

**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**

1 THE COMMISSIONER: Good morning.

2

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

7

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

20

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

23

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

25

26 <GERARD JOHN HAYES, sworn: [10.03am]

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28 <SHAYE MAREE CANDISH, affirmed:

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30 <MELISSA ANNE COLLINS, affirmed:

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32 <DOMINIQUE EGAN, sworn:

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34 <ANDREW HOLLAND, affirmed:

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36 <PHILLIP GREGORY MINNS, sworn:

37

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

40

41 MR HAYES: Gerard John Hayes.

42

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

45

46 MR HAYES: That's correct.

47

1 MR MUSTON: Have you had an opportunity to read that
2 statement before giving your evidence this morning?
3
4 MR HAYES: I have.
5
6 MR MUSTON: You are satisfied that its contents are, to
7 the best of your knowledge, true and correct?
8
9 MR HAYES: That's correct.
10
11 MR MUSTON: That's the document at L15, Commissioner.
12
13 Ms Candish, could you state your full name for the
14 record, please.
15
16 MS CANDISH: Shaye Maree Candish.
17
18 MR MUSTON: Did you participate in the preparation of the
19 Nurses and Midwives' Association submission to the
20 Commission?
21
22 MS CANDISH: Yes, I did.
23
24 MR MUSTON: Have you had an opportunity to review that
25 more recently?
26
27 MS CANDISH: Yes.
28
29 MR MUSTON: Are you satisfied that it is true and correct,
30 to the best of your knowledge?
31
32 MS CANDISH: Yes, it is.
33
34 MR MUSTON: And reflects the views of your organisation?
35
36 MS CANDISH: Yes, it does, thank you.
37
38 MR MUSTON: Ms Collins, could you state your full name for
39 the record.
40
41 MS COLLINS: Melissa Anne Collins.
42
43 MR MUSTON: You have prepared three statements to assist
44 the Inquiry with its work, the most recent being a
45 statement dated 4 October 2024?
46
47 MS COLLINS: Yes.

1
2 MR MUSTON: Have you had an opportunity to review that
3 before giving your evidence this morning?
4
5 MS COLLINS: I have.
6
7 MR MUSTON: Are you satisfied that its contents are true
8 and correct?
9
10 MS COLLINS: Yes.
11
12 MR MUSTON: Commissioner, that is at L5. Just for the
13 record, the other two statements are 17 July 2024, H5.23,
14 and 3 August 2024, which is H5.23.2.
15
16 THE COMMISSIONER: I have them all here.
17
18 MR MUSTON: There are more to come.
19
20 Ms Egan, could you state your full name for the
21 record, please?
22
23 MS EGAN: Dominique Egan.
24
25 MR MUSTON: You've prepared a statement to assist the
26 Inquiry with its work, dated 25 July 2024?
27
28 MS EGAN: Yes, I have.
29
30 MR MUSTON: Commissioner, that statement was tendered as
31 H7.13.
32
33 THE COMMISSIONER: Yes.
34
35 MR MUSTON: Mr Holland, could you state your name for the
36 record, please.
37
38 MR HOLLAND: Andrew Holland.
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40 MR MUSTON: You have prepared a statement to assist the
41 Inquiry with its work, dated 30 September 2024?
42
43 MR HOLLAND: Yes.
44
45 MR MUSTON: Have you had an opportunity to review that
46 this morning before giving your evidence?
47

1 MR HOLLAND: I have.
2
3 MR MUSTON: Are you satisfied that its contents are true
4 and correct?
5
6 MR HOLLAND: Yes.
7
8 MR MUSTON: That's document L16, Commissioner,
9
10 Mr Minns could you state your full name for the
11 record.
12
13 MR MINNS: Phillip Gregory Minns.
14
15 MR MUSTON: You have prepared five statements to assist
16 the Inquiry with its work, the most recent of which is
17 dated 16 October 2024?
18
19 MR MINNS: Correct.
20
21 MR MUSTON: In respect of that statement, have you had an
22 opportunity to review it this morning before giving your
23 evidence?
24
25 MR MINNS: Yes.
26
27 MR MUSTON: Are you satisfied that its contents are, to
28 the best of your knowledge, true and correct?
29
30 MR MINNS: I am.
31
32 MR MUSTON: Commissioner, that is the document at L6.3.
33
34 For the record, the other statements prepared by
35 Mr Minns are 9 April 2024, which is D5; 7 June 2024, which
36 is G112; 17 July 2024, which is H5.22; and 8 October 2024,
37 which is L6.
38
39 The evidence that the Commission has received to date,
40 both in its metropolitan hearings and through its regional
41 hearings suggests that the existing awards - and in using
42 the term "awards" I will include the VMO determination for
43 present purposes - for members of the health workforce,
44 have failed to evolve and therefore don't appropriately
45 reflect the way in which health care is, or at least should
46 be, delivered by that workforce in 2024. The suggestion or
47 the term that has been used, not infrequently, is that the

1 awards are not "fit for purpose".

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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

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

5
6 MS COLLINS: Look, it is not a simple answer, of course.
7 You've got to look at each of the awards, but I certainly
8 do concur. Especially in relation to Mr Hayes's evidence,
9 I think you would actually look at both our statements and
10 see a lot of similarities. I think we are on the same
11 page around consolidation, modernisation.

12
13 In looking at what is fit for purpose, obviously the
14 ministry, as the employer, is going to have slightly
15 different views to my colleagues at the table around we
16 would see things, modernisation and fit for purpose being
17 about increasing flexibility and streamlining awards, where
18 generally the unions will want more in the awards, you
19 know, and rightly so. But certainly I think there are
20 barriers in many of the awards that we would - if we had
21 the opportunity, we would like to review and increase
22 flexibility. So --

23
24 MR MUSTON: Can I ask you specifically in relation to the
25 awards covering nurses and midwives, is it your view that
26 they are currently fit for purpose or do you have a view
27 that a process of modernisation of that award would also be
28 of some benefit to the system?

29
30 MS COLLINS: Look, I think there's always, you know,
31 changes that an employer might make to an award, but
32 largely I agree with Ms Candish that it's an award that has
33 been through a more modernised process, it is generally -
34 generally - relatively easy to understand. I don't think
35 there are many clauses where there are disputes between the
36 parties about what it means.

37
38 But certainly, of course, you could always - the
39 telephone allowance is probably a bit redundant, but
40 generally, we use that award; we employ many - over
41 60,000 - nurses on it. There's not necessarily barriers in
42 that award. We might have different views around, you
43 know, the implementation of safe staffing, but generally,
44 no, I would say in terms of modernisation and being fit for
45 purpose, I think we're probably on the same page there.

46
47 MR MUSTON: Mr Minns, did you want to add anything to

1 that?

2

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

4

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

14

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

19

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

29

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

37

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

45

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

1 that skill back that they have in 2024?

2

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

14

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

20

21 MR HAYES: We firmly believe in terms of our allied health
22 membership it should probably go from about 15 awards and
23 determinations down to three to five. That is reflective
24 of the particular streams that they're associated with.
25 Our broader membership has 35 different awards, I think
26 15 to 16 different determinations, including - and I say
27 this consistently, many of my younger staff don't quite
28 understand what an incinerator is, let alone the
29 incinerator allowance. These things haven't existed for
30 decades and yet we're entertaining them in the awards.

31

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

39

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

45

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

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

8
9 Now, this is getting probably a bit controversial,
10 but, of course, that would be easy, that would be what true
11 modernisation and simplification is. Then you would have,
12 I guess, additional awards for particular craft groups that
13 don't fit into the modern award. I think Mr Hayes is more
14 realistic. I think, you know, between three to seven in
15 the HSU space would be worthwhile.

16
17 MR MUSTON: Other than the administrative challenges
18 associated with making sure that you're working out who's
19 on what award and what that means in terms of the way in
20 which you're dealing with that member of your workforce,
21 what are the other challenges that the multitude of awards
22 pose for the health system generally and the way in which
23 it operates?

24
25 MS COLLINS: Look, I think you could look at each
26 individual award and talk to its challenges. In terms of
27 the multiple awards, I think demarcations can be difficult
28 between the high-level craft groups but also individually,
29 as in what does a wardsperson do versus a cleaner versus
30 a - oh, gosh, what they are called - patient services
31 assistant.

