abla Australian Business Lawyers & Advisors

IN THE FAIR WORK COMMISSION

SUBMISSIONS

WORK VALUE CASE - AGED CARE INDUSTRY

(AM2020/99; AM2021/63; AM2021/65)

FILED ON BEHALF OF:

AGED & COMMUNITY SERVICES AUSTRALIA

LEADING AGE SERVICES AUSTRALIA

AUSTRALIAN BUSINESS INDUSTRIAL

4 MARCH 2022

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1. INTRODUCTION

1.1 This submission is made on behalf of:

(a) Aged & Community Services Australia (**ACSA**);

(b) Leading Age Services Australia (**LASA**); and

(c) Australian Business Industrial (**ABI**).

1.2 On 18 December 2020, the Fair Work Commission (the **Commission**) issued Directions in *Aged Care Award 2010* (AM2020/99). President Ross made the following directions:

> *"1. The Applicants and other union parties to file evidence and submissions by 4pm on Thursday 1 April 2021.*
>
> *2. Employers and Employer Associations to file evidence and submissions by 4pm on Monday 16 August 2021.*
>
> *3. The matter will be listed for Mention at 9:30am on Monday 23 August 2021. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.*
>
> *4. The Applicants and other union parties to file evidence and submissions in reply by 4pm on Monday 18 October 2021.*
>
> *5. Submissions to be filed in both Word and PDF formats to amod@fwc.gov.au.*
>
> *6. The parties are granted liberty to apply to vary the above directions."*

1.3 On 1 April 2021, United Workers' Union (**UWU**), Australian Nursing and Midwifery Federation (**ANMF**) and Health Services Union (**HSU**) filed evidence and submissions.

1.4 On 1 July 2021, the Commission issued a Statement and Directions in *Aged Care Award 2010* [2021] FWCFB 3726 (AM2020/99; AM2021/63 and AM2021/65) (the **Directions**), which set aside the 18 December 2020 directions.

1.5 The Commission directed:

> *"1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.*

2. The directions dated 18 December 2020 in relation to application in AM2020/99 are set aside.

3. The Australian Government is to confer with the Applicants in relation to the requests for information and data in Schedule 1.

4. The Australian Government is to file its response to the request for information and data, specifying what information and data it can provide and by when, by 4pm on 16 July 2021.

5. The Australian Government is to file the information and data then available by 23 July 2021, and any additional information and data as soon as it is available.

6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on Friday 20 August 2021.

7. The Applicants and other union parties will file evidence and submissions by 4pm on Friday 8 October 2021. This includes any updated submission or evidence already filed in matter AM2020/99 in accordance with the directions dated 18 December 2020.

8. Employers and employer organisations will file evidence and submissions by 4pm on Friday 18 February 2022.

…

16. The parties are granted liberty to apply to vary the above directions."

1.6 The Directions have since be varied on two occasions following applications made by the ANMF.[1]

1.7 On 4 January 2022, an extension was granted to ACSA, LASA and ABI for the filing of evidence and submissions, namely:

"8. Employers and employer organisations will file evidence and submissions by 4pm on Friday 4 March 2022.

[1] *Aged Care Award 2010* [2021] FWCFB 4667 at [4]; Amended Directions published 18 November 2021.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on Thursday 21 April 2022."

1.8 Pursuant to the amended Directions, ACSA, LASA and ABI filed the following evidence:

(a) Statement of Kim Bradshaw, General Manager at Warrigal, dated 4 March 2022;

(b) Statement of Johannes Brockhaus, Chief Executive Officer at Buckland Aged Care Services, dated 3 March 2022;

(c) Statement of Emma Brown, Special Care Project Manager at Warrigal, dated 2 March 2022;

(d) Statement of Sue Cudmore, Chief Operating Officer - Recruitment Solutions Group Australia, dated 4 March 2022;

(e) Statement of Paul Sadler, Chief Executive Officer at ACSA, dated 1 March 2022;

(f) Statement of Mark Sewell, Chief Executive Officer at Warrigal, dated 3 March 2022;

(g) Statement of Craig Smith, Executive Leader Service Integrated Communities at Warrigal, dated 2 March 2022;

(h) Statement of Anna-Maria Wade, National Manager - Employee Relations and State Manager - NSW and ACT at ACSA, dated 4 March 2022; and

(i) Statement of Cheyne Woolsey, Chief Human Resources Officer at KinCare, dated 4 March 2022.

1.9 For the assistance of the Commission, to the extent we have made reference to various reports and related documents, we have collated that material into a reference bundle.[2]

[2] Reference Material for Submissions dated 4 March 2022, filed 4 March 2022 (**Reference Bundle**).

2. OVERVIEW: THE APPLICATIONS

2.1 The applications brought by the HSU and ANMF seek the variation of the following awards:

(a) *Aged Care Award 2010* (***Aged Care Award***);[3]

(b) *Nurses Award 2010* (***Nurses Award***);[4] and

(c) *Social, Community, Home Care and Disability Services Industry Award 2010* (***SCHADS Award***),[5]

(collectively, **the awards**).

Applications by the HSU

2.2 On 17 November 2020, an amended application was filed by the HSU[6] to vary the *Aged Care Award* in relation to:

(a) Clause 14.1 Minimum wages – Aged Care Employee, and

(b) Schedule B – Classification definitions,

(**the HSU Aged Care Application**).

2.3 By that application the HSU seeks an increase to wages of 25% for *all classification levels* in the *Aged Care Award* to rectify the purported undervaluation of employees covered by the *Aged Care Award*.

2.4 By reference to the *Aged Care Award* and current minimum wage rates,[7] that increase appears below:

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[3] See *Aged Care Award* 2010 (AM2020/99) (filed 17 November 2020) and *Aged Care Award* 2010 and *Nurses Award* 2010 (AM2021/63) (filed 21 May 2021).

[4] See *Aged Care Award* 2010 and *Nurses Award* 2010 (AM2021/63) (filed 18 May 2021).

[5] See Social, Community, Home Care and Disability Services Industry Award 2010 (AM2021/65) (filed 1 June 2021).

[6] Together with HSU members Virginia Ellis, Mark Castieau, Sanu Ghimire and Paul Jones (**the HSU members**).

[7] See *Annual Wage Review 2020–21* [2021] FWCFB 3500.

	Current Rate	Current Rate + 25%
Classification	**Per Week** $	**Per Week** $
Aged Care employee - level 1	821.40	1026.75
Aged Care employee - level 2	855.50	1069.38
Aged Care employee - level 3	889.00	1111.25
Aged Care employee - level 4	899.50	1124.38
Aged Care employee - level 5	930.00	1162.50
Aged Care employee - level 6	980.10	1225.13
Aged Care employee - level 7	997.70	1247.13

2.5 In support of that increase, the HSU submit that the rates in the *Aged Care Award* were not subject to any work value assessment at the time of the making of the award and the precise origin of the rates remain unclear.[8]

2.6 The variation to Schedule B is *"to provide for an additional pay level for personal care workers who have undertaken specialised training in a specific areas of care and use those skills"*.[9]

2.7 On 1 June 2021, a further application was filed by the HSU to vary the minimum wage rates in the *SCHADS Award* (**the HSU SCHADS Application**). By the HSU SCHADS Application, the HSU seek to insert a new definition into the award:

[8] HSU Aged Care Application, Annexure B, page 1.

[9] HSU Aged Care Application, Annexure B, page 9 at paragraph 4.

*"**Home aged care employee** means a home care employee providing personal care, domestic assistance or home maintenance to an aged person in a private residence"*[10]

2.8 The *SCHADS Award* currently only recognises the following classifications:

(a) social and community services employee level 1-8;

(b) family day care employee level 1-5; and

(c) home care employee level 1-5.

2.9 The proposed minimum weekly wages for *"home aged care employees"* is as follows:[11]

Proposed Classification	**Per Week** **$**
Home aged care employee Level 1	
Pay point 1	1014.13
Home aged care employee Level 2	
Pay point 1	1074.88
Pay point 2	1082.25
Home aged care employee Level 3	
Pay point 1 (Cert III)	1097.00
Pay point 2	1130.75
Home aged care employee Level 4	
Pay point 1 (Cert IV)	1196.88
Pay point 2	1220.75
Home aged care employee Level 5	
Pay point 1 (Degree or Diploma)	1283.13

[10] HSU SCHADS Application, page 3, para 2.2.

[11] HSU SCHADS Application, page 3, para 2.2.

Proposed Classification	**Per Week** **$**
Pay point 2	1333.75

2.10 The increase in wages sought is 25% for all employees providing aged care in home settings covered by the *SCHADS Award*.[12] That application does not otherwise seek to agitate or vary minimum rates with respect to home care employees.

2.11 In support of this specific variation, the HSU submit that the minimum wage rates in the *SCHADS Award* pertaining to home aged care employees were not evaluated during the award modernisation process. No consideration of the minimum wages (other than by annual minimum wage adjustments) or the work value of the work performed by home aged care employees covered by the *SCHADS Award* has been conducted since that Award commenced to operate in 2010.[13]

Application by ANMF

2.12 On 18 May 2021, an application was filed by the ANMF to:

(a) vary the *Aged Care Award* in relation to:

(i) Clause 14.1 Minimum wages – Aged Care Employee, and

(ii) Schedule B – Classification definitions; and

(b) vary the *Nurses Award* by inserting a new Schedule F,

(**the ANMF Application**).

[12] HSU SCHADS Application, Annexure A, paragraphs 2 and 6.

[13] HSU SCHADS Application, Annexure A, paragraph 3.

2.13 By the ANMF Application, the ANMF seeks:

(a) the creation of a new classification structure for *"personal care workers"* under the *Aged Care Award*, together with an increase to wages of 25% for those employees;[14] and

(b) the creation of a new classification structure for employees covered under the *Nurses Award* that are engaged in services for aged persons, together with an increase to wages of 25% for those employees.[15]

2.14 The new classification structure in the *Aged Care Award* would require deletion of any reference to *"personal care"* in connection to aged care employees as set out in Schedule B. Next, the following new classifications would be inserted:

Grade 1 - Personal Care Worker (entry up to 6 months)

Grade 2 - Personal Care Worker (from 6 months) & Recreational/Lifestyle activities officer (unqualified)

Grade 3 - Personal Care Worker (qualified)

Grade 4 - Senior Personal Care Worker

Grade 5 - Specialist Personal Care Worker

2.15 By reference to the *Aged Care Award* and current minimum wage rates,[16] the proposed minimum rates for personal care workers with an increase appears below:

		Current Rate	**Current Rate + 25%**
Current Classification	**Proposed Personal Care Worker Classification**	**Per Week $**	**Per Week $**
Aged Care employee - level 1	-	821.40	1026.75

[14] ANMF Application, Annexure 2, paragraph 5.

[15] ANMF Application, Annexure 2, paragraph 5.

[16] See *Annual Wage Review 2020–21* [2021] FWCFB 3500.

		Current Rate	Current Rate + 25%
Aged Care employee - level 2	Grade 1	855.50	1069.38
Aged Care employee - level 3	Grade 2	889.00	1111.25
Aged Care employee - level 4	Grade 3	899.50	1124.38
Aged Care employee - level 5	Grade 4	930.00	1162.50
Aged Care employee - level 6	-	980.10	1225.13
Aged Care employee - level 7	Grade 5	997.70	1247.13

2.16 The strict delineation between the aged care employee performing support services and the aged care employee performing personal care is to reflect *"the nature of work done by PCWs differs qualitatively from the work done by general and administrative services and food services workers"*.[17] By this proposed variation, the ANMF Application differed from the HSU Aged Care Application, as only the personal care workers covered by the *Aged Care Award* would receive an increase in pay.

2.17 The new classification structure within the *Nurses Award* creates a new category of employee within the health industry by reference to *"services for aged persons"* and/or *"services for an aged person in a private residence"* (the aged care category).[18]

2.18 The same employee classifications appear within the aged care category as the current award (together with corresponding pay points and grades), namely:

(a) nursing assistant;

(b) enrolled nurses (including student enrolled nurse);

(c) registered nurses (levels 1-5); and

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[17] ANMF Application, Annexure 2, paragraph 9.

[18] ANMF Application, Annexure 1.

(d) nurse practitioner.

2.19 By the ANMF application, a 25% wage increase is proposed for all classifications falling within the aged care category.[19] By reference to the *Nurses Award* and current minimum wage rates, the proposed minimum rates for employees with a 25% increase appears below:[20]

	Current Rate	**Current Rate + 25%**
Current Classification	**Per Week $**	**Per Week $**
Nursing assistant		
Entry up to 6 months *(current award: "1st year")*	843.40	1054.25
From 6 months *(current award: "2nd year")*	857.20	1071.50
From 12 months *(current award: "3rd year and thereafter")*	871.50	1089.38
Experienced (Cert III or equivalent)	899.50	1124.38
Enrolled nurses		
(a) Student enrolled nurses		
Less than 21 years of age	780.70	975.88
21 years of age and over	821.40	1026.75
(b) Enrolled nurses		
Pay point 1	916.20	1145.25
Pay point 2	928.30	1160.38

[19] See ANMF Application, Annexure 2, paragraph 7: *"By this application the ANMF do not submit that pay increases to non-aged-care classifications under the Nurses Award are not justified or necessary; that is simply outside of the scope of the application"*.

[20] *Nurses Award*; see also *Determination - 4 yearly review of modern awards—Nurses Award 2010* (AM2019/17) (dated 29 July 2021); *4 yearly review of modern awards—Nurses Award 2010* [2021] FWCFB 4504 at [61], citing *Annual Wage Review 2020–21* [2021] FWCFB 3500 at [175].

	Current Rate	Current Rate + 25%
Pay point 3	940.60	1175.75
Pay point 4	954.20	1192.75
Pay point 5	963.80	1204.75
Registered nurse - level 1		
Pay point 1	980.10	1225.13
Pay point 2	1000.20	1250.25
Pay point 3	1024.80	1281
Pay point 4	1052.00	1315
Pay point 5	1084.30	1355.38
Pay point 6	1115.70	1394.63
Pay point 7	1148.00	1435
Pay point 8 and thereafter	1177.80	1472.25
Registered nurse - level 2		
Pay point 1	1209.10	1511.38
Pay point 2	1228.30	1535.38
Pay point 3	1249.60	1562
Pay point 4 and thereafter	1270.10	1587.63
Registered nurse - level 3		
Pay point 1	1311.00	1638.75
Pay point 2	1335.10	1668.88
Pay point 3	1358.10	1697.63
Pay point 4 and thereafter	1382.50	1728.13
Registered nurse - level 4		
Grade 1	1496.30	1870.38

	Current Rate	Current Rate + 25%
Grade 2	1603.50	2004.38
Grade 3	1697.00	2121.25
Registered nurse - level 5		
Grade 1	1509.90	1887.38
Grade 2	1590.10	1987.63
Grade 3	1697.00	2121.25
Grade 4	1802.90	2253.63
Grade 5	1988.40	2485.50
Grade 6	2175.60	2719.50
Nurse practitioner		
1st year	1508.60	1885.60
2nd year	1553.40	1941.75

2.20 (The Applications by the HSU and ANMF shall be collectively referred to as **the Applications**).

3. SUMMARY OF POSITION

3.1 The aged care sector has been subject to substantial scrutiny including through the Royal Commission into Aged Care Quality and Safety (**Royal Commission**).[21]

3.2 The aged care sector in the main acknowledges and accepts the Royal Commission findings and recommendations in relation to its workforce, including that workers are not competitively paid by comparison to similar roles in other sectors of the economy and for other sectors that compete with aged care for labour. This has led to a labour supply challenge in the aged care sector.

3.3 Where such a position develops in an industrial setting in the private sector it is usually solved by paying 'market' rates and as required recovering this through pricing. Such an approach is simply not available for the aged care sector as it is constrained by its reliance on government funding to operate however this funding is inadequate to pay for the services that aged care employers provide. These employers are not free to simply increase prices to consumers in order to be able to increase pay for their employees due to government regulation. Aged care employers require additional funding to be able to increase wages for their employees.

3.4 This issue can only be addressed by changes in government policy to provide the funding to allow increases in workforce spending including wages.

3.5 Ultimately, government policy will need to address this issue. However, in these matters the Commission is not dealing with the notion of competitive market rates of pay but rather the Commission is asked to vary minimum rates of pay in the awards and this requires a consideration of "work value reasons".[22]

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[21] Royal Commission into Aged Care Quality and Safety (Final Report, 2021) (**Royal Commission Final Report**); see Reference Bundle, Tabs 6-7.

[22] *Fair Work Act* (2009) (Cth), s 157(2) (**FW Act**).

3.6 In doing this the Commission can be well informed by *Independent Education Union of Australia* [2021] FWCFB 2051 (**Teachers' Case**) and *Pharmacy Industry Award 2010* [2018] FWCFB 7621 (**Pharmacy Case**).

3.7 A number of points should be uncontroversial.

3.8 The starting point to the Commission's consideration is whether the minimum rates in the awards have been properly set.[23]

3.9 This involves a consideration of whether the minimum rates were set with regard to the C10 framework and with this the Australian Quality Framework (**AQF**).

3.10 In tracing the history for this, while some decisions have alluded to the C10 framework, the classification structures in the awards were not based on a pre-reform award classification structure that was expressly mapped to the C10 framework. There are certain correlations to the C10 framework in the awards however it does not appear that the minimum rates in the awards were properly set as part of the award modernisation process. It is also the case that this exercise has not occurred since 2010.

3.11 Each of the awards has a classification (or classifications) that can reasonably be used as a benchmark classification for the C10 exercise. This does not operate without some reservations and also highlights some anomalies that we address in these submissions.

3.12 Part of this exercise will involve the Commission considering whether the classification structures are appropriate for properly setting minimum rates and are based on a foundation of competency whether formal or acquired through experience.[24]

3.13 The Commission does not review work value reasons from a static datum point as was the case before the *Fair Work Act 2009*[25] but will likely be informed by some temporal consideration and in this regard the parties appear to have focussed on the last two decades

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[23] *Independent Education Union of Australia* [2021] FWCFB 2051 at [560]-587] (**Teachers' Case**).

[24] *Teachers Case* at [653]-[657].

[25] *Pharmacy Industry Award 2010* [2018] FWCFB 7621 at [168] (**Pharmacy Case**).

likely because this aligns with the introduction of the *Aged Care Act* in 1997 and the first round of accreditation emanating from this in 2000.

3.14 The Commission will need to examine the work being performed and determine whether any changes in work are merely evolutionary in nature, reflect changes in the value of work or reflect a significant net addition to the work value to justify a change in minimum rates.[26]

3.15 The Commission will also need to be satisfied, if this hurdle is reached, that any change to minimum rates is consistent with the modern awards objective[27] and the minimum wages objective.[28]

3.16 The starting point for any evaluation of minimum rates to be properly set should be the C10 framework and the AQF and the alignment of key classifications to this.[29]

3.17 Whether there is justification to differentiate a minimum rate for a classification from this point will likely be a matter of degree depending on the evidence and findings it compels.

3.18 Against this back drop a number of contentions can be made which will be supported by these submissions and the evidence advanced by the 'employers' in the case:

(a) The Aged Care Industry has experienced an increase in regulatory and administrative oversight although the burden of this has not in itself changed the work undertaken by most employees. The primary focus of this has been management positions and the secondary focus has been Registered Nurses (**RN**).

(b) In this regard the work of RNs in aged care has changed in that they have more administrative tasks and with this more administrative responsibility along with their

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[26] *Pharmacy Case* at [163]-[165].

[27] *FW Act*, s 157 (2) refers s 134.

[28] *FW Act*, s 157 (2) refers s 284.

[29] *Teachers Case* at [560] to [587] and see *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 (**ACT Child Care decision**).

hands-on clinical tasks. In part this is a substitution of work focus but it also has introduced a different and additional responsibility.

(c) This has had a flow-on effect to care workers who increasingly operate under general supervision (within operating routines) rather than direct supervision occasioned while working alongside an RN. This has been reflected in the change to the workforce composition. Since 2003, there has been a decrease in the number of nurses, both RNs and Enrolled Nurses (**ENs**), as a proportion of the total workforce employed in aged care.[30] There has been an increase in the proportion of care workers (i.e. personal care workers and Assistants in Nursing (**AINs**)) in the workforce.

(d) The Aged Care Industry has experienced three general shifts in regards to how older Australians are utilising aged care services. Firstly, as governments have funded 'home care' the elderly are choosing to reside for longer in their home setting. Secondly, and because of this, persons entering aged care are on the whole more likely to be older and have comorbidity and/or dementia and also likely to stay in aged care for a shorter duration. Thirdly, there has been an increase in care for people who are palliative.

(e) This has had implications for the work undertaken in aged care although these implications are not uniformly felt across the workforce in all classifications.

(f) The qualifications required to perform work have not changed except that there is an increased preference for care workers to obtain a Certificate III (noting that some AINs require a Cert III). This is done to ensure that the standard of care provided

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[30] The 2016 Aged Care Workforce census and survey report undertaken by the National Institute of Labour Studies (NILS) research team shows in 2003 RNs were 21.4% of the direct care workforce; this decreased to 16.8% in 2007, and to 14.7% in 2012, and that it increased to 14.9% in 2016. The latest census and survey, the 2020 Aged Care Workforce Census Report, indicates nurses 23% of direct care workers and personal care workers compromise of 70%.

continues to meet the expectations of the employer, clients, residents and their families and caregivers.

(g) Where employees are working directly with clients or residents with higher care needs they experience an intensity of work occasioned from the shift in demographic profile. This has largely impacted care workers.

(h) There has been a philosophical shift in care to being "client centric". Many aged care operators adopted such an approach previously however a level of adaptability is now evident with clients empowered to determine personal preferences and activities. This involves a need for greater flexibility in rostering of staff and also an ability for employees involved in hands-on direct care to be responsive and adaptive but still work within their operating routine.

(i) Along with this has been an increase in engagement with family and next of kin. It has changed the focus of general managers and those involved in the administration of aged care (such as a RN) and involves the evolution of work for most employees in ensuring sociability with family and visitors.

(j) There is now an increased emphasis on diet and nutrition for the aged and this has involved head chefs and head cooks becoming more aware of and proactive in relation to the dining experience, nutrition and the varied dietary needs of residents.

(k) All aged care providers provide in-house training. This has developed progressively. Providers generally require staff to undertake formal and informal training on such areas as diabetes management, oral health and dementia.

(l) Care workers who are new entrants to the industry and have a Certificate III but minimal experience are materially less competent than such an employee who has three years' experience which allows for the real acquisition of applied competence. Experienced care workers are highly valued for their ability to apply their skills and

experience accumulated over a number of years. They have also benefitted from the formal and informal training provided over time to them by their employers.

(m) Technology in terms of mechanical aids has made the work of those involved in direct hands-on care less physically demanding.

(n) The work environment within residential aged care is less ‘institutional’ and more purpose built reflecting the residential or ‘hotel’ setting which makes it easier and more comfortable to work in.

(o) The work environment for home care has changed little or improved with the adoption of technology in the home setting.

3.19 While many of the changes in work in aged care are evolutionary, or positive (environment, technology) or reflect doing more of one thing and less of another, it is contended that, on balance (this “balance” is discussed in detail is section 14) the work undertaken by the following classes of employee in residential aged care has significantly changed over the past two decades:

(a) Registered Nurses;

(b) (Cert III) Care Workers; and

(c) Head Chefs and Head Cooks.

3.20 Clearly, proper alignment to the C10 framework could for some classifications justify a change to minimum rates.

3.21 Whether any marginal departure from properly setting the minimum rates against the C10 framework and the AQF is supported will only emerge after the evidence is taken.

3.22 Such a consideration will always present challenges as the C10 schema is inherently situated in an industrial sector context not a health sector context with the *Manufacturing and Associated Industries and Occupations Award 2020* (**Manufacturing Award**) (where

the C10 framework now resides) covering a vast scale and breadth of enterprises and industries.

4. THE RELEVANT PROVISIONS OF THE FAIR WORK ACT

4.1 The Applications before the Commission each seek a determination varying modern award minimum wages, together with related classification variations.

4.2 The Commission is empowered with discretion to make such determinations, subject to the criteria set out in s 157 of the *FW Act*.[31]

4.3 Section 157, relevantly, provides:

> "***157 FWC may vary etc. modern awards if necessary to achieve modern awards objective***
>
> *(1) The FWC may:*
>
> *(a)* ***make a determination varying a modern award, otherwise than to vary modern award minimum wages*** *or to vary a default fund term of the award; or*
>
> *(b) make a modern award; or*
>
> *(c) make a determination revoking a modern award;*
>
> ***if the FWC is satisfied that making the determination or modern award is necessary to achieve the modern awards objective****.*
>
> *Note 1: Generally, the FWC must be constituted by a Full Bench to make, vary or revoke a modern award. However, the President may direct a single FWC Member to make a variation (see section 616).*
>
> *Note 2: Special criteria apply to changing coverage of modern awards or revoking modern awards (see sections 163 and 164).*
>
> *Note 3: If the FWC is setting modern award minimum wages,* ***the minimum wages objective also applies*** *(see section 284).*
>
> ***(2) The FWC may make a determination varying modern award minimum wages if the FWC is satisfied that:***

[31] *FW Act*, s 157.

> ***(a) the variation of modern award minimum wages is <u>justified by work value reasons</u>; and***
>
> ***(b) <u>making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective</u>.***
>
> *Note: As the FWC is varying modern award minimum wages, **<u>the minimum wages objective also applies</u>** (see section 284).*
>
> *…"*

(Emphasis added)

4.4 In considering whether to vary the award minimum wages, the Commission must, per s 157(2), be satisfied that:

(a) the variation is justified by *"work value reasons";* and

(b) it is necessary to make the variation outside the system of annual wage reviews to achieve the modern awards objective.

4.5 The definition of *"work value reasons"* appears at s 157(2A) of the *FW Act.* That provision is:

> *"(2A)* ***Work value reasons*** *are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:*
>
> *(a) the nature of the work;*
>
> *(b) the level of skill or responsibility involved in doing the work;*
>
> *(c) the conditions under which the work is done."*

4.6 As to the proposed variations the Commission must, per s 157(1), be satisfied that making the determination or modern award is necessary to achieve the modern awards objective.

4.7 In both cases, consideration must also be paid to the *"minimum wages objective"*.

(A) The variation of modern award minimum wages is justified by work value reasons

4.8 The phase *"justified by work value reasons"* was considered in the *Pharmacy Case* in the context of s 156 (which contains equivalent wording to s 157(2)(a) and (2A)).

4.9 The following principles apply to the construction of s 157(2):

(a) *First*, the terms of the provision establish a jurisdictional perquisite for the exercise of power to vary minimum wages in a modern award is the Commission being satisfied that the variation is *"justified by work value reasons"*: see s 157(2)(a).[32]

(b) *Second*, *"because the jurisdictional prerequisite is expressed in terms of the Commission's 'satisfaction' concerning whether a variation is 'justified' by the prescribed type of reasons - a requirement which involves an element of subjectivity and about which reasonable minds may differ - it requires the formation of a broad evaluative judgment involving the exercise of a discretion"*.[33]

(c) *Third*, the definition of *"work value reasons"* in s 157(2A) (which is in equivalent terms to s 156(4)), requires only that the reasons justifying the amount to be paid for a particular kind of work be *"related to any of the following"* matters set out in paragraphs (a)-(c):

(i) The expression *"related to"* is one of broad import that requires a sufficient connection or association between two subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental.[34]

(ii) The subject matters between which there must be a sufficient connection are, on the one hand, the reasons for the pay rate and, on the other hand,

[32] *Pharmacy Case* at [163].

[33] *Pharmacy Case* at [164]; see e.g. *Buck v Bavone* (1976) 135 CLR 110 at 118-119 (per Gibbs J).

[34] *Pharmacy Case* at [165].

any of the three matters identified in paragraphs (a)-(c) – that is, any one or more of the three matters.[35]

(d) *Fourth*, *“although the three matters identified - the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done - clearly import the fundamental criteria used to assess work value changes under the wage fixing principles which operated from 1975 to 1981 and 1983 to 2006, the legislature in enacting s 156(4) chose not to import the additional requirements contained in those wage-fixing principles”*.[36]

(e) *Fifth,* by that provision, the Commission is not restricted by a *“datum point requirement”* or a *“the test in the wage-fixing principles that the change in the nature of work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification”*. Its satisfaction is left to the Commission “*to exercise a broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay similar to the position which applied prior to the establishment of wage fixing principles in 1975”*.[37]

(f) *Sixth*, *“it would be open to the Commission to have regard, in the exercise of its discretion, to considerations which have been taken into account in previous work value cases under differing past statutory regimes”*.[38] In *Pharmacy Case*, the Commission observed, in that respect:

> *“[168] … For example, although as already stated s.156(4) contains no requirement for the measurement of work value changes from a fixed datum point, we consider it likely that the Commission would usually take into account whether any feature of*

[35] *Pharmacy Case* at [165]

[36] *Pharmacy Case* at [166].

[37] *Pharmacy Case* at [166]-[167]; see also *Equal Remuneration Case 2015* [2015] FWCFB 8200; (2015) 256 IR 362.

[38] *Pharmacy Case* at [168]

the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way (that is, in a way which is free of gender bias and any other improper considerations) in assessing wages in the relevant modern award or its predecessor in order to ensure that there is no "double counting". Likewise, we consider that the considerations referred to in paragraph [190] of the ACT Child Care Decision, which we have earlier quoted, may be of relevance in particular cases, as may considerations in other authoritative past work value cases."

(g) *Finally*, the Commission must be satisfied that the variation *"would be necessary to achieve the modern awards objective and the minimum wages objective"*: see s 157(2)(b).[39] It has also been observed, in that respect, *"where the wage rates in a modern award have not previously been the subject of a proper work value consideration, there can be no implicit assumption that at the time the award was made its wage rates were consistent with the modern awards objective"*.[40]

4.10 The Full Bench have also observed that *"gender-related reasons"* can constitute relevant considerations for the purposes of s 157(2).[41] For example, if relevant, the Commission may consider *"any gender issue which has historically caused any female-dominated occupation or industry currently regulated by a modern award to be undervalued".* [42]

4.11 The Full Bench in the *ACT Child Care decision* gave consideration to a claim, advanced under the *"Work Value Changes principle",* for increases to the wages of child care workers. The Full Bench referred to the matters taken into account in assessing changes in work value by Senior Commissioner Taylor in the *1968 Vehicle Industry Award* decision and then

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[39] *Pharmacy Case* at [169].

[40] *Pharmacy Case* at [169], citing *4 yearly review of modern awards - Real Estate Industry Award 2010* [2017] FWCFB 3543 at [80]

[41] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [292].

[42] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [292].

set out a number of propositions derived from cases decided under the Work Value Changes principle. The following principles were reinforced:

(a) The evolvement of methods and/or modifications over time is not *"genuine work value change".* It is in the nature of things that new methods of doing the same thing evolve with time, and that skills which qualify a person for a particular category of work may become fully tested, or in some cases the work may thereby be made easier.[43]

(b) The following factors are relevant to the assessment of *"significant net addition to work requirements":*[44]

> • ***Rapidly changing technology, dramatic or unanticipated changes*** *which result in a need for new skills and/or increased responsibility may justify a wage increase on work value grounds.* ***<u>But progressive or evolutionary change is insufficient.</u>***
>
> • ***An increase in the skills, knowledge or other expertise required*** *to adequately under take the duties concerned demonstrates an increase in work value.*
>
> • *The* ***mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition*** *to work requirements. It must be demonstrated that there has been some change in the work itself or in the skills and/or responsibility required. However, where additional training is required to become certified and hence to fulfil a statutory requirement a wage increase may be warranted.*
>
> • *A requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase. But* ***<u>an increase in the level of responsibility required to be exercised may warrant a wage increase on work value grounds</u>. Such a change may be demonstrated by a requirement to work with less supervision****.*

[43] *ACT Child Care decision* at [189].

[44] *ACT Child Care decision* at [190], citing *Vehicle Industry Award 1953* (1968) 124 CAR 295 at 308.

• The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.

*• **The fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements**.*

• The introduction of a new training program or the necessity to undertake additional training is illustrative of the increased level of skill required due to the change in the nature of the work. But keeping abreast of changes and developments in any trade or profession is part of the requirements of that trade or profession and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value.

*• **Increased workload generally goes to the issue of manning levels not work value. But, where an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.***

(Emphasis added).

(c) Such an assessment should normally be based on the previous work requirements, the wage previously fixed for the work, and the nature and extent of the change in work. However, *"it is open to the arbitrator to make comparisons with other wages and work requirements within the award, and in other awards, provided such comparisons are fair, proper and reasonable in all the circumstances. In particular, regard may be had to the wage increases ascribed to comparable changes in work value in other areas. Care must be taken in relation to making a comparison with a provision found in a consent award".*[45]

4.12 The decision in *Teachers Case* is instructive as to the approach to be taken with respect to applications to vary an award based on work value reasons. In summary, the following approach was taken:

[45] *ACT Child Care decision* at [191].

(a) *First,* the Full Bench considered whether the minimum rates had been properly set. The Full Bench followed the principles set out in *ACT Child Care decision* and had regard to the C10 framework.[46]

(b) *Second,* prior to addressing arguments as to the minimum rates, the Full Bench considered the classification structure. The following questions were considered: do the classifications align with the C10 framework and if there are pay points and/or increments between classification levels, are they based on competency and/or work value considerations - or set based upon years of service. That latter was described as *"anachronistic"*.[47]

(c) *Third,* returning to the minimum rates and consider proposed adjustments, the Full Bench undertook an extensive evaluation of the evidence and considered whether work value reasons existed that would justify an increase in wages.[48]

(d) *Fourth*, in doing this the Full Bench gave primacy to fixing a benchmark classification (Proficient Teacher) to the C10 framework and then resetting internal relativities in the new classification structure.[49]

4.13 The recent decision in the *Pharmacy Case* is also instructive. In summary, the Full Bench made the following conclusions:[50]

(a) The APESMA had demonstrated that there was an increase in work value associated with the introduction of Home Medicine Reviews and Residential Medication Management Reviews that justified a *"discrete adjustment"* to award remuneration by means of the introduction of a new allowance.

