



TRANSCRIPT OF PROCEEDINGS  
*Fair Work Act 2009*

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

**AM2024/20**

**s.157 - FWC may vary etc. modern awards if necessary to achieve modern awards objective**

**Gender undervaluation — priority awards review — Health Professionals and Support Services Award 2020**

**Melbourne**

**10.00 AM, THURSDAY, 20 NOVEMBER 2025**

**Continued from 13/11/2025**

PN5161

JUSTICE HATCHER: I'll take the appearance again: Ms Burke and Mr Lettau, you appear for the ACTU, HSU and UWU?

PN5162

MS BURKE: Yes, thank you.

PN5163

JUSTICE HATCHER: Mr Tracey, you appear for Pathology Australia?

PN5164

MR TRACEY: I do, Your Honour.

PN5165

JUSTICE HATCHER: Ms Leoncio, you appear for Healthscope Operations and the Adelaide Community Healthcare Alliance?

PN5166

MS LEONCIO: Yes, I do, Your Honour.

PN5167

JUSTICE HATCHER: Mr Manos, you appear for the Australian Diagnostic Imaging Association?

PN5168

MR MANOS: I do, I'm substituting for Ms Pase, who gives her apologies for being unable to attend today.

PN5169

JUSTICE HATCHER: Yes, all right, thank you. And by Teams, Mr Stanton, you appear for the Australian Industry Group?

PN5170

MR STANTON: Yes, I do, Your Honour.

PN5171

JUSTICE HATCHER: And, Ms Bulut, you appear for the Commonwealth?

PN5172

MS BULUT: I do, Your Honour.

PN5173

JUSTICE HATCHER: All right, so there's any understanding about the order of submissions?

PN5174

MS BURKE: Yes, Your Honour. I'm going first and then after that, it's in the hands of others.

PN5175

JUSTICE HATCHER: That sounds like a unilateral decision to me.

PN5176

MS BURKE: There was some performative consultation earlier. Now, the unions have provided, moments ago, some written submissions and I'll just briefly explain what they are or what they do. They traverse all of the issues between the parties. It's not necessary for anyone to have read them before but nor will I read them this morning. What I want to do is highlight a couple of the key issues that are addressed in the written submissions but as I said the written submissions do themselves cover all of the issues between the parties.

PN5177

JUSTICE HATCHER: Sorry, just so I understand what you're talking about: this is the closing submissions of the ACTU, HSU and UWU? Is that what (indistinct)?

PN5178

MS BURKE: Yes, that's right, and the version that Your Honours should have will have a confidential word in the title.

PN5179

JUSTICE HATCHER: Yes.

PN5180

MS BURKE: Parts of the submission are shaded in grey. They are visible only to members of the Full Bench and to the representatives of the IDIA and then that version but with full redactions has been provided to everyone else and that version is suitable for publication online.

PN5181

VICE PRESIDENT ASBURY: No wonder you needed an additional time to disseminate all of those, Ms Burke.

PN5182

MS BURKE: I'm very grateful to Your Honours for that understanding. Attached to our written submissions are two draft determinations. They contain amendments to the union's draft determinations that were filed on 12 September and I will address those and go through them in the course of this morning. So the issues that I want to address this morning orally are first I want to deal with what we've called the entry level issue. This is the point at which an employee is first classified when they commence their work under this award. Second, I'll deal with some of the criteria for levels 2 to 4: so specifically progression within level 2 and between levels 2, 3 and 4.

PN5183

I'll address the appropriate descriptors for level 2 in accordance with the provisional view that that level should include specialist, supervisory and managerial roles. I'll address the inclusion of clinicians at level 3 and then briefly the treatment of managers at levels 3 and 4. I'll then say something briefly about the economic evidence and it will be brief because that topic is comprehensively addressed in our written submissions and because I'm constrained by the confidentiality order about what I can say about Mr Houston's evidence. Mr Lettau will then address the Full Bench on issues relating to pathology collectors.

PN5184

Now, we can start with the entry-level issue. It might be most convenient if you can have to hand the draft determination for health professionals.

PN5185

DEPUTY PRESIDENT GRAYSON: The one you proposed?

PN5186

MS BURKE: Yes, which is at annexure A to our submissions and I'll just get the PDF page number - 44. And the relevant clause is schedule A.2, which is the definitions for health professionals, which is at page 48 of that PDF. Now, the entry-level issue is addressed in our written submissions at paragraphs 21 to 33 and it's captured here in our amended clause 8.2.1. I'll just summarise what the issue is. It is essentially the AQF level at which a professional in their first year of practice enters level 1. And the question is complicated in this setting because of matters that are outside of the control of the industrial parties but are nonetheless very significant.

PN5187

The issue arises because there are numerous and varied pathways to registration with an APRA-regulated profession and for the non-APRA professions, numerous and varied pathways to registration with the relevant professional association. And most critically, there is no standard qualifying degree across the health profession also, very much unlike nurses and teachers. There is not even any standard qualifying degree within certain health professions and not only is there no standard, it's not accurate, in our submission, to say there's no minimum because minimum implies, for example, that you could enter the profession with a Bachelor's degree with it's also an option to get a Masters if that's what you would like.

PN5188

But depending on the university and the state a Masters degree might be the only degree available to qualify for registration. So that's - so in that case the Masters degree is the minimum and that's why we say the language of minimum is unhelpful and apt to mislead. You can see the variation of degrees offered and approved by APRA in appendix D of our submissions, where we've extracted the APRA-approved programs of study from the APRA website. We say it's critically important that the award reflects industrial reality and does not reintroduce work undervaluation by disregarding the professional qualifications actually held by health professionals that entitle them to practice.

PN5189

Further to that point it is relevant that the enterprise agreements in the sector provide that new employees are classified according to the qualification they hold. Now, we have included in appendix A of Mr Leszczynski's statement a table with hyperlinks to a number of industry enterprise agreements. I just want to take Your Honours to two examples. I hope you have been emailed two enterprise agreements. The first of those is the Allied Health Victorian Public Sector Agreement.

PN5190

JUSTICE HATCHER: Yes.

PN5191

MS BURKE: Thank you. If you turn to clause 85, which is at page 175 of the PDF, or 168 internally for future transcript reference - - -

PN5192

JUSTICE HATCHER: What was that, 175?

PN5193

MS BURKE: Hundred and seventy-five - this is in the agreement at Part J, classification definitions and wages. This agreement of course applies to all allied health professionals in the Victorian public sector which is covered by this award. And looking at clause 85.5, it reads there that:

PN5194

*Advancement by an employee whose experience increments will occur upon completion of a 12-month period - - -*

PN5195

Et cetera, et cetera. The relevant words are the last two of the chapeau. They've provided that - and then over the page you see at subparagraph (a):

PN5196

*An employee who holds or is qualified to hold a relevant Masters Degree will commence in the AHP1 Grade 1 Year 2 rate and an employee who holds or is qualified to hold a relevant doctoral degree will commence at the AHP1 Grade 1 Year 4 rate.*

PN5197

So that is, we say, a very clear illustration that a new graduate or a person in the first year of their profession goes in at the level corresponding to the correct qualification that they hold and interestingly, you can see here this also provides for entry at the PHD level. So that's the Victorian public sector. The next agreement that I would like to take you to is the Healthscope agreement. That's the Healthscope Victoria Allied Health Professionals Enterprise Agreement 2023 to 2026. And the relevant page is page 22 of the PDF, clause 17. Again, the relevant subclause is clause 17.5. The language there is very similar to clause 85.5 that we just looked at in the Victorian Allied Health Agreement. Again, you'll see at the bottom of the chapeau: 'Provided that an employee commencing in Grade 1' - which is the entry level grade:

PN5198

*Who holds or if qualified to hold a three-year undergraduate degree, a four-year undergraduate qualification, an Honours Degree, a Masters Degree or a doctoral degree will be classified as or deemed to be classified as a range of levels within level 1.*

PN5199

Again, reflecting the qualification held by the employee. Now, if it's helpful we can provide an update to the table in Mr Leszczynski's - I'm sure I'm pronouncing

that wrong, I'm sorry - statement, annexure A of his statement which sets out all of the enterprise agreements and provides a hyperlink to them. We can amend that to update references to all of these clauses if it would be helpful. But we do say that this is evidence of the industry practice and specifically that employers value the qualifying degree according to the degree actually held by the employee and not some frankly arbitrary concept of minima.

PN5200

A further reason why we say that point of entry should be according to the qualification held by the employee is that to do otherwise would produce inequities. In our submissions we use physiotherapists as an example. In Tasmania the only pathway to registration with the physiotherapy board is to obtain a Masters of Physiotherapy. No bachelors degree is offered. It would be, we say, manifestly unfair and contrary to the recognition of the expert panel that the significance of university degrees to assessing work value, if the Tasmanian qualified physiotherapist essentially has the value of their Masters downgraded by the industrial award despite there being no other way to qualify than by obtaining a Masters or leaving the state.

PN5201

JUSTICE HATCHER: So that's not an APRA recognised profession?

PN5202

MS BURKE: It is.

PN5203

JUSTICE HATCHER: It is.

PN5204

MS BURKE: Yes.

PN5205

JUSTICE HATCHER: But they don't set any standard?

PN5206

MS BURKE: Well, what APRA does is it accredits a range of degrees and it accredits bachelors degrees. Physiotherapists, it accredits a number of bachelors degrees but also some masters. But in Tasmania the universities in Tasmania offer physiotherapy qualifications only offer a masters. So the qualification entitles you to eligibility for registration depends on part of the offerings of the university and then the accreditation via APRA.

PN5207

JUSTICE HATCHER: Is there a physiotherapist recognised board or professional association?

PN5208

MS BURKE: There is, yes.

PN5209

JUSTICE HATCHER: Do they have a standard?

PN5210

MS BURKE: Well, the physiotherapist board is the component of APRA.

PN5211

JUSTICE HATCHER: Yes.

PN5212

MS BURKE: Being the product of the creation of the national law in 2010 - there were a series of state-based boards and then they were brought in under the umbrella of the Commonwealth board. And that's why under APRA there's the medical board, the nurses' board, the physiotherapist board, the dentistry board and so on.

PN5213

JUSTICE HATCHER: Just going back to your draft A.2.1 - - -

PN5214

MS BURKE: Yes.

PN5215

JUSTICE HATCHER: - - - the alternative version.

PN5216

MS BURKE: Yes.

PN5217

JUSTICE HATCHER: So just those additional words: 'If there's no requirement such qualification is deemed acceptable by the employers'. How does that work in practice?

PN5218

MS BURKE: Well, in our submission it's not necessary for the employer to deem a qualification acceptable because either the degree will have been accredited by one of the boards under the APRA umbrella or it will be recognised by one of the non-APRA professional associations. And so as long as it is recognised by one of those organisations it's not necessary for the employer to have to otherwise deem the degree to be acceptable or not. The current award includes a reference to - sorry, the current award reads:

PN5219

*This level is the entry level for new graduates who meet the requirement to practice as a health professional where appropriate in accordance with the professional association's rules and be eligible for membership of their professional association or such qualifications deemed acceptable by the employer.*

PN5220

And so we say in light of the evidence we've heard and bearing in mind of course that the modern award was made the same year that the national health law came into effect, those words - 'As deemed acceptable by the employer' - are no longer necessary.

PN5221

JUSTICE HATCHER: So does that formulation you propose apply to those health occupations which have a qualification below AQS7?

PN5222

MS BURKE: Well, Your Honour, I think there's only one or two of those. Can I just take that on notice?

PN5223

JUSTICE HATCHER: Yes.

PN5224

MS BURKE: But yes, the table that was prepared jointly by the parties and made its way into paragraph 123 of the decision was of course a table setting out all of the - setting out the minimum qualifications looked at globally. And so we emphasise in our written submissions that table was prepared to assist the Commission to understand the variety of pathways to registration or accreditation. But it should not be taken as representing anything like the standard or prevalent pathway to registration. And we think that the enterprise agreements with respect do a good job of recognising the complexity of this issue and ensuring that employees are properly compensated for the value of their qualification.

PN5225

VICE PRESIDENT ASBURY: Ms Burke, can I just ask the masters degree from the Tasmanian university you were referring to earlier, is that a degree where you enrol as an undergraduate and you take units from the masters program and is it - what's the length of the - what's the duration of the degree?

PN5226

MS BURKE: I will find out and confirm, yes, because - quite right, it could be you do a Bachelor of Science and then you get a masters on top of that or it could be something different. I'll find out.

PN5227

VICE PRESIDENT ASBURY: Because there was some time - there was some nursing, I recall, degrees where some were four years and some were three years and essentially they were the same but someone had just elected to do an extra - -  
-

PN5228

MS BURKE: Like an honours year in - - -

PN5229

VICE PRESIDENT ASBURY: Or get some science qualification or something of that nature. But arguably it makes a difference how the masters degree is obtained because in some courses you can study masters units as part of your undergraduate degree and essentially count them twice.

PN5230

MS BURKE: Yes. That's right, and some of the - as far as I understand it some of the bachelor degree offerings are three years and some are four years and some are three years plus an honours year so a sort of hybrid four-year bachelors degree and getting that honours year is not formally a requirement but everyone does it. And so there is that significant diversity of qualifications. So I will investigate the Tasmanian masters situation.

PN5231

VICE PRESIDENT ASBURY: Thanks.

PN5232

MS BURKE: Now, none of the employer submissions really deal directly with this issue in their submissions and - but they do as I say deal with it in their enterprise agreements and we think respectfully they do so appropriately. We say that this issue should not be ignored in the award and a rational and fair approach is that contended for by the unions. Turning now to what I've loosely described as level 2 issues: the provisional view expressed by the expert panel was that levels 2 to 4 operate as higher classifications for health professionals and specialist supervisory and managerial roles. And schedule A.2 of the draft determination - A.2.2, excuse me - implements that provisional view. We have drafted it to cover the five areas that the evidence demonstrates health professionals commonly work in and they are set out in paragraph 39 of our written submissions. I'll just summarise them - and I should say these are based on the evidence heard last year.

PN5233

So there's a clinical stream which includes what you might think: working directly with patients but also it can include specialising within more particular areas. So for example a physiotherapist might specialise as an orthopaedic physiotherapist. There is what we've described as specialist stream which encompasses health professionals working in education, conducting research or engaged in quality assurance and control work. This is a common feature of the work of medical scientists. And thirdly, there's the supervisory or managerial stream and those duties are common across the health sector, although the titles used for the roles covering those duties does vary.

PN5234

We've set out the evidence supporting our approach in paragraphs 49 to 68 of our submissions, which include appendix C, where we identify all of the relevant lay evidence. Now it's important, we say, given the huge variety and size of employers and organisations that these definitions in clause A.2.2 remain sufficiently flexible to accommodate the different ways in which organisations operate. The larger employer interests have been represented throughout the evidentiary hearing but the Commission has also received submissions from smaller organisations whose members might only employ two or three health professionals: for example, the Australian Physiotherapy Association or Speech Pathology Australia.

PN5235

We have looked carefully those submissions.

PN5236

It's not easy to draft an award that accommodates the range of employers and employees covered by this award but it is necessary. Now, to some extent there is agreement between the parties about level 2. We agree with Healthscope that level 2 should include non-clinical roles but we say level 2 should also include those roles in the union's specialist stream, which is education, research and quality control. I'm not sure that there's any substantive resistance to that course but I will be told if I'm wrong.

PN5237

JUSTICE HATCHER: So that overlaps with the educator role described in Healthscope's proposal?

PN5238

MS BURKE: Yes, that's right. We also agree that there should be a separate stream in level 2 for supervisors and we accept that our original draft of that separate stream, which is A.2.2(c), needed further work and we've done that. And you can see the amendments marked up in our updated draft determination. We did that because we recognised that many health professionals engage in supervision of some description of their junior colleagues. This stream in level 2 is not intended to capture incidental or ad hoc supervision but rather someone whose role is substantively a supervisor.

PN5239

This is to be contrasted with supervision responsibilities that a clinical specialist may or may not have but also recognises that in smaller practices, a highly experienced and advanced practitioner may not fit neatly into a clinical stream or a supervisor stream. We say the descriptors in clause A.2.2 accommodate that flexibility and in any event, and critically the rates of pay are the same. Healthscope's proposed definition of team leader is, we say, too Healthscope specific or perhaps more fairly too large private hospital specific. We explain why in paragraph 45 of our written submissions. Healthscope's definition of team leader, which is sort of equivalent to supervisor, contains detailed list of duties that will be performed by a team leader and that may well be performed by team leaders within Healthscope.

PN5240

But there's no evidence to suggest that those duties are applicable to health professionals generally who work in - as supervisors. A further issue that arises in relation to level 2 as well as levels 3 and 4 relates to progression to level 2 and beyond. We deal with this in paragraphs 40 to 47 of our submissions. Healthscope say that the award should state that classification at level 2 and beyond is by appointment. This is we say an unusual approach in a modern award and we say it's unnecessary and could impede the proper classification by reference to the work an employee is actually required to do. Now, we understand employers' concerns in this regard is to prevent a situation where an employee might self-identify as a level 2 by taking on extra duties that they haven't been asked to do in the hope, I suppose, of turning around and saying to their employer, 'Look, I'm now a level 2 and you must pay me accordingly'.

PN5241

I'm not really sure how credible a threat that is. We recognise that employees should be classified according to the work they are required to do by their employer. And we propose proposed amendments to our clause A.2.2 to make that clear. Subparagraph (a) already referred to senior clinicians working in areas of their profession that required specialist knowledge but we've added those words, those references to requirements, in subparagraph (b) and (c). We think this deals with that particular concern. Finally, in relation to the draft determination I want to say something about level 3 and 4 classifications. Level 3 we say should include clinicians and senior specialists and we deal with this in paragraphs 46 to 47. That was the provisional view of the expert panel and the unions endorse it.

