Special Commission of Inquiry into Healthcare Funding

Statement of Melissa Collins

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1. This statement sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**). The statement is true to the best of my knowledge and belief.

A. SCOPE OF STATEMENT

2. I have provided statements to the Inquiry dated 17 July 2024 (**MOH.0011.0025.0001**) (my **First Statement**) and 3 August 2024 (**MOH.0011.0038.0001**). This statement should be read in conjunction with those statements.

3. This statement is provided in response to the Inquiry's Issues Paper 2/24 Workforce Solutions dated 16 September 2024 (**SCI.0011.0468.0001**).

B. CONSIDERATIONS IN FORMULATING SOLUTIONS

4. NSW Health concurs with the premise that industrial awards and instruments applicable to the NSW Health workforce, which I refer to at [36] of my First Statement (**the awards and instruments**), are outdated. This is largely in relation to the language used and the style of their terms, which can be overly prescriptive and in some cases place limitations on the ability of NSW Health to maintain an agile workforce.

5. Below I address what I perceive to be some considerations which, in my experience, need to be considered in formulating any solution to this problem.

(i) Government Wages Position

6. The *NSW Government Fair Pay and Bargaining Policy 2023* (**the Wages Policy**) applies to the government sector as defined in the *Government Sector Employment Act 2013*, including public service agencies, departments, executive agencies, independent statutory bodies, and the NSW Health Service. A copy of the Wages Policy is exhibited to this statement (**MOH.0010.0143.0001**). A copy of the associated commentary to

Unions is also exhibited to this statement (**MOH.0010.0150.0001**). The Wages Policy applies to any negotiations, variations, claims or offers by agencies that impact on remuneration or other conditions of employment, whether or not they are formalised in an industrial instrument.

7. Although the Health Secretary has the power, under s 116A(1) of the *Health Services Act 1997*, to fix the salary, wages and conditions of employment of staff employed under that part (so far as they are not fixed by or under any other law), the Secretary is still bound by the Wages Policy and budget constraints in the setting of any salary, wages or other conditions of employment. This facilitates a consistent approach to wages across the Government sector to minimise sector leveraging of wages, including via industrial disputation, and to ensure that employee-related expenses are costed and can be funded by Government based on its current fiscal position. Maintaining this approach remains in the interest of the State.

8. To ensure the ongoing financial sustainability of NSW Health, enhancement of remuneration can only occur where cost savings are identified and realised, or additional funding is provided by NSW Treasury and accounted for in the health budget.

9. The scale and nature of the NSW Health workforce means that any small increase or change to conditions has large scale cost; NSW Health wage expenditure is approximately $18 billion per annum. For example, the NSW Nurses and Midwives Association (**NSWNMA**) claim to increase night shift penalties is estimated to cost over $100 million in the first year. Consequently, unless there is additional funding from NSW Treasury, there is no capacity for NSW Health to fund or absorb increases to employee related costs without a reduction to service provision. I expect that part of NSW Treasury's consideration for additional funding would be that any wage increases for NSW Health staff will have a significant budgetary impact for the NSW Government more broadly.

(ii) Industrial Relations Commission

10. The NSW Industrial Relations Commission (**IRC**) has a long and successful history of managing industrial affairs in the State, balancing the needs of employers, employees and industrial associations.

11. The IRC has various functions and powers under the *Industrial Relations Act 1996* which can support award reform and the resolution of industrial relations. Those mechanisms are available and are part of the process of how reform to industrial instruments can be

achieved. The *Industrial Relations Act 1996* (**IR Act**) facilitates reform and modernisation, including via:

a. New Awards or variation of Awards

b. Reviews of Awards under section 19 of the IR Act

c. Mutual gains bargaining, and

d. Resolution of industrial disputes under section 130 of the IR Act.

12. Action via the IRC allows parties to have their claims independently reviewed and evidence tested by experienced industrial Judges and Commissioners.