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[46] See *Teachers Case* at [560]-[563] and [653].

[47] *Teachers Case* at [647] and [653].

[48] *Teachers Case* at [646]-[651].

[49] *Teachers Case* at [654].

[50] *4 Yearly Review Of Modern Awards--Pharmacy Industry Award* [2019] FWCFB 3949 (13 June 2019), citing *Pharmacy Case*.

(b) There had been an increase in the work value of pharmacists since 1998 in respect of the introduction of inoculations, the provisions of emergency contraception, the downscaling of medicines to pharmacy-only status, and a general increase in the level of responsibility and accountability.

(c) There was a lack of alignment in pay rates and relativities as between pharmacists (who require a four-year undergraduate degree) under the Pharmacy Award and those for classifications requiring equivalent qualifications under the *Manufacturing and Associated Industries and Occupations Award 2010*, as well as a lack of a consistent relationship with the AQF.[51]

4.14 The Full Bench considered further submissions with respect to each conclusion. The Full Bench's decision as to the appropriate increases concerning the first and second conclusion appear in *4 Yearly Review Of Modern Awards--Pharmacy Industry Awar*d [2019] FWCFB 3949.[52] The third conclusion was addressed separately.[53]

4.15 The history as to the Commission's approach to work value is set out in detail in *Pharmacy Case* at [122]-[162]. To the extent that history may be relevant we adopt it.

4.16 Based upon that history, the following factors may be accepted as informing the assessment of work value reasons set out in the *FW Act*, in particular whether there has been *"significant net addition to work requirements":*

(a) rapidly changing technology, dramatic or unanticipated changes which result in a need for new skills and/or increased responsibility;

(b) an increase in the skills, knowledge or other expertise required to adequately under take the duties concerned;

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[51] See *Section 157 proceeding* [2019] FWC 5934 (27 August 2019).

[52] *4 Yearly Review Of Modern Awards--Pharmacy Industry Award* [2019] FWCFB 3949 (13 June 2019).

[53] See *Section 157 proceeding* [2019] FWC 5934 (27 August 2019).

(c) additional training is required to become certified and hence to fulfil a statutory requirement;

(d) an increase in the level of responsibility required to be exercised (for example, a requirement to work with less supervision);

(e) an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made;

(f) requirement to exercise a quality control function, when associated with increased accountability; and

(g) a change in conditions, concerning the work environment.

4.17 The foregoing summary of principles also demonstrates that the mere presence of change is not enough to establish work value changes. In particular, it was noted that the following factors generally do not support a finding of work value change:

(a) the evolvement of methods and/or modifications over time is not *"genuine work value change"*;

(b) mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition to work requirements;

(c) a requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase;

(d) the fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements; and

(e) increased workload generally goes to the issue of manning levels not work value.

(B) Making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective

4.18 If satisfied that a particular variation is justified by work value reasons, the Commission is to turn to the question of whether making the determination outside the system of annual wage reviews is *necessary* to achieve the modern awards objective (s 157(2)(b)).

4.19 To be *"necessary"* is to form a view that the determination *"must be done"*, as opposed the outcome being merely desirable.[54] And what is necessary in a particular case is a value judgment taking into account the s 134 considerations, to the extent that they are relevant having regard to the submissions and evidence directed to those considerations.

4.20 Section 134(1) contains the modern awards objective. It provides:

> *"What is the modern awards objective?*
>
> *(1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:*
>
> > *(a) relative living standards and the needs of the low paid; and*
> >
> > *(b) the need to encourage collective bargaining; and*
> >
> > *(c) the need to promote social inclusion through increased workforce participation; and*
> >
> > *(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and*
> >
> > *(da) the need to provide additional remuneration for:*
> >
> > > *(i) employees working overtime; or*
> > >
> > > *(ii) employees working unsocial, irregular or unpredictable hours; or*

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[54] *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* (2012) 205 FCR 227; [2012] FCA 480 at [46] (Tracey J).

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts; and

(e) the principle of equal remuneration for work of equal or comparable value; and

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and

(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

This is the ***modern awards objective****."*

4.21 The principles informing that assessment were recently summarised in *Pharmacy Case* as follows:

"• the modern awards objective is very broadly expressed, and is a composite expression which requires that modern awards, together with the NES, provide "a fair and relevant minimum safety net of terms and conditions", taking into account the matters in ss 134(1)(a)–(h);

• fairness in this context is to be assessed from the perspective of the employees and employers covered by the modern award in question;

• the obligation to take into account the s 134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process;

• no particular primacy is attached to any of the s 134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award;

• it is not necessary to make a finding that the award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of a modern award;

• the s 134 considerations do not set a particular standard against which a modern award can be evaluated; many of them may be characterised as broad social objectives;

• in giving effect to the modern awards objective the Commission is performing an evaluative function taking into account the matters in s 134(1)(a)–(h) and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance;

• what is necessary is for the Commission to review a particular modern award and, by reference to the s 134 considerations and any other consideration consistent with the purpose of the objective, come to an evaluative judgment about the objective and what terms should be included only to the extent necessary to achieve the objective of a fair and relevant minimum safety net;

• the matters which may be taken into account are not confined to the s 134 considerations;

• section 138, in requiring that modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable)

the minimum wages objective, emphasises the fact it is the minimum safety net and minimum wages objective to which the modern awards are directed;

• *what is necessary to achieve the modern awards objective in a particular case is a value judgment, taking into account the s 134 considerations to the extent that they are relevant having regard to the context, including the circumstances pertaining to the particular modern award, the terms of any proposed variation and the submissions and evidence"*[55]

(Footnotes omitted).

4.22 If the classifications in a particular modern award have not previously been the subject of *"a proper work value consideration"*, there can be no implicit assumption that the minimum wages as they presently exist are consistent with the modern awards objective.[56]

(C) As the FWC is varying modern award minimum wages, the minimum wages objective also applies.

4.23 The minimum wages objective applies to the Commission's powers in relation to varying modern award wages.[57] The *"minimum wages objective"* is defined at s 284. That provision provides:

"What is the minimum wages objective?

(1) The FWC must establish and maintain a safety net of fair minimum wages, taking into account:

(a) the performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and

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[55] *Pharmacy Case* at [126], citing *Alpine Resorts Award 2010* [2018] FWCFB 4984 at [52]; see also *Teachers Case* at [220].

[56] *Pharmacy Case* at [169].

[57] *FW Act*, s 284(2).

(b) promoting social inclusion through increased workforce participation; and

(c) relative living standards and the needs of the low paid; and

(d) the principle of equal remuneration for work of equal or comparable value; and

(e) providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability.

This is the ***minimum wages objective****."*

4.24 The statutory tasks in ss 134 and 284 involve an evaluative exercise which is informed by the considerations in s 134(1)(a)–(h) and s 284(1)(a)–(e). These statutory considerations inform the evaluation of what might constitute *"a fair and relevant minimum safety net of terms and conditions' and 'a safety net of fair minimum wages".*[58]

4.25 The meaning of *"work of equal or comparable value"* was considered in the *Equal Remuneration Decision 2015*:[59]

> *"[280] There was no issue, and we accept, that the expression 'work of equal or comparable value' refers to equality or comparability in 'work value'. The established industrial conception of that term, as developed in decisions of this Commission's predecessor tribunals as well as by the various State industrial tribunals is the primary source of guidance in this regard.* ***Such decisions point to the nature of the work, skill and responsibility required and the conditions under which the work is performed as being the principal criteria of work value. We consider that those criteria are relevant in determining whether the work being compared is of equal or comparable value. However, as noted in the principle set down in the 1972 Equal Remuneration Pay Case, work value enquiries have been characterised by the exercise of broad judgment.*** *Further, as Justice Munro observed in the second HPM case (discussed at [89]–[90] above),:*

[58] *Annual Wage Review 2019–20* [2020] FWCFB 3500 at [208]; see also *Teachers Case* at [221]; *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [272].

[59] [2015] FWCFB 8200.

> *'experience of work value cases suggests that work value equivalence is a relative measure, sometimes dependent upon an exercise of judgment. A history of such cases would disclose that a number of evaluation techniques have been applied for various purposes and with various outcomes from time to time'.*

…

[282] 'Equal' in respect of work value should, as with 'remuneration', be given its ordinary meaning - that is, the same as or alike. The meaning to be assigned to 'comparable' is somewhat more difficult. As earlier discussed, 'comparable' is an innovation in the FW Act and was clearly intended to expand the application of Part 2–7.

[283] The 'work of equal or comparable value' formulation first appeared in Australian industrial relations legislation in the context of gender pay equity in the NSW IR Act. The purpose of the inclusion of 'comparable' in the NSW IR Act was considered in the Pay Equity Inquiry – Report to the Minister of Glynn J in 1998 as follows: 'In my view the inclusion of the words 'comparable value' serves two purposes in the legislation. The first purpose is to make plain that the legislation is directed to the comparison of value and not the identification of equivalent job content. Thus the word 'comparable' indicates that the Commission is required to make assessments of comparisons of 'value'. Secondly, the word 'comparable' makes it clear that the assessment may include a comparison of dissimilar work as well as similar work. Thus, the reference to 'comparable' is not to indicate that a likeness of value was required but that by a comparison of the value of work there may be found sufficient basis to establish inequality of remuneration.'

[284] Although not referenced in the Pay Equity Inquiry - Report to the Minister, the use of the word 'comparable' as the criterion of the circumstances in which dissimilar work can be compared for work value purposes probably originated in the 1928 Metalliferous Miners Case, in which the NSW IRC said: 'It must always be remembered that the rate of pay awarded in one industry is not to be accepted as a guide to the rate to be awarded in another unless the tribunal is satisfied that the work done in each is fairly comparable'.

…

[286] The references in the extrinsic materials do not support the adoption of a gender based undervaluation approach, rather they point to the adoption of comparator based methodology.

[287] The ordinary meaning of 'comparable' is 'capable of being compared' or 'worthy of comparison'. We consider that, having regard to the extrinsic matters referred to above, the inclusion of 'comparable' serves the purpose of applying the provisions of Part 2–7 not just to the same or similar work that is equal in value, but also to dissimilar work which is nonetheless capable of comparison."[60]

(Emphasis added).

4.26 As to the *"cumulative effect"* of ss 157, 134 and 284, the Full Bench have observed that in order to grant a work value application in whole or in part, the Commission need to:

"(1) be satisfied that the variation to minimum wages prescribed in the EST Award is justified by work value reasons;

(2) be satisfied that the variation is necessary to achieve the modern awards objective;

(3) be satisfied that the variation is necessary to meet the minimum wages objective; and

(4) take into account the rate of the national minimum wage as currently set in a national minimum wage order."[61]

Conclusion

4.27 Given that the notion of a datum point and the progressively updating of work value is no longer a statutory consideration and given that the notion of stability is invested in s 134(g) of the *FW Act* the Commission should be primarily guided by the C10 framework in properly setting minimum wages in modern awards.

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[60] *Equal Remuneration Decision 2015* at [280]-[287].

[61] *Teachers Case* at [217].

5. THE AGED CARE SECTOR: INTRODUCTION

Introduction

5.1 In summary, this next section of the submissions will address the following aspects of the aged care sector:

(a) the definition of *"aged care"*, *"care needs"* and *"aged persons"*;

(b) identify the relevant employees and industries in the aged care sector;

(c) the regulatory framework of the aged care sector;

(d) funding in the aged care sector;

(e) explain the aged care services provided;

(f) aged care consumer statistics; and

(g) the work performed by employees in the aged care sector.

6. THE AGED CARE SECTOR: DEFINITIONS

Aged Care

6.1 *"Aged care"* is a specific type of residential, home or flexible care.[62] The *"care"* refers to services and/or accommodation that is provided to an aged person whose physical, mental or social functioning is affected to such a degree that the person cannot maintain themselves independently.[63] The care may be provided in the person's own home, supported and assisted residential facilities or in residential aged care facilities.

6.2 The care that is provided ranges from low-level support to more intensive services. Aged care includes:

(a) assistance with everyday living activities, such as cleaning, laundry, shopping, meals and social participation;

(b) equipment and home modifications, such as handrails;

(c) personal care, such as help getting dressed, eating and going to the toilet;

(d) health care, including nursing and allied health care; and

(e) accommodation.[64]

Care Needs

6.3 Care needs exist across a range of different domains that are assessed using a range of different tools for different purposes. Care needs for funding eligibility purposes are assessed using the National Screening and Assessment Form (**NSAF**). The NSAF assesses needs across social, physical, medical and psychological domains. The NSAF may be used to conduct a home support assessment that will qualify people for small amounts of entry level support at home through the Commonwealth Home Support

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[62] *Aged Care Act 1997* (Cth), Sch 1.

[63] *Aged Care Act 1997* (Cth), Sch 1.

[64] Royal Commission Final Report, Volume 2, page 6; Reference Bundle, Tab 7, page 1058.

Programme (**CHSP**) or comprehensive assessment that qualifies people for more intensive support through other aged care programs, mainly the Home Care Packages Program or residential aged care.

6.4 Upon entry into residential aged care, people are further classified to determine funding levels and care needs. Currently this classification occurs through the Aged Care Funding Instrument (**ACFI**), which assigns people to nil, low, medium or high needs across the domains of Activities of Daily Living, Behaviour and Complex Healthcare.[65]

6.5 Examples of complex health care procedures include:[66]

(a) complex pain management and practice undertaken by an allied health professional or RN;

(b) complex skin integrity management for residents with compromised skin integrity who are usually confined to bed and/ or chair or cannot self-ambulate;

(c) management of special feeding undertaken by a RN, on a one-to-one basis, for people with severe dysphagia;

(d) management of chronic wounds, including varicose and pressure ulcers, and diabetic foot ulcers;

(e) management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and dialysis;

(f) palliative care program involving *'End of Life'* care where ongoing care will involve very intensive clinical nursing and/or complex pain management in the residential care setting; and

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[65] See Department of Health, "Aged Care Funding Instrument (ACFI): Answer Appraisal Pack"; Reference Bundle, Tab 17,

[66] Department of Health, *"Aged Care Funding Instrument (ACFI): Answer Appraisal Pack"*, ACFI 12 Complex Health Care, pages 16-18; Reference Bundle, Tab 17, pages 1513-1515.

(g) technical equipment for continuous monitoring of vital signs including Continuous Positive Airway Pressure (**CPAP**).

6.6 In October 2022, the government has announced that ACFI will be replaced with a new assessment tool called the Australian National Aged Care Classification (**AN-ACC**). Where ACFI assess the care a person needs, AN-ACC is designed to assess a person's level of function for the purposes of assigning a level of funding. Providers are then responsible for assessing care needs and developing care plans. This change in assessment tool does not change the basic nature of person's care needs.

Aged Person

6.7 The Applications refer to *"aged person"* and/or *"elderly"* as being the consumer, patient and/or client receiving aged care. Neither are the subject of definition in award or legislation. Given that fact, the following may be noted:

(a) a person becomes eligible for the Age Pension between 66-67 years of age;[67]

(b) a person becomes eligible for assessment for aged care (see below) at 65 years of age (50 years for Aboriginal or Torres Strait Islander people);[68] and

(c) a person becomes eligible for a NSW Seniors Card at 60 years of age.[69]

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[67] See example, Service NSW, *"Getting the Age Pension"* (website): <https://www.nsw.gov.au/life-events/retirement>; Reference Bundle, Tab 25, page 1743.

[68] My Aged Care, *"My Aged Care: Am I eligible?"* (website): <https://www.myagedcare.gov.au/>; Reference Bundle, Tab 23, page 1736.

[69] Service NSW, *"Apply for a NSW Seniors Card or NSW Senior Savers Card"* (website): <https://www.service.nsw.gov.au/transaction/apply-nsw-seniors-card-or-nsw-senior-savers-card>; Reference Bundle, Tab 24, page 1740.

7. THE AGED CARE SECTOR: RELEVANT EMPLOYEES AND INDUSTRIES IN THE AGED CARE SECTOR

7.1 The Applications before the Commission are concerned with work value of aged care employees, nursing employees and home care employees covered under the awards. Those employees, collectively, work in the following industries:

(a) the aged care industry;

(b) the health industry; and

(c) home care sector.

7.2 The *Aged Care Award* defines the *"aged care industry"* as *"the provision of accommodation and care services for aged persons in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility".*[70] That industry award covers employers and employees working in residential aged care. Employees covered by that award are described as *"aged care employees"* and include:

(a) employees that provide general and administrative services;

(b) employees that provide food services; and

(c) personal care workers.

7.3 The *Nurses Award* defines *"health industry"* as *"employers in the business and/or activity of providing health and medical services and who employ nurses and persons who directly assist nurses in the provision of nursing care and nursing services"*.[71] That occupational award covers nurses and persons who directly assist nurses (collectively, **nursing employees**). As such, its coverage is not limited to the aged care sector.

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[70] *Aged Care Award*, cl 3.1.

[71] *Nurses Award*, cl 4.2.

7.4 The *SCHADS Award* defines *"home care sector"* as "*the provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence"*. That industry award covers employers and employees in, *inter alia*, the home care sector to the exclusion of any other modern award.[72] Employers and home care employees may work in the aged care sector but are not covered by the *Aged Care Award*.[73]

7.5 The work groups in the aged care sector consist of the following:

(a) RNs;

(b) ENs;

(c) personal care workers / AIN;

(d) kitchen or cookery;

(e) laundry;

(f) maintenance (gardeners, facility maintainers who could hold a trade or similar experience);

(g) allied health; and

(h) recreational/lifestyle workers.

7.6 However, the composition of work groups may differ between providers depending on the service it is offering.

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[72] *SCHADS Award*, cl 4.1 and 4.2.

[73] *SCHADS Award*, cl 4.2.

8. THE AGED CARE SECTOR: THE REGULATORY FRAMEWORK

Legislative Framework

8.1 Since 1997, there has been a nationally consistent approach to regulation of the aged care sector. The main law covering government-funded aged care is the *Aged Care Act 1997* (Cth) (**the Act**). It should be noted that aged care services are also provided through contractual arrangements outside of the Act.

8.2 The Act sets out the rules for, *inter alia*, funding, regulation, standards, quality of care, rights of people receiving care and non-compliance of the Act and the quality standards. Several principles have also been established that provide further details on the rules created under the Act.[74]

National Regulator

8.3 The primary national regulator of aged care services, and the primary point of contact for consumers and provides in relation to quality and safety, is the Aged Care Quality and Safety Commission (**ACQSC**). The ACQSC has oversight of the following:

(a) approval of all residential and home care providers;

(b) aged care compliance activity; and

(c) the administration of compulsory reporting of assaults by approved providers.[75]

8.4 The powers and responsibilities of the national regulator are set out in the *Aged Care Quality and Safety Commission Act 2018* (Cth) and *Aged Care Quality and Safety Commission Rules 2018* (**Commission Rules**).

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[74] See example, *Accountability Principles 2014* (Cth), *Approval of Care Recipients Principles 2014* (Cth), *Approved Provider Principles 2014* (Cth), *Quality of Care Principles 2014* (Cth), *User Rights Principles 2014* (Cth).

[75] Prior to 1 January 2020, the regulation of the aged sector was divided between the Department of Health, Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.

8.5 The Commonwealth Department of Health retains responsibility for some elements of aged care regulation, including regulation of funding claims.

Assessment

8.6 *"My Aged Care"* provides an entry point to government-funded aged care services for the general public. It is accessible via a website and/or call centre.

8.7 An assessor from My Aged Care will refer a consumer to one of two assessments:

(a) a home support assessment by the Regional Assessment Service (**RAS**) in order to access support through the Commonwealth Home Support Programme (**CHSP**); or

(b) a comprehensive assessment with an Aged Care Assessment Team (**ACAT**) in order to access residential aged care and home care packages.

8.8 During the assessment, the assessor will ask for information from the consumer's doctor and/or other healthcare professionals.

8.9 Following a referral for assessment, a tool used to assess the care needs of people in permanent residential aged care and allocate subsidies to residential aged care services is the Aged Care Funding Instrument (**ACFI**). The ACFI focuses on care needs that contribute to the costs of care.

Recent Changes in Regulation

8.10 This next section identifies and outlines some of the recent changes in regulation within the aged care sector, between 2019-2021, including the introduction of the following:

(a) new Aged Care Quality Standards which emphasises *"person-centred care";*

(b) changes to the Commission Rules;

(c) mandatory participation in the National Quality Indicator Program; and

(d) the Serious Incident Response Scheme, together with mandatory reporting.

8.11 We now address the changes in turn.

(a) Aged Care Quality Standards

8.12 On 1 July 2019, the Aged Care Quality Standard (**Quality Standards**) took effect.

8.13 The Quality Standards consist of eight standards with the *"consumer dignity and choice"* standard at the core. The eight Standards are:

(a) Standard 1—consumer dignity and choice;

(b) Standard 2—ongoing assessment and planning with consumers;

(c) Standard 3—personal care and clinical care;

(d) Standard 4—services and supports for daily living;

(e) Standard 5—organisation's service environment;

(f) Standard 6—feedback and complaints;

(g) Standard 7—human resources; and

(h) Standard 8—organisational governance.

8.14 The Quality Standards apply to all government-funded aged care services and were developed by the ACQSC to define what good aged care should look like.[76] The primary difference between the Quality Standards developed by the ACQSC and the old standards is the emphasis upon *"person-centred care"*.[77]

(b) Aged Care Quality and Safety Commission Rules 2018

8.15 From 1 January 2020, the Commission Rules changed. This resulted in regulatory power being transferred to the ACQSC. This also resulted in a change to the regulatory arrangements of the following:[78]

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[76] See *Quality of Care Principles 2014* (Cth), Sch 2.

[77] See ACQSC, *"Person-centred care"* (website): <https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care>; Reference Bundle, Tab 10, 1348.

[78] ACQSC, *"Key changes for providers from 1 January 2020: Aged Care Quality and Safety Commission Rules"* (Fact Sheet); Reference Bundle, Tab 9, pages 1344.

(a) *"Approved providers"* of residential aged care services, home care services and short-term restorative care services.

(b) *"Service providers"* of Commonwealth-funded aged care services (this includes CHSP and National Aboriginal and Torres Strait Islander Flexible Care Program (**NATSIFACP**) services).

8.16 In summary, the regulatory changes include:[79]

(a) arrangements for reporting about performance assessments are now more consistent (which includes an assessment of performance measure against the Quality Standards);

(b) the ACQSC may identify areas for improvement that a provider must make to ensure the Quality Standards are complied with, and where necessary, direct the provider to revise its plan for continuous improvement;

(c) changes to Notices of Non-compliance and enforceable sanctions processes;

(d) risk-based monitoring and management of non-compliance is determined based on the nature of non-compliance and the level of risk to consumers; and

(e) the quality audit process is more closely aligned to the process for site audits and review audits.

(c) National Quality Indicator Program

8.17 On 1 July 2019, the National Quality Indicator Program (**QI Program**) became mandatory (previously, this was voluntary) for all approved providers of residential care services. The program collects quality indicator data from residential aged care services every 3 months.

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[79] ACQSC, *"Key changes for providers from 1 January 2020: Aged Care Quality and Safety Commission Rules"* (Fact Sheet); Reference Bundle, Tab 9, pages 1345-1346.

The purpose of that data collection is to provide an evidence base that can be used to improve the quality of services provided to care recipients.[80]

8.18 With that implementation, approved providers of residential care were now required to provide information on three quality indicators to the Australian Department of Health. These are:

(a) pressure injuries;

(b) use of physical restraint; and

(c) unplanned weight loss.

8.19 From 1 July 2021, in addition to the above listed indicators, providers were also required to collect and report on falls and major injury indicators and medication management indicators (collectively, **the 5 quality indicators**).[81] The 5 quality indicators are reported at a national and State and Territory level on the Australian Institute of Health and Welfare GEN Aged Care Data website.[82]

(d) Serious Incident Response Scheme

8.20 The Serious Incident Response Scheme (**SIRS**) is a national framework for incident management and reporting of serious incidents in residential aged care. It imposes obligations on residential aged care providers to manage and report on specific incidents and expands the powers of the ACQSC.

8.21 The SIRS imposed two obligations upon residential aged care providers:

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[80] Department of Health, *"National Aged Care Mandatory Quality Indicator Program (QI Program)"* (website): <https://www.health.gov.au/initiatives-and-programs/national-aged-care-mandatory-quality-indicator-program-qi-program>; Reference Bundle, Tab 21, page 1522.

[81] See also, *Accountability Principles 2014* (Cth) and *Records Principles 2014* (Cth), which were expanded following *the Aged Care Legislation Amendment (Quality Indicator Program) Principles 2021* (Cth) taking effect on 1 July 2021.

[82] Royal Commission Final Report, Volume 2, page 45.

(a) ***incident management obligations**,* namely, each provider must have a set of protocols, processes and standard operation procedures that staff are trained to use; and

(b) ***reportable incident obligations*** for *"Priority 1"* and *"Priority 2"* reportable incidents.[83]

8.22 Reportable incidents are reported to the ACQSC and, where appropriate, the police as well.

8.23 The SIRS was introduced in two stages. From 1 April 2021, providers were required to have an incident management system in place and report on all Priority 1 incidents. From 1 October 2021, providers were required to report on all Priority 2 incidents as well.[84]

8.24 The *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) is currently before the Senate, and if passed would extend the SIRS to the home care sector.

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[83] ACQSC, *"Serious Incident Response Scheme"* (website): <https://www.agedcarequality.gov.au/sirs#what-is-the-serious-incident-response-scheme-sirs-?>; Reference Bundle, Tab 11, 1352-1354.

[84] ACQSC, *"Serious Incident Response Scheme"* (website): <https://www.agedcarequality.gov.au/sirs#what-is-the-serious-incident-response-scheme-sirs-?>; Reference Bundle, Tab 11, 1355.

9. THE AGED CARE SECTOR: FUNDING

9.1 The Australian Government is the major funder of aged care, with aged care consumers contributing to the cost of their care where able to do so. Australian Government expenditure for aged care throughout 2020–21 totalled $23.6 billion, an increase of 11.4 per cent from the previous year. [85] By reference to type of care, that expenditure is broken down as follows:[86]

(a) Residential Care - $14.1 billion;

(b) Home Care - $4.2 billion;

(c) Basic support at home - $3.5 billion;

(d) Flexible and short-term aged care - $0.7 billion; and

(e) Other aged care support - $1.1 billion.

9.2 In 2019-20 the federal government subsidised:

(a) 1,452 CHSP providers;

(b) 920 home care providers;

(c) 845 residential care providers;[87] and

(d) with regards to funding provided to residential aged care facilities, employee expenses in 2019-20 were $13,965.1 million and made up 66% of the proportion of residential care provider total expenses. [88]

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[85] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 10; Reference Bundle, Tab 4, 433.

[86] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 11; Reference Bundle, Tab 4, page 434.

[87] Aged Care Financing Authority, *Ninth Report on the Funding and Financing of the Aged Care Industry* (July 2021), page 6; Reference Bundle, Tab 1, page 16.

[88] Aged Care Financing Authority, *Ninth Report on the Funding and Financing of the Aged Care Industry* (July 2021), page 73; Reference Bundle, Tab 1, page 83.

9.3 In home care, the staffing expenses make up an estimated 65% of provider expenses.[89] Similar data on how funding is allocated is not available for CHSP.

[89] Estimate based upon the total wages and salaries - care staff and a proportion of the subcontracted customer services data from the Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Sector July 2020*, page 48; Reference Bundle, Tab 2, page 228.

10. THE AGED CARE SECTOR: AGED CARE SERVICES

10.1 The two main types of government-funded services are:

(a) residential aged care services; and

(b) home based care:

(i) CHSP; and

(ii) Home Care Packages (**HCP**).

10.2 In 2020–21, approximately 1.5 million people received some form of aged care, with the majority receiving home-based care. By reference to category of care, that number breaks down as follows: [90]

(a) 825,383 people received home support through the CHSP;

(b) 212,293 people received care through a HCP;

(c) 67,775 people received residential respite care, of whom 39,404 (approximately 58.1 per cent) were later admitted to permanent care; and

(d) 243,117 people received permanent residential aged care.

10.3 For completeness, non-government funded services include private home care, supported and assisted living complexes or Supported Residential Services / Supported Residential Facilities.

10.4 This next section will set out the structure of each category and expand upon the type of *"care"* provided under each service.

(a) Residential Aged Care

10.5 Residential aged care provides support and accommodation for older people who are unable to continue living independently in their own homes and who need ongoing help with

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[90] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 13; Reference Bundle, Tab 4, page 436.

everyday tasks. It includes accommodation and personal care 24 hours a day, as well as access to nursing and general health care services.

(i) Access and Assessment

10.6 Historically, persons in residential care were classified as *"higher"* or *"lower"* needs depending on the level of care required through the (now defunct) Consumer Classification Scale. The classification had an impact upon the amount of funding a provider is given to support the consumer.

10.7 Now, consumers are assessed by the ACAT which determines the most appropriate type of care for the consumer in the aged care sector, namely, whether the consumer needs higher levels of care than can be provided in the home. Residential care is provided on either a permanent or a temporary (respite) basis.

10.8 An ACFI assessment is then undertaken by the provider which then determines the level of funding a provider will receive for the consumer.

10.9 A person who has been assessed as eligible to receive residential aged care may be admitted to any residential aged care home of their choice, provided that the aged care home has an available place, agrees to admit them, and is able to meet the required care needs of that person.[91]

(ii) Services and Environment

<u>Services</u>

10.10 Under the *Quality of Care Principles 2014* (Cth), made under s 96-1 of the Act, approved providers of residential aged care must provide a range of care and services to residents, whenever they may need them. The type of care and services provided include:[92]

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[91] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

[92] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

(a) hotel-like services (for example, bedding, furniture, toiletries, cleaning and meals);

(b) personal care (for example, showering, dressing and assisting with toileting);

(c) clinical care (for example, wound management, administering medication and nursing services); and

(d) social care (for example, recreational activities and emotional support).

10.11 All care and services are required to be delivered in accordance with the resident's care needs and clearly outlined in their resident agreement and care plan.[93]

Environment

10.12 The broad architecture of residential aged care facilities has changed over the last 20 years. There has been progressive movement away from institutional ward based (hospital style accommodation) and shared facilities towards individual rooms (with *ensuites* etc). It is now more common than not, for residential aged care facilities to have individual rooms.

(iii) Providers

10.13 Approved providers of residential aged care can be from a range of sectors, including religious, charitable, community, for-profit and government. All providers must be approved under the Act and are required to adhere to the Quality Standards when delivering care.[94]

10.14 As at 30 June 2021, there were 2,704 residential aged care services, operated by 830 approved residential aged care providers.[95]

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[93] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

[94] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

[95] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

(iv) Average age of Entry; and

(v) Residential Aged Care Statistics

10.15 The following statistics relate to residential aged care in 2020-21: [96]

(a) 243,117 people received permanent residential aged care at some time during the year, an increase of 1,246 from 2019–20;

(b) the average age (on entry) was 82.9 years for men, 85 years for women;

(c) the average completed length of stay was 36 months.

10.16 On 30 June 2021, there were 183,894 people receiving permanent residential aged care. [97] The following table breaks that number down by state: [98]

State/territory	**Permanent residents**
NSW	60,287
Vic	47,495
Qld	36,273
WA	16,334
SA	16,233
Tas	4,516
ACT	2,267
NT	489
Australia	**183,894**

[96] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 53; Reference Bundle, Tab 4, page 53.

[97] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 53; Reference Bundle, Tab 4, page 53.

[98] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 53; Reference Bundle, Tab 4, page 53.

10.17 Almost all persons living in permanent residential care are assessed as having some care needs for activities of daily living and complex health care, and 96% of people had some care needs for cognition and behaviour.[99]

10.18 Data from the StewartBrown Aged Care Financial Performance Survey Sector Report - June 2021 shows that 56% of residential aged care providers across metropolitan, regional, and remote locations are operating at a loss.[100]

10.19 Since 2003, there has been an increase in the proportion of personal care workers and a slight decrease in the proportion of RNs and ENs within the total workforce in residential aged care.[101]

(b) Home Care

10.20 Home care employees are more likely to work without direct supervision and the work performed may vary within guidelines and procedure. The nature of the work requires the home care employee to provide services to the consumer direct in the consumer’s home in accordance with the consumer’s care plan. All home care employees operate within established guidelines and procedures.

10.21 Home care employees escalate matters outside of their scope of work to a case manager or team leader for instruction and guidance.

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[99] Australian Institute of Health and Welfare, *“People’s care needs in aged care”* (website): <https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care>; Reference Bundle, Tab 12, page 1363.

[100] *StewartBrown Aged Care Financial Performance Survey Sector Report* (June 2021), page 12; Reference Bundle, Tab 8, pages 1322.

[101] The 2016 Aged Care Workforce census and survey report undertaken by the National Institute of Labour Studies (NILS) research team shows in 2003 RNs were 21.4% of the direct care workforce; this decreased to 16.8% in 2007, and to 14.7% in 2012, and that it increased to 14.9% in 2016. The latest census and survey, the 2020 Aged Care Workforce Census Report, indicates nurses 23% of direct care workers and personal care workers compromise of 70%.

(A) CHSP

(i) Access and Assessment

10.22 To access the CHSP, people are first assessed by RAS, or an ACAT, to determine their eligibility and service requirements.

