DECISION

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

Gender-based undervaluation – priority awards review
(AM2024/19, AM2024/20, AM2024/21, AM2024/22, AM2024/23)

Social, Community, Home Care and Disability Services Industry Award 2010 **— application for variation by Australian Municipal, Administrative, Clerical and Services Union, The Australian Workers' Union, Health Services Union and United Workers' Union**
(AM2024/25)

Social, Community, Home Care and Disability Services Industry Award 2010 **— application for variation by Australian Municipal, Administrative, Clerical and Services Union**
(AM2024/27)

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

SYDNEY, 16 APRIL 2025

Gender-based undervaluation – priority awards review – Pharmacy Industry Award 2020 – Health Professionals and Support Services Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020 – Children's Services Award 2010 – applications to vary Social, Community, Home Care and Disability Services Industry Award 2010 relating to definition of 'social and community services sector' ('home care loophole') and equal remuneration order and classification structure.

CONTENTS

DEFINITIONS

Defined term	Definition
1969 Equal Pay Case	[1969] CthArbRp 278, 127 CAR 1142
1972 Equal Pay Case	[1972] CthArbRp 1420, 147 CAR 172
1990 Child Care decision	*Re Child Care Industry (Australian Capital Territory) Award 1985; Re Child Care Industry (Northern Territory) Award 1986* [1990] AIRC 996, Print J4316
ABI	Australian Business Industrial
ABS	Australian Bureau of Statistics
ACA	Australian Childcare Alliance
ACCHO	Aboriginal community controlled health organisation
ACCPA	Aged & Community Care Providers Association
ACHA	Adelaide Community Healthcare Alliance
ACT Child Care decision	*Re Australian Liquor, Hospitality and Miscellaneous Workers Union* [2005] AIRC 28, PR954938
ACTU	Australian Council of Trade Unions
Aged Care Award	*Aged Care Award 2010* [MA000018]
Aged Care Nurses decision	*Application by Australian Nursing and Midwifery Federation* [2024] FWCFB 452
AHPRA	Australian Health Practitioner Regulation Agency
Ai Group	The Australian Industry Group
AIN	Assistant in nursing
AIRC	Australian Industrial Relations Commission
AJD	Agreed Joint Document between APESMA and PGA regarding Pharmacy Award, 18 October 2024 (Exhibit PH1)
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industrial Classification
APESMA	The Association of Professional Engineers, Scientists and Managers, Australia
APHA	Australian Private Hospitals Association
AQF	Australian Qualifications Framework
ASU	Australian Municipal, Administrative, Clerical and Services Union
ASU application	Originating application in matter AM2024/27 by ASU

Defined term	Definition
ATSIHW Award	*Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* [MA000115]
AWR	Annual wage review
AWR 2023 decision	*Annual Wage Review 2022–23* [2023] FWCFB 3500, 323 IR 332
AWR 2024 decision	*Annual Wage Review 2023–24* [2024] FWCFB 3500, 331 IR 248
AWU	The Australian Workers' Union
Balnave/Briar Report	Exhibit CS27 (expert report of Associate Professor Nikola Balnave and Dr Celia Briar, filed 11 October 2024)
C10 Metals Framework Alignment Approach	Approach to setting award minimum wage rates described in the *Stage 1 Aged Care decision* at [177]–[178]
C1(a) benchmark rate	The benchmark rate identified in paragraph [204] of the *Stage 3 Aged Care decision*, as adjusted by the *AWR 2024 decision*
Caring Skills benchmark rate	The benchmark rate identified in paragraphs [170] and [172] of the *Stage 3 Aged Care decision*, as adjusted by the *AWR 2024 decision*
Charlesworth Report	Exhibit HPSS112 annexure SC-1 (expert report of Dr Sara Charlesworth)
Cortis/Blaxland Report	Exhibit SCH26 (expert report of Associate Professor Natasha Cortis and Dr Megan Blaxland, 19 April 2024)
CS Award	*Children's Services Award 2010* [MA000120]
CSE	Children's Services Employee (in the CS Award)
DAPA	Dental Assistants Professional Association Incorporated
December note	Pharmacy Industry Award 2020: Data Discrepancy (Information Note, 17 December 2024)
Duckett Report	Exhibit HPSS116 annexure SD-1 (expert report of Dr Stephen Duckett)
ECEC	Early childhood education and care
ECEC Agreement	*Early Childhood Education and Care Multi-Employer Agreement 2024-2026* [2024] FWCFB 455, AE527165
EEH	ABS 'Employee Earnings and Hours, Australia' dataset
ERO	*Social, Community and Disability Services Industry Equal Remuneration Order 2012* PR525485

Defined term	Definition
EST Award	*Educational Services (Teachers) Award 2020* [MA000077]
FW Act	*Fair Work Act 2009* (Cth)
HCW	Home care worker
Health Workers	Aboriginal and/or Torres Strait Islander Health Worker / Aboriginal and/or Torres Strait Islander Community Health Worker employees
HPSS Award	*Health Professionals and Support Services Award 2020* [MA000027]
HSU	Health Services Union
Joint union application	Originating application in matter AM2024/25 by ASU, AWU, HSU and UWU
Jumbunna Report	Literature review undertaken by the Jumbunna Institute for Indigenous Education and Research and University of Technology Sydney Business School examining the intersection of gender-based skills and cultural skills under the ATSIHW Award and the history of the ACCHO sector and domestic and caring work performed by Aboriginal and Torres Strait Islander women
Manufacturing Award	*Manufacturing and Associated Industries and Occupations Award 2020* [MA000010]
NACCHO	National Aboriginal Community Controlled Health Organisation
National Wage Case August 1989	[1989] AIRC 525, 30 IR 81, Print H9100
NDIS	National Disability Insurance Scheme
NSW Commission	New South Wales Industrial Relations Commission
NSWBC	New South Wales Business Chamber
Nurses Award	*Nurses Award 2020* [MA000034]
Paid Rates Review decision	[1998] AIRC 1413, 123 IR 240, Print Q7661
PCA	Phlebotomists Council of Australia
PCW	Personal care worker
PGA	Pharmacy Guild of Australia
Pharmacists Data Profile	Pharmacists and the *Pharmacy Industry Award 2020* (Data Profile, 30 August 2024)
Pharmacy Award	*Pharmacy Industry Award 2020* [MA000012]
Pharmacy decision	*4 yearly review of modern awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621, 284 IR 121

Defined term	Definition
Private Hospitals Group	Jointly-represented group of employer entities comprising the Australian Private Hospitals Association, Catholic Health Australia, Day Hospitals Australia, Healthscope Operations Pty Limited and Adelaide Community Health Care Alliance Incorporated
QIRC	Queensland Industrial Relations Commission
Queensland CSCA Award decision	*Queensland Services, Industrial Union of Employees v Queensland Chamber of Commerce and Industry Limited, Industrial Organisation of Employers and Others* [2009] QIRComm 33, 191 QGIG 19
Queensland Dental Assistants decision	*LHMU v The Australian Dental Association (Queensland Branch) Union of Employers* [2005] QIRComm 139, 180 QGIG 187
Review	This gender-based undervaluation – priority awards review, commenced pursuant to paragraph [171] of the *AWR 2024 decision*
SACS	Social and community services
SACS Equal Remuneration decisions	*Application by ASU & Ors; Application by ABI (Re Equal Remuneration Case)* [2012] FWAFB 1000, 208 IR 446; *Application by ASU & Ors (Re Equal Remuneration Case)* [2012] FWAFB 5184, 223 IR 410
SCHADS Award	*Social, Community, Home Care and Disability Services Industry Award 2010* [MA000100]
SJBP Act	*Fair Work Legislation Amendment (Secure Jobs, Better Pay) Act 2022* (Cth)
Stage 1 Aged Care decision	*Aged Care Award 2010; Nurses Award 2020; Social, Community, Home Care and Disability Services Industry Award 2010* [2022] FWCFB 200, 319 IR 127
Stage 1 Report	Natasha Cortis et al, UNSW Social Policy Research Centre, *Gender-based Occupational Segregation: A National Data Profile* (Final Report, 6 November 2023)
Stage 2 Report	Fair Work Commission, *Stage 2 Report — Gender Pay Equity Research — Annual Wage Review 2023–24* (Report, 4 April 2024)
Stage 3 Aged Care decision	*Aged Care Award 2010; Nurses Award 2020; Social, Community, Home Care and Disability Services Industry Award 2010* [2024] FWCFB 150, 331 IR 137
Teachers decision	*Application by Independent Education Union of Australia* [2021] FWCFB 2051
UWU	United Workers' Union

Defined term	Definition
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

1. INTRODUCTION

1.1 The proceedings the subject of this decision

[1] In the *Annual Wage Review 2023–24* decision[1] (*AWR 2024 decision*), this Commission (constituted as an Expert Panel) determined to undertake a review (Review) on its own initiative pursuant to s 157(3)(a) of the *Fair Work Act 2009* (Cth) (FW Act) of identified classifications in five modern awards. The purpose of the Review is to consider whether the classifications have been the subject of gender-based undervaluation requiring remedy by way of variations under s 157(2) on work value grounds. The Review was formally initiated on 7 June 2024 by way of the constitution of an Expert Panel for pay equity in the care and community sector pursuant to s 620(1D) to conduct the Review and the publication of a statement setting out the subject matter and, provisionally, the issues and timetable for the Review.[2] The classifications in the five awards as identified in the *AWR 2024 decision* (with their matter numbers in the Review), as further articulated and clarified in a statement issued on 20 September 2024,[3] are:

(1) AM2024/19: *Pharmacy Industry Award 2020*[4] (Pharmacy Award) — All pharmacist classifications in clause 16.1 (including pharmacy interns).

(2) AM2024/20: *Health Professionals and Support Services Award 2020*[5] (HPSS Award) — All 'Health Professional' classifications (which are contained in clause 17 and defined in clause A.2 and Schedule B), and the following Support Services employee classifications and indicative roles contained in clause 16 and defined in clause A.1:

- Support Services employee—level 1: Dental assistant (unqualified).
- Support Services employee—level 2: Dental assistant (unqualified).
- Support Services employee—level 3: Laboratory Assistant; Theatre Technician.
- Support Services employee—level 4: Dental assistant (qualified); Dental technician; Orthotic Technician; Pathology Collector; Pathology Technician; Theatre Technician (qualified)
- Support Services employee—level 5: Dental assistant; Orthotic Technician; Pathology Collector; Pharmacy Technician; Theatre Technician.
- Support Services employee—level 6: Anaesthetic Technician; Pathology Collector; Pathology Technician; Pharmacy Technician.

(3) AM2024/21: *Social, Community, Home Care and Disability Services Industry Award 2010*[6] (SCHADS Award) — classifications applying to the occupation of Disabled Carer and other classifications applying to social and community

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1 *Annual Wage Review 2023–24* [2024] FWCFB 3500, 331 IR 248 ('*AWR 2024 decision*').

2 [2024] FWCFB 280.

3 [2024] FWCFB 382.

4 MA000012.

5 MA000027.

6 MA000100.

services (SACS), home care and family day care workers generally as set out in clauses 15–17 and defined in Schedules B, C, D and E.

(4) AM2024/22: *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020*[7] (ATSIHW Award) — Dental Assistant and Dental/Oral Therapist classifications set out in clause 16.1(c).

(5) AM2024/23: *Children's Services Award 2010*[8] (CS Award) — classifications applying to the occupation of Child Carer, namely Children's Services Employee (CSE) classifications set out in clause 14.1 and defined in clause B.1.

[2] On 17 June 2024, an application (matter AM2024/25) was filed by the Australian Services Union (ASU), the Australian Workers' Union (AWU), the Health Services Union (HSU) and the United Workers' Union (UWU) to vary the SCHADS Award. This application (joint union application), as amended, sought a variation to the definition of 'home care sector' in clause 3 of the SCHADS Award to exclude the care of persons with disability. Its purpose was to ensure that employees who provide services funded by the National Disability Insurance Scheme (NDIS) will be entitled to the minimum rates of pay prescribed by clause 15 for SACS employee classifications as defined in Schedule B of the award (to which an equal remuneration order[9] (ERO) providing for an additional pay increment of 23 per cent applies) rather than the minimum rates of pay in clause 17.1 for Home care employees engaged in disability care as defined in Schedule E (to which the ERO does not apply). On 24 June 2024, we determined, contrary to the position of the applicants, that the joint union application should be joined with matter AM2024/21 and heard as part of the Review proceedings.[10] In making this determination, we took into account that the *AWR 2024 decision* had contemplated that, as part of our consideration of potential gender-based undervaluation in the SCHADS Award, there should be a holistic review of the classification structure in that award and that this Review was capable of resolving the problem sought to be addressed by the joint union application.[11]

[3] On 8 July 2024, the ASU lodged a further application (matter AM2024/27) (ASU application) seeking variations to the SCHADS Award in three phases:

(1) The incorporation into Schedules B and C to the SCHADS Award of the ERO rates in respect of the classifications to which the ERO applies and the revocation of the ERO.

(2) Interim variations to the classification definitions in Schedules B and C to incorporate indicative job titles at each level.

(3) Variations to simplify the classification structure and adjust rates of pay to address undervaluation caused by work value changes in the industry since 2012.

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7 MA000115.

8 MA000120.

9 *Social, Community and Disability Services Industry Equal Remuneration Order 2012* PR525485.

10 [2024] FWCFB 291 [8].

11 Ibid.

[4] On 12 August 2024, we determined that the first and second 'phases' of the ASU application would be dealt with together with the Review proceedings and the joint union application given their overlap with the issues in those proceedings, and that the third 'phase' of the ASU application would be stood over generally pending the hearing and determination of those proceedings.[12]

[5] This decision deals with matters AM2024/19, AM2024/20, AM2024/21, AM2024/22, AM2024/23 and AM2024/25, and also matter AM2024/27 to the extent identified above.

1.2 Background to the consideration of gender-based undervaluation

[6] The current consideration of gender-based undervaluation in this Review has arisen principally as a consequence of amendments to the FW Act effected by the *Fair Work Legislation Amendment (Secure Jobs, Better Pay) Act 2022* (Cth) (SJBP Act) which commenced on 7 December 2022. Four amendments are relevant to the subject matter of these proceedings:

(1) section 3(a) now includes the promotion of 'gender equality' as a means by which the object of the FW Act is to be achieved;

(2) the modern awards objective in s 134(1) now includes, at paragraph (ab), a requirement for the Commission to take into account 'the need to achieve gender equality in the workplace by ensuring equal remuneration for work of equal or comparable value, eliminating gender-based undervaluation of work and providing workplace conditions that facilitate women's full economic participation' in ensuring that modern awards, together with the National Employment Standards, provide a fair and minimum safety net of terms and conditions;

(3) section 157(2B) now requires the Commission's consideration of whether there are work value reasons (within the meaning of s 157(2A)) for making a determination under s 157(2) to vary modern award minimum wages to be free of assumptions based on gender and include consideration of whether historically the work has been undervalued because of assumptions based on gender; and

(4) the minimum wages objective in s 284(1) now requires, in paragraph (aa), that the Commission take into account 'the need to achieve gender equality, including by ensuring equal remuneration for work of equal or comparable value, eliminating gender-based undervaluation of work and addressing gender pay gaps' in establishing and maintaining a safety net of fair minimum wages.

[7] The implications of these amendments for modern award wage-fixing were first considered in the *Annual Wage Review 2022–23* decision[13] (*AWR 2023 decision*). In that decision, the Expert Panel said in relation to the amendment to s 284(1) that the new

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[12] [2024] FWCFB 334 [14].

[13] [2023] FWCFB 3500, 323 IR 332 ('*AWR 2023 decision*').

requirement to take into account the elimination of gender-based undervaluation of work in the conduct of the annual wage review (AWR) necessarily required consideration as to whether the existing National Minimum Wage and modern award minimum wage rates constituted a properly-valued and non-gender-biased foundation upon which wage adjustments could be made.[14] The Panel concluded that any issues of unequal remuneration for work of equal or comparable value or gender-based undervaluation relating to modern award minimum wage rates could no longer be left to be dealt with on an application-by-application basis outside the framework of the AWR process and that any issues of this nature that were identified should now be dealt with in the AWR process or in other Commission-initiated proceedings between AWRs.[15]

[8] The *AWR 2023 decision* identified a number of potential issues bearing upon whether minimum wage rates for female-dominated work were equal to minimum wage rates for male-dominated work of equal or comparable value or were based on a valuation of work that was free from gender considerations. In particular, the method of minimum award wage fixation established in the late 1980s (the C10 Metals Framework Alignment Approach) whereby benchmark award rates were set in alignment with or relative to the tradesperson (C10) wage rate in the then-*Metal Industry Award*[16] (Metal Industry Award) was seen as giving rise to two potential difficulties. First, this alignment process once completed foreclosed any retrospective reconsideration of work value in federal awards, meaning that there could not be any review in accordance with contemporary standards of rates of pay in female-dominated awards which may have been influenced by previously prevalent gender-based assumptions about work value. Second, the benchmarks for this alignment process were derived solely from male-dominated occupations and industries, and their application to female-dominated awards may have involved gender-based assumptions about relative work value.[17] The decision also identified a further potential issue, namely that award classifications covering occupations requiring a degree qualification or higher had never been aligned with the C1 rate in the Metal Industry Award, and thus had never been assigned their proper relativity to the C10 rate, as had been intended in the wage-fixing system established in the late 1980s. This was said to have a gender dimension because women are more award-reliant than men, with the proportion of women in the award-reliant workforce being at its highest level at higher-paid classifications including those requiring undergraduate qualifications, and because there is a considerable overlap between the 29 modern awards containing undergraduate classifications and those applying to female-dominated industries.[18] As the Expert Panel observed, these issues had been flagged in a number of recent Full Bench decisions, including the *Pharmacy decision*,[19] the *Teachers decision*[20] and the *Stage 1 Aged Care decision*.[21]

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[14] Ibid [40].