13. The IRC has long had a role in resolving industrial disputes and setting remuneration and other conditions of employment. In exercising these functions, the IRC takes into account the state of the economy of New South Wales and the likely effect of its decisions on the economy.

14. In recent years, industrial associations voiced concern that the IRC's independence was restricted, in that it was required to have regard to the Government's Wages Policy when determining a matter. That restriction is no longer in place with the removal of the *Industrial Relations (Public Sector Conditions of Employment) Regulation 2014*. Since the removal of that limitation, the jurisdiction of the IRC hasnot as yet been utilised fully by NSW Health or the industrial associations to determine any disputes. Doing so is one potential avenue to modernisation of awards.

15. In my experience, for both parties, there can be trepidation attached to advancing matters through the IRC, including where negotiation fails. From an employer's perspective, there could be concern about the reaction of employees and industrial associations, and risks associated with potential back pay. This could encourage a mindset in which the easiest road is often to do nothing, so as to maintain short to medium term industrial harmony, including to avoid industrial action. However, holding such a mindset ultimately leads to stagnation of arrangements and slow modernisation of Award conditions which are out of date.

(iii) Attraction and Retention

16. For many award classifications, salaries and wages in NSW are not competitive compared to other jurisdictions and this can negatively impact on staff satisfaction, engagement and morale.

17. Workforce data provided in the report of Rian Thompson dated 16 July 2024 (**MOH.0010.0377.0001**) demonstrates that the attrition rate is low at 6.6% in the 2023/2024 financial year, and that NSW Health has a high permanent staff retention rate at 92.8% as at June 2024. It is also clear that since 2022, retention has increased. Any decision to provide increases which depart from the Wages Policy will need to involve a cost benefit analysis for that additional cost of wages.

18. Increasing pay rates in line with other states will not necessarily result in increased retention as there are multifaceted reasons as to why an individual will choose to work in one jurisdiction over another, or public versus private. Some of these reasons include:

    a. the type of work and patients seen in the public system versus private sector

    b. the resources available, and

    c. the overheads in running a business, reputation and career progression.

19. Accordingly, increasing salaries in the public health system may not result in greater (or significantly greater) levels of attraction and retention as individuals may simply prefer to work in the private sector where they have greater control over their working life.

20. Against those possible benefits, it would also be necessary to consider the cost of increasing salaries in line with other states. For example, increasing the pay rate for nurses and midwives so that it is in line with Queensland would have a very considerable cost burden as it would apply State-wide, but the effectiveness in terms of attracting some additional staff where they are most needed, such as in rural and remote regions, may be marginal.

21. In addition, an increase in salary and changes to conditions does not necessarily alter any shortage of clinical staff being produced nationally and internationally. If there is an underlying supply constraint, such as in the case of midwives, then increasing salary alone may not resolve staffing shortages, but would put pressure on other states to match the increase. This may then escalate into a bidding war for staff, which is not in line with developing national sustainable health services.

22. As canvassed in my First Statement, workforce challenges are not unique to NSW Health and are experienced across all jurisdictions. NSW Health is mindful that significant changes to remuneration and employment arrangements in NSW will likely impact other public health systems (and potentially the private sector). While NSW Health's salaries are generally not competitive, NSW is still a desirable place to work especially for senior medical practitioners. There is a significant public interest in the states avoiding a counterproductive "bidding war", in order to maintain the sustainability of the public health system in NSW and nationally.

23. Additionally, in my experience, remuneration-based initiatives (or those which are only based on remuneration increases) can create disharmony between sectors of the NSW Health workforce. An example of this is the Rural Health Workforce Incentive Scheme which assists rural and remote facilities, however, it does not provide support for some regional facilities which have recruitment issues because they are not within the geographical boundaries eligible to access the incentives.

24. Another consideration is that paying one staff member a different rate to another that is performing the same role creates internal inequities. While these arrangements are conducted outside of award arrangements, awards generally require equal pay for those doing equal work.