PN5242

Healthscope though proposes that level 3 be restricted to managers. There's no sound basis for that proposition. It's contrary to the provisional view. It's not supported by any evidence and it's inconsistent with industry practice as exemplified by the enterprise agreements annexed to Mr Leszczynski's statement. Our concern is that Healthscope's proposal would close off progression for clinical and non-clinical specialists by reserving half of the available levels under the award to management. It's critically important, we say, that subject matter experts are able to progress to high levels of employment and have that work properly valued. They should not be required to relinquish those advanced skills in favour of management activity if they are to have any opportunity of advancement. Now, in case there's any suggestion that I'm disparaging managers we do say that levels 3 and 4 should accommodate managerial positions. Level 4, we say, should be reserved for the highest manager role, essentially the last level before the executive which members of an executive are not captured by the HPSS award. So those roles include, for example, directors and departmental managers, who report to the executive. Department manager in the context of a hospital can have a range of meanings but my general understanding is that a department in a hospital, such as for example the department of surgery, will have within it a number of smaller units, the general surgery unit, the vascular surgery unit, for example.

PN5243

The head of department could be a level 4 manager under this concept, even though I'm borrowing from the medical to the health professionals for the purpose of illustration. But the head of a unit, general surgery unit, the vascular unit would be a level 3 manager.

PN5244

JUSTICE HATCHER: I think at least the Australian Industry Group and perhaps others have made a submission that the designation of level 4 as a senior manager might go beyond the scope of the classifications in the existing award and I think by extension might involve some infringement of the prohibition section 143(7)?

PN5245

MS BURKE: That's not our intention. We're not seeking - - -

PN5246

JUSTICE HATCHER: It's not even the case of your intention. It may be that that was in the provisional view and perhaps the provisional view strayed beyond the scope of the existing award.

PN5247

MS BURKE: I'm sure it didn't, Your Honour. In any event, we say that departmental managers are captured - are covered by the award and there is no intention through out drafting, in any event, to by stealth draw in executive level management to the award.

PN5248

DEPUTY PRESIDENT GRAYSON: You haven't amended that to make that clear, though, have you? I'm looking at the language that Healthscope have proposed, which the first dot point says: 'Be accountable to the executive team'. But is that clear in your drafting and if so, how do I find that?

PN5249

MS BURKE: Yes. We don't say accountable to the executive team in our definition of level 4. And that's of course because not every organisation will have an executive. But larger organisations certainly will. I'll need to get some instructions but without that I can't imagine there being an objection to a note, for example, or an illustrative note to that effect for those sorts of organisations.

PN5250

DEPUTY PRESIDENT GRAYSON: If such an executive existed.

PN5251

MS BURKE: Yes.

PN5252

DEPUTY PRESIDENT GRAYSON: That may deal with that concern in terms of the extension of the - or the potential for extension of the award.

PN5253

MS BURKE: Yes.

PN5254

DEPUTY PRESIDENT GRAYSON: And what do you say - and you may say this in your submissions, Ms Burke, but I haven't got there yet - do you deal with the submission that it should be by appointment at levels 3 and 4, the submission that Healthscope make about that? I think that is the current state of play in this award, isn't it, from memory?

PN5255

MS BURKE: I'll just refresh my memory. The award does not currently state by appointment but it does say, 'At this level health professionals will have additional responsibilities'. I think - and we didn't do this and we should have - if there's to be an amendment to level 3 and level 4 in schedule A, it should reflect the language that we have inserted in level 2: that is refer to there being a requirement to undertake those roles. I think it would be - I'm thinking out loud, which I won't do.

PN5256

DEPUTY PRESIDENT GRAYSON: You can come back to that.

PN5257

MS BURKE: I suppose what I mean is I think the risk of occupying a managerial or senior managerial position by stealth is very low. Sorry, yes: in our written submissions we do say at paragraph 42 that the question about appointment and our submissions about that covers levels 2, 3 and 4. But you're quite right, Your Honour: we didn't make a variation, an amendment to our draft determination for levels 3 and 4.

PN5258

DEPUTY PRESIDENT GRAYSON: All right, I'll have a read of those, thank you.

PN5259

MS BURKE: Now, finally on this manager question, Healthscope also contends the department managers should be classified at level 3. Now, this might just be semantic confusion. But if it's intended to have the effect that senior managers who as we say are the last level before the executive be classified at level 3, we say that's the wrong approach and it's inconsistent with Healthscope's own practice, which we identify in our submissions at paragraph 65. It also begs the question that if a department manager at level 3 is reporting to the executive then who are the senior managers at level 4? We think the better approach is that level 3 managers include essentially subsidiary heads reporting to level 4 managers and level 4 managers report to whoever is in charge who isn't covered by the award.

PN5260

Finally I just want to briefly address the evidence concerning the cost to employers if the provisional views are confirmed. The expert panel heard evidence from Dr James Stanford, called by the unions, Mr Greg Houston, called by the ADIA and Mr Oliver Browne, called by Australian Pathology. In our submission Dr Stanford's evidence is the only credible evidence before the Commission on the question of cost. His modelling covers the entire relevant industry, not just a small subset of it. He properly acknowledged the limitations of his modelling in part as a result of the complexity of the sector employing health professionals.

PN5261

But of course that does not mean just because it's complex that his evidence is of little use. As Mr Stanford said, his evidence demonstrates a legitimate approach to understanding the order of magnitude of the likely wage increases. By contrast Mr Houston and Mr Browne's evidence was not careful and was not considered. We've set out in detail in our written submissions the issues with their respective reports. I'll just emphasise the following: both reports involved modelling the provisional increases to assess the impact on employers' costs. Neither made their model available so we have no insight into whether the models were any good.

PN5262

But even if they were perfect, the model is only ever as good as its inputs. Put very starkly, rubbish in equals rubbish out. Both Mr Houston and Mr Browne's models involved the employer groups providing their current and estimated labour costs. That task is complicated. In the case of ADIA members, I would say extraordinarily complicated. There was no testing or interrogation of the data. It was wholly accepted at face value by Mr Browne and largely so by Mr Houston. I can't say any more about that. But it is a significant issue and it's addressed in the confidential part of our submissions. Mr Houston's model relied entirely on inputs from employers, not just in respect of labour costs but all other measures, such as the proportion of wages to expenses and revenue. Mr Browne's model involved his own calculation of a pathology-specific measure operating net profit after tax. That calculation, which he described as operating NPAT, was obscure and it contrasts unfavourably with earnings before interest in tax as a measure of profit, EBIT being of course reported by the company themselves and relied on by IBISWorld, which Mr Browne otherwise drew from and was happy to endorse as a reliable source of data.

PN5263

Notably Mr Browne himself started off using EBIT as the measure of profit but switch to NPAT which paints a more much dire picture of the profitability of the sector when he was asked to do (indistinct) of the pathology companies. And for this and other reasons, particularly the reliance on actual or projected labour costs from the pathology companies, Mr Browne's report we say is more accurately described as a piece of advocacy on behalf of Australian Pathology and not a truly disinterested expert report. The ultimate conclusion of both Mr Browne and Mr Houston was that money spent on wage increases is money diverted from profits, setting aside the question of pass-through, which there was evidence of.

PN5264

The point is an obvious one: money spent on wage increases will be money that the firms would otherwise have at their disposal but it is important to contextualise this issue. The expert panel has found that there's been undervaluation of wages in the case of health professionals to a very significant extent and in the case of pathology collectors, to a lesser extent but for a substantially low-paid workforce. This undervaluation has been the state of affairs for years, years. In equity, these workers might have claims for restitution because they've been kept out of their money and are still being kept out of their money for as long as the wages have been undervalued.

PN5265

But we are generous. We don't seek retrospective draft determinations. We don't ask that employers disgorge past profits that are generated in part by employees' labour that hasn't been properly compensated. But we do ask that the wages be properly fixed as soon as possible, consistent with the expert panel's statutory obligation to eliminate gender-based undervaluation. Yes, that will mean in some cases employers may experience a short-term reduction in profits. But again, to be very stark about this, some one has to pay. The Commission has found that the work of hundreds of thousands of professional - health professionals and pathology collectors has been undervalued. These workers are out of pocket and these workers have paid the cost of gender-based undervaluation. It is time for the

employers to bear the true cost of the work that they benefit from and continue to benefit from. The evidence of Dr Stanford is that that will not be a catastrophe for them; quite the contrary. I'll now hand over to Mr Lettau to address the Full Bench on pathology collectors.

PN5266

JUSTICE HATCHER: Mr Lettau.

PN5267

MR LETTAU: Thank you, Your Honour. So I'll address the panel in relation to the evidence on pathology collectors, firstly covering single-staff collection centres issue. I'll make a brief comment as well on the issue of home collectors which arose in cross-examination of the Australian Pathology witnesses and then address the Commission briefly on the unions' position on phasing in. Just before I start, going to the - our closing submissions, the topics on - the topics I'll be addressing that are addressed at paragraphs 87 to 100 of those written submissions. That's from page 23 to page 26.

PN5268

Also relevant is appendix B at page 61 in which the Commission will note one change we've made to our proposed definition of single staff centre, where we've inserted the word, 'Ordinarily'. I'll come to that in a moment. So starting with single staff collection centres, the Commission found in the decision at paragraph 20 at 228 that pathology collectors predominantly work at single-staff collection centres where they are the only employee of the business present at any one time and where the only access to guidance and supervision is by telephone. The provisional view then sets out at paragraph 236, the basis for including single-staff collection centres at level 7.

PN5269

Our submission is that the evidence that has been filed since the provisional view supports those findings and nothing has been disturbed in that respect. This includes the evidence filed by Australian Pathology which was the two witness statements from pathology collection management and the evidence relied on by the unions which were the four witness statements from currently practising pathology collectors. That was Ms Slack, Ms Slight, Ms Cleland and Ms Burke. To the extent there's any inconsistencies between Australian Pathology's evidence and the union's evidence, we say that the evidence of these four pathologists should be preferred. They gave - - -

PN5270

JUSTICE HATCHER: When you took us to paragraph 228 of the decision, the last sentence, that would also be true of the mobile collectors in a sense?

PN5271

MR LETTAU: Correct - and I'll be addressing the Commission on that in a moment.

PN5272

JUSTICE HATCHER: And also it might be true - at least the second part of the sentence is true - in respect of a collection centre which is not single staff but

simply has, for example, two pathology collectors of equal standing working in the centre. That is they likewise might not have any supervision present.

PN5273

MR LETTAU: The key distinction is - yes, in some instances that might be the case, the key distinction being without supervision or any other support staff around you at the single staff collection centre. So we say to the extent there's any inconsistencies the union's evidence should be preferred. The union witnesses gave specific, detailed and largely consistent evidence about the work done in single staff collection centres and this is across different employers and across different states as well. By contrast the evidence of Ms Wolow and Mr Meckiff was broader - consisted of broader-brush statements.

PN5274

Mr (indistinct) stated in cross-examination that he'd never actually worked as a pathology collector. He has a background in physiotherapy. And he accepted as well that some of his key evidence in particular about the complexity of the work of pathologists, was based on what had been reported to him rather than his direct first-hand experience. Now, we set out at paragraph 97 of our written submissions some broad conclusions that we say can be drawn from the evidence.

PN5275

JUSTICE HATCHER: Sorry, what paragraph was that?

PN5276

MR LETTAU: Paragraph 97.

PN5277

JUSTICE HATCHER: Thank you.

PN5278

MR LETTAU: In summary, collectors open and close the site, they manage the waiting room, they perform all clinical tasks. I won't list them all. They triage, they deal with patient interactions. Both the employer witnesses gave evidence that certain complex tests, in particular the - there was some evidence about the paediatric tests - usually are performed with secondary staff and are preferred to be performed with secondary staff due to the complexity of those tests yet all the pathologists - all the union witnesses - gave evidence that they do these paediatric tests in single staff collection centres. So the idea that they're doing simpler work I think the Commission can reject. Ms Wolow gave evidence about - both the employer witnesses - gave evidence about the support that's available on the telephone. I think materially the submission we would make is that the Commission can find that support a pathology collector has at a single staff centre is weaker than the support they have in a multi-staff centre. Ms Wolow's evidence was that ACL has 550 pathology collectors spread across New South Wales and ACT with only 12 supervisors between them. That's about 45 or 50 collectors per supervisor. I think objectively speaking that's a fairly thing coverage in terms of supervision.

PN5279

Another thing that arose in the employers' evidence was to do with - it was said that pathology collectors in single staff centres can rely on other staff, so doctors or nurses who may be employed by the medical centres, for instance, that the pathology collector is working at. Mr Meckiff accepted in cross-examination that the employer - in this case Healius - has no control over those staff. Whether they're willing or able to assist the lone pathology collector depends on their whims, really, and their availability. Mr Meckiff made the point that they - Healius - likes to have pathology collectors assigned to a centre in the long term to allow them time to build up rapport with the other staff and through that rapport and those relationships they build, get the support that they need on the ground.

PN5280

Our submission there is that provides further work value reasons for why single staff pathology collectors should be uplifted since they're going to have to rely on interpersonal skills and invisible skills to build those relationships with support staff. Cross-examination, we say, didn't disturb any of the evidence of the union witnesses. One of the main themes we observed in the cross-examination was the theme of the core duties of the single staff collectors are the same as core duties of multi-staff collectors. So they all collect blood, they all data entry, they all maintain stock and hygiene and those sorts of things.

PN5281

JUSTICE HATCHER: I thought there was evidence that some of the more complex tests might not be conducted in single staff centres.

PN5282

MS LETTAU: The evidence of the union witnesses is that many of these tests are done in single staff centres, firstly, and secondly, that the reference to complexity is not always a reference to the complexity for the pathology collector. It's complexity with the actual processing of the collection after it's been collected. So - and indeed some of that evidence on complexity came from Mr Meckiff who stated himself he has never done these tests himself directly firsthand. The key point though really is that it's not about the different sets of tasks and the findings of the expert panel, which I refer to at paragraph 228, which were behind the provisional view, was not that they're doing different tasks but that they're doing the tasks on their own and the work value reasons arise from the autonomy, the pressure, the risk associated with doing that work independently.

PN5283

JUSTICE HATCHER: I'm just looking at your 97(b). Why do you say it might be true of some multi-staff centres but not all of them? That is they may not have reception support, for example. I mean, there might be a multi-staff centre in a private hospital, which has all that. But there might be one out in the field where it's just like a single centre except there's two pathology collectors working in two separate little rooms but they're still managing the flow of the patients and the authority and that sort of thing.

PN5284

MR LETTAU: There's exceptions. The evidence of the employers was that the vast majority of collecting rooms are connected to medical centres, not hospitals. That's a quite small percentage but - in the hospitals.

PN5285

DEPUTY PRESIDENT GRAYSON: So you say that reception support counts not just that provided by, for example, Healius or whatever. Is that what you're saying - on the reception support?

PN5286

MR LETTAU: Sorry, could I ask for that question to be repeated?

PN5287

DEPUTY PRESIDENT GRAYSON: Sorry, I was just saying - so the evidence I think from the employers and from some of your witnesses was that there weren't - there wasn't reception support at multi-staff centres. Are you saying that having reception support from a doctor's surgery or whatever counts for the purpose of that submission in terms of the triaging?

PN5288

MR LETTAU: Counts in the sense - in the single staff collection centre, do you mean?

PN5289

DEPUTY PRESIDENT GRAYSON: Exactly.

PN5290

MR LETTAU: Look, I guess all I can say is that there'll be some instances where there might be that support in terms of triaging but the evidence of - at least one of the collectors, I forget who, went into some detail about, you know, the triaging they do in the collection centre. Sometimes well and truly isolated from the medical centre they're working in.

PN5291

JUSTICE HATCHER: My understanding is these collection centres are often co-located in a medical centre. But they're not in any business sense working in conjunction with the medical centre. They're not assisted by the medical centre's reception or anything. They're just going to be at the back of the medical centre.

PN5292

MR LETTAU: Yes, exactly. And Mr Meckiff's evidence was that the nature of the relationship is a rental agreement.

PN5293

JUSTICE HATCHER: Yes.

PN5294

MR LETTAU: So there's no partnership or anything. So for those reasons we say that there's no justification to depart from the provisional view on this issue. All the evidence supports the findings of the Commission in relation to single staff collection centres. Just briefly as well is this issue of home collections. It was revealed in the cross-examination - - -

PN5295

DEPUTY PRESIDENT GRAYSON: Sorry, Mr Lettau, just before you move off that: there is a submission I think from - it might be - I can't remember who now actually - which talks about there should be a requirement for somebody to perform the majority of their shifts in a single staff collection centre. Do you address that in your submissions?

PN5296

MR LETTAU: We don't in our written submissions. But I can say - there's two things to say about this issue. So one is in relation to our proposed amendment in annexure - appendix B - and this in relation to the definition of single-staffed collection centres.

PN5297

DEPUTY PRESIDENT GRAYSON: I wasn't sure that that would actually address that issue.

PN5298

MR LETTAU: No, I've got a second point to follow up on that one.

PN5299

DEPUTY PRESIDENT GRAYSON: Sure, knock yourself out.

