Defence Force Remuneration Tribunal

DECISION

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

AUSTRALIAN DEFENCE FORCE MEDIC
(Matter 6 of 2024)

MS B. O'NEILL, PRESIDENT

MR A. MORRIS, MEMBER

CANBERRA, 2 SEPTEMBER 2024

MAJGEN G. FOGARTY AO RETD, MEMBER

[1] This decision arises from a listing application from the Australian Defence Force (ADF) for a determination to be made under Section 58H of the *Defence Act 1903* (the Act). The listing application[1] seeks to contemporise the ADF Medic workforce across Navy, Army and Air Force by introducing common training courses and aligning pay grades where possible, while also incorporating Service-specific requirements.

[2] We considered this matter in a hearing on 13 August 2024. Ms K Hagan appeared for the ADF and Mr K Wong for the Commonwealth. Rear Admiral S Bennett RAN, Commander Joint Health and Surgeon General ADF appeared as a witness for the ADF.

Background

[3] Medics provide medical support and carry out duties ranging from general nursing to advanced first aid. They organise aeromedical evacuations and pre-hospital and emergency care for the sick and wounded in hospitals, and on deployments, at sea or ashore.

[4] ADF Medics are required to gain and maintain national registration as a health practitioner as regulated by the Australian Health Practitioner Regulation Agency. Over the last decade, Medics have been required to elevate their skills and knowledge in response to increasingly complex working environments. At the same time, the workforce has undergone a series of adjustments to training, structures, casualty profiles, and technical and operational changes.

Submissions

ADF

[5] The ADF submission seeks to amalgamate the essential common skills and training of Navy, Army and Air Force Medics where appropriate. Further the proposition seeks to align pay grade placement, training and career progression '*as far as practicable'*. While the submission seeks broad commonality, it does state that some Service-specific distinctions will be retained.[2]

[6] The ADF submit the proposal is '*the initial step in a phased approach to improve flexibility across the ADF Medic workforce'* stating '*the purpose is two-fold – to recognise additional work value associated with certain career stages and for specific capabilities, but to also optimise entry to the trained workforce'*.[3]

[7] Specifically, the ADF seeks to:

a. establish a new ADF Medic employment category that is comprised of Navy Medic, Army Medic (Health Operator and Medical Technician pathways) and Air Force Medical Technician employment categories with salary placements from pay grades 1 to 6 (8 for submariners) in the Graded Other Ranks Pay Structure (GORPS);

b. transition the current Navy Medical Sailor, Army Medical Technician, Army Combat Paramedic, Army Combat Medical Attendant and Air Force Medical Technician employment categories into the corresponding new categories in accordance with the proposed salary placement requirements; and

c. remove the current employment categories once all current members are transitioned to the proposed ADF Medic structure.[4]

[8] For the majority of the full-time ADF Medic workforce, pay grade placements range from pay grade 3 to 6 in the GORPS. All Services seek a permanent entry point of skill grade 1 pay grade 3 for their Medic employment categories to target and recruit civilian qualified health professionals (with the exception of the Army Health Operator category which is considered to be a '*base-level capability*[5]*).*

Commonwealth

[9] The Commonwealth supports the ADF submission and the '*standardisation of Joint training and progression across each of the Services whilst allowing for Service-specific changes and adaptations'*.[6] It further recognises the '*extensive work value assessment conducted on skill grades'*.[7]

[10] The Commonwealth did question '*whether civilian qualified health professionals entering the ADF Medic workforce with different levels of health qualification will have their qualifications recognised in the same skill and grade placement*'.[8]

Witness evidence

[11] Rear Admiral (RADM) S Bennett AM RAN gave written and oral evidence in support of the proposal. She described the Defence Health System as a '*collaborative system of health consumers (Defence members), the Services, Joint Operations Command, health providers and other stakeholders'* with health care provided in '*multiple locations and contexts'*.[9]

[12] RADM Bennett reiterated that, following single-Service reviews of the various employment categories, there are '*now more commonalities than differences'* however Service-specific requirements were identified and will remain.[10]

[13] In the hearing, RADM Bennett explained that the provision of common courses, with flexibility in training, means that '*we'll get the best outcome from both of those things'*. Further, she detailed that '*targeted specific training which has Service components will grow us the capability we need in our Medic workforce'* while *'we need to keep abreast of training required for the capability requirements and it may be that some of that is better accessed, or more readily accessed, outside'*.[11]

