- The Agreement defines a Senior Medical Practitioner[8] as a medical practitioner who does not have a recognised specialist qualification.
- The 'Essential' Selection Criteria lists Fellowship of the Royal Australian College of General Practitioners or Fellow of the Australian College of Rural and Remote Medicine, or equivalent postgraduate experience. Both RACGP and ACRRM are AMC recognised specialist qualifications.
- Wage theft equivalent to at least $27,880 per annum, per FTE.

[redacted] *– District Medical Officer – Non Procedural –* [redacted]

- The Agreement defines a District Medical Officer[9] as a medical practitioner that does not have a recognised specialist qualification.
- The 'Essential' Selection Criteria lists Fellowship of the Royal Australian College of General Practitioners or Fellow of the Australian College of Rural and Remote Medicine, or equivalent postgraduate experience. Both RACGP and ACRRM are AMC recognised specialist qualifications.
- Wage theft equivalent to at least $52,552 per annum, per FTE.

[redacted] *District Medical Officer – Procedural – Anaesthetics (Attachment 5)*

- The Agreement defines a District Medical Officer[10] as a medical practitioner that does not have a recognised specialist qualification.
- The 'Essential' Selection Criteria lists Fellowship of the Royal Australian College of General Practitioners or Fellow of the Australian College of Rural and Remote Medicine, or equivalent postgraduate experience. Both RACGP and ACRRM are AMC recognised specialist qualifications.
- Wage theft equivalent to at least $19,477 per annum, per FTE.

AMA (WA) has raised these misclassifications with the relevant [redacted] Employers.

[8] *Ibid.,* Clause 8
[9] *Ibid.,* Sched. 3, Clause 2(4)
[10] *Ibid.,* Sched. 3, Clause 2(4)

Call Back not requiring attendance at the workplace

The Agreement prescribes payment for a call back not requiring attendance at the workplace, provided that certain requirements are met. Clause 33(3) of the Agreement states:

"*A practitioner who is rostered by the Employer-*

(i) *On call for call back requiring attendance at the workplace at one or more metropolitan public hospitals; and*

(ii) *simultaneously rostered on call for tele-medicine / tele-consultation for multiple metropolitan public hospitals and for multiple WA Country Health Service public hospitals; and*

(iii) *who is recalled to duty and undertakes all the required work without going to the workplace shall be paid for a minimum of one hours work at the ordinary base hourly rate…"*

The rationale for introducing a payment regime is that being on call for multiple sites places a significantly higher onus on the practitioner in terms of the volume of calls they are required to field and their clinical responsibility for more patients.

AMA (WA) believes that [redacted] engage in wage theft by expecting practitioners who are only formally rostered on call at one site, to take calls from multiple metropolitan hospitals and multiple WACHS sites. Practitioners are therefore held to be readily contactable by multiple sites to provide tele health advice and assistance over the phone, but as they are not formally rostered in accordance with clause 33(3), [redacted] avoid payment obligations under the Agreement. This wage theft is equivalent to a minimum $89 per hour for a Consultant Year 1.

2. What are the reasons wage theft is occurring, including whether it has become the business model for some organisations.

Medical practitioners are committed to providing high quality care to patients. Their primary concern remains the health and wellbeing of their patients, not their industrial entitlements.

AMA (WA) points to a number of additional factors that facilitate wage theft by [redacted]:

Short Term Contacts

At present, there is a prevailing culture of fear and retribution amongst medical practitioners in WA's public health system. This is primarily due to:

- Doctors in Training are employed on fixed term contracts, of typically no more than 12 months duration. They often depend on a [redacted] offering future employment in order to complete their training.
- Senior Practitioners are employed on fixed term contracts of 5 years. An increasing number are reappointed on short term contracts of between 6 and 12 months, in breach of the Agreement.

AMA (WA) asserts that the fixed term employment of medical practitioners is used by [redacted] to intimidate employees and create a culture of fear within the workforce, to the extent that medical practitioners are reluctant to question decisions of management out of fear of not having their contract of employment renewed.

As a result of the aforementioned factors, medical practitioners employed in the [redacted], particularly Doctors in Training, are vulnerable to mistreatment by employers and are often anxious

about pursuing industrial issues, including wage theft, for fear of being regarded as a trouble makers and being unable to secure future employment or training opportunities. AMA (WA) members continuously cite their future employment prospects as the reason they decide not to pursue wage theft.

In addition to AMA (WA) raising the mismanagement of employment contracts over a number of years, numerous public reviews have been critical of the practice and pointed to the abuse of short term employment contracts:

Review of the morale and engagement of clinical staff at Princess Margaret Hospital[11]

"What was quite profound to the review team was the number of staff from across the hospital who spoke of fear of retribution, including loss of employment or loss of career development, if they were to speak up, express concerns or views contrary to those of the management team or executive… Staff spoke of a perception that the widespread use of short term contracts was also being used as a mechanism for staff compliance."

[redacted]

While AMA (WA) is reluctant to assert that such dangerous and systemic practices have become a "model of business" for the provision of public health services in WA, we note that in spite of the improved safety, quality and administrative implications of long term and permanent employment, medical practitioners are the only non-executive public sector employees who are not entitled to conversion of fixed term appointments to permanency in accordance with the Public Sector Commissioner's Instruction No. 23,[13] having been expressly excluded from its scope and application.

