[2025] FWCFB 297 [Note: a correction has been issued to this document]

DECISION

Fair Work Act 2009
s 157—FWC may vary etc. modern awards if necessary to achieve modern awards objective

Gender-based undervaluation — priority awards review — *Health Professional and Support Services Award 2020*
(AM2024/20)

JUSTICE HATCHER, PRESIDENT
VICE PRESIDENT ASBURY
DEPUTY PRESIDENT O'NEILL
DEPUTY PRESIDENT SLEVIN
DEPUTY PRESIDENT GRAYSON

SYDNEY, 24 DECEMBER 2025

Gender-based undervaluation – priority awards review – Health Professional and Support Services Award 2020 – dental assistants, pathology collectors and health professionals – finalisation of variations to the award.

Introduction

[1] On 7 June 2024, the Commission initiated a review of identified classifications in five modern awards to consider whether those classifications have been the subject of gender-based undervaluation (**Review**). This decision finalises the Review in respect of classifications applying to dental assistants, pathology collectors and health professionals covered by the *Health Professionals and Support Services Award 2020*[1] (**HPSS Award**).

[2] In our initial decision issued on 16 April 2025[2] (**April decision**) we found that the classifications and minimum wage rates prescribed by the HPSS Award for dental assistants, pathology collectors and health professionals had been the subject of gender-based undervaluation and that, for the purpose of s 157(2)(a) of the *Fair Work Act 2009* (Cth) (**FW Act**), an adjustment to those rates of pay was justified by 'work value reasons' (as defined in s 157(2A)). In respect of each category of these classifications, we expressed *provisional* views as to how the identified gender-based undervaluation should be rectified by way of variations to the classifications and rates of pay in the HPSS Award.

[3] After the April decision was issued, individual members of this Expert Panel conducted a number of conferences in an endeavour to gauge the response of interested parties to our *provisional* views and to seek consensus as to the variations which should be made to the HPSS Award. To aid this process, staff of the Commission published a draft determination which

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[1] MA000027.

[2] *Gender-based undervaluation – priority awards review* [2025] FWCFB 74, 340 IR 1 ('April decision').

would give effect to the *provisional* views concerning dental assistants and pathology collectors. No consensus was able to be achieved, but there was a degree of narrowing of the issues in contention.

[4] We then issued directions for the filing of evidence and submissions concerning the outstanding issues. We conducted a hearing in relation to dental assistants on 21–23 October 2025 and, in relation to pathology collectors and health professionals, on 12–13 and 20 November 2025.

[5] In relation to dental assistants, the issues in contention concerned the new classifications and rates of pay to be adopted to rectify the identified gender-based undervaluation, and the operative date and phasing-in of the minimum wage rate adjustments involved. The same issues arose in respect of pathology collectors and health professionals, but there was also a submission made (by Australian Pathology) that no variations to the classifications and minimum wage rates for these employees should be made at all because they were not necessary to achieve the modern awards objective (s 134(1)) or the minimum wages objective (s 284(1)).

Dental assistants

[6] In the April decision at [288], we concluded that gender-based undervaluation of the work of dental assistants which we had identified should be addressed according to the following principles:

- dental assistants should be reclassified within the existing classification structure for Support Services employees in clauses 16 and A.1 of the HPSS Award;
- based on our findings as to their work value, dental assistants, including unqualified dental assistants, should be placed above Level 4 in the existing structure (which is aligned with the C10 rate); and
- Certificate III-qualified dental assistants should be classified higher than unqualified dental assistants.

[7] Based on these principles, our *provisional* view was that the 'Technical and clinical' indicative roles contained in the classification definitions for the Support Services employees classification structure should be varied to place dental assistants in the following levels (with the wage rates stated in the April decision updated to the current HPSS Award minimum wage rates as adjusted by the *Annual Wage Review 2025*):

Support Services classification	**Criteria**	**$ per week**
Level 1	Entry level Less than three months' experience	978.20
Level 5	Unqualified Has undertaken on-the-job training	1104.70
Level 6	Qualified Holds Certificate III or equivalent qualification or experience	1164.20
Level 7	Advanced Holds Certificate IV or equivalent qualification or experience	1185.10

[8] Consistent with this *provisional* view, we proposed that existing employees would translate from their current levels to new levels in the new classification structure as follows:

Existing classification	New classification	Increase %
Level 1	Level 1	0
Level 2	Level 5	8.6
Level 4	Level 6	9.0
Level 5	Level 7	7.2

[9] The following parties filed evidence and submissions in response to the *provisional* view:

- the Australian Council of Trade Unions (**ACTU**), the Health Services Union (**HSU**) and the United Workers' Union (**UWU**) (collectively, the **Joint Unions**);
- the Dental Assistants Professional Association (**DAPA**);
- the Dental Service Business Council (**DSBC**); and
- the Australian Dental Association (**ADA**).

[10] No party submitted that the HPSS Award should not be varied to deal with the findings as to gender-based undervaluation made in the April decision. The parties' submissions raised three main issues in response to our *provisional* view. The first was whether the classification structure should be amended to provide a further level between Level 1 and Level 5 for the progression of unqualified dental assistants and, if so, which level would be appropriate. The second concerned the appropriate qualifications and experience for progression between levels. The third concerned the operative date and phasing in arrangements for the changes proposed.

[11] The Joint Unions supported the *provisional* view that it was appropriate that the dental assistants move from Level 1 to Level 5 upon the completion of three months' experience but, in the alternative, submitted that if there was to be an additional level, it should be at Level 4 and apply for the first 6–12 months. The Joint Unions also supported the *provisional* view as to the classification criteria for Levels 6 and 7. As to operative date and phasing-in, the Joint Unions submitted that, subject to the allowance of a 1–2 month notice period to allow administrative arrangements for the translation of employees to their new classifications to take place, the variations and associated wage increases should be implemented immediately and without phasing-in. In support of its position, the Joint Unions relied on the evidence of the following witnesses:

(1) Emmily Medwin, a dental assistant holding a Certificate III in Dental Assisting and employed by Attention Dental, which provides clinics with temporary staff. Ms Medwin's evidence was in addition to the evidence she gave in the initial phase of the proceeding. Ms Medwin's further evidence focused on the significance of the Certificate III qualification for the development of the essential skills and knowledge required of dental assistants.[3]

[3] Exhibit HPSS140 (supplementary witness statement of Emmily Medwin, 15 October 2025).

(2) Dr James Stanford, the Director of the Centre for Future Work in Canada. Dr Stanford also gave evidence, via an expert report, in the earlier stage of the proceeding. Dr Stanford prepared an additional expert report (**second Stanford report**) concerning how the minimum wage rate increases that would arise from the implementation of the *provisional* view would affect employment costs, job growth, and the broader economy.[4]

[12] Both Ms Medwin and Dr Stanford were cross-examined.

[13] The DAPA submitted that we should depart from the *provisional* view by establishing an intermediate classification for unqualified dental assistants at Level 3, to apply to employees with three to 12 months' experience. This proposition involved an acceptance that there was a substantial difference between someone with three months' experience and 12 months' experience. The DAPA also proposed that unqualified dental assistants should be able to progress from Level 5 to Level 6 upon acquiring three years' experience, and to progress to Level 7 after a further four years' experience. The DAPA supported the Joint Unions' position as to operative date and phasing-in but also proposed, in the alternative, that the increases should be implemented in three phases: 50 per cent from 1 December 2025, 25 per cent from 1 March 2026 and the final 25 per cent from 1 July 2026.

[14] The DAPA relied on witness statements made by the following persons:

(1) Samuel Manns, a solicitor for the DAPA. His statement annexed research into the entities represented by the DSBC including Abano Healthcare Group, National Dental Care, Pacific Smiles Group, and Primary Dental.[5]

(2) Martin Thomas, the CEO of the DAPA. Mr Thomas gave evidence about a survey conducted by the DAPA concerning retention issues for dental assistants.[6]

(3) Barbara Hayes, the Chairperson of the Board of the DAPA, who holds a Certificate III in Dental Assisting, a Certificate IV in Work Health and Safety and a Certificate in Training and Assessment. Ms Hayes practised as a dental assistant for over 50 years before retiring in 2021. She previously gave evidence in the earlier phase of this proceeding. The evidence she gave in this stage concerned the importance of Certificate III and IV qualifications for dental assistants.[7]

(4) Catherine Shakespeare, a trainer and assessor for the DAPA. Her evidence likewise went to the importance of Certificate III and IV qualifications in developing dental assistants' advanced skills.[8]

[15] All of the above witnesses except Mr Manns were cross-examined.

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[4] Exhibit HPSS146 (witness statement (with annexed supplementary expert report) of Dr James Stanford, 15 October 2025).

[5] Exhibit HPSS125 (witness statement of Samuel Manns, 13 October 2025).

[6] Exhibit HPSS135 (witness statement of Martin Thomas, 5 September 2025).

[7] Exhibit HPSS137 (second witness statement of Barbara Hayes, 10 October 2025).

[8] Exhibit HPSS138 (witness statement of Catherine Shakespeare, 14 October 2025).

[16] The DSBC did not appear in the earlier phase of the proceedings. In its submissions made in response to the *provisional* view in the April decision, the DSBC acknowledged that dental assistants are overwhelmingly female and that the evidence and findings of the Commission supported a reconsideration of the classification of dental assistants, but advanced a proposal in that respect which differed substantially from the *provisional* view. Its proposed classification structure was as follows:

Support Services classification	**Criteria**
Level 1	New entrant Unqualified with less than three months' experience
Level 2	New entrant with three months' experience Unqualified with more than 3 months' experience with limited responsibility, accountability and discretion and works under limited supervision either individually or in a team.
Level 3	Intermediate Unqualified with more than 3 months' and up to 2 years' experience.
Level 5	Intermediate (qualified) or experienced Has up to 2 years' experience and a Certificate III or IV qualification; or has 2–5 years' experience and no qualifications.
Level 6	Experienced Has over 3 years' experience and a Certificate III qualification; or has 5–7 years' experience and no qualifications.
Level 7	Advanced Has over 6 years' experience and a Certificate IV qualification; or has over 7 years' experience and no qualifications.
Level 8	Supervising Trains and supervises other dental assistants.

[17] On the issue of phasing-in, the DSBC proposed that 50 per cent of the minimum wage rate increases should take effect from 1 July 2026, with a further 25 per cent from 1 July 2027 and the final 25 per cent from 1 July 2028.

[18] The DSBC relied on the evidence of Dr Antony Benedetto,[9] a part-time clinical dentist and a board director of National Dental Care (**NDC**), one of the largest providers of dental services in Australia. Dr Benedetto, who was cross-examined, gave evidence about the financial impact of proposed wage increase for dental assistants.

[19] The ADA only participated in the initial phase of the proceedings to the extent of making a brief written submission. In response to the *provisional* view, the ADA also proposed a significantly different classification structure as follows:

Support Services classification	**Criteria**
Level 1	New entrant

[9] Exhibit HPSS141 (witness statement of Dr Antony Benedetto, 5 September 2025).

Support Services classification	Criteria
	Up to 3 months' industry experience as a dental assistant.
Level 3	Unqualified Up to 2 years' industry experience as a dental assistant.
Level 4	Qualified Dental assistant with Certificate III qualification and up to 2 years' industry experience as a dental assistant.
Level 5	Unqualified Over 2 and less than 5 years' industry experience as a dental assistant Qualified Dental assistant with Certificate III qualification and over 2 and less than 3 years' industry experience as a dental assistant.
Level 6	Unqualified but experienced Over 5 years' industry experience as a dental assistant. Qualified – Certificate III Certificate III qualification and over 3 years' industry experience as a dental assistant.
Level 7	Advanced Certificate IV qualification and over 5 years' industry experience as a dental assistant.

[20] The ADA proposed the same phase-in timetable for the minimum wage rate increases as the DSBC.

[21] The ADA relied on witness statements made by the following dental practitioners:

(1) Dr Jane Boroky — St Peters Dental Clinic, St Peters, South Australia.[10]
(2) Dr Kang Kim — Cura Health Advisory [11].
(3) Dr Arosha Weerakoon — Tewantin Family Dental, Tewantin, Queensland.[12]
(4) Dr Katherine Bailey — Riviera Dental Care, Bairnsdale, Victoria.[13]
(5) Dr Nauvneel Kashyap — Practice Ownership Consulting. [14]
(6) Dr Nomikos Rakkas — Goodlife Dental Studio, Alawa, Northern Territory.[15]
(7) Dr Vincenzo Figliomeni — Amore Dental, Hammond Park, Western Australia.[16]
(8) Dr Matthew Littleton — The Littleton Cole Dental Centre, Fortitude Valley, Queensland.[17]

[22] These witnesses gave evidence in their statements about the commercial profile of their respective dental businesses, their employment practices with respect to dental assistants, and

[10] Exhibit HPSS126 (witness statement of Dr Jane Boroky, 4 September 2025).

[11] Exhibit HPSS129 (witness statement of Dr Kang Kim, 9 September 2025).

[12] Exhibit HPSS130 (witness statement of Dr Arosha Weerakoon, 5 September 2025).

[13] Exhibit HPSS133 (witness statement of Dr Katherine Bailey, 5 September 2025).

[14] Exhibit HPSS139 (witness statement of Dr Nauvneel Kashyap, 9 September 2025).

[15] Exhibit HPSS142 (witness statement of Dr Nomikos Rakkas, 8 September 2025).

[16] Exhibit HPSS144 (witness statement of Dr Vincenzo Figliomeni, 5 September 2025).

[17] Exhibit HPSS145 (witness statement of Dr Matthew Littleton, 4 September 2025).

the financial impact of the wage increases that would arise from implementation of the *provisional* view. Each of these witnesses was cross-examined.

The classification structure – criteria and progression

[23] The first major issue concerning the proposal for a revised classification structure in the *provisional* view is whether there should be an intermediate classification for progression from Level 1 to Level 5. However, for those parties which sought modifications to the *provisional* view in this respect, this issue has played out in different ways. As set out above, the DAPA advanced the modest proposal that an unqualified dental assistant with more than three months but less than 12 months of industry experience should be placed in an intermediate classification at Level 3. The DSBC and the ADA, by contrast, proposed two intermediate classifications between Levels 1 and 5 as part of a more complex scheme whereby dental assistants would move through six or seven classification levels.

[24] Independent of our consideration of this first issue, we do not intend to adopt the classification proposals of the DSBC or the ADA for two reasons. First, they are fundamentally inconsistent with the work value findings in the April decision. As earlier stated, we determined on the basis of our work value findings that an unqualified dental assistant should be placed *above Level 4* in the existing structure — that is, at least at Level 5 — and a Certificate III-qualified dental assistant should be placed *above this* — that is, at least at Level 6. These conclusions were not qualified by any requirement for a particular level of service, apart from new entrants to the sector. However, the DSBC proposal places an unqualified dental assistant with up to two years' experience at Level 3 or below and a qualified dental assistant with up to two years' experience at Level 5. The ADA proposal similarly places an unqualified dental assistant with up to two years' experience at Level 3 and a qualified dental assistant with up to two years' experience at Level 4. The proposals therefore seek, unacceptably, to vitiate the work value findings in the April decision and to achieve a diminution in the minimum award rates of pay which we considered appropriate to properly value the work of dental assistants. Second, the proposals have a degree of complexity which is not justified by the various levels of training, knowledge and experience which, on the evidence, characterises the work of dental assistants. There are currently only four classification levels applicable to dental assistants, and the evidence does not support the proposition that there are sufficient gradations in the work of dental assistants to support the six or seven levels proposed by the ADA and the DSBC respectively. Some of the ADA's own witnesses were critical of this level of complexity. Dr Figliomeni, for example, said at least partly in reference to the ADA proposal:[18]

> Some of the proposals are so convoluted that it would take [an] administrative burden, a significant administrative burden to maintain and be on top of what's being proposed.

