Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Thursday, 17 October 2024 at 10am

(Day 057)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu SC with
Ms Emily Aitken for NSW Health

THE COMMISSIONER: Good morning.

MR MUSTON: Good morning, Commissioner. This morning we're having a panel which has as its principal focus issues around award reform and the way in which that might be approached.

From your left to your right, we have Gerard Hayes AM, the New South Wales state secretary of the Health Services Union; Shaye Candish, the general secretary of the NSW Nurses and Midwives' Association; Melissa Collins, acting executive director of workplace relations within the ministry, who has given some evidence before us before; Dominic Egan, the director of workplace relations at the AMA, who again has given some evidence to the Commission before; Andrew Holland, the executive director of ASMOF; and Phil Minns, deputy secretary people, culture and governance in the New South Wales ministry, who has given evidence twice before. We're burdening him once again.

I haven't worked out which of them are taking oaths or affirmations.

THE COMMISSIONER: We might just do it one by one.

<GERARD JOHN HAYES, sworn: [10.03am]

<SHAYE MAREE CANDISH, affirmed:

<MELISSA ANNE COLLINS, affirmed:

<DOMINIQUE EGAN, sworn:

<ANDREW HOLLAND, affirmed:

<PHILLIP GREGORY MINNS, sworn:

MR MUSTON: Thank you. Mr Hayes, could you state your full name for the record, please.

MR HAYES: Gerard John Hayes.

MR MUSTON: You've prepared a statement to assist the Inquiry with its work dated 30 September 2024?

MR HAYES: That's correct.

MR MUSTON: Have you had an opportunity to read that statement before giving your evidence this morning?

MR HAYES: I have.

MR MUSTON: You are satisfied that its contents are, to the best of your knowledge, true and correct?

MR HAYES: That's correct.

MR MUSTON: That's the document at L15, Commissioner.

Ms Candish, could you state your full name for the record, please.

MS CANDISH: Shaye Maree Candish.

MR MUSTON: Did you participate in the preparation of the Nurses and Midwives' Association submission to the Commission?

MS CANDISH: Yes, I did.

MR MUSTON: Have you had an opportunity to review that more recently?

MS CANDISH: Yes.

MR MUSTON: Are you satisfied that it is true and correct, to the best of your knowledge?

MS CANDISH: Yes, it is.

MR MUSTON: And reflects the views of your organisation?

MS CANDISH: Yes, it does, thank you.

MR MUSTON: Ms Collins, could you state your full name for the record.

MS COLLINS: Melissa Anne Collins.

MR MUSTON: You have prepared three statements to assist the Inquiry with its work, the most recent being a statement dated 4 October 2024?

MS COLLINS: Yes.

MR MUSTON: Have you had an opportunity to review that before giving your evidence this morning?

MS COLLINS: I have.

MR MUSTON: Are you satisfied that its contents are true and correct?

MS COLLINS: Yes.

MR MUSTON: Commissioner, that is at L5. Just for the record, the other two statements are 17 July 2024, H5.23, and 3 August 2024, which is H5.23.2.

THE COMMISSIONER: I have them all here.

MR MUSTON: There are more to come.

Ms Egan, could you state your full name for the record, please?

MS EGAN: Dominique Egan.

MR MUSTON: You've prepared a statement to assist the Inquiry with its work, dated 25 July 2024?

MS EGAN: Yes, I have.

MR MUSTON: Commissioner, that statement was tendered as H7.13.

THE COMMISSIONER: Yes.

MR MUSTON: Mr Holland, could you state your name for the record, please.

MR HOLLAND: Andrew Holland.

MR MUSTON: You have prepared a statement to assist the Inquiry with its work, dated 30 September 2024?

MR HOLLAND: Yes.

MR MUSTON: Have you had an opportunity to review that this morning before giving your evidence?

MR HOLLAND: I have.

MR MUSTON: Are you satisfied that its contents are true and correct?

MR HOLLAND: Yes.

MR MUSTON: That's document L16, Commissioner,

Mr Minns could you state your full name for the record.

MR MINNS: Phillip Gregory Minns.

MR MUSTON: You have prepared five statements to assist the Inquiry with its work, the most recent of which is dated 16 October 2024?

MR MINNS: Correct.

MR MUSTON: In respect of that statement, have you had an opportunity to review it this morning before giving your evidence?

MR MINNS: Yes.

MR MUSTON: Are you satisfied that its contents are, to the best of your knowledge, true and correct?

MR MINNS: I am.

MR MUSTON: Commissioner, that is the document at L6.3.

For the record, the other statements prepared by Mr Minns are 9 April 2024, which is D5; 7 June 2024, which is G112; 17 July 2024, which is H5.22; and 8 October 2024, which is L6.

The evidence that the Commission has received to date, both in its metropolitan hearings and through its regional hearings suggests that the existing awards - and in using the term "awards" I will include the VMO determination for present purposes - for members of the health workforce, have failed to evolve and therefore don't appropriately reflect the way in which health care is, or at least should be, delivered by that workforce in 2024. The suggestion or the term that has been used, not infrequently, is that the

awards are not "fit for purpose".

Perhaps going through each of you one at a time, Mr Hayes, at least insofar as the group of or the section of health workforce that your organisation represents, does that accord with your view?

MR HAYES: Absolutely. There is no doubt about that at all.

MR MUSTON: Ms Candish, does that accord with your view?

MS CANDISH: No, that doesn't.

MR MUSTON: In what sense do you say - in what way do you say that the award that relates to the nursing section, the nursing and midwifery section of the workforce, is fit for purpose?

MS CANDISH: I think from our perspective, we really have one predominant award that covers nurses and midwives in the public health system, and over the years, we have seen some modernisation. We don't really have clauses that we would reference as being not fit for purpose. Most of those have already been removed. So I think the issues probably that other parties are experiencing might not be quite the same as ours.

MR MUSTON: I might jump over you momentarily, Ms Collins, and come back to the ministry's views.

Ms Egan, insofar as the VMO determination is concerned, I think you've given evidence to this effect previously, but does that effectively capture your views and the views of your organisation in respect of that determination?

MS EGAN: Yes, it does.

MR MUSTON: Mr Holland? From ASMOF?

MR HOLLAND: Yes, most definitely.

MR MUSTON: Ms Collins, in relation to at least the awards which are captured by Mr Hayes's membership, the VMO determination and the staff specialist and junior doctors awards, is it your view and the ministry view that they

have failed to evolve and therefore do not appropriately reflect the way in which those sections of the workforce are or should be delivering health care in a contemporary era?

MS COLLINS: Look, it is not a simple answer, of course. You've got to look at each of the awards, but I certainly do concur. Especially in relation to Mr Hayes's evidence, I think you would actually look at both our statements and see a lot of similarities. I think we are on the same page around consolidation, modernisation.

In looking at what is fit for purpose, obviously the ministry, as the employer, is going to have slightly different views to my colleagues at the table around we would see things, modernisation and fit for purpose being about increasing flexibility and streamlining awards, where generally the unions will want more in the awards, you know, and rightly so. But certainly I think there are barriers in many of the awards that we would - if we had the opportunity, we would like to review and increase flexibility. So --

MR MUSTON: Can I ask you specifically in relation to the awards covering nurses and midwives, is it your view that they are currently fit for purpose or do you have a view that a process of modernisation of that award would also be of some benefit to the system?

MS COLLINS: Look, I think there's always, you know, changes that an employer might make to an award, but largely I agree with Ms Candish that it's an award that has been through a more modernised process, it is generally - generally - relatively easy to understand. I don't think there are many clauses where there are disputes between the parties about what it means.

But certainly, of course, you could always - the telephone allowance is probably a bit redundant, but generally, we use that award; we employ many - over 60,000 - nurses on it. There's not necessarily barriers in that award. We might have different views around, you know, the implementation of safe staffing, but generally, no, I would say in terms of modernisation and being fit for purpose, I think we're probably on the same page there.

MR MUSTON: Mr Minns, did you want to add anything to

that?

MR MINNS: No, I would support Ms Collins's remarks.

MR MUSTON: At a high level - I'm not asking you, Mr Hayes, to go through line by line the awards and tell us what is wrong with it - broadly conceptually what is it that you see from the point of view of your membership which renders those awards no longer fit for purpose? If we could just park for the moment the question of the actual rate of remuneration, understanding it's important to all of you, but I think we understand where that controversy lies.

MR HAYES: Yes. I think in this day and age we - in terms of remuneration, it goes to the point of it's a competitive market now and there are certain finite resources in terms of a range of employment roles.

What we see particularly with our allied health professionals is scope of practice - and our paramedics. Paramedics last year received effectively a 28 per cent increase over 18 months. That wasn't because of the government's good graces, that was because of the scope of practice they have on the road now that actually can change people's lives but the risk that they take in applying the skills that they have, they're now professionals in their own right.

Effectively, their role has evolved from being an ambulance driver, where, you know, in effect, their remuneration was commensurate with that; now they are far more than that. They are clinicians in the community that actually can change lives and not necessarily have to take people to hospital anymore. So that's one basic part there.

In terms of the allied health professionals, we're looking at people like sonographers and radiotherapists who - not only are Queensland and other states screaming out for them to come, the qualifications they have when the award was written didn't exist. So in terms of what they're actually doing now, we're dealing with 2007 as opposed to 2024.

MR MUSTON: So in that respect, are there aspects of the awards which constrain in some way their ability to utilise

that skill back that they have in 2024?

MR HAYES: There is more and more pressure, but particularly with our paramedic membership, to do more and basically suck it up. They are putting themselves, in my view, into a very dynamic clinical situation that, done well, gets amazing outcomes, but, like any clinical situation, there is always risk associated with that. That risk had not been appreciated up until a point, but every single year we will see more and more added to their scope of practice, which is wonderful for community, fantastic for our members, but recognising that that comes with consequences as well.