C. INITIATIVES WITHIN NSW HEALTH

25. Despite the challenges outlined above and below, there are a range of initiatives which are underway or under consideration which seek to address attraction and retention concerns. There are particular efforts underway to attract General Practitioners (**GPs**) to the NSW health system and to live in rural towns, as well as entice GPs to work in their local public health service. This is a focus of the Ministry of Health (**MOH**) as the current Rural Doctors Settlement Package and GP Visiting Medical Officer (**VMO**) model faces sustainability challenges in an evolving workforce.

26. The MOH's Workplace Relations Branch is implementing some initiatives under the existing industrial instruments to assist with this, including:

    a. recognition of Rural Generalist GPs as specialists for remuneration under the model sessional VMO contracts

b. engagement of GPs as Staff Specialists in busier rural sites, granting permanent employment and entitlements such as paid annual leave, paid parental leave, and paid leave for continuing professional education

c. exploration of an all-encompassing daily payment for rural work, giving the VMO certainty of income while still allowing opportunity to attend to their private patients, and

d. exploration of an additional Award which could support a staff specialist type model in rural and remote sites.

27. Option a was delivered with the benefit of additional funding arising from recommendations of the Rural Health Inquiry.

28. Further, an example of recent award changes which had cost implications, but which have provided enhanced conditions and clarified confusing clauses in the award for Junior Medical Officers and will hopefully have a positive impact on attraction and retention, is the variation to the *Public Hospital Medical Officers (State) Award* introduced from 1 July 2024. In summary, the award changes:

a. Changed the definition of "registrar", resolving a longstanding dispute between NSW Health and the Australian Salaried Medical Officers Federation (**ASMOF**), and improving pay for some junior doctors employed in registrar roles. This change may also have future benefits in the attraction and retention of junior doctors due to the consequent increase in remuneration during training for those doctors that meet the criteria to progress to registrar more quickly during training.

b. Increased on-call rates and introduction of a new classification of on-call to recognise the system expectations of doctors to provide remote clinical advice whilst on-call.

c. Clarified which shifts include an unpaid 30-minute meal break, resolving an existing ambiguity and promoting a consistent application of the Award across all NSW Health facilities.

d. Clarified calculations relating to overtime rates which has resolved longstanding ambiguity and prevented further disputes in relation to the issue.

29. Building on this work, further initiatives to attract and retain Junior Medical Officers could include:

a. Modernisation and plain English drafting of the Award to reflect the way Junior Medical Officers work in the modern environment. This will reduce disputes around outdated clauses that create tension between employers and Junior Medical Officers and enable Junior Medical Officers to have conditions that they can understand.

b. Rostering specialists on evenings and night would have additional benefits to Junior Medical Officers. Reducing reliance on specialists being on-call after hours, would in turn reduce the clinical workload burden on junior doctors during these times. The provision of additional hours of training and supervision could be recognised by the relevant college for specialist training programs.

c. Consideration of the structure of training rotation allocations with a view to simplify and reduce the frequency of rotations during prevocational training and beyond. This would require significant system adjustment as training networks are designed to ensure that areas of need are appropriately resourced with junior doctors and NSW Health does not have the ability to influence allocation of college-appointed trainees.

d. Colleges reducing their fees in areas of need such as rural and remote facilities; however, this is something that is outside of the control of NSW Health.

30. Each of the potential solutions in (a)-(c) above would have a significant cost to NSW Health, and could not occur without increased funding from NSW Treasury as well as the support of all stakeholders such as the Australian Medical Association (**AMA**), the Colleges and ASMOF.

D. BARGAINING WITH UNIONS

31. The current iterations of NSW Health awards do not allow for the flexibility required to adjust to a changing work environment. There are clauses in the awards that prescribe outdated practices based on hospital or clinical environments from 30 years ago that are not industrial matters and no longer meet the needs of modern workplaces. For example:

a. Awards are restrictive to the level of duties employees might be required to undertake, meaning that, particularly in small hospitals, multiple staff are required to complete different tasks to run a service. A specific example is the NSWNMA recently undertaking industrial action in support of their wages claims, outlining that nurses should not be required to undertake functions such as collecting

medications, answering/talking on phones, updating patient locations, undertaking lower acuity transports and transporting patients.