[15] Ibid [120].

[16] *Metal Industry Award 1984* [AW819234], Print F8925, later the *Metal, Engineering and Associated Industries Award, 1998 – Part 1* [AW789529], Print Q2527. Following the award modernisation process before the Australian Industrial Relations Commission, this was replaced by the *Manufacturing and Associated Industries and Occupations Award 2010* [MA000010].

[17] [2023] FWCFB 3500, 323 IR 332 [124].

[18] Ibid [136].

[19] *4 yearly review of modern awards - Pharmacy Industry Award 2010* [2018] FWCFB 7621, 284 IR 121 (‘*Pharmacy decision*’).

[20] *Application by Independent Education Union of Australia* [2021] FWCFB 2051 (‘*Teachers decision*’).

[21] *Aged Care Award 2010; Nurses Award 2020; Social, Community, Home Care and Disability Services Industry Award 2010* [2022] FWCFB 200, 319 IR 127 (‘*Stage 1 Aged Care decision*’).

[9] The Expert Panel concluded that these issues were too broad and complex to be resolved within the limited timeframe of the 2023 AWR and instead determined that a previously foreshadowed research project to identify occupations and industries in which there is gender pay inequity and potential undervaluation of work and qualifications would inform and underpin consideration of gender pay equity issues in future AWRs. The research project was to consist of two stages. Stage 1 was to be an evidence-based process to identify occupations and industries in which gender-based occupational segregation is prevalent, including at the classification level if possible. Stage 2 was to build upon the findings of Stage 1 of the project by reporting on the extent to which the gender-segregated occupations, industries and classifications (including classifications requiring an undergraduate degree or higher qualification) identified in Stage 1 have associated indicia that suggest they may also be subject to gender-based undervaluation. Upon the completion of this research project, it was contemplated that Commission proceedings would be initiated to consider and, if necessary, address the outcomes of the research project.[22]

[10] Stage 1 of the research project commenced after the completion of the 2023 AWR and was conducted by the Social Policy Research Centre at the University of New South Wales. The Stage 1 Report[23] was published on the Commission's website on 15 November 2023. The contents of that report are summarised in the *AWR 2024 decision*.[24] It is sufficient to say for present purposes that the report identified 29 occupations covered by 13 modern awards which are large in size, over 80 per cent female, and located within feminised industry classes. These included Child Carers covered by the CS Award, Medical Technicians covered by the HPSS Award, Dental Assistants covered by the HPSS Award and the ATSIHW Award, Psychologists covered by the HPSS Award, and Aged and Disabled Carers covered by the SCHADS Award. The Stage 1 Report also identified Child Carers, Medical Technicians, Dental Assistants and Aged and Disabled Carers as being occupations that were significantly reliant upon award rates of pay for pay-setting.

[11] Stage 2 of the research project was conducted by the Commission's own research staff, with the report being published on 4 April 2024. The Stage 2 Report[25] examined the history of wage fixation for 12 of the 13 awards covering the highly-feminised occupations identified in the Stage 1 Report. The report identified a number of indicia of gender-based undervaluation in the relevant history of these awards, namely some or all of the following:

- the wage rates had not been the product of a proper work value assessment;
- the classification structure and wage rates had been constructed on the basis of the alignment of a key classification with the C10 rate on the basis of a requirement for an Australian Qualifications Framework (AQF) Level 3 qualification (generally a Certificate III) or equivalent; or

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[22] *AWR 2023 decision* [2023] FWCFB 3500, 323 IR 332 [137]–[139].

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

[24] [2024] FWCFB 3500, 331 IR 248 [92]–[96].

[25] Fair Work Commission, *Stage 2 Report — Gender Pay Equity Research — Annual Wage Review 2023–24* (Report, 4 April 2024).

- wage rates for employees requiring an undergraduate qualification had not been aligned with the C1 rate.

[12] In the *AWR 2024 decision*, the Expert Panel considered which occupations and awards should, in light of the Stage 1 and Stage 2 Reports, be given priority attention in respect of the elimination of potential gender-based undervaluation. The first priority occupation identified was that of Child Carers in Preschool Education and Child Care Services covered by the CS Award. The Expert Panel found, on the basis of the Stage 1 Report, that Child Carers comprised 133,520 employees who are 96–97 per cent female and a majority of whom have their pay rates set in accordance with the CS Award. The Panel also referred to the history of the CS Award outlined in the Stage 2 Report and, in particular, noted that although the work of Child Carers had been the subject of a comprehensive work value assessment in 2005 (in the *ACT Child Care decision*[26]), that assessment had been constrained by the C10 Metals Framework Alignment Approach. The Panel also considered it probable, on the basis of findings made in the *ACT Child Care decision*, that the role of a Child Carer involved the exercise of 'invisible' caring skills of the type considered in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*,[27] and said:[28]

> Without making any finding about the issue at this stage, it is in our view apparent that consideration needs to be given to whether the benchmark rate for female-dominated 'caring' work identified in the *Stage 3 Aged Care decision*… should be applied to the CS Award.

[13] The second priority group the Expert Panel identified was that of disability workers covered by the SCHADS Award, who fell into the occupation of 'Aged and Disabled Carers' considered in the Stage 1 and Stage 2 Reports. Disability workers and aged care workers involved in home care had previously been covered by a single classification stream under the SCHADS Award but, as a result of the aged care work value proceedings, aged care employees had been split off into a separate stream with higher rates of pay. The Expert Panel described this result as 'plainly anomalous'[29], and indicated that there was no reason to believe that findings made in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision* that home care workers (HCWs) in aged care had been the subject of gender-based undervaluation would not apply equally to disability workers in home care. The Panel considered that this anomaly merited priority attention, but also indicated that a wider review of the classifications in the SCHADS Award was called for:[30]

> Indeed, we consider that a broader review of all classifications in the SCHADS Award is timely. As the Stage 2 report demonstrates, the development of the SCHADS Award during the award modernisation process involved an amalgam of provisions from various pre-modern and State awards covering various different parts of the social services sector. This resulted in the SCHADS Award containing three different classification streams, which has itself caused difficulty in the application of the award at the workplace level. This has been exacerbated by

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[26] *Re Australian Liquor, Hospitality and Miscellaneous Workers Union* [2005] AIRC 28, PR954938 ('*ACT Child Care decision*').

[27] *Aged Care Award 2010; Nurses Award 2020; Social, Community, Home Care and Disability Services Industry Award 2010* [2024] FWCFB 150, 331 IR 137 ('*Stage 3 Aged Care decision*').

[28] *AWR 2024 decision* [2024] FWCFB 3500, 331 IR 248 [116].

[29] Ibid [118].

[30] Ibid [119].

> the operation of the ERO rates upon one of the streams and now the application of the aged care wage increases on part of one of the other streams. In our view, consideration needs to be given to whether the classifications in the SCHADS Award can be integrated, or at least aligned, on the basis that the whole of the coverage of the award is female-dominated and is likely to involve the exercise of 'invisible' caring skills. This would require consideration as to whether the ERO rates should be incorporated into the SCHADS Award and the ERO itself revoked.

[14] The third priority area identified was a composite of Medical Technicians, Dental Assistants and Psychologists covered by the HPSS Award and Dental Assistants covered by the ATSIHW Award. The Panel referred to the indicia of gender-based undervaluation in respect of these two awards described in the Stage 2 Report and other potential issues including the possibility of the performance of caring work to some degree and the non-application of the C1 alignment to classifications requiring an undergraduate degree. In this last respect, the Panel indicated that:[31]

> … consideration of the HPSS Award may also need to involve an examination as to whether the professional classifications in that award generally (not just psychologists) should be aligned with the C1 rate in accordance with the methodology adopted in the *Teachers decision* and the *Stage 3 Aged Care decision*.

[15] Finally, although they were not dealt with in detail in the Stage 1 or Stage 2 Reports, the Panel identified pharmacists covered by the Pharmacy Award as constituting a fourth priority area. The Panel referred to a work value issue arising from the fact that degree-qualified pharmacists had never been aligned with the C1 rate in accordance with the C10 Metals Framework Alignment Approach and in fact had a minimum rate of pay that was less than the C3 rate, for an employee holding an Advanced Diploma. This work value issue has gender implications because approximately two-thirds of pharmacists are female.

1.3 The decision

[16] For the reasons which follow, we have determined that:

- pharmacists covered by the Pharmacy Award;
- health professionals, pathology collectors and dental assistants covered by the HPSS Award;
- SACS employees, crisis accommodation employees and home care employees in disability care covered by the SCHADS Award;
- dental assistants and dental/oral therapists covered by the ATSIHW Award; and
- CSEs covered by the CS Award

have been the subject of gender-based undervaluation. We consider that these findings constitute work value reasons justifying the variation of the modern award minimum wage rates applying to each category of employees.

[17] In the case of the Pharmacy Award, we have determined the terms of an award variation to rectify the identified gender-based undervaluation. This will involve a total increase in minimum wage rates of 14.1 per cent, to be implemented in three phases from 30 June 2025,

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[31] Ibid [120].

30 June 2026 and 30 June 2027 respectively. In the case of each of the other awards, we have set out our *provisional* views on appropriate award variations to remedy the gender-based undervaluation we have found to have occurred which, in brief summary are as follows:

(1) For health professional employees covered by the HPSS Award, we propose to establish a new, simplified classification and minimum wage rate structure based on an alignment, for an AQF Level 7-qualified employee with 12 months' service, with the C1(a) benchmark rate identified in paragraph [204] of the *Stage 3 Aged Care decision*, as adjusted by the *AWR 2024 decision* ($1525.90 per week) — see paragraphs [177]–[179].

(2) For pathology collectors covered by the HPSS Award, we propose to re-classify the placement of their indicative roles in the Support Services employees structure to Levels 5, 6 and 7 — see paragraphs [235]–[236].

(3) For dental assistants covered by the HPSS Award, we propose to re-classify the placement of their indicative roles in the Support Services employees structure to Levels 1, 5, 6 and 7 — see paragraphs [289]–[290].

(4) In respect of the SCHADS Award, we propose to abolish the current five separate classification structures and implement a single, simplified classification and wage rate structure based on an alignment with the 'Caring Skills' benchmark rate identified in paragraphs [170] and [172] of the *Stage 3 Aged Care decision*, as adjusted by the *AWR 2024 decision* ($1269.80 per week) for a Certificate III-qualified employee. We also propose to revoke the ERO as part of the implementation of this new classification structure — see paragraphs [392]–[396].

(5) For dental assistants covered by the ATSIHW Award, we propose to abolish the current classification structure and place dental assistants within the existing Health Worker classification structure at Levels 2, 3 and 4. Dental/oral therapists under this award will have a new classification structure which mirrors that which we propose to apply under the HPSS Award for AQF Level 7-qualified employees — see paragraphs [447]–[451].

(6) For CSEs under the CS Award, we propose a new and simplified classification and wage rate structure based on an alignment with the Caring Skills benchmark rate ($1269.80 per week) for a Certificate III-qualified employee. We propose that this be phased in over a period of five years, with a first instalment consisting of a 5 per cent increase to be operative from 1 August 2025 — see paragraphs [557]–[561].

[18] We will afford interested parties an opportunity to be heard in relation to the above *provisional* views, including as to operative date and phasing-in, before we proceed to vary the subject awards. The joint union application to vary the SCHADS Award in matter AM2024/25, and the further application for variations to the award as proposed by the ASU in 'phases' 1 and 2 of matter AM2024/27, are dismissed.

2. GENDER-BASED UNDERVALUATION — CONCEPTS AND PRINCIPLES

[19] The principles applicable to the conduct of this Review, including those pertaining to the proper construction of the applicable provisions of the FW Act and the assessment of the existence of gender-based undervaluation, may be derived from a number of decisions of this Commission, including the *SACS Equal Remuneration decisions*,[32] the *Pharmacy decision*,[33] the *Teachers decision*,[34] the *Stage 1 Aged Care decision*,[35] the *AWR 2023 decision*,[36] the *Stage 3 Aged Care decision*[37] and the *AWR 2024 decision*.[38] Further conceptual guidance may be obtained from the Stage 1 Report and the Stage 2 Report. It is convenient at the outset to set out in a consolidated form the concepts and principles upon which our consideration in this Review will be based.

2.1 The statutory framework

[20] The fundamental purpose of this Review is, first, for the Commission to consider whether the minimum wage rates prescribed by the five subject modern awards in respect of the particular identified occupational groups are founded on a proper, gender-neutral assessment of the value of the work performed by those groups and, second, to vary those award minimum wage rates appropriately if it is found that they do not properly reflect work value for gender-based reasons. The Commission's power to consider variations to modern award minimum wage rates outside of the AWR process is found in s 157(2) of the FW Act, which provides:

> (2) The FWC may make a determination varying modern award minimum wages if the FWC is satisfied that:
>
> (a) the variation of modern award minimum wages is justified by work value reasons; and
>
> (b) making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective.
>
> Note: As the FWC is varying modern award minimum wages, the minimum wages objective also applies (see section 284).

[21] The power under s 157(2) may be exercised by the Commission on its own initiative as well as upon application: s 157(3).

[22] Section 157(2) establishes two prerequisites about which the Commission must be satisfied before it can vary modern award minimum wages under s 157(2). The first, in s 157(2)(a), is that there are 'work value reasons' justifying the variation. The expression 'work value reasons' is defined in s 157(2A) as follows:

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[32] *Application by ASU & Ors; Application by ABI (Re Equal Remuneration Case)* [2012] FWAFB 1000, 208 IR 446; *Application by ASU & Ors (Re Equal Remuneration Case)* [2012] FWAFB 5184, 223 IR 410.

[33] [2018] FWCFB 7621, 284 IR 121.

[34] [2021] FWCFB 2051.

[35] [2022] FWCFB 200, 319 IR 127.

[36] [2023] FWCFB 3500, 323 IR 332.

[37] [2024] FWCFB 150, 331 IR 137.

[38] [2024] FWCFB 3500, 331 IR 248.

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

[23] Because the existence of 'work value reasons' within the meaning of s 157(2A) 'justifying' the variation of modern award minimum wages under s 157(2)(a) is a matter about which the Commission must reach a state of satisfaction, the assessment required will involve an element of subjectivity and is one about which reasonable minds may differ. It may therefore be characterised as requiring the formation of a broad evaluative judgment involving the exercise of a discretion.[39] 'Justifying' in s 157(2)(a) is to be given its ordinary meaning such that the work value reasons must show that the variation of modern award minimum wages is just, right or warranted, or provide a satisfactory reason for the variation.[40] The definition of 'work value reasons' in s 157(2A) requires only that the reasons justifying a variation of modern award minimum wages be 'related to any of the following' matters set out in paragraphs (a)–(c). The expression 'related to' is one of broad import that requires a sufficient connection or association between two subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental. The reasons only need to relate to *any* of the three matters identified in paragraphs (a)–(c) — that is, any one or more of the three matters.[41]

[24] It is significant that s 157(2A) does not contain any requirement for work value reasons justifying the variation of modern award minimum wages to consist of identified *changes* in work value measured from a fixed datum point. In this respect, the subsection differs from the work value change requirement under the previous wage-fixing principles which operated from 1975 to 1981 and 1983 to 2006. Nor does the subsection contain any requirement of the type formerly found in those wage-fixing principles that the change in the nature of the work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification.[42]

[25] Previous Full Bench decisions concerning s 157(2A) have made clear that 'work value reasons' are defined broadly enough in the subsection to allow a wide-ranging consideration of any contention that, for historical reasons and/or on the application of an 'indicia' approach (which we discuss further below), undervaluation has occurred because of gender inequity.[43] This might involve an assessment of whether the work in question had been properly valued in past decisions of the Commission or its predecessors in a way free of gender-based undervaluation and other improper considerations. However, this position has been overtaken by the addition of s 157(2A) to the FW Act as a result of the SJBP Act, which renders the

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[39] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [164]; *Stage 1 Aged Care decision* [2022] FWCFB 200, 319 IR 127 [128], [156].

[40] *Stage 1 Aged Care decision* [2022] FWCFB 200, 319 IR 127 [136]–[137].

[41] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [165]; *Stage 1 Aged Care decision* [2022] FWCFB 200, 319 IR 127 [138], [150]–[155].

[42] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [166]; *Stage 1 Aged Care decision* [2022] FWCFB 200, 319 IR 127 [157]–[166].

[43] *Equal Remuneration Decision 2015* [2015] FWCFB 8200, 256 IR 362 [292]; *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [166].

Commission's consideration of 'work value reasons' under s 157(2A) subject to the requirements of s 157(2B). Section 157(2B) provides:

> (2B) The FWC's consideration of work value reasons must:
> (a) be free of assumptions based on gender; and
> (b) include consideration of whether historically the work has been undervalued because of assumptions based on gender.