32
33 Those things create practical on-the-ground
34 difficulties. But I think to Mr Hayes's point as well, it
35 is some of the outdatedness of the awards. The incinerator
36 allowance is an obvious one but many of the awards refer to
37 numbers of beds, peer group levels, you know, patients and
38 kind of what are more outdated, kind of, you know, rigid
39 models.

40
41 The more flexibility there is in the awards, the
42 easier it will be to manage such a large health system at
43 an individual level. I think you probably have heard
44 evidence that the challenges are unique to different
45 facilities. The facility down the road, you know, can have
46 very different challenges to the one up the road. There
47 needs to be, I think, a lot more flexibility and less

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

4
5 MR MUSTON: Mr Holland, we've heard from many of your
6 members who have told us that the staff specialist award,
7 in particular, is no longer fit for purpose or is outdated
8 in a range of respects.

9
10 From the organisation's point of view, could you just
11 identify for us what are the sorts of issues in terms of
12 the way in which the award operates which hinder the way
13 health care is able to be delivered in the public system in
14 your view?

15
16 MR HOLLAND: I might commence by saying our approach isn't
17 just in relation to the staff specialist award. We do have
18 three other awards, including, as referenced, the medical
19 officers or junior medical officers award.

20
21 In relation to the staff specialist award, our
22 approach has been very much about taking the opportunity
23 that the new Labor government introduced to engage in their
24 mutual gains bargaining approach because a fundamental and
25 underlying issue for us has just been the lack of any type
26 of modernisation, review of the award. So taking the
27 opportunity to work, we believe, collaboratively with our
28 members and with the ministry, to actually look at a whole
29 range of concerns in the award, and through that we've
30 developed quite a comprehensive set of issues or claims
31 that we've put forward.

32
33 If we narrow it down to the key issue, for us, it is
34 the question of attracting and retaining staff specialists,
35 you know, within the public system at full fractions. The
36 question of both attraction and retention isn't just about
37 losing doctors interstate, it's going private, but it's
38 also reducing fractions in the public system to work
39 privately.

40
41 At the core of that are questions around remuneration,
42 in particular out of hours work. The staff specialists
43 award has no provision for overtime and has very limited
44 scope in relation to recognising and paying for out of
45 hours work. Currently it only applies to the emergency
46 physicians.

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

3
4 MR HOLLAND: That most definitely doesn't prevent it, and
5 in fact this is one of the problems that our members raise,
6 that in spite of the lack of provisions in the award which
7 formally recognise and formally pay penalties or overtime,
8 there's a lot of unpaid work being undertaken by staff
9 specialists.

10
11 That links to other issues regarding workloads, so,
12 you know, the inability of an award to actually address or
13 deal with questions of workload fatigue, safe staffing.
14 Under the broad umbrella of work health and safety, none of
15 the awards have any provisions in relation to safe work
16 hours which presents and causes many problems for our
17 members.

18
19 They're kind of the key issues. I don't want to imply
20 that they're the only issues, but they are the key issues
21 for that award.

22
23 Similar issues in the other awards, but they have
24 their own details that we can look at as well.

25
26 MR MUSTON: You've raised this issue of safe staffing
27 hours and safe staffing levels. Could I perhaps turn to
28 you, Ms Collins. You gave some evidence a moment ago about
29 concerns around a lack of flexibility within awards, the
30 existing awards. Perhaps could I invite you to just expand
31 on what you meant by that and whether that - how that might
32 sit in the context of a rigid award structure which
33 included things like an identified level of safe hours or
34 in the case of some evidence we heard this week from the
35 nurses and midwives around ratios and the extent to which
36 building that into an award can impact on a health system.
37 What are you able to tell us about that?

38
39 MS COLLINS: Certainly. Of course, as an employer, of
40 course we want safe hours and we want safe workloads.
41 I think I should say that up-front. The question is -
42 whether that needs to be in an award is a different
43 question. Nursing hours per patient day I guess is the
44 best example. I think that was in 2008, and that's,
45 I think, probably largely worked well.

46
47 Now, of course, the problem with a system such as not

1 just NSW Health but health systems across Australia and
2 internationally, is we have workforce shortages,
3 particularly in medical, but in New South Wales we're very
4 much seeing it in allied health and then rurally and
5 regionally.
6

7 So the other challenge, of course, is we can't shut
8 our doors. We must continue to provide health services.
9 So if we don't have the staff, we will have to look at
10 changing models of care and how we provide care safely
11 because we just don't have the option to say, "Ten people
12 called in sick", or, "we've got so many vacancies, this
13 hospital is shut today." That's just not available to us,
14 it is available in other industries.
15

16 I think the challenge of putting very rigid workload
17 or ratio tools - safe staffing levels, for example - is the
18 rigidity it requires, and the consequence of when we can't
19 meet those, for whatever reason, what we've seen is penalty
20 proceedings and civil penalty proceedings against us.
21

22 Now, when you look at nursing hours per patient day,
23 I guess, there's unders and overs, so often we do staff
24 above but there are occasions where we can't staff.
25 Nursing hours per patient day has traditionally been
26 perceived - is probably a bit more flexible in that it
27 balances across the week, so that it allows managers a bit
28 more discretion to, I guess, move staff in accordance with
29 activity.
30

31 I think that's probably - we do need that flexibility
32 to put staff where there is activity as opposed to kind of,
33 I guess, cruder workload tools that say, "Well, we must
34 have this many staff on this many shifts", that doesn't
35 necessarily take into account activity and acuity.
36

37 I just think in an area, especially in medical, where
38 there's an international workforce shortage, to put such
39 tools in the award is going to create further issues for
40 NSW Health. We have to, as an employer, balance all these
41 considerations and not just say that it might be better in
42 a policy. You know, we've recently updated our fatigue
43 management policy, so there are certainly avenues
44 available, but if you are talking about modern streamlined
45 awards, have a look at the modern awards and many EBAs,
46 they don't contain these restrictive provisions.
47

1 So modernisation and streamlining is also about
2 creating flexibility and I accept it's a really hard
3 balance.
4

5 MR MUSTON: Can I ask you, Ms Candish, perhaps to comment
6 on that? Without needing to get into the detail of any
7 ratio or provision, just speaking for present purposes
8 conceptually, what is the value, if any, of including in
9 industrial instruments these things which might bring
10 a level of inflexibility in terms of the way in which
11 health care is able to be delivered day-to-day,
12 particularly having regard to workforce challenges?
13

14 MS CANDISH: I suppose what we would say is somewhat
15 different than Ms Collins. From our perspective, there is
16 still flexibility available with workload tools like ratios
17 and nursing hours per patient day. Fundamentally, I think
18 we have a different view about how they're applied. From
19 our perspective, these tools are a minimum which gives you
20 the capacity to flex up or down. What we've seen happen is
21 that they're applied as a maximum.
22

23 The logic of applying a tool such as this is that it
24 protects vulnerable groups. We see it in schools, we see
25 it child care. The prospect of having a minimum staffing
26 arrangement to provide the necessary resources is not
27 really all that surprising or unheard of.
28

29 What we've, though, also observed is the exploitation
30 that happens when we don't have staffing models applied or
31 when staffing models are not being enforced appropriately.
32

33 This is off the back of, I suppose, a bigger picture
34 and bigger consideration where we've seen psychosocial
35 injury increase by 150 per cent here in New South Wales in
36 relation to nurses and midwives.
37

38 One of the key components of that is in relation to
39 role overload. The evidence is incredibly compelling about
40 the numbers of appropriate nursing staff to patients, in
41 relation to how that improves statistics in relation to
42 mortality and morbidity, but clearly, it also has an impact
43 on the psychological welfare of the workforce as well.
44

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

1 care.

2

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

17

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

28

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

36

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

44

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

1
2 MS CANDISH: Our view is that that wouldn't be appropriate
3 given the lack of enforceability. I'm sure Ms Collins
4 could probably give you more accurate evidence, but I think
5 the NSW Health program have some thousands of policies,
6 which would make us fairly reluctant to rely upon that as
7 any type of enforceable measure to make sure that minimum
8 staffing applied, given the significance of this particular
9 area.