32. NSW Health has taken steps to negotiate or pursue changes to the awards and instruments with an aim to addressing modern awards that allow for the contemporary delivery of healthcare. It should also be noted that the modernisation of awards is supported by section 19(2) of the IR Act which outlines that the purpose of award review is to modernise awards, to consolidate awards relating to the same industry, and to rescind obsolete awards. In practice, the award review process is an award-by-award review pursuant to some principles of award review and is often not triggered when new awards are routinely made (as the award review process is required every three years – and when new awards are routinely being made then the review process may not be triggered, albeit the IRC will still satisfy itself there is a basis to make a new award). There may be capacity for the IRC to revisit the award review principles, including factoring in some of the developments and considerations of the Fair Work modernisation processes.

33. However, the flexibility around service delivery is hampered by awards, such that scope of practice for staff should not be limited by the award, rather determined by the facility with consideration to size, nature and services and the capacity of the individual in terms of credentialing, qualifications, and training. For example, in a small facility, a cleaner with security credentials could be engaged in a role that allows them to fulfil duties relative to both roles.

34. The awards restrict such flexible arrangements unnecessarily and result in silos of employee types, rather than a collaborative approach to undertaking the tasks required to deliver safe patient care with the resources available. There can be industrial disputes/ submissions such that staff should be able to work to their full scope of practice and not undertake functions such as transporting of patients, yet there is also resistance to team based models of care and allowing support functions such as Assistant in Nursing (NSWNMA has resisted such staff being included as ‘staff’ for the purpose of minimum staffing numbers, and resisted the engagement of Care Assistants to provide provisions such as patient support and care and making beds).

35. Unlike other workplaces, hospitals must continue to run regardless of factors such as staffing levels. A hospital cannot close nor select which patients are accepted. Where there are limiting factors such as staffing availability, it is up to hospital management to

ensure that the safety mechanisms for employees are in place to ensure that appropriate services can be provided for patient and community safety.

36. There are some challenges to the modernisation and reform of industrial instruments, including that:

    a. All industrial instruments are currently subject to bargaining and have new award or award variation applications before the IRC if bargaining is unsuccessful.

    b. It is difficult to vary award terms, including those that have become outdated as it usually requires the parties' consent or by arbitration and decision of the IRC. A party is often loathe to agree to an award variation change unless it benefits their position. For example, the recent log of claim submitted by ASMOF included claims for conditions around performance management and misconduct, workplace health and safety and flexible work arrangements to be included in the award which would not ordinarily be contained in awards, but would be covered in policies or are existing legislative rights. Such conditions create unwieldy and unnecessarily complex instruments.

    c. Ambiguous terms can be utilised by unions to initiate negotiations or industrial disputes, as demonstrated by the series of matters brought in the IRC concerning the scope of the infectious cleaning clause in the *Health Employees' Conditions of Employment (State) Award 2022.* This provision has been in existence for over 40 years. Since 2018 there have been three arbitrated decisions involving the interpretation and application of this provision and a number of disputes at the LHD level about the eligibility and scope of the clause.

    d. under the mutual gains bargaining framework, efficiency gains (offsets) are more readily achieved over extended timeframes. By contrast, remuneration increases sought by unions in agreeing to modernisation and award reform must be realised in the short term; as noted in the NSWNMA's campaign for a 15% pay rise in one year.

37. As shown in the examples set out below, NSW Health is keen to continue with these steps, but any solution must overcome several issues that have arisen in the experiences to date.

(i) Health Services Union (HSU)

38. MOH and the HSU are in discussions on an award reform process which will seek to modernise and update the definitions and classification structures to better suit the needs of the contemporary health workforce.