[14] RADM Bennett clarified that the ADF seeks to include an 'or equivalent' option for recognition of training courses so as to give greater flexibility - both in training and for recognition of qualifications held at recruitment. She explained that, in this context, equivalent will mean '*equal or greater than the learning outcome or competency of the training in place at the relevant time'* and will be consistent with set capability descriptors.[12] She reinforced the 'or equivalent' consideration is important to Defence because it allows for '*a recognition of prior learning that is equivalent, or greater than, what that requirement is in the defined curriculum*'.[13] Therefore, where Defence cannot provide the training, or where it may be able to be provided externally to Defence, '*it will take pressure off our own training resources'* while, at the same time, '*where Service-specific training needs are required, then it allows that flexibility too'*.[14]

[15] RADM Bennett remarked that in addition to the introduction of joint training and greater integration '*one of the key benefits will be establishing an entry pathway for civilian qualified and registered professionals on an ongoing basis at pay grade 3'*.[15] She considers this is because '*from a salary perspective, it will align Medic salaries as far as practical and recognise the work value they are bringing'* as well as '*so that somebody who has had equivalent training on the outside can enter at the appropriate pay scale'*.[16]

Consideration

[16] We made our deliberations in the following context:

a. **Navy.** Navy's current workforce includes specialisation in Underwater Medicine and Submarine service. Navy Medics are currently allocated a skill grade within a three-tiered structure and receive pay grades 3 to 6 (surface fleet) and 7 to 8 (submariners).There is also '*growing need for the employment of Medics in Minor War Vessels'*.[17] Navy seeks non-reduction provisions for a period of 5 years to support transition. Navy considers the proposed changes will:

   i. provide Medics with improved clinical skills earlier in their career to enable them to better support the required capability at the Able Seaman/Leading Seaman ranks particularly on Minor War Vessels and Submarines;

   ii. provide training to Medics that delivers content phased to appropriate stages throughout their career;

   iii. achieve integrated training that builds stronger inter-Service networks and provides greater posting flexibility; and

   iv. support streamlined training and improved pay grade placement for qualified civilian personnel looking to enter Navy's Medic workforce. This will improve recruiting opportunities, provide capability in a shortened timeframe and bring greater diversity and experience to the Navy Medic employment category.[18]

b. Army. Army's Medic workforce presently consists of three employment categories – Army Medical Technician, Combat Paramedic and Combat Medical Attendant. The current pay grades range from 1 to 4 in the GORPS. Army seeks non-reduction provisions for a 5 year period. Army expects the changes will:

   i. reduce reliance on ab initio entry for full-time personnel;

   ii. enhance capability through use of qualified entry for paramedicine and nursing in both Permanent and Reserve service options;

iii. provide enhanced education/training through the Medic career path, specifically in upskilling clinical capability, health governance, health administration, and casualty regulation;

iv. overcome training difficulties in sustaining the current Technician Operating Theatre capability;

v. retain skill and pay relativity across Services where sufficient commonalities allow;

vi. contemporise and encompass the relevant aspects of capability provided by the terminated Psychological Examiners employment category in order to deliver mental health support effects; and

vii. remediate moderate attrition of Medical Technicians.[19]

c. **Air Force.** The Medical Technician employment category is Air Force's enlisted medical workforce. Air Force Medical Technicians are allocated a skill grade within a three-tiered structure and are placed between paygrades 3 and 5 in the GORPS. Air Force does not seek non-reduction provisions. Air Force states '*the key Medic workforce issue for it is attraction and retention with recruitment and training being the primary limitations*'. Air Force considers that '*by reforming the recruitment pathway for registered health practitioners it will seek to attract suitable candidates that will not require significant training thereby reducing the impact of workforce separation by mitigating the time to train candidates'*. It also considers a career oriented training continuum will provide Medical Technicians with '*structured development opportunities at key ranks in preparation for roles in the broad spectrum of the health system'*. Finally, Air Force considers the proposal will provide a '*foundation of integration with Navy and Army to provide health effects for the Joint force through standardised training that remains flexible enough to recognise the specific requirements for the environments in which Air Force operates'*.[20]

[17] We considered the evidence that the ADF Medic category is structured differently within each of the Services. We note that the proposal has been underpinned by the application of the Chief of Defence Force's intent for a 'same by default, separate by necessity and similar by exception'[21] approach and we accept that Service-specific distinctions will need to be retained.