10
11 MR MUSTON: Mr Holland, I might come back to you just on
12 this issue of the benefit or disbenefit, depending on which
13 view you take, of including details like ratios or, in your
14 case, minimum or maximum safe working hours, into an
15 industrial award rather than having it as part of a policy
16 or an overarching workplace health and safety procedure.
17 What is it about the current state of affairs which means
18 there is value in including those arguably inflexible
19 matters in industrial instruments?
20

21 MR HOLLAND: I think the only way to really address it is
22 to look at the underlying premise around what constitutes
23 flexibility. From our position, if flexibility is more
24 than just a one-sided equation, ie, if flexibility truly is
25 about taking on board the ability for employees and
26 employer to collaborate, to engage with each other, to find
27 the best solutions via an instrument, whether it be
28 a policy or an industrial instrument, and if there's
29 a commitment from both sides in relation to questions
30 around safe staffing and workloads - if there is commitment
31 from the employer to ensure that fundamental work health
32 and safety issues are met or obligations are met, then
33 neither the policy nor the industrial instrument should be
34 more or less flexible or inflexible. That is, the question
35 of the commitment from the employer to implement what they
36 put in policy should equally apply as in an industrial
37 instrument.
38

39 Our concern - this is really, I think, at the crux of
40 the issue, and not solely related, I think, to the ministry
41 but many employers - is that the fundamental difference is
42 the ability of the unions and the ability of our members to
43 be able to enforce conditions or better enforce conditions
44 that are laid out in an industrial instrument.
45

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

1 environment and the provision of, you know, NSW Health
2 being what we've called in our claims, for instance, an
3 employer of choice.
4

5 As it currently stands, I think there is evidence, and
6 I think all three unions probably experience this, where -
7 there is evidence that our ability to enforce some minimum
8 standards or enforce some basic principles, where they're
9 only found in policy is far, far more difficult to be able
10 to do that, and obviously there's the inability of the
11 Industrial Relations Commission, for example, to be able to
12 adequately deal with any disputes or any concerns around
13 conditions that are solving policy.
14

15 So basically for us, getting a provision in an
16 instrument is about certainty, providing certainty for both
17 members and the employer. It's about consistency, for us.
18 You know, the issue of having a single or fewer industrial
19 instruments which provide fundamental conditions is
20 certainty all around. Ultimately, though, it is the
21 ability for everyone to ensure that commitments made on any
22 of these issues are met and we have a regime to be able to
23 ensure those commitments are met.
24

25 MR MUSTON: Given we're surveying a landscape which is
26 still littered with things like, as Mr Hayes tells us,
27 incinerator allowances and the like, is there not a risk
28 that by including these sorts of matters in the industrial
29 instrument, the health system loses its ability to be
30 dynamic and change and adjust, and the way in which we're
31 able to safely and effectively deliver medicine with
32 emerging technologies, changes in modes of practice and the
33 like come about will be hampered in some way?
34

35 MR HOLLAND: I suggest that over the last decade and
36 a bit, where the single - or one of the main reasons for
37 the failure for there to be an agile and dynamic approach
38 to conditions has been the implementation of a rigid policy
39 of the previous government and the regulation.
40

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

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

10
11 I think if you look at a lot of experiences where
12 there has been a degree of flexibility that is truly
13 flexibility on both sides, not a one-sided equation from
14 the employer, I think the experience across the country can
15 show that in many industries, including our own, the
16 evidence does not suggest that it in any way, shape or form
17 prohibits or prevents innovation or prevents new ways of
18 working or new ways of adapting to change in a workplace.
19 Quite the contrary.

20
21 I think one of the issues we have identified with our
22 members - I think it's come up in the Inquiry - is a degree
23 of lack of trust. When we look at some of the issues that
24 were raised a number of years ago in the Garling Inquiry
25 about clinical engagement, I think the failure of proper
26 clinical engagement extends all the way through - a lack of
27 trust to actually trust the members to come up with some
28 good solutions. I think that's inherent here, too.

29
30 Putting these terms and conditions in awards that are
31 going to be renegotiated over the years doesn't mean that
32 we are just going to rigidly apply one provision forever
33 and a day. We want the flexibility to be able to negotiate
34 better terms and conditions for the members, and taking
35 into account the concerns that have been put forward by the
36 government and the ministry.

37
38 MR MUSTON: The lack of trust you refer to, would it be
39 fair to say it goes both ways, in the sense that whilst
40 you've pointed to a perceived lack of trust on the part of
41 the ministry to trust in your members and its workforce to
42 engage in relation to these matters, similarly, I rather
43 infer from your evidence that the perceived need to include
44 these matters in industrial instruments so that they can be
45 enforced is driven by a lack of trust on the part of your
46 organisation and its members in the ministry?
47

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

11
12 I acknowledge that, and it's an issue we need to deal
13 with, it's an issue we're trying to deal with internally
14 and grapple with. It's not easy. It's not easy. Yes, at
15 no point in time do I want to suggest that it's a single
16 highway there. It goes both ways. Yes. We've got a lot
17 of work to do there.

18
19 MR MUSTON: Is the situation similar, Ms Candish, within
20 your membership in terms of that lack of trust, perhaps
21 bi-directional lack of trust as you perceive it?

22
23 MS CANDISH: I think that's correct. I suppose I would
24 make the observation that we've had a decade of wage policy
25 that has prevented negotiations, so it isn't really built
26 into the culture here in New South Wales.

27
28 I can't speak for other unions, but our union bargains
29 in the federal system as well. It's fundamentally built
30 into what we do, we collaboratively work with many of the
31 employers. At times there's disputation, you don't always
32 agree, but again, you know, we obviously operate across
33 a number of different health companies, and we don't see
34 any stagnation around innovation. We deal with
35 modernisation as each of the EA negotiation processes come
36 up, and you work through the issues and you get to an
37 outcome.

38
39 I think what we haven't had here in New South Wales is
40 the ability to engage in that similar way and so all of the
41 parties, I think, are attempting to try and re-establish
42 what some of those terms of engagement look like. I do
43 think that there is - I hope I'm not speaking - well, I'll
44 speak for myself. I suspect that there is a different view
45 about what flexibility looks like and who should have
46 flexibility. The flexibility that the Ministry of Health
47 is seeking in awards, I think, is equally being sought by

1 my members, because what they're coming up against is
2 community expectation for more flexibility in their own
3 lives, and so what they want is certainty about their work.
4

5 There is a complexity in the health industry that
6 doesn't apply to a lot of other industries, when they're
7 required to work 24/7, and so it's important that people
8 are able to have some certainty about what their work and
9 home life pattern can look like. If you can't have
10 confidence that that can be applied in the workplace or
11 negotiated with your direct manager, you have to have some
12 terms of employment that you can go and point to.
13

14 So there is a balance to strike there, I think, around
15 what the employer seeks for their flexibility and what the
16 employee seeks for their flexibility, because these are
17 people who have their own carer responsibilities, but are
18 employed on a 24/7 basis, which makes it incredibly
19 difficult to give any commitment to anything - like even
20 a sporting team. So there has to be some cognisance of
21 what it is for the workforce to work in that type of
22 environment, too.
23

24 MR MUSTON: Mr Hayes, obviously you represent a wide range
25 of different workers within the health system, but the
26 issues that we've been talking about in terms of balancing
27 flexibility with a degree of rigidity within conditions
28 included in awards - is there anything you want to add to
29 that in relation to your membership?
30

31 MR HAYES: No, I'd concur with what my colleagues have had
32 to say. I think your point in terms of trust is absolutely
33 there. I think there's a common denominator here, that the
34 health services as well as our members want a good patient
35 outcome as well as to be able to look after themselves and
36 their families, and that lack of trust is there.
37

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

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

15
16 MR MUSTON: Mr Minns, can I ask you whether you have
17 a view on where the balance should lie in an ideal world
18 between flexibility and the incorporation into industrial
19 instruments of some of the types of issues that we've been
20 talking about, which at one level you might say are
21 occupational work health and safety issues that sort of
22 should trump the award and should be business as usual; at
23 another level, it's been suggested, well, if that's right,
24 why not include them in the award?

25
26 MR MINNS: It comes down to the level of prescription.
27 If you're a nurse unit manager in any one of our facilities
28 and you're just trying to organise care for the next shift
29 or the one that follows, what's the level of absolute
30 prescription that you face in navigating those decisions
31 and what is your capacity for what Ms Collins has called
32 "flexibility"? So the more prescription that goes into an
33 industrial instrument, the less in-the-moment flexibility
34 actually exists.

35
36 The dilemma that that generates is the one that
37 Ms Collins also referenced, which is the patients are going
38 to keep coming through the door. So from our perspective,
39 we support the idea of principles associated with safe
40 staffing. We're not setting out to run unsafe care
41 settings, right? So for them to be safe for patients, they
42 have to be safe for staff. But we have to adapt to what we
43 meet.