39. An example of the issues we are seeking to solve through this process is the *Health Professionals Award.* It has a modern and simple structure, but the career pathways for senior Allied Health roles are limited due to the number of senior classifications within the Award. This has resulted in LHDs using the *Health Managers (State) Award*, a copy of which is exhibited to this statement (**MOH.0010.0109.0001**), as an alternative mechanism, to try to attract senior management and clinical expertise. The *Health Managers (State) Award* does not allow for weekend work or shift work penalties making it difficult to roster senior professionals after hours.

40. Additionally, many awards do not meet the needs of a 24/7 health service with on-call provisions only applying to some classifications. For example, both the *Health and Community Employees Psychologists (State) Award* and *Public Hospitals (Professional and Associated Staff) Conditions of Employment (State) Award* do not presently permit on-call/ recall allowances to be paid to psychologists that may need to be called in.

41. Another example of discussions with the HSU involves the use of the *Health Managers (State) Award* for senior Allied Health positions. The parties are considering the introduction of new levels at the top of the Allied Health scale. It is the position of NSW Health that any new levels have equivalent pay to the Health Manager grades that are currently being used.

42. There is in-principle support between the parties for reducing the number of awards to allow for more consistency across classifications. It is the position of NSW Health that any new conditions should allow for senior Allied Health professionals to be rostered 24/7.

43. The HSU and NSW Health have been working on a proposed structure that would reduce the awards with prescribed salaries from 21 to approximately 4 to 5. It is the preference of NSW Health that these classifications be generic, rather than specific to discrete professions. This would allow for Allied Health professionals to provide a wider range of clinical work within their scope of practice.

44. While there is in-principle support from both parties for streamlining the conditions and salaries awards, my concern is that reaching consensus with the HSU will be difficult as it is their current expectation that there be a significant increase in conditions and salaries as an outcome of this process. NSW Health has undertaken modelling of the impact of rolling up allowances across the HSU workforce. Based on analysis of the 2022-23 financial year workforce data, should allowances be rolled up and distributed across the HSU workforce, this would result in an increase of 0.88% across the HSU classifications. While approximately 64% of the HSU workforce would be advantaged, this would leave 36% of the HSU workforce being disadvantaged. A table showing the modelling of the estimated FTE of the HSU employee groups which would be advantaged or disadvantaged by the rolling up of allowances is exhibited (**MOH.0010.0681.0001**).

45. There are also proposed increases to personal leave and annual leave that are estimated to cost hundreds of millions of dollars and have the potential to flow on to demands from other health unions. If agreement cannot be reached, such as because of constraints on funding to provide for these increases to conditions and salaries, this would delay the parties attaining improvements for senior Allied Health professionals as these changes rely on the outcome of award reform.

46. The challenge posed by consolidation of Awards should not be underestimated. An example is where there is disparity between the rates. The night shift penalty rates for Technical Officers is set by the *Health Employees Conditions of Employment (State) Award* at 15%, which is consistent with the rates applying to a majority of health workers. These staff are often working alongside Hospital Scientists who are paid 50% night penalties under the *Hospital Scientists (State) Award*.

47. In any negotiation regarding consolidation of conditions, unions will typically seek the highest rates (e.g. 50%), regardless of whether those rates continue to be fair and relevant in a contemporary workforce setting. If this demand is accepted, it would result in substantial cost increases and compromise the ongoing viability of 24/7 shift operations. In any negotiation regarding the penalty rates, it is unlikely that the HSU would accept any rate lower than the Scientific Officers rate. This is despite the Technical Officer rate being the standard for the majority of Health Workers.

(ii) ASMOF and HSU (the Medical Awards)

48. The *Staff Specialist (State) Award* has deficiencies in that it does not reflect the way in which staff specialists work, including hours of work and overtime provisions. NSW

Health has sought to address these deficiencies through an application to vary the Award lodged by the Health Secretary in June 2023. The IRC made a recommendation on 19 April 2024 that the parties engage in Mutual Gains Bargaining.

49. Arising from this, ASMOF, HSU and NSW Health have commenced Mutual Gains Bargaining for all medical awards, including the *Staff Specialist (State) Award*.