PN5300

MR LETTAU: Which is in relation to the definition of - or the description in - it's at paragraph 235 of the decision, the table there. So it's the level 7. It states Certificate III or equivalent training and experience and four years of more of industry experience or required to work in a single staff collection centre and my understanding of the submission Your Honour's describing is well, our definition of single-staffed collection centre doesn't adequately define what, 'required', means. Our submission is it can be very easily tied up, just by adding to the level 7 table, before the word, 'required', 'regularly required'. And that deals with those issues where you might have relievers who don't regularly work in a collection centre or the reverse situation where you have a multi-staff centre that is - someone's on personal leave on a given day and it becomes a de facto single staff collection centre.

PN5301

The same issue is dealt with by our change to the definition so that's why we've added in ordinarily. So that sorts out the collection centres that are ordinarily single staff collection centres from those who might become de facto for a day due to some temporary staff absences.

PN5302

DEPUTY PRESIDENT GRAYSON: Thank you.

PN5303

MR LETTAU: So dealing with the home collections briefly, so they came up in the cross-examination of Ms Wolow and Mr Meckiff, that there's another type of work which is analogous to the single-staff collector which is the home collector. We've set out some conclusions, we say, can be drawn from that evidence in our written submissions at paragraph 99. Some of that evidence was

that the home mobile collection centres are performed obviously by a single staff collector working alone. They have to travel between homes or nursing homes, typically complete around 15 to 20 collections per day with no onsite pathology colleagues present. So this is again - it's very similar to the single staff collector.

PN5304

They need to plan, equip and run their collections each day independently. They perform the full range of tests. Ms Wolow confirmed that in cross-examination. Mr Meckiff also gave evidence that the employer's data has identified that the home collectors have the highest risk in terms of health and safety issues. He gave an example of a dog bite and stitches. There are other examples of psychiatrically unwell patients and there are formal procedures that are in place and the collector has to deal with that independently. So for those reasons we submit that the carve out for single staff collection centres at level 7, there are work value reasons to say, that should also include coverage of home collectors for all the same work value reasons.

PN5305

DEPUTY PRESIDENT GRAYSON: So you would see an express amendment to what was in the draft determination that we put out at level 7 to deal with those particular operators?

PN5306

MR LETTAU: Yes, yes.

PN5307

DEPUTY PRESIDENT O'NEILL: I don't think you propose any language, though, to deal with that, do you, in your draft determination or do you say they come within the proposed definition of single staff collection centre?

PN5308

MR LETTAU: I have some language for you right now.

PN5309

JUSTICE HATCHER: I'm just wondering whether the criterion could be more objectively expressed as somebody who is required to work without direct supervision, which might cover people in different circumstances. When I mean direct I mean in-person supervision.

PN5310

MR LETTAU: Yes. I might need to take it on notice. I'm getting nods from my instructor. But I might take that question on notice and I can give you what our first proposition is and I can come back to the Bench on that proposed wording. So the proposal that I have here is for - again, it's to amend the level 7 table and just to append to that: 'Or is required to perform in-home collections'. I assume that means, 'To perform work in-home collections'.

PN5311

DEPUTY PRESIDENT O'NEILL: I think the evidence was that it wasn't just to people's homes but also nursing centres and nursing homes.

PN5312

MR LETTAU: Yes.

PN5313

DEPUTY PRESIDENT GRAYSON: I guess there's a question about whether that would be included by in-home in any event.

PN5314

MR LETTAU: I might take that on notice and give some refined wording around how to deal with those issues.

PN5315

DEPUTY PRESIDENT GRAYSON: And whether you would also suggest, 'Regularly required', there as well.

PN5316

MR LETTAU: Yes. It may be that there could be a definition of home collection and collection centres as well. I'll come back to the Bench on that.

PN5317

JUSTICE HATCHER: There may be a defect in the provisional view in the sense that somebody without a Certificate III is level 6 with one year or more of industry experience. But then when you go to 11.7 for somebody without a Certificate III, that one-year requirement disappears. Should that be included in level 7?

PN5318

MR LETTAU: We might add that one to the list, Your Honour.

PN5319

JUSTICE HATCHER: Yes, all right.

PN5320

MR LETTAU: Unless there's further questions on that issue I'm going to turn now the question of phasing in. I won't address the Bench on the evidence about costs, merely just put to the Commission the union's position on phasing in. So just a few things to note about Mr Browne's evidence on phasing in, which was based on a five-year proposal. His evidence in cross-examination was that he more or less hadn't based on that on the modelling but pulled it out by reference to children's award and the - I think - the common issues phase in, the modern awards transitions arrangement. The first thing to note about that is the modern awards transition arrangement was four years, not five years is my instructions.

PN5321

The second thing to note is the children's award as we're largely aware involves a much larger percentage increase to the rates of pay.

PN5322

JUSTICE HATCHER: I think if I remember correctly Mr Browne's report was dealing with the overall cost of both professionals and pathology collectors. I think the one thing that was clear from his report is the bulk of the cost is with the

professional employees, not the collectors themselves, which might suggest that perhaps there could be different phasing in for pathology collectors. That is a short period for pathology collectors as distinct from health professionals employed by pathology companies.

PN5323

MR LETTAU: That's exactly our position, is that there should be a shorter phasing in period for pathology collectors, if there is going to be phasing in. Dr Stanford's evidence was that the weighted average increase for pathology collectors was between 5.51 per cent and 6.28 per cent. That involved two different methods of calculation. It's objectively a lot lower than the professionals. It's worth noting as well that even the annual wage reviews of the last few years have ranged from 3.5 to 5.75 per cent. So not far off the weighted average, according to Dr Stanford. So on that basis the union's position is that the maximum period of any phasing in should be two years.

PN5324

With an implementation date of no later than 1 March 2025 and that March date is chosen on the basis that it will give the employers some time to get the house in order in terms of putting - implementing these wage increases. Unless there are any questions - - -

PN5325

DEPUTY PRESIDENT O'NEILL: I just had a couple, Mr Lettau. Just to take you back to some - I think there were some pathology Australia submissions. I think one was there was a proposal to amend industry experience which was in the draft determination to change that terminology to experience in pathology collection.

PN5326

MR LETTAU: The union's neutral on that proposal (indistinct).

PN5327

DEPUTY PRESIDENT O'NEILL: All right. And there was also a proposal to specify that the qualification referred to I think just as a Certificate III from memory in the draft determination should specifically say Certificate III in pathology collection. Any opposition to that?

PN5328

MR LETTAU: Again, neutral on that point.

PN5329

DEPUTY PRESIDENT O'NEILL: Thank you.

PN5330

MR LETTAU: Thank you.

PN5331

JUSTICE HATCHER: Thank you. Are you next, Mr Tracey?

PN5332

MR TRACEY: I am, (indistinct) to Your Honour.

PN5333

MS BURKE: Sorry.

PN5334

MR TRACEY: I'll let Ms Burke go.

PN5335

MS BURKE: Just before Mr Tracey I'll just answer a question from the Vice President about the masters physiotherapy at University of Tasmania. It's a full-time two-year degree. You must have a Bachelor's degree before - to be eligible to apply for that degree and the list of qualifications accredited by the physiotherapy board is in our submissions from page 84 of the PDF and just in response to something Your Honour the President said just now in relation to Mr Browne's evidence about the health professionals subset of the private pathology industry, we address that at paragraph 133 of our submissions. That's all, thank you.

PN5336

JUSTICE HATCHER: Mr Tracey.

PN5337

MR TRACEY: Thank Your Honour. May I hand up to the Bench some closing submissions? They are only 14 pages long. They just have annexures so they're not as voluminous as they might initially appear. And they do do a lot of consolidating of what we've already submitted in writing so I will however reference them in my oral submissions now but note at the outset that we rely on those written submissions as our closing submissions. The overwhelming indeed uncontradicted evidence is that the pathology industry is in the vulnerable position. It already has - and this is before any wage increases are considered - low profit margins. It already has and will continue to have a high reliance upon fixed government funding. It makes it quite a unique industry in that regard. Now, I'll be addressing that government funding matter in more detail later in my submissions this morning but the short point is that that funding has not increased in real terms in over 25 years.

PN5338

The Commonwealth government is uncommitted to providing that as at the present is uncommitted to providing funding in the future. Paragraph 299 of the expert panel's decision - the expert panel concluded that the private pathology sector is labour intensive, with most pathology collectors being paid at the minimum award rate. Labour constitutes about 55 per cent of total industry costs or 44.9 per cent of total revenue and as accepted by Dr Stanford, a large proportion of labour costs heightens the industry and industry sensitivities or wage increases. Labour costs are a higher proportion of pathology employers costs which in our submission renders them particular vulnerable to the effects of the proposed award increases and classification changes.

PN5339

As found by the expert panel in its decision the pathology industry is primarily funded by Medicare payments and there is a very limited capacity for private pathology providers to increase their revenue in what is a low margin industry because essentially high bulk billing rates are not being indexed and as Mr Browne explains in his second report, the profit margin of employers operating in the Australian pathology industry is - and I quote - thin. We address that at paragraph 11 of our closing submissions. If the provisional views were implemented there would be severe damage to pathology employers' profitability: a 72 per cent reduction in net profit after tax and we've addressed that at paragraphs 20 and 25 of our closing submissions.

PN5340

Just pausing there: that kind of reduction in profitability would be devastating for any business and when - that is only then compounded by the fact that this - these are businesses - the members of my client are businesses - which provide essential health services where there is - as I've noted - a limited capacity to increase revenue. Now, that means that as Mr Browne has clearly stated and it's not right, with respect, to without putting to him that he's an advocate or that he is anything other than disinterested to make the submission my learned friend made, the fact is he is an expert economist with deep experience in relation to how businesses faced with these kind of cost increases notoriously respond. And he's given that clear evidence as to what he expects will occur. Ms Wett has given similar evidence in her three statements before the Commission as to what would be likely to happen and one of the notable things, if wages are increased, is that collection centres would be likely to be closed and that would particularly affect collection centres that are unprofitable ones in the regions of this country.

PN5341

That would lead to two further related effects. The first is at paragraph 20 and elsewhere in our submissions. First of all, the employees who work at those collection centres - and there's a very large number of pathology collectors who are affected by this review - and who would be affected in this regard - would if they work at those centres very likely lose their employment and would lose the security of that employment. Secondly - and we can't forget this aspect of this industry - patients, and especially those in regional areas would then lose access to important healthcare services in that they would have to travel a lot further in order to have pathology testing done and we submit that the closure of the collection centres isn't just a theoretical matter. There is evidence - and we reference this at paragraph 28 of your submissions - that there has been closure of collection centres. Again that's before any of the increases.

PN5342

JUSTICE HATCHER: Mr Tracey, I just find it hard to reconcile that picture of the pathology industry with the picture painted in the IBISWorld report, which shows profit margins of 13.4 per cent and revenue rising faster than wages and the number of employees.

PN5343

MR TRACEY: The IBISWorld report, Your Honour, refers to - first of all that's one source. It doesn't rely on the direct data that was provided by the employers to Mr Browne. But putting that limitation to one side, although it shouldn't be, in

my submission, the IBISWorld report itself states that industry EBIT is down 12.7 per cent over the last five years. Now, it also states that that's the IBIS report that industry volatility is very high. All of that noting the high level analysis that IBISWorld provides relative to the more specific approach of Browne - that is actually not inconsistent with - taking that into account - it's not actually inconsistent with what Mr Browne says. He presents a more negative financial picture, absolutely.

PN5344

But that can be explained by IBISWorld's - we really don't have any understanding of what went in, to use Ms Burke's concept from before. You know, what is the data that goes in? What was the modelling? At least with Mr Browne he's received data from the employers. He's modelled these matters and he has reached a specific conclusion based on the data he had and yes, it's a more negative picture. But taking into account the IBISWorld limitations, there's no reason to doubt Mr Browne's conclusions, in my submission.

PN5345

JUSTICE HATCHER: His conclusions from the data he is provided that is - what's the difference between that and the IBISWorld report in that we have a set of conclusions that - and a picture of the sector based on input data which in both cases we haven't seen?

PN5346

MR TRACEY: Well, we don't - with Mr Browne he confirms he has received input data. Now, there's no reason to doubt the accuracy to that.

PN5347

JUSTICE HATCHER: I don't doubt that Mr Browne was given data. I mean, if this was a court, the expert report would have no weight because you haven't proven the inputs.

PN5348

MR TRACEY: In my submission it would have weight because Mr Browne has avowedly - and there is no dispute about this - looked at the data and has based his opinion on that data and the Commission does have an understanding from Mr Browne's report as to the nature of what he was provided. He was provided with - as he says on page 2 - baseline labour costs, labour costs after proposed changes, assuming all workers earn the statutory minimum, and labour costs after proposed changes assuming workers earning more than the statutory minimum under an EBA have their relativities preserved. Now, there is no basis for doubting that data or questioning its accuracy just because it's not specifically before the Commission. Mr Browne has looked at it. He's an expert economist.

PN5349

JUSTICE HATCHER: I'm not doubting what Mr Browne did with the data. It's just that I don't understand how input data coming presumably from the same companies can result in two different results. I mean, if you look at page 3 of the IBISWorld report it's clear that they've got the revenue figures for all the major players in the industry and it's a very consolidated industry so that the three or four major companies have it appears about 80 per cent of the industry.

PN5350

MR TRACEY: But there's no - I don't have the IBIS report immediately to hand but I don't think there's any suggestion that that data was provided directly, that data of the nature I've just summarised on page 2 of Mr Browne's report was provided by IBISWorld.

PN5351

JUSTICE HATCHER: Right.

PN5352

MR TRACEY: That explains - that must explain any difference in the percentage profitability conclusions.

PN5353

JUSTICE HATCHER: So what must explain the difference?

PN5354

MR TRACEY: That we don't know what IBISWorld received or the nature of it or from whom or when and when I say the nature of it, was it in the nature of items 1, 2 and 3 on page 2 of Mr Browne's report? We don't know. What's clear from his report, under oath, he's looked at the data, he's analysed it, he's formed his conclusions. That is a weighty set of conclusions in my respectful submission and he has concluded as you're aware that there's a profit margin of only 2.1 per cent in this industry. It's the most reliable, most direct evidence of profit margin and profitability and likely effect on profitability that is before the Commission. The IBISWorld report was not prepared for the Commission or for the purposes of the Commission's analysis of the matters before it. So it is one piece of evidence that I say is not - is not to be - well, it's not a report that would be given any great - given greater weight than Mr Browne's report, in our submission.

PN5355

And it's what Mr Browne says, especially at pages 14 and 15, is his own expert opinion as to what businesses faced with these kinds of challenges may do and we rely on that. And there is an evidentiary basis, we say, to conclude and to infer that if wage increases of the kind proposed occurred there would be an acceleration in the closure of pathology collection centres. There would be the other effects. There would likely be the other effects that Mr Browne talks about at 14 and 15 of his report, his second report. So that's the primary submission we make which is in part B of our closing submissions, that the economic employer costs aspects to be taken into account as part of the modern award, consideration of the modern award and minimum wage objectives, tells against the provisional views being implemented, noting that gender undervaluation is one factor in the application of those objectives.

PN5356

The Bench has said in the decision that it's a significant factor or entitled to significant weight. That does not mean that one's employment costs and the economic aspects are taken into account and we say they should be given significant weight themselves that the provisional views should be proceeded with. Now, if we don't - if the Bench doesn't accept our primary submission then

I will come back to that primary submission in conclusion, but we make some alternative submissions and this is in part C of our submissions. Which in essence we say that there should be length in phasing in and delay of any wage classification structure changes. That would be in furtherance of the modern award and minimum wages objectives.

PN5357

DEPUTY PRESIDENT GRAYSON: So just on that, Mr Tracey, I think your previous submissions had said five to seven years and they were filed at the same time as the Browne Report, and I think these ones that we've just received now say categorically seven. Is that your position?

PN5358

MR TRACEY: That is our position. We do accept, however, that every other employer related (indistinct) proposes five.

PN5359

DEPUTY PRESIDENT GRAYSON: Or three.

PN5360

MR TRACEY: Sorry, yes. Sorry, the ones - I think we've referenced some that propose five but yes - so, look, we accept that that's at the outer limit of what could be done. But we make that submission because of just how damaging this would be on the pathology industry. It would be a longer phasing in period than is perhaps orthodox but it is warranted. But in the alternative we say five years is appropriate.

PN5361

We have noted an issue - that applies practically if the expert panel were minded to have a phasing in period, it applies quite easily to the health professional stream. But in relation to pathology collectors, given the nature of the amendment, which would be changing the structure to change classification levels, an alternative method may be delaying the implementation date of the determination in relation to pathology collectors, as distinct from having complex transitional arrangements.

PN5362

We are - from our perspective, Australian Pathology, we are agnostic about how it's done but some sort of transitional or delay arrangement whereby these increases were delayed is - - -

PN5363

JUSTICE HATCHER: Just so I understand that. So are you saying for pathology collectors we could have a delayed operative date in lieu of any phasing in of increases?

PN5364

MR TRACEY: Yes. We've proposed a delay whereby the reclassification of pathology collectors would happen from 1 July 2028, so two years.

PN5365

JUSTICE HATCHER: Sorry, from when?

PN5366

MR TRACEY: 1 July 2028, is what we've put in our submissions as a way of recognising the point that was made earlier. Namely, that you refer to, your Honour, in relation to the difference in economic effect, if I can put it that way, between pathology collector increases and health professional increases. That kind of difference in delay or transition, however one wants to characterise it, would reflect that difference.

PN5367

DEPUTY PRESIDENT GRAYSON: I had understood your submission to be that would be the first tranche and then over seven years but are you now saying that you could have a one off implementation of a structure with no phase in but starting on 1 July 2028? Just so I just - - -

PN5368

JUSTICE HATCHER: For pathology collectors only.