[26] In the *Stage 3 Aged Care decision*, the Full Bench made the following observations about the construction and application of s 157(2B):[44]

> Section 157(2B) imposes requirements as to the Commission's 'consideration' of the work value reasons referred to in s 157(2A). 'Consideration' in this context refers to the Commission's decision-making process. Section 157(2B)(a) requires this decision-making process to be 'free of assumptions based on gender'. The FW Act, as amended by the Amending Act, does not define what are 'assumptions based on gender'. This expression has its origins in academic literature concerning gender inequality... For present purposes, we take its meaning in the context of the consideration of 'work value reasons' as being subjective preconceptions and stereotypes derived from cultural and social norms about gender roles, skills and responsibilities. This may include, for example, assumptions that tasks and skills such as caregiving, manual dexterity, human relations and working with children commonly required in female-dominated occupations are inherently female characteristics and as such are of lesser work value than 'hard' tasks and skills performed in male-dominated occupations. Section 157(2B)(a) requires the Commission to exclude considerations of this nature from its decision-making process.
>
> Section 157(2B)(b) requires the Commission, as part of its decision-making process, to 'include consideration' concerning whether 'historically the work has been undervalued because of assumptions based on gender'. The requirement to 'include consideration' may be equated in meaning to statutory requirements to consider, or take into account, or have regard to, specified matters. A requirement of this nature means that the specified matters must, at least, be the subject of active intellectual engagement and given 'proper, genuine and realistic consideration'. In some circumstances, the terms, statutory context and manner of operation of a term requiring that a matter be considered may indicate a requirement that a determination be made or a conclusion formed about the specified matter.
>
> The term 'undervalued' in s 157(2B)(b) is not defined, but the context provided by sub-ss (2) and (2A) of s 157, to which sub-s (2B) relates, makes its intended meaning apparent. Subsection (2) empowers the Commission to vary minimum award wage rates where this is justified by 'work value reasons' and doing so outside the annual wage review process is necessary to achieve the modern awards objective. As earlier stated, sub-s (2A) defines what are 'work value reasons' for the purpose of sub-s (2). It is necessarily implicit in the scheme that, where an adjustment to award rates is considered to be justified for work value reasons, the existing award wage rates do not properly reflect the value of the work to which the work applies. Where the relevant adjustment is by way of an increase to the minimum award wage rates, the existing wage rates may therefore be described as 'undervaluing' the work in question — that is, assigning a minimum wage rate to the work which is less than the rate which would properly remunerate the work in question in accordance with the work value considerations identified in sub-s (2A).

[44] [2024] FWCFB 150, 331 IR 137 [13]–[16].

> In this context, s 157(2B)(b) may therefore be concerned with a requirement to consider whether any undervaluation which is found to exist is 'historical' in nature — that is, has arisen from some past decision, consideration, act or omission of the Commission or relevant predecessor institutions — and has occurred by reason of assumptions based on gender. This aligns with the well-understood industrial concept of gender-based undervaluation whereby the minimum rates in an award have been established based on an undervaluation of the relevant work that has occurred for gender-related reasons.
>
> (citations omitted)

[27] Thus, a gender-neutral consideration of work value, and an assessment of whether there has been historical gender-based undervaluation, are now mandatory elements of the Commission's consideration of 'work value reasons' under ss 157(2)(a) and (2A). In the *Stage 3 Aged Care decision*, the Expert Panel added that the consideration required by s 157(2B) requires the making of findings or the statement of conclusions in respect of each of the matters in paragraphs (a) and (b) of the provision:[45]

> Section 157(2B) has given central importance to gender equality issues in the consideration of award wage increases based on work value considerations. Accordingly, we consider that a transparent process of reasoning and findings which demonstrates the way in which any gender-based assumptions have been dealt with and excluded from consideration of the outcome pursuant to paragraph (a) of the subsection is necessary to achieve the new provision's policy purpose. That would in turn suggest that the consideration required by paragraph (b) must involve an explicit finding as to whether the work in question has historically been undervalued because of gender-based assumptions. Without such findings being made, it will not be demonstrable that gender undervaluation has properly been addressed and that past assumptions about gender have been removed from consideration.

[28] The second requirement for the variation of modern award minimum wages, in s 157(2)(b), is that making the variation outside the AWR system is 'necessary to achieve the modern awards objective'. Section 157(2)(b) is framed in terms consistent with s 138, which provides that a modern award:

> … may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective.

[29] The modern awards objective is set out in s 134(1), which provides:

> (1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:
>
> (a) relative living standards and the needs of the low paid; and
>
> (aa) the need to improve access to secure work across the economy; and
>
> (ab) the need to achieve gender equality in the workplace by ensuring equal remuneration for work of equal or comparable value, eliminating gender-based undervaluation of work and providing workplace conditions that facilitate women's full economic participation; and
>
> (b) the need to encourage collective bargaining; and

[45] Ibid [21].

(c) the need to promote social inclusion through increased workforce participation; and

(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and

(da) the need to provide additional remuneration for:

(i) employees working overtime; or

(ii) employees working unsocial, irregular or unpredictable hours; or

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

(iv) employees working shifts; and

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

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

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

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

[30] The general principles applicable to the interpretation and application of s 134(1) are well-established. They were summarised by a Full Bench in *Applications to vary the Real Estate Industry Award 2020* as follows:[46]

> The modern awards objective is very broadly expressed. It is a composite expression which requires that modern awards, together with the National Employment Standards (NES), provide a fair and relevant minimum safety net of terms and conditions, taking into account the matters in s 134(1)(a)–(h). Fairness in this context is to be assessed from the perspective of the employees and employers covered by the modern award in question. The obligation to take into account the s 134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process. No particular primacy is attached to any of the s 134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award.
>
> It is not necessary to make a finding that the award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of a modern award. Generally speaking, the s 134 considerations do not set a particular standard against which a modern award can be evaluated; many of them may be characterised as broad social objectives. In giving effect to the modern awards objective the Commission is performing an evaluative function taking into account the matters in s 134(1)(a)–(h) and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance.
>
> What is '*necessary*' to achieve the modern awards objective in a particular case is a value judgment, taking into account the s 134 considerations to the extent that they are relevant having regard to the context, including the circumstances pertaining to the particular modern award, the terms of any proposed variation and the submissions and evidence…
>
> (citations omitted)

[46] [2020] FWCFB 3946 [54]–[56].

[31] The mandatory consideration in s 134(1)(ab) was added by the SJBP Act (replacing the now-repealed paragraph (e)). Section 134(1)(b) uses a number of key terms the meaning of which are critical to this Review:

- 'gender equality';
- 'equal remuneration for work of equal or comparable value';
- 'gender-based undervaluation of work'; and
- 'conditions that facilitate women's full economic participation'.

[32] As to 'gender equality', the use of that expression in s 134(1)(ab) is consistent with the SJBP Act's amendment to the object of the FW Act in s 3 whereby the 'promot[ion] of gender equality' has been added as a characteristic of 'workplace relations laws that are fair to working Australians'. The Revised Explanatory Memorandum for the *Fair Work Legislation Amendment (Secure Jobs, Better Pay) Bill 2022* (REM) explained the concept of 'gender equality' by reference to the United Nations *Convention on the Elimination of All Forms of Discrimination against Women* (UN Convention) and the International Labour Organisation *Convention concerning Discrimination in Respect of Employment and Occupation (No 111)* (ILO Convention). In the *AWR 2023 decision*, the Expert Panel referenced the UN Convention and the ILO Convention and said:[47]

> The key concepts which may be derived from the UN Convention and the ILO Convention, as potentially relevant to the Commission's NMW and modern award powers, are ensuring equality as between men and women of employment opportunity (including equality as to the right to work, selection for employment, promotion and access to training) and equality of treatment in employment (including equality as to remuneration and other benefits of employment, and as to the treatment of work of equal value and the evaluation of the quality of work). This is consistent with the statement in paragraph 334 of the REM that the reference to promoting gender equality in s 3(a) recognises the importance of people of all genders 'having equal rights, opportunities and treatment in the workplace and in their terms and conditions of employment, including equal pay'. On its ordinary meaning, the expression 'gender equality', once placed in the framework of workplace relations established by the chapeau to s 3 and the overall subject matter of the FW Act, comfortably carries the connotations which may be derived from the UN Convention, the ILO Convention and the REM.

[33] In s 134(1)(ab), the achievement of gender equality 'in the workplace' is identified as the overarching 'need' which must be taken into account in connection with the provision of a fair and relevant safety net of terms and conditions, with 'ensuring equal remuneration for work of equal or comparable value', 'eliminating gender-based undervaluation of work' and 'providing conditions that facilitate women's full economic participation' constituting means by which this overarching 'need' may be met. The expression 'equal remuneration for work of equal or comparable value' is defined in sub-s (2) of s 302, which section is concerned with the separate scheme for the making of equal remuneration orders, to mean 'equal remuneration for men and women workers for work of equal or comparable value'. This definition applies to the use of the expression in s 134(1)(ab) (as well as in s 284(1)(aa), which we discuss further

[47] [2023] FWCFB 3500, 323 IR 332 [36].

below).[48] Subsections (3A), (3B) and (3C) of s 302, which were added to the FW Act by the SJBP Act, go on to provide:

> (3A) For the purposes of this Act, in deciding whether there is equal remuneration for work of equal or comparable value, the FWC may take into account:
> (a) comparisons within and between occupations and industries to establish whether the work has been undervalued on the basis of gender; or
> (b) whether historically the work has been undervalued on the basis of gender; or
> (c) any fair work instrument or State industrial instrument.
> (3B) If the FWC takes into account a comparison for the purposes of paragraph (3A)(a), the comparison:
> (a) is not limited to similar work; and
> (b) does not need to be a comparison with an historically male-dominated occupation or industry.
> (3C) If the FWC takes into account a matter referred to in paragraph (3A)(a) or (b), the FWC is not required to find discrimination on the basis of gender to establish the work has been undervalued as referred to in that paragraph.

[34] It is doubtful whether the above provisions apply directly to s 134(1)(ab) (or s 284(1)(aa)) because, unlike s 302 itself, the modern awards objective (and the minimum wages objective) do not in terms require the Commission to 'decide whether' there is equal remuneration for work of equal or comparable value. Nevertheless, these provisions at least guide the analytical approach to be taken in assessing whether there is, in a given case, equal remuneration for work of equal or comparable value, and indicate an intersection with the concept of 'gender-based undervaluation'. In the context of s 134(1)(ab), 'ensuring' equal pay for work of equal or comparable value — that is, guaranteeing it or making it certain — is one of the means to achieve gender equality in the workplace.

[35] We have discussed the concept of 'gender-based undervaluation' in connection with s 157(2B) above. It is a well-established industrial concept which, in the award context, refers to a situation where minimum rates in an award have been established on the basis of an undervaluation of the relevant work that has occurred for gender-related reasons. In s 134(1)(ab), 'eliminating' — that is, completely removing — gender-based undervaluation is the second of the three identified means for the achievement of gender equality in the workplace. The third means, 'providing workplace conditions that facilitate women's full economic participation', is of less relevance to this Review since it relates to terms of employment other than rates of pay, such as flexible working hours, access to stable part-time employment and special types of leave such as family and domestic violence leave.[49]

[36] As the note to s 157(2) reminds, s 284(2)(b) provides that the minimum wages objective in s 284(1) applies to the variation of modern award minimum wages under s 157. The relevant effect of s 138 is that modern award terms relating to minimum wages must be necessary to achieve the minimum wages objective. Section 284(1) provides:

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[48] *Annual Wage Review 2017–18* [2018] FWCFB 3500, 279 IR 215 [34]; *AWR 2023 decision* [2023] FWCFB 3500, 323 IR 332 [31].

[49] *AWR 2023 decision* [2023] FWCFB 3500, 323 IR 332 [41].

> (1) The FWC must establish and maintain a safety net of fair minimum wages, taking into account:
>
> (a) the performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and
>
> (aa) the need to achieve gender equality, including by ensuring equal remuneration for work of equal or comparable value, eliminating gender-based undervaluation of work and addressing gender pay gaps; and
>
> (b) promoting social inclusion through increased workforce participation; and
>
> (c) relative living standards and the needs of the low paid; and
>
> (e) providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability.
>
> This is the ***minimum wages objective***.

[37] The general approach to be taken to the interpretation and application of the minimum wages objective is broadly the same as for the modern awards objective as set out in paragraphs [29]–[30] above. Paragraph (aa) of s 284(1) was added to the section by the SJBP Act, and replaced the now-repealed paragraph (d). Section 284(1)(aa) is in similar terms to s 134(1)(a) except that the third identified means of achieving gender equality is 'addressing gender pay gaps' (rather than 'providing workplace conditions that facilitate women's full economic participation' which, as earlier stated, do not relate to rates of pay). This concept was explained in the *AWR 2023 decision* as follows:[50]

> The term 'gender pay gap' refers to the 'difference in the earnings of men and women'. The gender pay gap can be measured in different ways and in different workforce segments, giving rise to the notion of gender pay *gaps* (e.g. adult average weekly ordinary time earnings; adult average weekly full time earnings including overtime and bonuses, average weekly total earnings; hourly earnings, industry pay gap or occupation pay gap). It is usually expressed either as a ratio of female to male wages (e.g. females earn 87 per cent of male wages) or the difference between male and female wages (e.g. 13 per cent)…
>
> (citations omitted)

[38] The significance of modern award minimum wage rates for gender pay gaps is the position, both historically and currently, that women are significantly more likely to be paid at the award rate than men are at all levels of the award structure, that workers paid at the award rate are much more likely to be low-paid than are other workers, and that, at least at the highest classifications in awards, women are heavily over-represented among those who are paid at the award rate.[51] Thus, increases to modern award minimum wage rates, particularly for awards which apply to female-dominated occupations and industries, are likely to disproportionately benefit women, have some positive effect on gender pay gaps and thus 'address' them to that extent.

2.2 Historical gender-based undervaluation in the federal award system

[39] The *Stage 3 Aged Care decision* contains a lengthy analysis of the way in which, historically, gender-based assumptions have become embedded in award minimum wage-setting in the federal industrial relations system. It is not necessary to repeat that analysis

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[50] Ibid [111].

[51] Ibid [43].

here in full, but it is necessary to reiterate some of the matters most closely bearing on the awards under consideration in this Review.

[40] In the first historical phase of federal award-making, from 1906 to 1967, award wage rates consisted of two elements: the basic wage and margins for skill. The basic wage overtly discriminated against women, in that a lower basic wage was set for female-dominated industries and occupations than for male ones based on then-prevailing socio-economic assumptions about gender roles and family composition. The female basic wage was initially set at about 54 per cent of the male basic wage, but this had risen to about 75 per cent by the time that the basic wage and margin structure was replaced by the 'total wage' in 1967. Margins for skill were ostensibly set on a gender-neutral basis but were nonetheless affected by assumptions based on gender. In particular, unlike skills typically exercised in male-dominated occupations and industries, many of the skills exercised in what was referred to as 'women's work' or 'work suitable to women' were not recognised or properly valued as skills as such but rather treated as gender-specific traits having a lower value than 'male' skills. In addition, because so many awards in this era were made by consent in settlement of interstate industrial disputes, the basis upon which margins were set is often not transparent. However, it is clear that the extent of union bargaining power, in an era of male-dominated and -led unions, heavily influenced bargained outcomes which were put into effect as award rates of pay.

[41] The establishment of the 'total wage' in 1967 initially served only to import the lower female basic wage into the new total wage rates set by awards. However, the 'total wage' model fatally undermined the rationale for lower female award wage rates. The *1969 Equal Pay Case*[52] brought an end to the historical phase of overt gender discrimination within awards arising from the original basic wage concept by establishing the principle of equal pay for equal work. Under this principle, gender-based differences in pay rates within awards for work of the same or like nature and of equal value which had arisen from historical basic wage differentials were to be abolished. However, the *1969 Equal Pay Case* did not address gender differentials in pay rates between different awards or in awards covering female-dominated work, or historical gender disparities in margins.

[42] The *1972 Equal Pay Case*[53] took the further step of introducing the principle of 'equal pay for work of equal value', under which award rates for all work were to be considered without regard to the sex of the employee. This new principle was to be implemented by agreement or arbitration and, where arbitration was required, it was contemplated that there should be work value inquiries which, in the case of female-dominated areas of work, might involve comparisons of work value between female classifications within an award, comparisons of work value between female classifications in different awards, or comparisons with male classifications in other awards.

[43] The principle established by the *1972 Equal Pay Case* was only ever implemented in part. Remaining awards containing overtly-discriminatory wage rates arising from previous gender-based differences in margins were for the most part remedied pursuant to the principle. However, there is little evidence that the more complex task of properly valuing work in awards covering female-dominated occupations and industries was ever undertaken. Rather, the

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[52] [1969] CthArbRp 278, 127 CAR 1142.

[53] [1972] CthArbRp 1420, 147 CAR 172.

implementation of the principle of equal pay for work of equal value was overtaken by other events — principally, the high-inflation period which began in about 1974 and extended into the 1980s, and the 'wages explosions' of 1973–75 and 1980–82. In response to this, wage-fixing principles were established and applied from 1975 to 1981 and, after an interval in which a further 'wages explosion' occurred, from 1983 until 2006. These wage-fixing principles sought to strictly limit the capacity to obtain wage increases through the award system. In respect of claims based on work value, the principles limited the consideration of these to *changes* in work value from identified points in time, thus preventing any wholesale review of whether award rates had been based on a proper, gender-neutral valuation of the relevant work in the first place. From 1983 until 1991, the datum point for any work value claim was the last work value adjustment affecting the relevant award but in no case earlier than 1 January 1978. Although the 'equal pay for work of equal value' principle established in the *1972 Equal Pay Case* was never formally abolished, it was not incorporated in the wage-fixing principles, and the fundamental work value reassessments contemplated by the *1972 Equal Pay Case* were not permitted except through the very restricted 'Anomalies and Inequities' mechanism.

