COMMUNITY DOCTOR
October 2018

GPEP 2 CONTRACTS: WHAT TO EXPECT

Since June 2016, NZRDA has provided advice to 38 members on their GPEP2 contracts. The contracts we advised on were 17 employment agreements and 21 independent contractor arrangements.

Our analysis of the contracts we have advised on shows the average pay for GPEP2s working as independent contractors is $99.35 per hour, with the most common rate offered being $100 per hour (plus GST). Four GPEP2s working as independent contractors were offered more than $110 per hour.

However, our advice to GPEP2s is to not accept an independent contractor arrangement and to seek an employment agreement. If you are an independent contractor you are not going to get annual leave or sick leave, nor reimbursement of indemnity and APC costs, and you will have to do your own accounts.

You can find a template Individual Employment Agreement for GPEP2s based on our advice on our website.

Employment Agreements

Pay: In the 17 employment agreements we saw, the range of hourly pay rates offered to GPEP2s in employment agreements was between $69 and $101. Five employment agreements had hourly pay rates of $100 or more.

We advise members to negotiate for an hourly pay rate of $95 hr and accept no less than $90 hr.

Six employment agreements had hourly pay rates below $90. These agreements tended to have either five or six weeks' annual leave.

Reimbursements: Only two of the seventeen employment agreements did not provide for the employer to reimburse employment-related expenses. Most provided for reimbursement of both indemnity insurance and annual practicing certificate costs.

And six employment agreements provided for reimbursement of indemnity insurance, APC and RNZCGP fees.

Three contracts also provided for reimbursement of CPR courses. Another six employment agreements provided for reimbursement of professional development costs of between $500 and $2000.

We advise members to ensure their contracts provide for reimbursement of indemnity, APC, CPR, RNZCGP fees, and $2000 professional development.

Leave: It is fairly common for GPEP2s to receive a minimum entitlement of leave, being 4 weeks' annual leave and 5 days sick leave per year. However, some contracts we saw provided for a week's study leave, and some GPEP2s get sick leave of ten days per annum and five weeks' annual leave.

We advise members to negotiate for five weeks' annual leave, 10 days' sick leave and one week of study leave.

Restraint of Trade: Restraint of trade clauses in contracts affect where and when you can work if you leave an employer. Restraint of trade clauses are only enforceable by an employer to the extent that they are reasonable, and they should be strictly limited in duration and geographical range if used at all.

We advise members not to agree to any restraint of trade clause in their agreement.

In the 17 employment agreements we advised on, nine did not have a restraint of trade clause in them. The ten that did said the employee could not work for another practice between three and twenty kilometres of the employer's practice for a period of around three to six months.

In small towns, a restraint of trade clause could essentially lock you in to working for one practice for good.

Still a Few Sponsored Positions Available!

Don't forget the NZRDA Health and Wellbeing Conference is taking place at SKYCITY Auckland Convention Centre on the 8th and 9th of November.

The Hon Dr David Clark will be providing the opening address and we have (amongst many other speakers) Dr Caroline Christie from Pegasus Health presenting on challenges and solutions to achieving good health and wellbeing in Primary Care.

The NZRDA Education Trust is sponsoring (by covering accommodation and travel costs) a limited number of RMOs to attend this event. To register your interest and for more information please email us at conference@nzrda.org.nz.

Dissatisfaction with PSAAP

A recent letter to the Ministry of Health's new Clinical Chief Advisor with a focus on primary health care (Dr Juliet Rumball-Smith) from a Whangaparoa GP (see over page) has sparked quite some discussion on the GP Facebook page, with many GPs expressing dissatisfaction with the new PSAAP deal.

For those who don't know this acronym, PSAAP is the agreement for funding between the Ministry of Health, DHBs and PHOs. GPs receive their funding through their PHO who are effectively negotiating on behalf of GPs in the PSAAP environment. The issues at the core of this negotiation are the government's promises to make visits to the GP free to under 14s (from the previous free visit for under 13s) and changes to funding for those patients with community services cards.

Preliminary modelling in the Wellington area indicates that under the proposed agreement:

- 39% of practices would be better off (net increase of at least 2% annual revenue)
- 50% of practices would be approximately break-even (within the modelling margin of error)
- 11% of practices would have a net loss (net reduction of 1% of total revenue or greater).