PN5369

DEPUTY PRESIDENT GRAYSON: Yes. Yes.

PN5370

MR TRACEY: Yes. I just said the seven - the five to seven year phase in is the health professionals. For pathology collectors we proposed the 1 July 2028 date or after as a date of the determination taking effect. And we've done that simply because we were having a bit of trouble - and this could be just our inability to work this out in applying a transitional type arrangement to the pathology collectors, in a similar way to the health professionals.

PN5371

DEPUTY PRESIDENT GRAYSON: I see. Thank you.

PN5372

MR TRACEY: So another alternative submission we make, and I won't address this because I understand Ms Leoncio's going to address this, which is the - we agree with the Healthscope - we essentially agree with the Healthscope proposed classification structure for the health professionals and Mr Leoncio will address that and we agree with Healthscope's submissions in relation to that matter.

PN5373

When it comes to pathology collectors, some further alternative submissions we make are that the outcome we submit that would remedy the gender undervaluation that's been found would be we agree with the provisional view that - would be as follows. We agree with the provisional view that level 4 should no longer be a level at which collectors are classified, and broadly we also agree with the provisional view that levels 5, 6 and 7 should be the levels at which collectors are classified.

PN5374

However, within that we make submissions which really have the effect that level 6 is where the great majority of collectors are classified, and level 5 and level 7 cater for some specific circumstances, and this is all based on what we say is a fair and appropriate work value or relative work value analysis which I'll take the panel through.

PN5375

Level 5, we say, is - ought to be the classification for those who do not hold a Certificate III or - sorry, withdraw that. Only those who do not have a Certificate III but who have worked up to three years - they have three years' experience. If they exceed three years, and this is all given effect by our annexure A to our submissions. If they achieve three years experience or if they have the certificate, and the evidence is that a large number of collectors do have the certificate, they will be in level 6.

PN5376

Level 7 is then reserved for those collectors who are involved in, as we put in our annexure A, the supervision or training of other pathology collectors. Now, Lauren Bourke is a witness called by the ACTU. She is a person who would be classified at level 6 under the new structure. However, she is someone who supervises and trains other pathology collectors.

PN5377

The current proposal would have the anomalous effect that somebody who is very junior, very new in the job, merely because they worked at a so-called single staff centre is immediately classified at level 7. Whereas someone like Ms Bourke who does valuable work supervising and training other collectors, is classified at a lower level. The work value of what she does is not being recognised in that scenario, and we've - - -

PN5378

JUSTICE HATCHER: So what did you say she was doing again?

PN5379

MR TRACEY: So she supervises and trains other collectors in the Launceston area and she would be a level 6 on the basis that she has not - if the provisional draft determination were adopted, she would not become a level 7 until she achieved four years' experience.

PN5380

DEPUTY PRESIDENT GRAYSON: So would that be - I understand your primary submissions about what should be in level 7 but assuming we weren't persuaded on that, is that something that we should add into the level 7 drafting, following the current words, 'in a single staff collection centre.' That is all someone who, looking at the language of your submissions, supervises - - -

PN5381

MR TRACEY: Yes, but we've used the language, Deputy President. This is on page - this is in our annexure A to the closing submissions. We've used the language of 'supervise or train other pathology collectors.'

PN5382

DEPUTY PRESIDENT GRAYSON: Yes. So assuming we didn't agree with your alternative alternative submissions and proposed determination, is that something you would suggest that we should insert regardless into level 7?

PN5383

MR TRACEY: Well, we really make the submission as part of a package.

PN5384

DEPUTY PRESIDENT GRAYSON: I understand that.

PN5385

MR TRACEY: Now, I mean it may be, for example, that Ms - the work value inequity, if I can put it that way, that I've just described, could also be remedied if there was some other arrangement whereby someone like Ms Bourke remained as a level 6 and someone who doesn't supervise or train is a level 4 - level 5 rather. But - - -

PN5386

JUSTICE HATCHER: Mr Tracey, just remember the context of this award is these are indicative roles but it remains the case under this structure that the level is to be determined by reference to the functions described. So I think Ms Bourke would have to be, if she's supervising and training, at least level 7 and perhaps 8 or 9.

PN5387

MR TRACEY: Well, on the draft determination in the - - -

PN5388

JUSTICE HATCHER: The determinations are changing indicative role but they're not changing the classification descriptors.

PN5389

MR TRACEY: I'll just need to bring the award up, sorry, your Honour. Could I just take that on notice briefly and I will come back to it.

PN5390

JUSTICE HATCHER: Yes.

PN5391

MR TRACEY: I mean the other aspect of the anomaly though if I could focus on that as well, is merely by working in a single staff centre, even though you have very little competence or experience, you could start the job and you could be at level 7 straight away. And that's not proper reflection of relative work value, let alone fair or equitable.

PN5392

JUSTICE HATCHER: Does evidence disclose that's what happened? That is somebody with no experience would be put into an unsupervised working environment?

PN5393

MR TRACEY: The evidence last week included that there were quite new people that had been there a few months, for example, who were then working in the single staff environment and someone like that would immediately be a level 7.

PN5394

VICE PRESIDENT ASBURY: But if they're required to exercise additional responsibilities because they're on their own in a facility, why do they - why should they be paid less than another person who exercises the same responsibilities, simply on the basis of service?

PN5395

MR TRACEY: We don't accept that premise of course. What we say is that there is no additional responsibility holistically looked at. If you're in a multi or a single staff centre, you are doing the same job, you are working - you have equal responsibility for performing the test and you - in that regard you don't have extra levels of support in relation to your core duties. Whether you work in a single - so-called single or multi staff centre.

PN5396

There's another problem with single staff which I'll come to but even accepting that premise, Vice President, someone who is performing greater responsibilities, we accept, should be at a higher classification than someone who is performing fewer, where that could be accommodated practically. But someone like that would best belong in level 6 because they are not supervising, they are not training, they are in a different category from that kind of more - - -

PN5397

JUSTICE HATCHER: I mean people - I mean entry level rates and first year rates are set up for people on the premise that they're still learning the job and they require kinds of supervision. But the thing about the single staff centre seems to me, speaking for myself, is that the employer has assessed them as capable of working autonomously and without direct supervision. So if that's the case and that's the employer's decision to put them in that environment, why should they be treated as some sort of entry level employee?

PN5398

MR TRACEY: Well, the concept that they're working autonomously or without direct supervision needs to be unpacked, in my submission. They have a vast number of supports being - when they're in the single centre environment, both in the form of the computer software they operate, and I took one of the witnesses to this last week. It was the witness who might have been driving initially. I can't remember her name but I'll confirm that.

PN5399

But that is a whole suite of supports they have. It's not just on the telephone to the supervisor. It's guidance in all of the systems that operate and processes that operate. So in that sense to say they're working autonomously, they are working in just the same way as someone at a multi centre, that is autonomously as well. Multi staff centre that - that is still though direct supervision. You can call your supervisor as you need them. That's what happens in the multi centre as well.

PN5400

So the other issue with the single staff concept that we've addressed in our closing submissions at paragraph 43, where we've noted that - beg your pardon, 45. That there's the point I've just made that we say there is no relative difference in work value substance between single staff and multi staff but there's an initial - there's an anterior issue there though. That is, what is a single staff centre? What is a multi staff centre? It changes. That's the evidence of Mr Meckiff.

PN5401

And the fact is, on the evidence, that these places can be one or the other at different times - - -

PN5402

DEPUTY PRESIDENT GRAYSON: Is that dealt with by the two proposals that the ACTU and HSU have made today in terms of both regularly required to perform and ordinarily staffed by one person? I don't have the exact wording in front of me, Mr Tracey.

PN5403

MR TRACEY: I was wondering the same thing, Deputy President. But that's sort of vague language with respect to that draft - the draft of that is very difficult in applying it - to apply, we say. We're only saying that for the first time but it doesn't deal with the initial question which is what is actually a single staff centre?

PN5404

The evidence is that these centres are variably single staffed or multi staffed, so if you ordinarily work in a single or regularly work in a single staff centre, what's that - what is that concept actually referring to? It assumes an understanding of what the single staff collection centre actually is. And we say it's not capable of precise definition or application. And that's clear from Mr Meckiff's evidence.

PN5405

So there's also evidence that during the course of even a day a single centre might suddenly have more than one - so-called single staff might have another collector who comes along and there's suddenly two collectors or three collectors.

PN5406

DEPUTY PRESIDENT GRAYSON: I thought the evidence was more the other way, that is that a multi staffed might by reason of sick leave or other unanticipated absences kind of power down to being a single staff collection centre.

PN5407

MR TRACEY: There was certainly - yes. And there was, there was definitely that evidence and perhaps - yes, perhaps more that way we'd accept that. But again, the person in the - well, how does that work for the person who's ordinarily or regularly in the multi staff centre, I rhetorically ask, who does not get treated as a level 7?

PN5408

Now, these are matters that in other industrial instruments might be the subject of something like an allowance because it reflects the difference of what happens on a particular shift, as compared to another shift. It's not normally bound up in a particular classification definition. So that's a - this adds complexity and in that sense it doesn't accord with the modern awards objective because it's giving far too much weight to this concept of working in a single staff centre, something that's not capable of precise definition and actually thereby undervaluing work done in a multi centre - multi staff centre. Because someone in that centre doesn't automatically proceed to level 7 on the proposed structure.

PN5409

So we respectfully submit that our use of the 5, 6, 7 structure gives due and fair weight and work value to people's level of experience, to people's qualification where they have it in the form of a Certificate III and to people who are at a - working at a more advanced level by (indistinct) of the fact that they are supervising and training people.

PN5410

VICE PRESIDENT ASBURY: So you say there's essentially no difference between pathology collectors, whether they're working in a single or a multi staff facility because they're all supervised, all capable of being - seeking assistance from a supervisor in the same way.

PN5411

MR TRACEY: That's exactly the submission, Vice President. Yes.

PN5412

VICE PRESIDENT ASBURY: And that a - - -

PN5413

MR TRACEY: In essence, that's the position.

PN5414

VICE PRESIDENT ASBURY: And that a single centre can become a multi centre at any point in a particular day or shift.

PN5415

MR TRACEY: And vice versa further to Deputy President Grayson's question or observation.

PN5416

JUSTICE HATCHER: Well, perhaps the real distinction is the degree of supervision and autonomy. I mean I'm looking at - you mentioned Ms Bourke. I'm just looking at her statement again. She says that - this is at paragraph 14.

PN5417

MR TRACEY: Yes.

PN5418

JUSTICE HATCHER: And she describes different categories. So in 14(a) she talks about obviously a large collection centre with 10 collection rooms and an onsite laboratory with medical science and specimen collection staff. And then (b) two centres with just two collectors each, and then single staff collectors. And then (d) hospital centres. So you might be right to the extent that there's a big difference between, for example, (a) and (b), even though both are multi collection centres.

PN5419

MR TRACEY: That's correct. And it's also - and this comes to something I was going to raise as well, your Honour, which is paragraph 15 of her statement, which is to the effect that all specimen collectors, which is a synonym for pathology collectors, are expected to work across all Launceston pathology collection centres. And I asked her about that in cross-examination and she confirmed that that was the case.

PN5420

This is another issue that would create problems associated with the regularly/ordinarily language the ACTU is now proposing. It just become overly complex and unworkable to determine for someone like that who works across all these centres, how do you classify them as someone who regularly or ordinarily works in a single staff centre. Sometimes that might be easier than other times but as we know, the modern awards objective is about relevantly, on this point, ensuring, - I'm paraphrasing, a simple and easy to apply structure and definition and clarity as to, you know, what the employer's obligation is by way of paying people.

PN5421

The simplicity of our structure, which we say is broadly consistent with the provisional views and everyone becomes a 5, 6 or 7, and which remedies gender undervaluation and does so in a free from assumptions based on gender by particularly removing the level 4 level for collectors. We say our structure best achieves the modern awards, the minimum wage objective. So subject to taking on notice that matter that you raise with me, your Honour, which I will come back to, perhaps after Ms Leoncio's submissions if that's convenient, we really - and this is what I want to do now is just come back to our primary submission because I don't want to under estimate the significance of this from my client's perspective.

PN5422

This is not, as in now, is not a time, in our submission, for substantial let alone high wage increases that have been contemplated to this award. We have inflation increasing again. We have long term labour productivity growth slowing since 2015-16. As at last year the 20 year average annual growth rate was .8 per cent.

PN5423

As Professor Stanford said last year in his - during cross-examination by Mr O'Grady - in fact it might have been in response to a question from you, your Honour. The rate in decline over the last decade in productivity is close to zero, and as the Commission found in the recent annual wage review - this is at paragraph 9, it's clear that it's the government funded healthcare and social services sectors, namely those that are the subject of this review, that are - and this

is my term - the driver behind Australia's poor labour productivity growth. And as the Bench should be aware, poor productivity was a restraining factor on the size of the annual increase this year in that recent review.

PN5424

VICE PRESIDENT ASBURY: But Mr Tracey, that wasn't a comment on the productivity of those workers. That was a comment on the fact that the productivity of those workers is difficult to measure, and that that impacts the overall productivity figures. And that if you remove that aspect, it's a different picture.

PN5425

I mean how do you measure the productivity of pathology collectors? They can only collect as fast as they can draw blood or do whatever from people. They can't - there's no way of increasing the production line, is there?

PN5426

MR TRACEY: It's difficult but the modern awards objective says productivity must be considered in all of this and the nature - - -

PN5427

JUSTICE HATCHER: But you're quoting national economic figures for productivity but is there any data for productivity for the pathology sector?

PN5428

MR TRACEY: Not specifically but we rely on the annual review's finding about that and I understand the context in which you say that that was the finding, Vice President. Let's just say, for argument's sake, that it's impossible to measure productivity in this industry and that - - -

PN5429

VICE PRESIDENT ASBURY: Well, I'm not saying it's impossible.

PN5430

MR TRACEY: No.

PN5431

VICE PRESIDENT ASBURY: I'm just saying it's - I'm not aware of any figures measuring it and it's not something within the control of the pathology collectors. They can only collect as fast as people come in.

PN5432

MR TRACEY: Which we absolutely accept.

PN5433

VICE PRESIDENT ASBURY: And they can't hurry or rush procedures and probably the only thing that's going to improve their productivity is technology, rather than them working any faster.

PN5434

MR TRACEY: The submission I make is at a broader economic level, which is that productivity in that sector, so the non-market sector I think the annual age

review talks about is statistically, at least, where - what contributes to low labour productivity figures, the kind I was referencing.

PN5435

Now, that's just the economic reality, which is the setting in which the Commission is exercising its modern award powers at this time. This is no criticism of any particular way in which pathology collectors work, or anything, it is entirely accepted, what you just said Vice President, they can't increase productivity in terms of what they do with their work because it's responsible, it's health care, they've got to do it properly and it's a very important role. But we're talking about a situation, though, nevertheless, where there is not an ability to offset against these wage increases, a situation where there is high productivity, which might apply in another hypothetical scenario where award wage increases are being proposed. That's just the reality.

PN5436

VICE PRESIDENT ASBURY: Having regard to productivity includes having regard to the fact that the non market sector has grown and that the non market sector is difficult, notoriously difficulty, to measure productivity in. So having regard for productivity could mean that less weight is placed on it then other factors, because of that issue.

PN5437

MR TRACEY: We would accept what you just said then, Vice President, we would accept that. But we say it's still entitled to a wage. That's because the modern awards objective, specifically mentions it. Inflation seems to be increasing at the moment as well, that's another contextual aspect.

PN5438

So we say it's the wrong time and economic environment in which to make these substantial wage increases. And in that regard I just want to make some final points about the role of the Commonwealth, in relation to all of this.

PN5439

The Commonwealth, as the expert panel is aware, has not committed to any finding of the proposed increases. That's even when the Commonwealth has known of what is proposed in the decision for over six months. This illustrates that there is no guarantee that there will be any funding of the wage increases. And, indeed, given the Commonwealth's position, the proper inference to draw at this juncture, on the evidence currently available, is that no funding will be provided, whether by way of Medicare benefit schedule increases or any form of indemnity or subsidisation with respect to any award wage increases that are implemented. That contrasts this matter, notably, with what happened in the aged care scenario.

PN5440

We say that, against that backdrop, we cannot - with our low profit margins, with our low revenue, as a major employer affected by any of these provisional changes, we cannot offset the increase in employment costs, realistically. That's even if there is a transitional or delayed arrangements, because these changes will be entrenched, they will be ongoing. And, as Mr Browne puts it, the steady state

outcome will not be altered. He mentions that in the context of considering a phasing in position. The steady state outcome will become entrenched. So there is every reason that the increased employer costs will be entrenched for the future and so will the negative effects that Mr Browne attests to, at pages 14 to 17. That's all in the context of the government not taking steps.

PN5441

We don't make any value judgment one way or the other about that, but the facts that the government is unlikely to take steps to ameliorate or mitigate these very substantial employment costs. Those costs must, in our respectful submission, be taken into account at this next state of this review, where the expert panel is applying the modern award's minimum wages objectives as a whole and it outweighs these matters in the particular circumstances of this case, in relation to pathology, especially outweigh the finding of gender underevaluation.

PN5442

Subject to that matter, I raised, unless the panel has any questions, those are the oral submissions.

PN5443

JUSTICE HATCHER: Thank you.

PN5444

MR TRACEY: Commission pleases.

PN5445

JUSTICE HATCHER: Ms Leoncio.