[44] The modern era in award wage fixation can be said to have commenced in 1989. In the *National Wage Case February 1989 Review*[54] and the *National Wage Case August 1989*,[55] the Australian Industrial Relations Commission (AIRC) established a process to systematise wage rates across federal awards as part of a broader 'structural efficiency' process to modernise awards. This would involve establishing award classification and wage rate structures 'on the basis of relative skill, responsibility and the conditions under which the particular work is normally performed', but with relativities 'consistent with the rates and relativities fixed for comparable classifications in other awards'. The organising principle for this process was the establishment of a relativity with the standard award rate, fixed in the *National Wage Case August 1989*, for a metal industry tradesperson and a building industry tradesperson. This process was described in the *Stage 3 Aged Care decision* as follows:[56]

> The approach determined by the AIRC thus locked in as its integral element the tradespersons' rate in the male-dominated metal and building industries... In the new 14-level classification structure introduced into the then *Metal Industry Award 1984* (Metal Industry Award) on 20 March 1990 pursuant to the structural efficiency principle, the metal industry tradesperson's classification was designated as 'C10' and contained a requirement that the employee hold a recognised trade certificate or a relevant Certificate III qualification under the Australian Qualifications Framework (AQF). All other classifications in the Metal Industry Award were assigned a percentage relativity to the C10 rate of pay. The approach of establishing across-award alignments with the C10 rate was referred to in the [*Stage 1 Aged Care decision*] as the 'C10 Metals Framework Alignment Approach'. The process of varying awards to establish such alignments was known as the 'minimum rate adjustment' (MRA) process.
>
> (citations omitted)

[45] The new classification structure in the Metal Industry Award (C10 Metals Framework) introduced in 1990 identified for each classification wage rate its percentage relativity to the C10 rate. That classification structure and the percentage relativities remain in the modern award successor to the Metal Industry Award, the *Manufacturing and Associated Industries*

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[54] [1989] AIRC 345, 27 IR 196, Print H8200.

[55] [1989] AIRC 525, 30 IR 81, Print H9100.

[56] [2024] FWCFB 150, 331 IR 137 [80].

and Occupations Award 2020[57] (Manufacturing Award) at clause A.3.1. However, these are no longer the actual relativities between the current wage rates in the Manufacturing Award because the practice of awarding flat dollar-amount increases in national wage decisions which prevailed from 1993 to 2010 had the effect of compressing the relativities. The original and current relativities for key classifications in the C10 Metals Framework are as follows (noting that the current relativities for the C1 classification are notional, for reasons which will be explained):

Classification	**Minimum training requirement**	**Original relativity to C10 (%)**	**Current relativity to C10 (%)**
C1	Degree	(b) 210 (a) 180	(b) 167 (a) 147.8
C2	Advanced diploma	(b) 160 (a) 150	(b) 135.2 (a) 129.6
C5	Diploma	130	117
C7	Certificate IV/advanced certificate	115	109.1
C10	Certificate III/trade certificate	100	100
C11	Certificate II	92.4	95
C14	Entry level	78	86.4

[46] As explained in the *Stage 3 Aged Care decision*, the model of award wage fixation which prevailed from the *National Wage Case August 1989* until 2006, when the *Workplace Relations Amendment (Work Choices) Act 2005* (Cth) (Work Choices Act) took effect, embedded gender-based undervaluation in four fundamental ways:

(1) The use of the C10 tradesperson's rate as the lodestar for wage fixation across all awards entrenched masculinist assumptions about work value into the system. The rates of pay in the Metal Industry Award, including the tradesperson's rate, had their ultimate origin in the *1921 Metals decision*[58] and their more immediate origin in the 1967 *Metal Trades Award Work Value Inquiry decision*.[59] These rates were fixed on the basis of a male standard of work value that focused on traditional technical or 'hard' skills in industry and was not apt to properly recognise or value the type of skills, including caring, 'soft' or 'invisible' skills, characteristic of feminised occupations and industries. Thus, the adoption of the C10 benchmark involved a gendered assumption about work value.

(2) As originally conceived in the *National Wage Case August 1989*, the C10 Metals Framework Alignment Approach was not intended to operate mechanistically so as to *mandate* that wages for employees with qualifications equivalent to C10 must be equal to the C10 wage rate, nor did it require equivalency of qualifications to be the only means for considering appropriate relativities. As stated above, it allowed for relative skill, responsibility and the conditions under which the particular work is normally performed to be taken into account. This, in theory, allowed for departures from an automatic alignment with the C10 rate for work which required skills which were not characteristic of a tradesperson in the metals

[57] MA000010.

[58] *Amalgamated Society of Engineers and The Adelaide Steam-ship Company Limited* [1921] CthArbRp 57, 15 CAR 297.

[59] *Metal Trades Employers' Association & Ors re Metal Trades Award, 1952* [1967] CthArbRp 1144, 121 CAR 587.

or building industry. However, in practice, the implementation of the C10 Metals Framework Alignment Approach usually involved no more than identifying the 'key classification' in any award as that for which a Certificate III qualification under the AQF, or the equivalent, was required and then aligning that with the C10 classification rate in the Metal Industry Award. This was most commonly done in consent arrangements by which the structural efficiency principle was implemented. This mechanistic approach was articulated in the principles established for the proper fixation of minimum award rates of pay in the 1998 *Paid Rates Review decision*[60] of a Full Bench of the AIRC, and further entrenched the gender-based assumptions of the C10 Metals Framework Alignment Approach.

(3) The C1 classification rate's relativity to the C10 rate for degree-qualified workers which formed part of the C10 Metals Industry Framework was never implemented in practice since, for the most part, classifications for such workers were set at a significantly lower relativity. To illustrate this, the classification structure in clause A.3.1 of the Manufacturing Award notionally retains the C1 classifications for degree-qualified professional engineers and scientists and refers to the original relativities of 180/210 per cent. However, clause 20.1 of the Manufacturing Award, which prescribes minimum wage rates, contains no wage rate for the C1 classification. The minimum wage rates for professional engineers and scientists are in fact located in the *Professional Employees Award 2020*.[61] The annual rate of pay for a three-, four- or five-year degree-qualified professional engineer or scientist in their second year of 'practical professional experience' prescribed by clause 14.1 of this award, once converted to a weekly rate, bears a relativity of approximately 119.4 per cent to the C10 rate. This is significantly lower than both the originally intended relativities of 180–210 per cent, and the notional current relativities of 147.8–167 per cent which may be calculated taking into account the flat dollar amount wage increases which occurred from 1993 to 2010. As explained in the *AWR 2023 decision* at [136], this failure to implement the C1 relativity, even on a *prima facie* basis, disadvantaged female workers and failed to properly value their work because, first, women are more award-reliant than men, with the proportion of female award-reliance being at its largest at higher-paid award classifications including those requiring undergraduate qualifications and, second, there is a considerable overlap between those awards containing classifications requiring an undergraduate degree and those applying to female-dominated industries.

(4) From the *National Wage Case August 1989* up until their disappearance in 2006 following the commencement of the Work Choices Act, the wage-fixing principles continued to restrict claims for higher wages based on work value to those based on *changes* to work value from a fixed datum point, being the completion of the structural efficiency exercise required for each award by that decision. That effectively foreclosed any *ab initio* consideration of whether the

[60] [1998] AIRC 1413, 123 IR 240, Print Q7661.

[61] MA000065.

> minimum wage rates in any award had been properly set in the first place based upon an assessment of work value free of gender-based assumptions.

[47] The current (modern) awards of the Commission were made during the award modernisation process conducted by a Full Bench of the AIRC during 2008–2009 pursuant to Part 10A of the *Workplace Relations Act 1996* (WR Act). In that process, the AIRC was required to construct a streamlined set of 'modern' federal awards to replace some thousands of pre-existing federal and State awards. In theory, as stated in the *Stage 3 Aged Care decision* at [95], the award modernisation process was not constrained by the previous wage-fixing principles and could have involved a full *ab initio* work value assessment of any female-dominated occupation or industry that was to be the subject of a modern award. However, two constraints meant that this was simply not a feasible proposition. The first was the timeframe in which the process had to be conducted. Section 576C of the WR Act required the AIRC to conduct the award modernisation process in accordance with a written request (the 'award modernisation request') made by the Minister for Employment and Workplace Relations to the AIRC. The then-Minister's award modernisation request, which was initially issued on 28 March 2008, required the process to be completed by 31 December 2009. The scale of the task required meant that it was never practicable for the AIRC Full Bench which conducted the process to engage in work value hearings or inquiries in the course of making modern awards. The second constraint was that the award modernisation request stated an intention that the creation of modern awards was not to disadvantage employees, nor increase costs for employers. That effectively precluded the AIRC Full Bench from making significant changes to existing wage rates (although some changes had to be made to achieve, subject to transitional provisions, uniform national rates of pay for certain occupations and industries). In the *Stage 3 Aged Care decision*, the Full Bench characterised what occurred in actuality as a result of these (and other) constraints as follows:[62]

> In practice, the classifications and rates of pay in most major modern awards were based on a precursor federal award, or in some cases a State award, and where the C10 Metals Framework Alignment Approach had previously been applied, this was retained. In some cases, as we discuss below, it was applied for the first time. This meant that, to the extent that gender biases had historically been embedded in federal awards for all the reasons we have earlier discussed, this generally migrated into the modern award system.

2.3 Identification and rectification of gender-based undervaluation in awards

[48] The first attempt to reinvigorate the elimination of gender-based undervaluation in award wage-fixing following the historical failure to properly implement the 'equal pay for work of equal value' principle established in the *1972 Equal Pay Case* occurred in the New South Wales industrial relations jurisdiction. In 1998, the NSW Industrial Relations Commission (Glynn J) published the landmark *Pay Equity Inquiry Report*[63] pursuant to a statutory request from the then-NSW Minister for Industrial Relations to inquire into and report upon a range of identified gender pay equity issues. Two matters addressed in the *Pay Equity Inquiry Report* may be highlighted. The first is that Glynn J articulated a new approach for the

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[62] [2024] FWCFB 150, 331 IR 137 [95].

[63] *Pay Equity Inquiry: Reference by the Minister for Industrial Relations Pursuant to Section 146(1)(d) of the Industrial Relations Act 1996* (Report to the NSW Minister for Industrial Relations, Matter No. IRC6320 of 1997, 14 December 1998).

identification of gender-based undervaluation which was not dependent on the demonstration of discrimination but rather operated by reference to certain 'indicia':[64]

> On the basis of the selected industries and occupations, it would seem that a profile which, prima facie, could indicate the possibility, or even the probability, of an undervaluation of work based on gender, would include the following elements:
>
> - female dominated;
> - female characterisation of work;
> - often no work value exercise conducted by the Commission;
> - inadequate application of equal pay principles;
> - weak union;
> - few union members;
> - consent award/agreements, and
> - large component of casual workers;
> - lack of, or inadequate recognition of, qualifications (including misalignment of qualifications);
> - deprivation of access to training or career paths;
> - small workplaces;
> - new industry or occupation;
> - service industry;
> - home based occupations.

[49] The second was that Glynn J recommended that, as part of its wage-fixing principles, the NSW Commission should establish a new 'Equal Remuneration principle' to facilitate claims to vary awards to rectify gender-based undervaluation. The NSW Commission took up this recommendation in *Re Equal Remuneration Principle*[65] in 2000. In that decision, it established a new 'Equal Remuneration and Other Conditions' principle which included the following key provisions:[66]

> (a) Claims may be made in accordance with the requirements of this principle for an alteration in wage rates or other conditions of employment on the basis that the work, skill and responsibility required or the conditions under which the work is performed have been undervalued on a gender basis.
> (b) The assessment of the work, skill and responsibility required under this principle is to be approached on a gender[-]neutral basis and in the absence of assumptions based on gender.
> (c) Where the undervaluation is sought to be demonstrated by reference to any comparator awards or classifications, the assessment is not to have regard to factors incorporated in the rates of such other awards which do not reflect the value of work, such as labour market attraction or retention rates or productivity factors.
> (d) The application of any formula, which is inconsistent with a proper consideration of the value of the work performed, is inappropriate to the implementation of this principle.
> (e) The assessment of wage rates and other conditions of employment under this principle is to have regard to the history of the award concerned.
> …
> (g) In applying this principle, the Commission will ensure that any alteration to wage relativities is based upon the work, skill and responsibility required, including the conditions under which the work is performed.

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[64] Ibid vol 1 46–47.

[65] [2000] NSWIRComm 113, 97 IR 177.

[66] Ibid [158].

> (h) Where the requirements of this principle have been satisfied, an assessment shall be made as to how the undervaluation should be addressed in money terms or by other changes in conditions of employment, such as reclassification of the work, establishment of new career paths or changes in incremental scales. Such assessments will reflect the wages and conditions of employment previously fixed for the work and the nature and extent of the undervaluation established.
> (i) Any changes made to the award as the result of this assessment may be phased in and any increase in wages may be absorbed in individual employees' overaward payments. …

[50] Since the above principle was established, there have been successful cases advanced in the NSW Commission to rectify gender-based undervaluation in respect of librarians and archivists,[67] child care workers[68] and school administrative and support staff.[69]

[51] A similar approach was taken in the Queensland industrial relations jurisdiction shortly afterwards. In 2001, the Queensland Industrial Relations Commission (QIRC) (Fisher C) published its own pay equity report, *Worth Valuing: A Report of the Pay Equity Inquiry*.[70] In this report, Commissioner Fisher endorsed the 'indicia' approach of Glynn J and recommended the establishment of a new pay equity principle. The report also contained a case study relating to dental assistants which identified, among other things, that they exercised 'soft' skills which had not previously been considered in respect of dental assistants' work value. The report also concluded that the analysis of award histories was useful to understand the position of the occupation in question.

[52] In 2002, a Full Bench of the QIRC formally declared, by consent, a new 'Equal Remuneration Principle'[71] consistent with the recommendations of Fisher C. Importantly, this principle incorporated in its provisions the 'indicia' approach, the desirability of historical award analysis and the need to inquire about the existence of feminised or 'soft' skills. Clause 6 of the principle stated:

> In assessing the value of the work, the Commission is to have regard to the history of the award including whether there have been any assessments of the work in the past and whether remuneration has been affected by the gender of the workers. Relevant matters to consider may include:
>
> (a) whether there has been some characterisation or labelling of the work as 'female';
> (b) whether there has been some underrating or undervaluation of the skills of female employees;
> (c) whether remuneration in an industry or occupation has been undervalued as a result of occupational segregation or segmentation;
> (d) whether there are features of the industry or occupation that may have influenced the value of the work such as the degree of occupational segregation, the disproportionate representation of women in part-time or casual work, low rates of unionisation, limited

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[67] *Re Crown Librarians, Library Officers and Archivists Award Proceedings - Applications under the Equal Remuneration Principle* [2002] NSWIRComm 55, 111 IR 48.

[68] *Re Miscellaneous Workers Kindergartens and Child Care Centres etc (State) Award* [2006] NSWIRComm 64, 150 IR 290.

[69] *Re Crown Employees (School Administrative and Support Staff) Award* [2019] NSWIRComm 1082.

[70] *Worth Valuing: A Report of the Pay Equity Inquiry* (Report to the Queensland Minister for Employment, Training and Industrial Relations, Case No B1568 of 2000, 30 March 2001).

[71] (2002) 114 IR 305.

representation by unions in workplaces covered by formal or informal work agreements, the incidence of consent awards or agreements and other considerations of that type; or

(e) whether sufficient and adequate weight has been placed on the typical work performed and the skills and responsibilities exercised by women as well as the conditions under which the work is performed and other relevant work features.

[53] The Queensland Equal Remuneration Principle was subsequently applied in cases concerning dental assistants[72] (*Queensland Dental Assistants decision*), child care workers,[73] community services workers[74] (*Queensland CSCA Award decision*) and disability support workers.[75] We discuss the *Queensland Dental Assistants decision* in greater detail later in this decision. It is sufficient to note for present purposes that the decision contained an analysis of the relevant award history, followed the 'indicia' approach and relied upon an identification of 'soft' skills exercised by dental assistants.

[54] In the federal jurisdiction, aspects of this new approach to gender-based undervaluation were applied for the first time in the two *SACS Equal Remuneration decisions* in 2012. These decisions concerned an application for an equal remuneration order under s 302 of the FW Act in respect of SACS and crisis accommodation workers rather than an application for variation to the minimum wage rates in the award which applied to them (the SCHADS Award). Nonetheless, the decisions involved an assessment by a Full Bench of the Commission of the value of the work under consideration including consideration of whether the 'caring' nature of the work meant that the skills and experience required were 'disguised' or 'invisible' and thus not properly valued. The Full Bench also considered the 'indicia' approach, which it applied in some respects but rejected in others. Importantly, in respect of awards made by consent (that is, without there having been an arbitrated work value assessment, the Full Bench said:[76]

> We do not regard the prevalence of consent awards and agreements as indicative, at least in the federal system, of gender-based undervaluation. Given the encouragement provided by legislative policy to consent arrangements and their prevalence in the workplace relations system, there is no reason, nor is there any firm basis in the evidence, to conclude that such arrangements are more likely than not to indicate gender-based undervaluation.