44
45 Whilst we might say, in some circumstances, that the
46 adaptation we had to make on that shift or for that week is
47 not ideal and we don't want it to persist, well, we then

1 need a process where we address that over time. But you've
2 got to be able to deal with what comes through that door
3 and so, from our perspective, it's how we preserve that for
4 our operational managers. But they need to do it within
5 a principles-based framework.
6

7 I guess the other point I would make about the many
8 comments that have been made about trust is, for good or
9 ill, the last government had a particular policy with
10 respect to wages and it had a regulation that supported it,
11 that bound the Industrial Relations Commission. So they
12 were the riding instructions and context that the ministry
13 took into 12 years of discussions.
14

15 I guess our experience was - I've sort of been here
16 for about six of those years - there weren't many instances
17 where there was an opportunity available between the
18 parties to do some significant reform within the scope that
19 you could still achieve under that regime of policy and
20 regulation.
21

22 We did, in fact, make such an offer to ASMOF in 2020
23 to say, "What about an MOU for a holistic rethink of how
24 medical awards are organised?" I think we talked about it
25 having three phases, a research phase or - a benchmarking
26 phase, a get to core principles phase, and then we would
27 accept that, after that, we were in active negotiation.
28 Now, that never really came to pass, for a range of
29 factors.
30

31 There haven't been conducive circumstances for
32 pragmatic bargaining to operate in the New South Wales
33 public health context since 2012. Now, that's recently
34 changed, and the parties are - right at this stage there
35 are discussions going on between my team and the teams of
36 all of the industrial organisations at the table. To some
37 degree, it's an active case study, which means that some of
38 the responses that we might be required to give, we might
39 have to place a condition on because we don't want anything
40 we say here today to be prejudicial to those other
41 discussions.
42

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

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

3
4 What is it about the way in which that industrial
5 relations system operates, or at least the way in which the
6 health workforce, and the industrial organisations that
7 represent it have been engaging, which has resulted in this
8 what would seem to be an effective stagnation of the
9 process of award reform and evolution?

10
11 MR MINNS: I joined health in 2017, so I can't offer a lot
12 of perspective on what happened between the mid 1980s and
13 2017. Seemingly, not a great deal, in terms of ongoing
14 negotiation around awards.

15
16 I think probably Ms Collins and the others at the
17 table would have a clearer view that there were several
18 kind of landmark arbitrations across that period where the
19 parties must have tried to get somewhere and didn't, and so
20 therefore sought the involvement of the commission.

21
22 From the point of the wages policy and the regulation,
23 and I don't think the regulation comes in until about 2013,
24 it effectively meant that you would open an annual
25 bargaining round with all unions, where the government's
26 standing offer was 2.5 per cent, and that was regardless of
27 the prevailing inflation rate.

28
29 As I gave in evidence in my last appearance, there
30 were several years, until quite recently, where that
31 2.5 per cent was ahead of the prevailing inflation rate.
32 So the question for unions was, "Well, do I want to come
33 forward and engage in a process of bargaining under the
34 government's policy that involves trying to do better than
35 2.5 per cent, which involves a process of trade-off
36 bargaining?" The colleagues at the table can speak for
37 themselves, but I think for the most part, that didn't
38 create a lot of warm interest for them and their members.
39 So it was easier to discuss the prospects, agree the
40 2.5 per cent, it's done and dusted, file for consent award
41 and off we go. I think that's largely what must have
42 happened across the decade, but I would invite other people
43 to comment.

44
45 MR MUSTON: I might ask you, Mr Hayes, having been
46 involved in a solid portion of that process - what is it
47 about the industrial relations landscape, at least for the

1 period you have been involved in it and to the extent you
2 could look backwards beyond your time, what is it that has
3 led to these awards not keeping up to date with the way in
4 which the workforce is mobilised within the health system?
5

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

10
11 MR MUSTON: Just pausing there, you still had an
12 incinerator allowance as at 2011?
13

14 MR HAYES: Yes, but the issue that I have is since 2012,
15 as Mr Minns just indicated, it's 2.5 per cent, then we all
16 move on. Each year, are you seriously going to trade-off
17 things out of your award for another, you know, sort of
18 percentage point, half a percentage point? You'll have
19 nothing left.
20

21 But it was all about trade-offs. It wasn't about
22 innovation. It wasn't how a paramedic can keep a person
23 out of a hospital, which is going to be a saving to the
24 hospital system. You know, work-related savings were all
25 about what can we get out of your award. It was just so
26 focused in a way that was just prejudicial to any kind of
27 real negotiation. That's where we're at at the moment.
28

29 I think over the past 18 months with the new
30 government, there's been a range of industrial activity.
31 I think this is, on both sides, people getting used to
32 actually engaging with each other again. So we've got
33 virtually, in my organisation, a whole group of people now
34 who have never, in a state system, had to have
35 a negotiation, and that's why at times we flare to
36 a dispute because it's easier to actually get there.
37

38 As I said, we want to be able to negotiate on
39 productivity, efficiency, that's going to be good for our
40 members, it's going to be good for the community, it's
41 going to be good for society in itself, not about, "Here,
42 we'll give you a percentage point but you've got to give
43 away A, B, C and D."
44

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

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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

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

3
4 But structurally, I think there is quite a significant
5 difference. When we go into a round of negotiations in the
6 federal system, there's an expectation from both parties
7 that - or multiple parties in some instances - you will
8 draw up terms of agreement, you will draw up a schedule,
9 you will outline what are the negotiations and the process
10 of those negotiations will be from the beginning. You work
11 through those processes. Members are entitled to go
12 through a range of industrial actions including protected
13 action. There are processes to facilitate that. It's an
14 appropriate and reasonable way to work through an
15 industrial relations dispute. You have an independent
16 umpire to be able to influence whatever the final outcome
17 is, should parties not be able to reach agreement.

18
19 We haven't had access to those things here, as the
20 other speakers have indicated. So what that, I think, has
21 generated for us is a situation where parties in New South
22 Wales haven't had to work through any kind of collaborative
23 approach to seek an outcome for the workforce and so there
24 is a real loss of that industrial knowledge and muscle,
25 I think, in the system, probably from both sides, to be
26 honest, that we're hoping to try and get back to.

27
28 I think it's critical that we do have it, but the
29 purpose of being able to achieve the modernisation in an
30 incremental way - I'm not going to take a view on a whole
31 of system reform, but I think the absence of being able to
32 do it in an incremental way is often why we're sitting in
33 the situation we're in now.

34
35 MR MUSTON: Mr Holland, you are nodding your head.

36
37 MR HOLLAND: Indeed. I would look at it in at least two
38 phases, or at least two phases in the period of my work
39 within unions.

40
41 So for the last nine years that I've been working at
42 ASMOF, I think the fundamental constraint, again, has been
43 the wages cap and the regulation in the Act, and a very
44 clear, I would say, ideological approach by the then
45 government to deliberately put downward pressure not just
46 on wage increases but on, you know, having agencies and
47 unions engage in meaningful negotiations.

1
2 I might use my previous experience as an example
3 to kind of compare and contrast different systems. For
4 20 years prior to that, I worked in a large public sector
5 union in New South Wales, which had a significant
6 proportion of members working in the national system and
7 the majority working in the state system.
8

9 What I'm about to say might be unpopular with some
10 within the movement and I think it's hotly contested about
11 the benefits of the introduction of enterprise bargaining
12 in the federal system.
13

14 What we saw, and my area was in the national system,
15 over many years of rounds of enterprise bargaining, where
16 similar to what Ms Candish said in relation to the way
17 national system employees engaged with the union in health,
18 we had a fair degree of trust, we had structures in place
19 where we knew how - you know, to coin a phrase, we knew how
20 to play the game. We knew there was a degree of
21 willingness on both sides to engage in problem solving and
22 productive and genuine negotiations.
23

24 What we saw over that time was the national system
25 members - and these were in universities - their conditions
26 and pay in many instances surpassing the majority of our
27 members under the core state award.
28

29 Now, that wasn't under the Liberal wages policy,
30 I think it was a culture created at the time where we
31 clearly - and I still support the concept of core awards in
32 the state - there was a mismatch between the idea of having
33 core awards which protected fundamental conditions, but
34 over time within government, having, in particular driven
35 by treasury, a very simplistic approach to cost
36 containment.
37

38 There was no incentive. Even under the previous
39 regime, there was no incentive to engage openly in anything
40 other than getting 4 per cent pay increases and tinkering
41 around the edges of awards, because of the imposition, pre
42 the Coalition Government coming in power, at least policy,
43 which mandated that there will be this cost containment,
44 and we have that now and I think that's one of the problems
45 we encounter.
46

47 I might just want to comment on some parts of my

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

12
13 I just want to say, too, I agree with Mr Hayes that
14 our members - our members - are also very willing to
15 negotiate around the concept of productivity improvements
16 and productivity changes. It's not this idea that we're
17 only seeking to take and not give. But we need to do that,
18 again, as I previously said. We need to do that in an
19 environment where there's trust and it's not just the
20 constant response that, "We can't afford", "We can't
21 afford", "We can't afford", and that's a problem we
22 encounter now.