MR MUSTON: In terms of award modernisation, the fact that your membership is covered by a very large number of awards, what is it that you think should ideally happen as part of a modernisation process in respect of the sheer number of the awards, before we even move to their content?

MR HAYES: We firmly believe in terms of our allied health membership it should probably go from about 15 awards and determinations down to three to five. That is reflective of the particular streams that they're associated with. Our broader membership has 35 different awards, I think 15 to 16 different determinations, including - and I say this consistently, many of my younger staff don't quite understand what an incinerator is, let alone the incinerator allowance. These things haven't existed for decades and yet we're entertaining them in the awards.

So what we're saying is that we can make the awards more efficient, more productive, better outcomes for the community, at the same time respecting the actual quality and experience and qualifications that our members have. We can either compete in the market or we don't, and if we don't, well, we're just going to watch people just leaving anyway.

MR MUSTON: Ms Collins, in terms of the award consolidation concept that Mr Hayes has just alluded, do you share his view? I gather from your statement that you do, but to make sure you share it as it's been expressed today?

MS COLLINS: Yes, certainly. I think 36 awards, and that's just HSU qualifications, is no doubt unwieldy. It

is hard for managers, because you have different conditions, you'll be having people working in the same unit, different conditions. It is difficult. You know, in an ideal world, total blue sky, you would move to a fair work kind of model where you've got the national employment standards, there's, like, core conditions that would go across NSW Health.

Now, this is getting probably a bit controversial, but, of course, that would be easy, that would be what true modernisation and simplification is. Then you would have, I guess, additional awards for particular craft groups that don't fit into the modern award. I think Mr Hayes is more realistic. I think, you know, between three to seven in the HSU space would be worthwhile.

MR MUSTON: Other than the administrative challenges associated with making sure that you're working out who's on what award and what that means in terms of the way in which you're dealing with that member of your workforce, what are the other challenges that the multitude of awards pose for the health system generally and the way in which it operates?

MS COLLINS: Look, I think you could look at each individual award and talk to its challenges. In terms of the multiple awards, I think demarcations can be difficult between the high-level craft groups but also individually, as in what does a wardsperson do versus a cleaner versus a - oh, gosh, what they are called - patient services assistant.

Those things create practical on-the-ground difficulties. But I think to Mr Hayes's point as well, it is some of the outdatedness of the awards. The incinerator allowance is an obvious one but many of the awards refer to numbers of beds, peer group levels, you know, patients and kind of what are more outdated, kind of, you know, rigid models.

The more flexibility there is in the awards, the easier it will be to manage such a large health system at an individual level. I think you probably have heard evidence that the challenges are unique to different facilities. The facility down the road, you know, can have very different challenges to the one up the road. There needs to be, I think, a lot more flexibility and less

rigidity in the awards to be able to let health services, I guess, manage to their unique circumstances, and the awards can be a barrier to that.

MR MUSTON: Mr Holland, we've heard from many of your members who have told us that the staff specialist award, in particular, is no longer fit for purpose or is outdated in a range of respects.

From the organisation's point of view, could you just identify for us what are the sorts of issues in terms of the way in which the award operates which hinder the way health care is able to be delivered in the public system in your view?

MR HOLLAND: I might commence by saying our approach isn't just in relation to the staff specialist award. We do have three other awards, including, as referenced, the medical officers or junior medical officers award.

In relation to the staff specialist award, our approach has been very much about taking the opportunity that the new Labor government introduced to engage in their mutual gains bargaining approach because a fundamental and underlying issue for us has just been the lack of any type of modernisation, review of the award. So taking the opportunity to work, we believe, collaboratively with our members and with the ministry, to actually look at a whole range of concerns in the award, and through that we've developed quite a comprehensive set of issues or claims that we've put forward.

If we narrow it down to the key issue, for us, it is the question of attracting and retaining staff specialists, you know, within the public system at full fractions. The question of both attraction and retention isn't just about losing doctors interstate, it's going private, but it's also reducing fractions in the public system to work privately.

At the core of that are questions around remuneration, in particular out of hours work. The staff specialists award has no provision for overtime and has very limited scope in relation to recognising and paying for out of hours work. Currently it only applies to the emergency physicians.

MR MUSTON: Just pausing there, that's not preventing out of hours work from being done within the system, I assume?

MR HOLLAND: That most definitely doesn't prevent it, and in fact this is one of the problems that our members raise, that in spite of the lack of provisions in the award which formally recognise and formally pay penalties or overtime, there's a lot of unpaid work being undertaken by staff specialists.

That links to other issues regarding workloads, so, you know, the inability of an award to actually address or deal with questions of workload fatigue, safe staffing. Under the broad umbrella of work health and safety, none of the awards have any provisions in relation to safe work hours which presents and causes many problems for our members.

They're kind of the key issues. I don't want to imply that they're the only issues, but they are the key issues for that award.

Similar issues in the other awards, but they have their own details that we can look at as well.

MR MUSTON: You've raised this issue of safe staffing hours and safe staffing levels. Could I perhaps turn to you, Ms Collins. You gave some evidence a moment ago about concerns around a lack of flexibility within awards, the existing awards. Perhaps could I invite you to just expand on what you meant by that and whether that - how that might sit in the context of a rigid award structure which included things like an identified level of safe hours or in the case of some evidence we heard this week from the nurses and midwives around ratios and the extent to which building that into an award can impact on a health system. What are you able to tell us about that?

MS COLLINS: Certainly. Of course, as an employer, of course we want safe hours and we want safe workloads. I think I should say that up-front. The question is - whether that needs to be in an award is a different question. Nursing hours per patient day I guess is the best example. I think that was in 2008, and that's, I think, probably largely worked well.

Now, of course, the problem with a system such as not

just NSW Health but health systems across Australia and internationally, is we have workforce shortages, particularly in medical, but in New South Wales we're very much seeing it in allied health and then rurally and regionally.

So the other challenge, of course, is we can't shut our doors. We must continue to provide health services. So if we don't have the staff, we will have to look at changing models of care and how we provide care safely because we just don't have the option to say, "Ten people called in sick", or, "we've got so many vacancies, this hospital is shut today." That's just not available to us, it is available in other industries.

I think the challenge of putting very rigid workload or ratio tools - safe staffing levels, for example - is the rigidity it requires, and the consequence of when we can't meet those, for whatever reason, what we've seen is penalty proceedings and civil penalty proceedings against us.

Now, when you look at nursing hours per patient day, I guess, there's unders and overs, so often we do staff above but there are occasions where we can't staff. Nursing hours per patient day has traditionally been perceived - is probably a bit more flexible in that it balances across the week, so that it allows managers a bit more discretion to, I guess, move staff in accordance with activity.

I think that's probably - we do need that flexibility to put staff where there is activity as opposed to kind of, I guess, cruder workload tools that say, "Well, we must have this many staff on this many shifts", that doesn't necessarily take into account activity and acuity.

I just think in an area, especially in medical, where there's an international workforce shortage, to put such tools in the award is going to create further issues for NSW Health. We have to, as an employer, balance all these considerations and not just say that it might be better in a policy. You know, we've recently updated our fatigue management policy, so there are certainly avenues available, but if you are talking about modern streamlined awards, have a look at the modern awards and many EBAs, they don't contain these restrictive provisions.

So modernisation and streamlining is also about creating flexibility and I accept it's a really hard balance.

MR MUSTON: Can I ask you, Ms Candish, perhaps to comment on that? Without needing to get into the detail of any ratio or provision, just speaking for present purposes conceptually, what is the value, if any, of including in industrial instruments these things which might bring a level of inflexibility in terms of the way in which health care is able to be delivered day-to-day, particularly having regard to workforce challenges?

MS CANDISH: I suppose what we would say is somewhat different than Ms Collins. From our perspective, there is still flexibility available with workload tools like ratios and nursing hours per patient day. Fundamentally, I think we have a different view about how they're applied. From our perspective, these tools are a minimum which gives you the capacity to flex up or down. What we've seen happen is that they're applied as a maximum.

The logic of applying a tool such as this is that it protects vulnerable groups. We see it in schools, we see it child care. The prospect of having a minimum staffing arrangement to provide the necessary resources is not really all that surprising or unheard of.

What we've, though, also observed is the exploitation that happens when we don't have staffing models applied or when staffing models are not being enforced appropriately.

This is off the back of, I suppose, a bigger picture and bigger consideration where we've seen psychosocial injury increase by 150 per cent here in New South Wales in relation to nurses and midwives.

One of the key components of that is in relation to role overload. The evidence is incredibly compelling about the numbers of appropriate nursing staff to patients, in relation to how that improves statistics in relation to mortality and morbidity, but clearly, it also has an impact on the psychological welfare of the workforce as well.

So having some fundamental minimums, we think, and we say, supports the work health safety requirements of NSW Health, but also provides quality outcomes for patient

care.

MR MUSTON: How do you deal with a situation where the workforce challenges, which the Inquiry has been told so much about, make it impossible on a particular day or in a particular location to meet the requirements of an industrial instrument, if that's where it's included? Accepting that, as I think Ms Collins has said, a safe workplace is something that everyone should aspire to, and whether it's in a policy or an industrial instrument might be a matter that could be teased out, but how do you suggest that this situation be dealt with where they can't be satisfied? You mentioned child care. As unappealing to any parent as it might be, it is possible for a childcare centre to say, "We can't take them today", but you can't say that in a hospital.