50. ASMOF has submitted its draft log of claims, which is significant with 47 items including a 30% wage claim (**MOH.0010.0686.0001**). No productivity or efficiency measures have been identified which would enable an increase beyond the Government's offer of 10.5% over 3 years.

51. NSW Health hopes that the parties will reach an agreed position, but the variance between the parties' respective positions is vast. The matter may need to proceed to arbitration.

52. NSW Health intends to address four primary objectives during bargaining:

    a. Award flexibility to support service needs

    b. Financial sustainability of arrangements

    c. Improved governance, and

    d. Modernisation and redrafting to plain English.

53. It is NSW Health's position in relation to the bargaining that improved award flexibility, financial sustainability, modernisation and governance will provide a framework which is consistent, clear and equitable for staff and ensure the award is not a barrier to the contemporary delivery of healthcare now and into the future. Clarification and modernisation of the awards will address existing issues and reduce award disputation in the future.

(iii) Nurses' and Midwives' Association

54. There has been significant historical disputation with the NSWNMA regarding the interpretation of ambiguous award provisions. For example, subclause 12(v) of the *Public Health System Nurses and Midwives (State) Award* contains a clause that provides an in charge (of shift) allowance where there is no Nursing/Midwifery Unit Manager rostered and a staff member is designated to be in charge of a ward/unit. It also provides for the

allowance to be payable where a Nursing/Midwifery Unit Manager is rostered, but the clinical management role for the shift is delegated to a designated registered nurse/midwife. The clause has been the subject of many disputes (including multiple IRC arbitrations) that has included submissions on questions such as whether:

a. the clinical management role of the shift has been delegated to a designated nurse/midwife

b. some or all of the functions needs to be delegated to attract the allowance

c. there needs to be expressed delegation of the functions (or mere knowledge that staff were performing such functions), and

d. multiple staff can be designated as in charge of shift.

55. There would be difficulties in modernising this clause. From NSW Health's perspective, it is concerned that any attempt to do so may lead to a risk of an interpretation that is different to the current application. The NSWNMA may be concerned that the clause may cease to be paid for some staff who are currently in receipt of the allowance.

56. In 2024, NSWNMA made an extensive award claim, seeking a 15% wage increase for the first year and significant enhancements to its staffing claim including mandated staffing levels and broadened labour restrictions.

57. There has been considerable disputation in relation to this claim, including work bans on functions such as:

a. answering phones

b. transporting patients

c. collecting patient medication

d. filling out paperwork or records such as patient locations and risk assessments, and

e. clinical protocols.

58. There have also been strikes on 10 and 24 September 2024. On 30 September 2024, the parties agreed to accept the IRCs recommendation for a resolution pathway that involves payment of a 3% interim increase, a period of extensive discussions, arbitration

where parties are unable to reach agreement, and limitations on taking industrial action throughout this process

(iv) General observations on bargaining as a solution to Award reform

59. In my experience, while "award reform" as a general concept is welcomed by all parties, specific award reform initiatives face significant resistance in practice.

60. There might not be complete agreement between parties as to what constitutes "award reform". From my dealings with health sector unions, across many negotiations and disputes, my impression is that unions interpret "award reform" differently from NSW Health.

61. NSW Health interprets "award reform" as the process of modernising, simplifying, and reducing the number of NSW Health awards, determinations and classifications so that they are fit for purpose now and into the future, by creating:

    a. industrial instruments that provide for flexibility and facilitate rather than hinder clinical and operational improvement.

    b. plain English, streamlined awards that provide consistent and easy to understand salaries, salary progression and workplace entitlements across the sector which may bring benefits such as clarity, reduced industrial disputes, and potentially realise workforce operational benefits.

62. On the other hand, unions view "award reform" as a mechanism to improve workplace entitlements and salaries for their members, including the introduction of additional allowances and leave.

63. One reason for this divergence of views is that the parties and stakeholders to award reform and agreement often have different interests; the unions seeking pay increases and better employment terms and conditions. On the other hand, NSW Health is subject to the Wages Policy, where the identification of efficiency and productivity measures is challenging, and reduction to FTE or service provision is not politically acceptable or acceptable to the community and unions.