[25] Returning to the first issue, the key question is whether the evidence demonstrates that an unqualified dental assistant who has completed their first three months of industry experience will nonetheless lack a sufficient degree of proficiency such as to be paid the standard rate (Level 5) for a dental assistant without qualifications. We do not consider that the evidence has established this to the degree necessary to cause us to depart from our *provisional* view. The ADA's witnesses expressed a range of opinions on the question. Dr Rakkas gave evidence that it takes approximately six months for dental assistants to become competent in

[18] Transcript, 22 October 2025 PN1726.

basic tasks, such as chairside assisting and sterilization, but more complex tasks require additional time and experience. Dr Kashyap said that in a large company group structure with training resources, an inexperienced dental assistant can reach a standard that 80–90 per cent of dentists would be happy to work with in five weeks, but in smaller dental practices, it typically takes 18 months to two years to get a dental assistant to a standard that the dentist can productively work with. Dr Boroky and Dr Figliomeni said that an unqualified dental assistant with one year on-the-job training is equivalent to someone who has completed a Certificate III. Dr Littleton said that the step from Level 1 to Level 5 in the *provisional* view for an unqualified dental assistant after three months' experience 'may actually be a good thing for employers in helping them to make up their mind to move someone on who is still raising concerns about their suitability'[19], but otherwise said that it took around two years before a dental assistant became a 'bona fide asset to the practice'.[20]

[26] The DSBC's witness, Dr Benedetto, said that a dental assistant with three months' experience would understand basic infection control and instrument handling, patient confidentiality, and be able to set up and clean the dentist's room between patients, and may also have begun to develop some 'chairside skills'.[21] However, he said, they would not yet have the level of experience to assist with advanced procedures or taking X-rays, interact with patients, including nervous patients, give post-operative instructions, introduce the patient to the dentist by giving a detailed patient presentation, or work unsupervised in the sterilisation room operating the autoclave and filling out the required documentation. He described various stages of the acquisition of experience by dental assistants at three to nine months, one year and two years.

[27] The DAPA's witness, Ms Shakespeare, who has had industry-wide experience in training dental assistants, disagreed with Dr Benedetto's assessment. Her evidence was to the effect that, after three months' experience, a dental assistant 'should have acquired the fundamental skills required for the position',[22] would have 'developed a clear understanding of how common dental procedures are performed',[23] and 'is generally able to assist with procedures competently and without significance difficulty'.[24] Ms Shakespeare acknowledged, however, that at the three months mark there 'may still be some variation in the level of communication required between the dentist and the dental assistant, for example, in naming or identifying instruments'[25] and that, beyond that point, 'continued experience primarily serves to build greater proficiency, speed, and confidence in performing [their] tasks'.[26] Ms Medwin opined, based on her experience in training staff at NDC, that it would take an unqualified dental assistant without prior experience up to three months to develop knowledge of the 'key principles and basic skills' of a dental assistant.[27]

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[19] Exhibit HPSS145 (witness statement of Matthew Littleton, 4 September 2025) [15].

[20] Ibid.

[21] Exhibit HPSS141 (witness statement of Dr Antony Benedetto, 5 September 2025) [23].

[22] Exhibit HPSS138 (witness statement of Catherine Shakespeare, 14 October 2025) [37].

[23] Ibid [36].

[24] Ibid.

[25] Ibid.

[26] Ibid.

[27] Exhibit HPSS140 (supplementary witness statement of Emmily Medwin, 15 October 2025) [24].

[28] The assessment we made in the April decision at [288] concerning the work value of dental assistants was that, in ongoing employment, dental assistants (including unqualified dental assistants) who 'perform the basic duties and are subject to the employer expectations we have identified' (described at [253]–[278] of the April decision) should be classified at *above* Level 4. We accept that the DSBC and ADA evidence in this stage of the proceedings establishes that dental assistants will continue to acquire skills, knowledge and experience over time once they are past the three-month induction stage, and we also accept (as we go on to discuss) that this should be recognised and accommodated in the classification structure. However, this does not vitiate our conclusion in the April decision concerning the work value of dental assistants. The proposals advanced by the DSBC and the ADA for intermediate classifications between Level 1 and Level 5, in the terms advanced, appears to us to be a proxy for an attempted revisitation of the valuation placed upon the work of dental assistants in the April decision.

[29] As we acknowledged in the April decision at [291], there are some imperfections in the outcome that would obtain from adoption of the *provisional* view resulting from the approach of 'rectifying gender-based undervaluation within the constraints of the existing classification structure'. One of those imperfections is that the wage increment from the entry level at Level 1 to Level 5 is disproportionately large compared to the pay increments between Levels 5 to 6, and 6 to 7. This imperfection is the result of the existing structure for Support Services employees placing all such employees at Level 1 for the first three months of work in the industry, rather than the rate for Level 5 being too high to properly reflect the work value of unqualified dental assistants after the first three months' experience.

[30] The DAPA's proposal to resolve this problem by establishing an intermediate indicative role at Level 3 for unqualified dental assistants with 3-12 months' experience would lead to an excessively complex classification structure. We consider, taking into account the evidence to which we have referred, that a better resolution of the problem would be to establish a single entry-level indicative role at Level 3 to apply to the first 12 months' experience. This will recognise the continuing acquisition of skills in the initial 12-month period and facilitate a smoother transition to Level 5. Because a 12-month entry-level classification involves a period during which there is a considerably greater level of skill acquisition, work value considerations mean that it cannot be placed at Level 1 or 2.

[31] The other main issue concerns the descriptors to apply for the indicative roles of dental assistants at Levels 6 and 7. As just stated, the evidence before us in this stage of the proceedings establishes, and the parties agree, that dental assistants continue to acquire skills, knowledge and experience over time. This includes dental assistants without a qualification, concerning whom there is a consensus that at some level of experience (the parties differed as to when) they can be regarded as equivalent in work value to a qualified dental assistant. The *provisional* view contemplated that unqualified dental assistants could be classified at Level 6 if they had experience equivalent to a Certificate III, and likewise contemplated that an unqualified dental assistant, or a Certificate III-qualified dental assistant, could be classified at Level 7 if they had experience equivalent to the Certificate IV qualification. The proposals advanced by the DAPA, the DSBC and the ADA all involve measuring equivalency by reference to an employee's years of experience as a dental assistant.

[32] We consider that, for progression by an unqualified dental assistant to Level 6, four years' industry experience should be established as the benchmark for equivalency with a

Certificate III qualification. This is a conservative approach given that a number of the ADA witnesses expressed the opinion that a lesser period of experience was sufficient for an unqualified dental assistant to have work value equivalent to that of a Certificate III-qualified dental assistant. Employers may, in addition, have the discretion to assess equivalency at less than four years' experience. In respect of Level 7, we will simply leave it to the employer's discretion to assess whether an unqualified or Certificate III-qualified dental assistant has experience equivalent to a Certificate IV qualification.

[33] The indicative roles for dental assistants in the Support Services employees classification definition will therefore be as follows:

Support Services classification	**Criteria**	**$ per week**
Level 3	Dental assistant (unqualified with less than 12 months' industry experience as a dental assistant)	1056.00
Level 5	Dental assistant (unqualified with 12 months' to up to 4 years' industry experience as a dental assistant)	1104.70
Level 6	Dental assistant: • with Certificate III or equivalent qualification **or** • unqualified with 4 years' or more industry experience as a dental assistant **or** • unqualified with equivalent experience to a Certificate III qualification as assessed by the employer	1164.20
Level 7	Dental assistant: • with Certificate IV or equivalent qualification **or** • with equivalent experience to a Certificate IV qualification as assessed by the employer	1185.10

Cost impact, operative date and phasing-in

[34] The parties' differing positions on operative date and phasing-in of minimum wage rate increases were primarily founded on their respective perspectives on the cost impact of the those increases and how that was to be balanced with the need to rectify the gender-based undervaluation of dental assistants' work found to have occurred in the April decision.

[35] The starting point for the consideration of the cost impact is the fact that only 33.5 per cent of dental assistants are 'award reliant' — that is, they have their pay set in accordance with the HPSS Award rates of pay.[28] The fact that two-thirds of dental assistants are paid above-award rates of pay means that it is likely that the majority of dental practices

[28] Natasha Cortis et al, UNSW Social Policy Research Centre, Gender-based Occupational Segregation: A National Data Profile (Final Report, 6 November 2023) ('Stage 1 Report') Table 7.2.

either will not legally be obliged to pay any wage increases to dental assistants at all as a result of this decision or, if they do have to pay any wage increase, it will be a lesser amount than the increases indicated in the *provisional* view (see [8] above). Assessed on an industry basis, this by itself limits the aggregate impact of the wage increases necessary to rectify gender-based undervaluation.

[36] The second Stanford report attempted to estimate the direct impact of the implementation of the *provisional* view upon total remuneration costs for the dental services sector as a whole. Based on data drawn primarily from the Stage 1 report, a report of Jobs and Skills Australia published in 2025[29] and the IBISWorld report entitled 'Dental Services in Australia',[30] Dr Stanford modelled the 'low case' direct cost of the implementation of the *provisional* view as increasing industry remuneration costs by 0.54 per cent and increasing total operating costs by 0.28 per cent. Dr Stanford modelled the 'high case' for the additional indirect cost of employers paying increases to dental assistants already paid above-award rates in order to maintain relativities as being, at a maximum, the same percentage amounts again, but his view was that the final impact would be somewhere between the low and high cases. Dr Stanford's methodology was not the subject of any serious challenge in cross-examination and no alternative analysis was advanced by any other parties. Acknowledging (as Dr Stanford did) that the data he relied upon was incomplete and, in some cases, inconsistent, we accept his methodology as sound and we consider his estimate of the aggregate cost impact to be reasonable and capable of being relied upon.

[37] Dr Stanford also referred to data concerning aggregate revenue and profit level for the dental services sector: total industry revenue was estimated at $14.8 billion with profits at $3.8 billion, implying an industry profit margin of 25 per cent. The ADA submitted, partially on the basis of the evidence of its individual witnesses, that the 'typical profit margin is 10% to 27% of annual revenue but often as low as 5%'.[31] However, as the cross-examination of the ADA's witnesses revealed, it is often difficult to quantify the amount of earnings which dental owner/practitioners draw from their businesses, since this may consist of a combination of wages paid and profits taken, and may be obscured by payments made pursuant to services and facilities agreements. The ADA's witness, Dr Kim, gave evidence based on his experience as a dental business broker and consultant that the average profit margin for dental practices was 15–25 per cent. We conclude on the basis of this evidence that the dental services sector has at least some capacity to absorb the cost of the wage increases, thus limiting the extent to which that cost would need to be passed through as price increases to clients.

[38] The ADA, supported by the DSBC, made a submission that the proposed increases would ultimately have a detrimental impact on the national economy, since the resultant increased costs to patients would result in fewer visits to dentists, a decline in oral health, and consequently an adverse effect on health generally — the cost of which would need to be borne by the entire community. This submission was not supported by any econometric analysis. It may be accepted, at a high level of generality, that large increases to prescribed minimum wage rates for the dental service sector might lead to sufficiently high increases in prices such as to significantly deter the use of dental services and result in detrimental national health outcomes.

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[29] Jobs and Skills Australia, *Dental Assistants* (Data Profile, August 2025).

[30] Exhibit HPSS136 (Arna Richardson, IBISWorld, *Dental Services in Australia*, September 2025)).

[31] Australian Dental Association submission, 10 September 2025 [68].

However, on the basis of Dr Stanford's analysis of the likely effect of the foreshadowed wage increases on total operating costs for the industry, it is difficult to imagine that any effect on costs to clients will be sufficient to discernibly effect aggregate demand for dental services. The ADA's submission is not accepted.

[39] However, because Dr Stanford's analysis only assessed the impact of the costs of the minimum wage rate increases on an aggregate basis, it does not tell the whole story because the cost impact will be borne unevenly by dental practices. For some practices, there will be minimal or no direct cost impact because they already pay most or all of their dental assistants significantly above the minimum HPSS Award rates. For example, Dr Weerakoon gave evidence that she pays her dental assistants (bar one new entrant) at least 20 per cent above the award rate, and Dr Littleton's evidence was that he pays four out of his five dental assistants above the award, with some receiving up to 60 per cent above the award rate. In some cases, practices pay above the award but not by a sufficient amount to absorb the entirety of the minimum wage rate increases: for example, Dr Bailey said that she paid her dental assistants in the range of 5–10 per cent above the award rate, which likely means that she will be required to pay some level of increase to at least some of her employees.

[40] The biggest impact will be upon the minority of dental practices which currently pay their dental assistants wholly or substantially at the HPSS Award rates of pay. Dr Rakkas, who operates a suburban dental practice in Darwin, gave evidence that he pays the award rate to all of his dental assistants apart from one who works as his Practice Manager. He estimated he would need to increase the wage rates for his award-reliant dental assistants by nearly 10 per cent, in circumstances where wages (including on-costs) for his non-clinical staff constituted about 20 per cent of his total business costs. This suggests that the minimum wage rate increases may directly increase his total business costs by up to 2 per cent, which is significantly above Dr Stanford's estimate of a 0.28 per cent direct increase in total business costs on a sectoral basis. More broadly, Dr Kim's evidence was that the implementation of the *provisional* view would most significantly affect smaller suburban dental practices with lower revenue:[32]

> I have previously conducted financial assessments for three dental practices based in the outer suburbs of Perth, all within geographical areas with patients of middle and working class, family-oriented households. These dental practices spent varying percentages of revenue on auxiliary staff wage costs and do not employ allied dental providers. The dental practice with the highest revenue spent approximately 10–13% of its revenue on auxiliary staff wages. By contrast, the dental practice with the lowest revenue spent approximately 26–30% of its revenue on auxiliary staff wages, while the practice with more representative revenue bands spent between 15–17% of its revenue on auxiliary staff wages.
>
> The aforementioned examples represent patient-centred, family-oriented general dental practices. These practices typically provide a wide range of dental services. They are not specifically geared towards high-revenue, high-cost procedures nor do they leverage heavily on government programs or superannuation-funded dental care. Conversely, practices that are specifically positioned to deliver high-revenue procedures may incur less auxiliary staff costs as a proportion of their overall revenue.
>
> My view is that, if the proposed changes by the FWC as described in the Draft Determination,

[32] Exhibit HPSS129 (witness statement of Dr Kang Kim, 9 September 2025) [13]-[16].

> were to be implemented, they could discriminately disadvantage smaller, family-oriented dental practices that operate under more conventional and health-focused models of care. From what I've observed in my experience, practices like these are less prepared to absorb increased auxiliary staff wage costs, and may face significant pressure to increase patient fees or drive higher patient throughput, which could risk exerting downward pressure on quality of care for their patients.

[41] A number of the ADA's witnesses gave evidence that, notwithstanding that they already paid their dental assistants at significantly above-award rates, they would nonetheless have to pay them wage increases in order to maintain relativities or for retention reasons. For example, Dr Bailey said that she would need to increase rates for her senior dental assistants '…to ensure they continued to be paid a rate of pay which adequately remunerates them for their level of seniority within the business compared to other employees with less experience…',[33] while Dr Weerakoon said that in her view she would be 'forced to further increase the dental assistants' wages to retain staff and mitigate the risk that they will move on to other Practice's that have increased their pay to comply with the proposed changes'.[34] It may be accepted that the implementation of the outcome we have determined above (which is unlikely to be significantly different in its cost impact to the *provisional* view) will have second-order effects beyond the direct effect of the legal prescription of minimum award rates of pay but, as stated by Dr Stanford, the specific responses of employers to award wage increases is not knowable. We take the potential indirect cost impact into account but give this significantly less weight than the direct cost impact because of the difficulty in quantifying it and because it arises due to discretionary business decisions made by individual employers rather than by award prescription.

[42] Finally, we take into account that for some categories of dental work undertaken by some employers, it will not be possible to pass on increased costs to clients in the form of higher prices for some time. Firstly, some dental businesses (usually larger multi-practice businesses) have entered into 'preferred provider' arrangements with private health insurers whereby they provide specified dental services for an agreed price. These practices cannot increase the price they charge for such services until they have the opportunity to renegotiate the arrangement with the private health insurers. This usually occurs annually, and there is no guarantee that a price increase can be negotiated. Secondly, some dental practices participate in publicly-funded voucher and other schemes such as the Child Dental Benefits Scheme, the Oral Health Fee for Service Scheme in New South Wales or the Australian First Nation Aboriginal Dental Grants scheme. They often participate in such schemes at very low profit margins or even at a loss, and some dental practices may decide not to continue to participate unless the rebates or subsidies involved are increased by the relevant governments.

[43] Having regard to these matters, we do not consider that the position of the Joint Unions, supported by the DAPA, that the award minimum wage rate increases should be implemented in a single tranche and without a reasonable period of notice should be adopted. That would, in our view, put too immediate and large a burden upon those mainly smaller dental practices which pay most or all of their dental assistants at award rates, and would also detrimentally affect dental practices which operate pursuant to the fixed-fee arrangements which we have described. Nor do we accept the position of the DSBC and the ADA that it is necessary to have

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[33] Exhibit HPSS133 (witness statement of Dr Katherine Bailey, 5 September 2025) [25].