The GPs have been given 2 weeks to consider the deal. This is not felt to be enough time for many to analyse the impact on their practices, and given the number that may lose money as a result, they are understandably nervous.

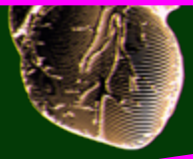
At the heart of the issue, however, is the lack of a strong collective GP voice. Whilst acting on their behalf, the PHO's communication around what is happening and the negotiation itself has been variable (depending on the PHO), but in some areas at least, GPs feel it has been inadequate and the "rush" to sign off the deal (or not) felt to be a "divide and rule" tactic. In Auckland and Wellington, meetings to discuss further are being hastily arranged, but again without any organisation behind them, it is being left to a few enthusiastic GPs to manage – although the support through their Facebook page is strong.

We recommend all GPEP registrars take an interest in what is happening here. This is not just about PSAAP – as big a deal as that is! It is about the vulnerability of and risk for primary care in general when the GP voice is not being effectively heard.

A copy of the letter sent to Dr Juliet Rumball-Smith is given on the next page.

RNZCGP Annual Conference Report

The RNZCGP Annual Conference held in Auckland in July was a great experience. I wasn't sure what the presentations would be like when I initially signed up, but when the speakers and topics were announced I was tentatively hopeful – the conference didn't let me down in that regard. There were fantastic quality speakers almost across the board, with both thought-provoking (Camara Jones was I think a highlight of most attendees) and educational sessions (I found the discussions on cellulitis and topical skin cancer treatment particularly useful). The partial funding by RNZCGP for College-employed GPEP1 attendance meant that a good crowd turned out for much of the event, although the numbers seem to drastically reduce above this level other than local GPs. Overall I enjoyed my time spent at the College conference, and for those who can make it I suspect next year's conference in Dunedin will be well worth your time." — **Dr Sarah Rance, Community-based National Executive Rep**



"Something has to give"

Letter to the Ministry of Health's new Clinical Chief Advisor

Dear Dr Juliet Rumball-Smith

Firstly, congratulations on your newly appointed position of director of primary healthcare, and thank you for extending the invitation to communicate with you directly. I am sure you are being drenched in a deluge of emails from GPs and PHOs at the moment, especially in light of the upcoming changes to primary care funding in support of improved access for patients with high needs to see GPs.

My name is Marcia Walker. I am a fellow of the GP college having completed my training in 2015. 2 years ago I (excitedly, and nervously) invested in my own practice when I bought out a retiring GP from his 32 year practice in Whangaparaoa. It has been a steep learning curve learning the intricacies of running my own practice, dealing with clinical governance and negotiating the tenuous path between patient safety, satisfaction and access, with balancing increasing workloads and expectations. In the 2 short years of practice ownership, I have observed some concerning trends that have lead somewhat to the apparent "devaluing of general practice" that I feel compelled to share.

The first is that speaking with my colleagues who own their own practices, there appears to be an increasing fear that the costs of running your own practice are escalating far faster than our funding allows us to comfortably cope with. Investment in vital and expensive technological infrastructure such as PMS upgrades, coupled with upcoming primary care nurse salary increases, at a time when funding is being cut (most recently was the loss of CVDR funding in our PHO) is creating some real fear. It seems that there are risks to our sector that are being largely ignored and that GPs will just have to "suck it and see". This may mean GPs enrol more patients than is comfortable in order to meet increasing costs, which can lead to burn out and a largely unsatisfying work environment. Worse still, there are only so many hours in a day before you have to turn patients away to the local A&E where you are met with the all too painful reality that is clawback. We have been given only 3 weeks to consider the proposal and sign it if we wish to be involved. Hardly long enough to do due diligence I would suggest. But the offer is there like the sword of Democles, with many practices probably feeling compelled to sign (probably against better judgement) for fear that if they don't, their practices will empty to the clinic down the road who is funded better. The time frames involved is almost enough to actually hold a game of "funding chicken". See which clinic blinks first! I'm not sure if that's a deliberate strategy being employed here, or if the government just wants to get their policies moving so they can show their constituents just how effective they really are at getting policy through, but once you've let this cat out of the bag, it won't go back in again very easily.