MS CANDISH: As we've worked through this process, particularly in relation to ratios, we've spoken in the negotiations about provisions that allow for us to have amended ratios. But there still needs to be some consideration of what a minimum requirement should be, in our view, because that really sets everyone's sights to how you achieve and how you maintain what that minimum standard would be and what the strategies are that you put in place to go and address what that shortage might be for that period of time.

Now, there will be places, like in regional New South Wales, for example, where those challenges are more acute than others, but what we're frankly seeing in previous behaviour from some of the LHDs is a disregard for the requirements, where other people in other LHDs are able to apply different methodologies and achieve different outcomes.

What we would hope to see is the standardisation of expectation around what minimum staffing looks like and the strategies that are implemented to try and achieve those improvements where we are identifying challenges. We've certainly been open to exploring what those options can be when we've been in discussions and negotiations about how ratios would apply.

MR MUSTON: Could that be achieved through a policy rather than including it in an industrial instrument or do you have a view that that would not work and, if so, why not?

MS CANDISH: Our view is that that wouldn't be appropriate given the lack of enforceability. I'm sure Ms Collins could probably give you more accurate evidence, but I think the NSW Health program have some thousands of policies, which would make us fairly reluctant to rely upon that as any type of enforceable measure to make sure that minimum staffing applied, given the significance of this particular area.

MR MUSTON: Mr Holland, I might come back to you just on this issue of the benefit or disbenefit, depending on which view you take, of including details like ratios or, in your case, minimum or maximum safe working hours, into an industrial award rather than having it as part of a policy or an overarching workplace health and safety procedure. What is it about the current state of affairs which means there is value in including those arguably inflexible matters in industrial instruments?

MR HOLLAND: I think the only way to really address it is to look at the underlying premise around what constitutes flexibility. From our position, if flexibility is more than just a one-sided equation, ie, if flexibility truly is about taking on board the ability for employees and employer to collaborate, to engage with each other, to find the best solutions via an instrument, whether it be a policy or an industrial instrument, and if there's a commitment from both sides in relation to questions around safe staffing and workloads - if there is commitment from the employer to ensure that fundamental work health and safety issues are met or obligations are met, then neither the policy nor the industrial instrument should be more or less flexible or inflexible. That is, the question of the commitment from the employer to implement what they put in policy should equally apply as in an industrial instrument.

Our concern - this is really, I think, at the crux of the issue, and not solely related, I think, to the ministry but many employers - is that the fundamental difference is the ability of the unions and the ability of our members to be able to enforce conditions or better enforce conditions that are laid out in an industrial instrument.

We do not accept that is inflexible. We believe that is fundamental to the provision of a safe working

environment and the provision of, you know, NSW Health being what we've called in our claims, for instance, an employer of choice.

As it currently stands, I think there is evidence, and I think all three unions probably experience this, where - there is evidence that our ability to enforce some minimum standards or enforce some basic principles, where they're only found in policy is far, far more difficult to be able to do that, and obviously there's the inability of the Industrial Relations Commission, for example, to be able to adequately deal with any disputes or any concerns around conditions that are solving policy.

So basically for us, getting a provision in an instrument is about certainty, providing certainty for both members and the employer. It's about consistency, for us. You know, the issue of having a single or fewer industrial instruments which provide fundamental conditions is certainty all around. Ultimately, though, it is the ability for everyone to ensure that commitments made on any of these issues are met and we have a regime to be able to ensure those commitments are met.

MR MUSTON: Given we're surveying a landscape which is still littered with things like, as Mr Hayes tells us, incinerator allowances and the like, is there not a risk that by including these sorts of matters in the industrial instrument, the health system loses its ability to be dynamic and change and adjust, and the way in which we're able to safely and effectively deliver medicine with emerging technologies, changes in modes of practice and the like come about will be hampered in some way?

MR HOLLAND: I suggest that over the last decade and a bit, where the single - or one of the main reasons for the failure for there to be an agile and dynamic approach to conditions has been the implementation of a rigid policy of the previous government and the regulation.

I would answer your question in a comparison with interstate, where our colleagues, if I take Victoria, for example, have been bargaining under the fair work regime for a number of years, where they, through that process, there's been regular review and engagement between the union and the members and management. I don't think it would be appropriate for anyone to suggest that the

iterations of enterprise agreements that have evolved through those other states in any way prevent flexibility or prevent the system to work, and from the members' perspective, at the same time providing certain guarantees where we have enterprise agreements and awards in other states that go well beyond - well beyond - what we currently have in our awards in New South Wales. I'm not just talking about remuneration; I'm talking about a range of conditions that have been touched on today.

I think if you look at a lot of experiences where there has been a degree of flexibility that is truly flexibility on both sides, not a one-sided equation from the employer, I think the experience across the country can show that in many industries, including our own, the evidence does not suggest that it in any way, shape or form prohibits or prevents innovation or prevents new ways of working or new ways of adapting to change in a workplace. Quite the contrary.

I think one of the issues we have identified with our members - I think it's come up in the Inquiry - is a degree of lack of trust. When we look at some of the issues that were raised a number of years ago in the Garling Inquiry about clinical engagement, I think the failure of proper clinical engagement extends all the way through - a lack of trust to actually trust the members to come up with some good solutions. I think that's inherent here, too.

Putting these terms and conditions in awards that are going to be renegotiated over the years doesn't mean that we are just going to rigidly apply one provision forever and a day. We want the flexibility to be able to negotiate better terms and conditions for the members, and taking into account the concerns that have been put forward by the government and the ministry.

MR MUSTON: The lack of trust you refer to, would it be fair to say it goes both ways, in the sense that whilst you've pointed to a perceived lack of trust on the part of the ministry to trust in your members and its workforce to engage in relation to these matters, similarly, I rather infer from your evidence that the perceived need to include these matters in industrial instruments so that they can be enforced is driven by a lack of trust on the part of your organisation and its members in the ministry?

MR HOLLAND: Absolutely. No, I fully acknowledge that, and as I think I have touched on in my evidence - you know, and the cliche about culture eating strategy for breakfast, I think structurally, there's been some positive changes implemented by the new government, but the culture remains, and I think from the union's perspective - and here I can only speak from our union's perspective - there is a degree of lack of - and the members - there is still a degree of distrust of agendas and what genuineness is being brought to the table from the ministry.

I acknowledge that, and it's an issue we need to deal with, it's an issue we're trying to deal with internally and grapple with. It's not easy. It's not easy. Yes, at no point in time do I want to suggest that it's a single highway there. It goes both ways. Yes. We've got a lot of work to do there.

MR MUSTON: Is the situation similar, Ms Candish, within your membership in terms of that lack of trust, perhaps bi-directional lack of trust as you perceive it?

MS CANDISH: I think that's correct. I suppose I would make the observation that we've had a decade of wage policy that has prevented negotiations, so it isn't really built into the culture here in New South Wales.

I can't speak for other unions, but our union bargains in the federal system as well. It's fundamentally built into what we do, we collaboratively work with many of the employers. At times there's disputation, you don't always agree, but again, you know, we obviously operate across a number of different health companies, and we don't see any stagnation around innovation. We deal with modernisation as each of the EA negotiation processes come up, and you work through the issues and you get to an outcome.

I think what we haven't had here in New South Wales is the ability to engage in that similar way and so all of the parties, I think, are attempting to try and re-establish what some of those terms of engagement look like. I do think that there is - I hope I'm not speaking - well, I'll speak for myself. I suspect that there is a different view about what flexibility looks like and who should have flexibility. The flexibility that the Ministry of Health is seeking in awards, I think, is equally being sought by

my members, because what they're coming up against is community expectation for more flexibility in their own lives, and so what they want is certainty about their work.

There is a complexity in the health industry that doesn't apply to a lot of other industries, when they're required to work 24/7, and so it's important that people are able to have some certainty about what their work and home life pattern can look like. If you can't have confidence that that can be applied in the workplace or negotiated with your direct manager, you have to have some terms of employment that you can go and point to.

So there is a balance to strike there, I think, around what the employer seeks for their flexibility and what the employee seeks for their flexibility, because these are people who have their own carer responsibilities, but are employed on a 24/7 basis, which makes it incredibly difficult to give any commitment to anything - like even a sporting team. So there has to be some cognisance of what it is for the workforce to work in that type of environment, too.

MR MUSTON: Mr Hayes, obviously you represent a wide range of different workers within the health system, but the issues that we've been talking about in terms of balancing flexibility with a degree of rigidity within conditions included in awards - is there anything you want to add to that in relation to your membership?

MR HAYES: No, I'd concur with what my colleagues have had to say. I think your point in terms of trust is absolutely there. I think there's a common denominator here, that the health services as well as our members want a good patient outcome as well as to be able to look after themselves and their families, and that lack of trust is there.

Over the years, there was an example being that each local health district would have establishment figures of what the staff numbers were. Well, they don't exist anymore. So the staffing numbers can flex, you know, not necessarily on the requirements of the community; they can flex on the budget that's available. I think we need to have an honest discussion about that and if we can get to that point, well, then we can share the information that we need to be able to be more flexible, but also we can be more innovative. Because your point was absolutely right:

where we were previously and where we're going to, the staffing structures, the skill set, the scope of practice will change dramatically over the next 10, 15 years, and yet we're still struggling with an anchor around our neck that's come from the last 30 years. So what we do now and the way we are able to engage - an example being with the ambulance service at the moment. The governments over the past two years have put in an extra 2,500 paramedics, which is unheard of, and yet, are those rosters now, which should be fit for purpose, being able to be maintained? The answer is no, they're not. So what are we doing about that collaboratively to make sure that that delivery of service on the ground is getting there, given that the resources have been applied? So the point of trust is paramount.