PN5446

MS LEONCIO: Thank you, your Honour. Healthscope continues to rely on the written submissions that have been filed in this stage of the proceedings. That is, the titled, 'September 2025' submissions and the reply submissions dated 31 October 2025. It does also continue to rely on aspects of the private hospitals' closing submissions that were filed on 20 December 2024, which is relevant to the question of costs. That is at paragraphs 68 to 80 and paragraphs 149 to 166 of those submissions.

PN5447

I will, in a moment, when I turn to it, hand up an aide which we'll also be relying on, which seeks to draw together the evidence that we rely upon, in respect of costs and the question of phasing in. That consolidates evidence that, we say, continues to be relevant but that was led in the initial state of the proceeding with that evidence which has been led in the second part of the proceedings. So I will turn to that in a moment, when we get to that point.

PN5448

Now, there are two key issues which Healthscope has sought to address the expert panel on: the question of the appropriate classification structure, and the second; the question of the operative date and phasing in.

PN5449

In terms of the classification structure, if I just deal with that first; Healthscope continues to rely on the proposed classification structure that it identified in the annexure to the September submissions of this year, subject to minor modifications to incorporate the views of a number of the other interested parties that were made in reply. I'll just note what those are. So Healthscope agrees to the changes proposed by Australian Pathology to Healthscope's proposed classification structure. That is, the amendments that are recorded in the annexure to the reply submissions of Australian Pathology. Healthscope also agrees to the ACTU's proposal, in respect of the research and quality assurance control specialisation that they form part of the level 2 specialist stream. That is, as identified by the ACTU in their reply submissions, at paragraph 18.

PN5450

Now, in terms of the classification structure, Healthscope has, in its written submissions, detailed the approach that has been taken and the rationale for Healthscope's proposed classification structure. What I propose to do orally is to: (1) briefly just explain the approach that has been taken, at a very high level and then, (2) to identify a couple of issues that have been, or three issues: one being entry level, which was the entry level qualification, which has been the subject of some submissions by my learned friend this morning; the appropriate definition of levels 2, 3 and 4; and the third is the question of the translation, and there is one aspect of our submissions that I'll need to correct, by reference to that translation and I'll deal with that when I get to it shortly.

PN5451

So turning then, just quickly to the structure that has been proposed by Healthscope, if the panel has in front of it the annexure to Australian Pathology's submissions within that, the version of the classification structure which we propose, you'll see what Healthscope has done is to take the foundations of the classification structure that was laid out in the expert panel's provisional views at paragraphs 177 to 179 of the decision regarding the proposed new classification structure.

PN5452

So we have entry level at the first year, at level 1, pay points 1 to 4, then the proposed classifications dealing with the higher classifications at 224. What Healthscope has done is to augment the classification structure that was identified in the provisional view to include additional narrations in respect of the skills and responsibilities of each classification level. It has done that to ensure greater certainty in the application of these classification levels in practise and to ensure which will minimise, hopefully, any dispute that may arise in terms of the application of that structure in practise.

PN5453

The other reason that it has sought to elaborate on the classification levels and to give some greater definition to those proposed levels, is to ensure that the work value for each proposed classification level justifies the proposed wage rates that have been identified in the provisional views of the panel.

PN5454

JUSTICE HATCHER: It gives greater certainty, but an alternative view might be that expressions such as 'Employees generally progress to this level', might in fact be somewhat uncertain. That is, I'm not sure what that means and I'm not sure how the time scale referred to then interrelates with the descriptors that you've added. That is, which has primacy and does it mean that some people won't be progressing after 12 months, two years or three years; how does it work?

PN5455

MS LEONCIO: Well, it's intended to reflect the current approach, which includes both a time based progression but also a recognition of the skills and responsibilities, and that's part of the HPSS Award's classification clause, which I can take you to, but it's intended to incorporate into the classification structure both a recognition of the time served by the health professional, but also that that time served has within it and carries with it those additional responsibilities.

PN5456

It's to ensure that there is in fact additional work value that has been provided, because it may not be the case in every health professional occupation a recognition of work value increasing simply based on time.

PN5457

JUSTICE HATCHER: So if I've done the first 12 months, then how do I know if I've got an entitlement to progress or not?

PN5458

MS LEONCIO: Well, in terms of the second to third year, it will be of course a question of - there is a just a time criteria, so you can tick the box that that has been satisfied, but then it will be a matter for the employer to consider whether the employees are generally responsible for their own work on a day-to-day basis and may require some degree of supervision and/or mentoring. So, it's a matter of considering the duties or the responsibilities that are identified in that column in conjunction with the time - I appreciate the word 'generally' may introduce some ambiguity.

PN5459

JUSTICE HATCHER: I think there are two 'generally's' there, but, yes.

PN5460

MS LEONCIO: Yes, but it is intended to recognise that this classification structure will apply across a range of different occupations and professions, and to allow some flexibility in the way in which we assess work value. It's indicative of the additional work value that will be provided at that classification level, but it allows for the flexibility so that if in the particular scenario of an employee there is some other measurement that indicates some additional responsibility.

PN5461

There are general descriptors, I accept that, but in the absence of that we have the difficulty that there is not any certainty that with that additional time comes greater responsibilities or skills.

PN5462

JUSTICE HATCHER: Thank you.

PN5463

DEPUTY PRESIDENT GRAYSON: Could it also be read - I'm just having a quick look at it. I'm looking at level 1; your second level in level 1. Could somebody progress there more quickly or does it - - -

PN5464

MS LEONCIO: It does allow for that. It does.

PN5465

DEPUTY PRESIDENT GRAYSON: Right.

PN5466

MS LEONCIO: I accept that that is a possibility, because it is drafted in terms that employees will generally progress to this level after at least 12 months, so 'generally' could attach to the time period; that's correct. Now, we focused on level 1, but, in my submission, this is of particular importance in terms of adding some greater definition when you get to the levels 2 and above.

PN5467

That's particularly given the nature of the term 'specialist supervisor and manager' which, based on paragraph 178 of the decision, was what was in contemplation in the provisional view of the panel, but they are terms that are broad in nature. There is a risk that, if not properly defined, it could apply to a wider range of health professionals than was contemplated in the provisional view.

PN5468

So, that is the reasons why Healthscope has proposed some additional clarification about the nature of those specialist supervisor and managerial responsibilities, to ensure that the wage rates that are being proposed for those levels are applied to employees who are performing work of a value that justifies that wage rate.

PN5469

Now, the final point to highlight in terms of the process of crafting this classification structure is that the definitions which have been proposed - and this is detailed in the written submissions - those definitions have been drafted by reference to the classification definitions that exist on the current Health Professionals Award. The classification definitions of equivalent roles receiving the same rate of pay such as under the Nurses Award and evidenced before the panel of the various work that is performed, and the skills and responsibilities performed by health professionals. That is really just to give you a sense of the approach that was taken by Healthscope in proposing that structure.

PN5470

I want to then just turn to some discrete issues that have arisen in respect of the competing classification structures between Healthscope and the unions. Starting first with the question of entry level qualification, in identifying which AQF level should be used for an occupation it's necessary to revisit the relevance of the qualifications to the question of work value. As identified at paragraph 124 of the decision:

PN5471

*The qualification and period of training/education needed to enter an occupation is fundamental to an assessment of its work value ... complexity and the degree of autonomous judgment required in the conduct of the occupation.*

PN5472

I want to pause there because it's a question about the work value of the occupation. Not the work value of the individual health professionals and individual qualifications that they hold, but in assessing the work value of, say, for example, physiotherapists, the task that the Commission is to undertake is to understand the standard in that occupation.

PN5473

It also draws attention to the qualification that is required in the conduct of that occupation, so it focuses, in my submission, on the minimum qualification because when there are various pathways - and I understand from my learned friend that the competing view is to look at the various pathways of entry into a profession - in my submission, it is the minimum qualification that indicates the intellectual demands, complexity and degree of autonomous judgment that is required for the occupation.

PN5474

That is, all health professionals must have at its core that level of qualification. That indicates the intellectual demands, complexity, et cetera, of that occupation. That there is a separate pathway to entry through a higher level qualification, does not necessarily demonstrate that that qualification is required to conduct that occupation and that the higher level of intellectual demands attached to that qualification are required for that occupation given that a lower level would suffice.

PN5475

In my submission, it's not to be viewed on a geographical basis, so it's a national award, it's the national minimum. To the extent that in Tasmania they may have access only to the masters degree, that's not what defines the work value or the qualification that is relevant for the question of work value. It's about the minimum qualification as identified by the relevant awards that would be, in my submission, indicative for the reasons that I've indicated earlier - indicative of the work value of the occupation.

PN5476

In respect of the suggestion about inequities, in my submission if we were to look at it at an individual basis and the individual qualifications that are held rather than looking at the requirement of the qualification for an occupation, you could end up with quite an inequitable situation where two persons who are performing the same work are paid at different rates simply because one holds a qualification that is a higher level that is not required by that occupation as a minimum.

PN5477

Now, I want to then just move on to the question of the appropriate definitions of levels 2, 3 and 4, which are the higher level of classifications. I've already indicated the process that Healthscope has gone through to propose the

classification definitions and I continue to rely on the written submissions of Healthscope at paragraphs 32 to 45 in the September submissions, and paragraphs 22 to 32 in the reply submissions.

PN5478

I did want to just briefly touch on the question of the senior specialist, because it has been put against Healthscope that it is inconsistent in the approach that has been identified in the provisional views of the panel. There is a degree to which we accept that there is an inconsistency between what is proposed by Healthscope and what is strictly identified at paragraph 178 where the table of levels 2 and above are identified.

PN5479

If I can just take you to the Australian Pathology version of our classification structure. You will see at level 2.1 there is a reference to a specialist health professional and that, of course, aligns with the specialist with additional postgraduate qualifications that was contemplated by the panel to be at level 2.1, at paragraph 178 of the decision. Now, the reasons why the specialist reaches the limit within that classification structure at level 2.2 is really just to indicate that from Healthscope's perspective the question of seniority is really one of the experience and that that occurs at that level 2.2 when the relevant health professional has five years' experience at level 2.1.

PN5480

That is the way in which Healthscope has considered the senior specialist is normally identified and that is because, unlike the managerial and other roles and streams, it is really is just a question of the additional experience by reference to the seniority. It's a proxy for time, really. When we're talking about senior, it's talking about the level of time that a specialist has been at that position. In Healthscope's submission, there isn't an additional added work value post that five years' experience for a senior specialist.

PN5481

The other difficulty that this exposes in the ACTU's classification structure is that part of the reason why - and I might just ask you to turn to the ACTU's proposal, but in dealing with a specialist, if you have page 48 of their present submissions and this is the draft determination, you will see that level 2 deals with a senior clinician and then a specialist required to perform:

PN5482

*...duties within or across one or more of the following areas of expertise: education, research, and/or quality assurance and control.*

PN5483

The notion of a specialist within Healthscope's structure is more specific to clinics - it aligns more closely with this clinician at subparagraph (a), which is where we have, say, for example, a physiotherapist who has decided to specialise in a particular type of physiotherapy. In my submission, that's not the specialist as contemplated by subparagraph (b), but it's the type of health professional at subparagraph (a) who, in the ACTU's version at level 2, they're not identified yet as a specialist, they are a:

PN5484

*...senior clinician working in a clinical area of their profession that requires specialist knowledge or depth of experience.*

PN5485

Whereas, what is identified in Healthscope's classification structure is that at that level 2 level you need to be a specialist. It's not simply that you're working in a clinician area that requires a specialist knowledge because what appears is that when you then turn to level 3, you will see there subparagraph (a) of the ACTU's classification structure. That is the concept of a specialist as we might commonly think of a specialist. It's an 'advanced clinician who is a specialist in a clinical area'.

PN5486

The reason why it appears to be missing at that level 3 level for Healthscope is that we, consistent with the provisional views of the panel, have inserted the specialist at the level 2.1 role, whereas the ACTU have inserted a clinical who is some level before they become a specialist. In my submission, Healthscope's classification structure should be proposed and it is in fact more consistent with the expert panel's proposed structure, noting that of course there is this difference about whether or not after five years or more is sufficiently senior as contemplated by the panel.

PN5487

DEPUTY PRESIDENT GRAYSON: Ms Leoncio, can you remind me, the evidentiary basis for the seven years at level 2.1 and the additional five years at level 2.2?

PN5488

MS LEONCIO: I have not been able to ascertain whether there was in fact an evidentiary basis, but I will take that on notice because it may be that there was an aspect of the evidence that indicated that.

PN5489

DEPUTY PRESIDENT GRAYSON: I don't remember it, but you can take the opportunity.

PN5490

MS LEONCIO: Yes, I will take that on notice.

PN5491

The other last point on the classification definitions is just to address the ACTU's amendments to the 'supervisor' definition, which I understand now is at clause A.2.2(c), and there has been a modification to that proposed definition to give it more parameters, so is required as a substantive part of the role, and that the supervision's on an ongoing and day-to-day basis.

PN5492

In my submission, that amendment, though we appreciate the effort that has been undertaken, doesn't go far enough, and one of the reasons, if we look at the persons that the health professional would be capable of supervising, they are

students and other employees. It is, in my submission, based on the equivalent roles, which is the nurse manager role in the Nurses Award structure, appreciating that, of course, these are different occupations, but a nurse manager role is a much more senior role than a person who is a health professional who has some ongoing supervision of students. In my submission, that is not sufficiently significant in supervisory responsibilities to justify a wage rate that is the same as a nurse manager's wage rate.

PN5493

The last point on the classification structure - - -

PN5494

DEPUTY PRESIDENT GRAYSON: Just before you move off that, so if the words 'and/or student' at the end of the ACTU's proposal were removed, does that remove that concern?

PN5495

MS LEONCIO: It is a step towards, it's a step in the right direction, but, in my submission, the proposal as put by Healthscope is to be preferred and that is because that makes abundantly clear the nature of those supervisory duties and that they are of a greater significance than what could possibly fall within clause 2.2(c) of the ACTU's structure.

PN5496

The last point is just to correct something in our submissions. In our reply submissions, we had indicated a translation table and identified that for all translations going from level 3 at the current award, that once translated across to the new structure in the Healthscope structure, that all health professionals would receive a pay increase. Having now gone through and done that calculation, I need to correct the record and identify that there are some classifications that following that translation process would result in a reduction. I understand my learned friends have a copy of this. I might just hand up a copy of this table to the Bench.

PN5497

DEPUTY PRESIDENT GRAYSON: This is on your alternative translation proposal?

PN5498

MS LEONCIO: This is Healthscope's, yes. Just to explain, this table is seeking to depict the translation from an existing award level to the new classification structure under Healthscope's proposal, and because of the differences in which we define supervisor and other definitions within levels 2 and also – so levels 1.4, 2.1 and 3 - we end up with a different classification translation than the ACTU.

PN5499

You will see the red. That's where we've identified the reduction in pay rates under the new structure. I'd make this submission at the start, which is just to confirm that, consistent with the Expert Panel's proposed approach, we would be contending that, to the extent there is any reduction, there would be transitional

provisions to ensure that any employees who are paid according to those existing rates would not go backwards, as proposed by the Expert Panel in the decision.

PN5500

But, I also just make the point that what we had identified is that, given the level 3 classification description isn't strictly focused on managerial responsibilities, specialists, educator, all of those types of classification indicators that now form part of levels 2, 3, 4 onwards, there may be some that fall through the cracks, there may be some health professionals that don't exhibit or perform those duties or hold those responsibilities, and it's really for those health professionals, which presumably is a small cohort, but it's for those health professionals that are currently at level 3 but are not performing those additional responsibilities that would justify the higher rates at level 2 onwards where there may be some reduction and, in my submission, that is just the function of the classification structure, and particularly the Expert Panel's views about the way in which the AQF levels need to be disaggregated, that the current classification structure needs to be disaggregated to recognise the different AQF levels, combined with the now clear level 1, which is now distinct from the higher level of classifications. I just wanted to make that point briefly.

PN5501

If I can then move to the question of the operative date and phasing in. Healthscope contends that, in considering whether to exercise the discretion to specify a later operative date or the phasing of increases in stages, the relevant question for the Commission in terms of whether it exercises those powers under the Fair Work Act is whether it is appropriate, and in considering whether it is appropriate, the Panel should also consider whether it is fair and just, including by reference to the perspective of the employers.

PN5502

Now the timeline proposed by Healthscope, which is either an operative date of 1 July or, in support of the Commonwealth's submissions, a delay of six months from the determination, which would allow some of these classification structure issues which have a degree of complexity to be ironed out before the increases became effective, and for that to occur over five annual instalments.

PN5503

In Healthscope's submissions, that timeline is appropriate, but also possibly necessary, given the fragility of the private hospitals sector at this point in time and the need to phase in the increases in a sustainable manner which will ameliorate the risk posed to the viability of the private hospitals sector, and that is of course important, not just in terms of the employers' interests in remaining viable, but also in terms of the potential loss of jobs which will inevitably occur if there is a closure of parts of the private hospitals sector.

PN5504

JUSTICE HATCHER: Ms Leoncio, does Healthscope have any health professionals who are not covered by enterprise agreements?

PN5505

MS LEONCIO: I'm trying to recall back from the evidence that was led at the end of last year. I might have to take that on notice.

PN5506

JUSTICE HATCHER: Because I'm trying to work out in respect of your client or clients what's the actual import of this submissions. I mean I'm just sitting here browsing the enterprise agreement website and there seems to be a whole range of Healthscope Agreements applying to allied health professionals, psychologists and dieticians which are in force.

PN5507

MS LEONCIO: Yes.