[55] The new approach established in the NSW Commission and the QIRC was adopted more firmly in four award work value decisions issued by this Commission in recent years. The first of these was the *Pharmacy decision* of 2018, which concerned a claim for an increase to the wage rates for pharmacists under the Pharmacy Award on work value grounds. We discuss this decision further below. For present purposes, although the case was not advanced or determined through the lens of gender, it identified for the first time that the failure to apply the C1 classification relativity under the C10 Metals Framework to pharmacists' award wage rates potentially constituted a work value consideration.[77] This same issue arose again in the 2021

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[72] *LHMU v The Australian Dental Association (Queensland Branch) Union of Employers* [2005] QIRComm 139, 180 QGIG 187.

[73] *LHMU v Children's Services Employers Association* [2006] QIRComm 50, 181 QGIG 568.

[74] *Queensland Services, Industrial Union of Employees v Queensland Chamber of Commerce and Industry Limited, Industrial Organisation of Employers and Others* [2009] QIRComm 33, 191 QGIG 19.

[75] *AWU v Queensland Community Services Employers Association Inc*. [2009] QIRComm 69, 192 QGIG 46.

[76] [2012] FWAFB 1000, 208 IR 446 [255].

[77] [2018] FWCFB 7621, 284 IR 121 [190]–[198].

Teachers decision, which concerned (among other things) an application for an increase to wage rates for teachers covered by the *Educational Services (Teachers) Award 2020*[78] (EST Award) on work value grounds. In that matter, the work value case was firmly advanced on grounds which included that teachers' work, which was predominantly undertaken by women, had been undervalued due to assumptions based on gender. The Full Bench did not make a specific finding of gender-based undervaluation since the applicant's case was primarily advanced as one concerned with work value change occurring from an identified datum point. Nevertheless, the Full Bench did make, in addition to a finding that work value change had occurred, the following finding:[79]

> The rates for teachers under the EST Award and its federal predecessors have never been fixed on the basis of a proper assessment of the work value of teachers nor are they properly fixed minimum rates. In particular, the rates of pay do not recognise that teachers are degree-qualified professionals and accordingly do not have an appropriate relativity with the Metal Industry classification structure.

[56] In setting new rates of pay for teachers under the EST Award which properly reflected work value, the Full Bench said:[80]

> We consider that a new classification structure should be established which is anchored upon the professional career standards established by the [Australian Professional Standards for Teachers] and is tied to teacher registration (where applicable). The key classification, in our view, would be a Proficient Teacher who has a degree and has obtained registration (or, in the case of an early childhood teacher, if registration is not yet required in their jurisdiction, has met the requirements for registration as if they applied). A teacher at that level is fully qualified and capable of exercising the skills and discharging the responsibilities of the profession in an entirely unsupervised and autonomous way. In reaching this conclusion, we accept the submission made by the [Australian Federation of Employers and Industries] that a graduate teacher will not be the appropriate anchor classification for fixing wage rates because at that level the skills and responsibilities of the profession are not yet being fully exercised, as is recognised in the national registration system requirements.
>
> We consider that the appropriate alignment of this Proficient Teacher classification would be with Level C1(a) in the Metal Industry classification structure. As set out in the table… above, the notional salary for the classification C1(a) at the compressed relativity of 148 percent compared to C10 is $1297.20 per week (or $67,688 per year). … In our assessment this would produce a properly fixed rate of pay for a Proficient Teacher that properly takes into account the work value attaching to the practice of the teaching profession at that level.

[57] The proper approach to the identification and rectification of gender-based undervaluation has been most clearly articulated in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. In the *Stage 1 Aged Care decision*, the Full Bench identified, on the basis of expert evidence, historical barriers to the proper assessment of work value in female-dominated industries and occupations arising from the approach taken by Australian industrial tribunals. These included:[81]

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[78] MA000077.

[79] [2021] FWCFB 2051 [645].

[80] Ibid [653]–[654].

[81] [2022] FWCFB 200, 319 IR 127 [758].

(i) The requirement for tribunals to make an adjustment to minimum rates based only on a change in work value has meant that there has been a limited capacity to address what may have been errors and flaws in the setting of minimum rates for work in female dominated industries and occupations. These limitations in the capacity of tribunals to properly value the work arise because any potential errors in the valuation of the work may have predated the last assessment of the work by the tribunals.

(ii) Errors in the valuation of work may have arisen from the female characterisation of the work, or the lack of a detailed assessment of the work. The time frame or datum point for the measurement of work value which limit assessment of work value to changes of work value, or changes measured from a specific point in time mitigated against a proper, full-scale assessment of the work free of assumptions based on gender.

(iii) The capacity to address the valuation of feminised work has also been limited by the requirement to position that valuation against masculinised benchmarks. Work value comparisons continued to be grounded by a male standard, that being primarily the classification structure of the metal industry awards and to a lesser extent a suite of building and construction awards.

(citations omitted)

[58] The Full Bench also emphasised in its findings the importance of the proper identification of 'invisible' or 'soft' skills exercised by workers in feminised occupations and industries which have not previously been recognised in assessments of work value. The Full Bench firmly rejected the proposition that the exercise of emotional intelligence, emotion management, empathy, communication and interpersonal skills, and flexibility and resilience in response to rapidly evolving and distressing work situations were not work skills that needed to be assigned their proper value. In this latter respect, the Full Bench said:[82]

> Indeed it seems to us the mischaracterisation of the so called 'soft skills' as personality traits or 'the simple cognitive activity of adults['] is at the heart of the gendered undervaluation of work.

[59] In the *Stage 3 Aged Care decision*, the Expert Panel developed these concepts further. It undertook an extensive analysis of the historical development of the federal award rates applying to personal care workers (PCWs), HCWs and assistants in nursing (AINs) in the aged care sector, and reached the following conclusions:[83]

> Our historical analysis of the federal award rates of pay for PCWs, HCWs and AINs shows that that they have never been the subject of a work value assessment by the Commission or its predecessors. The pay rate alignment at the Certificate III level in the Aged Care Award, the SCHADS Award and the Nurses Award with the C10 classification in the Metal Industry Award structure has meant that the award rates of pay for PCWs, HCWs and AINs have never properly comprehended the exercise of the 'invisible' skills involved in aged care work… These skills of interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination were effectively disregarded by the simplistic use of the masculinised C10 benchmark as the basis for the award pay structures for PCWs, HCWs and AINs. This represents a continuation of the history we have earlier outlined of treating the skills exercised in female-dominated industries and occupations as merely feminine

[82] Ibid [848].

[83] [2024] FWCFB 150, 331 IR 137 [156].

> traits and not representative of work value in the traditional, narrowly-defined sense. …The result is that, even leaving aside the issue of changes in work value, the starting-point award rates for direct care employees were not properly set in the first place.

[60] In respect of degree-qualified registered nurses (RNs) in aged care, the Panel said:[84]

> Although the work of nurses has been the subject of previous work value assessments at the federal level historically, this process did not properly take into account either the professionalisation of the nursing occupation which occurred during the 1990s or the 'invisible' skills exercised in the aged care sector… The rates set for undergraduate degree-qualified RNs were never aligned with the C1 rate as contemplated by the C10 Metals Framework Alignment Approach, with the result that the starting rate for a degree-qualified RN in the modern Nurses Award made in 2009 was less than the C7 rate in the Manufacturing Award for a person qualified with an advanced certificate at AQF [L]evel 4. This represented historic[al] gender-based undervaluation of nurses' work which likewise rendered unsound the starting-point award rates in the Nurses Award.

[61] In respect of the rectification of the identified gender-based undervaluation of the work of aged care workers, the Expert Panel identified the correct approach as being to select a benchmark pay rate for a key classification and then construct a new and uniform pay structure on the basis of that benchmark rate. In respect of PCWs, aged care HCWs and AINs, the Panel selected the key classification as being that applicable to Certificate III-qualified employees and, as to the fixation of a benchmark rate for this classification, said:[85]

> The benchmark rate which we set must be one which is justified by work value reasons, as required by s 157(2)(a), and our determination of this rate must be free of assumptions based on gender in accordance with s 157(2B)(a). Within these statutory constraints, we also consider it desirable to establish a rate which is consistent with minimum rates for like work and which will be conducive to a stable award system which, while free of gender bias, does not encourage leapfrogging.
>
> In respect of this last consideration, there is a difficulty in that much of our earlier analysis as to how historic[al] gender assumptions have vitiated the proper fixation of award rates based on work value for the aged care sector is also likely to equally apply to award rates for other types of female-dominated 'caring' work. This makes problematic the search for an award comparator. Certainly, an appropriate comparator is not to be found in the C10 classification framework currently found in the Manufacturing Award.

[62] The Expert Panel determined that this benchmark rate (the Caring Skills benchmark rate) should be the minimum weekly wage rate applicable to Certificate III-qualified SACS employees established by the SCHADS Award operating in conjunction with the equal remuneration order (ERO) in effect as a result of the *SACS Equal Remuneration decisions*. At the time of the *Stage 3 Aged Care decision*, this rate was $1223.85 per week and is now, as a result of the *AWR 2024 decision*, $1269.80 per week. The Panel said in this respect:[86]

> We consider that the rate of $1223.90 per week (rounded to the nearest 10 cents) is appropriate to serve as the benchmark rate for Certificate III-qualified PCWs, AINs and HCWs. Prior to the

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[84] Ibid.

[85] Ibid [159]–[160].

[86] Ibid [170]–[172].

> making of the ERO there was, as earlier stated, a pay alignment between these classifications and the entry rate for a Certificate III[-]qualified social and community services employee under the SCHADS Award, and that provides a proper basis for the use of the SCHADS Award Level 2 classification as a comparator in the current circumstances. The basis upon which the ERO rates were determined closely parallel the work value reasons upon which we are proceeding in this matter: the high female composition of the industry in question, the significance of the work being 'caring' work, the disguising of the level of skill and experience required to perform the work, the gender-based undervaluation of the work, and the need to remedy the extent to which assumptions on the basis of gender had inhibited wages growth.
>
> Although the ERO rates were not made in the exercise of the award making and variation powers under the FW Act, the way in which the rates were set, for the reasons explained, essentially proceeded on what may be characterised as work value grounds within the meaning of s 157(2A). We also note that, despite the ERO having made pursuant to the Commission's powers under Pt 2-7 of the FW Act, the ERO was not intended to match market rates in the social and community services industry and thus may be characterised as operating as a minimum rate. For all functional purposes, the ERO rates operate in the same way as minimum award pay rates for employees to whom the SCHADS Award applies.
>
> Most importantly for our purposes, the ERO rates have been authoritatively determined to be rates which ensure equal remuneration for work of equal or comparable value. They can therefore be relied upon as being free of assumptions based on gender. …

[63] The Expert Panel went on to say more generally:[87]

> We anticipate, having regard to what was said concerning gender undervaluation in paragraphs [124]–[139] of the *Annual Wage Review 2022–23 decision* and in the *Stage 1 [Aged Care] decision*, and our analysis and conclusions in this decision, that there is likely to be further consideration of the question of whether female-dominated 'caring' work covered by other modern awards has been the subject of gender undervaluation. In that context, our identification of a benchmark rate for Certificate III-level PCWs, AINs and HCWs in aged care which aligns with the Certificate III level starting rate in the ERO applying to social and community services employees provides appropriate guidance as to the rectification of historic[al] gender undervaluation in respect of female-dominated 'caring' work. The adoption of such a benchmark rate for work of this nature, in replacement of the C10 rate, would provide a stable anchor point for a modern award system which ensures gender equality in the valuation of work.
>
> (citations omitted)

[64] The Expert Panel then proceeded to construct new classification structures for PCWs, aged care HCWs and AINs based on the identified key classification and the Caring Skills benchmark rate. With respect to RNs, the Expert Panel said:[88]

> The current minimum rate for a four-year degree[-]qualified RN in aged care under the Nurses Award is $1301.90 per week. The proper application of the C10 Metals Framework Alignment Approach in a manner free from gender assumptions and consistent with the principles stated by the Full Bench in the *Teachers decision* … would result in this rate being set at $1470.80 per week, with this becoming the benchmark rate for the fixation of minimum wages for RNs in aged care. We consider that this is a rate justified by the work value reasons identified in the *Stage 1 [Aged Care] decision* and this decision. Having regard to our earlier discussion

[87] Ibid [173].

[88] Ibid [204].

> concerning the ERO applicable to social and community services employees under the SCHADS Award, the fixation of this rate could confidently be regarded as one free from gender assumptions since it approximately equates to the rate ($1466.77 per week) for a four-year degree-qualified social and community services employee under the ERO.

[65] Following the *AWR 2024 decision*, the benchmark rate (C1(a) benchmark rate) referred to in the above passage is now $1525.90 per week.[89] The Full Bench went on to finalise a new classification structure for aged care nurses, with the benchmark rate applying to a RN after the first 12 months' service, in the *Aged Care Nurses decision*.[90]

[66] Having regard to the history we have summarised above of the development of a contemporary approach to the identification and rectification of gender-based undervaluation in award wage-fixing over the 26-year period from the *Pay Equity Inquiry Report* of Glynn J in 1998 through to the *Stage 3 Aged Care decision* in 2024, it is possible to articulate a number of principles which will guide our consideration in this Review in a manner consistent with the statutory framework.

[67] In respect of the identification of gender-based undervaluation, it is necessary to establish at the outset that the occupation group in question is female-dominated. The percentage of the relevant workforce required to meet that standard has usually been accepted as 60 per cent or more,[91] noting that the Stage 1 Report used a higher occupational threshold of 80 per cent women working in highly-feminised industries in order to identify *priority* areas for attention. It is then necessary, consistent with s 157(2B), to undertake a historical analysis of the development of the award rates of pay in order to ascertain whether there are any indicia of gender-based undervaluation. The most significant of these indicia are, we consider, as follows:

- whether the award minimum wage rates have ever been the subject of an independent work value assessment involving the consideration of skills and responsibilities of the work in question and the environment in which it has been performed;
- whether, if any work value assessment has occurred, the outcome has been constrained by the application of the C10 Metals Framework Alignment Approach or the requirement in previous wage-fixing principles that only work value change from a fixed datum point may be considered;
- whether the wage rates are the result of a consent arrangement which does not provide transparency as to the basis upon which the rates were fixed;
- whether the rates have been established on the basis of an automatic application of the C10 Metals Framework Alignment Approach without any further consideration as to whether the key classification in the award in question and the C10 classification involve equality or comparability of work value beyond a mere equivalence in qualifications; and
- in the case of classifications requiring a degree qualification, whether the pay rates have been established on the basis of an alignment with the C1 rate at a minimum

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[89] This is the C1 rate as determined in accordance with the methodology adopted in the *Teachers decision* and the *Stage 3 Aged Care decision*.

[90] *Application by Australian Nursing and Midwifery Federation* [2024] FWCFB 452 [43]–[62].

[91] Stage 1 Report 14.

or, if this has not occurred, whether there has been a work value assessment providing a justification for this.

[68] In respect of the third of the above indicia, we reject the approach taken in the first of the *SACS Equal Remuneration decisions* that, where a consent award for a female-dominated occupation represents the origin of the current award wage rates, this cannot be an indicium of gender-based undervaluation. The terms of consent awards, under the pre-FW Act system of conciliation and arbitration, have always been significantly influenced by the bargaining power of the parties, and female-dominated occupations have historically tended to have lesser bargaining power because of weaker union representation, the greater prevalence of part-time and casual employment, and the past prevalence of stereotypes about the value of work typically performed by women.

[69] The process of identifying gender-based undervaluation also requires a close examination, based on agreed facts or evidence, of the skills and duties of the work in question. An important element of this is to analyse whether the work is of a 'caring' nature requiring the exercise of 'soft' or 'invisible' skills, including but not limited to the skills of 'interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination',[92] which may not have previously been properly recognised or valued because of past assumptions based on gender. If the award rates have been set simply on the basis of the application of the C10 Metals Framework Alignment Approach, then it may be presumed, in the absence of evidence that indicates otherwise, that any 'soft' or 'invisible' skills found to be required for the performance of work have not been taken into account in the fixation of the wage rates.

[70] Ultimately, having regard to all the matters above, a conclusion must be reached as to whether the rates of pay in the relevant modern award have undervalued the work for gender-related reasons. Where a positive finding in this respect is made, this will likely constitute a work value reason within the meaning of s 157(2A) of the FW Act justifying the variation of modern award minimum wage rates under s 157(2)(a).

[71] Determining a variation to modern award minimum wages to rectify gender-based undervaluation is a matter requiring the making of a value judgment based on the need to achieve the modern awards objective and the minimum wages objective, having regard to the mandatory considerations in ss 134(1) and 284(1) of the FW Act respectively. In the Commission's determination of this, the gender equality considerations in ss 134(1)(ab) and 284(1)(aa) are likely to have significant weight. In respect of the exercise of the Commission's discretion, three guiding principles may be identified. *First*, while the C10 Metals Framework Alignment Approach remains a useful organising principle for stable and consistent award wage fixation, it should not be applied in a mechanistic way to determine the outcome. *Second*, in respect of work of a 'caring' nature involving the exercise of 'soft' or 'invisible' skills, the Caring Skills benchmark rate (currently $1269.80 per week) established in the *Stage 3 Aged Care decision* for a Certificate III-qualified employee indicates the upper end of the range of potential outcomes. This is because the aged care work considered in the *Stage 3 Aged Care decision* was found to have involved the constant exercise of the identified 'invisible' skills in a manner entirely integrated with all other aspects of the work. *Third*, in respect of the C1(a)

[92] *Stage 3 Aged Care decision* [2024] FWCFB 150, 331 IR 137 [156].

benchmark rate identified in the *Stage 3 Aged Care decision* for a degree-qualified RN, this rate (currently $1525.90 per week) should, as a minimum, apply to any classification for which a university degree is required (except at the entry level) in the absence of evidence justifying a different outcome on work value grounds.