[34] Exhibit HPSS130 (witness statement of Dr Arosha Weerakoon, 5 September 2025) [11].

the wage increases implemented in three annual tranches, with the first increase not applying until 1 July 2026 and the last from 1 July 2028. This does not represent an appropriate balance between the need to rectify gender-based undervaluation and the cost impact to dental businesses of the wages increases, noting that for a majority of dental practices there will be little or no direct cost impact because of the capacity to absorb wage increases into existing over-award wage rates.

[44] In order to give an appropriate balance to the competing relevant considerations, we consider that the increases should be implemented in two stages. The first stage would involve an initial increase from 1 April 2026. In the initial stage, dental assistants will translate from their current levels to new levels in the new classification structure. The rates of pay at the higher levels will, however, be phased in such that in the first stage, increases will be around 4 per cent. Higher percentage increases will apply for employees translating from Level 1 to Level 3 (7.95 per cent) and from Level 2 to Level 6 (9.26 per cent). However, Level 1 is the current entry level and it applies for three months only, meaning the increase for employees at that level will only be transitory. The higher increase from Level 2 to Level 6 will only apply to dental assistants with more than four years' experience. The evidence indicates that dental assistants with four years' experience tend to be paid above-award rates for attraction and retention reasons, which will mitigate the practical effect of the increases for such employees. The transitional rates will be reflected in amendments to clause 16.2 of the HPSS Award by adding a table of rates that will apply to dental assistants from 1 April 2026. The table will operate until 1 January 2027 when the full translation will take effect. The phase-in of the minimum wage rates associated with the translation, the bulk of which will involve an approximate 4 per cent increase, will allow dental practices a sufficient period to make the administrative arrangements to implement the new classification arrangements and to make other necessary business adjustments, noting that they have effectively been on notice since the April decision that changes of this nature will be forthcoming. The second stage will involve payment of the remaining amount of the total increases and will take effect from 1 January 2027.

Modern awards objective and minimum wages objective

[45] We are satisfied that the variations to the HPSS Award with respect to dental assistants which arise from this decision are necessary to achieve the modern awards objective in s 134(1), as required by s 138. For the award safety net to be 'fair and relevant', minimum wage rates must properly reflect work value and their determination must be free of assumptions based on gender.

[46] In reaching this conclusion, we have taken into account the considerations specified in s 134(1) of the FW Act in the following way (using the paragraph designations in the subsection):

> *Paragraph (a)*: Using the measure of 'low paid' as being two-thirds of median adult ordinary-time earnings for full-time employees, the 'low paid threshold' may be quantified in two ways: $1164.67 per week, using the ABS Characteristics of Employment (**CoE**) data for August 2025 or $1131.33 per week, using the ABS Employee Earnings and Hours (**EEH**) data for May 2023. Dental Assistants (Levels 1–5) currently have a weekly minimum rate of pay that falls below both of these

measures. Accordingly, because the wage rate adjustment will have the result of lifting some dental assistants to classifications in the HPSS Award up to or above the low paid threshold (Levels 6 and 7), this consideration weighs in favour of the variations.

Paragraph (aa): There is no evidence before us that the variations will have any effect, detrimental or otherwise, as to the need to improve access to secure work. This is therefore a neutral consideration.

Paragraph (ab): As set out in the April decision and above, the variations will rectify gender-based undervaluation of work in a female-dominated occupation and therefore aid in achieving gender equality, ensuring equal remuneration for work of equal value and eliminating gender-based undervaluation of work. This weighs significantly in favour of making the variations and, we consider, should be given paramount weight.

Paragraph (b): Collective bargaining is not currently a feature of the dental services industry. We cannot predict, based on the evidence before us, whether the variations will encourage collective bargaining to occur or otherwise. We consider this to be a neutral factor.

Paragraph (c): There was some evidence that above award payments are already used as a means of achieving recruitment and retention in the industry. It is possible that the variations, by increasing award rates and adjusting minimum rates of pay which fairly reflect work value, may attract more persons, especially women, to the occupation of dental assistant and thus increase workforce participation. This proposition is indirectly supported by the survey evidence given by Mr Thomas, which indicated that low rates of pay and lack of pay increases were two of the top four reasons given by dental assistants for leaving the occupation. This weighs marginally in favour of the variations.

Paragraph (d): We do not consider that this is a relevant consideration in this matter.

Paragraph (da): We do not consider that this is a relevant consideration in this matter.

Paragraph (f): We accept that the variations will have an impact on employment costs for the minority of employers in the dental services industry who pay their dental assistants at or near the current HPSS Award rates. The impact will be greatest for smaller dental practices operating in areas with challenging socio-economic circumstances. This weighs against the grant of the proposed variations. However, the adverse weight of this consideration is ameliorated by the fact that the effect on total business costs is not oppressive (at most, about a 2 per cent increase), will have a delayed operative date and will be implemented in two tranches. There is no reason to consider that the variations will affect productivity or the regulatory burden in the industry, and these are therefore neutral considerations.

Paragraph (g): This consideration is largely irrelevant and will be given neutral weight.

Paragraph (h): We have not accepted the ADA's submission that the variations will have an adverse effect upon the national economy. We will therefore treat this as a neutral factor.

[47] We also consider that the variations are consistent with the achievement of the minimum wages objective in s 284(1) of the FW Act. In respect of the considerations in ss 284(1)(a), (aa), (b) and (c), we make the same findings as in relation to ss 134(1)(h), (ab), (c), and (a) respectively. Section 284(1)(e) is not relevant to this matter.

[48] A determination varying the HPSS Award to, among other things, implement the first phase of the variations for dental assistants is published together with this decision.

Pathology collectors and health professionals

[49] In the April decision, we concluded that the gender-based undervaluation of the work of pathology collectors should be rectified by reclassifying them within the existing structure for Support Services employees (as with dental assistants). The key finding which we made to guide this reclassification process was:[35]

> We consider that an experienced pathology collector belongs most appropriately in Level 7. On the basis of our earlier findings, they fit most closely with the criteria in the Level 7 classification structure because they are 'capable of functioning autonomously, and prioritising their work… within established policies, guidelines and procedures', are 'responsible for work performed with a substantial level of accountability and responsibility', and possess 'well developed communication [and] interpersonal… skills'.

[50] We then expressed the *provisional* view that, on the basis of this finding, pathology collectors should be reclassified as follows (with the wages rates set out in the April decision updated as per the *Annual Wage Review 2025*):

Support Services classification	Criteria	$ per week
Level 5	Entry level Unqualified and 1st year of industry experience	1104.70
Level 6	Qualified Certificate III **or** equivalent training and experience and one year or more of industry experience	1164.20
Level 7	Experienced Certificate III or equivalent training and experience **and** four years or more of industry experience or required to work in a 'single-staffed' collection centre.	1185.10

[35] April decision [235].

[51] In respect of the proposed criteria for Level 7, we said at [236]:

> … we consider it likely, given the evidence of the work environment, the nature of the work, and the breadth and level of the skills utilised by pathology collectors in single-staffed collection centres, that their training and experience would be considered to be equivalent to a Certificate III qualification.

[52] In relation to the rectification of the gender-based undervaluation of health professionals' work, our *provisional* view was based on the following propositions (at [176]):

> (1) A new classification and pay structure should be established which is based on alignment of a benchmark classification with the C10 Metals Framework for equivalent qualifications.
>
> (2) The existing classification structure is not adaptable to meet the objective in (1) because, apart from entry-level rates (and the consequential time at which an employee moves through the annual increments), the existing structure makes no distinction between different types of qualification.
>
> (3) The current annual incremental pay structure is not consistent with proper conceptions of work value, for the reasons discussed in the *Teachers decision*, the *Stage 3 Aged Care decision* and the *Aged Care Nurses decision*.
>
> (4) The new pay structure should distinguish between the different professional occupations based on the AQF level of the standard educational qualification required for entry into the profession…
>
> (5) The new pay structure should be simplified and structured in a way broadly consistent with the classifications for teachers under the EST Award established in the *Teachers decision* and for aged care nurses under the *Nurses Award 2020*… established in the *Aged Care Nurses decision*.
>
> (6) The C1(a) benchmark rate (currently $1525.90 per week) will apply to professions requiring an AQF Level 7 qualification — that is, a Bachelor's degree (whether three or four years in duration) — after one year's employment post-graduation. Consistent with this approach, the equivalent for current UG2 professions would be the C5 or C3 rate, as applicable for the qualification required.

[53] On the basis of these principles, we stated at [177] the *provisional* view that the base rates for health professionals based on the AQF level of their qualification should be as follows (with the wage rate amounts updated for the *Annual Wage Review 2025*):

Classification criteria	**Qualification for profession—AQF Level**				
	AQF 5 $ per week	**AQF 6** $ per week	**AQF 7** $ per week	**AQF 8** $ per week	**AQF 9** $ per week
Entry-level – 1st year	1188.00	1283.30	1499.90	1545.40	1649.40
2nd – 3rd year	1250.10	1350.80	1579.30	1626.70	1736.20
4th – 6th year	1361.30	1471.00	1719.30	1771.10	1822.50
7th year +	1471.40	1589.90	1859.40	1960.70	1969.80

[54] We also stated, at [178], the *provisional* view that the higher classifications for health professionals in specialist, supervisory and managerial roles should be as follows (with wage

rates updated for the *Annual Wage Review 2025*):

Classification	Criteria	$ per week
Level 2.1	Supervisor or specialist with additional post-graduate qualification	1999.30
Level 2.2	After 5 years at Level 2.1	2121.90
Level 3	Manager/senior specialist	2282.00
Level 4	Senior manager	2588.20

Parties' positions and evidence

[55] The Joint Unions supported the *provisional* view with respect to pathology collectors and the draft determination with the exception that they proposed a definition of 'single-staffed collection centre'. They proposed that variations to give effect to this decision should take effect in full from 1 January 2026. In respect of health professionals, the HSU provided and the ACTU supported a draft determination which proposed modifications to the *provisional* view in the following respects:

- Health Professionals should be entitled to the rate of pay under the new structure according to the 'qualification they hold that enables them to practice in their profession'.

- The 'standard rate' for quantification of allowances in the HPSS Award should be aligned with the 2nd–3rd year rate for an AQF Level 7 qualified employee (that is, the benchmark C1(a) rate of $1579.30).

- An additional column of pay rates should be established for health professionals with an AQF Level 10 qualification.

- An additional pay point should be established for Level 2 classifications applicable to the third, fourth and fifth years of employment at that level.

- Clause 17.1 of the HPSS Award, which prescribes how progression through pay points occur in the current structure, should be removed.

- The criteria for the Levels 2 and 3 classifications should be modified to include the following:

Level 2	Level 3
Senior Clinician	Advanced/Lead Clinician
Specialist (education, research, quality control/assurance)	Senior Specialist (education, research, quality control/assurance)
Supervisor	Manager

[56] In respect of pathology collectors, the Joint Unions relied upon witness statements made by the following persons:

(1) Lauren Burke[36] is a training mentor at Launceston Pathology, employed by Diagnostic Services Pty Ltd. She holds a Certificate III in Pathology Collection and is voluntarily completing a Certificate IV in Training and Assessment through TAFE. Ms Burke gave evidence about her employment history, classification and rate of pay, her role as a training mentor and, in response to the witness statements made by Maja Wolow and John Meckiff (filed by Australian Pathology and discussed below), also provided evidence from her experience about work pressure, complexity, training, support and safety.

(2) Katrina Slack[37] is a pathology collector employed by Nicolaides Pathology. She holds a Certificate III in Pathology Collection from Bluestone Medical Training Centre. Ms Slack gave evidence about her classification and rate of pay, and her current work and role. In response to the witness statements of Ms Wolow and Mr Meckiff, she also provided evidence from her experience about work pressure, complexity, paediatric testing, training, support and safety.

(3) Paige Slight[38] is a pathology collector currently employed by Australian Clinical Labs (**ACL**). She holds a Certificate III in Pathology Collection from Lab Tech Training. Ms Slight gave evidence about her classification, rate of pay, work and role, and, in response to the witness statements of Ms Wolow and Mr Meckiff, also provided evidence from her experience about work pressure, complexity, paediatric testing, training, support, independent work, and safety.

(4) Stasia Cleland[39] is a pathology collector employed by Laverty Health. She holds a Certificate III in Pathology Collection from LTT, completed in 2022, in addition to work placement and training. Ms Cleland gave evidence about her classification, rate of pay, work and role, and, in response to the witness statements of Ms Wolow and Mr Meckiff, also provided evidence from her experience about training and work arrangements, support, safety, demand and complexity, independent work, work pressure, paediatric testing and training.

[57] The Joint Unions also relied on witness statements made by the following persons in relation to health professionals:

(1) Alex Leszczynski[40] is a Senior Industrial Officer at the HSU No. 3 Branch in Victoria, known as the Victorian Allied Health Professionals Association. He gave evidence, based on experience of over 12 years as an industrial officer, regarding standard qualifications, entry-level qualifications and specialisation in the health sector.

(2) Dr Helen Jeges[41] is the Director of Psychology for Latrobe Regional Health. She

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[36] Exhibit HPSS161 (witness statement of Lauren Burke, 30 October 2025).

[37] Exhibit HPSS162 (witness statement of Katrina Slack, 31 October 2025).

[38] Exhibit HPSS163 (witness statement of Paige Slight, 30 October 2025).

[39] Exhibit HPSS170 (witness statement of Stasia Cleland, 31 October 2025).

[40] Exhibit HPSS148 (second witness statement of Alex Leszczynski, 12 September 2025).

[41] Exhibit HPSS149 (third witness statement of Dr Helen Jeges, 12 September 2025).

took up this role on 7 April 2025 and was previously a senior paediatric neuropsychologist. Dr Jeges gave evidence about her role as a Director of Psychology, including her classification and rate of pay, duties, skills, experience and responsibilities.

(3) Dr Kerrie Clarke[42] is employed by the Royal Melbourne Hospital as a Statewide Principal Psychology Educator, but is on secondment to the Victorian Collaborative Centre for Mental Health and Wellbeing. She is also employed as a Principal Psychology Educator by Mercy Health Victoria. She holds a Bachelor of Behaviour Science (Honours) from La Trobe University, a Doctor of Psychology (Clinical) from Monash University, and is currently undertaking a Graduate Certificate in Clinical Education at Flinders University. She gave evidence about her qualifications and training, classification and rate of pay, her current role and tasks, and people with whom she works.

(4) Abby Foster[43] is an Allied Health Research Advisor employed by Monash Health. She holds a Bachelor of Speech Pathology (Honours) from La Trobe University, and a PhD in Speech Pathology from the University of Queensland. Ms Foster gave evidence about her profession, employment history, classification and rate of pay, the people with whom she works, and her role, duties and responsibilities, which includes supervision, administration and reporting.

(5) Dilani Ranamukhaarachchi[44] is a medical scientist in the Microbiology and Mycobacterium Reference Laboratories at the Peter Doherty Institute in Victoria. She holds a Diploma of Science and a Bachelor of Biomedical Science from Deakin University, and a Graduate Certificate in Public Health from Victoria University, in addition to further certificates and courses. Ms Ranamukhaarachchi gave evidence about her classification and rate of pay, and her previous role as a Quality Officer.

[58] The Joint Unions also relied on a further expert report and supplementary note by Dr Stanford[45] concerning the likely impact of the wage increases for pathology collectors and health professionals that would arise from the implementation of the *provisional* views in the April decision, having regard to economic and financial parameters, including employment and operating costs.

[59] The Phlebotomists Council of Australia (**PCA**) contended that the *provisional* view concerning pathology collectors should be implemented with a retrospective operative date in April 2025. It relied upon a witness statement made by its chief executive officer, Bec Luxton.[46] Ms Luxton's statement dealt with current cuts to pathology collector workforces and annexed

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[42] Exhibit HPSS150 (witness statement of Dr Kerrie Clarke, 11 September 2025).

[43] Exhibit HPSS151 (witness statement of Abby Foster, 11 September 2025).

[44] Exhibit HPSS152 (witness statement of Dilani Ranamukhaarachchi, 11 September 2025).

[45] Exhibit HPSS164 (witness statement with annexed supplementary expert report of Dr James Stanford, 31 October 2025); exhibit HPSS165 (supplementary note to expert report of Dr James Stanford ('Alternative Estimates for Pathology Collectors'), 4 November 2025).

[46] Exhibit HPSS154 (witness statement of Bec Luxton, 12 September 2025).

documents about the financial position of Healius Limited (**Healius**), one of the major businesses in the pathology sector, and its pathology collector 'role mandate' (job description).