PN5508

JUSTICE HATCHER: So I'm just wondering the basis of the submission about impact and timing in respect to your clients.

PN5509

MS LEONCIO: Yes. Well, as you may recall, there were attempts at the end of last year to model some of the wage increases that were proposed at that point in time. It is a complex and difficult task, and that's been demonstrated not just in that exercise but, of course, in the evidence that has been led in this proceeding, in this stage of the proceeding, and, unfortunately, we're not in a capacity to provide updated modelling which would provide a segment of the private hospitals sector, but, in my submission, the impact is not just the direct costs.

PN5510

The question that your Honour has put to me has focused on the enterprise agreements, and I presume is looking at the question of absorption, but, in my submission, it is accepted across all of the experts and across a number of the ACTU and HSU's witnesses - not all of them accept this to this degree - but it is an inevitability that there will be indirect cost effects, whether that be by reference to maintaining relativities between occupations or maintaining relativities between the margins between the current award rates and the enterprise agreements, and I presume that that is part of the reason why it is necessary to increase the minimum rates under this award because, of course, if most employees are covered by an agreement and there aren't many people who are going to be affected by this award really questions whether or not it's necessary.

PN5511

So it must be an important part of the structure of the Fair Work Act that changes to the minimum are to affect changes to any collective agreements that sit on top of that. That's the way the Fair Work Act is structured and, in my submission - - -

PN5512

JUSTICE HATCHER: It seems to me that's an effect that's more likely to happen somewhat down the track. That is why I'm asking you, when you're talking about, you know, a specific date next year, it seems to me that any impact is going to be more likely, unless there's an enterprise agreement which will immediately fall below the award rate, which looking at these agreements appears unlikely in the first instance, it's more likely to have an effect when the further increments take

effect down the track and when you then engage in further bargaining rather than something that might be happening next year.

PN5513

MS LEONCIO: Yes. I can't put it any higher than that there are multiple enterprise agreements that have expiry dates at various points in time. I suppose one thing that I can point to which indicates that there is at least evidence to indicate that it would not be entirely absorbed is the evidence that you may recall, there was a table and, sorry, I don't have a copy of it to provide to you, but there was a table of the award levels and the enterprise agreement rates that the ACTU filed at the end of last year. Now I've had a look at that table and identified a couple – and I accept that it's a small sample and only a couple – but there are at least two employees who, if we took their award level as gospel that that's what their current level is, and we translated them up across to the new award structure, the enterprise agreement rate would be exceeded.

PN5514

JUSTICE HATCHER: That's only if you did it in one go.

PN5515

MS LEONCIO: Yes.

PN5516

JUSTICE HATCHER: Which I don't see as a likelihood, speaking for myself, so that is, if we're talking about phasing in, it becomes less and less likely that's going to happen, doesn't it?

PN5517

MS LEONCIO: That is true, and we would – it's difficult to be precise about the exact period of time because of these various moving parts, but the period of time that Healthscope is contending for is five years and, in my submission, that is a reasonable period of time having regard to the various moving parts that are, as part of the evidence, part of the process of trying to recoup any revenue or increase any revenue to offset the expected impacts.

PN5518

I will just note for you, to the extent you want to revisit the table and the two employees that I had identified, there was an annexure to Healthscope's primary closing submissions in December last year, and there are two employees. Samantha Holmes, who is identified as level 1.6 under the award, if we translate her award level to the proposed level, which the translation is agreed – this is not a matter of contention – but she would go either to level 1.3 or level 1.4, and the wage rates under the proposed increases would be 47.96 or 51.84, which exceed the enterprise agreement rate, which is \$40.90. The other example - - -

PN5519

JUSTICE HATCHER: What was her occupation?

PN5520

MS LEONCIO: She was a medical scientist, so she's a health professional currently covered by the Melbourne Pathology and Health Services Union (Scientists and Technicians) Enterprise Agreement. Then there's Marni Jackson, who is also a physiotherapist. Her award level, as identified in this table, is 2.4. Under the proposed classification structure, she would be at either 2.1 or 2.2. That would result in a 52.61 proposed new award rate or 55.84 proposed new award rate and they exceed the 51.46 under the enterprise agreement. I appreciate some of those margins are small, it's only a couple of employees, but it at least provides some evidence that there are likely to be employees who fall below the proposed new rate, whose enterprise agreement rates fall below the proposed new award rates.

PN5521

I was intending to hand up an aide memoire, which really just consolidates the evidence that has been led in both the first and second part of this proceeding in respect of health professionals. As I have already indicated, the first section there is dealing with the proposed increases to minimum wage rates and the impact that they may have and, as I submitted earlier, there's the direct cost impacts, but there's also the indirect cost impacts that we need to be mindful of.

PN5522

The other matter to take note of is the concessions that were made by Dr Stanford regarding his estimates. There were a myriad of caveats peppered throughout his report about the limitation of those estimates. That's not to be critical of Dr Stanford, but it is just a difficult and complex task. It means that the estimates that he has put forward are not able to be confidently relied upon. That's partly because of the incomplete data, particularly the issue of award reliance, and that that really, once we dig deeper into it, doesn't have a good foundation in terms of identifying who would be impacted by the increases, and also did not have the specific component to deal with indirect cost effects.

PN5523

Now in terms of the capacity for the private hospitals sector to pay wage increases on an immediate basis, I understand that may not be what's in contemplation, but I just wanted to note that the Panel, of course, has already accepted in its decision at paragraph 297 the constraints on the private hospitals to increase changes in response to increases in labour costs, given multi agreements with private health insurers and the controls by the Commonwealth over insurers on premiums that they can charge.

PN5524

The Panel also accepted that the private hospitals sector has suffered from reduced profit margins and from costs rising faster than revenue.

PN5525

Now, at this point in time, some months later after the decision being handed down, the situation has only gotten worse. In the words of Dr Stanford, 'The challenges faced by the private hospitals a year ago are even more constraining today'.

PN5526

Now, I wish to also emphasise the evidence before the expert panel, of the declining profitability of the private hospital sector. That was made very clear in the evidence that was put to Dr Stanford, under cross-examination and that he accepted, that the private hospital sector has reported an operating profit/loss, before tax, of \$34 million, for the 2024 financial year. There are various other aspects of that declining profitability, I'm not sure it's really in contest, of the private hospital sector, at pages 5 and 6. But that is a trend that has - it has been declining since the 2020 financial year and it's accepted, by the experts, that the pandemic has a very significant impact on the operation of the private hospitals, with ongoing consequences. And the outlook, in terms of where to from here, doesn't necessarily demonstrate that that is going to be resolved quickly. Parts of the reasons, of course, for that is that there are these ongoing constraints in the capacity to increase revenue and it's important to keep in mind that the income from private health insurance represents a proportion of revenue generated from private health insurance funds, in the rate of 75 to 85 per cent. So it's a very significant part of their revenue.

PN5527

The fees that are to be reimbursed by those funds are the subject of multi year agreements. Of course the process that the Commonwealth Government undertakes, in respect of health insurance premiums, plays a key part in those negotiations as well, in terms of what the private health insurers can charge onto their customers.

PN5528

All of that will require time to renegotiate. That was accepted by Dr Stanford, under cross-examination. I also wish to draw to the panel's attention the statement of the expectations for the 2026 private health insurance round, which was issued by the Minister for Health, which indicates that there is a wide discretion, in terms of the matters that can be taken into account. I would urge the panel to have regard to that statement. In particular, that amongst the considerations that the Minister for Health will take into account as to whether or not premiums will be increased are the desire for premiums to be kept as low as possible, in the interests of the consumer.

PN5529

There is also, quite clearly from the statement, no guarantee that there would be, necessarily, an increase to protect the viability of the private hospital sector. But we accept that that is part of the consideration that the minister will take into account but it is, by no means, definitive in that statement that will - that process will necessarily result in the required funds to fund these increases.

PN5530

In my submission, having regard to each of the matters that are identified in Healthscope's aide-memoire each of those matters that are identified explain that or support the submission that, as things currently stand, there is no capacity for the private hospital sector to absorb, immediately in full, all of the proposed increased wages and that in order to ameliorate the impact, that there should be a phasing in period and that that period should be, although I don't consider five years to be lengthy, but it should be a longer period than what might otherwise, without a private hospital sector fragility, might have been contemplated. It's that

real concern about the ongoing viability of the private sector that Healthscope urges the panel to take into account in determining the phasing period.

PN5531

Unless I can be of any further assistance?

PN5532

JUSTICE HATCHER: If I could just clarify one matter about your clients, and you've probably said this sometime last year, but I've forgotten. The Adelaide Community Health Care Alliance Incorporated, so Healthscope, as a contractor, manages its operations, is that right?

PN5533

MS LEONCIO: I'm sorry, I missed that, your Honour. Is a contractor?

PN5534

JUSTICE HATCHER: Your second client is Adelaide Community Health Care Alliance.

PN5535

MS LEONCIO: Yes.

PN5536

JUSTICE HATCHER: So Healthscope has a contract to manage its operations, is that - - -

PN5537

MS LEONCIO: It is effectively part of Healthscope.

PN5538

JUSTICE HATCHER: Right. So who is the employer?

PN5539

MS LEONCIO: The employer is - I understand it to be Healthscope, but I can get instructions on whether or not the Adelaide - - -

PN5540

JUSTICE HATCHER: I just want to clarify that when you have a document that says, 'Healthscope's proposed classification structure', that's the proposal of both your clients?

PN5541

MS LEONCIO: Yes. You can take them almost as one and the same. Yes.

PN5542

JUSTICE HATCHER: All right. Thank you. Mr Manos, will you be longer than 10 minutes?

PN5543

MR MANOS: I am going to be slightly longer than 10 minutes, your Honour. Yes.

PN5544

JUSTICE HATCHER: That's fine. All right. We'll break for lunch now and we'll resume at 1.45.

**LUNCHEON ADJOURNMENT**

**[12.51 PM]**

**RESUMED**

**[1.47 PM]**

PN5545

JUSTICE HATCHER: Mr Manos. Mr Tracey.

PN5546

MR TRACEY: Mr Manos is comfortable with me just briefly raising that matter, if I may, your Honour. The question you asked me about Ms Burke, the pathology collector in Tasmania; as I read the draft determination, in its current form, she would - it's not entirely clear, but I think she would still be a level 6, not a level 7, on the basis that level 7, in the draft determination level 7 table, has, as a criterion, a minimum of four years or more of industry experience. In her statement, at paragraph 8, it's apparent that she would not have reached the four years. So even though it refers to level 7 in the award, the broader part of the award schedule, 'A level 7 employee may supervise', it comes down to award interpretation, but I think the better reading would be that the indicative role would, in the table, would suggest that she doesn't belong in level 7.

PN5547

JUSTICE HATCHER: She might be level 9.

PN5548

MR TRACEY: Well, I don't have level 9 in front of me but, yes. It's a bit ambiguous but we simply say that our proposal would ensure she was in level 7 and she would be properly remunerated.

PN5549

JUSTICE HATCHER: All right. Thank you, Mr Tracey. Mr Manos. Ms Leoncio.

PN5550

MS LEONCIO: There is two matters to come back to the panel on. The first is in respect of the query about award coverage for my client. I'm instructed that there are 30 employees in Darwin, private hospital employees, who are award covered. The other query that I wanted to report back on was in respect of Deputy President Grayson's query about the evidence, in respect of the time criteria.

PN5551

In the time available we have not been able to identify any consistent body of evidence in respect of those time period. My understanding is that the wage rates that are proposed, in respect of level 1, at the highest pay point, that that pay point is consistent with the pay rate that applies in the Nurses and Teachers Award and the same amount of time is taken to get to that pay point under those awards.

PN5552

I'd otherwise just note that I don't believe that there's been any party that has taken issue with the time criteria that has been proposed, in respect of either level 1 or the level 2 five-year minimum. They were the only matters that I wanted to report back on.

PN5553

JUSTICE HATCHER: All right. Mr Manos.

PN5554

MR MANOS: It's third time lucky, your Honour. If the Commission please, my submissions are made on behalf of Australian Diagnostic Imaging Association. We filed some written submissions dated 12 September 2025, I rely on those. My oral submissions today will just be confined to two issues. One will be weighing in on this entry level qualification classification debate. The Commission might not be surprised to hear that we favour the Healthscope view, that it ought to be the minimum requirement, rather than the qualification held. The second topic I propose to address the panel on is just the phasing in of wage rates.

PN5555

Now, in respect of the first of those points, the level 1 descriptor that's been proffered in support of the respondent or employer associations; there appear to be two. One is put forward by Healthscope, at paragraph 7 of its September submissions and that is we support that descriptor. That descriptor appears to be taken from the current version of the Health (Professional Services) Award. We would suggest one alteration to that descriptor to improve the clarity of it, and it's this. It currently reads, 'This level is the entry level for new graduates who meet the requirement to practice'. We would add, 'Who meet the minimum requirement to practice'. Then it continues on:

PN5556

*minimum requirement to practice as a health professional, where appropriate, in accordance with their professional association's rules and be eligible for membership of their professional association, or such qualification as deemed acceptable by the employer.*

PN5557

Now, the second alternative that's put forward is by the Pathology Association, in annexure B. That's in a slightly different form, but my reading of it is; it's the same in substance as what my client's seeking. That is, the minimum requirement. We would be content with that formulation of words as well.

PN5558

The Healthscope - - -

PN5559

JUSTICE HATCHER: In terms of ADIA's members, we're talking, what, radiographers and sonographers?

PN5560

MR MANOS: Yes. So we're talking four occupations: radiographers; MRT technologists; nuclear medicine technologists and sonographers.

PN5561

JUSTICE HATCHER: Is there any disparity or difference in qualifications for those occupations?

PN5562

MR MANOS: Yes, there is.

PN5563

JUSTICE HATCHER: So can you just tell us about that?

PN5564

MR MANOS: Yes. AQF7 for three of the four. The three being the radiographers, so this is bachelor degree for radiographers, MRT technologists and nuclear medicine technologists. I understand it's an AQF8 for the sonographers.

PN5565

JUSTICE HATCHER: All right. What I was trying to ask you was; does this issue about minimum qualification or qualification held have any implications for those four categories or, for example, do universities all offer qualifications at the same level or is there some disparity between qualifications available?

PN5566

MR MANOS: I'm told there is some disparity in the universities, between the universities and the courses they offer; yes.

PN5567

JUSTICE HATCHER: And I assume there would be professional associations applying to all those occupations?

PN5568

MR MANOS: There are. Again, three of the four fall within AHPRA's domain and one has a standalone association.

PN5569

JUSTICE HATCHER: Which is that?

PN5570

MR MANOS: The sonographers. What I propose to do is just to briefly address the panel on why, conceptually, the approach that my client seeks, the minimum qualification approach, is the proper approach. Then I'll address the union's submissions. And, as far as I can see, there are seven submissions that are put against us, which I've extracted from both the submissions that have been put today and the written submissions and in previous submissions and sometimes buried away in footnotes. But I just want to comprehensively deal with each of those seven submissions being put against us.

PN5571

I'll start by dealing with, conceptually and practically, why the minimum qualification approach is the right approach and there are three matters that I wish to draw the panel's attention to.

PN5572

First, it's the statutory objectives of this panel. As I understand it, it's to set a wage that is justified by the work performed and the level of education that's actually utilised by those engaging in these qualifications.

PN5573

If I draw the panel's attention to section 157(2A), it's the definition of work value reasons which, of course, is the gateway by which this panel seeks to vary the award outside of the normal ways in which the award is varied. The definition there of 'work value reasons' is:

PN5574

*Reasons justifying the amount paid for work, being reasons related to: (a) the nature of the work; (b) level of skill or responsibility involved in doing the work.*

PN5575

And it's the level of skill that's required to do the work that directly linked to the training or education needed to enter the occupation. As the expert panel has already indicated in its provisional findings, there are three good reasons why that should be so.

PN5576

First:

PN5577

*The minimum qualification is the best indicator of: (a) the intellectual demands of the role; (b) the complexity of the role; and (c) the degree of autonomous judgment required by the role.*

PN5578

That was the panel's finding, at paragraph 124 of the April 2025 decision.

PN5579

The second matter I will draw to the panel's attention in support of my conceptually sound submission is one of precedent. This is an issue which I understand the panel dealt with in a decision last year. It's the Aged Care Award decision [2024] FWCFB 298, dated 27 June 2024. The panel, as I understand it, was dealing with a similar submission from the unions as what's being put here. That is, the qualification actually held by the employees is what should be the determinant for the pay grade. That should be linked to the pay grade.

PN5580

That proposition was rejected and there the panel found, at paragraph 32:

PN5581

*There is no proper basis to require an employer to pay a higher level of minimum wages to an employee who has independently acquired an additional qualification which is not required by the employer for the performance of their duties.*

PN5582

JUSTICE HATCHER: But that's not quite their territory, is it? I mean if you want to be a radiologist and you've got a basic radiology degree and then you've done a PhD in English Literature then obviously the PhD is not relevant to the requirement. But if the university X offers it in a three-year degree and university Y offers it in a four-year degree, that's the sort of territory we're in; isn't it?

PN5583

MR MANOS: With respect, that comment applies to both. Of course you could have a higher degree that's completely unrelated to the occupation that the individual is engaging in but you could also have a higher qualification that is related to the role that they're engaging in but it just may not be necessary. That's the territory we're in. It's not perfect territory because there may be some assistance that can be derived from a higher qualification, but there's just no evidence here to suggest that in the occupations we're dealing with in this award that higher qualifications would actually be of assistance.