23
24 So my last comment: we also have a number of fair
25 work agreements. We negotiate - not as many as my
26 colleagues in the other two unions - but again, we have
27 a similar experience there, that the public sector is seen
28 as driving and providing a ceiling in relation to pay, but
29 we have a lot more flexibility to negotiate around
30 conditions, and there is a willingness on a number of those
31 employers to sit down and negotiate around conditions.

32
33 MR MUSTON: What sort of things, just by way of example?

34
35 MR HOLLAND: Questions around professional development;
36 questions around issues of safe working hours and workload
37 management. It's many of the issues we've put forward on
38 the table for NSW Health.

39
40 MR MUSTON: So has it been your experience that those
41 issues that we were talking about a little bit earlier as
42 potentially giving rise to inflexibility - so the working
43 hours and the ratios in the case of nurses, for example -
44 that they do still find their way into EBAs under the --

45
46 MR HOLLAND: Absolutely. We have those, both in New South
47 Wales and, as I've said previously, in other states.

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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

1 discussions with ASMOF under the mutual gains bargaining
2 set of principles, and we are in the middle of intense
3 discussions with the nurses association. So I think a lot
4 of the commentary's been about what was our restrictive
5 context until the change of government.
6

7 But the risk of, you know, finding a kerosene can and
8 a match, to just give you the perspective that operates for
9 the management members in bargaining, in a government
10 context, if all the things that emerge from a productive
11 bargaining process come with a practical requirement for
12 additional supplementary funding, and that funding isn't
13 available through other channels of government, then we are
14 signing off on an unsustainable set of changes. They might
15 be very innovative and useful changes that will produce
16 other results, but if they don't produce the capacity to
17 fund the ultimate changes to wages or conditions, then that
18 means we're committing, as a management team, to absorb
19 those costs within the operating budget of health.
20

21 Now, you can always do a little bit of that. You
22 can't do a lot of it. And the issue about employing
23 140,000 full time equivalent employees is that if one of
24 them catches a cold, you know, it's extensive in terms of
25 how the flow-on cost aggregates.
26

27 So that's the management dilemma, in either the last
28 government, this government, future government. What is
29 the surrounding context created by government policy to do
30 with funding outcomes that arise from negotiations?
31

32 We are bound by the government's fair pay and
33 bargaining policy, and we are absolutely constrained by the
34 capacity to make commitments to increase employee-related
35 costs if they don't come with supplementation from central
36 government.
37

38 THE COMMISSIONER: When you said, "listening to the
39 dialogue it would suggest that we don't meet and we don't
40 talk", that's not the impression I'm getting from the
41 evidence being given by the union leaders here. It's
42 probably more along the lines of what Mr Holland said, the
43 response being, "We can't afford it, we can't afford it, we
44 can't afford it", which, in a sense, is what you are
45 touching on, too, about sustainability.
46

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

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

9
10 MR MINNS: Yes, I think I agree with both of those points,
11 Commissioner.

12
13 What I was attempting to say was that I think several
14 of the witnesses of talked about the process of bargaining
15 in the fair work context and the approach to the bargaining
16 meetings. We didn't have any of those meetings for 10 or
17 12 years, but we have started to have them since. So those
18 sorts of process mechanisms and, you know, timelines and
19 mutual sets of issues, et cetera, they are now the subject
20 of our negotiations. But we still are impacted by that can
21 of kerosene.

22
23 MS COLLINS: If I may, probably building on the point of
24 some of the unions, whilst under the former government's
25 wages policy we were limited to 2.5, and in many years,
26 that was higher than CPI, Sydney CPI, what it did do was it
27 meant that there wasn't movement on conditions. Normally,
28 through just general bargaining, that's happening all the
29 time in the background. I'm not talking your wage
30 increases, but whether it's your incinerator allowance,
31 changes to leave, small things.

32
33 The other thing, of course, in the context is other
34 states then outstrip New South Wales. So my feeling -
35 I guess in many of the meetings we have and I guess in the
36 discussions with staff - is I say that there is pent-up
37 demand. It's probably not coming to the bargaining table
38 in the normal course of events, because there is all this
39 pent-up demand, as we've all put on evidence around
40 interstate jurisdictional wage comparison.

41
42 Normally you might be coming - you know, your list of
43 employee kind of interests or claims can, I guess, be
44 bargained potentially in a multi-year award, but when you
45 are coming with 12 years of demand, the claims are
46 significant, and I think it just presents an additional
47 challenge because the parties are far apart, given where we

1 are with butting in--

2

3 THE COMMISSIONER: That's the thing, isn't it? It might
4 be one thing that at a certain period of time the
5 2.5 per cent was more than the rate of inflation, but the
6 other factor, as you have just identified, is the
7 comparison between, if I give my labour to the public or to
8 the State of New South Wales in Sydney, and it might be
9 very naive to raise fairness, my expectation would be that
10 I would not be paid less for giving exactly the same labour
11 to the public in Adelaide or Melbourne or Brisbane.

12

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

23

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

27

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

29

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

33

34 THE COMMISSIONER: Yes, that's right.

35

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

40

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

44

45 THE COMMISSIONER: Of course.

46

47 MS COLLINS: I could move --

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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

1 the parties, remuneration, was capped by legislation, the
2 discussion just didn't happen around all of those - the
3 ancillary discussions that might have led to an evolution
4 of conditions and the like didn't happen because the
5 discussions in and of themselves were not happening?
6

7 MS COLLINS: But importantly, I think, and very
8 importantly, is the IRC was restricted by the regulation,
9 because even when discussions - there is freedom to have
10 those discussions, and even if there was budget for those
11 discussions, often the parties will not agree or will part
12 agree, and you will come into this very building, now that
13 the president is here, to have those matters determined.
14

15 I think in some form or another since 1901 there has
16 been an independent arbitration system to resolve these
17 disputes, and I think the restriction on the Industrial
18 Relations Commission to do so has been - it's not just the
19 policy but the binding nature of the commission has been
20 such a big factor. So I think it's not just about not
21 having the collaborative discussions, but it's around the
22 restriction of the commission, which is really a handbrake
23 on industrial relations. I think a wages cap might be
24 a very good short-term strategy, but to restrict the
25 independent umpire, I think, - I guess I can say it now -
26 has been hugely problematic.
27

28 I think as well the commission now has unfettered
29 power, so there is kind of a solution available where the
30 parties remain apart. I'm not saying it's an easy pathway,
31 but I think now that the industrial court, the Industrial
32 Relations Commission, I guess - the industrial court's been
33 reinstated and the power has been returned to the
34 Industrial Relations Commission, there is a pathway forward
35 if the parties can't agree.
36

37 MR MUSTON: I might come back to that in a moment. But
38 the second component of it or the more immediate challenge,
39 as I perceive it from your evidence, is as a result of
40 that, there is now such, I think you described, a build-up
41 of demand in relation to some of these issues that the
42 ability of the parties to deal with that built-up demand,
43 whilst at the same time trimming away the incinerator
44 allowances and the like, those small but important matters
45 maybe lose or don't attract the focus that perhaps they
46 should have. Would that be right?
47

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

9
10 MR MUSTON: It probably wasn't a good question to start
11 with.

12
13 Can I turn to you, Ms Egan. We're not ignoring you.
14 Obviously the instrument under which your membership
15 operates, predominantly - I appreciate that there are
16 doctors who are members of your organisation who are also
17 captured by some of the awards, but the instrument that I'm
18 particularly interested in asking you about is the VMO
19 determination.