(ii) Services and Environment

Service

10.23 The CHSP consists of four broad sub-programs:

(a) community and home support;

(b) care relationships and carer support;

(c) assistance with care and housing; and

(d) service system development.

10.24 The services provided under the CHSP are diverse and include:

(a) allied health and therapy services;

(b) domestic assistance;

(c) goods, equipment and assistive technology;

(d) home maintenance;

(e) home modifications;

(f) meals and other food services;

(g) nursing;

(h) personal care;

(i) social support;

(j) specialised support services;

(k) transport;

(l) centre-based respite; and

(m) flexible respite and cottage respite.[102]

Environment

10.25 Home care environments are more variable as the care is undertaken in the consumer's home.

(iii) Providers

10.26 In 2020–21, a total of 1,432 aged care organisations were funded to deliver CHSP home support services to clients. CHSP providers include government, non-government and not-for-profit organisations.[103]

10.27 Providers that deliver CHSP are not required to be *"approved providers".*

(iv) Average age of Entry

10.28 As at 2020-21, the average age of access to the CHSP was 80.2 years.[104]

(B) HCP

(i) Access and Assessment

10.29 To access a HCP, people are first assessed by an ACAT, which determines eligibility. Once assessed as eligible for home care, a person is placed on the National Priority System and is offered a HCP when one becomes available.[105]

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[102] Royal Commission Final Report, Volume 2, page 17; Reference Bundle, Tab 7, page 1069.

[103] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 34; Reference Bundle, Tab 4, page 457.

[104] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 34; Reference Bundle, Tab 4, page 457.

[105] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 38; Reference Bundle, Tab 4, page 461.

(ii) Services and Environment

Service

10.30 The HCP Program has four levels:

(a) Level 1—to support people with basic care needs;

(b) Level 2—to support people with low care needs;

(c) Level 3—to support people with intermediate care needs; and

(d) Level 4—to support people with high care needs.[106]

10.31 Under a HCP, a range of personal care, support services, clinical services and other services are tailored to meet the assessed needs of the consumer.

10.32 Services that may form part of a HCP include:

(a) support services, such as help with washing and ironing, house cleaning, gardening, basic home maintenance, home modifications related to care needs, transport to help with shopping, doctor visits or attending social activities;

(b) personal services, such as help with showering or bathing, dressing and mobility;

(c) care-related services, such as nursing and other health support, including physiotherapy (exercise, mobility, strength and balance), services of a dietitian (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services; and

(d) care management, such as coordinating care and services.[107]

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[106] Royal Commission Final Report, Volume 2, page 18; Reference Bundle, Tab 7, page 1070; see also Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 38; Reference Bundle, Tab 4, page 461.

[107] Royal Commission Final Report, Volume 2, page 18; Reference Bundle, Tab 7, page 1070.

Environment

10.33 Home care environments are more variable as the care is undertaken in the consumer's home.

(iii) Providers

10.34 HCPs are delivered by service providers who have been approved under the Act. This approval requires providers to comply with conditions relating to quality of care, consumer rights and accountability.

(iv) Average Age of Entry

10.35 In 2020–21, the average age of access to a HCP was 81 years.[108]

(v) HCP Statistics

10.36 As at 30 June 2021, there were 176,105 people who were in a HCP. This was an increase of 33,669 (or 23.6 per cent) from 30 June 2020 (142,436). The number of people in a Level 3 or 4 HCP grew from 67,176 at 30 June 2020 to 87,680 at 30 June 2021, an increase of 30.5 per cent.[109]

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[108] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 39; Reference Bundle, Tab 4, page 462.

[109] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 39; Reference Bundle, Tab 4, page 462.

10.37 The below table sets out the number of people in Australia in a HCP between 2017-2021:[110]

State/territory	2017	2018	2019	2020	2021
NSW	23,403	30,418	35,863	48,270	59,283
Vic	18,541	23,449	27,776	39,425	50,011
Qld	13,293	18,514	21,562	27,560	32,389
WA	6,752	8,246	8,999	11,049	13,911
SA	5,609	6,855	7,758	10,254	13,597
Tas	1,907	2,330	2,626	3,428	4,060
ACT	1,141	1,316	1,464	1,810	2,079
NT	777	719	659	640	775
Australia	**71,423**	**91,847**	**106,707**	**142,436**	**176,105**

[110] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 7; Reference Bundle, Tab 4, page 430.

11. THE AGED CARE SECTOR: AGED CARE CONSUMER STATISTICS

11.1 The following statistics provide an overview of the current composition of the following:

(a) the consumer of aged care; and

(b) the workforce in aged care.

(a) The Consumer

(i) Average age

11.2 The average age on admission to permanent residential aged care was 83 years for men and 85 years for women. For entry to a home care package the average was 81 years for both men and women.[111]

(ii) General

11.3 The following observations of the demographic were made in the Royal Commission:

(a) increasing frailty;

(b) longer life span; and

(c) increased prevalence of dementia.[112]

11.4 Aged care consumers with complex health care needs under ACFI rose from 13% in 2009 to 52% in 2019.[113] The aged care sector is facing caring for an ageing population with increasing frailty.

(iii) Dementia

11.5 As of 2019, it is estimated that around 50% of persons in residential care have been diagnosed with a form of dementia.[114]

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[111] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 13; Reference Bundle, Tab 4, page 436.

[112] Royal Commission Final Report, Volume 2, page 5; Reference Bundle, Tab 7, page 1057.

[113] Royal Commission Final Report, Volume 2, page 22; Reference Bundle, Tab 7, page 1074.

[114] Royal Commission Final Report, Volume 1, 92; Reference Bundle, Tab 6, page 788.

11.6 In 2021, there were an estimated 386,000 Australians with dementia, over 40 per cent of whom were aged 85 years and over.

11.7 As at 30 June 2021, just over half of all residential aged care residents with an ACFI assessment had a diagnosis of dementia.

(b) Workforce

(i) Size

11.8 The aged care workforce numbers over 370,000 and includes nurses, care workers, and allied health professionals, as well as management, administrative and ancillary staff.[115]

(ii) Qualifications

11.9 The minimum qualification requirements range from no formal training through to post-graduate degree subject to the position held within the aged care sector.

11.10 For example:

(a) By reference to the *Aged Care Award*, *SCHADS Award* and *Nurses Award*, a person can commence work as either a personal care worker or AIN without any prior qualification or experience. An experienced AIN is required to obtain a Certificate III.

(b) An EN is required to attain a Diploma of Nursing.

(c) A RN is required to attain a Bachelor of Nursing.

(d) A nurse practitioner (**NP**) is to complete a Master's Degree.

11.11 Despite the awards providing for entry-level positions, the majority of personal care workers hold a Certificate III in individual support (or equivalent).[116] This is the result of a shift over

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[115] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 15; Reference Bundle, Tab 4, page 438.

[116] Department of Health, *2020 Aged Care Workforce Census Report*, pages 6 and 45; Reference Bundle, Tab 3, page 346 and 385.

the past two decades, driven by employers and providers, to require personal care workers to have a Certificate III or undertake a traineeship to gain the qualification in order to be able to perform their role.

(iii) Internal Training

11.12 Over the last two decades, the internal training practice of employers has evolved within the aged care sector.

11.13 It is standard practice for providers to offer internal training. This training may include a combination of the following:

(a) elder abuse;

(b) infection control;

(c) dementia care;

(d) wound care;

(e) palliative care;

(f) diversity awareness;

(g) medications; and

(h) falls risk.

(iv) Roster

11.14 The rosters in residential aged care operate over 24 hours per day, 7 days per week. In residential care (unless the facility is a hostel or with low needs) a RN is generally rostered on each shift.

12. THE AGED CARE SECTOR: AGED CARE WORK

12.1 This section will address the work performed by employees within the aged care sector.

12.2 *First*, we will set out some features of the work performed that generally apply across both residential aged care and home care settings, differentiations will be made where appropriate. The following categories will be addressed:

(a) care plans;

(b) acute condition care;

(c) engagement with clients' family members; and

(d) technology.

12.3 *Second*, we will turn to the scope of duties of aged care employees, nursing employees and home care employees working in the aged care sector, respectively.

Common Features

(a) Care plans

(i) Overview

12.4 Care plans are produced in both residential aged care and home care settings. They are developed after an assessment of the following:

(a) the individual's needs, goals and preferences;

(b) the types of services the consumer will receive to meet those needs;

(c) who will provide the services; and

(d) when services will be provided.

12.5 Care plans are developed in conjunction and consultation with the consumer and their family/responsible person (if applicable).

12.6 The person responsible for organising and overseeing the development of the care plan differs between the two settings:

(a) In home care, a care plan (also referred to as a *"written plan of the care and services"*) is organised by a case manager and reviewed every 12 months.

(b) In residential aged care, a care plan (sometimes referred to as a *"nursing care plan"*) is organised by and through a RN. Any changes to the care plan in that setting require authorisation by the RN.

(ii) Care plans for HCP

12.7 An approved provider of home care must give to a care recipient a *"written plan of the care and services"* that the care recipient will receive either before the care recipient commences receiving home care or within 14 days after the care recipient commences receiving home care.[117]

12.8 A person's care plan should include:

(a) their goals, needs and preferences;

(b) the services that you will provide or organise;

(c) who will provide the services;

(d) when services will be provided, such as frequency, days and times;

(e) care management arrangements;

(f) how involved the person will be in managing their package; and

(g) how often you will do formal reassessments.

(b) Acute Condition Care

12.9 In both residential aged care and home care settings, consumers are transferred to hospital when clinically indicated as needing acute care.

12.10 The general process is that the consumer's doctor is consulted with in order to make the decision to transfer a consumer to the hospital:

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[117] *User Rights Principles 2014* (Cth), s 19AD.

(a) In the residential setting, this is undertaken in conjunction with the manager of the service or a RN.

(b) In the home care setting, this is undertaken in conjunction with the case manager.

12.11 In an emergency situation, which is quite rare, the decision is made without the consultation of a doctor.

(c) Engagement with Clients' Family Members

12.12 Providers and facilities have policies and procedures regarding communication and engagement with a consumer's family, which as a general proposition involves the RN (in residential care settings), or the Case Manager (in home care) communicating incidents, deterioration or changes in medication.

12.13 There are generally four circumstances in which a care worker engages with family members of a consumer:

(a) incident at facility;

(b) deterioration in health of consumer;

(c) complaint made by a family member; and

(d) informally at time of visitation and/or at the time of the home care appointment.

12.14 However, as to the first three circumstances, a care worker is trained as to who the request should be directed to (namely, manager, RN and/or emergency authorities). It is not the responsibility of the care worker to provide the family members information about the consumer that is outside of their scope of work.

(d) Technology

12.15 Over the last two decades, there has been an introduction of new digital technologies in the aged care sector which has replaced previous paper methods. This includes:

(a) care management and reporting systems/applications;

(b) electronic medication charts/medication management systems;

(c) rostering systems/applications; and

(d) online training systems.

12.16 Over the last two decades, there has also been an increase in the availability of assistive technologies such as mechanical aids.[118]

Aged Care Employees

12.17 This next section sets out the scope of duties of aged care employees covered under the *Aged Care Award*.

Personal Care Worker

12.18 The work of a personal care worker generally consists of the following:

(a) help consumers with dressing at start and end of day;

(b) social interaction;

(c) assist consumers with showering, toilet, etc;

(d) assist consumers with the function of eating;

(e) assist consumers with position change, movement and exercise; and

(f) documenting and reporting on (a)-(e).

12.19 The work performed is in accordance with the consumer's care plan.

12.20 There is an expectation that personal care workers are attuned to each individual's needs and preferences as they undertake their role. The psycho-social and physical interactions with the consumers are an important part of the work being performed and the wellbeing of the consumer.

12.21 Over the last two decades, due to an increase in consumers with higher needs as a proportion of the consumers in care, personal care workers now assist consumers, by:

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[118] Also referred to as *"technological aids"*.

(a) helping consumers with dressing at start and end of day;

(b) assisting consumers with showering and toileting;

(c) assisting consumers with the function of eating; and.

(d) assisting consumers with position change, movement and exercise.

12.22 Outside of those activities, the level of engagement with a consumer is as follows:

(a) consumers in their rooms (subject to cognitive needs);

(b) consumers remain in a communal area and participates in activities with other consumers, with minimal (if any) assistance provided by the personal care worker; or

(c) consumers may be transported, by the personal care worker, as part of a small group of consumers to participate in an activity outside of residential facility, such as to the movies, shopping or gardens.

12.23 Over the last two decades, there has been a progressive focus upon improving the social wellbeing of consumers through recreational activities.

Food Services

12.24 Over the last two decades, the role of a cook and kitchen hand has not transformed to any dramatic degree. A cook's role generally consists of the following:

(a) preparing ingredients;

(b) undertaking basic cooking of meals and food items in line with food safety guidelines;

(c) preparing meals and food items in line with consumer care and service plan; and

(d) cleaning.

12.25 The preparation with respect to menu and meal preparation has increased over the past decade. Food services employees are meeting the expectation for consumer choice with

respect to meals and catering to individual needs (for example, dietary and physical limitations).

General and Administrative Services

12.26 Over the last two decades, the role of laundry and cleaning staff has not changed, save for an increase in clothes and linen quantities and an easing in the physicality of the work with the assistance of technology.

12.27 The role of a laundry staff generally consists of the following:

(a) collection of consumer linen to be laundered (including clothes and bedding);

(b) operating machinery;

(c) pre-washing and/or pre-cleaning soiled linen;

(d) washing and drying with laundry machines;

(e) sorting linen; and

(f) distribution of laundered items throughout the facility.

12.28 The role of cleaning staff generally consists of cleaning and sanitising surfaces, rooms and areas within a residential aged care facility. The onset of the pandemic resulted in more regulated practice with respect to infection control, particularly during peak periods.

12.29 Over the last two decades, the role of maintenance staff has not transformed. The role of a maintenance staff generally consists of the following:

(a) upkeep of grounds and facilities;

(b) organising contractors;

(c) setting up rooms and equipment; and

(d) reporting damaged equipment of consumers.

Nursing Employees

12.30 This section sets out the scope of duties of nursing employees covered under the *Nurses Award*.

AIN

12.31 The duties of an AIN is consistent with a personal care worker (see above). As such, an AIN may be interchangeably referred to as a personal care worker. They are not required to hold a minimum qualification, but to be classified as an *"Experienced"* AIN they are required to hold a relevant Certificate III qualification.[119]

12.32 The scope of duties is limited to personal and domestic care. It does not extend to clinical care.

EN

12.33 An EN provides nursing care under the supervision of a RN.[120] An EN cannot work without supervision. Supervision may be direct or indirect. Their duties include assisting consumers with personal and domestic care. In addition to those duties, ENs contribute to the clinical care needs of the consumer (in a limited respect).

12.34 Typical duties include:

(a) regularly recording patients' temperature, pulse, blood pressure, respiration and so on;

(b) providing interventions, treatments and therapies from patient care plans;

(c) assisting RNs and other team members with health education activities; and

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[119] See *Nurses Award*, cl 15.2.

[120] See NMBA, "*Registered nurse standards for practice"* (1 June 2016), page 6; Reference Bundle, Tab 28, page 1764.

(d) helping patients with their activities of daily life.[121]

12.35 ENs with medication administration education can administer medications, including intravenous medications. However, ENs cannot administer medicines via intrathecal, intradermal or epidermal.

12.36 The latest data from the Nursing and Midwifery Board of Australia (**NMBA**) shows there are currently 74,059 ENs in Australia.[122]

RNs

12.37 The RN is generally the most senior employee providing nursing care within a residential aged care facility. The RN performs a clinical role and has more responsibility than an EN.

12.38 Typical duties include:

(a) assessing patients;

(b) developing a nursing care plan;

(c) administering medicine;

(d) providing specialised nursing care;

(e) working in multidisciplinary teams;

(f) supervising enrolled nurses and junior RNs;

(g) undertaking regular professional development; and

(h) performing leadership roles such as nursing unit manager or team leader.[123]

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[121] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1495.

[122] NMBA, *2020/21 Annual Report*; page 25; Reference Bundle, Tab 5, page 563.

[123] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1495.

12.39 A RN may delegate aspects of their nursing practice to another person such as an EN or AIN; this is described as *"delegated care"*. The following description of *"delegation"* is set out in the *"Registered Nurse Standards for Practice"*:

> *"The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment."* [124]

12.40 It is not uncommon for Case Managers in a home care setting to be qualified as a RN.

12.41 The latest data from the NMBA shows there are currently 345,149 RNs in Australia. [125]

NP

12.42 A NP is an experienced RN who has been endorsed as a *"nurse practitioner"* by the NMBA. They can practice independently in an advanced and extended clinical role and can prescribe some medicines. [126]

12.43 Most NPs are employed by state and territory governments in acute care settings. NPs are also employed in private settings, either as an employee or in their own practice. [127]

12.44 The latest data from the NMBA shows there are currently 2,251 NPs in Australia.[128]

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[124] See NMBA, "*Registered nurse standards for practice"* (1 June 2016), page 6; Reference Bundle, Tab 28. See also NMBA, *"National framework for the development of decision-making tools for nursing and midwifery practice"* (2013); Reference Bundle, Tab 27, pages 1753-1758.

[125] NMBA, *2020/21 Annual Report*, page 25; Reference Bundle, Tab 5, page 563.

[126] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1495.

[127] Department of Health*, "About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1496.

[128] NMBA, *2020/21 Annual Report*, page 25; Reference Bundle, Tab 5, page 563.

Home Care Employees

12.45 Home care employees are covered under the *SCHADS Award*. The scope of their duties is equivalent to a personal care worker under the *Aged Care Award* (see above). The role does not include clinical care. They work under the supervision of a Case Manager, which supervision is provided indirectly due to the nature of the work.

12.46 A notable difference between personal care workers in residential care and home care employees in home care, is that home care employees spend a significant proportion of their time providing domestic assistance, which may include task such as cleaning, laundry, shopping and meals preparation.

Conclusion: The Aged Care Sector

12.47 The above summary of the different aspects of the aged care sector, in particular the nature of the work completed by aged care, nursing and home care employees, provides the necessary background and context for assessing work value reasons.

12.48 We now turn to the relevant legal principles that inform the approach by which minimum rates are properly set.

13. THE LEGAL PRINCIPLES AND AUTHORITIES THAT INFORM THE APPROACH BY WHICH MINIMUM RATES ARE "PROPERLY SET"

Introduction

13.1 Prior to varying the minimum rates in the awards, the Commission must form a view as to whether the minimum rates were ever *"properly set".* The decision in the *Pharmacy Case* suggests and the decision in the *Teachers Case* confirms that the exercise of properly set minimum rates involves considering the C10 framework and the AQF. For completeness, it is useful to refresh the genesis of the C10 framework in the 1989 National Wage Cases, as well as summarise the principles governing the process as set out in the *Paid Rates Review decision*[129] and summarised in *ACT Child Care Decision*.

Historical Genesis

13.2 Arising out of the restructuring and structural efficiency principles in the 1980s, the Australian Industrial Relations Commission (**AIRC**) turned its attention in 1989 to how minimum rates should be properly set.

13.3 It did this to cure a number of historical events that contributed to wage instability and *"feelings of injustice"*[130]: paid rates awards, a history of *"leap frogging"*, *"flow-on"* settlements and arbitrated and consent work value cases. This played out in the *National Wage Case February 1989 Review*[131] and *National Wage Case August 1989*.[132]

13.4 In the *National Wage Case February 1989 Review*, the Australian Council of Trade Unions (**ACTU**) produced a *"blueprint"* for award restructuring which it considered would *"facilitate*

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[129] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998) (**Paid Rates Review decision**).

[130] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 201.

[131] *National Wage Case February 1989 Review* (1989) 27 IR 196.

[132] *National Wage Case August 1989* (1989) 30 IR 81.

major and sustainable award reform on a general basis, with a clear understanding of award relationships one to another and with the necessary level of control by this Commission".[133]

13.5 The ACTU contended that *"award restructuring"* should involve three steps:

> *"First, Raise the minimum rate in minimum rates awards to ensure that the restructuring is on an equitable base (Minimum Rate)*
>
> *Second, Broadbanding by establishing across industry six to eight skill levels (The Framework)*
>
> *Third, Provide the means by which upward mobility occurs through education, training and service (The Career Structure)".*[134]

13.6 The employers *"strongly opposed"* the proposals of the ACTU. The reasons for that opposition were several and included, *inter alia*, concerns that such a process *"would result in a rigid system which would deny the flexibility needed to meet differing rates of technological change in disparate industry sectors".* [135]

13.7 Despite the concerns raised, the AIRC formed a view that the existing system needed to be *"corrected"* to ensure the intended purpose of the structure efficiency principle - namely, to modernise awards in the interests of employees and employers - is not reduced in effect. As such, steps need to be taken to *"ensure stability"*. [136]

13.8 The AIRC *"endorse[d] in principle the approach proposed by the ACTU though not necessarily the particular award relationships submitted in [that] case"*. [137]

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[133] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 197.

[134] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 197.

[135] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 200.

[136] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 201.

[137] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 201.

13.9 In the *National Wage Case August 1989*, the AIRC addressed *"how the approach endorsed in principle by the Commission for ensuring stable relationships between awards and their relevance to industry is best translated into practice"*.[138]

13.10 The ACTU sought specific endorsement of the classification rates and supplementary payments, which referred to a *"Building industry tradesperson"* and *"Metal industry tradesperson"* with a minimum classification rate of $356.30.[139] The approach proposed by the ACTU was endorsed by the trade union movement and support by the Commonwealth. The employers continued to hold opposition. [140]

13.11 The AIRC ultimately held:

(a) The minimum classification rate to be established over time for a metal industry tradesperson and a building industry tradesperson should be $356.30 per week. Further, *"the minimum classification rate of $356.30 per week would reflect the final effect of the structural efficiency adjustment determined by this decision".* [141]

(b) *"Minimum classification rates and supplementary payments for other classifications throughout awards should be set in individual cases in relation to these rates on the basis of relative skill, responsibility and the conditions under which the particular work is normally performed. The Commission will only approve relativities in a particular award when satisfied that they are consistent with the rates and relativities fixed for comparable classifications in other awards. Before that requirement can be satisfied clear definitions will have to be established."* [142]

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[138] *National Wage Case August 1989* (1989) 30 IR 81 at 84.

[139] *National Wage Case August 1989* (1989) 30 IR 81 at 92-93.

[140] *National Wage Case August 1989* (1989) 30 IR 81 at 92-93.

[141] *National Wage Case August 1989* (1989) 30 IR 81 at 94.

[142] *National Wage Case August 1989* (1989) 30 IR 81 at 94.

(c) Settled upon *"appropriate relativities"* for the minimum classification by reference to *"key classifications"* in the Metal Industry Award. [143]

(d) The minimum rates should not include *"supplementary payments"* or *"amounts for disabilities"*, such inclusion would result in *"over"* payment. Those amounts should be separated out.[144]

(e) *"To achieve a proper and lasting reform of awards it is essential that the structural efficiency exercise and the proper fixation of minimum award rates be treated as a package".* [145]

13.12 By the *National Wage Case August 1989,*[146] the Commission settled upon the *"tradesperson"* in the Metal Industry as the benchmark classification for the purposes of determining appropriate relativities. That classification structure in the Metals Award ranged from the minimum wage C14 level through to degree qualification at C1 level. Hence its utility as a benchmark.

13.13 Following that determination of the minimum classification and the rates for other key classifications, the AIRC turned to consider the implementation arrangements for the wage increases (*"minimum rate adjustments"*) necessary to give effect to it conclusions.[147] It stated the objectives of the reforms it wished to implement as follows:

> *"These exercises provide an opportunity for the parties to display the maturity required to overcome the wage instabilities with which the community is only too familiar. It also provides the opportunity to take an essential step towards institutional reform which is a prerequisite to a more flexible system of wage fixation.* ***As part of that future we envisage that minimum classification rates will not***

[143] *National Wage Case August 1989* (1989) 30 IR 81 at 94.

[144] *National Wage Case August 1989* (1989) 30 IR 81 at 94.

[145] *National Wage Case August 1989* (1989) 30 IR 81 at 95.

[146] *National Wage Case August 1989* (1989) 30 IR 81.

[147] *National Wage Case August 1989* (1989) 30 IR 81 at 95-96.

> ***alter their relative position one to another unless warranted on work value grounds**."*[148]

13.14 Later in the decision the AIRC discussed whether, in the light of the establishment of the *structural efficiency principle*, any of the other wage fixing principles should be modified. The AIRC decided that *"structural efficiency exercises should incorporate all past work value considerations"*. [149] A separate new principle was established for the implementation of minimum rate adjustments. However the datum point requirement in ***paragraph (c) of the Work Value Changes principle was not at this stage modified.***[150]

13.15 In *National Wage Case April 1991*[151], the AIRC reaffirmed that *"minimum classification rates, once reviewed and fixed in an appropriate relationship, will not be moved from that relative position unless changes are warranted on work value grounds"*.[152] Hence, the starting point is the C10 framework.

13.16 Consequential upon that position, the AIRC determined that any future assessment of change in the nature of work of a particular classification in a future award would be measured from the date of the second structural efficiency adjustment allowable in accordance with the *National Wage Case August 1989*.[153] Hence the Work Value Changes Principle was modified so as to alter paragraph (c) and add a new paragraph (d) (with the following paragraphs correspondingly re-designated) as follows:[154]

> *"(c) The time from which work value changes in an award should be measured is, unless extraordinary circumstances can be demonstrated in special case*

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[148] *National Wage Case August 1989* (1989) 30 IR 81 at 96.

[149] *National Wage Case August 1989* (1989) 30 IR 81 at 99.

[150] *Pharmacy Case* at [154].

[151] *National Wage Case April 1991* (1991) 36 IR 120.

[152] *National Wage Case April 1991* (1991) 36 IR 120 at 160-161.

[153] *National Wage Case April 1991* (1991) 36 IR 120 at 172.

[154] *Pharmacy Case* at [155].

proceedings, the date of operation of the second structural efficiency allowable under the 7 August 1989 National Wage case decision.

(d) ***Care should be exercised to ensure that changes which were or should have been taken into account in any previous work value adjustments or in a structural efficiency exercise are not included in any work evaluation under this principle****."*

13.17 The significance of that *"modification"* was explained in the *Pharmacy Case* at [156]:

> *"[156] Subject only to the narrow exception provided by the capacity to mount a "special case", the effect of this modification was that,* ***once an award had been subject to the structural efficiency process in which, among other things, classification in minimum rates awards were to be fixed in appropriate relativities with other classifications within the award and in other awards, no adjustment on work value grounds was permissible other than on the basis of changes to work which occurred after the structural efficiency exercise had been completed****. Importantly,* ***the new paragraph (d) in the Work Value Changes Principle prevented any "double-counting"*** *not only of work changes which were taken into account in the structural efficiency exercise, but those which should have been taken into account, whether they actually were or not. This meant, for example, that the full work value assessment of awards covering female-dominated areas of work which was sought by various women's groups in the National Wage Case 1983 was permanently foreclosed (subject again only to the limited capacity to advance a special case)."*

13.18 The above summary demonstrates that the concept of properly set rates is not to be divided from work value assessment. It is the first step. Further, deviation from properly fixed wages, for example by increasing them, should only occur if work value reasons exist.

Relevant Principles

13.19 The principles set out in the *National Wage Case August 1989* were applied in the *Paid Rates Review decision*. In 1998, the Full Bench determined that all *"paid rates"*[155] in awards should be converted to *"properly fixed minimum rates of pay"*. This conversion process was to apply, in principle, to *"operate, as minimum rates and which do not bear a proper work value relationship to award rates which are properly fixed minima, should be subject to a conversion process so that they do contain properly fixed minimum rates of pay."*[156] It was described as the *"minimum rates adjustment"* principle.

13.20 The minimum rates adjustment principle has been described as *"designed to establish a stable matrix of minimum rates in Awards covering similar work".* Its purpose is to *"remove inconsistencies between Award rates".*[157]

13.21 The Full Bench characterised the minimum rates adjustment process which had arisen from the *National Wage Case August 1989* in the following terms:

> *"The MRA principle was designed to* ***<u>establish a consistent pattern of minimum rates in awards covering similar work thereby removing inequities and providing a stable foundation for enterprise bargaining.</u>*** *That objective is as important now, perhaps even more important, than it was in 1989."*[158]

13.22 As to the method of establishing *"properly fixed minimum rates"*, the Full Bench observed:

> *"Having considered all of the submissions we have decided to adopt an approach which gives primacy to the maintenance of internal relativities. The approach involves* ***identifying the key classification in the award under review, striking the appropriate work value relativity between that classification and the fitter in the Metal, Engineering and***

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[155] If an award included *"paid rates",* it specified the actual rates of pay received by employees. They are distinct from *"minimum rates".* In some paid rates awards, to pay above the paid rate would be in breach of that award.

[156] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998).

[157] *And Social And Community Services (ACT) Award 2001* (PR918263) (30 May 2002) at [20].

[158] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998).

Associated Industries Award, 1998 - Part 1 [Print Q2527], adjusting the rate for the key classification accordingly (if necessary) and then adjusting all of the rates in the award under review to maintain the pre-existing relativities with the key classification. We understand that this may lead to differences in minimum rates at particular skill levels across the award system."[159]

13.23 It established a series of principles for the conversion of awards which do not contain properly fixed minimum rates:

"The principles we have formulated pursuant to item 53 and s.106 are as follows:

1. Awards requiring review under item 51(4) will be:

(a) awards containing rates which have not been adjusted in accordance with the minimum rates adjustment principle in the August 1989 National Wage Case decision; and

(b) awards containing rates which have been adjusted in accordance with the minimum rates adjustment principle in the August 1989 National Wage Case decision but which have been varied since the adjustment other than for safety net increases or pursuant to the work value change principle.

2. The rates in the award under review should be examined to ascertain whether they equate to rates in other awards which have been adjusted in accordance with the August 1989 approach with particular reference to the current rates for the relevant classifications in the Metal, Engineering and Associated Industries Award, 1998 - Part 1 [Print Q2527]; where the rates do not equate they will require conversion in accordance with these principles.

3. Fixation of appropriate minimum rates should be achieved by making a comparison between the rate for the key classification within the award with rates for appropriate key

[159] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998).

classifications in awards which have been adjusted in accordance with the 1989 approach.

4. In the fixation of rates the relationship between the key classification in the award and the metal industry fitter should be the starting point; internal award relativities established, agreed or determined should be maintained: see, for example, the approach adopted in Kenworth Trucks Vehicle Industry Award 1981 [Print K0003] and Commonwealth Serum Laboratories Commission Sales Representative Award 1987 [Print K4939].

5. Any residual component above the identified minimum rate, including where relevant incremental payments, should be separately identified and not subject to future increases.

6. If the rates are too low it is consistent with the purpose and intent of item 51(4) that the rates be increased so that they are properly fixed minima.

7. Any future increases in rates in the award will only be applied to the minimum rates component and will be absorbed against any residual component; that is, the residual component will be reduced by the amount of the increase in the minimum rates component.

8. Increments will only be retained where they have been included in the award pursuant to the relevant work value principle or where it can be established that the increments were inserted by the Commission on grounds of structural efficiency and work value.

9. Where parties cannot agree on rates, or they agree on rates which the Commission is not satisfied are properly fixed minima, the Commission will determine the matter, subject to the right of any party to seek a reference pursuant to s.107.

10. Any party seeking to depart from these principles should make application to the President for the matter to be dealt with as a special case. The President may call a conference of the parties to the award and the parties to these proceedings prior to deciding any such application.

11. Award rates which have been dealt with pursuant to these principles cannot be used to found claims in other awards based on the restoration of relativities.

12. The conversion of awards, in accordance with these principles, to minimum rates awards is not a ground for reducing the conditions of employment in the converted awards or for increasing conditions of employment in other awards."

13.24 The Commission also stated: *"We have decided that safety net adjustments should not be applicable to awards which do not contain properly fixed minimum rates subject to the qualification contained in the April 1998 Safety Net Review decision [principle 8(f)]"*.

13.25 The Full Bench addressed its approach set out to determining a properly fixed award, with the following supplementation:[160]

> *[36] It is appropriate to indicate that in our first decision we were required to address the precise manner in which properly fixed minimum rates should be calculated in the APS award. We were not required to address the position in other awards in as much detail. It is likely that the approach we have adopted in the APS award will be appropriate in other awards. That approach entailed the adoption of the internal relativities created at the time of the structural efficiency adjustment (in that case in 1991) as forming the basis for establishing properly fixed minimum rates. The conversion process involved the application of subsequent safety net adjustments to the 1991 base. The rate arrived at through this process was then compared with the actual rates and the residual identified. This approach is appropriate because the subsequent safety net increases, being flat dollar amounts, compressed relativities between classifications in minimum rates awards. That compression should be maintained in awards which are converted [see: Safety Net Adjustments and Review September 1994 (1994) 56 IR 114 at 139]. …* ***However, depending***

[160] *Paid Rates Review - Supplementary Decision 1233/99* (M Print S0105) [1999] AIRC 1163 (14 October 1999).

upon the circumstances, it may be appropriate to maintain current internal relativities once the comparison has been made with the rate applying in the relevant trades classification (Metals C10) and any residual or increase identified. It should be noted that principle 3 of the principles contained in Appendix A to the Safety Net Review Wages April 1999 Decision [Print Q1999] permits applications to be made pursuant to the 1989 minimum rates adjustment principle. In multi-employer awards, which have not been subjected to the 1989 minimum rates adjustment principle, consideration should be given to whether or not external or internal relativities should be preferred. The approach to be adopted in the establishment of properly fixed minimum rates in a particular case will be a matter for the Commission to assess having regard to the work comprehended by the classification and the history of the award structure. In all circumstances the most important characteristic in seeking to fix minimum rates is the identification of the relationship of the key classification in the award being converted with the metal industry fitter.