3. PHARMACY INDUSTRY AWARD 2020

3.1 Classifications and minimum wage rates

[72] The Pharmacy Award covers employers in the 'community pharmacy industry' throughout Australia and their employees within the classifications defined in Schedule A of the award. The expression 'community pharmacy industry' is defined in clause 4.1 and, for relevant purposes, excludes pharmacy businesses which are owned by a hospital or other public institution or operated by the government. Hospital pharmacies are covered by the HPSS Award. The classifications in the award encompass pharmacy assistants, pharmacy students, pharmacy interns, and pharmacists at all levels. In this Review, we are only concerned with pharmacy interns and pharmacists. Clauses A.6–A.10 of Schedule A define the classifications applicable to them as follows:

> **Pharmacy intern** is an employee who has satisfied the examination requirements of an accredited program of study, as defined by the Health Practitioner Regulation National Law, and who is undertaking clinical training.
>
> **Pharmacist** is an employee registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession (other than as a student).
>
> **Experienced pharmacist** is an employee who is a pharmacist with at least 4 years full-time experience (or the part-time equivalent) in a community pharmacy.
>
> **Pharmacist in charge** is an employee who is a pharmacist who assumes responsibility for the day to day supervision and functioning of the community pharmacy.
>
> **Pharmacist manager** is an employee who is a pharmacist who is responsible to the owner of the community pharmacy for all aspects of the business.

[73] The regulatory requirements to be employed as a pharmacy intern are that the employee must have completed an approved program of study (usually involving a four-year undergraduate degree) and obtained provisional registration from the Pharmacy Board of Australia (Pharmacy Board). To practice as an employed pharmacist, the employee must have completed their internship and obtained general registration to work unsupervised from the Pharmacy Board.

[74] The minimum rates of pay currently prescribed by clause 16.1 of the award for the above classifications are:

Classification	$ per week	$ per hour
Pharmacy intern—1st half of training	1089.00	28.66
Pharmacy intern—2nd half of training	1126.10	29.63
Pharmacist	1337.60	35.20
Experienced pharmacist	1465.10	38.56

Classification	$ per week	$ per hour
Pharmacist in charge	1499.60	39.46
Pharmacist manager	1671.00	43.97

3.2 Award history

[75] The history of the development of minimum award wages for the community pharmacy industry in the federal industrial relations system was described in detail in the *Pharmacy decision*.[93] In summary, the first award applicable to pharmacists in community pharmacies was an interim award, the *Community Pharmacy (Victoria) Interim Award 1994*,[94] which was made in 1994 and applied in Victoria only following that State's referral of its industrial relations powers to the Commonwealth. This interim award replicated the terms of a previous award made by the former Industrial Relations Commission of Victoria. The interim award was adjusted in 1995 and 1996, with the key event being a decision[95] of Commissioner O'Shea on 6 March 1996 to establish a new classification structure referable to the pay rates for degree-qualified professional scientists covered by Part IV of the *Metal Industry Award 1976*.[96] As was observed in the *Pharmacy decision*, such professional scientists had never been aligned with the C1 classification level in the C10 Metals Framework, but were rather aligned on commencement with the C6 level for an employee requiring a three-year degree and the C5 level for an employee requiring a four- or five-year degree (which, under the C10 Metals Framework, respectively require a diploma-level qualification and 80 per cent towards a diploma-level qualification), with an experienced professional scientist being aligned with the C2(b) level. The alignment with professional scientists therefore 'effectively imported this difficulty into the *Community Pharmacy (Victoria) Interim Award*',[97] with a base-level degree-qualified pharmacist being given a relativity with the C10 Metals Framework midway between C4 and C3. The first national award applicable to pharmacists, the *Community Pharmacy Award 1996*,[98] was made in 1996. Arising from the award simplification process conducted in accordance with the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth), this award was varied to introduce a classification structure that applied nationally (except in Western Australia) which reflected that previously contained in the *Community Pharmacy (Victoria) Interim Award*[99] with the addition of a new classification of Experienced Pharmacist. When the modern Pharmacy Award was developed in the course of the award modernisation process conducted pursuant to Part 10A of the *Workplace Relations Act 1996* (Cth), the classification structure in the *Community Pharmacy Award 1996*[100] was largely retained but simplified by the removal of some incremental levels.

[76] The *Pharmacy decision* concerned an application by The Association of Professional Engineers, Scientists and Managers, Australia (APESMA) for a 25 per cent increase to the rates of pay in the Pharmacy Award on work value grounds. Importantly, as the Full Bench in the

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[93] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [170]–[176].

[94] C0597, Print L4131.

[95] Print M9831.

[96] M0043, Print D1642.

[97] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [174].

[98] AP773671 (Print N7370).

[99] C0597, Print L4131.

[100] AP773671 (Print N7370).

Pharmacy decision observed, the APESMA advanced its case primarily on the basis that the level of skill and responsibility of community pharmacists had increased significantly since 1998 (when the award simplification process for the *Community Pharmacy Award 1996*[101] had been completed), notwithstanding that the measurement of work value change from a specified datum point was not a prerequisite for the requirement for 'work value reasons' justifying variations to modern awards minimum wages in s 156(3) (since repealed, but with the requirement retained in s 157(2)(a)).[102] The Full Bench accepted this case to a limited extent and, on the basis of a number of specifically-identified work value changes, determined that the minimum wage rates for pharmacists should be increased by 5 per cent and, in addition, that a new allowance should be established for pharmacists conducting home medicine reviews or residential medication management reviews (now in clause 19.2 of the Pharmacy Award).[103]

[77] The APESMA advanced an alternative case that the relativities between pharmacists and C10 rate in the *Metal Industry Award 1976*[104] which were established by Commissioner O'Shea's 1996 decision, but which had been eroded by flat dollar-amount wage increases awarded in Safety Net Reviews and AWRs since that time and up until 2010, should be restored. This was rejected by the Full Bench, which found that the compression of relativities which had resulted from flat dollar amount increases was an intended outcome designed to improve the relative position of lower-paid award-wage workers and to depress that of higher-paid award-wage workers. Noting that this compression of relativities had occurred across the entire award system, the Full Bench said:[105]

> We do not think that there is any proper basis to attempt to unwind now, in one award only in response to a claim by a single union, a common approach to the adjustment of wages which was taken for deliberate policy reasons with the support of the union movement as a whole. It is obvious, in addition, that if the approach now urged by the APESMA was taken in relation to the Pharmacy Award, there would be no logical reason why this would not [be] sought to be flowed on to every other modern award, with ramifications that need not be spelled out.

[78] However, notwithstanding that the APESMA had not advanced a case for an *ab initio* consideration of the work value of pharmacists, the Full Bench analysed the then-current pay rates for pharmacists relative to the rates of pay in the Manufacturing Award and found:[106]

> [195] The above relativities do not align for equivalent qualifications, reflecting the difficulty arising from the original use of professional scientists as a reference point. Nor do they consistently relate to the [AQF]…
>
> [196] It can be seen, for example, that the rate of pay for a Pharmacy Intern, First half of training, who must possess a [Bachelor's] degree and is thus at Level 7 of the AQF, is lower than that of classification C8 in the Manufacturing Award, who is at Level 3 in the AQF. Similarly the base grade Pharmacist, who is at Level 7 in the AQF, is paid less than the C3 [classification], who is at Level 6 in the AQF.

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[101] Ibid.

[102] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [177].

[103] Ibid [185]–[187]; *4 yearly review of modern awards - Pharmacy Industry Award 2010* [2019] FWCFB 3949 [10]–[14].

[104] M0043, Print D1642.

[105] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [192].

[106] Ibid [195]–[198].

> [197] This outcome appears to be inconsistent with the principles stated and the approach taken concerning the proper fixation of award minimum rates in the *ACT Child Care Decision*, to which we have earlier made reference. However we note that the *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist.
>
> [198] This matter may potentially constitute a work value consideration relevant to the 4 yearly review of the Pharmacy Award. In the conduct of the review, the Commission is required to discharge its functions under s 156(2) and is not confined to matters raised by interested parties. We will as a first step invite further submissions from interested parties concerning this matter. We will then consider what course, if any, should be taken. One possibility is that this aspect of the review may need to be referred back to the President of the Commission for consideration as to the procedural course to be taken pursuant to s 582, since the matter raised may have implications for other awards of the Commission, including but not limited to the *Professional Employees Award 2010*.

[79] Ultimately, the Full Bench referred the above matter to the then-President of the Commission, and this issue has become part of this Review in the manner earlier described.

3.3 Available data concerning pharmacists

[80] On 6 September 2024, the Commission published a document[107] entitled *Data Profile — Pharmacists and the Pharmacy Industry Award 2020* (Pharmacists Data Profile) prepared by its Economic Analysis Team setting out data obtained from the most recent Australian Bureau of Statistics (ABS) Survey of Employee Earnings and Hours (EEH) (May 2023) and data from the August 2021 ABS Census to provide information on pharmacists covered by the Pharmacy Award. The ABS Census indicates that there are 16,850 employed retail pharmacists (i.e. pharmacists employed in community pharmacies and therefore covered by the Pharmacy Award) out of a total of 23,390 employed pharmacists in total. The following characteristics of retail pharmacists may be derived from the ABS Census data:

- 68.4 per cent are female.
- The average age is 36.2 years.
- 59.8 per cent work full-time hours and 40.2 per cent work part-time hours.
- The average number of weekly hours worked is 31.4.
- 92 per cent hold a Bachelor's degree or higher as their highest level of education attainment.

[81] Information on the method of pay-setting is available from the EEH data, but only in respect of pharmacists as a whole (i.e. including community, hospital and industrial pharmacists). This discloses that 12.7 per cent of pharmacists have their pay set by award only, 26.1 per cent by registered collective agreements, and 61.2 per cent by individual agreements. The EEH data also provides information concerning the characteristics of *all* employees covered by the Pharmacy Award, including sales staff. Of most relevance is that sales staff constitute 82.5 per cent of all employees covered by the Pharmacy Award, with the remainder

[107] Fair Work Commission, *Pharmacists and the Pharmacy Industry Award 2020* (Data Profile, 30 August 2024).

comprising Managers and Professionals (presumably wholly or principally pharmacists) as well as Technicians and trades workers and All other occupations.

[82] The Commission published a further information note[108] prepared by its Economic Analysis Team on 17 December 2024 (December note) in response to an issue raised by the Pharmacy Guild of Australia (PGA) concerning the accuracy of the calculation from the ABS Census date that 68.4 per cent of retail pharmacists are female. The December note confirmed the accuracy of this figure, noting that the competing figure of 61 per cent advanced by the PGA erroneously took into account non-employed pharmacists (such as owner-managers and contributing family workers) who would not be covered by the Pharmacy Award and of which only 36 per cent were female. The December note also referred to data from the National Health Workforce Dataset (NHWDS), which is maintained by the Department of Health and Aged Care, and confirmed the PGA's contention that this data indicated that 57.5 per cent of retail pharmacists were female as at 2023. The December note identified some potential deficiencies in the NHWDS data, namely that:

- it is based on a voluntary survey conducted at the time of registration, thus potentially producing a smaller sample than the one for the ABS Census; and
- it may include non-employees, resulting in a smaller proportion of females.

3.4 Parties' positions, agreed facts and evidence

[83] The parties with a primary interest in the pharmacist classifications in the Pharmacy Award are the APESMA, which is a registered organisation of employees entitled to represent the industrial interests of a range of professional occupations including pharmacists, and the PGA, which is a registered organisation of employers representing community pharmacies. We note that the PGA has a role that extends well beyond industrial relations matters and, as the accepted industry representative of community pharmacies, enters into agreements with the Commonwealth concerning funding, pricing and other regulatory matters. For the purpose of the Review, the APESMA and the PGA entered into an 'Agreed Joint Document' (AJD) which set out a joint position on a range of issues as well as some limited areas of disagreement, and also identified some agreed matters of fact. The AJD states an agreement as to the outcome on the Review in respect of the Pharmacy Award which, in summary, is:

(1) The process of setting the Pharmacist rate in the Pharmacy Award by reference to the C1 rate in the C10 Metals Framework has never occurred.

(2) Fixing the Pharmacist rate by reference to the C1 rate for degree-qualified classifications is free from gender-based assumptions.

(3) The C1(a) benchmark rate is appropriate to apply to the Pharmacist classification in the Pharmacy Award. That rate is $1525.90 per week.

(4) The other classification rates in the Pharmacy Award for work performed by pharmacists, and pharmacy interns, should maintain their existing relativity to the Pharmacist classification rate.

[108] Fair Work Commission, *Pharmacy Industry Award 2020: Data Discrepancy* (Information Note, 17 December 2024).

(5) The Experienced Pharmacist classification's relativity to the C1 rate in the Pharmacy Award appropriately takes into account the on-the-job application of technical education and skills acquired over the first four years of practice as a registered pharmacist working in community pharmacy.

(6) The variations to the rates are necessary to achieve the modern awards objective in s 134(1) and the minimum wages objective in s 284(1) of the FW Act and are justified by work value reasons within the meaning of s 157(2A).

(7) The agreed rates of pay should be phased in, with the wage increases to be implemented in addition to (and not absorbed into or applied in lieu of) any AWR increases.

(8) At the end of the phase-in period, the C1(a) rate in the Pharmacy Award should be consistent with the C1(a) rate in the *Aged Care Award 2010*[109] (Aged Care Award) rate at that point in time. The parties do not want the C1(a) pharmacist rate to become out of kilter with C1(a) rates in other awards because of the application of percentage phase-in amounts and AWR increases at different points in time.

[84] In relation to the last matter above, we note that the Aged Care Award does not contain a classification for which an undergraduate university degree is required or for which the rate of pay aligns with, or is intended to align in the future with, the C1(a) benchmark rate. However, we understand the proposition to be that, at the end of the phase-in process, the Pharmacist rate in the Pharmacy Award should align with that benchmark rate, as adjusted by AWR decisions which occur during the phase-in period, and that this rate will thereafter remain aligned with rates for classifications requiring an undergraduate degree in other modern awards which have similarly been adjusted to align with the C1(a) benchmark rate.

[85] The AJD records that the APESMA and the PGA disagree about the proposed length of the phase-in period. The APESMA, in separate submissions, proposes that the phase-in occur over a 12- to 18-month period. The PGA proposes that the phase-in occur 'over three years with equal increases on each of 1 July 2025, 1 July 2026 and 1 July 2027'.

[86] The AJD also sets out a number of agreed facts, or agreed inferences from primary facts, of which the following are most relevant:

(1) A pharmacist employed in community pharmacy must have attained a minimum of a four-year degree qualification and be registered to practice as a pharmacist with the Australian Health Practitioner Regulation Agency (AHPRA) in accordance with the *Australian Health Practitioners Regulation National Law*.

(2) Pharmacists are frontline health care professionals who are well-placed to provide primary health care to their local communities.

[109] MA000018.

(3) The scope of practice for a pharmacist — that is, what a pharmacist is permitted to do — is regulated at the State/Territory level. The scope of practice is evolving and changing to various levels and at various speeds across each State and Territory. The services provided by community pharmacies within the scope of practice may vary depending on matters including the needs of the community, local supply and the interests of the pharmacy owner and pharmacist employees.

(4) According to the *Community and Hospital Pharmacists' Remuneration Survey Report 2011* undertaken and published by the APESMA, the average pharmacist was being paid approximately 154 per cent of the minimum hourly award rate in 2011. The equivalent report on 2019–20 data (being the most recent) had this falling to 119 per cent of the minimum hourly award rate (i.e. $5.59 per hour above the award rate).

(5) There has been no change to the work of a pharmacist that would necessitate an increase to wages on work value grounds since the *Pharmacy decision*.

[87] The Australian Council of Trade Unions (ACTU), in submissions adopted by the APESMA, submitted that the classifications of pharmacists in the Pharmacy Award were subject to the following indicia of gender-based undervaluation:

- The occupation of pharmacist is highly (almost two-thirds) feminised.
- The setting of pharmacists' award rates in 1996 by reference to the rates of pay for professional scientists (and not by reference to the C1 rate) had the effect of incorporating in the federal award from the outset an undervaluation of degree-qualified pharmacists.
- The *Community Pharmacy Award 1998*[110] reflected the structure and relativities used in the 1996 decision and those established by the structural efficiency process, which were determined to have incorporated all past work value considerations.
- No work value assessment of the work of community pharmacists was undertaken during award modernisation.
- The *Pharmacy decision* dealt with changes to the work of pharmacists said to have occurred since 1998, but the Full Bench also identified the fact that the rates of pay for pharmacists were not aligned with the theoretical C1 rate as a potential work value issue.

[88] The ACTU submitted that, following the approach in the *Stage 3 Aged Care decision*, the failure to properly fix minimum rates for pharmacists in accordance with the C10 Metals Framework Alignment Approach should, by itself, be a sufficient work value justification for the adjustment of rates of pay for pharmacists and was, for the purpose of the Review, one indicium of gender-based undervaluation albeit of considerable weight. It was submitted that the failure to align the rates of pay for degree-qualified pharmacists has had negative consequences for all pharmacists, but has impacted greater numbers of women than men, given the degree of occupational segregation in the community pharmacy sector. It followed therefore that the Commission could be comfortably satisfied that the occupation of pharmacist has been

[110] AP773671 (Print Q2647).

subject to historical gender-based undervaluation, and that the agreed outcome in the AJD would be an appropriate remedy.