I believe many practices are operating at saturation point and my concern is that the latest proposal has not taken into account the impact that increased utilisation will have. Many practices will have to adjust fees accordingly placing more burden on others to offset losses in the proposed areas. Even things like prescription fees will be affected as the cost of "seeing the GP" is now cheaper than requesting a repeat script. The free under 13s (soon to be extended to free under 14s) has resulted in so many patients coming in for "check ups" that did not need a doctor to be involved. Previously nurse visits weren't included (and I understand under the new proposal they are) but our nurses are already very busy doing valuable clinical work but to have them seeing the worried well is not a good use of their time either. And again, with increased utilisation, we reduce our ability to see our other patients and they have to attend elsewhere (at our expense) or wait until they get sicker and potentially end up in hospital. As it is, the anxious parent who has their child / children checked multiple times in a month at an after hours clinic can cost a practice thousands of dollars in clawback over a year.

The problem with making something "free" or "cheap" in some ways reduces the perceived value and there isn't a day that goes by that I don't have patients utilising that to "get free Pamol for my child" or to "just listen to his heart" (in a completely asymptomatic child). We wouldn't accept this in a hospital, and yet, we have opened the flood gates into general practice which is already dealing with an increased workload and expectations from secondary care to perform more clinical work in the community, and an uprising of consumer and convenience based medicine from our patients.

Something actually has to give here.

GPs have historically sucked up the carnage because we all work in isolation from one another, and, as a disparate and busy group, it is difficult to collectively act. However, I know from my discussions at peer review and on the GP Facebook forum, that the discontent is running very deep. It's leading to GPs wanting to leave their practices / sell them to "corporates" and then simply "work for someone else" for a bit. Now as appealing as this may sound on one hand... from my experience as both a GP owner, and as a previous employee, You never work so hard for your patients as you do when you have your own skin in the game. I know I give them far better service because of my commitment to my practice and the fact I've Invested so much of my own money, time, family life and mental energy into it. But I do worry that the ongoing devaluing of general practice is gutting it. It's death by a thousand cuts to be sure.

I would urge our politicians not to use primary care as a vote buying tactic by offering up baubles and delights at the expense of an area of health that is already under significant pressure, only to underdeliver on funding the promises correctly. We have an aging GP workforce. What is the state of the sector that we are offering up to the next generation of GPs I wonder? I'm not sure I would recommend ownership to those coming through which is a real shame because I know what ownership means for my patients.

I am not a senior GP with decades of experience. I am not a GP who has written great books or been published in any leading journals. I am not a GP who has been overtly prominent in any one community. I am not a GP with aspirations for politics, or for academia, or for peer acclaim. I am a young(ish) GP at the relatively early phase of her career who has spent the last two years watching my colleagues become more and more bewildered, and I'm worried what this means for the future of the profession. At the risk of adding to the devaluation further. I am just a GP.

Nga mihi,

Dr Marcia Walker, FRNZCGP

GP SECA FAQs

These frequently asked questions are also available on our website:
www.nzrda.org.nz/sick-leave-seca-faqs

Where do I find the relevant provisions in my SECA?

Clause 11.4 (page 11 of your SECA)

How much sick leave am I entitled to?

You are entitled to paid leave of up to 15 days (pro rata for part-time employees).

What rate am I paid when on sick leave?

You are entitled to your normal pay when you are on sick leave.

Can I take sick leave to care for an unwell child/household member?

You can apply for leave on pay which is deducted from your sick leave to stay at home and care for an unwell spouse/partner or a person who is dependent on you (e.g. your child).

Do I need to provide a medical certificate if I take sick leave?

You may be required to provide a medical certificate or other evidence of illness to the RNZCGP. If you are sick/injured for less than three days and you are asked for proof then the RNZCGP must cover the cost of getting the proof e.g. visit to the doctor.

Get in touch sooner rather than later

If you are experiencing any issues at your practice, get in touch with us sooner rather than later.

It can feel isolating working in such an intimate workspace, so don't forget we're always here to provide advice; your communication with us is always confidential.

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