(Emphasis added).

13.26 The requirements for the fixation of minimum rates which flowed from the *Paid Rates Review decision* were summarised by an AIRC Full Bench in *ACT Child Care Decision* in the following terms:[161]

> *"1. The key classification in the relevant award is to be* ***fixed by reference to appropriate key classifications in awards which have been adjusted in accordance with the MRA process*** *with particular reference to the current rates for the relevant classifications in the Metal Industry Award. In this regard the relationship between* ***<u>the key classification and the Engineering Tradesperson Level 1 (the C10 level) is the starting point</u>****.*

[161] *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 at [155].

> *2. Once the key classification rate has been properly fixed,* ***the other rates in the award are set by applying the internal award relativities which have been established, agreed or maintained****.*
>
> *3.* ***<u>If the existing rates are too low they should be increased</u>*** *so that they are properly fixed minima."* [162]

13.27 In the *ACT Child Care Decision* the Full Bench found that there had been a significant net addition to work requirements since the 1990 datum point such as to satisfy the requirements of the Work Value Changes Principle.

13.28 The Full Bench also decided that, based on the AQF, that minimum pay alignments should be established between the child care awards under consideration and the Metal Industry Award between <u>classifications with equivalent training and qualification levels</u>.[163] The relevant passages are set out below:

> *"[181] A central feature of this case is the* ***<u>alignment</u> of the Child Care Certificate III and Diploma levels in the ACT and Victorian Awards <u>with the appropriate comparators in the Metal Industry Award.</u>***
>
> *[182] We have considered all of the evidence and submissions in respect of this issue. In our view the rate at the* ***AQF Diploma level*** *in the ACT and Victorian Awards should be* ***linked to the C5 level*** *in the Metal Industry Award. It is also appropriate that* ***there be a nexus between the CCW level 3 on commencement classification in the ACT Award*** *(and the Certificate III level in the Victorian Award)* ***and the C10 level in the Metal Industry Award****.*
>
> *[183] In reaching this conclusion we have considered - as contended by the Employers -* ***<u>the conditions under which work is performed</u>****. But contrary to the Employers' submissions this consideration does not lead us to conclude that child*

[162] *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 at [155], cited in *Pharmacy Case* at [159].

[163] *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 at [181]-[183].

care workers with qualifications at the same AQF level as workers under the Metal Industry Award should be paid less. ***If anything the nature of the work performed by child care workers and the conditions under which that work is performed suggest that they should be paid more, not less****, than their Metal Industry Award counterparts."*

13.29 Following the modernisation of awards, the Metal Industry Award was consolidated into the *Manufacturing Award*. The classification of tradesperson (C10 level) remains the key classification when properly fixing minimum rates.

13.30 Thus, the process by which minimum rates were *"properly set"* or *"properly fixed'* is as follows:

(a) *First*, the classifications in the relevant award(s) were fixed by reference to the relevant classifications in the *Manufacturing Award*, specifically, the relationship between the *"key classification"* to the C10 level as the starting point. The alignment process is informed by reference to the training and qualification levels attached to the classifications between the awards (regard may also be had to the AQF).

(b) *Second*, the other rates in the relevant award(s) are set by applying *"the internal award relativities"* (which may have been established, agreed or maintained), by reference to the key classification.

13.31 This principled approach to setting minimum rates seeks to establish a consistent system of awards, each with properly set minimum rates. It was applied in the *Teachers Case.*[164]

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[164] See *Teachers Case* at [653].

14. WHETHER THE MINIMUM RATES IN THE AWARDS WERE PROPERLY SET?

14.1 The Commission must first form a view as to whether those rates were ever properly fixed in the awards and whether the relevant workers were the subject of prior work value considerations.

14.2 This process requires consideration of the history of award regulation with respect to the workers now covered under the awards, which traverses multiples sectors and includes aged care.

14.3 For each award, we will identify and examine in turn:

(a) the relevant NAPSA and pre-reform awards setting out wage rates (collectively, **the pre-form awards**);

(b) decisions relating to wage fixing of the pre-reform awards, including determinations based upon the work value; and

(c) any commentary from the Commission as to the drafting of classifications and setting of minimum rates in the modern awards.

14.4 Once a view is reached as to whether the minimum rates were properly set is reached, we will turn to an analysis of the work performed by employees in the aged care sector.

15. WHETHER THE MINIMUM RATES IN THE *AGED CARE AWARD* WERE PROPERLY SET?

Introduction

15.1 The industrial history underpinning the *Aged Care Award* demonstrates that issues as to minimum rates and classifications were debated in the context of pre-reform award and during the award modernisation process. This section is broken into two parts:

(a) *First,* an analysis of the *Health and Allied Services - Private Sector - Victoria Consolidated Award 1998* (**the HASA Award**), the federal award used as the basis for the *Aged Care Award*. The purpose of this analysis is to identity any relevant discussion and/or decisions with respect to rates.

(b) *Second*, an analysis of the pre-reform awards with respect to aged care more broadly. The purpose of this analysis is to consider the treatment of comparable awards prior to the award modernisation.

15.2 The combined effect of that analysis will demonstrate that the existing rates in the *Aged Care Award* do not appear to have been properly set.

Industrial History: *Aged Care Award*

15.3 Prior to the modernisation process, aged care services were regulated by a combination of state and federals awards.[165]

15.4 The *HASA Award* was the federal award used as the basis for the *Aged Care Award*.

15.5 The *HASA Award* followed the making of the *Health Services Union of Australia (Victoria-private sector) Interim Award 1993* (**the 1993 Award**) and the *Health and Allied Services - Private Sector - Victoria - Consolidated Award 1995* (**the 1995 Award**).

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[165] See generally, *"Draft award audit by modern awards"* (excel spreadsheet): https://www.fwc.gov.au/agreements-awards/awards/awards-research.

15.6 In 1997, the HSU and Kindilan Society made applications to the vary, *inter alia*, the *Health and Allied Services - Private Sector - Victoria 1995* and *Health (Residential Care - Victoria) Award 1995* (**Resicare Award**), including the insertion of a *"disability service stream"*.[166] The proposed rates of pay and classification structure sought by the HSU were based on three broad grounds:

(a) to give effect to an earlier agreement to apply the Structural Efficiency Principles established via previous National Wage Cases by establishing skill related career paths and to create appropriate relativities between different categories of workers within the award;

(b) increases in rates of pay are justified on the grounds of work value changes; and

(c) granting the application would be consistent with ss 90AA(2) and 150A of the *Industrial Relations Act 1988* (Cth).

15.7 The rates were also noted as being reached in agreement with employer parties (but not all).

15.8 The Victorian employer associations[167] submitted:

(a) The *Resicare Award* sets out rates of pay which are clearly and unambiguously minimum rates. The rates have been set by industrial tribunals according to proper wage fixing principles and must be taken to reflect a properly fixed minimum wage rate.

(b) The *HASA Award*, however, provide rates of pay and service payments which for many years were paid for all purposes. There is a historical link asserted with the

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[166] *Health Services Union of Australia Applications Dec 1559/97* (S Print P7638) [1997] AIRC 1336 (22 December 1997).

[167] Victorian Employers' Chamber of Commerce and Industry and Victorian Community Services Employers' Association.

State Incremental Payment Scheme and it was submitted that the rates in the *HASA Award* are overstated in work value terms.

(c) A comparison of rates on this premise leads to a conclusion, it was submitted, that no increase in rates of pay is warranted for employees under either the *Resicare Award* or the *HASA Award.*

15.9 The Commission did not reach a view as to whether the existing rates in the *HASA Award* were properly fixed.

15.10 On 30 June 1998, pursuant to an application under Item 49 of Part 2 of Schedule 5 of the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth), the 1995 Award was varied and replaced with the HASA Award.[168] The purpose of the variations were part of the award simplification process to ensure the *HASA Award* conformed with the prescribed allowable award matters. This did not involve review of the minimum rates.

15.11 The *HASA Award* recognised four streams of employment:

(a) Technical;

(b) Clinical and Personal Care;

(c) Administrative/Clerical; and

(d) General and Food Services.

15.12 In a subsequent decision, recorded on transcript, the AIRC varied the personal care classifications and added a sleepover clause.[169]

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[168] See *Australian Nursing Federation* [2012] FWA 6460 (1 August 2012) at [45].

[169] *Health Services Union of Australia Applications Dec 1559/97* (S Print P7638) [1997] AIRC 1336 (22 December 1997).

15.13 On 7 April 1999, the *HASA Award* was again varied. A reference to *"TAFE Certificate"* in the personal care worker Grade 3 classification was replaced with *"TAFE Advanced Certificate".*[170]

15.14 Following the 1997 decision, the Commission determined the appropriate course was for the disability services sector to be regulated by a *"stand alone"* award, namely, the *Residential and Support Services (Victoria) Award 1999* (**Residential Award**), which commenced on 28 October 1999.

15.15 The *Residential Award* was held to be properly fixed in accordance with the *Paid Rates Review decision* and, in all other respects, meet the requirements of the *Workplace Relations Act 1996* (Cth) (**WR Act**).[171]

15.16 The Commission determined that the Residential/Support Services Worker Grade 3 classification was properly equated to a C10 level. In the draft produced by the parties, they proposed a base rate less than the C10, but adjusted the other classification rates at the base level by maintaining existing internal relativities. The Commission specifically considered the impact the lower base rate on the rates in the second and third years of each grade. Notwithstanding the reduction to the base pay of the key classification, having considered the evidence, the Commission concluded *"the rates of pay at the base level and in the second and third year are fixed at an appropriate level on work value grounds".*[172]

15.17 The work value considerations concerned *"home care"* and did distinguish between aged care. The Commission's observations appear below:

> *"[15] The evidence disclosed that the work associated with providing a service to the intellectual disabled has altered significantly over the past five years. This has been brought*

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[170] See *Correction Order - Health and Allied Services – Private Sector – Victoria Consolidated Award 1998* (7 April 1999); Statement of Leigh Svendsen, Annexure LS-1, Tab 85.

[171] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999).

[172] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999) at [20].

about in part by the transfer of clients from large residential institutions many based on a medical type model to homes located in the community.

[16] The change from the medical type model to one in which the service is provided in community homes has resulted in a substantial change to the duties of those now employed to deliver the services to clients in such homes.

[17] For example residential care staff now have the responsibility for many procedures undertaken previously by medical or nursing staff. This has led to the need to provide intense internal training supplemented by external training.

[18] This training is ongoing as new treatment and methods of delivery services to the intellectually disabled are introduced. The private organisations that enter into contracts with the State Government to deliver the services to the intellectually disabled are funded to provide the necessary training to meet the quality of service required by the Government under the contract. There is on the evidence a constant upgrading of knowledge and skills of the employees in the industry.

[19] The changes affecting the skill and responsibility of employees can be summarised as follows:

> ** Transition from a medical model to a disability model;*
>
> ** Clients with more challenging problems;*
>
> ** Care workers contributing to client case plans;*
>
> ** An emphasis on formal qualifications being required or preferred;*
>
> ** With less input from professional care workers, care workers are exercising much higher level of responsibility in a range of areas.*

[20] The increased knowledge, skills and training together with the qualifications required at the entry level of each grade which has been proposed, leads us to conclude that a case has been made out that the rates of pay at the base level and in the second and third year are fixed at an appropriate level on work value grounds."

15.18 The award applied to the whole of Victoria in relation to persons employed in direct client support roles in residential and/or non-residential support services for people with disabilities and/or young people and/or children.[173] That award also provided that the *Residential Award* was to prevail to the extent of any potential coverage under the HASA Award.[174]

15.19 The *HASA Award* has been uncontroversially described as a *"minimum rates award"*.[175]

15.20 Turning to the award modernisation process, during a hearing on 23 February 2009, the following submission was advanced on behalf of the HSU:

> *"MR MCLEAHY: … The health exposure drafts have in our view calculated the rates of pay incorrectly when the wage rates of the wage skilled groups from the Health and Allied Services Private Sector Victoria Award are compared to the aged care exposure drafts and the health professionals and support services exposure drafts some workers will be worse off.*
>
> *In particular, entry level employees under the HASA classifications will be at a disadvantage. When compared to the pay scales entry level workers referred to in the - entry workers transferring into a modern award at a pay level that is $19 a week worse off, this situation is replicated throughout the levels and we propose that the way to amend that is to increase the rates up. We also say that there are a number of allowances which should also be included because they set the basis of the safety net.*
>
> *COMMISSIONER SMITH: Can I just ask you to pause for a moment. You've taken percentage rates, what do you say the percentage is for a three year entry, is 150 per cent?*

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[173] *Residential and Support Services (Victoria) Award 1999*, cl 4.2.

[174] *Residential and Support Services (Victoria) Award 1999*, c 4.3.

[175] *Australian Nursing Federation v Aaron Private Nursing Home* (055/99 S Print R0947) [1999] AIRC 67 (25 January 1999); *Victorian Patient Transport and another, Metropolitan Ambulance Services and others, Australian Liquor, Hospitality and Miscellaneous Workers Union and Wilson Patient Transport Pty Ltd Ambulance Employees - Victoria Interim Order 1994 and Ambulance Services and Patient Transport Employees Award Victoria 2002* (PR945582) [2004] AIRC 396 (26 April 2004) at [95].

MR MCLEAHY: I'm sorry, Commissioner?

COMMISSIONER SMITH: Percentage for a three year degree entry?

MR MCLEAHY: Yes, we say it's at 150 per cent.

COMMISSIONER SMITH: Where do you get that from?

MR MCLEAHY: When we proposed this we had a look at where the current rates of pay are, what are the relativities compared to other industries. We had a look at the metals model in terms of where the professionals sit above the C10 level."[176]

15.21 On 28 March 2008, as to the Aged Care Industry Award Exposure Draft, the Full Bench said:

[76] The exposure draft of the Aged Care Industry Award 2010 not only covers aged care provided in institutions but also extends to services provided in the home by persons who are covered by the award. This approach may require further consideration. There are a myriad of services for the elderly which are conducted by various organisations including private providers and local governments. Further, aged care activities may be an element in the provision of disability services. This will be examined further in dealing with social and community services in Stage 4.[177]

15.22 In a subsequent statement, a decision was made to not include *"home care employees"* under the *Aged Care Award*. The Full Bench determined that *"home care employees will be solely covered by the Social, Community, Home Care and Disability Services Industry Award 2010"*.[178]

15.23 The modern award was made on 3 April 2009.[179]

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[176] AM2008/13, Transcript of Proceedings [2009] FWATrans 133 (10 March 2009) at [PN613]- [PN620].

[177] *Statement - Award Modernisation (AM2008/13-24)* [2009] AIRCFB 50 (23 January 2009) at [76].

[178] *Award Modernisation - Decision - re Stage 4 modern awards* [2009] AIRCFB 945 (4 December 2009) at [77].

[179] *Award Modernisation - Decision - Full Bench* [2009] AIRCFB 345 (3 April 2009) at [145].

15.24 There have been approximately 153 variations to the *Aged Care Award* since publication. None of these decisions have varied the classification structure in the Award.

Industrial History: Pre-Reform Awards

15.25 An analysis of the pre-reform awards and surrounding commentary reveals the following:

(a) the minimum rates in at least three of the pre-reform awards appear to have been properly fixed against the C10 framework;[180]

(b) the minimum rates in at least three of the pre-reform awards have been fixed with reference to *"internal relativities"*;

(c) the majority of the pre-reform awards do not include an express reference to relativities and absent commentary or decisions by a tribunal to the contrary, suggest those rates were not properly fixed against the C10 framework.

15.26 We now set out the analysis underpinning those observations.

15.27 The minimum rates in the *Private Hospitals, Convalescent and Benevolent Homes (Northern Territory) Award 2003* appear to have been properly set. This is supported by the text of the award:

(a) At clause 17.5.1(a), the following table appears:

Column 1	**Column 2**	**Column 3**
	%	$
Training rate (1)		27432
Training rate (2)		27965
Health employee grade 1	90.5	27560
Health employee grade 2	94.0	28519
Health employee grade 3	100	30163

[180] *Private Hospitals, Convalescent and Benevolent Homes (Northern Territory) Award 2003; Private Hospitals and Nursing Homes Industry Award - State 2003; Health Services Employees Award.*

(b) At clause 17.5.2(a), the award provides: *"Health employee grade 3 has a 100% relativity with the metal trades trade rate"* and notes *"[c]olumn 2 sets out the internal relativities between the grades of Health employee".* Thus*, "Health employee grade 3"* is the key classification for the award.

(c) At clause 17.5.2(b), the award provides:

> *- Column 3 sets out the "on commencement" properly fixed minimum rates of pay for the classifications in the award, as provided for in the Commission's Principles for the Conversion of Awards which do not Contain Properly Fixed Minimum Rates [Print Q7661]. These rates of pay are inclusive of the arbitrated safety net adjustment payable under the June 2005 Safety Net Review wages decision [PR002005];*
>
> *- Subject to 17.6, Columns 4 and 6 set out the work value increments payable to employees who qualify for them – that is, employees in their second and third years of service, respectively*

15.28 The minimum rates in *Private Hospitals and Nursing Homes Industry Award - State 2003* may have been properly set. This is supported by the text of the award:

(a) Clause 5.2 sets out the wage rates for the award, which includes internal relativities. The key classification is Level 3 at pay point 1 (100%).

(b) Clause 5.1.3 sets out the qualifications and duties of Level 3, which include:

> *"A position at this level shall require formal qualifications equivalent to a trade certificate or similar or appropriate experience/training in the field to enable the duties of the position to be carried out.*
>
> *…*
>
> *Trade duties (qual), non-trade supervisory, clinic measurement (qual), non-nursing hygiene/pest control, housekeeper, therapy assistant (qual), fire safety and security, dresser, orderly, theatre assistant, anaesthetic technician."*

15.29 Whilst not expressly stated, the *"key classification"* of the award appears consistent with the C10 level in the *Metal Industry Award.*

15.30 Additionally, the wage rates in the *Nursing Homes Award* were set consistent with the State Wage Case Decision of 13 February 1992. By that decision, *"the award shall specify the classification prescribed in the relevant minimum rates award on which the actual rates prescribed for the key classification in the paid rates award is calculated".*

(a) In accordance with that decision, the award provided:

The following is set down in accordance with that requirement:

Minimum Rates Award - Metal and Engineering Industry Award

Classification - Wage Group Level 7

Paid Rates Award - Nursing Homes Award

Classification - Services Employee Level 5

(b) In clause 7, each classification in the award has a wage relativity to the *"Services Employee Level 5"* (the key classification).

15.31 The above inclusion appears to demonstrate an effort to rationalise and convert wage rates in the award by reference to a classification in the *Metal Industry Award* and the former paid rates award.

15.32 The *Health Services Employees Award* was considered by the Industrial Relations Court in South Australia between 2001 to 2002 in the context of an application to vary on work value reasons. The Union[181] contended the application was justified by the *"significant change in the aged care section of the award as a consequence of the enactment of the Commonwealth Aged Care Act in late 1997".* The matter before the Commission is to be processed pursuant to the provisions of the *State Wage Case June*[182] and, in particular, Principle 8 - Work Value Changes.

[181] Australian Liquor, Hospitality and Miscellaneous Workers Union.

[182] *State Wage Case June* (2002) 119 IR 275; [2002] SAIRComm 38.

15.33 The Commission found the Union had demonstrated a *"significant net addition*". That finding was supported by the following:

> *[85] For the Union to succeed in its application it must show that there has been, in the terms of the guidelines, "such a significant net addition to work requirements as to warrant a new classification or upgrading to a higher classification".*
>
> *[86] The introduction of Certificate 3, its take up by the employees, and in some cases it being a requirement by employers is of some significance in this matter.*
>
> *[87] Further I perceive that some of the legislative enactments envisage a level of work higher than that which may have been required in the past.*
>
> *[88] The work of the carers is an important part of the employers' obligations to adhere to the legislative regime. In some cases they are in the front line of caring for the aged and infirm in the community. That is an important task and function which must be properly rewarded.*
>
> *[89] I base that finding upon the evidence, the introduction of Aged Care Act 1997, the Aged Care Principles and the contents of the Residential Care Manual. Further and importantly is the fact shown in the evidence that many carers work without supervision and perform tasks critical to patient care. The fact that they do so is a consequence in my view of a staffing structure which the respondents to this Award have chosen to implement. It is a finding which can openly be made on all of the evidence before me.*

15.34 As to that exercise undertaken by Commissioner McCutcheon, Commissioner Dangerfield in *Child Care (SA) Award Work Value Case* observed:[183]

> *[100] In finding at first instance that there had been changes to the value of work performed under the aged care section of the Health Services Employees' Award McCutcheon C found that the introduction of a Certificate III qualification was a significant development in the context of various legislative requirements imposing obligations on employers to adhere to*

[183] *Child Care Industry (Australian Capital Territory) Award 1998 (PR954938)* [2005] AIRC 28 at [100]-[101].

a strict regulatory regime. The "C10" rate was used to assist in determining rates for aged care workers qualified at Certificate Level III.

[101] On appeal, the Full Commission, while overturning the retrospective date of operation awarded in the initial decision, nevertheless confirmed the relevance of the AQF certificate III as a means of classifying employees performing work at a level commensurate with the qualification.

15.35 Having regard to the decisions and observations made by the IRC in South Australia, a work value assessment occurred with respect to the *Health Services Employees Award* and it is arguable that the rates in that award were properly set.

15.36 It may also be observed that both the *Award for Accommodation and Care Services Employees for Aged Persons - South-Eastern Division 2004 and Award for Accommodation and Care Services Employees for Aged Persons - State (Excluding South-East Queensland) 2004* were fixed against internal relativities. The key classification identified by reference to the 100% relativity rate was *"Cooks"* (see cl 5.1.1). No further explanation is made, save for noting *"[t]he rates of pay in this Award are intended to include the arbitrated wage adjustment payable under the 1 September 2005 Declaration of General Ruling and earlier Safety Net Adjustments and arbitrated wage adjustments".*

15.37 As to the pre-reform awards that list internal relativities without reference to the relevant comparator (whether it be a related award or the Metals Industry Award), such references may by implication allude to the C10 framework, however, absent a decision by the Commission conducting an assessment of the minimum rates and making a firm finding, we cannot conclude with confidence that the minimum rates were properly set.

15.38 *Finally,* the majority of the pre-reform awards do not include an express reference to C10 relativities and absent commentary or decisions by a tribunal to the contrary, suggests those rates were not properly fixed against the C10 framework.

Conclusion: Industrial History

15.39 The industrial history underpinning the *Aged Care Award* demonstrates that minimum rates for employees within the aged care, disability and health sectors were the subject of consideration by the Commission (and its predecessors). At the time of modernisation, there was debate as to the scope of coverage for the *Aged Care Award*, which ultimately resulted in home carers being siloed into the *SCHADS Award*. The *HASA Award* was the *"minimum rates award*" used as the basis for the rates in the *Aged Care Award*. That description alone, however, is not conclusive the rates were properly fixed. As such, the rates may not be described with confidence as properly set.

15.40 In order to reach a conclusion the minimum rates in the *Aged Care Award* are properly set, reference must be made to a decision of the Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. It should be uncontroversial that to-date no such assessment has occurred. The preceding industrial history, which includes reference to *"properly set"* and/or *"relativities",* suggests that the existing rates may have some alignment to the C10 framework.

15.41 The Commission may find there is some alignment within the existing structure, noting some of the pre-reform award minimum rates allude to being *"properly set",* this exercise must be undertaken deliberately and expressly with respect to the *Aged Care Award* in order for the minimum rates to be considered properly set.

16. WHETHER THE MINIMUM RATES IN THE *NURSES AWARD* WERE PROPERLY SET?

Introduction

16.1 The industrial history underpinning the *Nurses Award* demonstrates that the minimum rates and classifications in the pre-reform awards were the subject of several decisions relating to wage fixing and adjustments, special cases and work value determinations and a combination of state and national decisions. This section is broken into two parts:

(a) *First*, an analysis of the *Nurses (South Australian Public Sector) Award 2002* and *Nurses (ANF - South Australian Private Sector) Award 2003* (collectively, **the SA Awards**), the pre-reform awards used as the basis for the classification structure in the *Nurses Award*. This analysis also demonstrates that an application by nurses led to the Full Bench affirming the importance of properly fixed minimum rates.

(b) *Second,* an analysis of the pre-reform awards with respect to nursing employees. The purpose of this analysis is to set out the developments in minimum rates and classification structure prior to the award modernisation.

16.2 The combined effect of that analysis will demonstrate that whilst the rates in some pre-reform awards were described as properly set, it is unclear whether the existing rates in the *Nurses Award* were ever assessed as properly set.

Industrial History: *Nurses Award*

16.3 Prior to the modernisation process, nurses were regulated by a combination of state and federals awards.[184]

16.4 The pre-reform awards that were used as the basis for the classification structure of the *Nurses Award* were the SA Awards.[185]

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[184] See generally, *"Draft award audit by modern awards"* (excel spreadsheet): <https://www.fwc.gov.au/agreements-awards/awards/awards-research>.

[185] See AM2008/13, Transcript of Proceedings (3 December 2008) at paragraphs 27-42.

16.5 In 1998, the rates of the SA Awards were the subject of consideration by the Commission in the *Paid Rates Review decision***.** That decision concerned, *inter alia*, two applications by the Australian Nursing Federation (**ANF**) pursuant to item 49, Part 2 of Schedule 5 of the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth) (the **WROLA Act**) to vary the SA Awards.

16.6 The Full Bench determined:

> *"We accept the submissions that although the rates contained in the awards (excluding Appendix A) have been treated as paid rates awards in the past, they* ***are nevertheless properly fixed minimum rates with rates for the relevant classifications being within the acceptable range of relativities in relevant minimum rates awards.*** ***<u>We are also satisfied that the incremental salary levels for nurses and enrolled nurses within the classification structures of the two nursing awards form part of the work value assessment of nurses rates of pay conducted by Full Benches of the Commission in the development of professional rates for the nursing profession in federal awards</u>****. Accordingly, they are not affected by our decision. …*

16.7 However, the Full Bench also determined that the rates of pay in Appendix A, which concerned *"Wage Rates - Aged Care Sector"* were *"in excess of properly fixed minimum rates for nursing classifications".* As to the source of the discrepancy, the Full Bench said:

> *The rates were inserted by a Full Bench of the Commission on 16 February 1996 as a special case and increased wages by 10% for nurses employed in the aged care sector in SA. The 10% increase reflected a bargaining outcome achieved by the ANF in the SA public and private health sectors. In the light of our decision there are no grounds to retain those components of the rates in Appendix A which reflect the 1996 special case increase. The amount by which the rates in Appendix A exceed the rates in the Award proper should be identified separately and dealt with in accordance with the principles in this decision. Whether any consequential changes are required in Appendix A, is a matter to be dealt with at the settlement of the order giving effect to our decision. An appropriate order in accordance with the principles containing a residual component above the minimum rate is to be drawn up by the ANF …"*

16.8 The task of adjusting the rates in accordance with the principles was subsequently settled by Commissioner Smith.[186]

16.9 In 2003, Commissioner Hingley observed: *"All rates of pay in this award have been updated to include the arbitrated safety net adjustment payable under the Safety Net Review — Wages May 2002 Decision [PR002002] and* ***satisfy me they are properly set minimum rates as required by the above relevant principles****"* (emphasis added).[187] In respect of rates of pay, it was also noted that this award was part of applications before the Full Bench in the *Paid Rates Review decision*. The award was varied and titled *"Nurses (ANF South Australian Private Sector) Award 2003"*.

16.10 On 3 April 2009, the *Nurses Award* was published. The Full Bench made the following observation at that time:

> *"[152] In the Nurses Award 2010 there is also a classification for nursing assistant. We were asked both to delete this classification and to make it more relevant. There were concerns about an overlap between this classification and the personal care worker. We have decided to retain the classification in the Nurses Award 2010 and make it directly relevant to the work of nurses. In addition, we have adopted the suggestion of the ANF to provide an additional salary point at the Certificate III level."*[188]

16.11 On 22 December 2010, the Full Bench published a decision relating to the award modernisation and, in particular, the termination of certain instruments replaced by modern awards, which included consideration of the SA Awards.[189] Those awards were terminated on 21 July 2011 in accordance with item 3 of Schedule 5 of the *Fair Work (Transitional Provisions and Consequential Amendments Act) 2009*.

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[186] Appendix A had been assessed by Commissioner Smith in his Decision of 18 February 2000 (Print S3326) and his subsequent order of 18 February 2000 (Print S3327).

[187] *Nurses (ANF - South Australian Private Sector) Award 1989* (PR933237) [2003] AIRC 797 (7 July 2003) at [16].

[188] *Award Modernisation - Decision - Full Bench* [2009] AIRCFB 345 (3 April 2009) at [145] and [152].

[189] *Re Award Modernisation* [2010] FWAFB 9916.

Industrial History: Pre-Reform Awards

16.12 The following observations are supported by an analysis of the pre-reform awards (covering nursing employees) and the surrounding context:

(a) several pre-reform awards were subject to work value enquires, including applications made pursuant to the *"Special Case"* wage fixing principles, which incorporated reference to the structural efficiency and the changes in work value principles; [190]

(b) the majority of the pre-reform awards were set against:

(i) State Wage Case adjustments;

(ii) the minimum wage; and

(iii) arbitrated safety net adjustments;

(c) national consistent salary rates were fixed for the following classifications:

(i) RNs in level 1, 2 and 3;[191]

(ii) RNs in level 4 and 5;[192] and

(iii) ENs;[193]

(d) the rates of pay based on an assessment of work value of *"Nurses Aide (assistant)"* occurred in 2005, following which the role was re-classified as "Assistant in Nursing (aged care)";[194]

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[190] See example, *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402)

[191] See *Industrial Relations Commission Decision 904/1990* (Print J4011) [1990] AIRC 862 (21 August 1990).

[192] See *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402).

[193] See *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

[194] *Australian Nursing Federation - Re Classification structure* (PR965496) [2005] AIRC 1000, regarding the *Nurses Private Employment (A.C.T.) Award 2002.*

(e) the rates of pay based on an assessment of work value for ENs and RNs were last fixed in 1998; and

(f) the minimum rates in some of the pre-reform awards were expressly described as *"properly set"* against the applicable principles and with reference to the C10 framework.[195]

16.13 We now turn to a chronological analysis of relevant wage fixing and work value developments with respect to the pre-reform awards from 1970s through to 2005.

1970s

16.14 Following the *1972 Equal Pay Case*[196] there were number of decisions granting increases to nurses in Federal awards. These included several consent orders in the early 1970s whereby increases were granted. Those consent orders do not disclose the basis of the increases and there are no decisions making any express reference to the *1972 Equal Pay Case*. Movements in wage rates apart from those consent arrangements have been as a result of National Wage Case movements or changes in work value.[197]

16.15 On 27 June 1975, the RANF filed an application with respect to wages and working conditions of nurses, midwives and ENs employed in hospitals, nursing homes, rest homes or convalescent homes covered by the *Nurses (South Australia) Award*. On 16 March 1976, the Commission varied the award which included updated salaries for each classification.[198] The award was also subject to increases following the review of award wages by the Full Commission (SA), which were made without regard to work value[199]

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[195] See example, *Nurses (State) Award* and *Nurses Private Employment (ACT) Award 2002*.

[196] *Equal Pay Case 1972* (1972) 147 CAR 172 (**1972 Equal Pay Case**).

[197] See *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420; [1987] AIRC 135 (7 May 1987) (**"A257" decision**).

[198] South Australian Government Gazette, No 15, 1 April 1976, 1772-1776.

[199] See example, *2008 General Review of Award Wages and the Minimum Standard for Remuneration* [2008] SAIRComm 10 (20 August 2008).

16.16 This next section will trace the history of work value decisions, with some elaboration on more significant decisions.

1980s

16.17 In 1981, work value cases for nurses covered by Federal awards:

(a) in the Department of Veterans' Affairs (**DVA**) hospitals by Commissioner Taylor;[200]

(b) in the ACT by Commissioner Brack;[201] and

(c) for nurses employed by the Northern Territory Public Service by Deputy Public Service Arbitrator Watson.[202]

16.18 In the *Nurses Comparable Worth Case*,[203] the Commission affirmed that cases based on the "*1972 equal pay principle*" could be advanced through the *"anomalies conference procedure"* provided for in the wage fixing principles. However, in doing so the Commission rejected any wider proposition that wages could be fixed on the basis of *"comparable worth"* between different types of work that were not related or similar.[204]

16.19 In the *Nurses Comparable Work case*,[205] the Full Bench concluded:

> *"In summary, we say that the 1972 Equal Pay Principle is available to be implemented in awards in which it has not been implemented and that all such applications should be processed through the Anomalies Conference. From the material that was put to us it appears that all parties acknowledge that a number of special factors may be relevant to a review of nurses' salaries. It is our view that the pursuit of this claim through the Anomalies*

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[200] *"A257" decision*, citing (1981) 79 CPSAR 789.

[201] *Capital Territory Health Commission and Royal Australian Nursing Federation* (Print E8456) (1982) 269 CAR 66.

[202] *"A257" decision*, citing Print N547

[203] *Nurses Comparable Worth Case* (1986) 13 IR 108.

[204] *Pharmacy Case* at [149], citing *Nurses Comparable Worth Case* (1986) 13 IR 108 at 113.

[205] *"A257" Decision* citing Print G2250 (18 February 1986).

Conference should involve the raising of all those issues, including those referred to in the ACTU Executive decision of November 1985."

16.20 Following *Nurses Comparable Worth Case* pay equity claims were processed through the anomalies and inequities principle. (The anomalies and inequities principle was dropped in the *1991 National Wage Case*[206]).