MR MUSTON: Mr Minns, can I ask you whether you have a view on where the balance should lie in an ideal world between flexibility and the incorporation into industrial instruments of some of the types of issues that we've been talking about, which at one level you might say are occupational work health and safety issues that sort of should trump the award and should be business as usual; at another level, it's been suggested, well, if that's right, why not include them in the award?

MR MINNS: It comes down to the level of prescription. If you're a nurse unit manager in any one of our facilities and you're just trying to organise care for the next shift or the one that follows, what's the level of absolute prescription that you face in navigating those decisions and what is your capacity for what Ms Collins has called "flexibility"? So the more prescription that goes into an industrial instrument, the less in-the-moment flexibility actually exists.

The dilemma that that generates is the one that Ms Collins also referenced, which is the patients are going to keep coming through the door. So from our perspective, we support the idea of principles associated with safe staffing. We're not setting out to run unsafe care settings, right? So for them to be safe for patients, they have to be safe for staff. But we have to adapt to what we meet.

Whilst we might say, in some circumstances, that the adaptation we had to make on that shift or for that week is not ideal and we don't want it to persist, well, we then

need a process where we address that over time. But you've got to be able to deal with what comes through that door and so, from our perspective, it's how we preserve that for our operational managers. But they need to do it within a principles-based framework.

I guess the other point I would make about the many comments that have been made about trust is, for good or ill, the last government had a particular policy with respect to wages and it had a regulation that supported it, that bound the Industrial Relations Commission. So they were the riding instructions and context that the ministry took into 12 years of discussions.

I guess our experience was - I've sort of been here for about six of those years - there weren't many instances where there was an opportunity available between the parties to do some significant reform within the scope that you could still achieve under that regime of policy and regulation.

We did, in fact, make such an offer to ASMOF in 2020 to say, "What about an MOU for a holistic rethink of how medical awards are organised?" I think we talked about it having three phases, a research phase or - a benchmarking phase, a get to core principles phase, and then we would accept that, after that, we were in active negotiation. Now, that never really came to pass, for a range of factors.

There haven't been conducive circumstances for pragmatic bargaining to operate in the New South Wales public health context since 2012. Now, that's recently changed, and the parties are - right at this stage there are discussions going on between my team and the teams of all of the industrial organisations at the table. To some degree, it's an active case study, which means that some of the responses that we might be required to give, we might have to place a condition on because we don't want anything we say here today to be prejudicial to those other discussions.

MR MUSTON: I'm interested to tease out a little bit more with you, and perhaps starting with you, Mr Minns, because you've raised it. We have an industrial relations system in New South Wales and you have all been engaging with one another, no doubt quite extensively, over the past - not

personally, necessarily, but 20 to 30 years, your respective organisations.

What is it about the way in which that industrial relations system operates, or at least the way in which the health workforce, and the industrial organisations that represent it have been engaging, which has resulted in this what would seem to be an effective stagnation of the process of award reform and evolution?

MR MINNS: I joined health in 2017, so I can't offer a lot of perspective on what happened between the mid 1980s and 2017. Seemingly, not a great deal, in terms of ongoing negotiation around awards.

I think probably Ms Collins and the others at the table would have a clearer view that there were several kind of landmark arbitrations across that period where the parties must have tried to get somewhere and didn't, and so therefore sought the involvement of the commission.

From the point of the wages policy and the regulation, and I don't think the regulation comes in until about 2013, it effectively meant that you would open an annual bargaining round with all unions, where the government's standing offer was 2.5 per cent, and that was regardless of the prevailing inflation rate.

As I gave in evidence in my last appearance, there were several years, until quite recently, where that 2.5 per cent was ahead of the prevailing inflation rate. So the question for unions was, "Well, do I want to come forward and engage in a process of bargaining under the government's policy that involves trying to do better than 2.5 per cent, which involves a process of trade-off bargaining?" The colleagues at the table can speak for themselves, but I think for the most part, that didn't create a lot of warm interest for them and their members. So it was easier to discuss the prospects, agree the 2.5 per cent, it's done and dusted, file for consent award and off we go. I think that's largely what must have happened across the decade, but I would invite other people to comment.

MR MUSTON: I might ask you, Mr Hayes, having been involved in a solid portion of that process - what is it about the industrial relations landscape, at least for the

period you have been involved in it and to the extent you could look backwards beyond your time, what is it that has led to these awards not keeping up to date with the way in which the workforce is mobilised within the health system?

MR HAYES: Yes, I've been fortunate enough to take this role at the same time as the government introduced the wages policy in 2012. Prior to 2012, we had a range of outcomes, and significant outcomes. Post 2012 --

MR MUSTON: Just pausing there, you still had an incinerator allowance as at 2011?

MR HAYES: Yes, but the issue that I have is since 2012, as Mr Minns just indicated, it's 2.5 per cent, then we all move on. Each year, are you seriously going to trade-off things out of your award for another, you know, sort of percentage point, half a percentage point? You'll have nothing left.

But it was all about trade-offs. It wasn't about innovation. It wasn't how a paramedic can keep a person out of a hospital, which is going to be a saving to the hospital system. You know, work-related savings were all about what can we get out of your award. It was just so focused in a way that was just prejudicial to any kind of real negotiation. That's where we're at at the moment.

I think over the past 18 months with the new government, there's been a range of industrial activity. I think this is, on both sides, people getting used to actually engaging with each other again. So we've got virtually, in my organisation, a whole group of people now who have never, in a state system, had to have a negotiation, and that's why at times we flare to a dispute because it's easier to actually get there.

As I said, we want to be able to negotiate on productivity, efficiency, that's going to be good for our members, it's going to be good for the community, it's going to be good for society in itself, not about, "Here, we'll give you a percentage point but you've got to give away A, B, C and D."

MR MUSTON: Do you, amongst your membership, also have people who are working outside of the state system, so working in private hospitals and other facilities?

MR HAYES: Yes, we do.

MR MUSTON: Is your experience consistent with Ms Candish's, that the process of negotiation - I think what has been described as a fair work process of negotiation - with those organisations operates differently to your negotiations with the state?

MR HAYES: Yes, so our enterprise agreements are far more robust. The negotiations themselves are far more involved and generally the outcomes are quite good.

If I could just go back to two things that I failed to mention. We ran two work value cases in the past 12 years, one for allied health assistants, where it was a 9 per cent outcome, and one for critical care paramedics, which was a 7.5 per cent outcome.

The first step is that it took about three and a half to four years to do. The second step was that you had to then virtually run a case to see how you were going to pay for that within the wages policy. So it was just such a waste of 12 years, and that's why we find ourselves where we are now.

But getting back to your point, absolutely, we work in with a lot of the private hospitals, aged care in particular. We've seen significant outcomes in aged care recently because we've got the ability to be involved and it's a collective involvement. The employers are supporting more flexibility; they're supporting pay rises. But in the state system, there is no support for that. It has been how do you trade-off what you've got, make your life effectively harder, and there's a percentage point that's not going to really make a difference.

MR MUSTON: Ms Candish, can I ask you to expand a little bit on contrasting your experience with the fair work system and negotiations that I think you've indicated seemed to be effective and produced evolving industrial instruments on the one hand in the private system and the situation we seem to find ourselves with the public system?

MS CANDISH: I would make one kind of qualifying statement. I think that overall pay rates generally are influenced heavily by the public system. So my observation

is that we don't see vast differentials between the federal and the state system because of the impact of that.

But structurally, I think there is quite a significant difference. When we go into a round of negotiations in the federal system, there's an expectation from both parties that - or multiple parties in some instances - you will draw up terms of agreement, you will draw up a schedule, you will outline what are the negotiations and the process of those negotiations will be from the beginning. You work through those processes. Members are entitled to go through a range of industrial actions including protected action. There are processes to facilitate that. It's an appropriate and reasonable way to work through an industrial relations dispute. You have an independent umpire to be able to influence whatever the final outcome is, should parties not be able to reach agreement.

We haven't had access to those things here, as the other speakers have indicated. So what that, I think, has generated for us is a situation where parties in New South Wales haven't had to work through any kind of collaborative approach to seek an outcome for the workforce and so there is a real loss of that industrial knowledge and muscle, I think, in the system, probably from both sides, to be honest, that we're hoping to try and get back to.

I think it's critical that we do have it, but the purpose of being able to achieve the modernisation in an incremental way - I'm not going to take a view on a whole of system reform, but I think the absence of being able to do it in an incremental way is often why we're sitting in the situation we're in now.

MR MUSTON: Mr Holland, you are nodding your head.

MR HOLLAND: Indeed. I would look at it in at least two phases, or at least two phases in the period of my work within unions.

So for the last nine years that I've been working at ASMOF, I think the fundamental constraint, again, has been the wages cap and the regulation in the Act, and a very clear, I would say, ideological approach by the then government to deliberately put downward pressure not just on wage increases but on, you know, having agencies and unions engage in meaningful negotiations.

I might use my previous experience as an example to kind of compare and contrast different systems. For 20 years prior to that, I worked in a large public sector union in New South Wales, which had a significant proportion of members working in the national system and the majority working in the state system.

What I'm about to say might be unpopular with some within the movement and I think it's hotly contested about the benefits of the introduction of enterprise bargaining in the federal system.

What we saw, and my area was in the national system, over many years of rounds of enterprise bargaining, where similar to what Ms Candish said in relation to the way national system employees engaged with the union in health, we had a fair degree of trust, we had structures in place where we knew how - you know, to coin a phrase, we knew how to play the game. We knew there was a degree of willingness on both sides to engage in problem solving and productive and genuine negotiations.

What we saw over that time was the national system members - and these were in universities - their conditions and pay in many instances surpassing the majority of our members under the core state award.