[60] Orthoptics Australia, the national peak body representing orthoptist members in Australia, supported the *provisional* view concerning health professionals but raised some specific issues concerning the variations to be made as they affected orthoptists covered by the HPSS Award:

- The table at [123] of the April decision identified Orthoptics as a profession requiring an AQF Level 8 qualification. However, while La Trobe University in Melbourne award a qualification at this level for orthoptists, more graduates came from the University of Technology, Sydney (**UTS**), which awards an AQF Masters degree. It therefore opposed defining the AQF level for orthoptists at AQF Level 8, since this would disadvantage UTS graduates. It proposed that an individual's minimum wage rate should be determined by reference to the qualification which they hold.

- The term 'specialist' in the criteria for Levels 2 and 3 required clarification since many advanced practice roles across allied health do not have defined educational pathways and the term is typically restricted to use by medical specialists.

[61] Speech Pathology Australia, the national peak body for speech pathologists in Australia, similarly supported implementation of the *provisional* view concerning health professionals but raised some issues specific to the interests of speech pathologists:

- Speech pathology should be recognised as an AQF Level 9 profession. There are 18 AQF Level 9 programs, compared to 11 at AQF Level 7 and 13 at AQF Level 8. Alternatively, the HPSS Award wage rates should converge with the AQF Level 9 rate after one year.

- Three- and four-year AQF Level 7 degrees should be recognised differently.

- The requirement for a post-graduate qualification to progress to Level 2.1 should be removed, and instead progression should be based on an extended scope of practice or appointment to a supervisory role.

- The concept of specialisation in Levels 2 and 3 should be changed to that of an 'extended scope of practice'.

- There needs to be a clear translation table for existing employees to be placed in the new classification structure.

- It must be ensured that supervisory work is not devalued, since it appears to have been reduced in pay on a translation from Level 4 in the current structure to Level 2.1 in the new structure.

[62] Speech Pathology Australia proposed a phasing-in approach to the timing of the implementation of the minimum wage rate increases, provided the period of phasing-in was not

protracted.

[63] The Australian Physiotherapy Association opposed the standardisation of the graduate entry level for physiotherapists at AQF Level 7 and submitted that there is currently a balanced mix of graduates at AQF Levels 7, 8 and 9 (at 28, 39 and 33 per cent of graduates respectively). On this basis, it submitted that physiotherapists should be paid according to the level of the qualifications they hold. The Association also submitted that there should be a minimum six-year phasing-in period of minimum wage rate increases commencing on 1 July 2026, on the assumption that Annual Wage Review increases are absorbed into the increases.

[64] The primary position of Australian Pathology was that there should be no variations to the classification structure or minimum wage rates for pathology collectors or health professionals in the HPSS Award. It contended that, having regard to the factors identified in ss 134(1)(aa), (f), (g) and (h) and 284(1)(a) of the FW Act, any variations to this effect are not necessary to meet the modern awards objective or the minimum wages objective and therefore, if they were made, would be contrary to ss 138 and 157(2)(b).

[65] In the alternative, Australian Pathology contended that the wage increases for health professionals should be phased-in over, desirably, a period of seven years, or a minimum of five years, to mitigate the adverse effects upon employment costs, employers' businesses and patients, and security of employment. As to pathology collectors, its position was that phasing-in appeared not to be possible, in which case there should be a delayed operative date.

[66] Australian Pathology also proposed changes to the *provisional* views concerning the proposed classification structures. In respect of health professionals, Australian Pathology proposed that, under the new classification structure, they should be classified and paid based on the qualification required for the role, not merely because the employee holds a certain qualification regardless of whether the employer requires the employee to hold that qualification in order to discharge their duties. Australian Pathology also contended that the application of the C1(a) benchmark rate to professions requiring an AQF Level 7 qualification is inappropriate and unsupported by the findings in the April decision as to work value and gender-based undervaluation or the modern awards and minimum wages objectives. In relation to pathology collectors, the following changes were proposed:

- Level 7 should be reserved for pathology collectors who supervise other employees, prioritise their work and the work of others, and are fully autonomous. Experienced pathology collectors who do not supervise or guide others and who do not work fully autonomously properly belong in Level 6.

- The performance of work in a 'single-staffed' collection centre should not be included as a classification criterion. The criterion is not supported by work value reasons and is ambiguous.

- References to 'industry experience' should be amended to instead require 'relevant experience in pathology collection'.

- If the classification structure is amended so that it is linked to a qualification, this should be clarified to be 'Certificate III in Pathology Collection'.

- The reference to a Certificate IV in the translation arrangement in the draft determination should be removed, since this is not supported by any proposed amendment to the body of the classification structure or the April decision.

[67] Australian Pathology relied on witness statements made by the following persons:

(1) Shaun Donovan[47] is the Chief Executive Officer of Diagnostic Services Pty Ltd. He holds a medical degree from the University of Tasmania Medical School, and trained in Anatomical Pathology at the Royal Hobart Hospital and St. Vincent's Hospital in Melbourne. Mr Donovan gave evidence about the current structure of Diagnostic Services including the number and types of its employees, its current enterprise agreement, and ongoing bargaining for a new enterprise agreement with the HSU.

(2) Liesel Wett[48] is the Chief Executive Officer of Pathology Australia Limited, trading as Australian Pathology. She gave evidence about the financial position of the private pathology sector and those of the three biggest pathology providers in Australia, being ACL, Healius and Sonic Healthcare Limited (**Sonic**), and the impact of prospective wage increases on the pathology sector.

(3) Maja Wolow[49] is the Collections Manager for ACL in New South Wales and the Australian Capital Territory. She holds a Certificate III in Pathology Collection, Certificate IV in Pathology, Certificate IV in Training and Assessment, Diploma of Laboratory Technology, and Diploma of Management. Ms Wolow gave evidence about her role and responsibility, the training and experience of pathology collectors under her management at ACL and her views on the *provisional* view in relation pathology collectors.

(4) John Meckiff[50] was, at the time he made his witness statement, the General Manager Pathology Collections Centres for Healius. He gave evidence about his responsibility in that role for all pathology collectors, their locations of work, training and work arrangements, and the differences between 'single-staffed' versus 'multi-staffed' collection sites.

[68] In addition, Australian Pathology relied upon a further expert report (**second Browne report**) made by Oliver Browne,[51] the Chief Economist at the Pragmatic Policy Group. In this report, Mr Browne assessed the potential impact of award minimum wage rate increases arising from the *provisional* views on the private pathology industry.

[69] The Australian Diagnostic Imaging Association (**ADIA**) made submissions in which it

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[47] Exhibit HPSS153 (witness statement of Shaun Donovan, 16 September 2025).

[48] Exhibit HPSS168 (further supplementary witness statement of Liesel Wett, 16 September 2025).

[49] Exhibit HPSS175 (witness statement of Maja Wolow, 27 June 2025 [amended 13 November 2025]).

[50] Exhibit HPSS176 (witness statement of John Meckiff, 27 June 2025).

[51] Exhibit HPSS171 (expert opinion of Oliver Browne ('on the Viability of Private Pathology under Proposed Award Rate Increases'), 17 September 2025).

contended that the proposed classification structure in the *provisional* view concerning health professionals should be modified so that:

- the classifications are anchored to the minimum standard level of educational qualification for each category of health professional; and

- the managerial, supervisory and specialist classifications (Levels 2–4) specify the number of employees supervised and the level of responsibility and accountability but do not expand the current scope of coverage of the HPSS Award.

[70] The ADIA relied upon an expert report, and a supplementary expert report, made by Greg Houston.[52] Mr Houston holds a Bachelor of Economics (Honours I) from the University of Canterbury and is a founding partner of the economic consulting firm HoustonKemp. Mr Houston's report assessed the likely effects of the implementation of the *provisional* view on the ADIA's members.

[71] Healthscope Operations Pty Ltd and the Adelaide Community Health Care Alliance Incorporated (collectively, **Healthscope**) took the position that the number of proposed classification levels, rate of progression and rates of pay in the classification structure proposed by the *provisional* view would rectify the gender-based undervaluation found in the April decision and, subject to the inclusion of appropriate classification descriptors, were appropriate to be included in the HPSS Award. The classification descriptors proposed by Healthscope were as follows:

Level 1.1 Graduate Clinician	This is the entry level for new graduates. Employees will be paid according to the AQF level required to practice as a health professional in their profession (where appropriate in accordance with their professional association's rules and to be eligible for membership of their professional association) or such qualification as deemed acceptable by the employer.
Level 1.2 Junior Clinician	Employees will generally progress to this level after at least 12 months' full-time clinical experience (or equivalent part[-]time or casual hours) as a Graduate Clinician. An employee at this level: • will be generally responsible for their own work on a day-to-day basis; • may require some degree of supervision and/or mentoring[.]
Level 1.3 Experienced Clinician	Employees generally progress to this level after at least two years' full-time (or equivalent part[-]time or casual) work as a Junior Clinician at a satisfactory level. An employee at this level: • will be able to self-manage a clinical workload without supervision (except for complex, novel or critical tasks) • may supervise others[.]

[52] Exhibit HPSS155 (expert report of Greg Houston, 12 September 2025); Exhibit HPSS156 (supplementary expert report of Greg Houston, 10 November 2025).

Level 1.4 Highly Experienced Clinician	Employees generally progress to this level after at least three years' full-time (or equivalent part-time or casual hours) work as an Experienced Clinician at a satisfactory level. An employee at this level: • will self-manage a clinical workload without supervision • may provide guidance to others on complex, novel or critical tasks • may supervise others[.]
Level 2.1 Specialist Clinician Educator Team Leader	An Employee will progress to this level by appointment. An employee at this level: • will be fully clinically proficient • will usually have at least 7 years of full-time (or equivalent part-time) clinical experience • will be working as either a Specialist Clinician, an Educator, a or a Team Leader (or performing a combination of these roles)[.] A Specialist Clinician will: • have attained a higher-level qualification (above the minimum entry qualification required for the profession) which is relevant to their area of daily practice • have specialist skill and knowledge which they apply in their daily practice • provide leadership and role modelling, particularly in areas of research and quality assurance • have the ability to implement assessments, treatment interventions and discharge planning at advanced level of practice • have the ability to act as a clinical consultant in their area of speciality • provide advice to others on complex, novel or critical tasks • actively contribute to the development of professional knowledge and skills in their field of work. An Educator will: • be accountable for the assessment, planning, implementation and evaluation of education and staff development programs for a specified population • provide leadership and role modelling, particularly in areas of research • have the ability to devise and evaluate evidence-based practice treatment protocols • be initiating and independently undertaking quality improvement and /or research projects • [be] actively contributing to the development of professional knowledge and skills in their field of work[.] A Team Leader will: • be responsible for staff selection, rostering and leave management • be accountable for the allocation and expenditure of resources to achieve optimal budget outcomes

	• participate in policy development and implementation • be responsible for providing support for the efficient, cost effective and timely delivery of services including involvement in budget preparation and cost control • be responsible for the clinical mentoring of the staff that they supervise and managing their performance[.]
Level 2.2 Senior Specialist Clinician Senior Educator	In addition to the responsibilities for a Level 2.1 employee, an employee at this level will be a Specialist Clinician or a Senior Educator with 5 years' experience at [L]evel 2.1.
Level 3 Manager	An Employee will progress to this level by appointment. An employee at this level will: • be responsible for coordinating and overseeing a department or service • provide clinical and professional supervision and support to their department • be responsible for clinical delivery, resource allocation and the budget of their department or service • coordinate a specified group of Specialist Clinicians, Educators and/or Team Leaders • be accountable for the development of management systems within their department or service • be responsible for the coordination and promotion of education and research projects • be accountable for the assessment, planning, implementation and evaluation of education and staff development programs for the department or service[.]
Level 4 Senior Manager	An Employee will progress to this level by appointment. An employee at this level will, within their organisation: • be accountable to the Executive Team for the standard of care across a health profession (or multiple professions) • be accountable to the Executive Team for the development and achievement of the budget for a health profession (or multiple professions) • provide leadership, direction and management for a health profession (or multiple professions) • ensure their allocated health profession(s) meet the changing needs of patients through strategic planning • comply with and ensure others comply with relevant ethical codes and legal requirements for their profession(s)[.]

[72] As to operative date and phasing-in, Healthscope contended that the variations should take effect in five stages commencing on 1 July 2026 with annual instalments of equal proportion on 1 July 2027, 1 July 2028, 1 July 2029 and 1 July 2030.

[73] It should be noted that, in the earlier phase of the proceedings, Healthscope participated as part of what is described in the April decision as the 'Private Hospitals Group'. The other participants in this group were the Australian Private Hospitals Association, Catholic Health Australia and Day Hospitals Australia. These participants did not make any submissions in response to the *provisional* views concerning health professionals in the April decision.

[74] Australian Business Industrial, Ageing Australia Ltd and the New South Wales Business

Chamber Ltd (collectively, **ABI**) proposed that variations to the HPSS Award consistent with the *provisional* view concerning health professionals should be phased in over a period of at least three years, commencing on 1 July 2026 at the earliest. It also made some specific proposals as to the variations, including that:

- references to qualifications should include the qualification title (e.g. 'diploma') and 'or equivalent', rather than just the AQF Level;
- classification at Levels 2–4 should be by appointment only;
- the progression provision in current clause 17.1 should be deleted; and
- tables setting out how existing employees would translate to the new classification structure should be included.

[75] ABI opposed a number of aspects of the ACTU's proposal including the introduction of AQF Level 10 rates, the proposed descriptors for Levels 1, 2, 3 and 4, and the addition of an intermediate pay point in Level 2.

[76] The Australian Industry Group (**Ai Group**) submitted that the first operative date for the variations to the HPSS Award for health professionals should be 12 months from the date of the final decision, with the minimum wage rate increases being phased in over at least a five-year period. The Ai Group supported Healthscope's proposed modifications to the classification descriptors and expressed concern that the higher classifications could potentially expand the reach of the HPSS Award to classes of employees who have not been previously covered by the award (unless the Healthscope proposal, which aligned with the existing HPSS Award classification, was adopted).

[77] The following organisations made written submissions concerning the timing of the implementation of the *provisional* view concerning health professionals:

- *Australian Chiropractors Association*: a staged phase-in over multiple years, at a minimum reflecting the phase-in period determined for the *Pharmacy Industry Award 2020* in the April decision (that is, three stages, each 12 months apart).
- *Exercise and Sports Science Australia*: a three-year phasing-in period.

[78] Finally, the Commonwealth submitted that the proposed variations to the HPSS Award should be phased in, with the first variation to occur at least six months after the final decision or from 1 July 2026, whichever is later. The Commonwealth advised that no decision had been made concerning whether it would provide any additional funding for the minimum wage rate increases in the HPSS Award which would flow from the Review.

Should the HPSS Award be varied to rectify gender-based undervaluation?

[79] As earlier stated, the primary position of Australian Pathology was that, notwithstanding the findings of gender-based undervaluation in respect of pathology collectors and health professionals in the April decision, the HPSS Award should not be varied to rectify this because this would not be necessary to achieve the modern awards objective, nor would it achieve the minimum wages objective. Its position in this respect was founded on the proposition that the cost of the minimum wage rate increases that would be involved would detrimentally affect profits, business activity, commercial viability and employment in the pathology sector, with

adverse consequences for the national health system. In support of this position, Australian Pathology relies on the following factual propositions, largely derived from the second Browne report and the further statement of Ms Wett:

- The private pathology industry is in a vulnerable position. The industry operates on thin profit margins, having recorded a profit margin of only 2.1 per cent in the year to 30 June 2025.

- The pathology sector is highly reliant on government funding, with close to 90 per cent of revenue generated by Medicare rebates paid by the Commonwealth.

- Medicare rebates for pathology services continue not to be indexed, and funding for some tests was cut from 1 July 2025.

- Profts continue to decline and share prices for the three largest businesses in the sector have fallen by an average of 60 per cent since 2022.

- Without additional Commonwealth funding, or the introduction of 'co-payments' (private fees for pathology services, most of which are presently free to the public), private pathology providers have no substantial way to offset a substantial one-off increase in costs.

- Labour costs represent a significant proportion (approximately 55 per cent) of pathology businesses' operating costs.

- If the *provisional* views concerning pathology collectors and health professionals are implemented without delay, industry-wide labour costs are expected to rise from about $936 million to $1,003 million, or to $1,051 million if wage rate relativities between enterprise agreements and award rates are preserved.

- The former scenario would reduce net profit across the industry to $65 million on the former scenario or $31 million on the latter scenario.

- The latter outcome would represent a decline in industry-wide net profit after tax (**NPAT**) of 72 per cent, and is the practical, real-world outcome, since unions and employees will seek to maintain relativities between minimum award wages and rates of pay in enterprise agreements.