"A257" decision

16.21 The *"A257" decision* concerned claims with respect to the wages, allowances and career structure of nurses whose conditions of employment are regulated by Federal awards (with the exception of RNs employed by the Australian Government in Victoria). It was observed at the outset, that nurses covered by Federal awards comprises *"a small portion of the total number of nurses within Australia"* with *"vast majority of nurses are subject to the terms of awards made by State Industrial Authorities".*

16.22 As to RNs in Victoria, the Commission said:

> *"By a decision of 6 August 1986 in matter A No. 262 the President granted a claim for resolution of Inequities pursuant to Principle 6(b) in respect of Registered Nurses employed by the Australian Government in Victoria. This decision resulted from an agreement reached between the parties to the Anomalies Conference involving the matching of rates of pay and award structure of Registered Nurses employed in Victoria by the Australian Government with the rates of pay and award structure of Registered Nurses covered by the Registered Nurses Award of the Industrial Relations Commission of Victoria. The agreement involved the withdrawal by the RANF from A No. 257 (the matter presently before us) of all those nurses subject to A No. 262, without prejudice to argument in favour of a national rate for nurses."*[207]

16.23 The Commission identified three categories of nursing personnel covered by the awards:

(a) RNs;

(b) ENs; and

[206] *National Wage Case 1991* (1991) 39 IR 127.

[207] *"A257" decision.*

(c) those undertaking training comprising ENs in Training and Student Nurses who are training to be RNs.

16.24 The RANF argued that there was inequity between nurses performing similar work who are subsequently paid dissimilar rate without good reason between awards (whilst not within the scope of the application, that argument extended to include reference to state awards). It was alleged that the rates were not properly fixed because the *1972 Equal Pay Case* had not been implemented in nurses' awards and because of the manner in which nurses' rates have been set.

16.25 As to changes in work, the following categories were relied upon:

> *"1. Increased patient dependency.*
>
> *2. New drugs, new techniques of drug administration and intravenous therapy.*
>
> *3. Changes in work orientation and the devolution of responsibility from medical officers.*
>
> *4. Technological changes and new procedures which have affected nurses' work.*
>
> *5. Staff shortages as they relate to nurses' work.*
>
> *6. Differences and changes in nursing techniques and functions.*
>
> *7. Changes in isolation and infection control which have come about through the advent of multi-resistant bacteria and new diseases.*
>
> *8. Changes in education necessitated by the other work value changes."*

16.26 The Commission made the following findings:

> *"In respect of the ACT, the NT and DVA hospitals in New South Wales, South Australia, Western Australia and Tasmania we are satisfied that there have been changes in the nature of the work, skill and responsibility of nurses which constitute a significant net addition to work requirements within the terms of Principle 4. This is acknowledged. We are also agreed that the changes are of a similar order to those relied upon by Mr Commissioner Wells in New South Wales and in the decisions of the other State tribunals referred to. Our conclusions generally in relation to work value changes are in harmony with these decisions.*

As we had no evidence in respect of the work of nurses at Repatriation General Hospital, Greenslopes in Queensland we cannot accept the RANF's submission that similar work value changes as those demonstrated in DVA hospitals in other States can be assumed for Commonwealth nurses in Queensland. We therefore make no finding as to whether Principle 4 has been satisfied in relation to these nurses."

16.27 The Full Bench, relevantly, held:

(a) the 1972 principle did not apply to RNs covered by federal awards;

(b) there were fundamental problems in the existing career structure;

(c) there was a shortage of nurses while there was a pool of qualified nurses outside the industry; and

(d) as to work value, as extracted above, they were satisfied that there had been changes in the nature of the work, skill and responsibility of nurses which constituted a significant net addition to work requirements within the terms of the work value principle.[208]

16.28 The Full Bench also rejected a movement towards *"professional rates"*, observed they had not been provided with *"any information or material which would justify a fixation of rates beyond the levels of the rates for nurses which have been assessed by recent decisions of State tribunals".*[209]

16.29 The Commission went on to grant a range of increases in respect of the awards before it on the basis of the identified anomaly, inequities and work value changes.

16.30 Between 1989 and 1990, the Commission delivered a series of decisions with respect to the rates for RNs in federal awards.

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[208] *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420 at 443; [1987] AIRC 135 (7 May 1987).

[209] *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420 at 446–447.

16.31 In *Industrial Relations Commission Decision 1052/1989* [1989] AIRC 1012 (21 December 1989), the Commission considered an application brought by the ANF and the Hospital Employees Federation of Australia to vary all federal awards and determinations regulating the salaries of registered nurses, for what are referred to as professional rates. The matter was referred under the *"Special Case"* provisions of the August 1988 and August 1989 National Wage Principles.

16.32 A useful summary of the decision was provided by the Commission in a subsequent decision: [210]

> *"In decisions handed down on 21 December 1989 (Print J0855) and 20 January 1990 (Print J1288) we determined that the ANF had made out a case for moving towards consistency of approach in the fixation of nurses' salaries. We said that we agreed with the objective of establishing nationally consistent rates and structures for nurses in federal awards, but that this would take time to achieve because of the differences previously existing in rates and conditions as between nurses in the various States and Territories.*
>
> ***As a first step towards national rates the Bench established a single entry point for registered nurses at level 1 in federal awards in all States and Territories except Tasmania, where an existing 4% differential was maintained. The percentage increase required to achieve the common entry rate was then applied to the existing salaries in each of the awards.*** *We indicated that we were not prepared to alter the internal relativities in the various awards, or to fix final rates, without greater attention being given to salary-related conditions. We said that whilst we believed that nationally consistent rates for nurses would be the best outcome in the long term, the concept of national rates was a fiction if it referred only to salaries. Differences in salary-related conditions, in particular those involving shift penalties, overtime and weekend work were to be addressed in structural efficiency negotiations in the various States and Territories and in relation to DVA hospitals. It was made clear that there would have to be significant progress on rationalisation of these conditions before there could be any further move towards nationally consistent rates. The*

[210] *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

Bench also indicated that the manner in which rationalisation of conditions was achieved would affect the final salary levels prescribed in these awards.

Commissioners Cross and Smith were delegated to deal with individual structural efficiency applications by way of conciliation and/or arbitration. This has now take place and first phase structural efficiency increases for nearly all of the nurses covered by these claims have been approved.

The matters were re-listed on 25 June 1990 to 'review final rates and relativities together with the timing of any further increases both in relation to the claims for more nationally consistent rates and structural efficiency.' It is now our task to assess the structural

efficiency results and to consider the new rates claimed for the classification structure in these awards. We have examined the Commissioners' decisions and are satisfied that the parties have properly addressed the structural efficiency principle taking into account the issues raised in our earlier decisions. It is anticipated that the latest decision of the Commissioners to be handed down today will enable the establishment of a consistent pattern of shift and weekend penalty rates in these award."[211]

16.33 By a 1990 Full Bench decision,[212] the Commission fixed national consistent salary rates for RNs in levels 1, 2 and 3 with salaries for levels 4 and 5 still to be determined (for completeness, Level 4 concerns "Assistant Directors of Nursing" (**ADONs**) and Level 5 are "Directors of Nursing" (**DONs**)). That application was heard alongside with an application for structural efficiency increased pursuant to the national wage decision of 12 August 1989. Rates were fixed for level 1, 2 and 3 with regard to work value consideration and structural efficiency adjustments.

[211] *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

[212] *I Industrial Relations Commission Decision 904/1990 (Print J4011)* [1990] AIRC 862 (21 August 1990).

16.34 A differently-constituted Full Bench on 21 December 1990 decided that Level 4 and Level 5 rates required still further attention from the parties; but it approved interim increases of 3.5 per cent at those levels.[213]

16.35 By a 1992 Full Bench decision,[214] salary increases were considered appropriate for Levels 4 and 5.

16.36 In an application brought by the ANF and HSU,[215] the following federal awards were subject to s 113 applications:[216]

(a) *Hospital Employees Etc. (Nursing Staff A.C.T.) Award 1980*;

(b) *Nurses Private Employment (A.C.T.) Award 1972*;

(c) *Nurses (Northern Territory Public Service) Award 1985*;

(d) *Nurses (Tasmanian Public Sector) Award 1988*;

(e) *Nurses (Tasmanian Private Sector) Award 1990*;

(f) *Nursing Staff (Repatriation Hospitals) Australian Nursing Federation Award 1991 (Determination No. 195 of 1970 [Nursing Staff - RANF])*;

(g) *Nurses (South Australian Public Sector) Award 1991 (Nurses (Registered Nurses - South Australian Public Hospitals and Health Agencies) Award 1989)*;

(h) *Nurses (ANF - South Australian Private Sector) Award 1989*;

(i) *Nurses (Northern Territory) Private Sector Award 1989*;

(j) *Doctors' Nurses (Northern Territory) Award 1980*;

(k) *Nurses (Government Subsidised Employers) Award 1989*;

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213 *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402) at 275, citing Print J6124.

214 *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402).

215 *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

216 *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

(l) *Nurses (Hetti Perkins Home For The Aged - Aboriginal Hostels Limited) Award, 1986*;

(m) *Nurses (Queensland Public Hospitals) Award 1991*;

(n) *Nurses (South Australian Public Sector) Award 1991*; and

(o) *Determination No. 3 of 1945 [General Staffs: Repatriation Institutions and Military Hospitals] Nurses (SA Mental Health Service) Award 1992*;

16.37 The applications were made pursuant to the Special Case wage fixing principle with reference to the structural efficiency and the changes in work value principles. The competing applications sought to provide for ENs a classification structure consistent with the objectives of those principles which has the following, *inter alia*, ingredients:

(a) wage levels which reflect relative skills attained and utilised at each classification level; and

(b) properly fixed internal relativities within the EN structure and within the nursing structure.

16.38 The differences between the unions' applications relate primarily to appropriate wage rates and relativities: in particular the number of levels within the proposed EN structure and the resultant relativities with the RN structure. Each union claims its structure, if adopted, would provide a further step in achieving the objective of properly fixed nationally consistent wage structures for nurses.

16.39 Having regard to the above history, it was observed:

> *"We have decided on the basis of the submissions before us that the historical perspective of this matter forms the basis for a special case pursuant to the August 1989 National Wage Case decision. We have considered the requirements of the relevant principles - structural efficiency and changes in work value within the parameters on which the anomaly was found to exist in the history of federal coverage of nurses in "A257". There is a requirement when determining rates and relativities under the work value changes principle that "structural*

efficiency exercises should incorporate all past work value considerations". As in other special cases we have found it unnecessary to compartmentalise the requirements of each principle.

The fundamental task facing the Commission in this matter is to ensure that the rates fixed for ENs bear a proper relativity having regard to internal and external comparisons. Such a requirement is implicit in the structural efficiency principle and explicit in the changes in work value principle. It is to that end result that we have directed our attention bearing in mind that one of the major grounds in support of the applications is the achievement of a national classification structure for ENs based on skill related comparabilities within the EN structure and with the RN structure. Those applications would be unnecessary if, by historical coincidence, the EN wage fixation in the various jurisdictions from which the federal awards are sourced were consistent in respect to rates and structures. It is because the pattern of award coverage is disparate and inconsistent, reflecting different backgrounds, that the applications are being pursued.

…

It is the new structure created for RNs with its own cohesive internal relativities which was set within an industry with a growing incidence of federal coverage which contributes to the circumstances in which we are asked to determine rates for ENs."

(Emphasis added).

16.40 The Commission made the following conclusions:

*"**The work of enrolled nurses was properly fixed as part of the "A257" case which fixed relativities for all classes of work of nurses. Since that decision a number of State tribunals have conducted work value or anomaly/special cases in respect to the nursing structure including ENs.** The classification structure of RNs has been fundamentally reviewed as part of a special case conducted in conjunction with structural efficiency exercise. **That case determined relativities different from those awarded in the "A257" case for reasons fully set out in relevant decisions. The parties foreshadowed their intention to conduct a review of EN rates following resolution of RN rates. As such the classification structure did not form part of the structural***

efficiency exercise for ENs but forms part of the special case which we have found to exist.

…

there is comparability in the work of ENs to attract a common classification structure across all awards; the increase in skills acquired and utilised as work experience increases with time can form the basis of a career path; a wage relationship between the EN and the RN Y1 should be established on work value grounds in fixing the limits of the classification structure.

Turning to the classification structure and salary levels we have decided that the awards will be varied to reflect the following:

…

The range is consistent with the relativity range 91% - 99% of the current registered nurse structure. The rates we have fixed are related to a Y1 RN who holds a UG 2 qualification. This represents the first stage position of the ANF. We have carefully considered the submissions of all the parties in relation to the treatment of EN relativities in the light of the shift of RN educational base from UG 2 to UG 1, the latter being awarded a higher starting point in the RN scale by a Full Bench decision. All employers opposed the automatic movement of the EN relativity to match the UG 1, describing such a move as premature, without foundation and industrially unsound. A number of submissions strongly challenged the unions' claims that the UG 2 classification would not have relevance in the future. Both the ANF and the HSUA argued that the changeover to UG1 was a viable goal to be progressively achieved in the States in the foreseeable future and that such a rate should be the appropriate ''enduring" benchmark.

…

In evaluating the work of the EN we note the planned developments in the educational area but stress that we have reached our decision on an assessment of the value of work including an assessment of the current educational base for an EN which is hospital based. However there can be no future double counting for increased work value arising out of changed educational qualification of ENs: for example in the form of accelerated entry together with a higher base relativity with the UG 1 qualified RN.

In making observations about the future educational preparation for an EN we further observe that a fundamentally important issue arising out of the evidence relates to the objective of a career path for ENs based on a skilled based classification structure. The attainment of this objective is shared by us and is consistent with the thrust of wage fixing principles based on restructuring since 1989. It forms an important part of the reason why we are prepared to adopt a new structure and definitions for ENs. We wish to make it clear on the basis of the material before us and our knowledge of the RN structure that the objective will be fully met when obstacles inhibiting ENs from advancing through to the RN structure are overcome. Until then we do not believe that opportunities for an integrated career path exist for all aspirants. However while the evidence of Ms Parkes in particular explains the interrelated developments in areas such as training, competency, accreditation, common standards etc, which as the ANF said, ''coalesce to give impetus to each other" the ultimate attainment of the objective is beyond the scope of this Commission. It remains however of fundamental importance to enable a genuine career path to be accessible to ENs working in the nursing profession."

(Emphasis added).

Award Simplification

16.41 The Full Bench of the AIRC delivered a test case decision on the simplification of federal awards on 23 December 1997.[217] The award simplification process means reviewing awards to see which provisions remain and which are to be removed. Where provisions are retained, the AIRC will attempt to ensure that they are easy to understand, that they support workplace efficiency and meet other tests. The 20 allowable award matters detailed in s 89A(2) of the *WR Act* provide primary guidance on provisions which will be retained in awards.

16.42 As part of the award simplification process, awards were varied so that they:

(a) act as a safety net of fair minimum wages and conditions of employment (s 88A(b) of the *WR Act*);

[217] *Award Simplification Decision* (Print P7500) (1997) 75 IR 272 (23 December 1997).

(b) are simplified and suited to the efficient performance of work according to the needs of particular workplaces or enterprises (s 88A(c) of the *WR Act*); and

(c) encourage the making of agreements between employers and employees at the workplace or enterprise level (s 88A(d) of the *WR Act*).

16.43 Several of the pre-reform awards were subject to this process following that test case.[218]

16.44 On 20 October 1998, the Commission published the *Paid Rates Review decision*, which set out the principles with respect to properly set minimum rates (considered earlier in these submissions).

2000-2005

16.45 In *Appln By Australian Nursing Federation To Vary Nurses Private Sector (ACT)*[219] (**ACT Decision**), the ANF commenced an application to vary the *Nurses Private Employment (ACT) Award 2002* pursuant to work value principles. The application sought to insert a new classification structure in relation to an *"Assistant in Nursing (Aged Care)"* and to update the wage rates contained in the award.

16.46 The ANF contended that, prior to 1990, the *"Nurses Aide (assistant) role"* was predominately one of personal care (e.g. feeding and dressing residents). By 2005, and primarily due to the increased requirements of the *Aged Care Act 1997* (Cth) and the increased acuity and dependency of residents, the role of the Nurses Aide (assistant), it was argued, has become more clinically focused.[220]

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[218] See examples, *ACT Nurses Award 2000 - re Award simplification* (PR902637) [2001] AIRC 279; *Aged and Disabled Persons' Hostels (ALHMWU) Interim Award 1996; Nursing Assistants (ALHMWU) Interim Award 1996; Private Hospitals and Nursing Homes (ALHMWU) Interim Award 1996 - re Award simplification* (PR910160) [2001] AIRC 1058.

[219] *Appln By Australian Nursing Federation To Vary Nurses Private Sector (ACT)* (PR 965496) (21 November 2005) (**ACT Decision**).

[220] *ACT Decision* at [10].

16.47 After considering the relevant work value considerations, the Commission was satisfied that an increase in work value justifies the insertion of a new classification structure in the award.

16.48 In making variations to the award, that were held to be justified by work value reasons, the Commission also ensured the proposed rates were aligned with the C10 classification and consistent with existing awards and principles. The Commission's observations, in this respect, are instructive:

> *[83] I am also satisfied that the wage rate proposed by the ANF for unqualified AINs appropriately recognises the role and responsibilities of an unqualified worker while providing sufficient incentive for employees to gain the relevant qualifications. The rate struck is slightly more than 89% of the C10 rate and has the advantage of just exceeding (albeit by little more than $1 per week) the current rate applying to Nurses Aide (assistant) under the award.*
>
> *[84]* ***I am also satisfied that the classification of Assistant in Nursing Level 2 is appropriately aligned with the C10 classification in the Metals Award.*** *I am also satisfied that further experience gained on the job at that level is appropriately remunerated by a further increment after one year to take the rate to 102% of the C10 rate. These rates are proposed by the ANF and consented to be the employers. To adopt these rates for an AIN with a Certificate III in Community Services (aged care) is consistent with the provisions of the Act and the Wage Fixing Principles. AINs in the aged care industry in the ACT will have similar rates of pay to those applying to qualified AINs employed under the Nurses Aged Care Award — State 2003 (Qld).*
>
> *[85] I am not satisfied that I have sufficient evidence before me to justify the awarding of a further increment to recognise experience gained after a second year of holding the Certificate III. Additionally, while the rate proposed by the ANF for the new Level 3 classification is apparently not opposed by the employers, I am not convinced that the evidence before me is sufficient to establish such relativities between an AIN with a Certificate III and another AIN holding a Level IV Certificate. The rate proposed by the AIN would result in a first year Level 3 AIN with Certificate IV qualifications having a minimum rate of pay under the award exceeding that of an Enrolled Nurse with one years' experience*

and the minimum rate for a Level 3 AIN with two years' experience exceeding that of an Enrolled Nurse with five years' experience. It may be that such rates can be justified but I am not persuaded that I have sufficient evidence before me concerning the relative qualifications and duties of Enrolled Nurses to accept this proposition.

[86] In this regard it is important to note that part of Principle 6 which states:

> *In addition to meeting this test a party making a work value application will need to justify any change to wage relativities that might result not only within the relevant internal award structure but also against external classifications to which that structure is related. There must be no likelihood of wage leapfrogging arising out of changes in relative position.*

[87] The majority of the evidence before me concentrated on the value of the Certificate III qualification and the duties and responsibilities given to AINs with this qualification. While some of the evidence went to the role of AINs with a Certificate IV qualification, and while I recognise that under the classification descriptors the AIN Level 3 position would be a promotable position, I am not prepared to insert a classification of Level 3 at the proposed rate in the absence of sufficient evidence to justify disturbing the relativities between the AIN and EN classifications. I note in this respect that, while the wage rates for Enrolled Nurses under the relevant Queensland State award are higher than those in this award, the maximum rate for an AIN does not exceed the minimum EN rate.

[88] I am, however, prepared to hear further evidence on the matter of an appropriate rate for the classification of AIN Level 3 to recognise the holding of a Certificate IV qualification.

[89] ***In reaching this conclusion I have accepted that this award contains properly fixed minimum rates as required by the legislation****. I am also satisfied that the variation I am prepared to make to the award meets the requirements of the legislation and the Statement of Principles.*[221] (Emphasis added)

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[221] *ACT Decision* at [84]-[89].

Conclusion: Industrial History

16.49 The industrial history underpinning the *Nurses Award* reveals that the classifications and wage rates of RNs, ENs and AINs have been subject to extensive review. Several work value applications were previously heard. Steps towards consistent minimum rates were achieved with decisions fixing minimum rates for the different levels of classification at a federal level.

16.50 Notwithstanding that history, which suggests that there may be a proper basis for finding the minimum rates in the *Nurses Award* were *"properly set"*, in order to reach a conclusion the minimum rates in the *Nurses Award* are properly set, reference must be made to a decision of the Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. Since the publication of the *Nurses Award*, it would not be controversial to conclude, this has not occurred.

16.51 The preceding industrial history may give the Commission some confidence to find there is some alignment within the existing classifications and minimum rates structure. However, the exercise of properly setting minimum rates against the C10 framework (and with regard for the AQF) is a deliberate exercise and one that we submit should be undertaken with respect to the existing classification structure in the *Nurses Award*.

17. WHETHER THE MINIMUM RATES IN THE *SCHADS AWARD* WERE PROPERLY SET?

Introduction

17.1 The industrial history underpinning the *SCHADS Award* demonstrate that the minimum rates and classification structures were not consistent throughout the pre-reform awards. This section is in two parts:

(a) *Firs*t, an analysis of the award modernisation process, together with identification of the pre-reform awards used as the basis for the classification structures and minimum rates in the *SCHADS Award*. This analysis will demonstrate that the structure of this award was the subject to extensive debate.

(b) *Second*, an analysis of the *Residential Award*, which provides an example of the overlap that exists within the aged care sector, home sector and disability sector. [222]

17.2 The combined effect of that analysis will demonstrate that whilst the rates in some pre-reform awards were described as properly set, and references were made to the C10 framework in submissions during the award modernisation, it is unclear whether the existing rates for home care employees in the *SCHADS Award* were ever assessed as properly set.

Industrial History: *SCHADS Award*

17.3 At the outset, it should be noted that the *SCHADS Award* covers four sectors:

(a) crisis assistance and supported housing sector;

(b) social and community services sector;

(c) home care sector; and

(d) family day care scheme sector.[223]

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[222] *Residential and Support Services (Victoria) Award 1999.*

[223] *SCHADS Award*, cl 4.2.

17.4 Several pre-reform awards addressed those sectors either individually and/or in combination.[224] Of those pre-reform awards, five were used as the basis for the classification structure and rates in the *SCHADS Award*.

17.5 In *Award Modernisation - Statement - Full Bench* - [2009] AIRC 865; [2009] AIRCFB 865 (25 September 2009), the Full Bench set out the pre-reform awards that formed the basis of classifications and wage rates in the *SCHADS Award* exposure draft:

(a) The classification and wage rates for *"social and community service employees"* largely reflect the *Social and Community Services (Queensland) Award 2001*.[225]

(b) The classification and wage rates for *"crisis accommodation employees"* reflect the *Crisis Assistance Supported Housing (Queensland) Award 1999*. It was also noted that those employees *"have been integrated into the social and community services employee wage rate structure taking into account qualification levels".*[226]

(c) The wage rates and definitions for *"family day care employees"* were derived from the federal *Family Day Care Services Award, 1999*.[227]

(d) The classification structure and wage rates for *"disability service employees"* largely reflect the *Residential and Support Services (Victoria) Award 1999*.[228]

(e) The wage rates and classification definitions for *"home care employees"* are based on the *Home and Community Care Award 2001*. It was also observed that "[t]he wage rate for a Certificate III qualified home care employee (grade 3) is the same

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[224] See generally, *"Draft award audit by modern awards"* (excel spreadsheet): https://www.fwc.gov.au/agreements-awards/awards/awards-research.

[225] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865; [2009] AIRCFB 865 (25 September 2009) at [101].

[226] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865 at [102].

[227] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865 at [103].

[228] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865 at [104].

rate as for a similarly qualified aged care employee (level 4) in the *Aged Care Award* 2010".[229]

17.6 As to pre-reform awards relating to social and community service, the Full Bench said:

> *"[101] … There are federal awards in this sector in all states except New South Wales, Tasmania and South Australia, where there are NAPSAs. The wage rates in the federal Australian Capital Territory, Western Australian and Queensland awards were reviewed as part of the award simplification process in 2002. They are all currently very similar. The New South Wales NAPSA provides for generally higher wage rates than the federal awards. The South Australian and Tasmanian NAPSA wage rates are generally lower than the federal awards. In adopting the federal Queensland award wage rates, we note that s.576(L) of the WR Act requires that modern awards provide a fair minimum safety net."*

17.7 At the time of consideration, it may also be noted, the *Queensland Community Services and Crisis Assistance Award – State 2008* (**Queensland SACS award**) wage rates were significantly higher than the wages in the federal and other state awards applying in the SACS industry.[230] However, the rates published in the exposure draft as to crisis accommodation workers were lower than that award.[231]

17.8 As to the pre-reform awards relating to disability services, the Full Bench said:

> *[104] Award coverage of disability services employees is currently spread over federal awards (Australian Capital Territory, Victoria and Northern Territory) and NAPSAs (New South Wales, Tasmania, South Australia and Queensland). Wage rates are largely comparable between the federal awards (the Australian Capital Territory award is slightly higher). The New South Wales NAPSA wage rates are again the highest rates. All of the other State NAPSAs contain generally lower rates.*

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229 Award Modernisation - Statement - Full Bench [2009] AIRC 865 at [106].

230 *Equal Remuneration Case* [2011] FWAFB 2700 (16 May 2011) at [2].

231 *Equal Remuneration Case* at [2].

17.9 On 5 November 2009, at a hearing with respect to the award modernisation, the exposure draft of the *SCHADS Award*, *"social and community services employee level 2, which is pay point 1"* was identified as the *"equivalent C10".*[232]

17.10 During the award modernisation process, support for aged persons or persons with a disability in their home was covered by both the *SCHADS Award* and *Aged Care Award*, with coverage subject to the industry of the employee. In a later decision, the Full Bench determined *"home care employees will be solely covered by the Social, Community, Home Care and Disability Services Industry Award 2010".* A clear decision was made to not include *"home care employees"* under the *Aged Care Award.*[233]

17.11 In December 2009, the Commission published the *SCHADS Award*.

17.12 As to the classifications and minimum rates, the Full Bench observed:

> *"[80] We have decided to make a modern award based on the terms of the exposure draft but with a number of alterations some of which we deal with below. The award will include the classifications and* ***minimum wages which appear to us, on the material available at this time, to be appropriate for a modern award in this industry****. We accept the force of the submissions made that in the circumstances it would be inconvenient to say the least to introduce new classifications and minimum wages for the industry covered by the award when a significant case is contemplated before Fair Work Australia next year. We have decided that the operative date for the implementation of the new classifications and wages should be delayed until 1 July 2011."*[234]

17.13 The decision referred to in that passage was the *Equal Remuneration Case* [2011] FWAFB 2700 (16 May 2011) (the **Equal Remuneration Case**).

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[232] AM2008/24, Transcript of Proceedings [2009] FWATrans 864 (24 November 2009) at [PN3067]-[PN3074].

[233] *Award Modernisation - Decision - re Stage 4 modern awards* [2009] AIRCFB 945 (4 December 2009) at [77].

[234] *Award Modernisation - Decision - re Stage 4 modern awards* [2009] AIRCFB 945 (4 December 2009) at [80].

17.14 By that publication, the *SCHADS Award "replaced, in whole or in part, the provisions of a number of federal and state awards previously applying in the industry. While the modern award contains a new classification structure and wage rates, when the award was made it contained a provision that the wage rates should not operate until 1 July 2011"*.[235]

17.15 The operation of rates was further delayed until 1 February 2012.[236] In this respect the *SCHADS Award* was different to the *Aged Care Award* and *Nurses Award* which both commenced on 1 July 2010.

17.16 Shortly after being made in 2010, the industrial history of the SACS Award was diverted with the *Equal Remuneration case*. In looking at minimum rates and the notion of properly set minimum rates, the Commission need not be unduly delayed by consideration of this decision because:

(a) it is arguable the decision was erroneously decided given the reasoning in the *Equal Remuneration Case 2015*;[237] and

(b) that decision was given effect to by an equal remuneration order and does not concern the setting of minimum rates and is not otherwise governed by ss 157, 134 or 284.

Industrial History: Pre-Reform Awards

17.17 As mentioned above, the *Residential Award* commenced on 28 October 1999. That award was held to be properly fixed in accordance with the *Paid Rates Review decision* and, in all other respects, meet the requirements of the *WR Act*.[238] That award was a *"stand alone"* award for employees within the disability services sector. It applied to the whole of Victoria

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[235] *Equal Remuneration Case* at [4].

[236] *Determination - Social, Community, Home Care and Disability Services Industry Award 2010* (PR508395) [MA000100] (12 April 2011).

[237] *Equal Remuneration Case 2015* (2015) 256 IR 362; [2015] FWCFB 8200.

[238] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999).

in relation to persons employed in direct client support roles in residential and/or non-residential support services for people with disabilities and/or young people and/or children.[239] That award also provided that the Residential Award was to prevail to the extent of any potential inconsistency under the *HASA Award*.[240]

17.18 The Commission determined that the Residential/Support Services Worker Grade 3 classification is properly equated to a C10. In the draft produced by the parties, they proposed a base rate less than the C10, but adjusted the other classification rates at the base level by maintaining existing internal relativities. The Commission specifically considered the impact the lower rate on the rates in the second and third years of each grade.

17.19 Notwithstanding the reduction to the base pay of the key classification, having considered the evidence, the Commission concluded *"the rates of pay at the base level and in the second and third year are fixed at an appropriate level on work value grounds".*[241]

Conclusion: Industrial History

17.20 The industrial history with respect to the *SCHADS Award* suggests that the classifications and minimum rates that appear in the *SCHADS Award* were the subject of extensive consideration, with reference to a combination of pre-reform awards that were considered properly fixed.

17.21 Despite that history, as previously mentioned, in order to reach a conclusion the minimum rates in the SCHADS Award are properly set, reference must be made to a decision of the Full Bench that expressly assesses the minimum rates by reference to the C10 framework

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[239] *Residential and Support Services (Victoria) Award 1999*, cl 4.2.

[240] *Residential and Support Services (Victoria) Award 1999*, c 4.3.

[241] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999) at [20].

and the AQF. Whilst the award has been the subject of much consideration, it would not be controversial to conclude that no such assessment has occurred.

17.22 The industrial history may support a finding that there is some alignment within the existing structure, however, the exercise of fixing properly set minimum rates must be undertaken in an express fashion. This exercise should occur with respect to all minimum rates in the *SCHADS Award.*

19. THE WORK PERFORMED BY AGED CARE EMPLOYEES

Introduction

19.1 This next section considers the *"changes"* that have occurred in the work of aged care employees and will distinguish between changes that are genuine work value reasons and those that are not. Having regard to the work value reasons listed at s 157(2A) and the work value consideration summarised above we will consider each classification stream in turn:

(a) personal care workers;

(b) general and administrative support workers; and

(c) food services workers.

(a) Personal Care Workers

19.2 At the outset of this analysis we note that personal care workers and AINs perform the same work. As previously mentioned, the terms are regularly used interchangeably. As such, the following observations and conclusion made with respect to personal care workers will apply to AINs.

The nature of the work

19.3 The nature of work performed by personal care workers has been impacted by two main changes to the aged care sector within the past decade:

(a) As evinced by the preceding overview of the aged care sector, the composition of aged care consumers *has* changed within the past 10 years. This has resulted in consumers entering residential aged care later in life[242] and with higher needs.[243]

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[242] Statement of Paul Sadler dated 1 March 2022 [57] (**Statement of Paul Sadler**); Supplementary Statement of Dr Gabrielle Anne Meagher dated 27 October 2021, Annexure GM-1: "Supplementary Expert Report", page 6. See Statement of Craig Smith dated 2 March 2022 at [34]-[40] (**Statement of Craig Smith**).

[243] Statement of Emma Brown dated 2 March 2022 at [44] (**Statement of Emma Brown**); Statement of Craig Smith at [39] and [61]-[63]; Statement of Paul Sadler at [58].

The majority of consumers are now have clinically more complex needs and are frail and have many more cognitive and mental health issues than in the past (including dementia).[244] Consumers are also staying in residential aged care facilities for shorter durations.[245]

(b) The introduction of the Quality Standards has also resulted in a shift to *"consumer focused care"*, this reform reinforced the *"focus"* of aged care is upon the in individual consumer.[246]

19.4 The combination of those two changes to the aged care sector has resulted in the following *"changes"* to the nature of the work performed by a personal care worker:

(a) ***Consumer preferences factored.*** Catering to the needs of the consumer is informed by the preferences of the consumer.[247] For example, the time in which assistance with showering is provided is not at the convenience of the personal care work but scheduled at time consistent with the preference of the consumer.[248]

(b) ***Consumers need more assistance*.** An increased number of consumers requiring *"more"* assistance. This extends to both general care needs (such as *"moving, getting out of bed, toileting, eating"*[249]) and responding to the needs of consumers less mobility.[250] This results in the following:

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[244] Statement of Dr Kathleen Eagar dated 29 March 2021, Annexure KE-1: *"Expert Report on Residential Aged Care"*; Statement of Emma Brown at [44]; Statement of Paul Sadler at [53]-[55] and Annexure PS-08; Statement of Kim Bradshaw dated 4 March 2022 at [13]-[14] (**Statement of Kim Bradshaw**).

[245] Statement of Craig Smith [64]-[65]; Statement of Mark Sewell dated 3 March 2022 at [56] (**Statement of Mark Sewell**); Statement of Emma Brown [44(c)]; Statement of Johannes Brockhaus dated 3 March 2022 at [35]-[37] (**Statement of Johannes Brockhaus**); Statement of Paul Sadler at [53]-[55] and Annexure PS-08.