20
21 MS EGAN: Yes.

22
23 MR MUSTON: We've heard the evidence that has been given
24 by the industrial relations organisations and the ministry
25 in relation to the way their discussions have been
26 happening, or not happening, as the case may be, around the
27 reform of the awards. Has your experience been similar
28 insofar as the VMO determination is concerned?

29
30 MS EGAN: I think our experience has been that we have
31 engaged in discussions with the ministry over a period of
32 time, perhaps not to achieve immediate change but, as I've
33 given in my evidence previously, a lot of our focus is on
34 how there's been a change in the delivery of medical
35 services, where they can be delivered from, technology that
36 we want to see reflected in the VMO determinations, and
37 that people are fairly remunerated for the work that they
38 are doing, perhaps regardless of where they're doing it.
39 So we have had those discussions with the ministry.

40
41 As Ms Collins has said, sometimes you just don't reach
42 agreement. It may well be that we're going to have to
43 arbitrate that issue because we don't agree about it, and
44 we want to get back into the New South Wales industrial
45 relations system to do that.

46
47 MR MUSTON: That was going to be my next question. Do you

1 see there being utility in any process of reforming and
2 refreshing the VMO determination happening first of all in
3 parallel with particularly the staff specialist award
4 process, but perhaps the wider-reaching award reform
5 program that might be about to take place?
6

7 MS EGAN: Yes, I mean, I think, again as Mr Holland has
8 said, there are changes in the way that medical services
9 are being provided. The industrial instruments have not
10 kept pace with that, and so there are - they're different
11 instruments and work differently but there are, I think,
12 similarities in some of the issues that need to be
13 addressed.
14

15 I can't speak to the other awards because I won't
16 profess to be across all the details of those. But I think
17 while those discussions are ongoing and we're looking at
18 the system as a whole, yes, if that could also - accepting
19 the ministry has a lot to deal with, but if that can all
20 sort of happen contemporaneously, I think that would be
21 constructive.
22

23 MR MUSTON: Just picking up on your comment about
24 re-entering the industrial relations system, do you see
25 value in having that process occurring in the same forum
26 as, say, the renewal of the staff specialists award?
27

28 MS EGAN: Yes, I think so. When the industrial court was
29 dismantled a number of years ago, they changed the
30 arrangements for the appointment of an arbitrator in
31 relation to VMO arrangements. We can seek the appointment
32 of an arbitrator now, but we want to come back into the
33 industrial relations system because I think it's helpful
34 that, you know, we are a part of the system, and also to
35 draw on the expertise of the people who constitute the
36 court and the commission.
37

38 MR MUSTON: You will have to assist me, and I will expose
39 my naivety about these matters, but would that require some
40 legislative change in order to bring --
41

42 MS EGAN: Yes, it will, yes.
43

44 MR MUSTON: -- you and your organisation back into the
45 arena of the people on level 5 of this building?
46

47 MS EGAN: Correct, yes.

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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

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

8
9 MR HOLLAND: Just for absolute clarity, could I ask: when
10 you refer to the same forum, and my colleagues have quite
11 deliberately, because that's my interpretation, focused on
12 bringing back the VMO determination into the court, was
13 that the intention or the purpose of your question?

14
15 MR MUSTON: That was the intention of my question, but if
16 there is another way in which --

17
18 MR HOLLAND: No, no, I don't think anyone, I would
19 suggest, on this side would be looking at somehow combining
20 or amalgamating other processes, for instance, bargaining
21 or, you know, consolidating the VMO and the staff
22 specialist provisions in one document.

23
24 MR MUSTON: That certainly wasn't something I had in mind.

25
26 MR HOLLAND: Thank you.

27
28 MR MUSTON: To the extent that different sectors of the
29 health workforce can agree with one another and move in
30 parallel, that seems positive, but that's probably well
31 beyond our power to deal with.

32
33 That really does get us, I guess, to the real crux the
34 question or the issue that we're here to deal with today.
35 What can we do to - well, when I say "we", what
36 recommendation could this Inquiry make that might actually
37 facilitate pushing through this process and encouraging
38 a wholesale renewal and refreshing of the health workforce
39 awards? For example, is the answer really: refer this, or
40 suggest that it be referred to the Industrial Relations
41 Commission to exercise the powers available to them under
42 I think section 19, with a view to starting from a blank
43 sheet of paper and producing a series of consolidated
44 awards that accurately reflects the way in which the health
45 workforce operates in a contemporary environment and
46 allowing each of you and your respective interests to go to
47 the commission and explain what that looks like from your

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

3
4 MR MINNS: I think in practice what the commission would
5 expect is that the parties would do some of the work on
6 their own first. So the negotiations that we're engaged
7 in, they would have an expectation, and indeed if they get
8 involved at all in conciliation, they will be directing us
9 to try and narrow the issues that we can't resolve.

10
11 Then, on that basis, they would perhaps see it as
12 important, and maybe even a priority, if we were unlucky,
13 for those matters to be arbitrated.

14
15 So, you know, that was my point earlier, that we're in
16 discussions with everyone at the table at the moment, and
17 the discussions are ongoing, and they're trying to see what
18 can be resolved and what might, in fact, have to be
19 identified as not where the parties can get close and
20 potentially eventually those things might be matters for
21 commission consideration.

22
23 But they wouldn't welcome us just popping upstairs
24 with a blank sheet of paper requesting their involvement.
25 I think they would see that as a dereliction of our
26 respective roles under the Act.

27
28 MR MUSTON: Mr Hayes? What's your view?

29
30 MR HAYES: I would love to jump into that. Yes, I think
31 the role of the commission - if we need to go to the
32 commission, I think there is a failure in the first
33 instance. We can either get to a consent position or we
34 can't, and I think - I totally agree along this table -
35 many discussions have been had. In fact, at the moment, in
36 many of our allied health groups, we've formulated awards
37 and my colleagues at the ministry have been heavily
38 involved in those negotiations. So when we get to the
39 point, if we have to get the assistance of the commission,
40 well, it comes from time to time, but I see it as a failure
41 in the first instance.

42
43 The second thing, which is incredibly important, and
44 it has been my hope from the outset, because this underpins
45 everything, if we can - I believe that the ministry and
46 ourselves agree on most things. It comes to the budget to
47 be able to do it. It's been my hope for two to three years

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

5
6 I believe we're on the same page operationally, we're
7 all on the same page in terms of award renewal, but it's
8 all about what is holding us back. But I have to say that.
9 I want to put that on record because that will be the
10 sticking point right the way through.

11
12 MR MUSTON: I should probably invite you, Mr Minns, and,
13 Ms Collins, to just respond to the proposition that waste
14 and inefficiency within the system is a fetter to these
15 negotiations. I gather you might take a slightly different
16 view.

17
18 MR MINNS: I guess what I would say is that if we are to
19 try and get to a position by consent, or any other way, to
20 see uplift in wages and/or conditions, it comes with
21 a bill, and we either manifest a way to pay for that or we
22 have a problem. If we can't find a way to pay for it, we
23 need the government to agree that they're going to
24 contribute in either whole or part.

25
26 But if that doesn't happen and we haven't manifested
27 a way to pay for it, we're completely aware, as managers,
28 because - I think I have told the Commission in evidence
29 before I can't remember exactly the number - around the
30 60 per cent mark of our operating budgets is
31 employee-related cost.

32
33 Then a significant next quotient of our budget is
34 goods and services through procurement, where we already
35 have some robust and challenging targets to reach as part
36 of the government's overall comprehensive efficiency
37 review.

38
39 So they're two very large contributors to our budget,
40 and if we see a lot of movement in wages and conditions,
41 employee-related cost, from our perspective, it's just how
42 do we cover that?