64. Further, I am of the view that modern awards should enable flexible work practices and the contemporary delivery of health care in a changing environment. However, complex sets of conditions in awards leave little room for the adaptation and modernisation of such awards. For example:

a. The HSU is seeking to include a requirement in awards for NSW Health to ensure workplaces are sufficiently staffed and resourced. While this may be an important matter it is not an industrial matter and is covered by NSW Health policy, continual review and consultation, and managerial decision making.

b. Current claims by the NSWNMA seek to restrict the number of non-Registered Nurses/Midwives that can exist in a staffing profile and restrict Assistants in Nursing as counting towards required staffing numbers and require minimum staffing levels of supernumerary staff (ie non direct care staff) irrespective of activity levels. ASMOF seeks to have Workplace Health and Safety clauses which is adequately covered in legislation.

65. While health sector unions and NSW Health can see benefit in providing consistent entitlements to health workers to promote fairness and reduce division, unions argue for increased entitlements across the board by choosing the best current award entitlements and proposing that they to apply to all health workers. In my experience, unions can use discrete and peripheral issues as bargaining chips in the context of award reform negotiations and will withhold their agreement to reforms (for example, removing ambiguity from a particular clause) unless they can exchange it for some other benefit.

66. To be clear, this is not a criticism of unions as it is their function to seek maximum benefit for their members. There may be improved efficiencies, operational ease and collaborative patient care should it be possible to consolidate, reduce and simplify awards and clauses. For example, there may be benefits in rostering across distinct groups of workers.

67. However, current health awards have clauses describing “normal hours” which differ, varied shift clauses which differ, and some classifications have an entitlement to ADOs, and others do not. These differences result in rosters being written for different groups working in the same department and caring for the same patients.

68. Having less classifications and more workers under awards with the same conditions could remove the need to roster classifications separately and allow for rostering across a department where there are different types of workers, thus promoting a team-based delivery of service. Presently doctors, nurses, Allied Health support and administrative employees are generally rostered by classification due to the different award clauses and complexity of the awards that apply. Rostering staff are often experts in rostering one classification such as medical due to the complexity of the award and the impact of

the award on the way rosters are written. There may be efficiency in less complex rostering systems, training and a reduction in policy and guidelines to assist in navigating the awards.

69. In my view, when considering award reform and other initiatives which reduce the outdated nature of the awards, it is crucial to take into account the industrial context in which any reforms and/or changes to industrial instruments would occur. The process for negotiating and agreeing reforms to industrial instruments cannot occur at the initiative of NSW Health unilaterally. Changes will either need the consent of industrial associations or the arrangements will need to be arbitrated by the IRC. Industrial relations involve constant bargaining processes, and NSW Health is but one party, together with the relevant unions, to the industrial instruments which apply to the NSW Health workforce. A negotiation is by its nature a process of give and take, and each party must bring 'something to the table' in order to reach agreement. That can present difficulties for progress when, as noted, additional increases to remuneration may only be offered when offset in accordance with the Wages Policy.

E. FUTURE REFORM

70. NSW Health has a range of initiatives to attract and retain staff by means other than an across-the-board remuneration increase. I understand that a number of these are addressed in my colleagues' statements to the Inquiry. I have limited my discussion below to those initiatives which could improve the operation of the awards and instruments.

71. Future reforms must focus on the ability of NSW Health to support the development of a multiskilled, adaptable workforce and this is achieved by removing restrictions and allowing increased flexibility.

72. Adopting restrictive staff practices, including within awards, can limit the capacity to build workforce pipelines and address issues such as workforce shortages. For example, placing workforce restrictions on the engagement of Assistants in Nursing/Midwifery (or adopting workplace practices that make such workforce unattractive) reduces a workforce pipeline for Nursing/Midwifery Staff, and reduces staffing models including in circumstances where there are limited or challenges associated with the Nursing/Midwifery workforces.