Now, that wasn't under the Liberal wages policy, I think it was a culture created at the time where we clearly - and I still support the concept of core awards in the state - there was a mismatch between the idea of having core awards which protected fundamental conditions, but over time within government, having, in particular driven by treasury, a very simplistic approach to cost containment.

There was no incentive. Even under the previous regime, there was no incentive to engage openly in anything other than getting 4 per cent pay increases and tinkering around the edges of awards, because of the imposition, pre the Coalition Government coming in power, at least policy, which mandated that there will be this cost containment, and we have that now and I think that's one of the problems we encounter.

I might just want to comment on some parts of my

statement, that I think I fully understand, or we fully understand, the dilemma that our colleagues in the ministry confront, in that we have a new - the government has put in place a new system of bargaining, but not really dealt with the way you pay for the outcomes that may logically come out of that bargaining process. This is what happens in the fair work system, where there is a genuine understanding on both sides that there will be changes and there will be increases and changes in conditions that are going to cost money, and if you don't take that approach to the table, then you will go nowhere.

I just want to say, too, I agree with Mr Hayes that our members - our members - are also very willing to negotiate around the concept of productivity improvements and productivity changes. It's not this idea that we're only seeking to take and not give. But we need to do that, again, as I previously said. We need to do that in an environment where there's trust and it's not just the constant response that, "We can't afford", "We can't afford", "We can't afford", and that's a problem we encounter now.

So my last comment: we also have a number of fair work agreements. We negotiate - not as many as my colleagues in the other two unions - but again, we have a similar experience there, that the public sector is seen as driving and providing a ceiling in relation to pay, but we have a lot more flexibility to negotiate around conditions, and there is a willingness on a number of those employers to sit down and negotiate around conditions.

MR MUSTON: What sort of things, just by way of example?

MR HOLLAND: Questions around professional development; questions around issues of safe working hours and workload management. It's many of the issues we've put forward on the table for NSW Health.

MR MUSTON: So has it been your experience that those issues that we were talking about a little bit earlier as potentially giving rise to inflexibility - so the working hours and the ratios in the case of nurses, for example - that they do still find their way into EBAs under the --

MR HOLLAND: Absolutely. We have those, both in New South Wales and, as I've said previously, in other states.

MR MUSTON: Ms Candish, you are nodding your head.

MS CANDISH: I would, I suppose, just share that most of the other jurisdictions in Australia have got ratios or are moving to a ratios model.

MR MUSTON: And in the bargaining that you engage in with, say, private hospitals and aged care facilities and the like, are the ratios built into those industrial instruments?

MS CANDISH: In some. And in some we have the similar arguments that we are also hearing from the other parties.

I suppose I would concur with Mr Holland, I think what we see is a far more equal approach to addressing issues. In most instances, both parties will come with their list of claims and you essentially work through what those claims are. Usually from the employer's perspective, it's around areas of modernisation out of the EBA or areas of new business that they would like to contemplate and how they have that resolved in the EBA.

For example, in our private hospital system, we'll often see changes around the way they might structure theatres. They might decide that they want longer or shorter Christmas shut-down periods. That's often something that's open for discussion in the negotiation process.

But we equally see things like improvements to leave, particularly around things like flexibility, family and domestic violence leave, carers leave, those types of things, education allowances, education support. All of those things are up for discussion when you work through a process of negotiation, given where each of the parties sort of indicate their preferences and priorities are in that process.

MR MUSTON: Mr Minns?

MR MINNS: I just want to make two comments. Listening to the dialogue, it would suggest that we don't meet and we don't talk. I think we've been talking to the HSU since February about award reform. I don't know how many meetings, but I think it's above 20. We are still in

discussions with ASMOF under the mutual gains bargaining set of principles, and we are in the middle of intense discussions with the nurses association. So I think a lot of the commentary's been about what was our restrictive context until the change of government.

But the risk of, you know, finding a kerosene can and a match, to just give you the perspective that operates for the management members in bargaining, in a government context, if all the things that emerge from a productive bargaining process come with a practical requirement for additional supplementary funding, and that funding isn't available through other channels of government, then we are signing off on an unsustainable set of changes. They might be very innovative and useful changes that will produce other results, but if they don't produce the capacity to fund the ultimate changes to wages or conditions, then that means we're committing, as a management team, to absorb those costs within the operating budget of health.

Now, you can always do a little bit of that. You can't do a lot of it. And the issue about employing 140,000 full time equivalent employees is that if one of them catches a cold, you know, it's extensive in terms of how the flow-on cost aggregates.

So that's the management dilemma, in either the last government, this government, future government. What is the surrounding context created by government policy to do with funding outcomes that arise from negotiations?

We are bound by the government's fair pay and bargaining policy, and we are absolutely constrained by the capacity to make commitments to increase employee-related costs if they don't come with supplementation from central government.

THE COMMISSIONER: When you said, "listening to the dialogue it would suggest that we don't meet and we don't talk", that's not the impression I'm getting from the evidence being given by the union leaders here. It's probably more along the lines of what Mr Holland said, the response being, "We can't afford it, we can't afford it, we can't afford it", which, in a sense, is what you are touching on, too, about sustainability.

There's also been the evidence about a lack of trust,

which I think probably is something that I would make the assumption - and I will be told if I'm wrong - is probably in the process of being repaired slowly. But I didn't get the impression, in any event, that there is not talking. It's just the impasse about what the union leaders consider award reform in a fair sense would look like and what you are saying, which is no doubt coming down from treasury, about what is affordable.

MR MINNS: Yes, I think I agree with both of those points, Commissioner.

What I was attempting to say was that I think several of the witnesses of talked about the process of bargaining in the fair work context and the approach to the bargaining meetings. We didn't have any of those meetings for 10 or 12 years, but we have started to have them since. So those sorts of process mechanisms and, you know, timelines and mutual sets of issues, et cetera, they are now the subject of our negotiations. But we still are impacted by that can of kerosene.

MS COLLINS: If I may, probably building on the point of some of the unions, whilst under the former government's wages policy we were limited to 2.5, and in many years, that was higher than CPI, Sydney CPI, what it did do was it meant that there wasn't movement on conditions. Normally, through just general bargaining, that's happening all the time in the background. I'm not talking your wage increases, but whether it's your incinerator allowance, changes to leave, small things.

The other thing, of course, in the context is other states then outstrip New South Wales. So my feeling - I guess in many of the meetings we have and I guess in the discussions with staff - is I say that there is pent-up demand. It's probably not coming to the bargaining table in the normal course of events, because there is all this pent-up demand, as we've all put on evidence around interstate jurisdictional wage comparison.

Normally you might be coming - you know, your list of employee kind of interests or claims can, I guess, be bargained potentially in a multi-year award, but when you are coming with 12 years of demand, the claims are significant, and I think it just presents an additional challenge because the parties are far apart, given where we

are with butting in--

THE COMMISSIONER: That's the thing, isn't it? It might be one thing that at a certain period of time the 2.5 per cent was more than the rate of inflation, but the other factor, as you have just identified, is the comparison between, if I give my labour to the public or to the State of New South Wales in Sydney, and it might be very naive to raise fairness, my expectation would be that I would not be paid less for giving exactly the same labour to the public in Adelaide or Melbourne or Brisbane.

That's probably what you are referring to when you're talking about pent-up demand; it's no doubt that sense of, "I work in New South Wales and I'm doing exactly the same labour and giving exactly the same labour to the public" - not just to the public, but in the pursuit of a system that is to provide health care to citizens - it seems radically unfair that, for exactly the same labour you're not paid at least the same here than you get either the other side of the northern border or the other side of the southern border.

MS COLLINS: I'll say a few things about that. I think in terms of pent-up demand there's the wages but there's the conditions as well, I think.

THE COMMISSIONER: Sure, of course. Of course, yes.

MS COLLINS: I think they go hand in hand and that's, again, why I think the parties are quite far apart in bargaining.

THE COMMISSIONER: Yes, that's right.

MS COLLINS: As Mr Minns has mentioned, there are the constraints around NSW Health budget and the existing - that we need to comply with the fair pay and bargaining policy.

I think perhaps fairness is front and centre in employees' minds, and why wouldn't it be, although I would say that's, in a way, a simplistic view, I think because --

THE COMMISSIONER: Of course.

MS COLLINS: I could move --

THE COMMISSIONER: Fairness, God, who would ever think about that?

MS COLLINS: I think I could be the head of workplace relations in BHP and earn significantly more, probably have an easier life.

THE COMMISSIONER: I'm obviously proving I'm not an industrial lawyer by talking about fairness.

MS COLLINS: It's multifaceted.

MR MINNS: It used to exist, Commissioner, the comparative wage justice concept.

THE COMMISSIONER: Yes, sure.

MR MINNS: I think there is one other point I would make in addition to those that Ms Collins has made. For medical, there's arguably a different economic vista available to you if you practise in Sydney or in Melbourne, when compared to probably any other capital city, in terms of what your opportunities for private practice earnings might be.

THE COMMISSIONER: Yes.

MR MINNS: So sometimes, you know, that is another factor which means the straight fairness comparison isn't the only one.

THE COMMISSIONER: You're talking about not the majority of the workforce there, though.

MR MINNS: Just doctors.

THE COMMISSIONER: Yes.

MR MUSTON: Can I pick up on something you said, Ms Collins, to make sure I have understood it correctly. Would this be a fair summary of at least what you perceive to be one of the root causes for the failure of these awards to evolve with the times: first is, over the past 12 years, the wage cap has led to effectively an absence of constructive discussions around award conditions because, in circumstances where that very important issue to all of

the parties, remuneration, was capped by legislation, the discussion just didn't happen around all of those - the ancillary discussions that might have led to an evolution of conditions and the like didn't happen because the discussions in and of themselves were not happening?