[246] See Statement of Johannes Brockhaus at [25].

[247] See Statement of Craig Smith at [31] and [33]; Statement of Paul Sadler at [25].

[248] See Statement of Emma Brown at [23]-[24]

[249] See example, Statement of Anita Field dated 30 March 2021 at [41].

[250] See Statement of Craig Smith [63]; See generally, Statement of Kim Bradshaw at [29]-[59].

(i) more time is spent assisting consumers;[251] and

(ii) an increasing prevalence of physical support (with the support of mechanical aids) to lift and reposition.[252]

For example, Warrigal has gone from 10% of consumers in hospital style beds, to now having 100% electric beds. Electronic lifters are now available for all employees to assist employees lift heavy and immobile residents. [253]

(c) ***Reduced emphasis on recreational activity.*** Due to the increasing frailty of consumers, some residential care facilities have ceased organising *"bus trips"* as social group activity. See example, Evergreen.[254]

(d) ***Emotional impact.*** The emotional impact of assisting persons with consumers with complex health problems and/or the grief associated with the death of a consumer.[255]

19.5 As to those changes, the following observations may be made:

(a) The increase in regulation with respect to the aged care sector has had no material impact upon the work of the personal care workers.[256]

(b) In contrast, the shift in core philosophy, namely, the focus upon *"consumer-directed care"* has had a modest impact on the need for sociability with the consumer. This shift requires the consumer's preference to be the priority, in particular, with respect

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[251] See Statement of Craig Smith at [66].

[252] Statement of Mark Sewell at [52], [60]-[61] and [117].

[253] Statement of Mark Sewell at [61].

[254] See Statement of Kerrie Boxsell dated 31 March 2021 at [66]. See also Statement of Johannes Brockhaus at [30]-[33].

[255] See example, Statement of Alison Curry dated 30 March 2021 at [60]; see also Statement of Kim Bradshaw at [34].

[256] See Statement of Mark Sewell at [112]; Statement of Craig Smith at [32].

to the scheduling of care. A prime example of this change in practice is that the timing of showering is set in accordance with the wishes of the consumer.

(c) The presence and/or prevalence of persons with high care needs is not dramatic or unanticipated in the context of residential aged care. The personal care worker has always assisted with the varying needs of consumer, which is informed by the individual consumer. However, the increased access and availability of technological aides has reduced some of the intense physicality of the work that existed in the past when catering to the needs, for example, of the immobile.[257]

(d) The number of consumers with high care needs has increased workload generally. This has had an impact upon the intensity of the work, with high needs consumers requiring more time for their needs to be met.[258] For example, consumers with commodities or dementia. Whilst the demographic change has not transformed the nature the tasks being undertaken by the personal worker, and it possible that part of this increased intensity may be attributed to the issue of staffing levels, this intensity has impacted at least to some degree the overall nature of work performed.

19.6 The primary change to the nature of the work performed by personal care workers is one of intensity resulting from the change in demographic of the consumer and the increased number of consumers with higher needs. The personal care worker is also expected to take more time attending to consumer needs, especially when consistent with the provision of "*consumer-directed care".*

The level of skill or responsibility involved in doing the work

19.7 Turning to the level of skill or responsibility involved in doing the work, the following observations can be made about personal care workers:

[257] See Statement of Emma Brown at [51]-[52].

[258] See Statement of Johannes Brockhaus at [29]; Statement of Kim Bradshaw at [25].

(a) ***Functional and cognitive impairment:*** There is greater difficulty and more potential for adverse outcomes associated with the delivery of personal care to residents with greater frailty, cognitive impairment or complex behaviours. There have always been a significant number of people in residential care who are cognitively impaired, high levels of frailty or functional impairment, but the increase in the number of such people over the past two decades has increased the frequency with which personal care workers are delivering care to people in these circumstances.

(b) ***Care plan****:* personal care workers in residential aged care are required to observe consumers, identify changes in countenance, appearance, behaviour and wellbeing and update charts.[259] They are at the *"frontline"* but not required to make decisions about care plans absent instruction and direction from the RN.[260]

Additionally, personal care workers must always follow instructions relating to care plan - whether the consumer is low needs or high needs - a consumer's care plan has been individually tailored by the RN with the consumer and is to be followed with precision.[261] There is also a greater expectation that personal care workers will be attuned to the expressed preferences of the older person in the delivery of the care plan.

(c) ***Medication:*** whilst the responsibilities of a personal care worker - with respect to medication - is not consistent across the states and territories, the responsibility for the *administration* of medications in residential care facilities is the RN.[262]

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[259] Statement of Mark Sewell at [38]-[39]; Statement of Kim Bradshaw at [25].

[260] See Statement of Mark Sewell at [116]-[118]; Statement of Emma Brown at [62]-[63].

[261] See Statement of Emma Brown at [58]-[64].

[262] See example, Statement of Emma Brown at [72].

In the states and territories that do allow personal care workers to *"assist"* with medication, they require appropriate training in medication administration.[263] Their responsibility is then limited to providing a *"prompt"* or pushing a pill out of a blister pack. Significantly, not all personal care workers assist with medication prompts.[264]

(d) ***Technology*:** many residential care facilities have transitioned from paper reliance to electronic systems. This is an evolvement within the industry, adopting modern technology that is simply learnt and once understood assists with streamlining processes to lessen physical paperwork.[265] Workers joining residential care facilities often commence with a working knowledge of social media, search-engines, online usage and texting, these general skills are transferrable to the system used by residential care facilities.[266]

(e) ***Organisation and administration:*** the mandatory reporting obligations that impact upon provider compliance do not increase the administrative duties of personal care workers. This task falls to RNs and the provider.[267]

(f) ***Interpersonal with consumer****:* personal care workers have always had an interpersonal element to their role.[268] The act of caring for another human being has *never* been characterised or attended upon mechanically or robotically. However, as mentioned above, a shift in the core philosophy of aged care has resulted in this crucial element of personal care work being emphasised.

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[263] See Statement of Johannes Brockhaus at [82]; Statement of Emma Brown at [73] and [76]; Statement of Paul Sadler at [80]-[84]; Statement of Anna-Maria Wade dated 4 March 2022 at [53] and Annexure AM-10 (**Statement of Anna-Maria Wade**).

[264] Statement of Anna-Maria Wade [51]-[53]; Statement of Mark Sewell at [124]-[126]; Statement of Emma Brown at [75]; Statement of Paul Sadler at [83].

[265] See Statement of Emma Brown at [81]-[83]; Statement of Paul Sadler at [96]-[97].

[266] Statement of Mark Sewell [84]-[87].

[267] Statement of Mark Sewell [32]-[38]. See Statement of Paul Sadler at [34]-[35].

[268] See Statement of Paul Sadler at [88] and [90].

(g) ***Engagement with consumer families:*** personal care workers are required to have a level of good customer service, interpersonal skills and personal interaction with the family. This has always been the case.[269] They are trained to know when to refer matters on to supervisor and/or RN.[270] The RN or care manager is responsible for reporting on clinical matters to families.[271] The extent of communication by a personal care worker is generally limited to general observations, with an expectation that all conversation is conducted in a friendly and helpful manner, but it does not extend to responding to complaints.[272]

(h) ***Contacting external services:*** An increase in complex health care needs, such as palliative care, has resulted in increased use of external services. For example, consumers who need palliative care at Warrigal are supported by an external palliative care provider engaged by Warrigal. That external provider then sends a clinical team to assess the consumer and helps develop their care plan based on their expertise in the area. A specialist palliative nurse from the external provider will visit the consumer regularly and monitor changes over time. The local health district also has palliative care nurses who are available 24 hours per day to assist with complex issues that may occur outside of the external palliative care providers operating hours.[273]

The increase in palliative consumers has generally not impacted the way that the work is being performed as this is tended to by the specialist provider. This

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[269] Statement of Mark Sewell at [96]. See also, Statement of Johannes Brockhaus at [39]; Statement of Paul Sadler at [90]-[91].

[270] See Statement of Emma Brown at [79] and Annexure EB-12.

[271] Statement of Mark Sewell at [100]-[101] and [104]; Statement of Johannes Brockhaus at [45].

[272] Statement of Mark Sewell at [96] and [104]; Statement of Paul Sadler at [88].

[273] Statement of Emma Brown [40]-[42].

engagement of external services has not materially impacted the day-to-day responsibilities of the personal care worker.[274]

19.8 The tasks performed by the personal care worker have, as a result of the evolution of the role over time, combined with a shift in core philosophy, become very much centralised upon the consumer. In the result, the interpersonal aspect of the role has received increasing emphasis and is recognised as an important part of the service provided. As such, whilst the level of responsibility with respect to interactions with the family has not changed, there is an increasing expectation that personal care workers will interact to some extent with families (primarily driven by the expectations of family members).

[274] See Statement of Johannes Brockhaus at [42].

Conditions under which the work is done

19.9 Turning to the conditions under which work is done, the following environmental changes may be noted:

(a) The introduction of the *"household model"* for delivery of care. Under this model, consumers may be in smaller groups with living arrangements akin to a *"share house".*[275]

(b) A shift away from multi-bedrooms and hostel style accommodation for consumers with lower needs to the majority being in single rooms with ensuites.[276]

(c) Facilities being retrofitted and/or *"purpose built"* single-rooms to accommodate caring for individuals with higher needs. Under this model, the provision of residential care becomes less like a hospital and more like a home.[277] This has allowed for easier use of mechanical aids, more room to assist the consumer with physical tasks (such as getting out of bed and showering) and providing more dignity for the consumer.[278]

19.10 The shift in working environment in residential aged care facilities has had a positive impact upon the personal care worker. In the past, the personal care worker worked in an environment that was institutional in nature. Now, the environment is purpose built, resembles a hotel environment that is also more aesthetically pleasing. This change has in many respects improved the ease at which personal care work is performed.

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[275] Statement of Lauren Hutchins dated 1 April 2021; Statement of Marion Jennings dated 26 March 2021.

[276] Statement of Craig Smith [68]-[69]; Statement of Paul Sadler at [60]-[61].

[277] Statement of Emma Brown [40]-[42]; Statement of Mark Sewell [59] and [65].

[278] Statement of Paul Sadler at [62]-[64].

Conclusion

19.11 It is true that in many respect the personal care worker is still performing the same role that existed for the past two decades, which consists of providing care and assistance with basic fundamental tasks. However, as observed, the work has been subject to change over time. In some respects, the work to be performed has been eased with the introduction and increasing prevalence of technology aides and the overall improvement in the working environment at residential aged care facilities has moved away from institutional and hospital-like settings to emphasis upon creating an environment closer aligned to a home. In other respects the work has attracted some challenges, most notably due to the increase in intensity that accompanies a consumer demographic that is predominantly high needs and the emphasis upon delivering consumer-centred care. and the shift in supervision to more general supervision within an operating routine

General and Administrative Services Workers

19.12 The general and administrative services stream is broad and covers a diverse range of worker in the aged care sector including, *inter alia*, maintenance, administration, gardening and cleaning.

Evidence

19.13 For the assistance of the Commission we identify the witness statements relevant to each of category of work under the general and administrative services stream.

19.14 **Gardening and Maintenance:**

(a) Statement of Kevin Mills dated 30 March 2021. Mr Mills was employed as a “greenkeeper” at Woonona-Bulli RSL for 12 years, before taking on the position of “gardener” at Warrigal Aged Care Facility in 2000.

(b) Statement of Andrew White dated 23 March 2021. Mr White is a *“Property Concierge Maintenance Officer”* at Warrigal.

(c) Statement of Stephen Barnes dated 28 March 2021. Mr Barnes is a "Property Concierge Maintenance Officer" at Warrigal.

19.15 **Administration:**

(a) Statement of Kathy Sweeney dated 1 April 2021. Ms Sweeney is an "Administration employee" at Huon Regional Care. She has worked in administration within the aged care sector for 14 years.

(b) Statement of Fiona Gauci dated 29 March 2021. Ms Gauci works as an *"Administration Office"* at Uniting Edinglassie Emu Plains. She has held that position since 2013.

(c) Statement of Lynette Flegg dated 30 March 2021. Ms Flegg commenced work as an "Administration Assistant" at Marion in 2010.

(d) Statement of Michelle Harden dated 30 March 2021. Ms Harden has worked at Royal Freemasons Benevolent Institution (**RFBI**) in Basin View Masonic Village for thirteen years. She worked in "administration" (and kitchen) for 10 years.

(e) Statement of Pamela Little dated 30 March 2021. Ms Little commenced employment with Uniting Wirreanda West Pennant Hills (**Uniting**) as an Administration Officer in 2011.

(f) Statement of Ross Heyan, Client Service Assistant / Admin Assistant.

19.16 **Cleaning and Laundry:**

(a) Statement of Agnes Charlier dated 31 March 2021. Mr Charlier worked shifts as a Cleaner and Laundry Hand (in addition to Kitchen Hand) at Hardi Aged Care between 2000-2017. He commenced work as a Cleaner in the aged care sector in 1998.

(b) Statement of Carol Austen dated 29 March 2021. In 2006, Ms Austen commenced work as a *"Cleaner"* at Uniting at the Caroona Jarman facility in Goonellabah.

(c) Statement of Tracy Roberts dated 23 March 2021. Ms Roberts commenced work as a Cleaner with Mt St Vincent in 2011 (subsequently Respect Group).

(d) Statement of Ms Harden (referred to above). Ms Harden also work in laundry service and as a cleaner at RFBI.

(e) Statement of Roseann Sodermans dated 1 April 2021. Ms Sodermans is employed as a Cleaner at Hakea Grove Residential Aged Care Facility.

(f) Statement of Anita Field dated 30 March 2021. In addition to shifts as an Assistant in Nursing, Ms Field also worked as a "Laundry Hand" at Leigh Place from 2015.

(g) Statement of Sandra O'Donnell dated 25 March 2021. Ms O'Donnell has worked in carer, cleaning and laundry positions at RSL LifeCare.

(h) Statement of Deborah Maree Kelly dated 31 March 2021. Mr Kelly works at John Goodlet Manor. Her duties include cleaning and laundry work.

(i) Statement of Kim Bradshaw dated 4 March 2022. Ms Bradshaw is a General Manager at Warrigal and provides a details account of the day-to-day duties of Laundry and Maintenance staff at Warrigal.[279]

(j) Statement of Johannes Brockhaus dated 3 March 2022. Mr Brockhaus is the Chief Executive Officer of Buckland Aged Care Services, a not-for-profit provider of aged care services to the Blue Mountains community.[280]

The nature of the work

19.17 The nature of work performed by general and administrative services workers has been impacted by the change in profile of the consumer and regulations. However, for the following reasons, the impact does not amount to a *"significant net addition to work requirements".*

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[279] See Statement of Kim Bradshaw at [114]-[124].

[280] Statement of Johannes Brockhaus at [2] and [7].

19.18 *First*, the requirement for all aged care employees to integrate *"consumer focused"* thinking into their day-to-day simply emphasises an aspect of their work. For example:

(a) In ***maintenance***, workers engage in conversation with consumers and, where deemed appropriate, involve the consumer by explaining the work that needs to be done and/or asking permission before proceeding to attend to a task.

(b) In ***gardening***, workers have regard to the practical and social needs of the consumers. As to the practical, garden designs are informed by considerations unique to aged care sector and the consumers. For example, certain plants may cause irritants (and so are avoided). As to social needs, consumers may be actively engaged in the process of maintaining their own patch of garden to greatest extent possible.[281]

(c) In ***administration***, in addition to answering phone at reception, workers may liaise with consumers to make appointments. For example, to go to the hairdresser. The administrative staff may also liaise with families and external parties attending the residential care facilities.[282]

(d) In ***cleaning***, cleaners are encouraged and/or required to avoid cleaning when a consumer is present. This requires adjustments to scheduling.[283]

19.19 That regard for the dignity of the consumers of aged care has been emphasised, this is not a change to the work performed. All workers in aged care are expected to interact with consumers with respect and treat them with dignity.[284] The consumer-focused principles reinforce that aspect of aged care services. The services in the general and administration stream have not been subject to significant change in the past decade.

[281] See example, Statement of Kevin Mills dated 30 March 2021 at [20]-[22].

[282] See example, Statement of Kathy Sweeney dated 1 April 2021 at [32].

[283] See Statement of Tracy Roberts dated 23 March 2021 at [145(a)].

[284] See Statement of Johannes Brockhaus at [136].

19.20 *Second,* the increased number of elderly consumers and/or consumers with high care needs has increased the workload of laundry employees. This is because consumers with dementia and/or late in years have a higher frequency of incontinence.[285] Clothing and sheets that have been soiled undergo thorough cleaning and sanitisation, which takes longer than ordinary dirty laundry.[286]

19.21 That increase in workload, however, has not resulted in increased pressure on skills and the speed at which vital decisions are made. Rather, it has increased the level of time required to spend doing tasks within the usual scope of duties. Any pressure resulting from the increased amount of laundry goes to the issue of staffing levels and not work value.

The level of skill or responsibility involved in doing the work

19.22 Turning to the level of skill or responsibility of general and administration worker, it remains unchanged. Each category of worker - maintenance, gardener, administrative staff, laundry staff and cleaning staff - are performing the same duties they have always performed.

19.23 The principal changes that have been identified are that they may spend more time doing a selection of duties (referred to above) and are exposed to an increasing number of consumers classified as high care. However, neither of those changes amount to significant change.

Conditions under which the work is done

19.24 As to the conditions under which work is done, we repeat our submissions advanced with respect to personal care workers. Those submissions also apply to general and administrative services workers.

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[285] Statement of Sandra O'Donnell dated 25 March 2021 at [99]; see also Statement of Anita Field dated 30 March 2021 at [28] and [41].

[286] Statement of Sandra O'Donnell dated 25 March 2021 at [100], see also [42]-[47].

Conclusion

19.25 In short, general and administrative services workers are still performing the same roles which have existed for the past two decades, providing assistance with specific categories of tasks including: administration, maintenance, gardening, laundry and cleaning.

Food Services Workers

19.26 The food services stream covers kitchen hands through to senior chef within the aged care sector.

Evidence

19.27 For the assistance of the Commission, the following statements are identified as relevant to the food services stream:

(a) Statement of Darren Kent dated 31 March 2021. Mr Kent commenced his career in aged care in 2004 as the Head Chef at Amity House at Aranda. As at 2021, he is the Head Chef at Warrigal.

(b) Statement of Mark Castieau dated 29 March 2021. Since 2004, Mr Castieau has worked as a Chef at St Vincent's Care Services in Edgecliff NSW. Prior to that he spent two years as a Chef at United Aged Care Georgina House in North Sydney.

(c) Statement of Lindy Twyford dated 1 April 2021. Ms Twyford has held several food services roles, including Head Cook and Head Catering Manager in the aged care sector.

(d) Statement of Kim Bradshaw dated 4 March 2022. Ms Bradshaw is a General Manager at Warrigal and provides a details account of the day-to-day duties of Kitchen Staff, Servery and Chef at Warrigal.[287]

[287] See Statement of Kim Bradshaw at [83]-[100].

(e) Statement of Anita Field dated 30 March 2021. Ms Field worked parttime as a Chef at Australian Unity from 2015.

(f) Statement of Agnes Charlier dated 31 March 2021. Mr Charlier worked shifts as a Kitchen Hand (in addition to Cleaner and Laundry Hand) at Hardi Aged Care between 2000-2017. He commenced work as a Kitchen Hand in the aged care sector in 1998.

(g) Statement of Carol Austen dated 29 March 2021. In 2013, Ms Austen commenced work as a *"Kitchen Hand / Cook"* at Uniting at the Caroona Jarman facility in Goonellabah.

(h) Statement of Tracey Colbert, Food Services Assistant.

(i) Statement of Johannes Brockhaus dated 3 March 2022. Mr Brockhaus is the Chief Executive Officer of Buckland Aged Care Services, a not-for-profit provider of aged care services to the Blue Mountains community.[288]

The nature of the work

19.28 The nature of the work in the food services stream has evolved over the past 10 years. This is due to a combination of regulatory change in the aged care sector (namely, *"consumer focused"* thinking), the increased number of high care needs of consumers, and improved regulation of food safety (generally).

19.29 In summary, those changes have had the following impact:

(a) ***The range of meals offered and the quality of food has increased.*** Mr Kent gives evidence that there is an expectation that consumers will get *"restaurant quality meals and service".* This requires preparation of a larger meal and multiple options,

[288] Statement of Johannes Brockhaus at [2] and [7].

including options that have regard for different cultures and dietary requirements. There is an expectation of choice, which also encourage agency of the consumer.[289]

(b) ***Increased preparation and cleaning time.*** The prevalence of residents with chronic conditions and/or complex needs may require the preparation of modified textured food and alternative presentation.[290] For example, pureeing food takes longer to prepare by the Chef/Cook. It also takes the Kitchen Hand longer to clean due to the need to dismantle equipment and sanitise.[291] Chefs might also be requested to attend to *"cut ups"* to assist consumers that are less independent.[292] The prevalence and impact is unclear on the evidence filed in these proceedings.

(c) ***Food Safety is a Priority.*** Food services staff are required to be confident with responsibilities and requirements associated with the NSW Food Authority and the ACQSC.[293]

19.30 As to whether those changes amount to work value reasons, we make the following observations:

(a) The change relating to meal preparation and the quality of food to be prepared may have some impact upon the level of responsibility of the chef in the aged care sector. It would not appear to extend to all levels of food services worker. However, consideration would also need to be given to the role of external services such as a dietician.

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289 Statement of Darren Kent dated 31 March 2021 at [91]-[94]; Statement of Lindy Twyford dated 1 April 2021 at [28]-[30]; Statement of Kathy Sweeney dated 1 April 2021 at [40]; Statement of Johannes Brockhaus at [114].

290 Statement of Tracy Roberts dated 23 March 2021 at [145(b)]; Statement of Dr Elizabeth Kurrle dated 25 April 2021, Annexure SK-1: "Expert Report", page 5; Statement of Johannes Brockhaus at [118].

291 Statement of Tracy Roberts dated 23 March 2021 at [145(c)].

292 See Statement of Lindy Twyford dated 1 April 2021 at [25].

293 Statement of Lindy Twyford dated 1 April 2021 at [21]-[22].

(b) The change relating to increased preparation and cleaning time does not appear to be a material change. The fact there is now a greater emphasis upon modifying food textures does not appear to demand greater skill from either the cook, chef or the kitchen hand (with respect to cleaning).

(c) The change relating to food safety appears to be a result of the evolvement of food services and food safety more broadly within the hospitality and food services industries (and, in particular, not limited to aged care). Food services employees were always required to exercise food safety. The introduction of regulations that mandate food safety compliance is not a material change.

The level of skill or responsibility involved in doing the work

19.31 Having regard to the changed nature of the work, the level of skill or responsibility has not substantially changed. Rather, it has evolved over time. The requirement for food services staff to be confident with food safety measures is consistent throughout the hospitality industry. The responsibility for training and information about compliance would fall to either the employer/provider and/or Head Chef. Again, such responsibility is not unexpected.

19.32 Finally, as to the increased contact with consumers, and the suggestion this requires special skills on the part of the food services worker, we would submit this may closely relate to an evolvement of the role. As with any hospitality worker, food services work incorporates an element of customer services and workers are required to adapt to an array of different persons. Equally, whilst such interaction may be encouraged - in keeping with a consumer focused model - the frequency does not amount to a requirement for a higher level of skill. Empathy is required by all workers throughout the aged care sector.

Conditions under which the work is done

19.33 As to the conditions under which work is done, we repeat our submissions advanced with respect to personal care workers. Those submissions also apply to food services workers.

Conclusion

19.34 In short, whilst the work performed by the food services workers has evolved over time, food services workers are still performing the same roles which have existed for the past two decades.

Conclusion: Aged Care Employees

19.35 In summary, when considering the change to work performed by aged care employees a distinction should be drawn between personal care workers and the support services within aged care (being the general and administrative services and food services streams). Whilst all workers in the aged care sector have benefited by the improved working environment, the broader impacts of the shift to consumer-directed care and change in consumer demographic has primarily impacted the personal care workers and not support employees.

19.36 As with any job, some of the changes may be evolutionary, some may be characterised as adding to what is required and others will detract from what is required to perform the work. Each of these considerations must be identified and weighed in their totality.

19.37 Out of the employees in the aged care sector, personal care workers in particular are responsible for providing sociability in their provision of care and are required to prioritise the preferences of the consumer wherever possible. Whilst the skills underpinning that care are not necessarily new or presenting entirely foreign difficulties, the prevalence of high needs consumers adds to the intensity of performing the work. Some of this intensity is offset by the availability of technology aids and some of this intensity is exacerbated by staff shortages.

19.38 On balance, especially given the issues of increased intensity, we submit there has been change in work performed by personal care workers that may be described as more than purely evolutionary.

20. THE WORK PERFORMED BY NURSING EMPLOYEES

Introduction

20.1 This next section considers the *“changes”* that have occurred in the work of nursing employees working in aged care and will distinguish between changes that are genuine work value reasons and those that are not. Having regard to the work value reasons listed at s 157(2A) and the work value consideration summarised above we will consider each classification in turn:

(a) AIN;

(b) EN;

(c) RN; and

(d) NP.

AIN

Evidence

20.2 For the assistance of the Commission, we identify the following statements as relevant to the assessment of the work value of an AIN (or personal care worker):

(a) Statement of John Edward Alberry, dated 29 October 2021;

(b) Statement of Virginia Laura Mashford, dated 29 October 2021;

(c) Statement of Rose Nasemena, dated 29 October 2021;

(d) Statement of Dianne Mary Power, dated 29 October 2021;

(e) Statement of Christine Spangler, dated 29 October 2021;

(f) Statement of Sherree Gai Clarke, dated 29 October 2021;

(g) Statement of Linda Hardman, dated 29 October 2021; and

(h) Statement of Patricia McLean, dated 29 October 2021.

The nature of the work

20.3 Consistent with the identification of changes impacting upon personal care workers working in the aged care sector, the nature of the work performed by AIN that work in aged care have been impacted by the regulatory shift to *"person centred care"* and the prevalence of high needs and complex health care needs amongst the elderly in residential aged care. As such, we repeat and rely upon the submissions advance with respect to personal care work.

The level of skill or responsibility involved in doing the work

20.4 Turning to the level of skill or responsibility involved in doing the work, the following observations are made:

(a) ***Increasing requirement by employers for a Certificate III qualification.*** The *Nurses Award* recognises that a Certificate III is the required minimum qualification of an *"experienced"* AIN. However, it also provides for entry into the industry absent qualification. Persons still enter the aged care industry without formal qualifications. The mere requirement to hold a Certificate III (or commence a traineeship) does not represent a change in work value.

(b) ***Additional skills and responsibilities, including observing and reporting changes to the physical or mental health of aged persons.*** The primary role of an AIN is consistent with a personal care worker: to observe changes in the consumer. This does not require any clinical experience or professional judgment. The increase in high needs has an impact on the number of potential changes that may occur. For example, mental health. However, this not new skill.

(c) ***Exercise judgment and discretion.*** AINs are trained to discern what changes need to be brought to the attention of the RN. They do not, however, exercise professional judgment or discretion with respect to clinical care. Even if a RN is not physically

present decisions as to clinical care fall to the RN. An increase in "indirect supervision" does not sustain an argument there is an absence of supervision.

(d) ***Increase administrative duties.*** The ANMF submissions contend that the evidence is to the effect that AINs are now expected to *"fully document and chart care provided to residents, including for the use in completing the ACFI care assessments".* AINs have always had some administrative duties, requiring them to document and/or communicate changes observed. This is not new. An increase in consumer may increase the number of reports, however, to the extent that increase creates pressure, it is an issue of staffing levels not work value.

Conditions under which the work is done

20.5 Turning to the conditions under which work is done, we repeat and rely upon the submissions advanced with respect to personal care workers in the aged care industry.

Conclusion

20.6 The conclusion reached with respect to the personal care worker in the aged care industry applies to AINs. In many respect the AIN is still performing the same role that existed for the past two decades, which consists of providing care and assistance with basic fundamental tasks. However, as observed, the work has been subject to change over time. In some respect, the work to be performed has been eased with the introduction and increasing prevalence of technology aides and the overall improvement in the working environment as residential aged care facilities moved away from institutional and hospital-like settings to emphasis upon creating an environment closer aligned to a home. In other respect the work has attracted some challenges, most notably due to the increase in intensity that accompanies a consumer demographic that is predominantly high needs and the emphasis upon delivering consumer-centred care.

ENs

Evidence

20.7 For the assistance of the Commission, the following statements are by workers who work or have worked in aged care in the capacity as EN:

(a) Statement of Patricia McLean, dated 29 October 2021;

(b) Statement of Paul Gilbert, dated 29 October 2021;

(c) Statement of Suzanne Claire Hewson, dated 29 October 2021; and

(d) Statement of Wendy Knights, dated 29 October 2021.

The nature of the work

20.8 The nature of work performed by ENs has been impacted by the change in profile of the consumer and regulations that apply to the aged care sector. However, for the following reasons, we submit the impact does not amount to a *"significant net addition to work requirements"*.

20.9 As with personal care workers, the increase in the number of consumers with high care needs and/or complex health care, requires an EN to spend more time with each consumer to respond to a combination of personal care and clinical care duties within the scope of duties of an EN (which we will turn to below). The primary change, in that respect, is restricted to time.

The level of skill or responsibility involved in doing the work

20.10 Turning to the level of skill or responsibility involved in doing the work, there has been no significant net addition to the work requirements of an EN. That contention is supported by the following observations:

(a) ***Supervision.*** An EN works with the RN as part of the health care team. Pursuant to the "*Enrolled Nurse Standards for Practice"*, an EN works under the direct or indirect supervision of a RN. Further, pursuant to the standard of practice, *"the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care".* The need for the EN to have a named and accessible RN

at all times and in all contexts of care for support and guidance is critical to patient safety.[294]

The absence of the physical presence of a RN in the room, on a ward or at a consumer's home does not mean the EN is acting unsupervised. It may suggest indirect supervision is increasing in practice.

(b) ***Medication.*** ENs are able to attend to a limited range of clinical care, which includes administering medicines if they have completed medication administration education at some stage in their career. This does not represent an increase in level of responsibility or an expansion in the role of EN.

(c) ***Implementation of care plans.*** The role of an EN to *"implement"* integrated care that optimises outcomes for consumers and the systems of care is well within the scope of duties of an EN.[295] Such implementation is attended to in accordance with the instructions and delegation by the RN as set out in the care plan.

(d) ***Support AINs.*** The duties of an EN, with the exception of clinical care, overlap with that of AINs. As such, in assisting with the implementation of the care plan and following the directions of the RN, the EN is capable of providing support, within the scope of their experience and competency, to AINs.

(e) ***Wound care****.* As with the administering of medication, an EN that is trained in wound care may assist (at the direction of a RN - who should be trained in wound management) with wound care. An untrained and/or inexperienced EN would not be required to do this task as that would put the consumer at risk. In delegating care duties, the RN is to factor in the competency of the EN.[296]

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[294] See, NMBA, *"Enrolled Nurse Standards for Practice"* (1 January 2016), page 2; Reference Bundle, Tab 26, page 1745.

[295] See, NMBA, *"Enrolled Nurse Standards for Practice"*, page 2; Reference Bundle, Tab 26, page 1745.

[296] See NMBA, "*Registered Nurse Standards For Practice"*, page 6; Reference Bundle, Tab 28, page 1764.

Conditions under which the work is done

20.11 Turning to the conditions under which work is performed, we repeat and rely upon the submissions advanced with respect to personal care workers in the aged care industry.

20.12 In supplementation, we repeat the submission advance with respect to indirect supervision. ENs are to act under the supervision of a RN. This supervision may be provided indirectly. If a residential aged care facility is being headed by an EN absent any form of supervision that presents a serious issue with respect to staffing levels. An EN is not qualified as a RN and does not have the same level of clinical care expertise. It is not a work value issue, but rather a concerning issue related to staff shortages and the adequacy as to the provision of care.

Conclusion

20.13 In short, ENs are still performing the same role which has existed for the past two decades, providing nursing care under the supervision of a RN, which comprises of a combination of personal care together with nursing care which includes a clinical care consistent with their competency and experience level.

RNs

Evidence

20.14 For the assistance of the Commission, the following statements are by workers who work or have worked in aged care in the capacity as RN:

(a) Statement of Lisa Maree Bayram, dated 29 October 2021;

(b) Statement of Maree Anne Bernoth, dated 29 October 2021;

(c) Statement of Julianne Bryce, dated 29 October 2021;

(d) Statement of Annie Butler, dated 29 October 2021;

(e) Statement of Jocelyn Hofman, dated 29 October 2021;

(f) Statement of Emmali Hannah Johnson, dated 29 October 2021;

(g) Statement of Irene McInerney, dated 29 October 2021; and

(h) Statement of Andrew Venosta, dated 29 October 2021.

The nature of the work

20.15 The nature of work performed by RNs has been impacted by the change in profile of the consumer and regulations that apply to the aged care sector.

20.16 The work of RNs within the aged care sector has changed in the following ways:

(a) ***Administration.*** Following the implementation of several regulatory reforms, including QI Program, the reporting duties of RN have increased to some extent. As to the administrative tasks associated with SIRS, the impact is less as this regulation simply confirmed the requirement to document incidents (the residential care facilities would, in practice, already document as part of caring for the consumer).[297]

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[297] See Statement of Emma Brown at [39].

(b) ***Care plans.*** The RN develops the care plan in consultation with the consumer. Whilst this duty has always fallen to the RNs and/or care manager in the context of residential aged care and home care settings, the importance of involving the consumer in the process is now emphasised. There is also now an increase in number of *"high needs"* care plans.