- In response to this, pathology businesses can be expected to restructure their business and workforces, including through layoffs, automation, consolidation and closure of unprofitable pathology collection centres, reduced operating hours, and introduction of co-payments.

- As a consequence, patient access to pathology services is likely to be reduced, particularly in rural and regional areas.

- A five-year or seven-year phasing-in period would ease the immediate burden but not alter the 'steady-state outcome'.

[80] Australian Pathology submitted, that having regard to these matters, critical weight should be given to the factors in ss 134(1)(aa), 134(1)(f), 134(1)(h) and 284(1)(a) in assessing the modern awards objective and the minimum wages objective.

[81] In considering Australian Pathology's position, the starting point must be that its case is confined to the circumstances of the pathology sector and takes no account of the interests of the broader health sector. In respect of pathology collectors, it may be accepted that the businesses represented by Australian Pathology will be those on the employer side primarily affected by the implementation of the *provisional* view. However, it appears that the primary impact on the pathology sector would, on Australian Pathology's own case, come from implementation of the *provisional* view concerning health professionals. The modelling in the second Browne report shows that the projected cost to the pathology sector of the proposed minimum wage rate increases for health professionals is almost three times greater than for pathology collectors: he estimates that the former would increase industry labour costs by $50 million directly and $86 million if relativities are preserved, compared to $17 million and $29 million respectively for pathology collectors. The entirety of that part of the health sector covered by the HPSS Award is necessarily affected by the *provisional* view concerning health professionals, and a proper assessment of the modern awards objective and the minimum wages objective in this case must take into account the circumstances of that entire sector when giving consideration to the factors specified in ss 134(1) and 284(1) respectively. In short, contrary to the implicit premise of Australian Pathology's case, this matter cannot legitimately be treated as one concerned solely with the pathology sector.

[82] No employer party apart from Australian Pathology took the position that nothing should be done to rectify the gender-based undervaluation of the work of pathology collectors and health professionals identified in the April decision. Those employer parties which made submissions in response to the *provisional* views either supported or did not oppose their implementation subject to appropriate phasing-in arrangements and various proposed modifications to the new classification structure for health professionals. And, as we have earlier observed, some of the major employer interests in the private hospital sector which participated in the earlier stage of the proceedings have made no submissions at all in response to the *provisional* views. Implementation of the *provisional* views, subject to various caveats, was also supported by the ACTU, the HSU and the various health professional associations which made submissions in response to the *provisional* views. It is necessary to give weight to the positions of all these parties with interests in the broader health sector.

[83] Dr Stanford's report modelled the cost of the minimum wage rate increases for health professionals arising from implementation of the *provisional* view. In doing so, he acknowledged the difficulty in this task:[53]

> Given the vast range of different [health professionals] affected by this decision, and the large number of different combinations of previous classifications and new classifications, it is highly complex to estimate the impact of the new classification system on the general compensation level of [health professionals] paid according to the [HPSS] Award.

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[53] Exhibit HPSS164 (witness statement with annexed supplementary expert report of Dr James Stanford, 31 October 2025) annexure JS-1 [44].

[84] Dr Stanford said that, in the absence of detailed data regarding the distribution of employed health professionals across these numerous categories of translation from the old to the new classification structure, he would use the ACTU's calculation of a simple average wage increase of 17.8 per cent to the minimum wage rates to model the effect on employment and operating costs. He said:[54]

> In my judgment this approach provides a reasonable first estimate of the overall order of magnitude of the impact of the draft determination on [HPSS] Award-reliant [health professionals'] compensation, but the uncertainty surrounding this estimate should be kept in mind in interpreting the following results.

[85] Dr Stanford modelled three estimated outcomes: a 'low case' where award reliance is assumed to be 10 per cent of health professionals covered by the HPSS Award, a 'medium case' where it is assumed to be 20 per cent, and a high case where it is assumed to be 30 per cent. He described the 'high case' as 'an extreme upper bound, with ample allowance for indirect wage effects that may result for health professionals currently paid above HPSS Award minimums'.[55] His modelling produced the following estimated outcomes:[56]

	Low case	**Medium case**	**High case**
Impact on total compensation (% increase)	0.44	0.87	1.31
Impact on total operating costs (% increase)	0.21	0.41	0.62

[86] Dr Stanford's modelling was not the subject of any significant challenge in cross-examination, nor was there any other evidence concerning the overall cost impact of the minimum wage rates increases for health professionals across the entirety of that part of the health sector covered by the HPSS Award. It is difficult to describe the cost impact of those minimum wage rates increases, particularly if phased in over a number of years, as being other than modest. They would certainly not cause us to conclude that, on a broader consideration of the health sector, the 'impact … on business' (s 134(1)(f)) is of such a degree as to set at nought the need to rectify identified gender-based undervaluation and thereby 'achieve gender equality… by… eliminating gender-based undervaluation of work' (ss 134(1)(ab) and 284(1)(aa)).

[87] Dr Stanford also separately modelled the cost impact of the implementation of the *provisional* view for pathology collectors. He produced a 'low case' estimate of the direct effect of the minimum wage rate increases produced by a change to the legal prescription and a 'high case' estimate' which included 'a generous allowance for indirect effects on the wages of workers who are not currently paid according to the Award, but may receive a wage increase anyway':[57]

	Low case	**High case**
Impact on total compensation	0.71	1.42

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[54] Ibid [46].

[55] Ibid [62]

[56] Ibid [62]–[63], [65].

[57] Ibid [35]–[36].

(% increase)		
Impact on total operating costs (% increase)	0.35	0.70

[88] Dr Stanford said of these outcomes:[58]

> Cost increases of that magnitude would be hard to distinguish from regular changes in nominal costs experienced in this industry due to annual wage gains, general inflation in inputs, growth in scale of service delivery, and other factors.

[89] These estimated cost impacts may be compared to those stated by Mr Browne for the minimum wage rate increases for pathology collectors. Similarly to Dr Stanford, Mr Browne modelled the impact according to two cases: first, the direct effect of the change to the legal minimum wages and, second, the effect if pathology collectors currently paid above-award wage rates were to have their wage rates increased to preserve relativities. Mr Browne's analysis was based on actual labour cost data provided by the three largest pathology businesses, ACL, Healius and Sonic, and scaled up to the industry as a whole based on a calculation that these companies generated 76 per cent of industry revenue. It is important to note that Mr Browne assessed these increases by reference to the labour costs pertaining to health professionals and pathology collectors only, not to total workforce compensation costs or total operating costs. The second Browne report gives an industry-wide figure for 'Other Costs + Taxes', but the inclusion of an unspecified amount of tax in this figure means that it cannot be compared to the total operating cost figure used by Dr Stanford. Mr Browne's estimates were:[59]

	Prescribed minimum rate	**Relativities preserved**
Impact on labour costs pertaining to pathology collectors and health professionals (% increase)	1.8	3.1

[90] It is reasonable to assume, having regard to Dr Stanford's analysis, that if the cost of the minimum wage rates increases for pathology collectors were assessed as a percentage of total industry operating costs, the increases would be less than half of the amounts in the table above (and likely well under half). While the resultant percentage amounts might be higher than in Dr Stanford's estimate, they would still be relatively modest in their effect.

[91] As earlier indicated, Mr Browne's analysis showed that the primary cost impact on pathology businesses would come from the implementation of the *provisional* view concerning health professionals. His estimate of the effect was as follows:[60]

	Prescribed minimum rate	**Relativities preserved**
Impact on labour costs pertaining to pathology	5.3	9.2

[58] Ibid [39].

[59] Exhibit HPSS171 (expert opinion of Oliver Browne ('on the Viability of Private Pathology under Proposed Award Rate Increases'), 17 September 2025) 12 (Table 5).

[60] Ibid 11 (Table 4).

collectors and health professionals (% increase)		

[92] Again, we consider it reasonable to assume that the cost of the minimum wage rate increases for health professionals measured as a percentage of total industry operating costs would be less than half of the above percentages.

[93] Mr Browne also analysed the effect of the minimum wage increases on the profitability of the three major pathology businesses. His conclusion as to current industry profitability was:[61]

> The Australian pathology industry operates on thin margins, having recorded a profit margin of only 2.1% in the year to 30 June 2025 *before* even including the impact of the proposed wage increase. Annual industry-wide net profit after tax (NPAT) was $112 million in the 2025 financial year.

[94] The 2.1 per cent figure was arrived at by deriving the operating NPAT for the three major businesses from their published financial data, scaling this up to an industry-wide number by reference to those three businesses' 76 per cent market share of revenue, and dividing this by industry revenue of $5,400 million. This last figure was taken from a report published by IBISWorld in September 2025 entitled 'Pathology Services in Australia'[62] (**IBISWorld Report**). Based on this calculation of profit levels, Mr Browne estimated that industry NPAT would be reduced by the following percentages as a result of the proposed minimum wage rate increases:

	Prescribed minimum rate	**Relativities preserved**
Pathology collectors only (% reduction in NPAT)	-11	-18
Health professionals only (% reduction in NPAT)	-31	-54
Pathology collectors and health professionals (% reduction in NPAT)	-42	-72

[95] Mr Browne went on to state his opinion that reductions in profit margins of this degree 'materially affects employment growth, job security, competitiveness and, in more extreme cases, the long-term viability of providers'.[63] Although Mr Browne did not model the impact of the *provisional* views on all pathology providers individually, he concluded based on his experience that there would be the following consequences:[64]

> ***Employment growth***: I find that cost pressures reduce the industry's financial capacity to expand employment or even sustain existing roles… Higher award rates may assist with recruitment and retention in undervalued classifications, but the overall effect is to suppress employment

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[61] Ibid 2.

[62] Exhibit HPSS174 (Arna Richardson, IBISWorld, *Pathology Services in Australia* (Report, September 2025)).

[63] Exhibit HPSS171 (expert opinion of Oliver Browne ('on the Viability of Private Pathology under Proposed Award Rate Increases'), 17 September 2025) 14.

[64] Ibid.

growth or increase layoffs. This burden is greatest for health professionals, where the Decision's wage cost increases are most significant. In my view, providers are most likely to respond by reducing headcount or restructuring roles in order to recover profitability.

Job security: In my opinion, as industry profits are compressed, cost-cutting measures such as layoffs, reduced hours, and wage freezes become far more likely. Even for roles that remain, I consider it likely that employees could face heightened uncertainty and fewer opportunities for progression. Lower industry profitability will transform cost control from optional to essential.

Competitiveness: I find that compressed profits also undermine the industry's ability to reinvest in innovation and technology. This weakens competitive intensity, as providers delay or cancel investments in service quality, automation, and new technologies such as agentic artificial intelligence (AI), which would otherwise improve efficiency and patient outcomes. The industry is already highly concentrated, with the three largest firms accounting for around 76% of revenue. In my opinion, some large providers may respond by reducing their service footprints and workforce, while smaller operators could bear proportionally greater strain, as their already thin gross margins leave less scope to cover fixed costs.

Viability: If EBA wage relativities to minimum award rates are preserved, the industry's annual profits decline from $112 million to $31 million, a decline of 72%. In my view, the Decision is also likely to accelerate attempts at industry consolidation (subject to ACCC approval), with smaller regional operators facing even more acute financial strain. Their already narrow margins leave little buffer to absorb higher labour costs. If smaller providers exit the market, patient access to pathology services outside metropolitan areas would be further reduced, particularly in rural and regional communities.

[96] There are some difficulties in accepting Mr Browne's conclusions in the terms stated. *First*, Mr Browne did not himself calculate the estimated cost to the three major pathology businesses of the minimum wage rate increases; he simply accepted cost figures supplied to him by those businesses, and did not verify their calculation methodology. The primary data input as to current and projected future labour costs was therefore not separately the subject of any evidence which would permit it to be scrutinised.

[97] *Second*, as to the projected cost figures based on an assumption of the preservation of relativities, no basis was disclosed as to why that might be a reasonable assumption. This is described in the second Browne report as the 'real-world'[65] scenario, and Mr Browne stated in the report that '[t]his data reflects the practical outcome for providers, most of whom operate under EBAs'.[66] However, in cross-examination, Mr Browne said 'I have not been asked to, nor have I given an opinion on whether that is likely to be a realistic scenario'.[67] In the absence of any evidence about the bargaining history in the pathology sector, the current coverage of enterprise agreements and the timing of them reaching their nominal expiry dates, it is difficult to make any assessment as to how likely this scenario is. In light of the conclusions stated in the second Browne report about the current profitability of the pathology sector and the commercial consequences of the implementation of the *provisional* views, it does seem somewhat counter-intuitive that pathology businesses would nonetheless give further wage increases beyond those they would legally be obliged to pay. We also note that the estimate of

[65] Ibid 7.

[66] Ibid.

[67] Transcript, 13 November 2025 PN4767.

the cost if relativities were preserved was based on calculations provided by only two of the three major pathology businesses and then applied to the rest of the sector on a proportionate basis[68] without any analysis of whether enterprise agreement coverage was at an equivalent level for the rest of the sector. In this context, it is significant that Ms Luxton gave unchallenged and uncontradicted evidence that, in current enterprise bargaining with the three major businesses, each has stated the position that, in relation to the 'forthcoming reclassifications', 'any associated cost increases will be absorbed, with no margin to be provided above the modern award'.[69]

[98] *Third*, Mr Browne's use and calculation of NPAT as the measure of profitability are problematic because:

(a) Mr Browne disclosed in cross-examination that, in the initial draft of his report, he had calculated profitability using EBITDA (earnings before interest, tax, depreciation and amortisation), but changed to using NPAT at the request of one of the companies the subject of the analysis.[70] That is, it appears that NPAT was not Mr Browne's initial choice for measuring profitability. Mr Browne said that EBIT (earnings before interest and tax) and EBITDA are 'common measure[s]' of profitability and 'truthfully, any of them [i.e. EBIT, EBITDA and NPAT] are valid'.[71]

(b) Unlike EBIT, the three major pathology businesses do not report NPAT. This was calculated by Mr Browne, but his methodology and actual calculations were not disclosed as part of his report or otherwise.

(c) The IBISWorld Report assesses the profit margin (EBIT) for the private pathology services sector at 13.4 per cent for the period 2021–26. It is not apparent, in the absence of any evidence of Mr Browne's methodology and calculations, whether an EBIT at that level can be reconciled with the NPAT arrived at by Mr Browne.

[99] Mr Browne's assessment that his estimated reductions in profit margins would detrimentally affect employment growth, job security and competitiveness, and perhaps the long-term viability of providers, is highly generalised in nature. While his description of the range of typical business responses to a significant one-off increase in costs may broadly be accepted, his assessment does not attempt to give any quantification of these responses, so that the degree in which, for example, employment growth and job security might be affected is not identifiable. Furthermore, Mr Browne's assessment is obviously dependent upon the accuracy of his estimates of the potential effect of the *provisional* views on profit margins.

[100] Ms Wett gave similar evidence about what she considered to be the business responses to the implementation of the *provisional* views, but this is merely expressed as matters of possibility and not of degree. Further, her views were largely reliant on the second Browne report and what she had been told by various persons amongst Australian Pathology's

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[68] Ibid PN4792.

[69] Exhibit HPSS154 (witness statement of Bec Luxton, 12 September 2025) [4].

[70] Ibid PNs 4819–4820, 4827.

[71] Ibid PN4808.

membership, who did not themselves give evidence.

[101] The IBISWorld Report paints a somewhat different picture of the current state of the private pathology services industry. After a fall in revenue from the abnormal heights of the COVID-19 pandemic, it forecasts an average increase in revenue of 4.2 per cent per year over the period 2026–31. The profit margin for 2021–26 was, as earlier stated, 13.4 per cent — a drop-off from the pandemic period but broadly consistent with pre-pandemic profitability. The forecast for wages growth for 2026–31 is 3.6 per cent, up from 1.8 per cent for 2021–26, although it is unclear whether this has factored in potential wage increases arising from the April decision. The Executive Summary in the IBISWorld Report relevantly states:[72]

> **Healthy diagnosis: Increased demand for early disease detection diagnostics is bolstering revenue growth**
>
> Pathology services providers supply vital information to help doctors diagnose and manage various diseases. Continual technological developments are increasing the range of available tests, boosting the scope of pathology referrals. Australia's ageing population and increased prevalence of chronic illnesses are also driving strong underlying demand for health services and associated referrals for pathology services. Medicare funding is supporting this demand, with the number of Medicare-funded services steadily rising, although the lack of Medicare Benefits Schedule (MBS) indexation over the past two decades has been eroding the industry's profitability.
>
> The most significant variable influencing demand for pathology services in recent years has been the COVID-19 pandemic. Private pathology providers were central to providing COVID-19 testing services through reverse transcription polymerase chain reaction (PCR) testing, which was crucial in detecting and controlling outbreaks. Between April 2020 and September 2022, 33.3 million services were provided under the relevant MBS item for Medicare bulk-billed PCR pathology tests, with $2.7 billion paid out in MBS benefits… This additional revenue stream underlies the dramatic spike in revenue in 2020–21 and 2021–22. Similarly, reduced requirement for PCR testing services — and the subsequent cuts to related Medicare funding — caused revenue to plummet in 2022–23. This high degree of revenue volatility has distorted yearly growth rates, with revenue contracting by an annualised 2.3% over the five years through 2025–26. Healthy growth of 4.0% in revenue to $5.7 billion is expected in 2025–26 as the industry benefits from the reintroduction of annual MBS indexation for one-third of Medicare-funded pathology services from 1 July 2025. The industry continues to campaign for indexation for the remaining two-thirds.
>
> Long-term demographic factors, including an ageing population and an increased reliance on pathology testing (supported by ongoing technological developments), will drive demand and revenue going forwards. The industry is set to benefit from a lower degree of volatility, with industry revenue forecast to climb at an annualised 4.2% over the five years through 2030–31 to $7.0 billion.