MS COLLINS: But importantly, I think, and very importantly, is the IRC was restricted by the regulation, because even when discussions - there is freedom to have those discussions, and even if there was budget for those discussions, often the parties will not agree or will part agree, and you will come into this very building, now that the president is here, to have those matters determined.

I think in some form or another since 1901 there has been an independent arbitration system to resolve these disputes, and I think the restriction on the Industrial Relations Commission to do so has been - it's not just the policy but the binding nature of the commission has been such a big factor. So I think it's not just about not having the collaborative discussions, but it's around the restriction of the commission, which is really a handbrake on industrial relations. I think a wages cap might be a very good short-term strategy, but to restrict the independent umpire, I think, - I guess I can say it now - has been hugely problematic.

I think as well the commission now has unfettered power, so there is kind of a solution available where the parties remain apart. I'm not saying it's an easy pathway, but I think now that the industrial court, the Industrial Relations Commission, I guess - the industrial court's been reinstated and the power has been returned to the Industrial Relations Commission, there is a pathway forward if the parties can't agree.

MR MUSTON: I might come back to that in a moment. But the second component of it or the more immediate challenge, as I perceive it from your evidence, is as a result of that, there is now such, I think you described, a build-up of demand in relation to some of these issues that the ability of the parties to deal with that built-up demand, whilst at the same time trimming away the incinerator allowances and the like, those small but important matters maybe lose or don't attract the focus that perhaps they should have. Would that be right?

MS COLLINS: Don't attract the focus? I guess there's so much to deal with, I think is perhaps the issue, and there is only so much time, you know. As Mr Hayes says, there are 36 awards. One union, one ministry, there is only so much we can tackle in a certain period of time. So I think it's perhaps the timing, and the fact that there's been no incremental change that has contributed. But I'm not sure if I've answered your question.

MR MUSTON: It probably wasn't a good question to start with.

Can I turn to you, Ms Egan. We're not ignoring you. Obviously the instrument under which your membership operates, predominantly - I appreciate that there are doctors who are members of your organisation who are also captured by some of the awards, but the instrument that I'm particularly interested in asking you about is the VMO determination.

MS EGAN: Yes.

MR MUSTON: We've heard the evidence that has been given by the industrial relations organisations and the ministry in relation to the way their discussions have been happening, or not happening, as the case may be, around the reform of the awards. Has your experience been similar insofar as the VMO determination is concerned?

MS EGAN: I think our experience has been that we have engaged in discussions with the ministry over a period of time, perhaps not to achieve immediate change but, as I've given in my evidence previously, a lot of our focus is on how there's been a change in the delivery of medical services, where they can be delivered from, technology that we want to see reflected in the VMO determinations, and that people are fairly remunerated for the work that they are doing, perhaps regardless of where they're doing it. So we have had those discussions with the ministry.

As Ms Collins has said, sometimes you just don't reach agreement. It may well be that we're going to have to arbitrate that issue because we don't agree about it, and we want to get back into the New South Wales industrial relations system to do that.

MR MUSTON: That was going to be my next question. Do you

see there being utility in any process of reforming and refreshing the VMO determination happening first of all in parallel with particularly the staff specialist award process, but perhaps the wider-reaching award reform program that might be about to take place?

MS EGAN: Yes, I mean, I think, again as Mr Holland has said, there are changes in the way that medical services are being provided. The industrial instruments have not kept pace with that, and so there are - they're different instruments and work differently but there are, I think, similarities in some of the issues that need to be addressed.

I can't speak to the other awards because I won't profess to be across all the details of those. But I think while those discussions are ongoing and we're looking at the system as a whole, yes, if that could also - accepting the ministry has a lot to deal with, but if that can all sort of happen contemporaneously, I think that would be constructive.

MR MUSTON: Just picking up on your comment about re-entering the industrial relations system, do you see value in having that process occurring in the same forum as, say, the renewal of the staff specialists award?

MS EGAN: Yes, I think so. When the industrial court was dismantled a number of years ago, they changed the arrangements for the appointment of an arbitrator in relation to VMO arrangements. We can seek the appointment of an arbitrator now, but we want to come back into the industrial relations system because I think it's helpful that, you know, we are a part of the system, and also to draw on the expertise of the people who constitute the court and the commission.

MR MUSTON: You will have to assist me, and I will expose my naivety about these matters, but would that require some legislative change in order to bring --

MS EGAN: Yes, it will, yes.

MR MUSTON: -- you and your organisation back into the arena of the people on level 5 of this building?

MS EGAN: Correct, yes.

MR MUSTON: Mr Minns?

MR MINNS: And the proposition to do that is currently being worked through for the presentation to the minister.

MR MUSTON: So I infer from that that it's the ministry's view that it would be a good thing to have.

MR MINNS: The timing could be a bit of an issue, yet to be clear on that, in terms of how long it takes to get a miscellaneous bill through the house, both houses.

MR MUSTON: Putting the timing to one side, conceptually, is it your view that having the VMO determination renewed or refreshed in parallel with both temporally but also within the same forum as this wider package of award reform would be a positive thing?

MR MINNS: I think it is my view, Mr Muston, but I stand to be corrected by Ms Collins, as to whether or not --

MS COLLINS: Yes, look --

MR MUSTON: Feel free to disagree.

MS COLLINS: Certainly I think the AMA and the ministry agree that returning VMO determinations to the industrial court is a good thing. As Mr Minns has said, I guess the wheels are in motion on that.

In terms of how that happens with the staff specialists, I think that is probably a discussion as well with the Industrial Relations Commission. You know, it won't just be the people at this table heading to the commission. Obviously, firefighters and other unions are in that space.

They do, I guess, operate differently, I think VMOs operate differently to the staff specialists. If you are proposing combining them, I think we would need to think about that and certainly --

MS EGAN: I wasn't suggesting that.

MS COLLINS: I was going to say I think we would want to have a discussion with our AMA and ASMOF colleagues around

that, but I think somewhat running in parallel. Certainly I think there is value, I would think there's - gosh, I probably don't want to put too much on the industrial relations, because it may be helpful to have some of the same commissioners or judges on both just so that they're, I guess, across the issues, but that's not a matter for me to really have an opinion on.

MR HOLLAND: Just for absolute clarity, could I ask: when you refer to the same forum, and my colleagues have quite deliberately, because that's my interpretation, focused on bringing back the VMO determination into the court, was that the intention or the purpose of your question?

MR MUSTON: That was the intention of my question, but if there is another way in which --

MR HOLLAND: No, no, I don't think anyone, I would suggest, on this side would be looking at somehow combining or amalgamating other processes, for instance, bargaining or, you know, consolidating the VMO and the staff specialist provisions in one document.

MR MUSTON: That certainly wasn't something I had in mind.

MR HOLLAND: Thank you.

MR MUSTON: To the extent that different sectors of the health workforce can agree with one another and move in parallel, that seems positive, but that's probably well beyond our power to deal with.

That really does get us, I guess, to the real crux the question or the issue that we're here to deal with today. What can we do to - well, when I say "we", what recommendation could this Inquiry make that might actually facilitate pushing through this process and encouraging a wholesale renewal and refreshing of the health workforce awards? For example, is the answer really: refer this, or suggest that it be referred to the Industrial Relations Commission to exercise the powers available to them under I think section 19, with a view to starting from a blank sheet of paper and producing a series of consolidated awards that accurately reflects the way in which the health workforce operates in a contemporary environment and allowing each of you and your respective interests to go to the commission and explain what that looks like from your

no doubt slightly conflicting but largely agreeing positions? Mr Minns?

MR MINNS: I think in practice what the commission would expect is that the parties would do some of the work on their own first. So the negotiations that we're engaged in, they would have an expectation, and indeed if they get involved at all in conciliation, they will be directing us to try and narrow the issues that we can't resolve.

Then, on that basis, they would perhaps see it as important, and maybe even a priority, if we were unlucky, for those matters to be arbitrated.

So, you know, that was my point earlier, that we're in discussions with everyone at the table at the moment, and the discussions are ongoing, and they're trying to see what can be resolved and what might, in fact, have to be identified as not where the parties can get close and potentially eventually those things might be matters for commission consideration.

But they wouldn't welcome us just popping upstairs with a blank sheet of paper requesting their involvement. I think they would see that as a dereliction of our respective roles under the Act.

MR MUSTON: Mr Hayes? What's your view?

MR HAYES: I would love to jump into that. Yes, I think the role of the commission - if we need to go to the commission, I think there is a failure in the first instance. We can either get to a consent position or we can't, and I think - I totally agree along this table - many discussions have been had. In fact, at the moment, in many of our allied health groups, we've formulated awards and my colleagues at the ministry have been heavily involved in those negotiations. So when we get to the point, if we have to get the assistance of the commission, well, it comes from time to time, but I see it as a failure in the first instance.

The second thing, which is incredibly important, and it has been my hope from the outset, because this underpins everything, if we can - I believe that the ministry and ourselves agree on most things. It comes to the budget to be able to do it. It's been my hope for two to three years

that something like this Commission can identify the waste and the profiteering that is taking that budget, that could be redistributed to these outcomes so that solves the problem.

I believe we're on the same page operationally, we're all on the same page in terms of award renewal, but it's all about what is holding us back. But I have to say that. I want to put that on record because that will be the sticking point right the way through.

MR MUSTON: I should probably invite you, Mr Minns, and, Ms Collins, to just respond to the proposition that waste and inefficiency within the system is a fetter to these negotiations. I gather you might take a slightly different view.