43
44 THE COMMISSIONER: It ends up being driven to almost
45 a philosophical position. So once you have eliminated all
46 the waste, and if you're paying the workers in the system
47 fairly and appropriately, and you're as efficient as you

1 could possibly be, then you end up with the situation, if
2 treasury is saying there is not enough money, as to
3 thinking about what sort of health system we actually want
4 as a country, whether we really want a free and universal
5 healthcare system, or government's honest in saying it
6 can't afford that on - it might even be the current rates
7 of taxation, whether it's income tax, GST or company tax.
8 It's whether we think a fully free and universal health
9 system is of benefit to the country, which might mean that
10 we have slightly different taxation arrangements - it's
11 fortunately not in my terms of reference - or whether we're
12 honest enough to say, "Well, yes, we're going to have
13 a good health system, but it may not be what it's
14 historically been advertised to be since Medicare was
15 introduced."
16

17 We are thinking about all of those things. But
18 that's, I think, where ultimately you're heading, in the
19 sense of if waste is eliminated, it's as efficient as it
20 can be, and if people are going to be paid fairly and
21 appropriately and there's still not enough money, well,
22 where does that leave us?
23

24 MR MINNS: I'm not sure if I was heading there,
25 Commissioner, but --
26

27 THE COMMISSIONER: Sorry, that's me.
28

29 MR MINNS: But you've gone there very effectively and
30 efficiently.
31

32 THE COMMISSIONER: I won't blame you for that, but you
33 tipped me in the direction.
34

35 MS CANDISH: I might just add, I do think that there is
36 some consideration, though, of the level of efficiency and
37 productivity savings that are being made every day in the
38 system, because structurally, there is no way for that to
39 be plugged into wages and improvements at the moment,
40 either.
41

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

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

4
5 I don't want you to move you away from your
6 philosophical views, but I do think structurally, there are
7 some components there. Once sort of waste and inefficiency
8 is looked at, the actual improvements that are already
9 happening, being captured in a more meaningful way.

10
11 THE COMMISSIONER: Sure. Is that a convenient time?

12
13 MR MUSTON: Yes. I don't have very much to go. I don't
14 know whether you have some questions to ask of these
15 witnesses, but it is --

16
17 THE COMMISSIONER: Yes, I think we will have a break now.
18 Can I, just before we have the break, tidy up a couple of
19 things.

20
21 Ms Egan, when you last gave evidence - it's in
22 paragraph 18 of your statement, and for those who are
23 interested, it starts at transcript page 4606, back on
24 5 August - the AMA was seeking current numbers of VMOs
25 working in the New South Wales public hospital system, and
26 you were having trouble getting that data. Has that been
27 resolved since then?

28
29 MS EGAN: Yes. We've been provided with some information
30 about that, thank you.

31
32 THE COMMISSIONER: All right.

33
34 Sorry, just on that theme, also, Mr Holland, in your
35 statement at paragraph 18, you'd been requesting vacancy
36 data. That's an ongoing request?

37
38 MR HOLLAND: It is an ongoing request, and we don't have
39 a response to that. My understanding, and I would stand to
40 be corrected, is that the response has been there is no
41 central way of collecting that information. But we don't
42 have any information at this point in time.

43
44 THE COMMISSIONER: All right. That can be followed up
45 after the break, if it needs to be.

46
47 The final thing is - this is a question more for the

1 team - in Ms Egan's statement from the prior hearings there
2 was reference to a Deloitte report on medical workforce
3 pressures in New South Wales, which I only read this
4 morning. Is that part of the tender? Has that been
5 tendered? You can check it over the break.
6

7 All right. We will adjourn until 11.55.
8

9 **SHORT ADJOURNMENT**

10
11 THE COMMISSIONER: When you are ready.
12

13 MR MUSTON: Can I ask you, Mr Hayes, earlier this morning
14 you made an observation about the role of waste and
15 profiteering in the overall consumption of the health
16 budget envelope. I think we all understand what waste is
17 and the way in which efficiency can be used to address
18 waste, but perhaps can I invite you to expand on when what
19 you had in mind when you referred to "profiteering".
20

21 MR HAYES: What I see as a form of profiteering is that
22 agencies come in, picking up staff, and then renting them
23 back to the health system. We've seen this recently in
24 Lismore with security officers being paid far more to be
25 able to be rented back. I think this is something that
26 moves into supply and demand, it moves into locum areas and
27 a whole range of areas. Clearly there's \$32 billion that
28 goes into NSW Health and a lot of people want a piece of
29 the pie.
30

31 At the same time, the federal government - I know this
32 is not the jurisdiction here, but Dr Margaret Faux and
33 Dr Philip, were able to see between three and eight billion
34 dollars worth of noncompliance.
35

36 Now, as I've indicated, with Mr Minns I would think we
37 are very close to being on a reasonable page, however, if
38 the money is not there at the end of the day, how can we be
39 in the same book? I think this is something that is
40 incredibly important to be able to deal with the outcomes
41 our members expect, that the community expects, a service
42 that should be able to be delivered in metropolitan and
43 regional New South Wales, but that is going to be
44 particularly hamstrung if - wastage is one point - but if
45 there's a hole in the bucket in that way too.
46

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

1 that. We've heard a lot of evidence about the use of
2 premium labour within the medical and clinical workforce,
3 but we haven't heard evidence about the use of premium
4 labour or agency in other facets of the health workforce.
5 Is that a similar problem?
6

7 MR MINNS: Look, I can't recall the rates of usage, but
8 I don't believe that the same proportion of expenditure is
9 going towards non-clinical roles related to premium labour.
10 I don't know anything about Lismore's context.
11

12 I know that in some instances, we have had different
13 facilities in different LHDs that have had a strong and
14 heavy reliance on contractors for security work, and
15 I think we've shared the view with Mr Hayes that an
16 over-reliance on contractors in that role is not useful.
17

18 It creates a couple of things for us - the lack of
19 continuity of provision of the service and appreciation of
20 how to do it in the health setting, and the sorts of
21 patients and carers that we need to address. We have, at
22 the urging of Mr Hayes and the former minister, on
23 occasion, gone out to the system and asked them to
24 investigate their level of non-permanent security staff,
25 with a pretty clear direction to rebalance their set-up.
26 But I don't know what's happening in Lismore at the moment.
27

28 MR MUSTON: Decisions of that kind are operational
29 decisions presumably made at LHD levels and perhaps even at
30 a facility level?
31

32 MR MINNS: Locally. But as a result of the escalated
33 issues that Mr Hayes brought to us at the time, I think we
34 probably did a data check. I can't quite recall but we
35 would have done some kind of workforce metric check of how
36 many contractors were there. We did point out that we felt
37 that they are an augmentation, premium labour device. We
38 don't see them as a replacement.
39

40 Now, there might be historical cases where, at
41 direction of government, we have outsourced entire service
42 provision, and some of that is related to the member areas
43 of Mr Hayes. I don't recall any recent ones. But there
44 are some historical legacy ones operating in the system.
45

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

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

5
6 MR HAYES: I wouldn't think so. I would certainly hope
7 that this Inquiry was a catalyst for many other states.

8
9 THE COMMISSIONER: The MBS is relevant to this Inquiry, in
10 the sense of what it means for GPs and what it means for
11 the GP market, because that has flow-on effects, when that
12 market is thin, to our public hospital system that are well
13 documented and I think everyone accepts. But we aren't
14 investigating Medicare fraud.

15
16 MR HAYES: I'm very mindful of that. Any opportunities --

17
18 THE COMMISSIONER: I wasn't suggesting you were thinking
19 we were, but I just wanted to make that clear on the
20 transcript. Sorry to interrupt.

21
22 MR MUSTON: Coming back, Mr Minns, to some answers you
23 gave earlier about the challenges from a negotiation
24 perspective of a constrained budgetary environment, as
25 we've heard it referred to in various places and from
26 various people, to the extent that you are referring to the
27 limitations on your ability to negotiate through this
28 process, just so I can understand it, is that limitation
29 a capacity to absorb increased wages or more costly
30 conditions within the existing health budget, or is there
31 a next step there which is, to the extent that negotiations
32 might involve an increase in the expenditure on a workforce
33 in order to reach agreement in relation to that, there
34 needs to be, prior to that, from your point of view, some
35 agreement on the part of the treasury to increase the
36 budgetary envelope that will be made available to the
37 ministry going forward?

38
39 MR MINNS: So government has the fair pay and bargaining
40 policy, and under that policy, we're bound by its
41 limitations, and to become more free than what is in the
42 standard policy, we would need a decision of the
43 expenditure review committee.

44
45 What happens, and if I reflect on the last 12 months,
46 is it's an iterative process between bargaining and
47 consulting with that committee of government, but we don't

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

3
4 MR MUSTON: In the absence of a decision of the
5 expenditure review committee, what impact would a decision
6 of the Industrial Relations Commission have on that
7 process?

8
9 MR MINNS: That's a matter for government. I think that's
10 probably all I should say. They are the government that
11 has recently amended the Industrial Relations Act, so it's
12 a matter for them to consider.