[102] The IBISWorld Report rates all four of the 'Key External Drivers', namely federal funding for Medicare, total visits to a general practitioner, population aged 70 and older, and number of births as positive. Three other matters in the IBISWorld Report may be noted. First, the report observes that a rising wages bill is impacting industry costs, with wages constituting the largest industry cost at 42.1 per cent of revenue, although this growth is attributed to a

[72] Exhibit HPSS174 (Arna Richardson, IBISWorld, *Pathology Services in Australia* (Report, September 2025)) 4.

higher headcount as well as 'award wage increases'. Second, the report states that technological change including automation of testing and the use of artificial intelligence is driving increased demand (and revenue) and displacement of some categories of health professionals; for example:[73]

> Technological and medical advancements have expanded the range of tests available and increased automation, dramatically changing the nature of pathology testing over the past decade. As industry equipment becomes more sophisticated and automated, the need for scientists tends to diminish. Instead, medical technicians may perform tests under the supervision of specialist pathologists.

[103] Third, the report notes that the industry has already gone through a process of consolidation in order to achieve economies of scale, leading to a high degree of market concentration, and is also already rationalising following the pandemic by 'the closure of unprofitable approved collection centres and associated headcount cuts'.[74] This is consistent with the Healius 'FY26 Outlook' document annexed to Ms Luxton's statement concerning projected wages cost savings, which refers to:[75]

> Cost growth minimised by expected labour efficiencies and support cost rationalisation
> - Reaffirming $15m – $20m in annual support cost savings
>   - $7.3m in annualised savings in FY25 / further $8.5m in annualised savings to be removed during the course of FY26
> - Labour costs — detailed plan to reduce labour cost base to be broadly flat on FY25

[104] In the April decision at [299], we found (based on evidence adduced in December 2024):

> The private pathology sector is also labour intensive, with most pathology collectors being paid at the minimum award rate. Private pathology providers (three of which account for more than 80 per cent of the market) are primarily (close to 90 per cent of revenue) funded by Medicare payments made by the Commonwealth, which are not indexed, and overwhelmingly bulk bill their services. There is therefore very limited capacity for private pathology providers to increase their revenue in a low margin industry.

[105] However, notwithstanding this finding, as well as findings we made at [297]–[298] concerning the capacity of the private hospital sector to pay wage increases, we stated the following conclusion at [300]:

> Having regard to the outcomes we have earlier proposed for health professionals and pathology collectors, our *provisional* view is that these findings are not sufficient to deter us from varying the HPSS Award to remedy the gender-based undervaluation we have found to have occurred, but they would necessitate consideration of an appropriate timetable for the phasing-in of the wage rate increases involved. …

[106] The evidence and submissions in the current stage of the proceedings have not persuaded us to depart from this *provisional* view, and we do not accept Australian Pathology's submissions in this regard. *First*, we do not consider that Australian Pathology has made out a

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[73] Ibid 8.

[74] Ibid 36.

[75] Exhibit HPSS154 (witness statement of Bec Luxton, 12 September 2025) annexure BL1-01.

case that the interests of the pathology industry should be given primacy over the rest of that part of the health sector covered by the HPSS Award. As earlier stated, apart from Australian Pathology, no employer party with an interest in the HPSS Award supported the position that no action should be taken to rectify the gender-based undervaluation identified in the April decision.

[107] *Second*, the cost to employers of implementing the *provisional* view with respect to pathology collectors is, on any view, entirely insufficient to justify the position that no action should be taken to rectify the gender-based undervaluation of their work. As set out above, Dr Stanford's estimate of the impact on total employer business costs of the minimum wage rate was in the range of 0.35–0.70 per cent. If Mr Browne's higher estimate of the direct cost impact is extrapolated to total business costs, it is likely well under 0.9 per cent, rendering it broadly comparable to Dr Stanford's estimate. This modest effect would be ameliorated further by a phasing-in arrangement.

[108] *Third*, although the minimum wage rates increases proposed for health professionals are clearly substantial, we do not consider for the reasons earlier stated that the second Browne report provides a reliable basis upon which to estimate their cost impact in the pathology industry. In particular, we do not consider that there is any proper basis to rely upon Mr Browne's higher cost impact estimate based on the assumption that employers will agree to maintain the existing relativities to the HPSS Award established in current enterprise agreements. No basis has been established to accept that assumption as a realistic one. Dr Stanford's estimate for the total business cost impact across the health sector covered by the HPSS Award as a whole was in the range of 0.21–0.62 per cent, with a 'medium case' estimate of 0.41 per cent. That is not an effect sufficient to leave the identified gender-based undervaluation for health professionals unrectified, even acknowledging that there will be a significantly greater cost impact in the pathology sector because of an apparently greater degree of award reliance in that sector.

[109] *Fourth*, the revenue position for the pathology industry is generally positive, as demonstrated by the IBISWorld Report, and the position has improved since the April decision with the Commonwealth commencing, from 1 July 2025, indexation of the Medicare rebate for about one-third of pathology services. Further, the IBISWorld Report indicates that pathology business are already engaged in processes to cut their costs, including their wages costs, and the use of new technology in testing is reducing the need to employ health professionals (principally medical scientists).

[110] *Fifth*, for Australian Pathology's primary case to succeed, it would need to demonstrate that, even with a phasing-in of the proposed minimum wage rate increases, there is no viable way in which gender-based undervaluation may be remedied. However, the second Browne report indicates that a longer phasing-in period would significantly mitigate the business impact of the implementation of the *provisional* view:[76]

> In my view, phasing alters the timing, not the size, of the increase in labour costs. I recommend a minimum 5-year phasing period, with consideration of extending to 7 years given the magnitude of the cost impact and the industry's structure. This aligns with precedent from other

[76] Exhibit HPSS171 (expert opinion of Oliver Browne ('on the Viability of Private Pathology under Proposed Award Rate Increases'), 17 September 2025) 14–15.

> major Australian sector reforms, including the 5-year phasing period recently approved by the Fair Work Commission for the Children's Services Award (April 2025) and the 5-year phasing of modern awards implementation (2010–2014). The 5-year minimum reflects best practice for significant sectoral transitions, while the 7-year option recognises the pathology sector's unique constraints (and funding model) and the scale of adjustment required. Such phasing would ease the immediate burden on providers by smoothing cash flow and giving more time to adjust. In my opinion, this breathing space is critical in an industry that is already experiencing financial pressures.
>
> (footnotes omitted)

[111] This is consistent with Dr Stanford's view:[77]

> … Nevertheless, if a phased-in approach were adopted, then the incremental impacts of the provisional wage increases would be muted further.

[112] We accept the evidence of Mr Browne and Dr Stanford in this respect. It demonstrates that an appropriate phasing-in period would serve to significantly mitigate the effects on business of the implementation of the *provisional* views.

[113] Accordingly, we will proceed to consider the basis upon which the gender-based undervaluation of the work of pathology collectors as found in the April decision may be rectified. We will give our reasons later in this decision as to why the variations we have ultimately determined to make are necessary to achieve the modern awards objective in s 134(1) and will achieve the minimum wages objective in s 284(1).

[114] We do not propose to give consideration to Australian Pathology's submission to the effect that the application of the C1(a) benchmark rate to professions requiring an AQF Level 7 qualification is inappropriate and unsupported by the findings in the April decision as to work value. This submission merely seeks a revisitation of findings already made in the April decision and is not supported by any evidence demonstrating that those findings should not have been made.

Proposed modifications to the provisional view regarding pathology collectors

[115] The main issue which has arisen in respect of the modifications to the Support Services employee classification structure for pathology collectors proposed in our *provisional* view concerns the description of those pathology collectors who, indicatively, should be classified at Level 7. In this respect, Australian Pathology has advanced two submissions challenging the *provisional* view.

[116] The first is that 'Level 7 should be reserved for pathology collectors who supervise other employees, prioritise their work and the work of others, and are fully autonomous'[78] and that '[e]xperienced pathology collectors who do not supervise or guide others and who do not work fully autonomously properly belong in Level 6'.[79] This submission appears to depend on the

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[77] Exhibit HPSS164 (witness statement with annexed supplementary expert report of Dr James Stanford, 31 October 2025) annexure JS-1 [40].

[78] Australian Pathology submission, 17 September 2025 [42(a)].

[79] Ibid.

premise that the existing general criteria for Level 7 (which we do not propose to alter) *require* that an employee at that level be engaged in the supervision of other employees. This is not correct, since clause A.1.7(iii) of the HPSS Award relevantly provides that an employee at that level '*may* supervise the work of others…' (emphasis added). In this respect, the provision is like a number of the other criteria in clause A.1.7 which are prefaced by the word 'may' and unlike those which are expressed in more mandatory terms. That the duty of supervising others is not a mandatory criterion is confirmed by the next criterion in clause A.1.7(iv), which provides that an employee at Level 7 'works either individually or in a team'.

[117] The key work value finding which we stated in the April decision at [235] (set out at [49] above) was based on the more detailed findings at [232] and addressed the critical mandatory criteria in clause A.1.7. That finding was conclusive rather than provisional in nature. Australian Pathology's submission essentially seeks to subvert that finding and, in any event, was not supported by any further evidence which would cause us to reconsider the finding. Accordingly, we reject the submission.

[118] Australian Pathology's second submission concerned the reference in the proposed indicative role description for pathology collectors at Level 7 to a requirement 'to work in a single-staffed collection centre'. In including this criterion in our *provisional* view concerning the variations to be made to the classification, we intended that this would express in practical terms the requirement in clause A.1.7(i) that an employee at Level 7 be 'capable of functioning autonomously' as well that in clause A.1.7(ii) that such an employee be 'responsible for work performed with a substantial level of accountability and responsibility'. We otherwise considered that four years' industry experience would be a reasonable proxy for an experienced pathology collector.

[119] Australian Pathology submitted that the indicative criteria for a Level 7 pathology collector would lead to anomalous results: a newly-qualified collector with no previous experience might be rostered to work at a single-staffed collection centre despite not being yet fully competent, while a fully competent collector with less than four years' experience who trains and supervises other employees but does not usually work at a single-staffed collection centre (such as the Joint Unions' witness Lauren Burke) would be classified at Level 6. Australian Pathology also submitted that:

- a 'single-staffed collection centre' is not capable of precise definition or application, since a given collection centre can be single-staffed on one day and multi-staffed on another;
- there is no material difference in work value that would justify the criterion of working in a single-staffed collection centre, since this is not more complex or difficult than working at multi-staffed collection centres, and collectors at the latter may have higher volumes of work and perform more difficult tests; and
- regardless of where they are located, collectors work independently, and their first point of contact is their supervisor rather than a fellow collector.

[120] We are persuaded by the evidence that employment at a single-staffed collection centre is not an appropriate distinguishing criterion for an experienced collector who is required to work autonomously and with a high degree of personal responsibility and accountability. Firstly, it is clear that pathology collectors may be required to work at a single-staffed collection

centre with only very limited experience. Ms Wolow's evidence was that, at ACL, pathology collectors holding a Certificate III may be assessed after only about two to four weeks' initial training and four weeks' initial experience in a multi-staffed collection centre as 'competent and able to work alone',[80] at least on a relief basis. Conversely, Ms Wolow said that senior and experienced collectors may work in a busy room or a hospital and perform more diverse tests compared to a less experienced pathology collector performing simpler, less busy work in a single-staffed collection centre. Mr Meckiff gave similar evidence to the effect that, at Healius, a pathology collector may be required to work in a room on their own after just a few months of experience. The evidence of the Joint Unions' witnesses did not contradict this to any significant degree. For example, Ms Cleland said that, after an initial six-week period training and two weeks of being mentored at Laverty, she was placed on the relief roster to work at both single- and multi-staffed collection centres. Ms Slight, who is employed by ACL, said she began working casually at single-staffed collection centres after the first four months of her employment, which were mostly spent at a multi-staffed collection centre. Ms Slack gave evidence that at Sullivan Nicolaides Pathology, where she is employed, Certificate III-qualified new employees are given two to six weeks of training, and unqualified new employees are given up to 12 weeks' training, after which they may be required to perform relief work at single-staffed collection centres. Ms Burke said in relation to Diagnostic Services Pty Ltd: 'Usually [new pathology collectors] have a couple of months' experience before they are sent out to the single specimen collector centres'.[81]

[121] Secondly, Australian Pathology's witnesses made it clear that *all* pathology collectors are expected, after their initial training, to work autonomously. Mr Meckiff said: 'After [the initial training/mentoring period], all Pathology Collectors are required to be able to work independently'.[82] This is not dependent on working in a single-staffed collection centre, so that Mr Meckiff described collectors in hospitals doing their ward rounds on their own and, even in a multi-staffed collection centre, collectors perform their own work independently: 'Pathology Collectors will greet the patient, do the test themselves, and do the labelling that goes on to tubes, whether working in a multi-staffed room or single-staffed room'.[83] Ms Wolow gave similar evidence in cross-examination:[84]

> …in a multi-staff[ed] centre, where there's more than one collector, there's opportunity to share some of those other tasks?---No, because both collectors working in a multi-site collection room they're working their own collection room and they work individually and independently from starting, taking the patient, the collection room, finishing the patient, preparing the specimens, completing the paperwork or anything else that is involved.

[122] Mr Meckiff also referred to 'domiciliary' collectors, who work alone when they visit residences and nursing homes to undertake sampling or testing. The Joint Unions' witnesses described the benefit of collegiate support when working in a multi-staffed collection centre. For example, Ms Slight said that in her first year of employment when she found it challenging to find 'hard veins',[85] she could call on a colleague for assistance after two attempts rather than

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[80] Exhibit HPSS175 (witness statement of Maja Wolow, 27 June 2025 [amended 13 November 2025]) [15].

[81] Transcript, 12 November 2025 PN4042.

[82] Exhibit HPSS176 (witness statement of John Meckiff, 27 June 2025) [7].

[83] Ibid [13].

[84] Transcript, 13 November 2025 PN4938.

[85] Exhibit HPSS163 (witness statement of Paige Slight, 30 October 2025) [47]–[48].

having to send the patient away, while Ms Cleland described the benefit of having other collectors to share the load with. However, the witnesses accepted that the fundamental duties were the same at single- and multi-staffed collection centres. Ms Cleland agreed with Mr Meckiff that pathology collectors in multi-staffed collection centres work independently in the way he described and said in cross-examination:[86]

> …reading and keeping up your skills, all your duties - they're the same thing whether you're at a multi-staffed or a single[-]staffed centre, aren't they?---That's correct, yes.
>
> You've got to work independently at both kinds of centre, don't you?---Definitely, yes.

[123] Ms Slight gave evidence to the same effect:[87]

> New starters, just to be clear, at a single-staff[ed] centre - a new starter can be required to work there independently. That's true, isn't it?---Yes.
>
> Yes. The nature of the work performed at single-staffed and multi-staffed centres is essentially the same, isn't it?---Yes.
>
> The duties are very similar, if not identical?---Yes.

[124] Accordingly, it is necessary for us to formulate a new criterion for the indicative role description for pathology collectors at Level 7. In doing so, we note that the descriptor in the *provisional* view was intended to capture a significant proportion of pathology collectors in a way consistent with our work value findings, since the large majority of collection centres are single-staffed. A simple reversion to the residuum of the descriptor in the *provisional* view (Certificate III or equivalent training and experience plus four years' or more industry experience) would be unsatisfactory because it would unduly narrow the scope of pathology collectors intended to be covered at Level 7. Additionally, as we explain, it is inconsistent with the evidence concerning when a pathology collector can be characterised as 'experienced'.