[89] The PGA's submissions departed from those of the ACTU and the APESMA only on the issue of whether the undervaluation in pharmacists' rates of pay in the Pharmacy Award was gender-related. The PGA submitted that the proportion of female pharmacists was not as high as contended by the ACTU and was likely about 56 per cent, there was no data as to the extent to which female, as distinct from male, pharmacists were award-dependent, and that the *Pharmacy decision* involved a proper work value assessment of the work of pharmacists. Its position was rather that it was appropriate for there to be consistency in setting minimum rates across modern awards for professional employees who have completed a four-year degree and the relevant registration to practice, that this of itself constituted the work value reasons required by s 157(2)(a), and that the Commission did not need to determine that there had been any gender-based undervaluation in pharmacists' rates in order to vary the minimum rates applying to pharmacists consistent with the agreed outcome in the AJD.

[90] Australian Business Industrial (ABI) and the New South Wales Business Chamber (NSWBC) adopted and supported the AJD and the submissions of the PGA. Pharmacy Australia (the trading name of The Society of Hospital Pharmacists of Australia) filed a short submission that also supported the fundamental propositions in the AJD and the position of the APESMA as to phasing-in.

[91] The Private Hospitals Group[111] opposed the outcome proposed in the AJD, and any variation to the Pharmacy Award on gender-based undervaluation grounds. However, the only entity in the Private Hospitals Group which actually employs pharmacists covered by the Pharmacy Award is Ramsay Health Care Australia (Ramsay). Ramsay does so pursuant to an arrangement whereby it supplies the labour of pharmacists it employs to 62 community pharmacy franchises.

[92] The Private Hospitals Group submitted that the findings of the Stage 1 and Stage 2 Reports and the Pharmacists Data Profile did not, by themselves, demonstrate that the work of pharmacists covered by the Pharmacy Award had been historically undervalued because of gender-based assumptions. Pharmacists, it was submitted, did not reach the 80 per cent threshold for female domination to be included for consideration in the Stage 1 Report, and the Stage 2 Report recorded that pharmacists had been the subject of work value consideration in the *Pharmacy decision*. The only basis for which the Stage 2 Report identified a potential work value case was in respect of the non-alignment of pharmacists with the C1 rate in the C10 Metals Framework. However, it was submitted, a simplistic application of the C10 Metals Alignment Framework without a proper evidentiary foundation as to the work value of the in-scope classifications would not discharge the Commission's statutory burden under s 157(2)(a) of the FW Act. It was further submitted that, balancing the considerations in s 134(1) and s 284(1), the Commission could not be satisfied that any increase to minimum wages was necessary to achieve the modern awards objective or minimum wages objective having regard, in particular, to the lack of evidence of gender-based undervaluation and the likely impact upon business costs. The Private Hospitals Group distinguished the position in this Review from that

[111] This comprised the Australian Private Hospitals Association (APHA), Catholic Health Australia (CHA), Day Hospitals Australia (DHA) Healthscope Operations Pty Limited (Healthscope) and Adelaide Community Health Care Alliance Incorporated (ACHA).

in the aged care work value proceedings, in which the Commission proceeded on the basis of funding commitments from the Commonwealth.

[93] The Private Hospitals Group submitted in the alternative that, if the Commission was minded to award the increases proposed in the AJD, they should be phased in consistent with the proposal advanced by the PGA.

[94] The Private Hospitals Group adduced evidence from two witnesses relevant to the Pharmacy Award. Michelle Lynch,[112] the Chief Executive of Ramsay's Pharmacy and Psychology Group gave evidence concerning Ramsay's hospital and community pharmacy business. Ms Lynch gave evidence that about 70 per cent of Ramsay's pharmacists (both in its hospital and community pharmacies) are female. Her evidence was initially that, in its community pharmacies, Ramsay employs approximately 215 pharmacists that it supplies to its franchisees, of whom 212 are paid above-award rates of pay. She later updated the latter figure as being 208 in respect of whom the average above-award payment was 26.04 per cent. Ms Lynch said:[113]

> The 'above award' rates negotiated in respect of some Community Pharmacists are to ensure talent is attracted and retained and are negotiated at that level because of the high demand for pharmacists and a shortage of qualified community pharmacists available to employ, particularly pharmacies in regional areas. Over the last five years and during the COVID-19 pandemic, lower number of pharmacists have qualified from Australian Universities and lower numbers of overseas graduates are coming to, and staying in, Australia. These trends are slowly starting to reverse. I would expect that any increase in the award rate would result in employees on above award rates seeking a corresponding increase.

[95] Ms Lynch described the work of community pharmacists and said that there had not been any significant change in the work of Ramsay's community pharmacists over the past five years, although she observed that the greater provision of vaccinations by community pharmacists had expanded their role and had allowed them to work to their full scope of practice.

[96] Peter Ryan[114] is the Director of Employment Relations and Policy for Ramsay. He holds a Bachelor of Business and a Bachelor of Laws. Mr Ryan provided internally-prepared estimates as to the financial impact of variations to the rates of pay in the Pharmacy Award to align the Pharmacist rate with the C1(a) rate. The Private Hospitals Group contended, on the basis of this analysis, that the outcome proposed in the AJD would result in an 8.8 per cent increase in labour costs for Ramsay's employed pharmacists covered by the Pharmacy Award.

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[112] Exhibit PH2 (witness statement of Michelle Lynch, 18 October 2024); exhibit PH3 (supplementary witness statement of Michelle Lynch, 29 November 2024).

[113] Exhibit PH2 (witness statement of Michelle Lynch, 18 October 2024) [13].

[114] Exhibit HPSS1 (witness statement of Peter Ryan, 18 October 2024); exhibit HPSS2 (confidential exhibit to witness statement of Peter Ryan, 18 October 2024 — spreadsheet, 'FWC work value modelling - Ramsay Enterprise Agreements'). We note that two amended versions of Mr Ryan's statement and the annexed spreadsheet were filed in the proceedings, the first on 9 December 2024 and the second on 19 December 2024.

3.5 Gender-based undervaluation

[97] While there is a widespread measure of agreement that there are work value reasons, within the meaning of s 157(2A), justifying the Pharmacy Award being varied to implement to outcome agreed in the AJD, there is disagreement as to whether this has been as a result of gender-based undervaluation. This disagreement turns primarily on two issues: (1) whether the occupation of pharmacist is female-dominated, and (2) whether the rates of pay in the Pharmacy Award have been established by reference to a proper work value exercise.

[98] As to the first issue, we are satisfied that the occupation of pharmacist is female-dominated. The Pharmacists Data Profile establishes that in excess of two-thirds of pharmacists (68.4 per cent) employed in community pharmacies are female. As the PGA points out in its submissions, there are some defects in the ABS Census data referred to in the Pharmacists Data Profile. Most notably, the statistic that only 92 per cent of pharmacists held a degree or higher qualification suggests that employees who were not pharmacists were erroneously included in the data. However, as the PGA concedes, this apparent error is not of sufficient numerical significance to displace the conclusion that community pharmacists meet the established criterion for female domination (i.e. in excess of 60 per cent female).[115] We also note that the PGA's own submissions cite Pharmacy Board registration data for June 2023 and June 2024 which show, respectively, that 64.1 and 64.4 per cent of all registered pharmacists are female. While the ABS Census data indicates that the female proportion of all pharmacists (70.1 per cent) is higher than for just community pharmacists (68.4 per cent), the difference is sufficiently small to infer that the Pharmacy Board registration data also indicates that community pharmacists are above the 60 per cent threshold. The NHWDS data (which, as stated above, shows 57.5 per cent of community pharmacists were female in 2023) is less reliable because, as observed in the December note, it is based on a voluntary survey and, as the PGA concedes, includes non-employed or 'owner' pharmacists. Given that the ABS Census data shows that non-employed community pharmacists constitute about 22 per cent of all community pharmacists and are 64 per cent male, we infer that their exclusion from the NHWDS data would also likely result in the 60 per cent threshold being exceeded for employed community pharmacists.

[99] However, the evidence does not establish that employed pharmacists, either generally or in the community pharmacy sector, have *historically* been female-dominated according to the 60 per cent criterion. The first published iteration of the Pharmacy Board registration data referred to by the PGA, for June 2012, shows that just over 57 per cent of pharmacists were female at that time.[116] It appears therefore that the occupation of Pharmacist has become significantly more female during the last decade. This may be indicative of a longer-term trend in the gender make-up of the occupation.

[100] In relation to the second issue, it is clear from the history earlier recited that the *Pharmacy decision* comprehensively dealt with *changes* in work value in the period from 1998 to 2018. It is further agreed in the AJD that there have been no further work value *changes* since the date of the *Pharmacy decision* which would justify an adjustment to the minimum rates of pay in the Pharmacy Award. However, the propositions just stated do not answer the question

[115] It may be that this discrepancy is explicable by the misidentification of employed pharmacy students, who have not yet obtained their degree qualification, as pharmacists.

[116] 'Registration Data Table - June 2012', *Pharmacy Board of Australia – Statistics* (Web Page, August 2012) 4.

of whether the starting point — the minimum rates for pharmacists set by the AIRC in 1996 — were ever established by reference to a proper and independent assessment of work value. It is clear that this did not happen. Instead, there was a consent alignment with the minimum award rates for professional scientists. That was, in principle, a sound starting point for comparison since professional scientists, like pharmacists, require a degree qualification to practise their occupation. However, as explained in detail in the *Pharmacy decision* and summarised above, the rates for professional scientists were themselves not established by way of any work value assessment but were, in a non-transparent way, set on the basis of a defective alignment with the C10 Metals Framework. That meant that the subsequent work value change consideration and wage rate adjustment in the *Pharmacy decision* proceeded upon a foundation of award wage rates which, at the datum point of 1998, were not properly established by reference to the work value of pharmacists.

[101] No party has essayed any justification for the relativity between pharmacists and the C10 Metals Framework established in 1996 and imported into the Pharmacy Award from its commencement in 2010. The position stated in the AJD involves an acceptance that this is inappropriate from a work value perspective and requires adjustment. We accept that position. On the basis of the principles earlier stated, the *prima facie* alignment with the C10 Metals Framework based on equivalent qualifications which has formed the starting point for award wage fixation for the last 35 years has never occurred, with the result that the current wage rates for pharmacists in the Pharmacy Award do not properly reflect their work value.

[102] For the reasons earlier stated, the material before us does not permit a finding that pharmacists have been the subject of *historical* undervaluation because of assumptions based on gender, because it is unknown whether the occupation was female-dominated or even mostly female when the starting point rates of pay were established in 1996. However, the undervaluation we have identified clearly has a contemporary gender dimension in that, by reason of the current and apparently growing female domination of the occupation, women are disproportionately affected and disadvantaged by it. This effect would be exacerbated if, consistent with the patterns in the labour market as a whole, female pharmacists were more likely to be paid only the minimum award rate than men. This is sufficient to permit the undervaluation to be characterised as gender-based.

[103] We therefore accept the position agreed in the AJD that there are work value reasons, within the meaning of s 157(2A), justifying the adjustment of the minimum rates of pay for pharmacists covered by the Pharmacy Award. The classification of Pharmacist, which applies upon obtaining general registration to work unsupervised, is clearly the benchmark classification and should align with the C1(a) benchmark rate in accordance with the principles earlier stated (as agreed in the AJD). We accept the position in the AJD that all other pharmacist and pharmacy intern classifications in the Pharmacy Award should be adjusted by an amount that maintains their relativity with the benchmark Pharmacist classification. The current classification structure is appropriate and suitable for retention in accordance with the principles stated in the *Teachers decision*,[117] the *Stage 3 Aged Care decision*[118] and the *Aged Care Nurses decision*. This would, subject to any phasing-in arrangements and AWR adjustments that might

[117] [2021] FWCFB 2051 [653]–[657].

[118] [2024] FWCFB 150, 331 IR 137 [174]–[202].

occur during any phase-in period, produce the following outcome for pharmacist classifications in the Pharmacy Award:

	$ per week	$ per hour
Pharmacy intern—1st half of training	1242.30	32.69
Pharmacy intern—2nd half of training	1284.60	33.81
Pharmacist	1525.90	40.16
Experienced pharmacist	1671.30	43.98
Pharmacist in charge	1710.70	45.02
Pharmacist manager	1906.20	50.16

[104] We are satisfied that the above rates of pay would be established on a basis that is free of assumptions based on gender.

3.6 Employer cost consequences and implementation

[105] The evidence given by Mr Ryan or otherwise provided by the Private Hospitals Group concerning the impact on Ramsay of the implementation of the outcome proposed in the AJD and adopted above cannot be accepted. The Private Hospitals Group did not provide the precise basis upon which the figure of a labour cost increase of 8.8 per cent was calculated, but it was presumably based upon the calculation of the dollar cost of the increases set out in spreadsheets attached to Mr Ryan's statement and subsequently amended a number of times. Those spreadsheets, if we understand them correctly, identify that a total of 77.2 full-time equivalent (FTE) retail pharmacists employed by Ramsay would, on their current rates of pay, fall below the award rate for pharmacists if increased by the 14.1 per cent proposed by the AJD (and would thus require pay increases). Of these, the spreadsheets appear to identify 72.5 FTE retail pharmacists employed by Ramsay who are paid at the current award rate. These figures constitute the entire premise of the calculation of the cost of the increases. The difficulty is that this premise is contradicted by the unchallenged evidence of Ms Lynch to the effect that at least 96.7 per cent of Ramsay's total employed retail pharmacists (about 215 in number) are paid in excess of the applicable award minimum rate and that the average amount of the above-award payment is over 26 per cent. If Ms Lynch's evidence about this is correct — and we do not consider that there is any reason why we should not accept it — then the direct cost to Ramsay of the increases will be negligible.

[106] We note Ms Lynch's evidence that she expects that any increase in the award rate would result in employees on above-award rates seeking a corresponding increase. While it may be accepted at a high level of generality that any significant adjustment to award minimum rates of pay is likely to have second-order labour market effects, we do not consider that we should give any significant weight to Ms Lynch's opinion in this respect. Ms Lynch did not give evidence of any primary facts to provide the foundation for her opinion, which must therefore be rejected as purely speculative. Further, Ms Lynch's own evidence indicates that there is no collective bargaining between Ramsay and its retail pharmacists and that their rates of pay are set individually having regard to local and general labour market considerations. Thus, it is unlikely that any expectation such as Ms Lynch describes will significantly affect Ramsay's wage-setting mechanisms for retail pharmacists, and Ms Lynch did not give evidence otherwise.

[107] Leaving aside Ramsay's position, it is clear however that, for a proportion of community pharmacies, the award wage increase of 14.1 per cent will have a significant cost consequence.

As the Pharmacists Data Profile discloses, 12.7 per cent of all pharmacists have their pay set by the award only, and the proportion may be greater in community pharmacies given the apparent greater prevalence of collective agreements in the hospital pharmacy sector. There is also likely to be a further proportion of community pharmacists who are currently paid in excess of the award but by an amount less than 14.1 per cent, meaning that some adjustment of their wages will also be required. This proportion is likely to be relatively significant if the current position remains the same as disclosed by the APESMA's 2019–20 remuneration survey, which indicated that the pharmacists are paid on average 19 per cent above the award. However, Ms Lynch's evidence quoted above suggests that the labour market for pharmacists has tightened since 2019, meaning that the average above-award margin may now be higher than 19 per cent. If Ramsay's average above-award payment margin of 26 per cent is representative of the market, then it may be that the proportion of pharmacists for whom a wage adjustment will be required is relatively low.

[108] It is obviously a matter of significance that the PGA, which is the widely-accepted employer representative of community pharmacies, agrees to the outcome above on the premise of its proposed phasing-in timetable and that no employer covered by the Pharmacy Award other than Ramsay appeared in the proceedings to oppose the outcome (which was foreshadowed in the AJD) or to otherwise make submissions. On that basis, we consider that we should adopt in principle the PGA's phasing-in timetable as one that renders the cost impact acceptable to employers generally (and to which Ramsay was, in the alternative, prepared to accede). We note the APESMA's preference for a quicker implementation period but, having regard to the fact that the misaligned award pay rates of pharmacists were first raised back in 2018 in the *Pharmacy decision*, the additional delay involved is relatively insignificant.

3.7 Modern awards objective and minimum wages objective

[109] We are satisfied that the variations to the Pharmacy Award which will be made arising from this decision are necessary to achieve the modern awards objective. For the award safety net to be fair and relevant, minimum wage rates must properly reflect work value and be consistent with the achievement of gender equality. In reaching this conclusion, we have taken into account the considerations specified in s 134(1) of the FW Act in the following way (using the paragraph designations in the subsection):

> *Paragraph (a)*: Using the measure of 'low paid' as being two-thirds of median adult ordinary-time earnings for full-time employees, the 'low paid threshold' may be quantified in two ways: $1139.65 per week (using the ABS Characteristics of Employment data for August 2024) or $1131.33 per week (using the EEH data for May 2023). Pharmacy interns (1st and 2nd half of training) and Pharmacists currently have a rate of pay below the former amount, and the Pharmacy intern classifications have a rate below the latter measure. Accordingly, because the wage rate adjustment will have the result of lifting some classifications above the low paid threshold, this consideration weighs in favour of the variations.
>
> *Paragraph (aa)*: There is no evidence before us that the variations will have any effect, detrimental or otherwise, as to the need to improve access to secure work. This is therefore a neutral consideration.