PN5584

So the better metric, we say, is the qualification that's needed to enter the profession and then for the pay increases to follow with experience, which is what happens under the incremental annual wage grading that's set up in the classification system.

PN5585

There's a further point there, which I was going to make in response to one of the union submissions, but I'll make it now. That is, the approach that's put forward by Healthscope and supported by my client doesn't ignore the higher qualifications that may be obtained by an individual performing a role because, at least from level 2 onwards, it becomes a requirement that you hold a qualification which exceeds the minimum requirement. So that additional qualification will be recognised, as you progress in your career. So you may not get the recognition at the entry level for your higher qualification, but you do at some stage.

PN5586

The third reason or the third point I wish to draw to the panel's attention, in support of my submission that conceptually this is the sound approach, is that this is the - - -

PN5587

JUSTICE HATCHER: Sorry, just go back, this is for the specialist clinician aspect of level 2?

PN5588

MR MANOS: Correct. Correct. The third matter I wish to draw to the panel's attention is the approach that my client seeks be made affirms the provisional

panel's findings. The provisional panel's findings, in April 2025, included, at paragraph 176(4), that:

PN5589

*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.*

PN5590

Then when one goes to the table at 123 one sees, in the second column, the minimum tertiary qualification. So what we're seeking to do is just give effect to the provisional findings, we say, of the expert panel.

PN5591

Now, the union's position is - - -

PN5592

JUSTICE HATCHER: Well, the standard may not be the minimum.

PN5593

MR MANOS: Well - - -

PN5594

JUSTICE HATCHER: Theoretically, for example, if, in a given profession, there's some very few AQF7 degrees available but most people get an AQF8 because that's the most commonly available form of the qualification, there might, in that scenario, be a difference between the minimum; that is, the shortest one you can do, and what's standard; that is, what's most common.

PN5595

MR MANOS: Yes. I understand your Honour's point there. And that's - I deliberately haven't drawn out that distinction because that's something that was addressed in one of the footnotes to the expert panel's finding that 'standard' doesn't necessarily, or 'minimum' doesn't equate to 'prevalent' but we don't know exactly what the standard is and in a situation where we're dealing with 50 or 60-odd different occupations, it's probably very difficult to ascertain that.

PN5596

But, conceptually, in my submission, it's still the right approach because what is needed is there is a certain minimum level of threshold that each employer association has designated to be the entry level qualification for each occupation. That is where each individual begins. That is where they begin their professional journey. In my submission, that is the best indicator of the qualification that is then actually being used to create work value, when the individual is performing the role.

PN5597

DEPUTY PRESIDENT GRAYSON: So even when you have a real outlier? I'm thinking, I think it was dieticians that I think there are two of 22 qualifications that are at the bottom level of the AQF, and I can't remember what it was, in relation

to this, and then the rest are all higher, so eights or nine, I can't remember. But you still say that the minimum is right, but you just have an outlier compared to a standard qualification or where the bulk of the qualifications on the application are?

PN5598

MR MANOS: That's right, Deputy President. Yes.

PN5599

JUSTICE HATCHER: I'm just trying to flesh this out, by reference to the example in paragraph 10 of your submission, about sonography. You say that's not uncommon for a person to first qualify as a radiographer and then move into sonography. So what qualification would you get in that circumstance, to be a sonographer?

PN5600

MR MANOS: Sorry, your Honour, if I could just have a moment. Could you just repeat the question?

PN5601

JUSTICE HATCHER: So in paragraph 10 of your submissions, you use, as an example of this issue, radiology and sonography and I think, in paragraph (a), you say, 'It's not uncommon for a sonographer to have first qualified as a radiographer'. So if they do a what is an AQF7 in radiography and then they decide to get qualified in sonography, what would be the sonography qualification? Is it just another AQF7 degree, or is it a masters degree?

PN5602

MR MANOS: I'm told it's an eight or a nine, because they're required to do a grad diploma or a masters.

PN5603

JUSTICE HATCHER: What's that again?

PN5604

MR MANOS: An AQF8 or 9.

PN5605

JUSTICE HATCHER: Yes. And why?

PN5606

MR MANOS: Because they're required to complete an additional qualification, which is higher than the bachelors degree.

PN5607

JUSTICE HATCHER: What is it, a masters degree?

PN5608

MR MANOS: Masters, or I'm told a grad diploma.

PN5609

JUSTICE HATCHER: All right. And what if I just wanted to go straight into the sonography, without ever having done radiology?

PN5610

MR MANOS: You'd still - you'd enter as an eight or a nine because the minimum is - the entry level is the eight. So that's the equivalent AQF minimum qualification required for a sonographer. So if I look at paragraph 123, I'm hoping that's going to tell me. Yes. On the table there.

PN5611

JUSTICE HATCHER: Where?

PN5612

MR MANOS: This is the table which follows paragraph 123 of the expert panel's April decision.

PN5613

JUSTICE HATCHER: Yes.

PN5614

MR MANOS: I understand they've already completed a bachelors degree, a relevant bachelors degree, and then they go on to complete an additional qualification, which is at least a graduate diploma, which then pushes them into an eight.

PN5615

JUSTICE HATCHER: What I'm trying to work out what's the practical problem here? That is, on any view it seems to me that if you're a sonographer you go in as an eight. Is there some doubt about this?

PN5616

MR MANOS: I don't think so.

PN5617

JUSTICE HATCHER: No. Why is this of importance to your client? That's what I'm trying to work out.

PN5618

MR MANOS: Well, because there are degrees around the country where individuals are able to obtain something higher than the bachelors degree. So if you look outside sonography and we look at the other three; nuclear medicine technologist, which is a seven; medical imaging technologist, which includes the radiographers; and the MRI technologists, which is a seven. There are individuals who sometimes choose to obtain a higher qualification.

PN5619

JUSTICE HATCHER: What might that be?

PN5620

MR MANOS: Well, any of those. Are you talking about which degree, your Honour?

PN5621

JUSTICE HATCHER: Of the professions of interest to your client, I'm just trying to work out what the practical implication is for your client are of this issue. That is, for example, in medical imaging is there some path that's higher than AQF7 to become a medical imaging technologist?

PN5622

MR MANOS: Yes, there is.

PN5623

JUSTICE HATCHER: What's that?

PN5624

MR MANOS: Masters.

PN5625

VICE PRESIDENT ASBURY: But they'd still be building on what they'd obtained in the bachelors degree, wouldn't they? They wouldn't go and start all over again.

PN5626

MR MANOS: That's correct.

PN5627

JUSTICE HATCHER: So what would the bachelors degree be?

PN5628

MR MANOS: Apparently the bachelors degree does not have to be related, so they can be various different degrees.

PN5629

JUSTICE HATCHER: That might be a science - a generalist science degree, for example?

PN5630

MR MANOS: Might be.

PN5631

JUSTICE HATCHER: Then what do they do? A masters degree in - - -

PN5632

MR MANOS: Masters of Medical Imaging.

PN5633

JUSTICE HATCHER: Right. Does the evidence show that that is common or happens?

PN5634

MR MANOS: I can't say, your Honour.

PN5635

VICE PRESIDENT ASBURY: So what do you mean then by this, by paragraph 10(a)? So giving that as an example, so for a sonographer to have first qualified as a radiographer, prior to moving into sonography and in performing the sonography role the employee should be classified with respect to the performance of that role, rather than by reason of any particular qualifications held in radiography but not used in sonography. So if you have to have an underpinning degree and then add your masters to it, how are you not using the qualifications that you obtained in the lower level degree?

PN5636

MR MANOS: Well, you are for sonography.

PN5637

VICE PRESIDENT ASBURY: Right.

PN5638

MR MANOS: But it's a minimum that you have also completed the grad diploma for sonography. So therefore you're coming in at the higher level. So sonography is not really a good example of the problem that I'm identifying because they're all going to come in at AQF8 or 9. It's more the other occupations.

PN5639

VICE PRESIDENT ASBURY: What other occupations?

PN5640

MR MANOS: The radiographers, MRT technologists, nuclear medicine technologists, which the minimum level entry there is a bachelors degree, but many universities offer the bachelors and they also offer a masters.

PN5641

JUSTICE HATCHER: So this is where you do the generalist degree then you do a specialist masters, is what - - -

PN5642

MR MANOS: That's right. So individuals who may choose, of their own volition, to engage in the masters course and then seek employment, there would be a difference between the classification we're pushing for, the minimum requirement, and we would say should be the bachelors degree, because that's the skill level that's been exerted at that entry level. Whereas, on the union's proposition, it would be the higher of the two. So we would pay at an AQF8, let's say, because they've achieved a masters degree. That's the degree they hold.

PN5643

JUSTICE HATCHER: All right. But anyway, you're content with a result that conforms with the table in paragraph 123; is that right?

PN5644

MR MANOS: 133, can I ask what your Honour is looking at?

PN5645

JUSTICE HATCHER: The table you took us to at 123 of the decision.

PN5646

MR MANOS: Yes.

PN5647

JUSTICE HATCHER: You're content with that as the approach to be taken with respect to your occupations?

PN5648

MR MANOS: Yes. So there are a number of submissions, I'll turn now to address the seven submissions that are put against us by the union. These were expressed in the union's submissions, dated 1 November, at paragraphs 9 to 13. I just noticed, in case it's easier for the panel, that the union's written closing submissions put forward today replicate these same paragraphs, at 29 to 33. So I'm going to deal with those one at a time.

PN5649

So at paragraph 29, the union's submission in favour of the qualification held approach is a practical one and it says, in effect, 'There is no standard qualification. There are often multiple qualifications. This could cause a practical problem when working out the appropriate qualification to be used'. Now, we say this is a non issue because the way the AQF is structured, there's a clear hierarchy between the qualifications and one can see that with the bachelors, the masters and the doctorate. So we don't understand that to cause any real problems and that's, in fact, how the panel has come up with the table, at paragraph 123. Apparently it hasn't caused any problems to come up with that table. We say there are no problems.

PN5650

The second union submission is at paragraph 30 of the closing submissions. This is what I might call a conceptual argument. They say that, 'The minimum tertiary qualification is determinative work value lacks a sound and rational basis'. Then they put up the example of the minimum degree offered by an institution in Australia, where it's a bachelors but becomes a masters. So the role has changed but the minimum required of the role has not.

PN5651

Now, firstly, we say they don't point to any example where this has occurred, and as far as we can see, there isn't any. This is a non-existent problem. But, secondly, even if that was to occur, the consequence of that outcome would be the individual is entitled to the higher rate of pay. So it can only favour the employee. It doesn't work against the individual. In my client's submission, that's a consequence it would prefer to live with. That is, having to pay a higher rate of pay in that situation rather than the actual qualification held approach. It's prepared to accept that trade off.

PN5652

DEPUTY PRESIDENT GRAYSON: But it can go the other way; can't it? If a new degree gets offered at a lower AQF level then suddenly everyone moves down.

PN5653

MR MANOS: Yes. But that would only be the case if the employer association had deemed that that was the minimum they needed to perform that role. So there would be a sound basis for it.

PN5654

DEPUTY PRESIDENT GRAYSON: If it was a regulated profession?

PN5655

MR MANOS: I'm sorry, Deputy President, I - - -

PN5656

DEPUTY PRESIDENT GRAYSON: If it was a regulated profession? If there was a professional body that required registration or qualifications.

PN5657

MR MANOS: That's true. Which I understand the vast majority are. Maybe I'm wrong about that. Perhaps I won't step outside my own domain.

PN5658

The third submission that's put against us is at paragraph 31 and it's a practical argument. It's the argument that was made today orally as well. It's the accident of educational geography argument. That is, take a university, like the University of Tasmania, that doesn't offer a bachelors degree in physiotherapy, it only offers a masters degree and therefore, it would be unfair if a physiotherapist in Tasmania who completed the masters degree was only able to enter at the bachelors degree, because they didn't have a choice, due to the accident of geography.

PN5659

Putting aside, for one moment, the inbuilt and perhaps incorrect assumption the individual must study at their local university, it assumes the additional qualification won't assist the individual. But as I said earlier, that assumption is not correct because as one progresses through the classifications, on the classification structure that we ask for, there is recognition given to the higher tertiary qualification, as the individual moves to level 2 specialist clinician.

PN5660

JUSTICE HATCHER: But don't they need to get another qualification on top of the one they entered with?

PN5661

MR MANOS: Why would that be?

PN5662

JUSTICE HATCHER: I'm just trying to understand the qualification proposal. But I must admit, I thought the specialist clinician must have acquired another qualification, above the minimum one it required for entry. Perhaps Ms Leoncio can - - -

PN5663

MR MANOS: At the risk of speaking to someone else's submission, my understanding of it was that:

PN5664

*The qualification needed to move to level 2 would be a higher level qualification (above the minimum entry qualification required for the profession).*

PN5665

So in that situation, where there are bachelor degrees in physiotherapy offered around the country, which there are, an individual physiotherapist who acquired a masters degree in Tasmania would have the minimum entry qualification and then, when it came time to move to a level 2, would also have a qualification that was higher than that, because they would already hold a masters.

PN5666

JUSTICE HATCHER: So if I'm an AQF7 radiologist, I can never get to level 2 without doing another degree. But if I'm an AQF8 radiologist, I can jump up to level 2.

PN5667

MR MANOS: That's right.

PN5668

JUSTICE HATCHER: That doesn't make sense, does it?

PN5669

MR MANOS: Well, except that it recognises your additional qualification, at the time you become a specialist clinician.

PN5670

JUSTICE HATCHER: Well, if it makes a difference, why wasn't it recognised from day one?

PN5671

MR MANOS: Because that's not what's needed to perform an A1 role. It's not till you move to that more specialised advanced role that it recognises that the additional qualification is giving something else extra to the role. There's additional work value that's being offered by your - the extra skill you're exercising, through your additional qualification.

PN5672

JUSTICE HATCHER: All right. Thank you.

PN5673

MR MANOS: Just the final point I wish to make about that, this is an equity point that's put against us but, in effect, what the union is asking for, by asking for the qualification held, is to - this assumes the panel accepts that conceptually the minimum degree required is the best indicator of the best proxy for the knowledge and skill that's been deployed by the individual. If the expert panel accepts that, what the union's asking for, in that type of Tasmania situation, is, in all the other states in Australia where physiotherapy bachelor degrees are offered, an individual who chooses to obtain a higher degree but doesn't then deploy that knowledge acquired in the degree in the exercise of their duties, would be entitled

to the higher pay. So it would be creating a greater inequity to solve what seems to be a very isolated problem.

PN5674

The fourth union submission put against us at paragraph 32 is a practical and conceptual one. This is one that says, in effect, 'There are no practical or conceptual reasons why the minimum qualification approach should be preferred.' I think I have already addressed the Expert Panel on that, and I refer to the statutory objectives and the precedent.

PN5675

The fifth, at paragraph 33, again is a practical and conceptual problem that arises. It's what might be called a global submission about creating simplicity, ease of understanding, stability and sustainability, but doesn't – in my submission, the approach that Healthscope forward and we support is one which does all of those things. There is no additional simplicity, ease of understanding, stability or sustainability that's put forward or that's advanced by the union's preferred approach.

PN5676

The sixth union submission, which doesn't appear in the written closing submissions but was a footnote to a prior submission, was that the union's approach is one which is consistent with the current version of the Health Professionals Award. As far as I can see, it's not consistent with the current version of the Health Professionals Award. There's nothing in there to suggest that the qualification actually held is the approach that's currently deployed.

PN5677

The seventh submission which was put forward today is this is consistent with industry practice. The Panel was taken to two enterprise agreements and taken to clauses of the enterprise agreements which identified that the relevant pay rates were determined by the actual qualification held, not the minimum, but those two enterprise agreements were Public Health Victorian Agreements. So the first thing to note is it's an enterprise agreement. Enterprise agreements, of course, are not the statutory minimum, they are the result of bargains between employees and employer which usually exceed the statutory minimum and, of course, they can involve trade-offs. There is just not enough known about those agreements to be able to dig into those details and exactly know what trade-offs occurred there. The second, of course, is that those were agreements which applied only to the Public Service. We're not dealing with that here, we're dealing with a national statutory minimum which applies to public and private.

PN5678

The final point – the second submission I wanted to make was just around the phasing in of the wage rates over – we say it should be five years. I should also acknowledge and thank my learned friend Ms Burke for her concession that she's not applying for any disgorging of profits over the years. Collectively, employers around Australia sigh – there's a sigh of relief exerted by us all.

PN5679

The increase in wages to my clients will be around 25 per cent, approximately. This will come at a cost to the private radiology clinics. Not all those costs can be absorbed, and that means the increase to the costs will either be for the end user, albeit result in a decrease in services, which means longer wait time. The clinics, as I understand it, that are most likely to be affected by this are the rural and regional clinics.

PN5680

So the duration of the phasing in won't avoid these consequences, but a longer duration will help to reduce the impact, and it's for that reason that my client asks for an extended period of time in the phasing in.

PN5681

Unless there's anything further, those are my submissions.

PN5682

JUSTICE HATCHER: All right. Thank you, Mr Manos. Before we go to Mr Stanton, Ms Leoncio, can I just clarify Healthscope's proposal in respect to this specialist clinical role in level 2. Is that a higher level qualification upon entry or higher level qualification post entry?

PN5683

MS LEONCIO: This is at level 2.1?

PN5684

JUSTICE HATCHER: Yes, so it's the first bullet point under 'Specialist Clinician'.