[125] Because the evidence demonstrates that all pathology collectors are required, after initial training, to work independently, it is not necessary to specify this in the indicative role criterion in order to give practical content to the general requirements for autonomous working, responsibility and accountability at Level 7. It is therefore sufficient to identify the level of experience required to give effect to the finding at [235] of the April decision. We consider that this is best expressed in terms of years of industry experience.

[126] Ms Wolow, while giving evidence in her witness statement that a new Certificate III-qualified pathology collector may be working on their own in a single-staffed collection centre about six weeks after commencing employment with ACL, went on to say:[88]

> You can't compare a collector in that position to a collector with four or five years' of experience. Their knowledge and skills are on a different level.

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[86] Transcript, 12 November 2025 PNs 4679–4680.

[87] Ibid PNs 4190–4192.

[88] Exhibit HPSS175 (witness statement of Maja Wolow, 27 June 2025 [amended 13 November 2025]) [18]–[19].

> Even after a year of working as [a] collector, there is still much more that collectors can learn to build up skills and experience with difficult bleeds and to be able to perform more diverse tests like paediatrics and AS4308 collections. Generally, after five years' experience, a collector can work in any type of [collection centre]. This is applicable across the pathology industry and pathology providers.

[127] If that evidence was intended to convey that a pathology collector requires four to five years' experience to be fully proficient, which is unclear, it was not consistent with the evidence given by witnesses who were themselves pathology collectors. Ms Slack gave the following evidence in her witness statement about the degree of experience necessary to be a 'fully competent' pathology collector:[89]

> I expect a pathology collector to be fully competent after 2 years' experience at a maximum. For me, I became fully competent and comfortable in my role after 1 year.

[128] Ms Slack expanded upon this in her oral evidence:[90]

> …When I was referring to being competent taking up to two years, that is more to do with personal confidence, competency with dealing with the variety and different tests, different procedures that are performed, and being able to know where to find information required and help required to get you to a level where you feel comfortable in anything that may walk through the door.
>
> That's what I was referring to in regards to feeling competent and confident and, myself, I felt that after 12 months of my employment at Sullivan Nicolaides.

[129] Ms Slight gave evidence in cross-examination on the same subject:[91]

> It would be fair to say, wouldn't it, that you were not as competent in your first year as you are now?---Within my first four months I would have not been as competent. However, within the duration of that first year, I very quickly became almost fully competent.

[130] Ms Cleland, who has been employed as a pathology collector for about three years, described herself as working entirely independently and without supervision, performing the full range of duties in a single-staffed collection centre. Similarly, in the first stage of the proceedings, Ms Summer George described herself as performing the full range of duties while working alone and without supervision in her second year of employment. We also note that some of Australian Pathology's witnesses in the first stage of the proceedings referred to pathology collectors regularly being 'reassessed'[92] for competency, with Dr Boon-Kiang Tan stating that at ACL this was undertaken every two years or more frequently if needed. 'Re-assessment' implies that the employee has also been assessed as fully competent at an earlier stage.

[131] Having regard to the evidence we have referred to concerning the training of pathology collectors once employed, the expectation that they will be required to work independently

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[89] Exhibit HPSS162 (witness statement of Katrina Slack, 31 October 2025) [41].

[90] Transcript, 12 November 2025 PNs 4135–4136.

[91] Ibid PN4182.

[92] Exhibit HPSS42 (witness statement of Boon-Kiang Tan, 26 November 2024) [20].

within the first six months, and the acquisition of skills by experience, we consider that the most appropriate way to give effect to our conclusion in the April decision that an experienced pathology collector should be classified at Level 7 is to allow progression to that level after a period of 12 months classified at Level 6. That would mean, in effect, that a new Certificate-III qualified employee would move to Level 7 after 12 months' industry experience, and a non-qualified employee would move to Level 7 after two years' industry experience.

[132] In response to the other matters raised by Australian Pathology:

- references to 'industry experience' will be replaced by 'industry experience as a pathology collector';
- the Certificate III qualification will be described as 'Certificate III in pathology collection'; and
- the reference to Certificate IV contained in the translation table in the draft determination will be removed.

[133] In accordance with the above findings and conclusions, the indicative roles for pathology collectors in the Support Services employee structure shall be expressed as follows:

Support Services classification	**Criteria**	**$ per week**
Level 5	Entry level Unqualified with less than 12 months' industry experience as a pathology collector.	1104.70
Level 6	Qualified Certificate III in pathology collection with less than 12 months' industry experience as a pathology collector **or** Unqualified with 12 months to up to 2 years' industry experience as a pathology collector.	1164.20
Level 7	Experienced Certificate III in pathology collection and 12 months' or more industry experience as a pathology collector **or** Unqualified with 2 years' or more industry experience as a pathology collector.	1185.10

Issues regarding the new classification structure for health professionals

[134] As earlier identified, a number of issues have been raised in response to the *provisional* view concerning the new classification structure for health professionals. We commence with the issues raised concerning the proposed base level classification for health professionals. The first issue we deal with concerns the basis upon which a health professional will be graded into a particular AQF payment stream at this level, noting that no party ultimately disagreed with the underlying principle that the level of pay should vary depending upon the level of the AQF qualification necessary to enter each profession. In the April decision at [123], we set out a table identifying what could be identified at the time as the 'minimum tertiary qualification' for each profession currently listed in Schedule B to the HPSS Award, which we defined (in

footnote 126) as meaning 'the AQF minimum level qualification currently offered through a program of study in Australia which is needed for registration and/or eligibility to practice or work in a health professional occupation'. We noted however that this did not necessarily mean the most *prevalent* qualification available for work in a profession. The approach taken in developing this table, however, was to attempt to identify the *standard* minimum qualification and to avoid 'outlier' qualifications which were at a lower level than the usual minimum qualification for the profession. Hence, at [176] of the April decision, we stated as a guiding principle for the new structure that:

> The new pay structure should distinguish between the different professional occupations based on the AQF level of the standard educational qualification required for entry into the profession, consistent with the table in paragraph [123] above.

[135] We have earlier outlined the parties' differing positions in respect of the criterion which should apply to give effect to the above principle. However, in practical terms, the contest in this respect arises in relation only to a relatively small proportion of the professions listed in Schedule B to the HPSS Award. For most professions, no issue was taken with the table in [123]. The practical issues which have arisen concern a number of professions where there is genuinely no standard as to the qualification level necessary to enter the profession. A notable example of this is speech pathology, where there are significant numbers of qualifying courses across Australian universities at each of AQF Levels 7, 8 and 9. Some of the other professions concerned are smaller ones where there only a few qualifying courses and no standard is identifiable (such as orthoptics).

[136] We do not consider that the relatively few professions for which these difficulties arise justify, as proposed by the ACTU and the HSU, a wholesale change from the *provisional* view to a criterion based upon the qualification held by the employee which enables them to practice their profession. It would be undesirable, generally speaking, for persons practising the same profession — perhaps even for the same employer — to be paid differently depending upon the university course which they happened to undertake to qualify for that profession. Thus, we consider it appropriate to retain the 'standard minimum qualification' as the general criterion for the application of the base level classification, noting as earlier stated that this criterion will remove 'outlier' courses at a lower AQF level from consideration. However, some accommodation needs to be made for the professions for which there is no identifiable 'standard minimum qualification'.

[137] The practical solution, we consider, is to replace the current Schedule B with a table which specifies, for each profession, what can be identified as the standard minimum qualification. Where no standard minimum qualification can be identified, the table will list the identifiable alternative minimum qualifications. The obligation upon the employer under the new classification structure will be to pay the employee at the rate for the standard minimum AQF qualification identified in the table or, where there is more than one, at the AQF qualification held by the employee provided it is one of the alternatives specified.

[138] Speech pathology is an example of a profession where there is no standard pathway for entry: Speech Pathology Australia's submission states that there are a substantial number of qualifying courses at each of AQF Levels 7, 8 and 9. Although, as their submission states, there were more courses at AQF Level 9 than at each of AQF Level 7 or AQF Level 8, the majority are not at this level and therefore we are not persuaded that speech pathology should be

recognised as an AQF Level 9 profession. Consistent with the approach we have just articulated, we consider instead that all three AQF levels should be specified in Schedule B, with an employee being paid according to the qualification held. The same will apply in relation to orthoptists and a number of other professions where a standard minimum qualification cannot be readily identified. As we discuss later, we will issue a draft determination in respect of the variations applicable to health professionals in the HPSS Award, so parties will have an opportunity to comment upon the proposed table in Schedule B in relation to other professions before the variations are finalised.

[139] We note that the HPSS Award is, in respect of health professionals, an occupational as well as an industry award (see clause 4.1), and Schedule B of the current Award does not include all health professionals who would be covered by the award. The obligation on an employer in the (likely rare) scenario where they engage a health professional whose profession is not included in the new table in Schedule B would be to ascertain the standard minimum AQF qualification for that profession and pay the employee at the rate for the standard minimum AQF qualification. Where, as with the examples of speech pathologists and orthoptists discussed above, no such standard minimum qualification may be identified, the employer will be required to pay the employee at the rate of pay for the qualification held by the employee.

[140] We recognise that the approach we prefer is not entirely free of difficulty given that the courses offered by Australian universities often change, meaning that a current standard minimum qualification for a profession may not remain so in the future. Further, we consider that the nomenclature of a number of the professions currently listed in Schedule B may no longer be fit for purpose. Potential examples of this include client adviser/rehabilitation consultant, medical record administrator, biomedical technologist, research technologist, musculoskeletal therapist and play therapist. This presents additional difficulties in identifying a standard minimum qualification. It also appears that some of the occupations currently identified in Schedule B, such as pastoral carer, may not properly be characterised as a health professional. We will, during the next two years, review the table to examine whether it should be retained or updated. However, before that occurs, parties may make submissions about these issues in response to the draft determination which we will issue.

[141] The second issue concerns the ACTU's proposal that an additional payment stream be added for health professionals with an AQF Level 10 qualification (that is, a doctoral degree). While there may be some professions which have a pathway to entry by obtaining a qualification at this level, it has not been demonstrated that such a qualification is either a minimum or standard for any profession currently listed in Schedule B. The ACTU/HSU's witness Mr Leszczynski identified only Art Therapist as a profession for which a doctorate may be an entry-level qualification, but an AQF Level 9 qualification is sufficient for entry to this profession (see the table at [123] of the April decision). This proposal is therefore rejected. We note that it may be the case that the acquisition of a doctorate as an additional post-graduate qualification may permit progression as a specialist to Level 2 in the proposed classification structure.

[142] The third issue concerns Healthscope's proposal to modify the criteria for the progressions through the pay levels in the base classification. The *provisional* view contemplated that progression would be automatic based on years of industry experience. The Healthscope proposal, which was supported by the Ai Group, proposes to alter this so that the

criteria for progression are based on a mixture of minimum periods of experience combined with requirements concerning the duties performed. Healthscope submitted in support of its proposal that:

(1) In the absence of detailed classification descriptions, progression through the levels of the proposed classification structure is solely service based. Consistent with the observations in the *Aged Care Nurses decision*[93] and the *Teachers decision*,[94] in the absence of clearly articulated classification definitions referring to the relevant skills and responsibilities of each classification level, the proposed service based incremental pay structure is not consistent with properly-fixed minimum rates of pay based on work value.

(2) The clear articulation of the level of work performed by each classification aids the identification of the employees entitled to the relevant rates. The absence of clearly-defined classification descriptions is liable to cause doubt and disputation and would be contrary to the modern awards objective and the need to ensure a simple, easy to understand, stable and sustainable modern award system.

(3) Healthscope's proposed classification definitions support a clear and contemporary classification structure.

[143] We do not accept these submissions. In the April decision, we said at [177] that the *provisional* view concerning the proposed benchmark classification contained pay increments 'broadly aligning with those established for teachers under the [*Educational Services (Teachers) Award 2020*[95] (**EST Award**)] as a result of the *Teachers decision*'. The EST Award, contains pay increments at Levels 3 and 4 for, respectively, three and six years' 'satisfactory teaching service' since progression to Level 2, with the pay rates for these classifications being aligned to the proposed AQF Level 7 rates for the 4th to 6th years of experience and for the 7th year and beyond respectively. There are no progression criteria beyond these requirements concerning years of experience. In relation to this, the Full Bench in the *Teachers decision* said at [656]:

> We consider that the [NSW Teachers Award 2020] structure, which is built on the APST professional career standards, may with some modifications be adapted for use in the EST Award. We consider that the structure has, to an excessive degree, retained service-based requirements which are unlikely to be related to work value… we think that the further service-based progressions at the Proficient level occur at intervals which are too short to properly relate to the acquisition of additional skills and responsibility through experience. A better approach would be to have two service-based increments at the Proficient level at three-[year] intervals.

[144] Similarly, the decision in the *Aged Care Nurses decision* led to a new classification structure which, for Level 1 registered aged care nurses, had service-based increments at one to four years' service and over four years' service without any other progression requirements. The proposed progression criteria for the benchmark classification are therefore consistent with the *Teachers decision* and the *Aged Care Nurses decision*. The passages in those decisions upon

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[93] [2024] FWCFB 452.

[94] [2021] FWCFB 2051.

[95] MA000077.

which Healthscope relies refer to previous classification structures with automatic annual pay point progression and not the structures which were ultimately determined.

[145] The Healthscope proposal, contrary to the submissions advanced in its support, would be likely to cause uncertainty as to the correct classification of health professional employees. First, its 'Clinician' labelling of each classification level may exclude some categories of health professionals, such as medical scientists in pathology laboratories, who do not work directly with patients. Second, the retained criteria for years of experience are expressed in vague and uncertain terms: for example, it is difficult to determine what, if any, legal obligation is conveyed in the words 'Employees *generally* progress to this level after *at least* two years' … work as a Junior Clinician…'. Third, the criteria which attempt to identify the nature of the duties performed at each level are expressed in very high-level and general terms, and over half the criteria used are prefaced by the work 'may' rather than 'will', rendering them not necessarily applicable.

[146] We are therefore not persuaded to depart from the *provisional* view concerning the benchmark classification in the way proposed by Healthscope.

[147] In relation to the *provisional* view concerning the proposed Levels 2, 3 and 4 classifications, a number of issues were raised by the ACTU and the HSU, and by Healthscope. The unions' claim for an additional pay point in Level 2 for the 3rd to 5th years of employment at that level was supported by a submission confined to the following:[96]

> This intermediate pay point provides modest recognition of accumulating experience and competence over years 3–5 and is justified on work value grounds given the incremental development of skills and responsibilities that is likely to occur during this stage of professional practice, after the completion of the graduate and first post-graduate years, and prior to the completion of a full 5 years of employment at Level 2.1. This approach recognises the significant difference in skills and experience held by a first year as compared to a fifth year, prevents wage stagnation over what would otherwise be a significant period of professional practice (5 years), while harmonising with the provisional view that there should be no automatic annual progression.

[148] This submission was not supported by any of the evidence adduced by the ACTU and the HSU and does not rise above the level of assertion. We are not persuaded to depart from the *provisional* view in this respect.

[149] The ACTU and the HSU, and Healthscope, advanced competing proposals for modified criteria to apply to Levels 2, 3 and 4. We accept the ACTU's proposal, which is supported by the evidence of Mr Leszczynski, that there should be greater specification of clinical, educational, research, training, quality assurance/control and supervision/management roles at Levels 2 and 3. The Healthscope proposal for the classification descriptors to apply to these levels is, in the terms presented, excessively and unnecessarily complex and prescriptive, but we note that it also recognises the range of roles specified in the ACTU/HSU proposal in greater detail than the *provisional* view and we accept it to that extent. We also accept Healthscope's position that, at least at Levels 3 and 4, we should make express what we consider was implicit in the *provisional* view, namely that progression to any managerial-level classification must be

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[96] ACTU submission, 12 September 2025 [15(a)].

upon appointment by the employer. For translation purposes, we will deem existing employees classified at the current Level 3 and 4 to have been appointed to roles at those levels.