(c) ***Supervision.*** The RN retains the role of being responsible and accountable for the coordination, supervision of and delegation to ENs and AINs who assist them in the provision of care. For example, supervision is aided by telephone communication. Whilst the RN might not be physically present at all times during residential aged care and/or home care, they are always contactable by telephone.[298] As such, there is an increased reliance upon communication via technology.

20.17 As to those changes, the following submissions are advanced *vis-à-vis* work value:

(a) The regulatory reforms with respect to mandatory reporting have undoubtedly increased the level of mandatory administration undertaken by RNs.[299] Whilst a RN always carries high levels of accountability, over the past decade this accountability has expanded to defined categories including QI Program and SIRS.[300] Subject to the evidence, this may amount to a work value change.

(b) As to care plans, the prevalence of consumers with high needs may require a level of clinical care to be provided that only a RN can provide.[301] This may increase the workload of the RN.[302] However, the resulting pressure is not due to unfamiliar skills

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[298] Statement of Mark Sewell at [115] and [120].

[299] See Statement of Mark Sewell at [113]-[114]; Statement of Johannes Brockhaus at [27]-[28], see also at [105]-[107].

[300] See Statement of Emma Brown at [38]-[39].

[301] See generally, Statement of Paul Sadler at [69]-[72].

[302] See Statement of Emma Brown at [26].

but arguably a shortage of RNs. As such, part of this impact may be connected to staffing issues.

(c) The provision of indirect supervision thorough a combination of communication forms (including telephone and apps) reflects an evolvement of methods of supervision.

The level of skill or responsibility involved in doing the work

20.18 The level of skill or responsibility involved in the work of a RNs is higher than AINs and ENs. The minimum qualification is a degree (or equivalent hospital base training) and as a RN progresses may hold "*other qualifications required for working in the employee's particular practice setting*".[303] The award contemplated that different practice settings may require different qualifications (and it follows, skills).

20.19 The following changes are raised in the evidence filed to-date:

(a) ***Increased exercise of professional judgment.***[304] RNs are the classification tasked with exercising professional judgment. Whilst the need to exercise discretion may be higher for consumers with complex health needs, the base skill is inherent in the position.

(b) ***Increased time exercising clinical skills.***[305] RNs are the classification tasked with exercising and overseeing clinical care. The increase in consumers with complex health needs increases the time a RN may spend attending to routine checks and/or increase the number of checks required per consumer. For example, revieing cognitive capacity, reviewing continence care, dementia care, infection prevention and ensuring effective care work is carried out by the care team.

303 *Nurses Award*, Sch A, A.5.2(a), A.5.3(a), A.5.4(a), A.5.5(a).

304 Statement of Jocelyn Hofman dated 29 October at [38] (**Statement of Jocelyn Hofman**).

305 Statement of Jocelyn Hofman at [39].

(c) ***Increased responsibility over high care patients.*** [306] RNs are generally the most senior staff at residential care facilities and are responsible for overseeing the care provided to all consumers (of all levels of care).[307] The increase in the number of high care needs consumers effects the ratio of low care to high care. However, notwithstanding the change in ratio over time, the responsibility has continued to fall to the RN.

(d) ***New administrative skills.*** Reforms within the aged care sector required RNs to be familiar with funding and reporting regimes in the sector.

(e) ***Advocate for consumers with external parties.*** This aspect of care is not new. Again, it may be increased due to the need to engage external care services (together with medical practitioners and/or allied health services) and the requirement to convey the needs of consumers. However, that is consistent with exercising and managing care.

20.20 Each of the above factors contribute to increasing the pressure of the RN to complete their duties. An increase in consumers with high needs, results in a high level of consumers requiring clinical care - which not all nursing employees are qualified to provide. In many respects, the provision of this level of care is limited to a RN and cannot easily be delegated absent nursing employees with sufficient competency and/or experience. Further, as identified in the context of the nature of the work, the administrative aspect of the RNs role has intensified.[308] This has plainly increased the RNs level of accountability. Whilst some of the intensity may be exacerbated by staff shortages, following the increase in regulation within the aged care sector, there has plainly been a significant net addition to the level of responsibility of the RN over the past decade.

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[306] Statement of Jocelyn Hofman at [41].

[307] See generally, Statement of Kim Bradshaw at [60]-[82].

[308] See Statement of Kim Bradshaw at [26].

Conditions under which the work is done

20.21 Turning to the conditions under which work is done, we repeat and rely upon the submissions advanced with respect to personal care workers in the aged care industry.

Conclusion

20.22 In summary, the shift in the nature of the work performed by RNs is more than the mere evolution with time. There has been a material change, with increasingly less emphasis upon the provision of direct care and more emphasis upon administrative duties. The increase to the latter has involved some work substitution but with this, the level of responsibility and accountability of the RN has increased.

20.23 Turning to the clinical aspect of the role, whilst there may be increased specialisation (for example in dementia) this is not dramatically different, noting RNs have always had the option to work and become qualified in specialised fields (for example, working as a RN in neurology or oncology).[309]

20.24 On balance, we consider the shift in emphasis with respect to the administrative duties of the work performed by RN, and the flow-on impact of an increase in accountability, may be properly described as a significant addition to their workload.

NPs

Evidence

20.25 The following statements are by workers who work or have worked in aged care in the capacity as NP:

(a) Statement of Hazel Bucher, dated 29 October 2021; and

(b) Statement of Stephen Andrew Voogt, dated 29 October 2021.

[309] See generally, Department of Health, *"Becoming a Registered Nurse"* (Fact Sheet); Reference Bundle, Tab 19, page 1519.

Work Value Reasons

20.26 The role of NP is very niche within the classifications of nursing employee. There are less than 3,000 throughout Australia. It is also unclear how many NPs work exclusively in aged care.[310] Presently, it is submitted that the Commission would not be satisfied as to the existence of any significant net addition requirements to the work requirements of NPs working in aged care. However, that submission will need to await the testing of evidence.

Conclusion: Nurses Award

20.27 In summary, the changes to the aged care sector have had an impact upon the work performed by AINs and RNs in aged care, with the latter being more significant.

20.28 Over the course of the past decade the RN has shifted away from the provision of direct supervision and direct care towards an increasingly administrative role. By this shift, the RN continues to retain the accountability and responsibility with respect to clinical care. However, the RN has increased accountability and levels of responsibility with respect to mandatory reporting. Equally, whilst the RN retains supervisory duties, the supervisory aspects of the role are increasingly more general and indirect. This change, however, does not diminish the RNs accountability with respect to delegated care.

20.29 As to the AIN role, we repeat our conclusions with respect to the personal care worker. However, that change is to a significantly lesser degree in contrast to the impact upon the RN.

[310] See generally, Department of Health, “Becoming a Nurse Practitioner” (Fact Sheet); Reference Bundle, Tab 18, page 1517.

21. THE WORK PERFORMED BY HOME CARE EMPLOYEES

Introduction

21.1 This next section considers the *"changes"* that have occurred in the work of home care employees working in aged care and will distinguish between changes that are genuine work value reasons and those that are not. That analysis will be informed by work value reasons listed at s 157(2A) and the work value consideration summarised earlier in the submissions.

Home Care Workers

Evidence

21.2 For the assistance of the Commission, the following statements are by workers who work or have worked in aged care in the capacity as a home care worker (noting, different job titles apply):

(a) Statement of Jennifer Wood, dated 27 October 2021 - Support Worker;

(b) Statement of Camilla Sedgman, dated 5 October 2021 - Personal Care Worker;

(c) Statement of Lorri Seifert, dated 6 October 2021 - Team Leader;

(d) Statement of Peter Doherty, dated 28 October 2021 - Coordinator;

(e) Statement of Susan Digney, dated 27 October 2021 - Support Worker;

(f) Supplementary Statement of Sally Fox, dated 28 October 2021 - Extended Care Assistant;

(g) Statement of Marea Phillips, dated 27 October 2021 - Community Support Worker;

(h) Statement of Michael Purdon, dated 6 October 2021 - Community Support Worker;

(i) Statement of Susanne Wagner, dated 28 October 2021 - Support Worker;

(j) Statement of Catherine Evans, dated 26 October 2021 - Home Service Worker;

(k) Statement of Theresa Heenan, dated 20 October 2021 - Home Care Employee;

(l) Statement of Julie Kupke, dated 28 October 2021 - Carer;

(m) Statement of Bridget Payton, dated 26 October 2021 - Personal Care Assistant;

(n) Statement of Veronique Vincent, dated 28 October 2021 - Home Support Worker;

(o) Statement of Adrienne Michelle "Shelly" White, dated 5 October 2021 - Home Care Worker;

(p) Statement of Susan Toner, dated 29 September 2021 - Home Care Worker;

(q) Statement of Catherine Goh, dated 13 October 2021 - Community Support Worker;

(r) Statement of Rosemarie Dennis, dated 5 October 2021 - Home Support Worker;

(s) Statement of Ngari Inglis, dated 19 October 2021 - Home Support Worker;

(t) Statement of Karen Roe, dated 30 September 2021 - Home Support Team Member;

(u) Statement of Kristy Conroy (undated) - Care Worker Coach;

(v) Statement of Maria Moffat, dated 27 October 2021 - Personal Carer;

(w) Statement of Paula Wheatley, dated 27 October 2021 - Personal Carer;

(x) Statement of Teresa Hetherington, dated 19 October 2021 - Carer; and

(y) Statement of Susan Morton, dated 27 October 2021 - Advanced Care Worker.

The nature of the work and conditions under which the work is done

21.3 The nature of work provided by home care workers is that it is care usually provided by a single worker in the personal residence of a consumer (often described as a *"client"*) in accordance with a care plan.[311] Home care employees generally service multiple clients and work according to a roster. The roster is fixed by the home care provider, with contribution by the home care worker. The worker is rarely subject to *"direct"* supervision

[311] See Statement of Mark Sewell at [119]; Statement of Sue Cudmore dated 4 March 2022 at [41] (**Statement of Sue Cudmore**); see also Statement of Paul Sadler at [66]; Statement of Cheyne Woolsey dated 4 March 2022 at [40]-[42] (**Statement of Cheyne Woolsey**).

during shifts (i.e. there is not a senior worker or RN overseeing the care provided at the time) but instead there is *"indirect"* supervision.[312] Indirect supervision means that workers communicate updates/reports in writing or orally to a case manager or RN and, in the event of any issue, immediately telephones management, RN or ambulance.[313]

21.4 The manner in which workers are indirectly supervised and contact management and RN has evolved with the development of modern technology. It is standard practice for carers to be provided with a smart phone and to utilise "apps" (such as *"Procura"*[314], *"Kronos"*[315], *"CareLink"*[316], "*MTA"*[317], "*My One App*[318]" and "*DoneSafe"*[319]) to document their services, record observations for the registered nurse and manage their rosters/leave.

21.5 The following changes to the nature of the work are referred to in the statements of carers:

(a) ***Increase in number of consumers staying longer in home care.*** As mentioned, this is due to consumers having the option to received care at home. More consumers take this option to stay longer in home care.[320]

(b) ***Increased prevalence of complex care needs.*** This includes *"dementia, Parkinson's, cancer, impaired vision, very limited mobility, even palliative clients"*.[321]

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312 See Statement of Mark Sewell at [120]-[123].

313 See Statement of Mark Sewell at [123]; Statement of Johannes Brockhaus at [158]; see generally, Statement of Sue Cudmore at [42]-[44]; Statement of Cheyne Woolsey at [48]-[53].

314 See Statement of Lorri Seifert dated 6 October 2021 at [53]-[54]; Statement of Paula Wheatley dated 27 October 2021 at [66]-[75] (**Statement of Paula Wheatley**); Statement of Teresa Hetherington dated 19 October 2021 at [103] (**Statement of Teresa Hetherington**); Statement of Sue Cudmore at [35]-[36].

315 Statement of Paula Wheatley at [66]-[75];

316 Statement of Jennifer Wood dated 27 October 2021 at [37]-[38].

317 Statement of Susan Digney dated 27 October 2021 at [48], [51] and [53] (**Statement of Susan Digney**).

318 Statement of Susan Digney at [50].

319 Statement of Teresa Hetherington at [100]-[103].

320 See example, Statement of Susan Digney at [27]; Statement of Catherine Evans dated 26 October 2021 at [83]-[85]; see also Statement of Paul Sadler at [67]-[68].

321 See Statement of Catherine Evans dated 26 October 2021 at [67] and [86].

(c) ***High expectations from consumers (and families).*** Despite home care often being subject to funding and a *particular "package"* level, consumers expect a full suite of domestic duties to be completed in 30-60 minutes.[322]

21.6 It follows that as the care is provided in the home environment, the setting for home care work has not changed. Home care work has always been provided to consumers with low level care and high level care needs.[323] It is often provided to elderly persons and workers are aware that the aging process carries with it an array of needs specific to the individual. It is for that reason that aged care work in the home care sector includes, *inter alia*, domestic duties, social and welfare checks, cleaning duties and personal care work.[324]

21.7 The primary impact of an increase in home care consumers and, in particular, consumers with complex care needs is the additional time that home care workers need to take to provide it. This has resulted in many home care workers in aged care expressing feelings of *"pressure"* to attend to care needs within a pre-fixed shift.

The level of skill or responsibility involved in doing the work

21.8 Turning to the level of skill or responsibility of home care employees in aged care, we make the following observations:

(a) ***Performance of "some clinical care".***[325] Home care employees are *not* medically trained or qualified. The reference to *"clinical care"* by carers is a reference to the following discrete and limited tasks:

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[322] See example, Statement of Susan Digney at [19]; Statement of Catherine Evans dated 26 October 2021 at [87].

[323] See Statement of Mark Sewell at [69].

[324] See Statement of Mark Sewell at [68].

[325] Statement of Veronique Vincent dated 28 October 2021 at [51] (**Statement of Veronique Vincent**).

(i) ***medication prompts*** in accordance with the instructions of a RN that may delegate the task;[326]

(ii) ***blood pressure checks*** in accordance with the instructions of a RN that may delegate the care and recording the result for the registered nurse;[327]

(iii) ***providing observations*** with respect to wounds (described by one carer as *"wound management"*).[328]

(b) ***Medical prompts.*** This task is not akin to administering medication or assisting consumers to take medication. This task is confined to providing a consumer with a *"prompt"* to take medication, which comes in a Webster (or blister) pack and recording the time at which medication was taken. If the consumer does not take medication, the home care worker calls the RN.[329] Consumers are responsible for administering their own medication.[330] If consumers have difficulty popping the blister packet, a home care employee may assist with that task.[331] Home care workers receive training from a RN prior to undertaking this task (which is consistent with the RNs responsibilities in relation to delegation).[332]

(c) ***Providing observations.*** It is the job a home care employee to take note of changes and report difference to a case manager and/or RN.[333] Observations may

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326 Statement of Veronique Vincent at [33] and [51]; Statement of Theresa Heenan dated 20 October 2021 at [112]; Statement of Julie Kupke dated 28 October 2021 at [109]; Statement of Teresa Hetherington at [96]. See also Statement of Mark Sewell at [128]; Statement of Cheyne Woolsey at [31].

327 Statement of Veronique Vincent at [51], [109] and [117].

328 Statement of Veronique Vincent at [51], [56], [109] and [114].

329 See Statement of Susan Toner at [21]; Statement of Veronique Vincent at [109].

330 Statement of Teresa Hetherington at [96]; Statement of Susan Morton dated 27 October 2021 at [20].

331 Statement of Veronique Vincent at [33].

332 See example, Statement of Veronique Vincent at [33]; see also Statement of Paul Sadler at [75]-[79]; Statement of Cheyne Woolsey at [31] and Annexure CW04.

333 Statement of Susan Digney at [31]; see Statement of Sue Cudmore at [46]-[47]; Statement of Cheyne Woolsey at [44]-[45].

concern a visible change to skin and/or a wound.[334] This observation does not require any clinical understanding - it is simply reporting on a difference (for example, colour change and/or bleeding).

(d) ***Blood pressure checks.*** There is limited evidence with respect to this check. However, such a task would only be performed following training by and at the direction of a RN.[335]

(e) ***Reporting.*** As mentioned, home care employees are required to log when they start and finish their shift and report any changes.[336] Some home care workers continue to attend to this with paper (described as a *"book"* stored at the client's home). Many utilise to an *"app"* on their phone.[337] This is not an increase in skills but represents an evolvement of reporting/communication methods consistent with developments in modern technology.

(f) ***Advocate for clients.*** Whilst some home care employees may give evidence of advocating for clients, *"advocacy"* does not fall within the scope of care.[338]

(g) ***Engagement with families.*** Home care employees may on occasion engage with families of consumers.[339] This can occur when family members are visiting their loved one at the same time that care is being provided. In such circumstance, home care employees would be expected to treat all persons they interact with courtesy

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[334] Statement of Veronique Vincent at [111].

[335] Statement of Veronique Vincent at [117].

[336] See example, Statement of Cheyne Woolsey at [46]-[48].

[337] See example, *"Procura", "Kronos", "CareLink", "MTA"* and *"My One App".* See Statement of Sue Cudmore at [35]-[36].

[338] Statement of Susan Wagner dated 28 October 2021 at [142]-[144].

[339] See Statement of Mark Sewell at [68].

and respect. Should a situation escalate into one of concern or abuse, they are to contact management, registered nurse and/or emergency services.[340]

(h) ***Exercising judgment, discretion and lots of skill.*** The overwhelming reference to *"judgement"* and *"lots of skill"* in the statements of home care workers concerns the manner in which they respond to a consumer that may be *"embarrassed"* and/or resistant to care needs.[341] For example, Ms Toner, Mr Purdon and Ms Phillips give evidence that consumers with dementia may exhibit *"determined"* behaviour that makes giving care harder and, in the result, requires some creativity to achieve goals (for example, to get into the shower and/or vacate a room).[342] All of which fall within the realm of provision of care for person with high care needs.

21.9 It is submitted that the evidence before the Commission will not establish a prevalence of home care workers attending to clinical care that is equivalent to the care provided by an EN or RN. Rather, it is submitted that there has been no significant net increase to the level of responsibility of home care workers.[343] The principal change is that the staffing of home care workers does not appear to have kept up with the increasing demand for home care workers.

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[340] See example, Supplementary Statement of Sally Fox dated 28 October 2021 at [50]-[51] (an exceptional circumstance in which Ms Fox witnessed elder abuse and contacted police); see also Statement of Paul Sadler at [93]; Statement of Sue Cudmore at [44]-[45]; Statement of Cheyne Woolsey at [51] and Annexure CW-05, see also [52]-[57].

[341] See example, Statement of Catherine Evans dated 26 October 2021 at [66]; Statement of Veronique Vincent at [68]-[70].

[342] Statement of Susan Toner dated 29 September 2021 at [19] (**Statement of Susan Toner**); Statement of Michael Purdon dated 6 October 2021 at [30]; see also Statement of Marea Phillips dated 27 October 2021 at [22].

[343] See Statement of Mark Sewell at [120]-[123].

Conclusion: Home Care Employee

21.10 In many regards the home care employee is similar to a personal care worker in a residential setting in that they will hold a Certificate III or equivalent and are providing personal care. There are important subtleties between the two roles. These include:

(a) working alone verses working as part of a team;

(b) the nature of supervision;

(c) the focus of home care work being more aligned to domestic residential duties, as opposed to care *per se*; and

(d) some clients being serviced by home care employees are increased in age than would have historically been the case as the purpose of home care is to allow the client to maintain occupancy of their residence. There is a distinction, however, with the concentrated nature of the consumer increasingly found in residential care, which, as we have discussed, has an older age profile and a higher propensity to comorbidity and forms of dementia.

22. THE AWARDS AND THE C10 FRAMEWORK

Introduction

22.1 By the preceding analysis, we arrived at the following conclusions:

(a) The *Aged Care Award* does not appear to have been properly set.

(b) The *Nurses Award* may have been properly set.

(c) The *SCHADS Award* may have been properly set.

22.2 Before turning to the C10 framework a number of preliminary contentions need considerations:

(a) The Commission will need to be satisfied that it is appropriate to dissect ‘nurses’ in aged care from the current *Nurses Award* classification structure and to properly set the minimum rates for such ‘nurses’ while not properly setting such rates for ‘nurses’ outside of aged care. It is questionable whether this is desirable and certainly not an approach that sits well with that taken in the *Teachers Case*.

(b) Any classification structure will need to be appropriate for the proper setting of minimum rates.

(c) In this regard, consideration should be given to the appropriateness of the current classification in the *Aged Care Award* which conflates care workers with support workers in a manner that challenges alignment to the C10 framework. These would at a minimum be better broken out before the C10 exercise was undertaken.

(d) Where service is used it must reflect the acquisition of experience and competence rather than the effluxion of time[344]. This prompts consideration of the shift in competency of care workers at and around three years of experience and also will

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[344] See *Teachers Case* at [647].

require the Commission to be satisfied that any use of service in the Nurses Award or the *SCHADS Award* meets this test.

The Benchmark Classification: The C10 Framework

22.3 In light of the role of the *Manufacturing Award* within the process, it is useful to briefly turn to the classification structure under that award.

22.4 Schedule A to the *Manufacturing Award* contains the Classification Structures and Definitions. Clauses A.4.7(a) and (b), in Schedule A contains a description of the qualifications and competencies of persons in Classification C10.

22.5 With respect to the former, cl A.4.7(a)(i) provides that the employee holds a trade certificate or tradesperson's rights certificate or equivalent as (relevantly) an *"Engineering Tradesperson (Mechanical) - Level 1 … and is able to exercise the skills and knowledge of the engineering trade so as to enable the employee to perform work within the scope of this level"*. Clause A.4.7(a)(ii) goes on to identify the skills, competence and training of an employee in classification C10 compared with an employee in classification C11. Equivalent wording is repeated with respect to *"Engineering/ Manufacturing Systems Employee—Level V"* in clause A.4.7(b)(i) and (ii).

22.6 The reference to *"or equivalent"* means:

- *any training which a registered provider (e.g. TAFE),or State recognition authority recognises as equivalent to a qualification which the relevant industry committee, which is currently the Manufacturing and Engineering Industry Reference Committee, recognises for this level, which can include advanced standing through recognition of prior learning and/or overseas qualifications; or*
- *where competencies meet the requirements set out in the metal and engineering competency standards in accordance with the National Metal and Engineering Competency Standards Implementation Guide.*[345]

[345] *Manufacturing Award,* Sch A, A.4.1(b)(i).

22.7 The percentage wage relativities to C10, reflecting the percentages as prescribed in 1990 in *Re Metal Industry Award 1984—Part I* (M039 Print J2043), together with the minimum training requirements, is extracted below:

Classification levels	Classification title	Minimum training requirement	Wage relativity to C10 (see clause A.3.2)
C1	Professional Engineer Professional Scientist	Degree	180/210%
C2(b)	Principal Technical Officer	Advanced Diploma or equivalent and sufficient additional training so as to enable the employee to meet the requirements of the relevant classification definition and to perform work within the scope of this level.	160%
C2(a)	Leading Technical Officer	Advanced Diploma or equivalent and sufficient additional training so as to enable the employee to meet the requirements of the relevant classification definition and to perform work within the scope of this level.	150%
C2(a)	Principal Supervisor/ Trainer/Co-ordinator	Advanced Diploma or equivalent of which at least 50% of the competencies are in supervision/training	150%
C3	Engineering Associate/ Laboratory Technical Officer—Level II	Advanced Diploma of Engineering, Advanced Diploma of Laboratory Operations, or equivalent.	145%
C4	Engineering Associate/ Laboratory Technical Officer—Level 1	80% towards an Advanced Diploma of Engineering,80% towards an Advanced Diploma of Laboratory Operations, or equivalent.	135%
C5	Advanced Engineering Tradesperson—Level II	Diploma of Engineering—Advanced Trade, or equivalent.	130%
C5	Engineering/Laboratory Technician—Level V	Diploma of Engineering—Technical, Diploma of Laboratory Technology, or equivalent.	130%
C6	Advanced Engineering Tradesperson—Level 1	C10 + 80% towards a Diploma of Engineering—Advanced Trade, or equivalent.	125%

Classification levels	Classification title	Minimum training requirement	Wage relativity to C10 (see clause A.3.2)
C6	Engineering/Laboratory Technician—Level IV	50% towards an Advanced Diploma of Engineering, or 85% towards a Diploma of Engineering—Technical,50% towards an Advanced Diploma of Laboratory Operations or 85% towards a Diploma of Laboratory Technology, or equivalent.	125%
C7	Engineering/ Manufacturing Tradesperson—Special Class Level II	Certificate IV in Engineering, or C10 + 60% towards a Diploma of Engineering,60% towards a Diploma of Laboratory Technology, or equivalent.	115%
C7	Engineering/Laboratory Technician—Level III	Certificate IV in Manufacturing Technology, provided that the minimum experience required for a Technology Cadet has been completed, or Certificate IV in Laboratory Techniques, or 45% towards an Advanced Diploma of Engineering, or 70% towards a Diploma of Engineering—Technical, 45% towards an Advanced Diploma of Laboratory Operations, or 70% towards a Diploma of Laboratory Technology, or equivalent	115%
C8	Engineering/ Manufacturing Tradesperson—Special Class Level I	C10 + 40% towards a Diploma of Engineering, or equivalent	110%
C8	Engineering/Laboratory Technician—Level II	40% towards an Advanced Diploma of Engineering, or 60% towards a Diploma of Engineering—Technical,40% towards an Advanced Diploma of Laboratory Operations,60% towards a Diploma of Laboratory Technology, or equivalent	110%
C9	Engineering/ Manufacturing Tradesperson—Level II	C10 + 20% towards a Diploma of Engineering or equivalent	105%
C9	Engineering/Laboratory Technician—Level I	Certificate III in Engineering—Technician, or Certificate III in Laboratory Skills, or Certificate III in Manufacturing Technology, provided that the minimum experience required for a Technology Cadet has been completed, or 50% towards a Diploma of Engineering, or equivalent	105%

Classification levels	Classification title	Minimum training requirement	Wage relativity to C10 (see clause A.3.2)
C10	**Engineering/Manufacturing Tradesperson – Level 1**	**Recognised Trade Certificate, or Certificate III in Engineering – Mechanical Trade, or Certificate III in Engineering – Fabrication Trade, or Certificate III in Engineering – Electrical/Electronic Trade, or equivalent**	**100%**
C10	**Engineering/ Manufacturing Systems Employee—Level V**	**Engineering Production Certificate III, or Certificate III in Engineering—Production Systems, or equivalent**	**100%**
C11	Engineering/ Manufacturing Employee—Level IV Laboratory Tester	Engineering Production Certificate II, or Certificate II in Engineering—Production Technology, or Certificate II in Sampling and Measurement, or equivalent	92.4%
C12	Engineering/ Manufacturing Employee—Level III	Engineering Production Certificate I or Certificate II in Engineering ,or equivalent	87.4%
C13	Engineering/ Manufacturing Employee—Level II	In-house training	82%
C14	Engineering/ Manufacturing Employee—Level 1	Up to 38 hours induction training	78%

22.8 It should be noted, the minimum rates in the *Manufacturing Award "do not reflect these relativities because some wage increases since 1990 have been expressed in dollar amounts rather than percentages and as a result have reduced the relativities".*[346]

22.9 Notwithstanding that caveat, and noting pay rates change from 1 July each year, the C10-C14 levels as set from 1 July 2021 by reference to the *"Adult - General Manufacturing - Full time & Part-time"* are as follows:[347]

Classification	Weekly pay rate	Hourly pay rate
C14 - Engineering/manufacturing employee - level I	$772.60	$20.33
C13 - Engineering/manufacturing employee - level II	$794.80	$20.92

[346] *Manufacturing Award*, Schedule A, clause A.3.2.

[347] Fair Work Ombudsman, *"Pay Guide: Manufacturing and Associated Industries and Occupations Award [MA000010]"* (Published 1 December 2021), Reference Bundle, Tab 22, page 1528.

C12 - Engineering/manufacturing employee - level III	$825.20	$21.72
C11 - Engineering/manufacturing employee - level IV	$853.60	$22.46
C11 - Laboratory tester	$853.60	$22.46
C10 - Engineering/manufacturing tradesperson - level I	**$899.50**	**$23.67**
C10 - Engineering/manufacturing systems employee - level V	**$899.50**	**$23.67**

22.10 Those classification levels, minimum requirements and wage rates will be returned to in the context of determining whether the pay rates and internal relativities in the awards were ever properly set.

The Australian Qualifications Framework

22.11 The *"minimum training requirement"* and/or *"minimum qualification"* cannot be considered absent the AQF. The AQF is the policy for regulated qualifications in the Australian education and training system, which underpins the national system of qualifications in Australia, encompassing higher education, vocational education and training (**VET**), and schools. It is the agreed policy of Commonwealth, State and Territory ministers.[348]

22.12 For completeness, the relevant AQF levels are listed below:

(a) Level 1 – Certificate I;

(b) Level 2 – Certificate II;

(c) Level 3 – Certificate III;

(d) Level 4 – Certificate IV;

(e) Level 5 – Diploma;

(f) Level 6 – Advanced Diploma, Associate Degree;

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[348] Department of Education, Skills and Employment, Australian Qualifications Framework, *"What is the AQF"*; Reference Bundle, Tab 14, page 1487. See also, Australian Qualifications Framework Council, *"Australian Qualifications Framework"* (second edition, January 2013); Reference Bundle, Tab 13.

(g) Level 7 – Bachelor Degree;

(h) Level 8 - Bachelor Honours Degree, Graduate Certificate, Graduate Diploma;

(i) Level 9 - Master's Degree; and

(j) Level 10 - Doctoral Degree.

22.13 It useful to briefly set out the AQF criteria with respect to Levels 1-6, given that overlap exists and the awards provide include reference to *"or equivalent"*. The AQF provides the following summary of criteria for each level:[349]

Qualification	Summary
Certificate I	Graduates at this level will have knowledge and skills for ***initial work, community involvement*** and/or further learning.
Certificate II	Graduates at this level will have knowledge and skills for work in a ***defined context*** and/or further learning.
Certificate III	Graduates at this level will have ***theoretical and practical knowledge and skills for work*** and/or further learning.
Certificate IV	Graduates at this level will have ***theoretical and practical knowledge and skills for specialised and/or skilled work*** and/or further learning.
Diploma	Graduates at this level will have ***specialised knowledge and skills for skilled/paraprofessional work*** and/or further learning.
Advanced Diploma / Associate Degree	Graduates at this level will have ***broad knowledge and skills for paraprofessional/highly skilled work*** and/or further learning.

[349] Australian Qualifications Framework Council, *"Australian Qualifications Framework"* (second edition, January 2013), page 12; Reference Bundle, Tab 13, page 1386.

Recent Considerations of the C10 Classification Structure

22.14 The Commission recently made observations with respect to the C10 framework in the context of the *Pharmacy Case* and the *Teachers Case*.

22.15 In the *Pharmacy Case*, the Full Bench found there was a lack of alignment in pay rates and relativities as between pharmacists under the *Pharmacy Industry Award 2010* (**Pharmacy Award**) and those classifications requiring equivalent qualifications under the *Manufacturing Award* (particularly those rates referable to undergraduate qualifications). The decision also noted a lack of consistency with the Australian Qualifications Framework. In that decision, the Full Bench also expressed a view that this issue may affect other awards which contain qualifications applying to employees who are required to hold undergraduate qualifications.

22.16 In *Section 157 proceeding* [2019] FWC 5934, the Commission issued a statement that expressed a provisional view that awards with classifications requiring undergraduate degrees should be referred to the Full Bench for review. As part of that statement, the Commission prepared tables setting out the current wage rates and relativities to the C10 rate in the *Manufacturing Award* for, *inter alia*, *Social, Community, Home Care and Disability Services Industry Award 2010* and *Nurses Award 2010,* based on the weekly wage rates following the *Annual Wage Review 2018-19*[350] decision.

22.17 In *Teachers Case*, the Full Bench observed:

> *"[561] The Metal Industry classification structure, as originally formulated, provided for 14 classifications with different qualifications and skill levels. Each classification was assigned a wage relativity, expressed in percentage terms, with the C10 tradesperson classification. However that structure in its current form has been altered in two ways. First, because of flat dollar increases awarded in safety net reviews by the AIRC, in wage decisions of the AFPC and in the initial annual wage reviews of this Commission,* ***the relativities between***

[350] *Annual Wage Review 2018–19* [2019] FWCFB 3500.

> ***classifications became compressed**. Second, although the full Metal Industry classification structure was incorporated by the AIRC into the modern Manufacturing Award when it was made on 19 December 2008 in the course of the award modernisation process, **the highest Level C1 classification was deleted on 30 December 2009**. This was done on the basis that degree qualified professional engineers and scientists previously covered by the classification would now be covered by the PE Award. However, the salary rates provided for in the PE Award were not consistent with the relativities originally provided for in the Metal Industry Award classification, and were generally lower than the Level C1 rates which originally appeared in the Manufacturing Award and were themselves the result of the compression of relativities."*[351]
>
> (Footnotes omitted)

22.18 In *Teachers Case*, it was found that the minimum rates in the EST Award were not he product of any proper fixation of minimum rates in accordance with principles stated in the *ACT Child Care decision.* The rates were fixed by reference to pre-existing rates, with subsequent adjustments made by reference to those first award rates without any proper minimum rate assessment process.[352]

Conclusion

22.19 Having earlier set out the applicable principles that underpin and inform the Commission's assessment of the current minimum rates, we now turn to analyse the classification structure and minimum rates in the awards.

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351 *Teachers Case* at [561].

352 *Teachers Case* at [562].

23. ANALYSIS OF THE *AGED CARE AWARD*

Introduction

23.1 With respect to each award we will address the following questions:

(a) What are the relevant benchmark classifications for the C10 comparison?

(b) If applied to the existing classification internal relativities what outcome does this drive?