[18] We considered the proposed training for ADF Medics will consist of a blend of civilian accredited training courses combined with ADF technical health courses, as well as Domain and Service-specific training – all of which will be complemented by single-Service promotion and mastery courses.

[19] We note that the Surgeon General ADF will *'appoint a delegate to approve all health training for the ADF Medic workforce including to determine if a course, training or education is 'equivalent''*.[22] We accept this will ensure that there is '*a process in place to determine whether something is equivalent, and that that is assessed in accordance with the Australian quality framework for learning and development, as well as methodology that is internationally recognised and Defence accepted for assessing 'or equivalent'*.[23] We note that a record of the courses, training and education determined as 'equivalent' will be kept for auditing and reporting purposes.[24]

[20] In the hearing, the Commonwealth queried how pay grade placement would reflect the prior learning of Medics joining the ADF. RADM Bennet expanded on this explaining that the capability descriptors '*will assess the qualifications held, and any gaps or delta they'll have to make up'* so that the outcome is '*not really about the qualification you have'* and more '*about the capability outcome'*.[25] We agree the capability descriptors will therefore be most important.

[21] The Commonwealth also queried the governance of the proposal and any intended '*reporting to assess the effectiveness of this new category*.' We are satisfied with RADM Bennett's evidence that '*there's governance around the training and capability outcomes'* and that it will be an *'ongoing piece of work*' that will continue to be monitored.[26]

[22] We accept that the workforce has '*been engaged in a variety of forums, formal and informal, largely through Single Service lines'*. We note the maritime workforce, while supportive of the overall proposition are '*somewhat cautious with their support'* and accept this is because the proposition does not yet fully incorporate the sub-surface fleet requirements. We accept '*these are under current consideration within the context of the new submarine requirements and will be incorporated in a future proposition to us in 2025'*.[27]

Conclusion

[23] In closing, we agree there are a set of shared fundamental and requisite skills which are shared across the ADF Medic workforce. We agree '*that the best outcome for the ADF Medic workforce will be achieved through a combination of joint elements blended with Domain of Service-specific inclusions'*.[28] We agree this will provide flexibility through the recognition of equivalent training and experience which will, in turn, directly improve the Joint health capability. We accept that some members may move through the continuum in different ways as a result of Service-specific requirements however consider commonalities have been achieved where possible.

[24] For Navy, we agree this proposal will '*start the process of making the changes required to provide qualified Medics suitable to undertake maritime and Joint deployable responsibilities.* Further, that *'this embodies the organisational preference to drive skills down to the lowest practical point and will enable Navy Medics to support current and future capabilities in remote, maritime and/or austere environments when required'*.[29]

[25] For Army, we agree the proposed restructure will '*generate a significant level of flexibility, particularly by providing multiple entry pathways and Permanent/Reserve transfer opportunities. It will deliver common clinical scopes of practice across differing qualifications. The proposed structure and revised training continuum ensures Army Medics will be capable to perform their roles at all rank levels and in all mission dictated configurations, whether autonomously or in a health team organisational structure'*.[30]

[26] For Air Force, we agree the proposed continuum will '*optimise the Air Force Medic workforce, particularly through career progression that recognises and aligns with attainment of increased skills and responsibilities. The proposed recruitment of registered health professionals (paramedics, registered nurses and enrolled nurses) will assist to address workforce supply challenges. It also reduces the time required to generate qualified Medics able to support capability. The proposed structure and revised training continuum will ensure Air Force Medical Technicians are capable of providing health care across the operational spectrum and provide health support to raise-train-sustain activities'*.[31]

[27] The table below summarises the comparison of each Service in the new structure:

	NAVY	ARMY	AIR FORCE
Pay Grade	**Skill Grade**	**Skill Grade**	**Skill Grade**
1		Health Operator 1	
2		Health Operator 2	
		Health Operator 3	
3	Medic 1	Health Technician 1A	Medical Technician 1
		Health Technician 1B#	
		Health Technician 1C#	
Joint Medic Initial Employment Training Course or equivalent*			
4/7**	Medic 2	Health Technician 2	Medical Technician 2
Joint Medic Advanced Course or equivalent*			
5/7**	Medic 3	Health Technician 3	Medical Technician 3
Underwater Medicine Clinician Course or equivalent* (Navy and Army)			
5/7**	Medic Underwater	Health Technician 3 Underwater	
Clinical Manager Course or equivalent* (Navy)			
5/8**	Medic 4		
Joint Medic Supervisor Course or equivalent*			
3		Health Operator Supervisor	
5		Health Technician Supervisor Underwater	
6/8** (Navy) 5 (Army and Air Force)	Medic Supervisor	Health Technician Supervisor	Medical Technician Supervisor
Joint Medic Manager Course or equivalent*			
4		Health Operator Manager	
6/8**	Medic Manager	Health Technician Manager	Medical Technician Manager
4		Health Operator Manager (A)	
6/8**	Medic Manager (A)	Health Technician Manager (A)	Medical Technician Manager (A)
6	*Navy Warrant Officer Tier B and Tier C are not specific to Medical Sailors.*	Health Technician Manager (B)	*Air Force Warrant Officer Tier B and Tier C are not specific to Medical Technicians.*
8		Health Technician Manager (C)	
* denotes courses where an 'equivalent' may be used in place of the named course. ** denotes Submariner Pay Grade # denotes Reservist only			

[28] We accept a related and subsequent submission will be made within a year to '*further strengthen and support the ADF Medic workforce including enhanced alignment across Services and adjustments to training and career continuums'*.[32]

[29] We agree that the entry pathway at skill grade 1 pay grade 3 (excepting Army Health Operator) is appropriate to attract health professionals to an ADF career.

[30] We note the application of non-reduction provisions as sought and accept they will be administered by the ADF under s.58B of the Act.

[31] We ask the ADF to report back to us on the outcomes of this contiguous approach, and the progress of the non-reduction provisions, three years after implementation in October 2027.

[32] Determination 8 of 2024 gives effect to our decision from 16 October 2024.

MS B. O'NEILL, PRESIDENT
MR A. MORRIS, MEMBER
MAJGEN G. FOGARTY AO RETD, MEMBER

Appearances:

Ms K Hagan for the ADF *assisted by Flight Lieutenant L Hawkett*

Mr K Wong for the Commonwealth *assisted by Mr C Johnson*

Witness:

Rear Admiral S Bennett AM RAN, Commander Joint Health and Surgeon General ADF

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[1] DMR BN79906304 Listing Application: ADF Joint Medic dated 3 April 2024.
[2] ADF Submission Matter 6 of 2024 ADF Medic dated 23 July 2024 (ADF1) page 1 paragraph 1.4 and 1.5.
[3] ADF1 page 3 paragraph 1.11.
[4] ADF1 page 2 paragraph 1.8.
[5] ADF1 page 11 paragraph 3.10.
[6] Commonwealth submission Matter 6 of 2024 ADF Medic date 01 August 29024 (CWLTH1) page 14 paragraphs 70 and 72.
[7] Transcript 13 August 2024 page 13 line 41.
[8] CWLTH1 page 14 paragraph 76.
[9] Affidavit of Rear Admiral S Bennett AM RAN (ADF2) dated 1 August 2024 page 3 paragraph 9.
[10] ADF2 page 5 paragraph 16.
[11] Transcript page 19 lines 14 to 32.
[12] Transcript page 10 lines 11 to 14.
[13] Transcript page 20 lines 10 to 18.
[14] Transcript page 19 lines 30 to 35.
[15] ADF2 page 9 paragraph 33.

[16] Transcript page 19 lines 1 to 5.
[17] ADF1 page 23 paragraph 4.10.
[18] ADF1 page 31 paragraph 4.37.
[19] ADF1 page 42 paragraph 4.64.
[20] ADF1 page 51 paragraphs 4.99 to 4.101.
[21] Joint Directive 6/2023 Implementation of the Defence Strategic Review.
[22] ADF1 page 17 paragraph 3.19.
[23] Transcript page 20 lines 25 to 30.
[24] ADF2 page 7 paragraph 26.
[25] Transcript page 23 lines 15 to 20.
[26] Transcript page 24 lines 1 to 13.
[27] Affidavit page 9 paragraph 35.
[28] ADF1 page 9 paragraph 3.2.
[29] ADF1 page 56 paragraph 6.2.
[30] ADF1 page 56 paragraph 6.3.
[31] ADF1 page 56 paragraph 6.4.
[32] ADF1 page 3 paragraph 1.2.