13
14 MR MUSTON: In terms of a recommendation that might be
15 made by this Inquiry, and accepting, I think, as Mr Hayes
16 pointed out, and Mr Minns agreed, that turning up to the
17 Industrial Relations Commission with a blank sheet of paper
18 and saying, "Solve this problem for us" might not be well
19 received but equally might reflect a failure of the
20 process, would it nevertheless - would there be some value
21 in suggesting to the Industrial Relations Commission
22 a particular outcome, not in terms of individual
23 conditions, but, rather, as an outcome of the process,
24 a complete renewal of the award structure such that it
25 accurately reflected the contemporary delivery of health
26 care in the public system, so that if you did reach an
27 agreement within a period of time - and we'll come back to
28 that in a minute - the Industrial Relations Commission
29 might then have a look at it and assess for itself whether
30 or not it actually achieves the objective of a proper
31 renewal and refreshing of the award?

32
33 Is there something that could be done by way of
34 recommendation, do you think, that might actually ensure
35 that the bargaining process, which has, to date, not, no
36 doubt despite the best efforts of various people, produced
37 that renewal - give the Industrial Relations Commission an
38 opportunity to independently assess whether or not any
39 process of bargaining adequately has achieved that?
40 Mr Hayes?

41
42 MR HAYES: That's a very good question. I think there is
43 an opportunity to have that assessment. Having the
44 capacity to be fully briefed as to the nuances that would
45 be involved, it certainly - I don't think it would hinder
46 the process, but it that way, but I'm not too sure how
47 successful it would be.

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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,

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

5
6 In my previous statement, we have submitted
7 a variation which provides for rostered overtime. It
8 doesn't have a loading attached to it. I won't go into the
9 background around that. I would suggest that that would be
10 unacceptable to ASMOF and staff specialists. Now, I think
11 there would be a lot of value in looking at how do we
12 potentially unscramble the egg of a salaried award, whether
13 we can narrow the issues, agree potentially how overtime
14 would work in the staff specialists award, potentially
15 agree a clause. I suspect, given the huge quantum that
16 that would cost, we probably won't be able to get agreement
17 between the parties.

18
19 That could really be a useful issue for the Industrial
20 Relations Commission to turn its mind to, "Well, what's the
21 quantum of what that overtime penalty would be?" So it's
22 not necessarily whole scale start from a piece of blank
23 paper, just because I think that's such a huge task, but
24 how do we narrow issues, come together where we agree and
25 then have maybe quantum determined, I see perhaps a pathway
26 with the HSU consolidation around some of that.

27
28 I maintain the hope - I'm ever the optimist - that we
29 will be able to agree significant components. But
30 potentially, we've all admitted, budget is going to be
31 a massive hurdle. Is there a place that does not have that
32 hurdle? And I see that being the Industrial Relations
33 Commission.

34
35 MR MUSTON: Part of that process, presumably, will involve
36 some bargaining around, obviously, the uncontroversial
37 matters and the removal of incinerator allowances, I'm
38 assuming, but is there a time frame within which, in the
39 ideal world, that should have occurred, after which the
40 Industrial Relations Commission might be encouraged to step
41 in and mark your homework, as it were?

42
43 MS COLLINS: Look, I guess potentially, yes and no.
44 I think as well you wouldn't - you know, the unions may
45 have pressure from their members to resolve matters earlier
46 and they need to take industrial action, as is their right
47 to do so. 0 I don't know that setting a hard deadline

1 necessarily helps, because also, of course, we have
2 submitted new awards. So I guess the deadline is somewhat
3 creeping up anyway because we have report-backs on the
4 numerous awards. I suspect we're already there in some
5 ways, where there's a consent award.
6

7 Gerard, just give me a nod or a cut, but the HSU have
8 put out to their membership to vote a new wage offer. That
9 will hopefully result in a consent award and then will kick
10 off or continue the process of award reform with the HSU.
11

12 I suspect there's already a deadline of 1 July 2025 to
13 make progress on that, because we will, of course, be back
14 in the commission, and I think the HSU and its members will
15 want to see where we've got to on that process.
16

17 We're in the process of bargaining. I don't want to
18 prejudice those discussions but I guess we have
19 a report-back on Monday with the nurses. We're in
20 intensive discussions. I don't want to predetermine where
21 they will go. I guess if unsuccessful, no doubt I would
22 think the commission will want to start a process of
23 conciliation and listing for arbitration.
24

25 With ASMOF, we are in mutual gains bargaining but
26 again, Mr Holland, will be able to - I can't remember the
27 date that we're back. It's a long way of saying I think
28 the deadline is somewhat already upon us, in a way, in that
29 we can't have these expired awards kind of continue
30 indefinitely. So I think the commission is already
31 involved in the process. That's probably a very long
32 answer to your question.
33

34 MR MUSTON: One question I might ask, and perhaps we can
35 ultimately address it through a summons, but one thing
36 I think that might be quite useful from our perspective
37 would be a table that identifies with respect to each of
38 the awards that are currently the subject of this process,
39 the date or the key date by which a stage is anticipated or
40 required to be reached and what's going to happen at that
41 point. If, as you say, the position is largely already
42 upon us, then a deadline of any sort is not going to be
43 particularly useful, particularly if it sits at odds with
44 deadlines that have already been set by the commission.
45

46 You were going to say something, I think, Mr Minns?
47

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

9
10 MR MUSTON: Do any of the representatives of the
11 industrial organisations have a different view in relation
12 to that? Feel free, any of you, to comment on the
13 proposition that there may be a deadline at some point by
14 which time this process of bargaining should have produced
15 an outcome and if not the Industrial Relations Commission
16 should embark upon its work under section 19.

17
18 MR HAYES: I guess from our perspective, we are, like most
19 unions, very heavily driven by our membership. So there
20 may be sort of an administrative timeline, but then there
21 may be an emotional response, so it becomes a little bit
22 true.

23
24 But I think to support the Ministry of Health, to
25 a large degree they do a lot of very good work with very,
26 very few resources, and this is - while I'm not advocating
27 for them, as a PSA person, but it is important, if we want
28 to be able to get an outcome, we have to have the
29 appropriate resources on both sides of this fence. That's
30 something that I think government needs to really think
31 about very heavily, if they do want to have a good
32 industrial relations system, that you've actually got the
33 players on the field to do it.

34
35 MR MUSTON: Ms Candish, do you want to add anything to
36 that?

37
38 MS CANDISH: I would say in principle we agree. Our
39 submission goes to some of our views in relation to the,
40 I suppose, industrial relations structure that exists
41 across the local health districts. We do see some
42 duplication. We think there would be some benefit in
43 centralising some of those services. That may deal with
44 some of the resourcing issues. We also think it would
45 standardise a lot of the interpretation and the response
46 that we receive to industrial relations matters, so there
47 could be something there to be looked at, would be our

1 view.

2

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

12

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

25

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

44

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

1 relations function will sit at odds with that. So the
2 opportunities for improvement are where Ms Collins has
3 noted.
4

5 None of us enjoy getting a stick in the eye because
6 there has been a particular position taken by either
7 a manager, an HR person, an IR person or a delegate or an
8 organiser and, you know, it rolls through, we eventually
9 hear about it, and the people at this table will generally
10 sort it through. So it's how you reduce the number of
11 those happening through the consistency of principles and
12 advice, which is what we're seeking to do through that
13 reform of a centre for excellence.
14

15 MR MUSTON: I have no further questions for these
16 witnesses, Commissioner.
17

18 THE COMMISSIONER: Mr Cheney or Mr Chiu, you can't both
19 ask, but do either of you have a question or question or
20 two?
21

22 MR CHENEY: No, Commissioner.
23

24 THE COMMISSIONER: Thank you.
25

26 To all six of you, thank you very much for your
27 attendance today.
28

29 I haven't said this before, but I do know that
30 inquiries of this kind, from past experience, are
31 disruptive to the key organisations involved, and whilst
32 it's formally done by compulsion, we are grateful for the
33 assistance and time from the executives of NSW Health and
34 also, too, the union leaders here. We know you've got
35 other things to do, but we're very grateful for the
36 assistance and time you've spent with us throughout the
37 Inquiry, but also today. So thank you very much. Having
38 said that, we will adjourn until 11.30 tomorrow.
39

40 You are all excused.
41

42 <THE WITNESSES WITHDREW
43

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