PN5685

MS LEONCIO: It's intended to be read in connection with the remainder of that sentence, which says, 'which is relevant to their area of daily practice'. It's meant to be a specialist role. So to the extent that they have an additional qualification, say a masters degree, that masters degree is used in the speciality, so what was in contemplation with this level 2.1 was not to capture simply a higher level of qualification that would satisfy an entry into the profession, it was intended to reflect additional qualifications relevant to the specialty. An example of that – I don't have a hearing book reference – the witness – I appreciate this is not in the radiology context - but in terms of how it's intended to apply, there was a witness called Ruch Ribiero(?), who is in social work. Ruch Ribiero has a Bachelor of Social Work and a Master of Advanced Social Work. It would be the Master of Advanced Social Work which provides for more complex psycho-social cases or enables this health professional to do that work, and that would satisfy the requirement in level 2.1 for that health professional to be a specialist. That was the intention.

PN5686

JUSTICE HATCHER: Are those criteria cumulative, that is, you have to have all of them?

PN5687

MS LEONCIO: I appreciate it is drafted in a way that suggests that that is how it's to be read. I might just clarify if that was in fact the intention. Yes, it is the intention that the health professional satisfy each of those criteria.

PN5688

JUSTICE HATCHER: All right. Thank you. Mr Stanton.

PN5689

MR STANTON: May it please your Honour, I can be brief. We are content to rely on the submissions which we've filed, that is the submissions of 12 September and, more recently, 31 October.

PN5690

There is just one point that I wanted to respond to and it's in response to a submission that was made earlier this morning in the proceedings by Ms Burke for the ACTU and other unions. The submission that was put towards the end of those submissions was a submission to the effect that it was time for employers to bear the true cost of engaging labour under this award. Your Honour, I may have – at the risk of some injustice to that submission, but it appeared to me that that submission, by drawing attention only to employers, suggests that employers carry some special responsibility for the gender undervaluation outcomes that have been identified by the Expert Panel, yet I could find nothing in the extensive decision of the Expert Panel, particularly the deep historical analysis brought to bear in the decision, that suggests that that is the case, or indeed that any particular party carries that responsibility, so I wished to make that point to counter that submission, if that was the intention.

PN5691

Other than that, we rely on our written submissions. May it please.

PN5692

JUSTICE HATCHER: Thank you. Ms Bulut.

PN5693

MS BULUT: Thank you, your Honour, I will be very brief. The Commonwealth relies on its written submissions dated 12 September 2025. Just briefly, they provide that the Commonwealth's position is that it supports the phasing in of the proposed changes to the classification structure and, secondly, that the operative date should commence no earlier than six months after the final decision and, in any event, no earlier than 1 July 2026. The basis for that is set out in paragraphs 14 to 23 and I place emphasis on paragraph 22 of the written submissions.

PN5694

One additional matter I wish to address is the question of Commonwealth funding, and it's really in response to a submission made earlier today by my learned friend Mr Tracey with respect to that matter. The position of the Commonwealth is set out in the written submission of 12 September at paragraph 3, that is, that the Commonwealth's position is that it has not made any decisions regarding whether to make any funding adjustment based on the outcome of these proceedings, that is, it has not made a decision one way or the

other, and I can confirm that my instructions have not changed, that is, that remains to be the position of the Commonwealth as at today's date. I am really foreshadowing a question that might be asked of me from the Bench.

PN5695

Other than that, the Commonwealth relies on its written submission.

PN5696

JUSTICE HATCHER: Ms Bulut, given that position, in our consideration, when we take into account the cost to business and the effects on business, should our working assumption be that there won't be any forthcoming funding from the Commonwealth?

PN5697

MS BULUT: I think that is the inference that my learned friend Mr Tracey was asking the Expert Panel to make or to draw. We don't invite the Expert Panel to draw an inference one way or the other, that is, the position of the Commonwealth is simply that that is a matter that is under consideration and its funding will be decided on a program by program basis, and so we don't invite the Expert Panel to draw an inference one way or the other in that regard.

PN5698

JUSTICE HATCHER: With respect, Ms Bulut, it makes a big difference to our consideration of that issue, that is, why, in the absence of any positive decision, would we assume that there would be funding forthcoming, or assume there is no funding forthcoming?

PN5699

MS BULUT: It is not my submission that it is not open to the Expert Panel to take that position. I am simply communicating the Commonwealth's position with respect to funding, that is, we're not asking or inviting the Expert Panel to draw that inference, but I can see how that inference may be drawn by the Expert Panel on the invitation of Mr Tracey.

PN5700

JUSTICE HATCHER: All right. Thank you.

PN5701

MS BULUT: May it please the Expert Panel.

PN5702

JUSTICE HATCHER: Anything in response, Ms Burke?

PN5703

MS BURKE: Yes, Mr Lettau will address you briefly on pathology collectors, then I'll say some things about health professionals.

PN5704

MR LETTAU: I have got four points in reply. The point is really a response to the questions that were on notice about the level 7 descriptors. My instructor, I

think, has circulated a document where we've drafted some words. Has that been received?

PN5705

JUSTICE HATCHER: Yes.

PN5706

MR LETTAU: I'll just take the Bench through this quickly. We have added there – so this has been lifted from the decision, paragraph 235, the table there. We have added in there the Certificate III in Pathology Collection, we have added as well connecting experience to experience in pathology collection.

PN5707

JUSTICE HATCHER: Why is that? I don't understand what those words mean 'and experience in pathology collection'. What experience?

PN5708

MR LETTAU: 'Or equivalent training and experience in pathology collection.'

PN5709

JUSTICE HATCHER: Sorry, yes.

PN5710

MR LETTAU: So to ground the experience in pathology collection rather than  
- - -

PN5711

JUSTICE HATCHER: I assume the 'industry experience' reference in the second page should also be read 'experience in pathology collection', and it's four years or more of experience in pathology collection?

PN5712

MR LETTAU: Yes. Point 3, we have added the word 'regularly required', as we mentioned in oral submissions, and then we've added, as well as 'single-staff collection centre' or – see if I can pronounce this properly – domiciliary collections, which is, I'm instructed, the term used to refer to the home collections, and we have then proposed a definition for that below, that it means 'collections performed by a pathology collector at the premises of a person's home or an organisation', and then some examples there that we have taken out of the witness evidence filed by both parties. Mr Meckiff gave an example of – an example of a nursing home was given in cross-examination. So that's our proposal in terms of dealing with that question.

PN5713

JUSTICE HATCHER: What about the issue of the first year pathology collector without a qualification? There seems to be anomaly that, generally speaking, after the first year, they're in level 6, but then the one year disappears when they go to level 7.

PN5714

MR LETTAU: Yes. Our understanding of that difference in the drafting between level 6 and level 7 is because the level 7 has the four year or more industry experience, and so the time period - - -

PN5715

JUSTICE HATCHER: No, I'm talking about if you have an unqualified pathology collector who works in a single-staff collection centre or a domiciliary collection, do they need one year's experience or not, that is, it would be odd that – essentially, there's some anomaly between 6 and 7 in that respect?

PN5716

MR LETTAU: Yes. Perhaps the way to deal with that would be to attach the one year's experience to that second criterion, so regularly required to work in a single-staff collection centre and with one year's industry experience or experience in pathology collection, at minimum, one or more year.

PN5717

DEPUTY PRESIDENT GRAYSON: So you would add that after the 'or' and before the 'regularly'? Is that right? I'm just looking at your draft.

PN5718

MR LETTAU: Sorry, please - - -

PN5719

DEPUTY PRESIDENT GRAYSON: I was just asking if you were proposing that you would insert the one year criteria after the 'or' in your draft, so before 'regularly'?

PN5720

MR LETTAU: 'Or' in the – sorry, I'm trying to get instructions on the question. Might I have leave just to put in an additional note without answering that question? That might be a more efficient way to deal with the question.

PN5721

JUSTICE HATCHER: Yes.

PN5722

MR LETTAU: Moving on from that issue, a few points in reply to Australian Pathology. The first one is in relation to Ms Burke and what level she would fall at. Her evidence is that she is required to work at a single-staff centre, so on that point she would fall into the level 7 at a minimum, our view is, but, in any case, the duties she performs would likely bring her, as your Honour observed, into some classification above level 7, so the point there seemed to be moot to us.

PN5723

In relation to the second point of my learned friend, which that there are anomalies produced by the level 7 descriptor in that it was put that a fresh employee pathology collector could go straight into a single-staff collection centre and become level 7. That's dealt with in two ways. Number one, with the proposal to put in a one-year minimum' number two, with the Certificate III or equivalent experience criterion. So it would be unusual if an employee without

Certificate III suddenly had the equivalent experience to be immediately bumped up to level 7.

PN5724

Finally, in relation to a point that was put by my learned friend in relation to our definition of single-staff collection centres being unclear even with the additional word 'ordinarily', the submission seemed to be that single-staff collection centres can turn into multi-staff collection centres and vice versa and that that uncertainty means that you never really know whether a collection centre is one or the other.

PN5725

Our submission and our response to that would be the evidence doesn't support that conclusion, number one. There was unequivocal evidence from Ms Slack, for example, at PN 4127, that while it is the case on occasions a multi-staff collection might become single-staff due to a temporary absence, it's not the case that the reverse occurs. The only evidence where the reverse occurs that was provided was from Mr Meckiff at PN 5044, but all the examples he gives are anomalies or extraordinary situations, not the ordinary course of events, so examples of emergencies, very busy periods, or in instances where there's not enough room in a multi-staff collection centre to train juniors, so they may have two staff in a single room on occasions, but these are all out of the ordinary and not the ordinary course of events. So, again, our submission there would be that it's a moot point and it's not supported by the evidence.

PN5726

Unless there are questions, those are our submissions.

PN5727

JUSTICE HATCHER: Thank you. Ms Burke.

PN5728

MS BURKE: Thank you. I will just start with a response to some questions from the Bench. Your Honour the President asked early on whether our clause A.2.1 applied to qualifications less than AQF 7, and the answer is that they do. Some of the dental professions, for example, permit registration at AQF 6. Those professions are regulated by the Dental Board, which is under the AHPRA umbrella.

PN5729

In a response to a question from Your Honour Deputy President Grayson about level 4, I said without instructions that it might be an idea to add a note to level 4 senior manager to the effect that senior manager might report to the executive, and I now have those instructions, so just confirming that.

PN5730

Then I have just got some remarks in reply to submissions made on behalf of Australian Pathology and Healthscope. In response to Australian Pathology, the submission was made that the provisional view should not be confirmed, and we say that is not a course open to the Fair Work Commission. The legislation requires the Commission to take steps to eliminate gender-based undervaluation. Having found that there is gender-based undervaluation, it's not

an option to do nothing, and this was addressed in our closing submissions in December last year. The transcript references are PN 9484 to 88.

PN5731

There was a discussion between the Bench and my learned friend Mr Tracey about the data underpinning the IBISWorld report about the pathology industry. I just want to reiterate these are public companies, they report their financial matrix, and we have set out a summary of the salient points from those annual reports at paragraph 153 of our written closing submissions. Those figures are consistent with the IBISWorld report into the pathology services. It should not be forgotten that Mr Browne referred to that report for the revenue input to his modelling, so either it's a good source of information or it's not, and we say it is good.

PN5732

There was also a discussion between the Bench and my learned friend Mr Tracey about productivity in relation to pathology collectors. Can I draw the Full Bench's attention to the annual reports of ACL and Healius, which were tendered as exhibit HPSS 169. I'll just give you the references, you don't need to go to them, but at page 33 of the Australian Clinical Labs annual report, they reported that, as a key operational achievement, that labour as a percentage of revenue improved by 60 basis points, now at 43 per cent, reflecting productivity gains, and Healius, at pages 7 and 18 of the annual report, also reported that there had been a detailed labour optimisation program, including collection centre opening hours and productivity measures, undertaken and a detailed plan was now being implemented across the network and showing benefits. I think in the ACL annual report in the directors' letter, there is a little more detail about where those productivity gains came from, and they come from an alignment of opening hours and the volume of patients presenting for collection.

PN5733

JUSTICE HATCHER: I thought at least one of the reports made reference to improvements through technology on the medical laboratory side of the operations.

PN5734

MS BURKE: Yes, that's right, but I was just focusing on the particular question about productivity gains for pathology collectors. These firms are looking into that and they are making those gains, and they report it in their annual reports.

PN5735

In reply to the submissions of Healthscope, there was a discussion about the level 1 descriptors in Healthscope's proposed draft determination, and all I need to do there is direct the Full Bench to paragraph 36 of our written submissions where we respond to that. We say it's unnecessary.

PN5736

In response to the submission from Healthscope, but also the ADIA, that the minimum qualification is the relevant qualification, it's not at all clear why the minimum qualification should be, or in fact is, determinative of work value. Universities, when offering degrees, and AHPRA, when accrediting them, do not do so with an eye to the work value of the profession by reference to the

other degrees and qualifications offered by the universities. Further, if the majority of employees hold a qualification other than the minimum, then it follows that the minimum is not reflective of the work value, and it would also produce highly impractical results.

PN5737

I can take you to an example. Annexed to our submissions at appendix D are the tables of the AHPRA accredited qualifications for the regulated professions. Take psychology as an example. There are 20 pages of accredited qualifications for psychologists and they take up pages 89 to 108 of our submissions. The vast majority of those offerings are bachelors or masters degrees, but one university, the University of Western Australia, has accredited a Diploma of Science as a qualifying degree. So that's AQF level 5. That's one qualification out of literally hundreds, but it is the minimum. On the submissions of my learned friends, that's enough, and all the other offerings are essentially nice to have.

PN5738

DEPUTY PRESIDENT GRAYSON: What page is it?

PN5739

MS BURKE: It's 95.

PN5740

JUSTICE HATCHER: Does the Psychology Board of Australia recognise that as an entry qualification?

PN5741

MS BURKE: It does. That is the list of accredited degrees by the Psychology Board of Australia.

PN5742

JUSTICE HATCHER: While we're on the subject, Ms Burke, and before I forget, can I ask you to turn to the reference to psychologists in the table following paragraph 123 of the April decision.

PN5743

MS BURKE: Yes, which refers to a masters.

PN5744

JUSTICE HATCHER: Yes, but then it says AQF 8. I think that's an error. Does anyone disagree that that should be AQF 9?

PN5745

MS BURKE: No, it should be AQF 9.

PN5746

JUSTICE HATCHER: Thank you. We might correct that.

PN5747

MS BURKE: Yes. Now we say that applying the minimum analysis endorsed by Healthscope and the ADIA would produce in this example a plainly absurd result. It also, we say, puts paid to the submission that minimum qualifications

reflect the intellectual and other demands of the role. If you have hundreds of qualifications at bachelor and masters levels, surely the presence of one diploma cannot be the standard setting, but that is the result that must follow if the entry point is set to the minimum qualification.

PN5748

Finally on this question of minima, I just note that the HPSS Award currently, at clause 17.2, provides for entry at grade 1 at the pay point linked to the qualification held by the employee. No complaint has been made about this by any of the employer parties in the hearing last year, and it just reiterates the point that the industrial practice is to link entry to the profession to the qualification held by the employee. We are not asking for anything other than to maintain the status quo in that regard.

PN5749

Briefly now the table, the translation table, handed up by Healthscope. We don't accept that this table accurately reflects the work done by employees at level 3. It's not at all clear where the words in the 'Role Description' column come from, but it's not the award. If you go to clause A.2.8 of the award, you will see there – this is for level 3 – a health professional at this level would be:

PN5750

*...experienced, able to individually provide professional knowledge and judgment with performing novel, complex or critical tasks specific to the discipline. At this level, they will have additional responsibilities.*

PN5751

It goes on to say:

PN5752

*An employee at this level works in an area that requires high levels of specialist knowledge and skill as recognised by the employer.*

PN5753

A little further down:

PN5754

*Is performing across a number of recognised specialties within a discipline.*

PN5755

And there are other descriptions in level 3, all of which suggests that it's difficult, if not impossible, to see how someone currently classified as level 3 under the award could possibly be reclassified as level 1 under the new arrangements.

PN5756

Finally, there was a submission that Dr Stanford had no component in his report to account for the indirect cost effects of wage increases for health professionals. There are multiple parts of Dr Stanford's report where he explains how he has accounted for indirect effects, and in particular his estimate of award reliance uses three scenarios of 10, 20 and 30 per cent, with the latter being a very high figure which contains a generous allowance for indirect costs effect. The

relevant paragraphs are 58 to 59 and 72, and Dr Stanford's estimate of the average weekly compensation for health professionals is based on the average compensation for the whole population of health professionals, not just award-reliant health professionals, and so again that overstates the starting compensation costs for award-reliant health professionals in Dr Stanford's report, and you can see reference to that in paragraphs 60 and 64.

PN5757

Those are all the matters I need to address in reply.

PN5758

JUSTICE HATCHER: All right. For completeness, we will let any other party say anything further they want to say in reply. Mr Tracey.

PN5759

MR TRACEY: Just one very short matter, your Honour. I understand Mr Lettau is going to provide a note and he's provided this wording in reply. Could we just have the opportunity to respond by way of a note, if we think we need to?

PN5760

JUSTICE HATCHER: How long will you need, Mr Lettau?

PN5761

MR LETTAU: By tomorrow, your Honour.

PN5762

JUSTICE HATCHER: All right. Can you reply by Monday, Mr Tracey?

PN5763

MR TRACEY: Yes, we can, thank you.

PN5764

JUSTICE HATCHER: Yes. All right. Anybody else want to say anything in addition? No?

PN5765

We thank counsel and the other representatives for their submissions. Subject to the receipt of the note and any reply, we reserve our decision and now adjourn.

**ADJOURNED INDEFINITELY**

**[2.53 PM]**