(c) What anomalies does this create compared to the C10 framework that need to be considered?

23.2 As part of that analysis we will also address issues relevant to the modern awards objective and minimum award objective, which will be further developed in closing submissions.

What are the relevant benchmark classifications for the C10 comparison?

23.3 We submit it would not be controversial for the Commission to determine that *"Aged Care employee Level 4"* is the key classification for the award. Under that level there are presently three categories of work:

(a) General and administrative services (with the position of *"Gardener"* at that level requiring *"trade or TAFE Certificate III or above"*);

(b) Senior cook (trade); and

(c) Personal Care Worker grade 3 (with a minimum qualification requirement of *"Certificate 3"*).

23.4 The minimum rate for an aged care employee - level 4 per week is $899.50, which is aligns with the current minimum rate for a C10 level under the *Manufacturing Award* (as does the minimum qualification of Certificate III).

If applied to the existing classification internal relativities what outcome does this drive?

23.5 By reference to the key classification, the existing classification internal relativities may be compared against the relativities in the *Manufacturing Award*. That comparison appears in the table below:

Manufacturing Award classification	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	Aged Care Employee classification	Current relativity to C10 (%)	Current Wage Rate ($)
C14	Up to 38 hours induction training	78	772.60			
C13	In-house training	82	794.80			
C12	Certificate I or Certificate II or equivalent	87.4	825.20			
				Level 1	91.3	821.40
C11	Certificate II	92.4	853.60			
				Level 2	95	855.50
				Level 3	98.8	889.00
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100**	**899.50**	**Level 4**	**100**	**899.50**
				Level 5	103.4	930.00
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105	927.70			
				Level 6	109	980.10
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110	955.90			
				Level 7	111	997.70
C7	Certificate IV OR C10 (Trade certificate III) + 60% towards Diploma or equivalent	115	981.50			

What anomalies does this create compared to the C10 framework that need to be considered?

23.6 In considering whether any anomalies are created when compared to the C10 framework, regard must be had to the *"minimum qualifications"*, which brings with it the need to turn to the AQF.

23.7 Whilst there is no minimum qualification for personal care workers in aged care, personal care workers may obtain the following qualifications:

(a) Certificate III in Individual Support (Ageing);

(b) Certificate III in Individual Support (Ageing, Home and Community);

(c) Certificate IV in Aged Care;

(d) Certificate IV in Ageing Support;

(e) Certificate IV in Disability.

23.8 An individual may also obtain a Certificate III in the form of a traineeship by which they study and *"train on the job",* within 12 months complete a Certificate III.

23.9 The qualification of Certificate III and IV align with AQF Levels 3 and 4, respectively.

23.10 The following table sets out the *"qualifications"* referred to in the *Aged Care Award*, together with reference to the corresponding AQF and the C10 level that properly aligns with that AQF:

Classification Level	Qualification / Experience	AQF	C10
1	Less than 3 months experience		C14
2	3-12 months experience		C13 - C12
3	Second and subsequent years of service		C11
4	Certificate III	L3	C10
5	Formal qualifications at trade or certificate level (*"may require"*)	L3 - L4	C10 - C7

Classification Level	Qualification / Experience	AQF	C10
6	Formal qualifications at post-trade or Advanced Certificate or Associate Diploma (*"may require"*)	L4 - L5	C7 - C6
7	Formal qualifications at post-trade or Advanced Certificate or Associate Diploma (*"may require"*)	L4 - L5	C7 - C6

23.11 The AQF provides that the equivalent qualification to an *"Advanced Certificate"* is a *"Certificate IV",* and the equivalent to *"Associate Diploma"* is *"Diploma"*.[353]

23.12 The inclusion of *"may require"* is arguably due to the broad scope of employees that work within the aged care sector, with the majority able to enter the workforce without any qualification, and the fact the award prescribed certain qualifications at some levels. For example, aged care employees at Level 7:

(a) *a "personal care worker"* at this level is required, at a minimum, to hold a Certificate III or equivalent (which is specified at Level 4);

(b) a *"gardener superintendent"* at this level is required, at a minimum, to hold a Certificate III or equivalent (which is specified at Level 4);

(c) a *"chef"* at this level is not required to hold any qualification, but may attain a Certificate III or IV;

(d) an *"interpreter"* at this level is required to be *"qualified"*, which requires the individual to attain a VET or university qualification and be certified with National Accreditation Authority for Translators and Interpreters.

23.13 The above analysis suggests some anomalies may exist in the current classifications. As such, prior to setting properly set minimum rates, the classification structure for aged care employees may benefit from additional description, the creation of additional levels and/or

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[353] Department of Education, Skills and Employment, *"Equivalency of pre-AQF qualifications"* (website); Reference Bundle, Tab 15, pages 1491-1492.

the separation of *"personal care worker"* as a separate classification structure within the *Aged Care Award*.

23.14 Putting aside consideration of the minimum rates, a comparison of the C10 level and the qualification provided for each level of aged care employee on either side of the key classification appears to sit at, above or below the C10 framework.

23.15 We now turn to an analysis of the minimum rates in the *Aged Care Award*, having regard to each of the factors set out above to consider the impact of the anomalies identified.

23.16 Having regard to the experience and skills required of level 1-3, the rates do not align to the requisite experience and skills required for those levels when compared to the C10 framework and AQF. That conclusion is informed by the following analysis:

Level 1

(a) The *Aged Care Award* provides that a level 1 aged care employee is *"entry level"* position that requires no previous experience or training. An employee at this level *"has less than three months' work experience in the industry and performs basic duties".* That employee is expected to work within established routines, methods and procedures with minimal responsibility, accountability or discretion. That employee also works under direct or routine supervision.[354]

(b) The rate of $21.62, with a relativity of 91.3%, is just short of the C12 level in the *Manufacturing Award*. The minimum requirements for C12 are *"Certificate I or Certificate II or equivalent"*.

(c) The minimum rate presently set at 91.3% relativity does not align to the C10 framework and, absent justification on work value reasons, appears to be set too high.

[354] *Aged Care Award*, Sch B, B.1.

Level 2

(d) The *Aged Care Award* provide that a level 2 aged care employee requires *"specific on-the-job-training"* and/or relevant skills training or experience. That employee has recognised capabilities as to prioritising work within established routines; is responsible for work performed with a limited level of accountability; and work under limited supervision. [355]

(e) The rate of $22.51, with a relativity of 95% sits between C11 and C10 levels in the *Manufacturing Award*. The minimum requirements for those levels being Certificate II and III, respectively.

(f) The description of the classification under the award more closely aligns with the C13 and C12 minimum requirements under the *Manufacturing Award*, having regard to the AQF skills and knowledge outcomes of graduates with a Certificate I or Certificate II.

(g) Based on those considerations, the minimum rate presently set at 95% relativity to the C10 rate appears to sit too high.

Level 3

(h) The *Aged Care Award* provides a level 3 aged care employee, with respect to "non admin/clerical" work, meets the requirements of a level 2 aged care employee. For admin/clerical employees, such employees *"undertake a range of basic clerical functions within established routines, methods and procedures".* It also includes a reference to *"arithmetic skills"*.

(i) The rate of $23.39, with a relativity of 98.8% sits under the C10 level in the *Manufacturing Award.*

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[355] *Aged Care Award*, Sch B, B.2.

(j) The indicative roles remain broad and include: *"second and subsequence years of services"* for a general clerk/typist; personal care worker grade 2 and *"unqualified"* recreational activities officer.

(k) By reference to AQF, the level 3 classification appears to align with the minimum requirements of a C11 classification - Certificate II. This also factors in the level of time and experience required (in contrast to level 1 which is *"entry level"*).

(l) Based on those considerations, and when considered against the classification requirements for level 1-4, the minimum rate presently set at 98.8% relativity to the C10 rate sits too high.

23.17 Turning to classification level 5-7, the minimum rates do not appear to have been properly set having regard to the requisite experience and skills required for those levels. That conclusion is supported by the following:

Level 5

(a) The *Aged Care Award* provides that a level 6 aged care employee *"requires substantial on-the-job training, may require formal qualifications at trade or certificate level and/or relevant skills training or experience".* Additionally, they must possess capabilities including: *"functioning semi-autonomously"* and *"responsible for work performed with a substantial level of accountability".*

(b) The rate of $24.47, with a relativity of 103.4% sits between C10 and C9 levels in the *Manufacturing Award*. The minimum requirement for C9 is *"C10 (Trade certificate III) + 20% towards Diploma or equivalent"*.

(c) Employees at this level are required to have *"broader"* skills than level 4. As such, rate above the C10 is appropriate. However, subject to a view as to whether the experience requires is equivalent to *"20% towards Diploma"*, noting the personal care worker each hold a Cert III at level 4, it is arguable the minimum rate for a level 5 aged care employee should be increased and aligned to a C9 rate.

(d) The minimum rate presently set at 103.5% relativity to the C10 rate appears to sit slightly low.

Level 6 and 7

(e) The *Aged Care Award* provides that a level 6 aged care employee *"may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience".* Similarly, a level 7 aged care employee *"may require formal qualifications at trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience".*

(f) Additionally, they must possess the following capabilities*:*

(i) Level 6: *"high level of autonomy", "responsible for work performed with a substantial level of accountability"* and possess *"well developed communication, interpersonal and/or arithmetic skills".*

(ii) Level 7: *"functioning autonomously"* and prioritising their work and the work of others within established policies, guidelines and procedures; responsible for work performed with a substantial level of accountability and responsibility; possesses *"well developed communication, interpersonal and/or arithmetic skills";* and may supervise the work of others, including work allocation, rostering and guidance.

(g) The skills required at both Level 6 and 7, even absent a mandatory requirement for qualification, represent a *"broad range of cognitive, technical and communication skills"* and in light of the reference to autonomy and accountability (and supervisory duties for level 7), such employees may be required to apply those skills in manner consistent with AQF Level 6 - Advanced Diploma qualification, namely: *"analyse information to complete a range of activities", "interpret and transmit solutions to unpredictable and sometimes complex problems"* and *"transmit information and skills to others"*.

(h) The rates of $25.79 and $26.26, with a relativity of 109% and 111% sit on either side of the C8 level in the *Manufacturing Award*. The minimum requirement for that level is *"C10 (Trade certificate III) + 40% towards Diploma or equivalent".*

(i) Noting that the personal care worker is required to have a Cert III (or relevant experience), having regard to those considerations which include a higher level of skills than level 4-6, the current rate appears to sit too low. This may be a result from trying the balance the three streams of worker currently falling within the Level 7 aged care employee classification.

23.18 The preceding analysis supports a conclusion that the minimum rates in the *Aged Care Award* when compared against the C10 framework and AQF contain anomalies.

The Modern Awards Objective: s 134(1)(f); and

The Minimum Wages Objective: s 284(1)(d)

23.19 Noting we will develop more fuller submissions in closing, we make the following preliminary observations with respect to the modern awards objective and minimum awards objective.

23.20 Given the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards, this next section sets out the minimum rates in awards covering similar work.[356]

23.21 This exercise will be undertaken by reference to the hourly rate[357] in the *Aged Care Award*, compared against equivalent roles within classifications in the following awards:

(a) *Clerks—Private Sector Award 2020* (**Clerks Award**);

(b) *Hospitality Industry (General) Award 2020* (**Hospitality Award**);

(c) *Gardening and Landscaping Services Award 2020* (**Gardening Award**);

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[356] *FW Act*, s 134(1)(f).

[357] As at 1 July 2021.

(d) *Dry Cleaning and Laundry Industry Award 2020* (**Dry Cleaning Award**);

(e) *Cleaning Services Award 2020* (**Cleaning Award**);

(f) *Road Transport and Distribution Award 2020* (**Road Transport Award**);

(g) *SCHADS Award*; and

(h) *Miscellaneous Award 2020*.

23.22 The following table compares the minimum rates for *"clerks"* covered under the *Aged Care Award*, *Clerks Award* and *Hospitality Award*:

Role	Aged Care	Rate	Clerks	Rate	Hospitality	Rate
General Clerk (<3 Months)	Level 1	21.62	Level 1, Year 1	21.62	Introductory Level	20.33
General Clerk/Typist (3-12 Months)	Level 2	22.51	Level 1, year 1	21.62	Clerical Level 2/3/4	21.72-23.67
General Clerk/Typist (1+ years)	Level 3	23.39	Level 1, Year 2/3	22.69 – 23.39	Clerical Level 2/3/4	21.72-23.67
Receptionist	Level 3	23.39	Level 1, Year 1/2/3, Level 2	21.62 – 23.39	Front Office (FO) Level 2, Guest Services (GS) Level 2, Clerical Level 4	21.72, 23.67
Pay Clerk	Level 3	23.39	Level 2	23.67-24.11	Clerical level 4	23.67
Senior Clerk	Level 4	23.67	Level 3	25.00	Clerical level 4	23.67
Senior Receptionist	Level 4	23.67	Level 3	25.00	Clerical level 4, FO Level 3/4	23.67, 22.46-23.67
Clerical Supervisor	Level 7	26.26	Level 5	27.32	Clerical level 5, FO Level 5	25.16

23.23 The following table compares the minimum rates for *"laundry hand"* covered under the *Aged Care Award*, *Dry Cleaning Award* and *Hospitality Award*:

Role	Aged Care	Rate	Dry Cleaning	Rate	Hospitality	Rate
Laundry hand (<3 Months)	Level 1	21.62	Level 1	20.33	Introductory Level	20.33
Laundry hand (3+ Months)	Level 2	22.51	Level 1/2/3/4	20.33-22.46	GS Level 1	20.92

23.24 The following table compares the minimum rates for *"cleaner"* covered under the *Aged Care Award*, *Cleaning* Award and *Hospitality Award*:

Role	Aged Care	Rate	Cleaning	Rate	Hospitality	Rate
Cleaner (<3 Months)	Level 1	21.62	Level 1	21.71	Introductory Level	20.33
Cleaner (3 + Months)	Level 2	22.51	Level 2	22.46	GS Level 1/2	20.92-21.72

23.25 The following table compares the minimum rates for *"gardener"* covered under the *Aged Care Award*, *Gardening Award* and *Hospitality Award*:

Role	Aged Care	Rate	Gardening	Rate	Hospitality	Rate
Assistant Gardener (<3 months)	Level 1	21.62	Introductory Level	20.33	Introductory Level	20.33
Gardener (non-trade)	Level 2	22.51	Level 1/2/3	20.92-22.72	Gardener Level 2/3	21.72-22.46
Gardener (trade or Cert III)	Level 4	23.67	Level 4	23.67	Gardener Level 4	23.67
Gardener (advanced)	Level 6	25.79	Level 5	24.41	Gardener Level 4	23.67

Role	Aged Care	Rate	Gardening	Rate	Hospitality	Rate
Gardener (superintendent)	Level 7	26.26	Level 5	24.41	Gardener Level 5	25.16

23.26 The following table compares the minimum rates for *"food services assistant"* and *"cook"* covered under the *Aged Care Award* and Hospitality Award:

Role	Aged Care	Rate	Hospitality	Rate
Food Services Assistant (<3 Months)	Level 1	21.62	Introductory Level	20.33
Food Services Assistant (3+ Months)	Level 2	22.51	Food and Beverage (FB) Level 1-2, Kitchen Level 1	20.92-21.72
Cook	Level 3	23.39	Cook Level 2/3	21.72-22.46
Senior Cook (Trade)	Level 4	23.67	Cook Level 4	23.67
Chef	Level 5	24.47	Cook Level 5	25.16
Senior Chef	Level 6	25.79	Cook Level 5	25.16
Chef/Food Services Supervisor	Level 7	26.26	FB Level 5, Cook Level 6	25.16-25.83

23.27 The following table compares the minimum rates for *"Maintenance/Handyperson"* covered under the *Aged Care Award*, *Miscellaneous Award* and *Hospitality Award*:

Role	Aged Care	Rate	Miscellaneous	Rate	Hospitality	Rate
Maintenance/Handyperson (unqualified)	Level 2	22.51	Level 2	21.72	Handyperson Level 3	22.46
Maintenance/Handyman (qualified)	Level 4	23.67	Level 3	23.69	Gardener Level 4	23.67
Maintenance Tradesperson (Advanced)	Level 6	25.79	Level 4	25.83	Gardener Level 4	23.67

23.28 The following table compares the minimum rates for *“driver”* covered under the *Aged Care Award*, *Road Transport Award* and *Hospitality Award*:

Role	Aged Care	Rate	RTD	Rate	Hospitality	Rate
Driver (less than 3 T)	Level 2	22.51	Level 2	22.08	GS Level 2	21.72
Driver (less than 3 T with First Aid)	Level 3	23.39	Level 2 + First Aid Allowance	22.08 + .36	GS Level 2	21.72
Driver (3 T and over)	Level 4	23.67	Level 2-10 depending on vehicle size	22.08-25.36	GS Level 2	21.72

23.29 The following table compares the minimum rates for *“personal care worker”* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
PCW 1	Level 2	22.51	HC level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 2	Level 3	23.39	HC Level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 3	Level 4	23.67	HC level 3	23.67-24.40	Level 2	29.12-31.77
PCW 4	Level 5	24.47	HC level 4	25.83-26.34	Level 3	32.54-34.90
PCW 5	Level 7	26.26	HC level 4 (maybe level 5)	26.34	Level 3 4)	32.54-34.90

23.30 The following table compares the minimum rates for *“Recreational/Lifestyle Activities Officer”* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
Recreational/Lifestyle Activities Officer (unqualified)	Level 2	22.51	Level 1/2	21.88-23.19	Level 1	22.11-23.67

23.31 The following table compares the minimum rates for *"general services supervisor"* covered under the *Aged Care Award* and Hospitality Award:

Role	Aged Care	Rate	Hospitality	Rate
General Services Supervisor	Level 7	26.26	GS Level 5, FO Level 5, Clerical Level 5,	25.16

23.32 The following table compares the minimum rates for *"interpreter"* covered under the *Aged Care Award* and *Miscellaneous Award*:

Role	Aged Care	Rate	Miscellaneous	Rate
Secretary Interpreter (unqualified)	Level 5	24.47	Level 2	21.72
Interpreter (qualified)	Level 7	26.26	Level 3/4	23.67-25.83

23.33 In light of that comparison, the following preliminary observations may be made with respect to the existing classifications in the *Aged Care Award*:

(a) ***Level 1:*** The comparable positions in the Gardening Award is described as *"entry level"* and under the Hospitality Award an employee is to remain at *"introductory level for up to 3 months".*

(b) ***Level 2:*** Having regard to equivalent roles under the Hospitality Award, Dry Cleaning Award, Cleaning Award and Gardening Award, the rate for aged care employee level 2 (excluding personal care worker) is higher than the majority of rates fixed for comparable roles.

(c) ***Level 3:*** The rates with respect to comparable work throughout the modern award system is less assistive, with each different classification grading levels and descriptions.

(d) ***Level 4:*** This is consistent throughout.

(e) ***Level 5:*** Turning to the comparable personal care worker roles, the rates of pay under the *SCHADS Award* sit between $25.83 and $26.34.

23.34 That analysis also indicates that the classification of *"aged care employee"* presently covers a broad range of general, administrative and food services positions that have comparable roles in several existing modern awards.

23.35 In contrast, the comparable roles for personal care worker are few. As such, for the benefit of ensuring consistency (as well as ongoing stability), the separation of the personal care worker would contribute to a simpler and consistent modern award system. We will further develop that argument in closing submissions.

Conclusion

23.36 The rates in the *Aged Care Award* were not properly set or subject to any work value assessment at or since the award modernisation process. The classification structure in the Aged Care Award currently conflates unrelated job families. We submit that a more appropriate classification structure would separate the personal care workers from the support services.

23.37 A question may also be raised as to whether the personal care worker should be required to hold a Certificate III and where the C10 classification should properly sit within a separate personal care worker structure.

24. ANALYSIS OF THE *NURSES AWARD*

What are the relevant benchmark classifications for the C10 comparison?

24.1 It should not be controversial for the Commission to determine that *"Nursing Assistant - Experienced"* is the key classification for the award. That classification requires the employee to be the holder of a relevant Certificate III qualification. The minimum rate for an that classification is $899.50, which is consistent with the minimum rate for a C10 level under the *Manufacturing Award.*

If applied to the existing classification internal relativities what outcome does this drive?

24.2 By reference to the key classification, the internal relativity to *"Nursing Assistant - Experienced"* allows for comparison against the existing relativities against the C10 framework (incremental payments are excluded for the purpose of this exercise). That comparison appears in the table below:

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*Nurses Award* classification	Current relativity to C10 (%)	Current Wage Rate ($)
C14	Up to 38 hours induction training	78	772.60			
C13	In-house training	82	794.80			
C12	Certificate I or Certificate II or equivalent	87.4	825.20			
C14	Up to 38 hours induction training	78	772.60			
				Student enrolled nurses 21 years of age and over	91	821.40
C11	Certificate II	92.4	853.60			
				Nursing assistant - 1st Year	94	843.40
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100**	**899.50**	Nursing assistant - Experienced (Cert III)	**100**	**899.50**
				Enrolled nurses - Pay point 1	102	916.20

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*Nurses Award* classification	Current relativity to C10 (%)	Current Wage Rate ($)
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105	927.70			
				RN - level 1 - Pay point 1	109	980.10
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110	955.90			
C7	Certificate IV OR C10 (Trade certificate III) + 60% towards Diploma or equivalent	115	981.50			
C6	C10 (Trade certificate III) + 80% towards Diploma or equivalent OR 50% towards Advanced Diploma or equivalent	125	1031.30			125
C5	Diploma or equivalent	130	1052.40			
				RN - level 2 - Pay point 1	134	1209.10
C4	80% towards an Advanced Diploma or equivalent	135	1080.60			
C3	Advanced Diploma or equivalent	145	1137.20			
				RN - level 3 - Pay point 1	146	1311.00
C2(a)	Advanced Diploma or equivalent + additional training	150	1165.60			
C2(b)	Advanced Diploma or equivalent + additional training	160	1216.50			
				RN - level 4 - Grade 1	166	1496.30
				Nurse Practitioner - 1st year	168	1508.60
				RN - level 5 Grade 1	168	1509.90
C1	Degree	180/210				

What anomalies does this create compared to the C10 framework that need to be considered?

24.3 Turning to the anomalies that arise by that exercise, it is useful to note the observations by the Commission at to the rates in the *Nurses Award* (see above: *"Recent Considerations of the C10 Classification Structure"* at [22.16]).

Classifications

24.4 In order to assist with assessing any anomalies arising with respect to the qualifications required at each classification level, the next table sets out the minimum qualification for each classification, together with reference to the corresponding AQF and the C10 level that properly aligns with that AQF:

Role	Minimum Qualification	AQF	C10
NA	Certificate III in Health Assistance	Level 3	C10
EN	Diploma of Nursing (Enrolled Nurse) - 18-24 months to complete Minimum of 400 clinical placement hours for clinical skills acquisition and registration Register as an EN through the Nursing and Midwifery Board of Australia (**NMBA**).[358]	Level 5	C5
RN	Accredited tertiary degree: • Bachelor of Nursing (3 year degree); or • Master of Nursing (Graduate Entry) Program (2 year). Register as an RN through the Nursing and Midwifery Board of Australia (**NMBA**) (renew each year).[359]	Level 7	C1

[358] Department of Health, *"Becoming an enrolled nurse"* (Fact Sheet); Reference Bundle, Tab 20, page 1520.

[359] Department of Health, *"Becoming a Registered Nurse"* (Fact Sheet); Reference Bundle, Tab 19, page 1518.

Role	Minimum Qualification	AQF	C10
NP	Master of Nursing (Nurse Practitioner) 3 years full time advanced practice experience which demonstrates that they meet the NMBA National Practice Standards for the NP.[360]	Level 8	C1

24.5 Putting aside consideration of the minimum rates, a comparison of the C10 level and the qualification provided for ENs, RNs and NPs appear to be sit too low within the C10 framework. We make the following observations:

(a) The minimum rates for ENs currently align at 102% relativity, which sits between C10 and C9. However, an EN is required to obtain a Diploma of Nursing, which aligns to the C5 rate.

(b) The minimum rates for a RN currently aligns just below a C8. However, the standard qualification for a RN is an accredited tertiary degree - which is an AQF Level 7 and aligns with C1.

(c) The minimum rates for a NP currently aligns with a C2(b) rate. However, the qualification for NP is a post-graduate degree. As such, the current rate aligned to minimum experience of *"Advanced Diploma"* does not correlate.

24.6 Save for that discrepancy by reference to qualification, the existing classification levels and descriptions appear to be appropriate. It may also be noted that whilst the ANMF seek to introduce a new classification structure for nurses providing aged care services, they do not seek to alter the existing structure.

[360] Department of Health, "Becoming a Nurse Practitioner" (Fact Sheet); Reference Bundle, Tab 18, page 1516.

Increments

24.7 In the earlier summary of decisions with respect to the pre-reform awards, the minimum rates - together with increments - were described as properly set. However, given that the minimum rates do not align to the C10 framework. The incremental pay points should be reviewed to ensure they relate to competency and not service.[361]

24.8 To the extent any of the increments are service based or the effluxion of time, they should be reviewed and only retained if set by reference to competency.[362]

24.9 Further, to the extend the Commission embrace any segregation of nurse employees in aged care, the relevance of service and acquisition of competency needs to be considered in the context of service in aged care and not generally.

Conclusion

24.10 The rates in the *Nurses Award* may have been properly set at one stage but having regard to qualifications and AQF required for each classification - the minimum rates do not correspond to the minimum qualifications of the positions when compared against the AQF. As such, there appears to be a significant anomaly when the existing minimum rates in the *Nurses Award* are compared against the C10 framework for some classifications.

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[361] See *Teachers Case.*

[362] *Teachers Case* at [647].

25. ANALYSIS OF THE *SCHADS AWARD*

What are the relevant benchmark classifications for the C10 comparison?

25.1 The starting point to analyse the rates as fixed is to determine the key classification. We submit it would not be controversial for the Commission to determine that home care employee level 3 is the key classification for the award. That classification requires the employee to be the holder of a relevant Certificate III qualification. The minimum rate for an that classification is $899.50, which is consistent with the minimum rate for a C10 level under the *Manufacturing Award.*

If applied to the existing classification internal relativities what outcome does this drive?

25.2 By reference to the key classification, the internal relativity to *"Level 3"*, allows for comparison against the current relativities in the *Manufacturing Award* (incremental payments are excluded for the purpose of this exercise). That comparison appears in the table below:

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*SCHADS Award* classification: Home care employee	Current relativity to C10 (%)	Current Wage Rate ($)
C14	Up to 38 hours induction training	78	772.60			
C13	In-house training	82	794.80			
C12	Certificate I or Certificate II or equivalent	87.4	825.20			
C11	Certificate II	92.4	853.60	Level 1 - Pay point 1	92	831.30
				Level 2 - Pay point 1	98	881.40
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100**	**899.50**	**Level 3 - Pay point 1**	**100**	**899.50**
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105	927.70			
				Level 4 - Pay point 1	109	981.40

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*SCHADS Award* classification: Home care employee	Current relativity to C10 (%)	Current Wage Rate ($)
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110	955.90			
C7	Certificate IV OR C10 (Trade certificate III) + 60% towards Diploma or equivalent	115	981.50			
				Level 5 - Pay point 1	117	1052.20
C6	C10 (Trade certificate III) + 80% towards Diploma or equivalent OR 50% towards Advanced Diploma or equivalent	125	1031.30			
C5	Diploma or equivalent	130	1052.40			
C4	80% towards an Advanced Diploma or equivalent	135	1080.60			
C3	Advanced Diploma or equivalent	145	1137.20			

What anomalies does this create compared to the C10 framework that need to be considered?

25.3 Prior to turning to potential anomalies, it useful to note recent observations by the Commission at to the rates in the *SCHADS Award* (see above: *"Recent Considerations of the C10 Classification Structure"* at [22.16]).

Classification

25.4 In comparing the existing minimum rates to the C10 framework, it is necessary to turn to the AQF. As mentioned above, there is no minimum qualification level for home care employees. However, similar to personal care workers, home care employees may obtain the following qualifications:

(a) Certificate III in Individual Support (Ageing);

(b) Certificate III in Individual Support (Ageing, Home and Community);

(c) Certificate IV in Aged Care;

(d) Certificate IV in Ageing Support; and

(e) Certificate IV in Disability.

25.5 An individual may also obtain a Certificate III in the form of a traineeship by which they study and *"train on the job",* within 12 months complete a Certificate III.

25.6 The qualification of Certificate III and IV align with AQF Levels 3 and 4, respectively.

25.7 The next table sets out the minimum qualification for each classification, together with reference to the corresponding AQF and the C10 level that properly aligns with that AQF:

Level	Qualification and Experience	AQF	C10
1	On-the-job training which may include an induction course		C14
2	Home Care Certificate or equivalent or relevant experience/on-the-job training commensurate with the requirements of work in this level	L1 - L2	C11
3	Certificate III or equivalent	L3	C10
4	Certificate III + relevant experience	L3	C9 - C8
5	Completion of a TAFE certificate or associate diploma. They might be acquired through completion of a degree or diploma course with little or no relevant work experience, or through lesser formal qualifications with relevant work skills, or through relevant experience and work skills commensurate with the requirements of work in this level.	L4 - L5 L5 - L7	C7 - C5 C5 - C1

25.8 When regard is had to the AQF, the qualifications attached to the respective classifications in some instances do not correlate. That conclusion is supported by the following:

(a) *First,* the C10 rate provides a benchmark reference point to set minimum rates. The prescribed qualification is Certificate III (or equivalent). This aligns to a Level 3 on the AQF. The Level 3 home care employee is appropriate classification.

(b) *Second*, the Level 1 and 2 home care employees align between C11 and C10. Notably, Level 1 aligns to C11, which has a minimum requirement of Certificate II. However, Level 1 is entry level and does not require outside qualification; with "*on-the-job training"* provides and possibly induction training. In contrast, Level 2 proscribes that a *"Home Care Certificate or equivalent"*. Given Certificate III is not proscribed, it may be assumed that the certificate referred to is either Certificate I or II. As such, both classifications do not align with the AQF and the minimum rates sit too high.

(c) *Third*, the Level 4 home care employee aligns between C9 and C8. It requires the employee to have Certificate III and relevant experience. That latter specification may properly bring the rate between those C9 and C8.

(d) *Fourth,* Level 5 home care employee aligns between C7 and C6. However, the classification description of potential qualification ranges from the completion of a TAFE certificate or associate diploma through to a diploma or degree. The current description is too broad. It may be advisable to provide for an additional classifications to accommodate higher qualification.

25.9 It should also be noted that the HSU SCHADS Application only invites consideration of one set of classification in the *SCHADS AWARD*: home care employees. As to the appropriateness of that classification structure, we make the following observations:

(a) The existing classification covers home care employees that provide care to children, adults and the elderly. The service may be temporary, short-term or long-term.

(b) The existing classifications do not provide for clear delineations between each level. As such, may benefit additional description and/or the creation of additional levels.

Increments

25.10 It is unclear whether the pay points within the classification levels are based upon competency and/or service. This should be reviewed at the time of making any adjustment to the minimum rates. Pay points based upon service should be either removed altogether or replaced with pay points fixed in relation to work value (i.e. competency).

Further Observations

25.11 The following preliminary observations are made with respect to the modern awards objective and minimum wages objective. We will develop more fuller submissions, in this respect, in closing submissions.

25.12 The following table compares the minimum rates for *"personal care worker"* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
PCW 1	Level 2	22.51	HC level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 2	Level 3	23.39	HC Level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 3	Level 4	23.67	HC level 3	23.67-24.40	Level 2	29.12-31.77
PCW 4	Level 5	24.47	HC level 4	25.83-26.34	Level 3	32.54-34.90
PCW 5	Level 7	26.26	HC level 4 (maybe level 5)	26.34	Level 3 4)	32.54-34.90

25.13 A further consideration relevant to considerations of stability and consistency, is the fact that the *SCHADS Award* comprises of four classification structures. If a conclusion is reached that the minimum rates with respect to home care employees were not properly set, it follow that the Commission should review the balance of the minimum rates within the *SCHADS Award*.

Conclusion

25.14 There appears to a material anomaly with respect to the classification structure concerning home care employees in the SCHADS Award. This anomaly is emphasised when the existing classifications and minimum rates are compared against the C10 framework and AQF.

26. CONCLUSION: DO WORK VALUE REASONS EXIST THAT WARRANT DEVIATION FROM C10 FRAMEWORK?

26.1 At this stage of the proceedings this question is difficult to answer. Section 134(g) of the *FW Act* naturally militates against this.

26.2 There is clearly no evidence (even taken at its highest) that supports the Applicants' claims of a 25% uniform increase to minimum wages in the *Aged Care Award, Nurses Award* and *SCHADS Award*. A uniform increase by itself offends in concept the proper setting of minimum rates against the C10 framework and the AQF.[363]

26.3 Clearly, proper alignment to the C10 framework will, for some classifications in the awards, justify a change to minimum rates and this is supported by the contentions advanced earlier in these submissions on work value reasons.

26.4 Whether any marginal departure from properly setting the minimum rates against the C10 framework and the AQF is supported will only emerge after the evidence is taken.

26.5 This consideration is always a challenging one as the C10 schema is inherently situated in an industrial sector context not a health sector context with the *Manufacturing Award* comprehending a vast scale and breadth of enterprises and industries.

26.6 The aged care sector by comparison to the industrial sector is generally characterised by the following:

(a) a primary focus on interpersonal relations with people as opposed to problem solving with *'things'*;

(b) a less *'industrialised'* work environment;

(c) responsibility being focussed on the provision of care rather than production outcomes; and

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[363] *ACT Child Care decision.*

(d) outcomes being measured in more intangible ways rather than production targets and efficiency.

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