MR MINNS: I guess what I would say is that if we are to try and get to a position by consent, or any other way, to see uplift in wages and/or conditions, it comes with a bill, and we either manifest a way to pay for that or we have a problem. If we can't find a way to pay for it, we need the government to agree that they're going to contribute in either whole or part.

But if that doesn't happen and we haven't manifested a way to pay for it, we're completely aware, as managers, because - I think I have told the Commission in evidence before I can't remember exactly the number - around the 60 per cent mark of our operating budgets is employee-related cost.

Then a significant next quotient of our budget is goods and services through procurement, where we already have some robust and challenging targets to reach as part of the government's overall comprehensive efficiency review.

So they're two very large contributors to our budget, and if we see a lot of movement in wages and conditions, employee-related cost, from our perspective, it's just how do we cover that?

THE COMMISSIONER: It ends up being driven to almost a philosophical position. So once you have eliminated all the waste, and if you're paying the workers in the system fairly and appropriately, and you're as efficient as you

could possibly be, then you end up with the situation, if treasury is saying there is not enough money, as to thinking about what sort of health system we actually want as a country, whether we really want a free and universal healthcare system, or government's honest in saying it can't afford that on - it might even be the current rates of taxation, whether it's income tax, GST or company tax. It's whether we think a fully free and universal health system is of benefit to the country, which might mean that we have slightly different taxation arrangements - it's fortunately not in my terms of reference - or whether we're honest enough to say, "Well, yes, we're going to have a good health system, but it may not be what it's historically been advertised to be since Medicare was introduced."

We are thinking about all of those things. But that's, I think, where ultimately you're heading, in the sense of if waste is eliminated, it's as efficient as it can be, and if people are going to be paid fairly and appropriately and there's still not enough money, well, where does that leave us?

MR MINNS: I'm not sure if I was heading there, Commissioner, but --

THE COMMISSIONER: Sorry, that's me.

MR MINNS: But you've gone there very effectively and efficiently.

THE COMMISSIONER: I won't blame you for that, but you tipped me in the direction.

MS CANDISH: I might just add, I do think that there is some consideration, though, of the level of efficiency and productivity savings that are being made every day in the system, because structurally, there is no way for that to be plugged into wages and improvements at the moment, either.

We know that there are some remarkable examples of innovation that are happening continuously. The size of the service, I think, makes it quite difficult to identify those moments of innovation and improvements. There is no way currently to capture how that could be reinvested back into improvements in the workforce. Mostly, these things

are happening on a unit level basis and that efficiency or productivity improvement is being plugged into another hole somewhere else.

I don't want you to move you away from your philosophical views, but I do think structurally, there are some components there. Once sort of waste and inefficiency is looked at, the actual improvements that are already happening, being captured in a more meaningful way.

THE COMMISSIONER: Sure. Is that a convenient time?

MR MUSTON: Yes. I don't have very much to go. I don't know whether you have some questions to ask of these witnesses, but it is --

THE COMMISSIONER: Yes, I think we will have a break now. Can I, just before we have the break, tidy up a couple of things.

Ms Egan, when you last gave evidence - it's in paragraph 18 of your statement, and for those who are interested, it starts at transcript page 4606, back on 5 August - the AMA was seeking current numbers of VMOs working in the New South Wales public hospital system, and you were having trouble getting that data. Has that been resolved since then?

MS EGAN: Yes. We've been provided with some information about that, thank you.

THE COMMISSIONER: All right.

Sorry, just on that theme, also, Mr Holland, in your statement at paragraph 18, you'd been requesting vacancy data. That's an ongoing request?

MR HOLLAND: It is an ongoing request, and we don't have a response to that. My understanding, and I would stand to be corrected, is that the response has been there is no central way of collecting that information. But we don't have any information at this point in time.

THE COMMISSIONER: All right. That can be followed up after the break, if it needs to be.

The final thing is - this is a question more for the

team - in Ms Egan's statement from the prior hearings there was reference to a Deloitte report on medical workforce pressures in New South Wales, which I only read this morning. Is that part of the tender? Has that been tendered? You can check it over the break.

All right. We will adjourn until 11.55.

SHORT ADJOURNMENT

THE COMMISSIONER: When you are ready.

MR MUSTON: Can I ask you, Mr Hayes, earlier this morning you made an observation about the role of waste and profiteering in the overall consumption of the health budget envelope. I think we all understand what waste is and the way in which efficiency can be used to address waste, but perhaps can I invite you to expand on when what you had in mind when you referred to "profiteering".

MR HAYES: What I see as a form of profiteering is that agencies come in, picking up staff, and then renting them back to the health system. We've seen this recently in Lismore with security officers being paid far more to be able to be rented back. I think this is something that moves into supply and demand, it moves into locum areas and a whole range of areas. Clearly there's $32 billion that goes into NSW Health and a lot of people want a piece of the pie.

At the same time, the federal government - I know this is not the jurisdiction here, but Dr Margaret Faux and Dr Philip, were able to see between three and eight billion dollars worth of noncompliance.

Now, as I've indicated, with Mr Minns I would think we are very close to being on a reasonable page, however, if the money is not there at the end of the day, how can we be in the same book? I think this is something that is incredibly important to be able to deal with the outcomes our members expect, that the community expects, a service that should be able to be delivered in metropolitan and regional New South Wales, but that is going to be particularly hamstrung if - wastage is one point - but if there's a hole in the bucket in that way too.

MR MUSTON: Mr Minns may be the best person to respond to

that. We've heard a lot of evidence about the use of premium labour within the medical and clinical workforce, but we haven't heard evidence about the use of premium labour or agency in other facets of the health workforce. Is that a similar problem?

MR MINNS: Look, I can't recall the rates of usage, but I don't believe that the same proportion of expenditure is going towards non-clinical roles related to premium labour. I don't know anything about Lismore's context.

I know that in some instances, we have had different facilities in different LHDs that have had a strong and heavy reliance on contractors for security work, and I think we've shared the view with Mr Hayes that an over-reliance on contractors in that role is not useful.

It creates a couple of things for us - the lack of continuity of provision of the service and appreciation of how to do it in the health setting, and the sorts of patients and carers that we need to address. We have, at the urging of Mr Hayes and the former minister, on occasion, gone out to the system and asked them to investigate their level of non-permanent security staff, with a pretty clear direction to rebalance their set-up. But I don't know what's happening in Lismore at the moment.

MR MUSTON: Decisions of that kind are operational decisions presumably made at LHD levels and perhaps even at a facility level?

MR MINNS: Locally. But as a result of the escalated issues that Mr Hayes brought to us at the time, I think we probably did a data check. I can't quite recall but we would have done some kind of workforce metric check of how many contractors were there. We did point out that we felt that they are an augmentation, premium labour device. We don't see them as a replacement.

Now, there might be historical cases where, at direction of government, we have outsourced entire service provision, and some of that is related to the member areas of Mr Hayes. I don't recall any recent ones. But there are some historical legacy ones operating in the system.

THE COMMISSIONER: Just to be clear, though, the general relevance of Dr Phillip's report to the system, in its

entirety, I perfectly well understand, but given it's mainly about the integrity of the MBS, I'm assuming the expectation is that this Inquiry isn't going to spend ten years on that.

MR HAYES: I wouldn't think so. I would certainly hope that this Inquiry was a catalyst for many other states.

THE COMMISSIONER: The MBS is relevant to this Inquiry, in the sense of what it means for GPs and what it means for the GP market, because that has flow-on effects, when that market is thin, to our public hospital system that are well documented and I think everyone accepts. But we aren't investigating Medicare fraud.

MR HAYES: I'm very mindful of that. Any opportunities --

THE COMMISSIONER: I wasn't suggesting you were thinking we were, but I just wanted to make that clear on the transcript. Sorry to interrupt.

MR MUSTON: Coming back, Mr Minns, to some answers you gave earlier about the challenges from a negotiation perspective of a constrained budgetary environment, as we've heard it referred to in various places and from various people, to the extent that you are referring to the limitations on your ability to negotiate through this process, just so I can understand it, is that limitation a capacity to absorb increased wages or more costly conditions within the existing health budget, or is there a next step there which is, to the extent that negotiations might involve an increase in the expenditure on a workforce in order to reach agreement in relation to that, there needs to be, prior to that, from your point of view, some agreement on the part of the treasury to increase the budgetary envelope that will be made available to the ministry going forward?

MR MINNS: So government has the fair pay and bargaining policy, and under that policy, we're bound by its limitations, and to become more free than what is in the standard policy, we would need a decision of the expenditure review committee.

What happens, and if I reflect on the last 12 months, is it's an iterative process between bargaining and consulting with that committee of government, but we don't

have universal, within health, authority to exceed the current standing decision of the committee.

MR MUSTON: In the absence of a decision of the expenditure review committee, what impact would a decision of the Industrial Relations Commission have on that process?

MR MINNS: That's a matter for government. I think that's probably all I should say. They are the government that has recently amended the Industrial Relations Act, so it's a matter for them to consider.

MR MUSTON: In terms of a recommendation that might be made by this Inquiry, and accepting, I think, as Mr Hayes pointed out, and Mr Minns agreed, that turning up to the Industrial Relations Commission with a blank sheet of paper and saying, "Solve this problem for us" might not be well received but equally might reflect a failure of the process, would it nevertheless - would there be some value in suggesting to the Industrial Relations Commission a particular outcome, not in terms of individual conditions, but, rather, as an outcome of the process, a complete renewal of the award structure such that it accurately reflected the contemporary delivery of health care in the public system, so that if you did reach an agreement within a period of time - and we'll come back to that in a minute - the Industrial Relations Commission might then have a look at it and assess for itself whether or not it actually achieves the objective of a proper renewal and refreshing of the award?