73. Taking a broader picture perspective, in my opinion, the classification of healthcare professional roles could be reconsidered, including to factor in team-based models of

care. In particular, the demarcation of nursing, medical and Allied Health roles leads to challenges in achieving effective workforce utilisation, efficiencies, flexibility and innovation in service delivery and staff satisfaction. The demarcation of roles, and the strict barriers between them, which are underpinned and maintained by the system of segregated awards, also causes operational challenges and disputes (for example, who is responsible to undertake a particular activity such as a cleaning service). If it were possible to redraw some of these classifications and boundaries, in my view, significant benefits could be realised.

74. For example, considerable disputes have arisen about the provision of patient meals and whether cleaning certain areas is a nurse function or a function of the health services union classifications. Having hard barriers is difficult as in reality what is appropriate may depend on the circumstances factoring in elements such as activity levels, staff availability and the size of the facility. For example, a health services union classification may deliver meals to patients, however, some patients may be seeing doctors or not able to access meals at this timing point. In such cases, it is necessary for nursing staff to continue to provide patient care which includes ensuring meals at a later time. Further, having regard to the size, activity levels and breadth of care, it may not be feasible to always have dedicated support staff on to perform the functions that are often subject to the demarcation issues.

75. I find it difficult to envisage that we would be able to achieve full modernisation of the award structure that supports the future health requirements without a significant investment in resources, even then it would be extremely challenging for the reasons I outline above. The professional workforce structure has evolved over a long period of time and there are many stakeholders beyond NSW Health who would play a critical and decisive role in any such reform. Some stakeholders, such as unions and medical colleges, have a vested interest in maintaining the present demarcation which defines their membership.

76. For example, the paramedic pilot is a 10-week trial that has commenced in Mudgee Hospital's emergency department and the Wagga Wagga Rapid Access Clinic and Hospital. The trial has paramedics on secondment from NSW Ambulance working alongside doctors, nurses and other healthcare professionals to improve access to care in regional healthcare settings. Paramedics are integrated into the emergency department and provide support to existing staff in the provision of patient care they are an addition to the regular full suite of staff at Mudgee and Wagga Wagga.

77. If the trial is successful there will still be significant industrial barriers to rolling out the program. The definition of the employer in the *NSW Ambulance Paramedics (State) Award 2023* does not extend to employing paramedics anywhere else in the Health System (other than NSW Ambulance). To enable Local Health Districts to employ paramedics, an industrial instrument for non-NSW Ambulance paramedics may need to be created.

78. However, any NSW Health application for a new award or an award variation that facilitates paramedics in hospital settings is likely to be opposed by the NSWNMA due to their traditional opposition to any role that opens up traditional nursing functions to areas not within their union coverage. In consultation regarding the trial, the NSWNMA have made it clear that they hold concerns that these roles will seek to replace nursing roles despite being given assurances that the paramedics will be providing assistance that is in addition to the current establishment or any outcomes from the roll out of the safe staffing level increases.

79. In the future, I would like to see reform of industrial instruments undertaken as a step to realise a clear vision of the future NSW Health workforce. In my opinion, that vision should first be articulated and then it should be supported by award reform planning.

80. In my experience, there can be a tendency for vision and planning to be constrained by, and factoring in, the existing award framework and industrial limitations. In my view, there is scope for a future workforce plan to instead shape the program of award reform for NSW Health. The awards should be an enabler, not a barrier to creating the health workforce and associated models of care for the future. This vision should be designed by workforce planners and clinicians linked to health system needs, not driven by industrial instruments. This reinforces the need for simplified, lean awards that are not overly prescriptive or restrictive of the changing needs of NSW Health.

81. A large and ongoing body of work requiring dedicated resources in the MOH is required to support large scale and efficient award reform for NSW Health. This will require funding in terms of the resources required, the costs that will come from bargaining large scale changes with Unions and to consolidate awards where the most favourable clauses will likely be those that are applied.

Melissa Collins

Louis Yuill

Date: 4 October 2024

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