[150] We also accept the Ai Group's submission that the designation of the Level 4 classification as applicable to 'Senior managers' *may* expand the coverage of the HPSS Award to higher levels of managerial employment than is currently the case. Clause A.2.4 of the HPSS Award defines a Level 4 Health Professional in the following terms:

> **(a)** A health professional at this level applies a high level of professional judgment and knowledge when performing a wide range of novel, complex, and critical tasks, specific to their discipline.
>
> **(b)** An employee at this level:
>
> **(i)** has a proven record of achievement at a senior level;
>
> **(ii)** has the capacity to allocate resources, set priorities and ensure budgets are met within a large and complex organisation;
>
> **(iii)** may be responsible to the executive for providing effective services and ensuring budget/strategic targets are met;
>
> **(iv)** supervises staff where required; and
>
> **(v)** is expected to develop/implement and deliver strategic business plans which increase the level of care to customers within a budget framework.

[151] While the duties identified at (b)(ii), (iii) and (v) describe managerial-level functions, we accept that, at least on one view, these functions are not aptly described as *senior* management functions. The significance of this issue is that s 143(7) of the FW Act provides:

> (7) A modern award must not be expressed to cover classes of employees:
>
> (a) who, because of the nature or seniority of their role, have traditionally not been covered by awards (whether made under laws of the Commonwealth or the States); or
>
> (b) who perform work that is not of a similar nature to work that has traditionally been regulated by such awards.
>
> Note: For example, in some industries, managerial employees have traditionally not been covered by awards.

[152] Clause 4.1 of the HPSS Award describes the scope of coverage of the award in part by reference to employees in the classifications in Schedule A. It follows that any expansion in the scope of any classification definitions to employees not previously encompassed will widen the coverage of the HPSS Award. Particularly where this involves managerial employees, there is a risk that by doing so we may infringe upon the prohibition in s 143(7). Accordingly, we consider it appropriate to take a cautious approach and better articulate the criterion for the Level 4 classification to make clear that the managerial functions at this level do not extend to more senior levels of management than is currently the case.

[153] Taking all these matters into account, we determine that the classification criteria for Levels 2, 3 and 4 shall be as follows:

Classification	Criteria	$ per week

Level 2.1 **Senior clinician** **Specialist** **Supervisor** **Educator**	A health professional who performs the following roles and duties: (a) senior clinician who works directly with patients in a clinical area of their profession that requires specialist knowledge or depth of experience and/or provides clinical guidance and direction to less experienced employees as needed. Such an employee may have obtained a post-graduate qualification and/or perform advanced practice work and/or have completed training which may involve credentialing relevant to their profession; or (b) specialist performing duties within or across one or more of areas of expertise. These areas may include research or quality assurance and control; or (c) supervisor who is required to provide supervision on a day-to-day basis to other health professionals, other employees (such as allied health assistants), and/or students; or (d) an educator who is accountable for the assessment, planning, implementation and evaluation of education and staff development programs.	$1999.30
Level 2.2	A health professional with 5 years’ experience at Level 2.1.	$2121.90
Level 3 **Advanced Clinician** **Senior Specialist** **Section Manager**	A health professional who has been appointed to perform the following roles and duties: (a) an advanced clinician who is a specialist in (a) clinical area(s) of their profession and has extensive levels of specialist knowledge and/or is a lead clinician/clinical lead who has extensive levels of knowledge across their profession; or (b) a senior specialist who holds accountability for educational, research and/or quality assurance and control. Such an employee may have responsibility for leading a team; or (c) is a manager who has responsibility for managing the activities of, and providing leadership, coordination and support to a specified group or team in an area, section or part of a department or service of the employer and may be accountable for ensuring budgets are met and/or the expenditure of set resources.	$2282.00
Level 4 **Manager**	A health professional who has been appointed as a manager and who: (a) has a proven record of achievement at a senior level;	$2588.20

	(b) has the capacity to allocate resources, set priorities and ensure budgets are met within a large and complex organisation; (c) may be responsible to the executive for providing effective services and ensuring budget/strategic targets are met; (d) manages staff where required; and (e) is expected to develop/implement and deliver strategic business plans which increase the level of care to customers within a budget framework.	

[154] There are two final matters raised by the submissions of the ACTU and the HSU. First, we accept the submission, which was not contested by any party, that current clause 17.1 of the HPSS Award should be deleted. Clause 17.1 prescribes the criteria for progression through the current classification structure for health professionals but will not be relevant to the new structure. Second, we reject the submission that the definition of the 'standard rate' in clause 2, which constitutes the mechanism by which wage-related allowances in the award are adjusted (see clauses D.1.1 and D.1.2), should be altered from the current 'minimum weekly rate for a Health Professional employee – level 1 pay point 2 in clause 17.2' to refer to the new rate for an AQF Level 7 health professional, 2nd–3rd year (that is, the C1(a) benchmark rate). The effect of this would be to increase wage-related allowances by over 35 per cent. The allowances in question concern matters such as working in excessive heat, nauseous work, occasional interpreting and being on call. None of these matters has any substantial connection with the subject matter of this Review, being the rectification of gender-based undervaluation of female-dominated work. Further, the allowance increases proposed would apply to all Support Services employees covered by the HPSS Award, many of whom have not been the subject of any finding of gender-based undervaluation. We do not consider therefore that there is a proper basis in this Review to vary the 'standard rate' definition as proposed. The definition will require variation because it refers to a classification which we intend to abolish and replace, but the variation that will be made will be such as to not effect an increase in wage-related allowances.

Operative date and phasing-in

[155] We have earlier discussed the evidence of Mr Browne and Dr Stanford in relation to Australian Pathology's submission that the gender-based undervaluation of the work of pathology collectors and health professionals identified in the April decision should not be rectified. We have rejected that submission, but the evidence referred to is equally relevant to the question of the operative date and phasing-in of the proposed wage increases. We rely upon, without repeating, our earlier analysis of their evidence. It is also necessary to refer to the evidence of Mr Houston concerning the likely effects of the implementation of the *provisional* view concerning health professionals upon the ADIA's members. In his supplementary report, which adjusted the conclusions in his first report, Mr Houston provided his estimate of the percentage increase in total costs for ADIA members that would result from the wage increases for health professionals. He estimated this in two ways: first, the *direct* cost effect arising from increasing wages to employees currently paid below the proposed new minimum wage rates and, second, the *indirect* cost effect arising from the ability of employees currently paid above the proposed new minimum wage rates to negotiate further wage increases. In respect of the

indirect effect, Mr Houston assessed 'low', 'medium' and 'high' scenarios by applying the hypothetical values of 0.4, 0.7 and 1.0 respectively to represent the proportion of the full wage increases applicable to the new minimum wage rate that above-minimum wage rate employees would be assumed to be able to negotiate in light of the minimum wage rate increases. Mr Houston's estimates (for ADIA members who responded to the survey upon which his analysis was based) were as follows:

Scenario	Direct effect	Indirect effect	Total effects
Low	2.19%	5.11%	7.31%
Medium	2.19%	8.95%	11.14%
High	2.19%	12.79%	14.98%

[156] We consider, notwithstanding various criticisms advanced by the ACTU and the HSU, that Mr Houston's direct cost estimate in respect of ADIA members who were survey respondents is reasonable since it was based on actual cost data provided by those members. The primary data upon which Mr Houston relied was not itself put into evidence so that, if we applied the rules of evidence, it might be that no reliance could be placed upon his report because its factual premises were not established. However, we are not bound by the rules of evidence (s 591) and we are prepared to assume, in the ADIA's favour, that the primary data was sufficiently accurate to provide Mr Houston with a sound basis upon which to conduct his analysis. However, it is important to note that the conclusions in Mr Houston's report were confined to a discrete category of employees and employers, namely radiographers, sonographers, MRI technologists, and nuclear medicine technologists employed by certain private diagnostic imaging employers. This constitutes only a small subset of employees and employers covered by the health professional provisions of the HPSS Award.

[157] We do not, however, accept Mr Houston's indirect cost estimates which are, on their face, highly improbable. These are multiples of the direct costs estimate of about 2.3 times for the low scenario, 4.1 times for the medium scenario and 5.8 times for the high scenario. This presumably reflects the fact that the relevant ADIA members employ much larger numbers of health professionals who are already above the proposed new minimum wage rates than those who are below them. Flow-on effects of this magnitude, which were the result of the selection of arbitrary multipliers by Mr Houston, could not reasonably be accepted in the absence of probative evidence concerning the bargaining power of health professionals employed by ADIA members. There is no evidence concerning the degree of unionisation or collective bargaining in this segment of the health sector, nor any evidence of other matters such as a labour shortage which might signify the existence of a capacity to achieve significant non-prescribed wage increases. It follows therefore that we also cannot accept Mr Houston's total cost estimates, which are the sum of his direct and indirect cost estimates.

[158] Mr Houston also referred in his first report to qualitative survey data from ADIA members which indicated their potential business responses to 'a cost increase that could not be passed on to patients'. The most preferred responses were 'Reduce staff hours/positions', 'Delay equipment purchases/upgrades', 'Reduce services offered', 'Defer maintenance/facility improvements', and 'Consider closing/selling practice'.[97] While it may be accepted that this represents the range of potential business responses to unrecoverable cost increases generally, it does not constitute evidence as to whether the cost of the proposed minimum wage rate

[97] Exhibit HPSS155 (expert report of Greg Houston, 12 September 2025) [42], Table 3.5.

increases in this case will be able to be passed on in whole or in part, nor does it present any attempt to quantify the business effects of the proposed increases if they cannot be passed on. This qualitative data is therefore of little assistance.

[159] In respect of pathology collectors, the proposed wage rate increases are in the range of 1.8 to 10.9 per cent. The expert evidence indicates that the direct impact on total costs of pathology businesses will be between an estimated increase in the range of 0.35 per cent (Dr Stanford's low case) to something under 0.9 per cent (extrapolated from Mr Browne's estimated impact on labour costs for pathology collectors and health professionals). These effects are relatively modest. Australian Pathology, in its alternative case, did not propose a phasing-in of the increases but rather a delayed operative date. However, we prefer an earlier commencement date combined with a two-stage phase-in of the wage increases. The increases are of a similar order to those for dental assistants, so we consider that the same timetable should apply. This will involve an initial increase of around 4 per cent effective from 1 April 2026 (or the entire increase if it is less than 4 per cent) and any remaining amount effective from 1 January 2027. A higher first stage percentage increase will apply for employees who are currently classified at Level 4 and moving to Level 7. The transitional rates will be reflected in amendments to clause 16.2 of the HPSS Award by adding a table of rates that will apply to pathology collectors from 1 April 2026. The table will operate until 1 January 2027 when the full translation will take effect. We are satisfied these operative dates are appropriate for the purpose of s 166(2) of the FW Act.

[160] The proposed minimum wage rate increases for health professionals are of a significantly greater order, and we accept the evidence of Mr Browne and Dr Stanford to the effect that a phasing-in period will operate to mitigate the cost impact upon businesses. In our recent decision concerning the *Children's Services Award 2010*,[98] we determined that the minimum wage rate increases necessary to rectify gender-based undervaluation of the work of children's services employees should be phased in over a maximum of five stages extending over 3¼ years.[99] The minimum wage rate increases here are substantial and, in some cases, in excess of the increases for the *Children's Services Award 2010*. Accordingly, we consider that the increases should be phased-in over a maximum of five approximately equal stages, 12 months apart. The implementation of the new structure and the first increase will operate from 30 June 2026, and the remaining increases will operate from 30 June in each of 2027, 2028, 2029 and 2030.

Modern awards objective and minimum wages objective

[161] We are satisfied that the variations to the HPSS Award in respect of pathology collectors and health professionals are necessary to achieve the modern awards objective in s 134(1), as required by s 138. Again, for the modern award safety net to be 'fair and relevant' (s 134(1)) and for the minimum wage safety net to be 'fair' (s 284(1)), we consider that it is fundamental that modern award minimum wage rates must properly reflect work value and their determination must be free of assumptions based on gender.

[162] In reaching this conclusion, we have taken into account the considerations specified in

[98] [2025] FWCFB 283.

[99] Ibid [11], [21].

s 134(1) of the FW Act in the following way (using the paragraph designations in the subsection):

> *Paragraph (a)*: We have earlier set out the two measures of the 'low paid' threshold using the most recent CoE and EEH data. Pathology collectors currently classified as Support Services employees at Level 5 and below, have minimum weekly rates of pay below both measures of the low paid threshold. The variations will significantly increase the incomes of pathology collectors who are award-reliant and will, for those classified at Levels 6 and 7, place them approximately at or above the low paid threshold. This weighs significantly in favour of the variations concerning pathology collectors. The 'low paid' consideration has less relevance to health professionals but, currently, the minimum weekly rates for entry-level professionals with an AQF Level 5 or 6 qualification (Level 1, pay point 1) is below the low paid threshold and with a 3-year degree (Level 1, pay point 2) sits approximately at the threshold on the CoE measure. Both will be raised above it as a result of the variations. This also weighs in favour of the variations for health professionals, albeit to a more limited degree than for pathology collectors.
>
> *Paragraph (aa)*: There is no evidence before us that the variations will have any effect, detrimental or otherwise, as to the need to improve access to secure work. This is therefore a neutral consideration.
>
> *Paragraph (ab)*: The variations will rectify the gender-based undervaluation of work in female-dominated occupations, as found in the April decision, and therefore aid in achieving gender equality, ensuring equal remuneration for work of equal value and eliminating gender-based undervaluation of work. This weighs significantly in favour of making the variations.
>
> *Paragraph (b)*: There is, currently, a reasonably significant degree of collective bargaining for pathology collectors employed by the large pathology businesses and for health professionals employed by private hospitals, large pathology businesses and other large private health sector businesses. There is no evidence before us which would allow us to make a sound assessment as to whether the variations will encourage collective bargaining to occur or otherwise. We consider this to be a neutral factor.
>
> *Paragraph (c)*: In respect of pathology collectors, the evidence establishes that there are difficulties in recruiting and retaining employees because of the low rates of pay in the pathology sector. It is possible therefore that the variations may attract more persons, especially women, to become and remain pathology collectors and thus increase workforce participation. This weighs to some degree in favour of the variations. There is insufficient evidence to assess whether the variations will increase workforce participation in respect of health professionals, and to this extent we treat this as a neutral factor.
>
> *Paragraph (d)*: We do not consider that this is a relevant consideration in this matter.
>
> *Paragraph (da)*: We do not consider that this is a relevant consideration in this matter.

> *Paragraph (f)*: We have earlier described and made findings in respect of the evidence concerning the cost impact of the variations. Considered in the aggregate across that part of the health sector covered by the HPSS Award, there will clearly be an increase in employment costs. However, this impact will differ as between individual employers: for some, the effect will be significant because they pay their pathology collectors and/or health professionals at or close to the award minimum wage rates whereas, for employers who already pay well above the award rates, the effect is likely to be negligible. This consideration weighs against the grant of the proposed variations although the employment costs impact will be significantly mitigated by the phasing-in arrangements we have determined. There is no basis to conclude that the variations will affect productivity or the regulatory burden in the health sector, and these are therefore neutral considerations.
>
> *Paragraph (g)*: The variations will not impact upon this consideration.
>
> *Paragraph (h)*: The evidence does not demonstrate that the variations will have an adverse effect upon the national economy. We therefore treat this as a neutral factor.

[163] We also consider that the variations are consistent with the achievement of the minimum wages objective in s 284(1) of the FW Act. In respect of the considerations in ss 284(1)(a), (aa), (b) and (c), we make the same findings as in relation to ss 134(1)(h), (ab), (c), and (a) respectively. Section 284(1)(e) is not relevant to this matter.

[164] The variations concerning pathology collectors which will take effect on 1 April 2026 will be included in the determination varying the HPSS Award in respect of dental assistants operating from the same date. Because the first stage variations concerning health professionals will take effect at a later date and involve a greater degree of complexity, we will publish a draft determination for comment prior to making a final variation determination. We anticipate that the draft determination will be published during January 2026 together with a statement which explains in greater detail its intended operation. Parties will have 28 days from the date the draft determination is published to file any submissions concerning any perceived drafting or other technical issues in the draft determination.

PRESIDENT

Appearances:

K Burke SC with *P Lettau*, counsel, instructed by *S Peldova-McClelland* and *L de Plater* for the Australian Council of Trade Unions, Health Services Union and United Workers' Union.
B Luxton for the Phlebotomists Council of Australia.

C Dowsett SC and *V Bulut*, counsel for the Commonwealth of Australia.
J Tracey KC with *B Holding*, counsel, for Australian Pathology.
F Leoncio, counsel, for Healthscope Operations Pty Ltd and the Adelaide Community Healthcare Alliance Incorporated.
C Pase, counsel, and *A Manos*, counsel, instructed by *S Blancquart*, solicitor, for the Australian Diagnostic Imaging Association.
J Stanton for The Australian Industry Group.
A Rafter for Australian Business Industrial, Ageing Australia Ltd and the NSW Business Chamber.

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