Is there something that could be done by way of recommendation, do you think, that might actually ensure that the bargaining process, which has, to date, not, no doubt despite the best efforts of various people, produced that renewal - give the Industrial Relations Commission an opportunity to independently assess whether or not any process of bargaining adequately has achieved that? Mr Hayes?

MR HAYES: That's a very good question. I think there is an opportunity to have that assessment. Having the capacity to be fully briefed as to the nuances that would be involved, it certainly - I don't think it would hinder the process, but it that way, but I'm not too sure how successful it would be.

MR MUSTON: Ms Candish?

MS CANDISH: I think the assumption of a wholesale refresh being needed in the nurses and midwives award isn't necessarily where our membership or myself would think we need it to go, so I don't know how useful that would be.

I do think there's value in a wholesale look at the process of bargaining. I do think that's started with the mutual gains approach. So whether it is needed at the moment or we wait and see what happens with mutual gains. Given it is only new and there are some parties only using it for the first time now, I'm not so clear on the timing. But I think it's important to continue to emphasise for the nurses award, I don't think the wholesale refresh is actually what's required for our award.

MR MUSTON: Ms Egan, assuming we get to a point where you are brought into the industrial relations landscape again, what is your view on that?

MS EGAN: Again, I think I would say, to be fair, there are aspects of the VMO determinations that work and that we wouldn't want to see cast aside, but in terms of setting a framework for review and a focus of negotiations and where the commission might direct its attention, I think that would be helpful.

MR MUSTON: Mr Holland?

MR HOLLAND: I agree with Mr Hayes. I don't think it would create any problems but whether or not it would have any positive outcome remains to be seen.

MR MUSTON: Ms Collins, on the other side of the ledger?

MS COLLINS: Look, I think it would be a huge task. I very, very much see the value in involvement in the Industrial Relations Commission where the parties can't reach a consent position, and I think given what we're terming the budget constraints, I think the commission is not constrained by that, and whilst it does have to take into account the state of the New South Wales economy, that's a very broad consideration.

I think there is a lot of value. As Mr Minns said,

I don't think we can lob up saying, "Here, fix it", but I see that there's a huge value where we can't consent in narrowing the issues. I think staff specialists' overtime is a really good example of that.

In my previous statement, we have submitted a variation which provides for rostered overtime. It doesn't have a loading attached to it. I won't go into the background around that. I would suggest that that would be unacceptable to ASMOF and staff specialists. Now, I think there would be a lot of value in looking at how do we potentially unscramble the egg of a salaried award, whether we can narrow the issues, agree potentially how overtime would work in the staff specialists award, potentially agree a clause. I suspect, given the huge quantum that that would cost, we probably won't be able to get agreement between the parties.

That could really be a useful issue for the Industrial Relations Commission to turn its mind to, "Well, what's the quantum of what that overtime penalty would be?" So it's not necessarily whole scale start from a piece of blank paper, just because I think that's such a huge task, but how do we narrow issues, come together where we agree and then have maybe quantum determined, I see perhaps a pathway with the HSU consolidation around some of that.

I maintain the hope - I'm ever the optimist - that we will be able to agree significant components. But potentially, we've all admitted, budget is going to be a massive hurdle. Is there a place that does not have that hurdle? And I see that being the Industrial Relations Commission.

MR MUSTON: Part of that process, presumably, will involve some bargaining around, obviously, the uncontroversial matters and the removal of incinerator allowances, I'm assuming, but is there a time frame within which, in the ideal world, that should have occurred, after which the Industrial Relations Commission might be encouraged to step in and mark your homework, as it were?

MS COLLINS: Look, I guess potentially, yes and no. I think as well you wouldn't - you know, the unions may have pressure from their members to resolve matters earlier and they need to take industrial action, as is their right to do so. O I don't know that setting a hard deadline

necessarily helps, because also, of course, we have submitted new awards. So I guess the deadline is somewhat creeping up anyway because we have report-backs on the numerous awards. I suspect we're already there in some ways, where there's a consent award.

Gerard, just give me a nod or a cut, but the HSU have put out to their membership to vote a new wage offer. That will hopefully result in a consent award and then will kick off or continue the process of award reform with the HSU.

I suspect there's already a deadline of 1 July 2025 to make progress on that, because we will, of course, be back in the commission, and I think the HSU and its members will want to see where we've got to on that process.

We're in the process of bargaining. I don't want to prejudice those discussions but I guess we have a report-back on Monday with the nurses. We're in intensive discussions. I don't want to predetermine where they will go. I guess if unsuccessful, no doubt I would think the commission will want to start a process of conciliation and listing for arbitration.

With ASMOF, we are in mutual gains bargaining but again, Mr Holland, will be able to - I can't remember the date that we're back. It's a long way of saying I think the deadline is somewhat already upon us, in a way, in that we can't have these expired awards kind of continue indefinitely. So I think the commission is already involved in the process. That's probably a very long answer to your question.

MR MUSTON: One question I might ask, and perhaps we can ultimately address it through a summons, but one thing I think that might be quite useful from our perspective would be a table that identifies with respect to each of the awards that are currently the subject of this process, the date or the key date by which a stage is anticipated or required to be reached and what's going to happen at that point. If, as you say, the position is largely already upon us, then a deadline of any sort is not going to be particularly useful, particularly if it sits at odds with deadlines that have already been set by the commission.

You were going to say something, I think, Mr Minns?

MR MINNS: I agree with Ms Collins. I think the real issue is that the commission is probably already sufficiently in the mix that it might be setting deadlines. Obviously I don't seek to influence them improperly, but they will have views about our rate of progress, as we report back in the next month. I think they will probably either direct us to keep going, if they see merit and purpose in it, or they will have another view.

MR MUSTON: Do any of the representatives of the industrial organisations have a different view in relation to that? Feel free, any of you, to comment on the proposition that there may be a deadline at some point by which time this process of bargaining should have produced an outcome and if not the Industrial Relations Commission should embark upon its work under section 19.

MR HAYES: I guess from our perspective, we are, like most unions, very heavily driven by our membership. So there may be sort of an administrative timeline, but then there may be an emotional response, so it becomes a little bit true.

But I think to support the Ministry of Health, to a large degree they do a lot of very good work with very, very few resources, and this is - while I'm not advocating for them, as a PSA person, but it is important, if we want to be able to get an outcome, we have to have the appropriate resources on both sides of this fence. That's something that I think government needs to really think about very heavily, if they do want to have a good industrial relations system, that you've actually got the players on the field to do it.

MR MUSTON: Ms Candish, do you want to add anything to that?

MS CANDISH: I would say in principle we agree. Our submission goes to some of our views in relation to the, I suppose, industrial relations structure that exists across the local health districts. We do see some duplication. We think there would be some benefit in centralising some of those services. That may deal with some of the resourcing issues. We also think it would standardise a lot of the interpretation and the response that we receive to industrial relations matters, so there could be something there to be looked at, would be our

view.

MR MUSTON: I might ask you, Ms Collins or Mr Minns, whichever of you feels best qualified to answer. That is something that has been mentioned in evidence given to date. Is there utility in centralising the industrial relations function to a greater extent than is currently the case - that is to say, bringing to the centre industrial relations functions which are being exercised within the local health districts as matters currently stand, which I accept is not award reform?

MS COLLINS: I think the answer is complicated. So bargaining is done at the centre. In a system the size of ours, I worry about complete centralisation of industrial relations. I think there's huge value in an industrial relations function at a local health district having relationships with the local organisers, having relationships with the local managers running the joint consultative committees. I would worry about removing that, because I think local issues are best resolved locally. You know, coming in to the ministry, we're not operational, so I think that tension - we can't resolve it all.

I think there is, I guess, an attraction to having a one-stop shop. I think there is value, however, in addressing some of the issues Ms Candish raised around inconsistency. There has been a people and culture review and that recommends an IR centre of excellence, and we're looking at how we can, I guess, enact the recommendation from that review. I think that's intended to provide, I guess, a heavier advice function for local health districts - often you might be the only practitioner in a district - to be able to, I guess, pick up the phone to someone. You can always - my phone rings all the time, but a dedicated, you know, this district rings this person. Getting consistency in how we approach things such as settlements, award interpretations. So I think there is always room for improvement, absolutely, and I'm a bit of a centrist anyway, so I'm probably more attracted to it, but I do worry about not having an industrial function locally.

MR MINNS: And we just have to sort of be prepared to recognise that if we've got a devolved structure of governance out there, to fully centralise the industrial

relations function will sit at odds with that. So the opportunities for improvement are where Ms Collins has noted.

None of us enjoy getting a stick in the eye because there has been a particular position taken by either a manager, an HR person, an IR person or a delegate or an organiser and, you know, it rolls through, we eventually hear about it, and the people at this table will generally sort it through. So it's how you reduce the number of those happening through the consistency of principles and advice, which is what we're seeking to do through that reform of a centre for excellence.

MR MUSTON: I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: Mr Cheney or Mr Chiu, you can't both ask, but do either of you have a question or question or two?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you.

To all six of you, thank you very much for your attendance today.

I haven't said this before, but I do know that inquiries of this kind, from past experience, are disruptive to the key organisations involved, and whilst it's formally done by compulsion, we are grateful for the assistance and time from the executives of NSW Health and also, too, the union leaders here. We know you've got other things to do, but we're very grateful for the assistance and time you've spent with us throughout the Inquiry, but also today. So thank you very much. Having said that, we will adjourn until 11.30 tomorrow.

You are all excused.

<THE WITNESSES WITHDREW

AT 12.22PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO FRIDAY, 18 OCTOBER 2024 AT 11.30AM

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