Fragmentation of Health Services and Outsourcing of Payroll Services

AMA (WA) believes that the creation of Health Service Boards, a System Manager and the delegation of payroll services to HSS has created confusion over Employers' responsibility and accountability to employees. This confusion is both external and internal. Medical practitioners are unsure who is responsible for correcting errors or to whom they should query salary payments. AMA (WA) has been expressly directed by [redacted] to contact HSS in order to resolve issues related to unpaid wages, despite the fact that HSS are not a party to the Agreement and have no direct legal obligation to the employee.

The fragmented system all too often provides [redacted] with a convenient excuse to refer issues to a third party. [redacted] continue to deflect their accountability

[11] WA Health - Child and Adolescent Health Service, *"Review of the morale and engagement of clinical staff at Princess Margaret Hospital (PMH)",* May 2017

[12] [redacted]

[13] Public Sector Commission (WA), "*Commissioner's Instruction No. 23 Conversion and appointment of fixed term contract and casual employees to permanency"*, August 2018, Source: <https://publicsector.wa.gov.au/sites/default/files/documents/commissioners_instruction_no.23_-_conversion_and_appointment_of_fixed_term_contract_and_casual_employees_to_permanency.pdf>, last accessed: 02/04/2019

which in turn, continues to cause confusion, unnecessary delays and at times a nonchalant approach towards medical practitioners' remuneration and industrial entitlements.

By way of example, in March 2018, AMA (WA) was made aware that over 400 termination payments were waiting to be processed, some dating back to January 2018, despite the Agreement prescribing payment of all monies due on the payday following termination.[14] The proposed solution to the delay in medical practitioners receiving the monies they were due, was for AMA (WA) to escalate any individual complaint that was raised with us. This is not a responsible approach to addressing a breach of [redacted]' legal obligations to medical practitioners and it is unacceptable that AMA (WA)'s threat of legal action appears to have been the only motivation to achieve Agreement compliance.

The lack of [redacted]' accountability is exacerbated by the issues constantly experience by medical practitioners in relation to their payslips, recording of their leave balances and salary payments. Neither medical practitioners employed by [redacted] nor AMA (WA) have any confidence in the accuracy and validity of record keeping and payroll systems. AMA (WA) believe that the ineffective and unreliable payroll systems make difficult for medical practitioners to easily identify and challenge underpayments.

3. What is the impact of wage theft on workers, businesses which are compliant with employment laws, and the Western Australian community and economy.

While AMA (WA) is only able to provide comment on the impact of wage theft on medical practitioners, we believe that there is a significant secondary impact on the WA community and economy.

Wage theft, and the workplace culture which facilitates wage theft, continues to contribute to a disengaged and demoralised workforce. In a clinical environment, this represents a risk to safe and quality clinical care. A disengaged clinical workforce directly contributes to increased costs of providing public health services in WA, with the link between clinical engagement and health system financial efficiency internationally recognised.

4. Whether wage theft is more prevalent in particular industries, occupations, forms of employment/engagement or parts of the State.

AMA (WA) represents the professional interests of medical practitioners and therefore cannot comment on other occupations.

While AMA (WA) acknowledges that issues may arise at all organisations that employ medical practitioners and note that the [redacted], AMA (WA) believes that wage theft is only a systemic practice in [redacted] and is not reported to the same degree at other employers of medical practitioners.

5. Whether the current State and federal regulatory framework for dealing with wage theft is effective in combating wage theft and supporting affected workers.

See below to AMA (WA) comment on Item 7.

[14] WA Health System – Medical Practitioner – AMA Industrial Agreement 2016, Clauses 9(7) & 20(12)

6. Whether new laws should be introduced in Western Australia to address wage theft, and if so, whether wage theft should be a criminal offence.

See below to AMA (WA) comment on Item 7.

7. Whether there are other strategies that could be implemented by the Western Australian Government, or industry stakeholders to combat wage theft.

AMA (WA) utilises all necessary conciliation and arbitration pathways available to it under the Agreement and the *Industrial Relations Act 1979 (WA),* when necessary. However, in order to address wage theft, AMA (WA) continues to rely on members to be prepared to identify themselves and their issue to the relevant [redacted]. Given the aforementioned issues with short term contracts, a disengaged workforce and underlying fear of retribution that exists for medical practitioners employed in the [redacted], many medical practitioners decide not to pursue their legal entitlements. AMA (WA) believes that recommendations addressing workplace culture that facilitate wage theft will have a positive impact on the incidence of wage theft, both in the WA Health System and across WA. Primarily, this should involve improving employer accountability and eliminating impunity for engaging in wage theft.

AMA (WA) believes that [redacted], and organisations of a similar size, are able to engage in wage theft with relative impunity. AMA (WA) notes that the financial penalties for breaching provisions of an industrial agreement are small and only occur as the direct result of taking action in the Industrial Magistrates Court. There is no personal liability for senior executive staff who are responsible for organisations that engage in wage theft. AMA (WA)'s experience with [redacted] is reflective of the fact that there is little incentive to comply with Agreement provisions and legislation, unless sufficient pressure is applied by AMA (WA). It is unacceptable that AMA (WA) is required to act as the guardian of medical practitioners' industrial entitlements and that in the absence of protest, [redacted] continue to engage in wage theft.

Consequently, the potential impact of increased financial penalties, senior executive liability and imprisonment for wilful wage theft should be considered as part of the Inquiry.

8. Whether there are strategies and legislative change the Western Australian Government could recommend to the Federal Government to deal with wage theft in the federal jurisdiction.

AMA (WA) is unable to provide any specific comment.

9. Other matters incidental or relevant to the Inquirer's consideration of the preceding terms of reference.

AMA (WA) has no comment on matters incidental or relevant to the Inquirer's consideration of the preceding terms of reference.