Paragraph (ab): As earlier set out, the variations will rectify undervaluation in a female-dominated occupation and therefore aid in achieving gender equality, ensuring equal remuneration for work of equal value and eliminating gender-based undervaluation of work. This weighs significantly in favour of making the variations.

Paragraph (b): There is little evidence that collective bargaining is a current feature of the community pharmacy sector, and there is no basis to make any sensible prediction about whether the variations will encourage collective bargaining to occur. We consider this to be a neutral factor.

Paragraph (c): It is possible that the variations, by implementing minimum rates of pay which fairly reflect work value, may attract more persons, especially women, to the occupation of pharmacist over the longer term and thus increase workforce participation. However, this is speculative, and we will treat this as a neutral factor.

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

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

Paragraph (f): The variations will have an impact on employment costs for employers in the community pharmacy sector to the extent earlier described. However, this is ameliorated by the phasing-in timetable which will be introduced and was the basis on which the PGA agreed to the ultimate outcome. To that extent, this consideration weighs against the variations to a limited degree. There is no reason to consider that the variations will affect productivity or the regulatory burden.

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

Paragraph (h): There is no evidence before us to indicate that the variations will have any material effect upon the national economy. We will therefore treat this as a neutral factor.

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

3.8 Operative date and variation determination

[111] Consistent with our conclusion as to phasing-in, the outcome determined in paragraph [103] above will be implemented in three equal phases. They will be operative from 30 June 2025, 30 June 2026 and 30 June 2027 respectively.[119] We are satisfied, for the purpose of s 166(2) of the FW Act, that these operative dates are appropriate having regard to the considerations we have earlier identified. A determination varying the Pharmacy Award to implement the first phase is published together with this decision.

[119] It is not practicable for award variations to operate from the same date as variations arising from the AWR, as the PGA phase-in timetable proposed.

4. HEALTH PROFESSIONALS AND SUPPORT SERVICES AWARD 2020

[112] Clause 4.1 of the HPSS Award provides that it covers employees in two overlapping categories:

(a) employers in the health industry and their employees in the classifications listed in Schedule A; and

(b) employers engaging a health professional employee in the classifications listed in Schedule A.

[113] For the purpose of clause 4.1(a), clause 4.2 defines the 'health industry' to mean 'employers whose business and/or activity is in the delivery of health care, medical services and dental services'. Schedule A of the HPSS Award contains classifications in two categories: support services employees (in clause A.1) and health professional employees (in clause A.2).

[114] The term 'support services employees' is not defined in the HPSS Award. The nine classification levels in clause A.1 define the employees covered at each level using generic terminology, but Levels 1–7 also contain lists of indicative roles performed at each level. As we discuss in greater detail later, these include the roles of dental assistant, laboratory assistant, theatre technician, pathology collector, pathology technician, orthotic technician, pharmacy technician and anaesthetic technician which are the subject of this Review.

[115] The term 'health professional employee' is likewise not defined in the award, but Schedule B sets out a list of 'Common Health Professionals'. The list is lengthy and we describe its contents below. It is indicative rather than exhaustive, as the preamble to clause A.2 makes plain. However, it is apparent that two categories of health professionals which do not appear in the list are intended to be excluded. First, clause 4.6(d) of the HPSS Award provides that 'Medical Practitioners' are not covered by the award, and there is a separate award (the *Medical Practitioners Award 2020*[120]) which covers such practitioners when employed by certain categories of employers including hospitals and day procedure centres. Medical practitioners employed in general practice and private specialist practice are award-free.[121] Second, notwithstanding that the 'health industry' is defined to include dental services, the list does not include dentists. This omission was deliberate, since dentists have not traditionally been the subject of award coverage.[122]

[116] The HPSS Award therefore has a hybrid industry and occupational coverage: under clause 4.1(a) it covers support services employees and health professionals employed in the health industry, as defined in clause 4.2, and under clause 4.2(b) it covers health professionals wherever employed.

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[120] MA000031.

[121] *Gourabi v Westgate Medical Centre* [2019] FWCFB 3874.

[122] *4 yearly review of modern awards—Health Professionals and Support Services Award 2020* [2020] FWCFB 6140, 302 IR 59 [223]–[224]; *Statement – Award Modernisation* [2009] AIRCFB 865, 188 IR 23 [126].

4.1 Health Professionals

4.1.1 Classification structure and minimum wage rates

[117] Clause A.2 provides for four classification levels for health professional employees which are defined as follows:

> **A.2.1 Health Professional—level 1**
>
> (a) Positions at level 1 are regarded as entry[-]level health professionals and for initial years of experience.
>
> (b) This level is the entry level for new graduates who meet the requirement to practise 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. It is also the level for the early stages of the career of a health professional.
>
> **A.2.2 Health Professional—level 2**
>
> (a) A health professional at this level works independently and is required to exercise independent judgment on routine matters. They may require professional supervision from more senior members of the profession or health team when performing novel, complex, or critical tasks. They have demonstrated a commitment to continuing professional development and may have contributed to workplace education through provision of seminars, lectures or in-services. At this level the health professional may be actively involved in quality improvement activities or research.
>
> (b) At this level the health professional contributes to the evaluation and analysis of guidelines, policies and procedures applicable to their clinical/professional work and may be required to contribute to the supervision of discipline specific students.
>
> **A.2.3 Health Professional—level 3**
>
> (a) A health professional at this level would be experienced and be able to independently apply professional knowledge and judgment when performing novel, complex, or critical tasks specific to their discipline. At this level health professionals will have additional responsibilities.
>
> (b) An employee at this level:
>
> (i) works in an area that requires high levels of specialist knowledge and skill as recognised by the employer;
> (ii) is actively contributing to the development of professional knowledge and skills in their field of work as demonstrated by positive impacts on service delivery, positive referral patterns to area of expertise and quantifiable/measurable improvements in health outcomes;
> (iii) may be a sole discipline specific health professional in a metropolitan, regional or rural setting who practices in professional isolation from health professionals from the same discipline;
> (iv) is performing across a number of recognised specialties within a discipline;

(v) may be accountable for allocation and/or expenditure of resources and ensuring targets are met and is responsible for ensuring optimal budget outcomes for their customers and communities;
(vi) may be responsible for providing regular feedback and appraisals for senior staff to improve health outcomes for customers and for maintaining a performance management system; and
(vii) is responsible for providing support for the efficient, cost effective and timely delivery of services.

A.2.4 Health Professional—level 4

(a) A health professional at this level applies a high level of professional judgment and knowledge when performing a wide range of novel, complex, and critical tasks, specific to their discipline.

(b) An employee at this level:

(i) has a proven record of achievement at a senior level;
(ii) has the capacity to allocate resources, set priorities and ensure budgets are met within a large and complex organisation;
(iii) may be responsible to the executive for providing effective services and ensuring budget/strategic targets are met;
(iv) supervises staff where required; and
(v) is expected to develop/implement and deliver strategic business plans which increase the level of care to customers within a budget framework.

[118] The above classifications are, like those for support services employees, expressed in generic terms which are not self-evident in their application and require a degree of judgment in that respect. However, it is at least apparent that Level 1 applies to entry- or base-level graduates, Level 2 applies to employees who are capable of working independently subject to some professional supervision, Level 3 applies to experienced health professionals performing specialist work and providing some input into management, and Level 4 applies to high-level health professional employees who may have managerial and supervisory responsibilities.

[119] The minimum pay rates for health professional employees are prescribed in clauses 17.2–17.5. A summary of the minimum weekly rates for full-time employees is as follows:

Classification level and pay point	Minimum weekly rate $
LEVEL 1	
Pay point 1 (UG 2 qualification)	1082.90
Pay point 2 (3 year degree entry)	1124.80
Pay point 3 (4 year degree entry)	1174.60
Pay point 4 (Master's degree entry)	1215.00
Pay point 5 (PhD entry)	1323.60
Pay point 6	1370.50
LEVEL 2	
Pay point 1	1378.00
Pay point 2	1428.10
Pay point 3	1482.60
Pay point 4	1541.60

Classification level and pay point	Minimum weekly rate $
LEVEL 3	
Pay point 1	1608.50
Pay point 2	1653.60
Pay point 3	1689.20
Pay point 4	1764.20
Pay point 5	1829.30
LEVEL 4	
Pay point 1	1947.60
Pay point 2	2078.40
Pay point 3	2260.20
Pay point 4	2495.10

[120] At Level 1, different entry pay points apply to employees holding different types of qualifications. The reference to 'UG2' (or 'undergraduate 2') is defined in clause 2 to mean an employee with a diploma or equivalent. We discuss this further below. Apart from these entry-level rates, clause 17.1 provides that employees at each level progress through the pay points on an annual basis for full-time employees (with an equivalent number of hours specified for part-time and casual employees). For employees at Levels 2–4, progression through the pay points is also subject to 'having regard to the acquisition and use of skills', but it is not clear that this requirement has any practical content.

[121] We have earlier referred to the indicative list of health professionals in Schedule B. It is clear, as clause 17.2 contemplates in establishing the 'UG2' pay point entry for Level 1, that the list of 'professions' includes a number of occupations for which only a diploma, and not a Bachelor's degree or higher, is required. On its face, this appears to encompass AQF Level 5 and 6 qualifications, and the indicative list in Schedule B includes occupations for which only an AQF Level 5 or 6 qualification is required. This goes beyond the usual understanding of what constitutes a profession for the purpose of award regulation. In *Re Crown Librarians, Library Officers & Archivists Award Proceedings*, for example, a Full Bench of the NSW Commission said:[123]

> We observe that all of the parties accepted the appropriateness of comparing rates of pay for librarians with rates for other professional groups…
>
> It is to be noted that the comparisons generally are with groups exhibiting some similar characteristics as librarians, namely, employees within the public service who require a [B]achelor's degree or equivalent for entry into the profession and whose career progression is based on a combination of years of experience and merit-based appointment and promotion
> . . .
> The term 'profession' is nowadays used to describe a multitude of occupations, callings and sporting endeavours and extends well beyond the traditional fields such as law and medicine. Librarians and archivists exercise skills based on theoretical knowledge, require high level tertiary qualifications, are eligible for membership of independent associations, are subject to standards of competence and are obliged to follow ethical codes of conduct. Each field has an accepted body of knowledge and skills acquired only after a long period of learning that is properly described as professional in nature and content.
>
> (underlining added)

[123] [2002] NSWIRComm 55, 111 IR 48 [25]–[26], [29].

[122] The requirement for 'high level tertiary qualifications' has usually been applied to occupations for which at least a university degree or equivalent qualification is required. Thus, for example, the modern *Professional Employees Award 2020*,[124] by the definitions in clauses 2.2–2.6, generally only applies (with some exceptions) to employees with university qualifications or their assessed equivalent. The categorisation of an employee as a 'professional' has practical implication for award regulation. In particular, it has been accepted that it is a 'defining feature' of being a professional that they must 'engage in continuing and self-driven education and development in order to stay abreast of new knowledge, technology and other changes in the profession',[125] and this is reflected in their level of remuneration and the way their entitlements are structured. This is not generally a feature of employment in roles which do not require a Bachelor's degree or higher.

[123] Apart from the entry-level starting rates, the current classification and minimum rates structure for health professional employees in the HPSS Award does not differentiate between different types of qualifications and occupations. The highest maximum rate (pay point 6) in Level 1 is the same for all the occupations listed in Schedule B, and in Levels 2–4 the minimum rates are the same at all pay point levels. The differences between the occupations in Schedule B as to minimum qualifications, the time needed to obtain those qualifications, professional registration requirements and their respective levels in the AQF is set out in the following table:

Occupation	**Minimum tertiary qualification[126] (length)**	**AQF level**	**Relevant body[127]**	**Mandatory registration[128] (when?)**
Acupuncturist	Bachelor's degree (3–5 years)	7	Chinese Medicine Board of Australia	Yes (immediately after degree is complete)
Aromatherapist	Diploma (1.5 years)	5	Australian Natural Therapists Association	No
Art therapist	Master's degree (2 years — this does not include the relevant undergraduate degree, of which there are a range)	9	Australian, New Zealand and Asian Creative Arts Therapies Association	No

[124] MA000065.

[125] *Pharmacy decision* [2018] FWCFB 7621, 284 IR 121 [184].

[126] 'Minimum tertiary qualification' here means the AQF minimum level qualification currently offered through a program of study in Australia which is needed for registration and/or eligibility to practice or work in a health professional occupation. We note that this does not necessarily mean it is the most *prevalent* qualification available for work in a profession.

[127] We note that registration and accreditation standards of National Boards, registries and professional associations, and the programs of study offered by educational institutions, are subject to frequent change. Therefore, the information captured below does not reflect a fixed assessment of qualifications required for each profession; rather it is a point-in-time assessment based on currently available information.

[128] 'Registration and/or eligibility to practice or work' has been assessed using the requirements of the relevant National Board, registry or professional association(s). Where registration for a profession is non-mandatory pursuant to the National Registration and Accreditation Scheme (NRAS), the relevance of qualifications listed will vary between professions.

Occupation	**Minimum tertiary qualification[126] (length)**	**AQF level**	**Relevant body[127]**	**Mandatory registration[128] (when?)**
Audiologist	Master's degree (2 years — this does not include the relevant undergraduate degree)	9	Audiology Australia	No
Biomedical engineer	Bachelor's degree with Honours (4 years)	8	Engineers Australia	No
Biomedical technologist	Diploma (1 year)	5	N/A	No
Cardiac technologist (cardiac physiology)	Bachelor's degree (3–4 years)	7	Professionals in Cardiac Sciences Australia	No
Child psychotherapist	Master's degree (3 years part-time — this does not include the relevant undergraduate degree)	9	Child Psychoanalytic Psychotherapy Association	No
Chiropractor	Bachelor's degree (4–5 years)	7	Chiropractic Board of Australia	Yes (immediately after degree is complete)
Client advisor/ rehabilitation consultant	Bachelor's degree (3 years)	7	Australian Rehabilitation Providers Association	No
Clinical perfusionist	Master's degree (2 years — this does not include the relevant undergraduate degree)	9	Australian and New Zealand College of Perfusionists	No
Community development worker	Diploma (2 years)	5	Community Work Australia	No
Counsellor	Diploma (1 year) (non-clinical) or Bachelor's degree (3 years) (clinical)	5–7	Australian Register of Counsellors & Psychotherapists	No
Dental hygienist	Advanced Diploma (2 years — this does not include the relevant prerequisite Certificate III)	6	Dental Board of Australia	Yes (immediately after course is complete)
Dental prosthetist	Advanced Diploma (2 years — this does not include the relevant prerequisite Diploma)	6	Dental Board of Australia	Yes (immediately after course is complete)
Dental therapist	Bachelor's degree (3 years)	7	Dental Board of Australia	Yes (immediately after degree is complete)

Occupation	**Minimum tertiary qualification[126] (length)**	**AQF level**	**Relevant body[127]**	**Mandatory registration[128] (when?)**
Dietician	Bachelor's degree (4 years)	7	Dietitians Australia	No
Diversional therapist (recreation therapist)	Bachelor's degree (3 years)	7	Australian Recreational Therapy Association	No
Exercise physiologist	Bachelor's degree (4 years)	7	Exercise & Sports Science Australia	No
Genetics counsellor	Master's degree (2 years — this does not include the relevant undergraduate degree)	9	Human Genetics Society of Australasia	No
Health information manager	Bachelor's degree (3 years)	7	Health Information Management Association Australia	No
Homeopathist[129]	Bachelor's degree (3 years)	7	Australian Register of Homoeopaths	No
Masseur, remedial	Diploma (1 year)	5	Association of Massage Therapists	No
Medical imaging technologist (includes medical radiographer, magnetic resonance imaging technologist)[130]	Bachelor's degree (4 years)	7	Medical Radiation Practice Board of Australia	Yes (immediately after degree is complete)
Medical laboratory technician	Diploma (1 year)	5	Australian Institute of Medical and Clinical Scientists	No
Medical librarian	Bachelor's degree (3 years)	7	Australian Library and Information Association	No
Medical photographer / illustrator	Diploma (1 year)	5	Australian Institute of Medical and Biological Illustration	No
Medical record administrator[131]	Bachelor's degree (3 years)	7	Health Information Management Association of Australia Ltd.	No

[129] There is no Nationally Recognised Training course for homeopaths. Homeopaths are categorised under ANZSCO 252212 Health Professionals nec [not elsewhere classified] and assigned Skill level 1, which is Bachelor's degree or higher.

[130] 'Radiation therapist' is included in this item in Sch B to the HPSS Award, but has been listed separately below in the table

[131] The unions' position is that this is the historical name for health information managers on the basis that the Health Information Management Association of Australia was previously the Medical Record Association, and therefore the required qualification is the same as for health information managers. The Private Hospitals' position is that this is a separate occupation on the basis that 'health information manager' and 'medical record administrator' are separately listed in Sch B to the HPSS Award, and that the relevant qualification for a medical record administrator is at Certificate III level.

Occupation	**Minimum tertiary qualification[126] (length)**	**AQF level**	**Relevant body[127]**	**Mandatory registration[128] (when?)**
Medical technician / renal dialysis technician[132]	Diploma/Advanced Diploma/Associate Degree	5	N/A	No
Musculoskeletal therapist	N/A (therapist) or Bachelor's degree (4 years) (physiotherapist)	N/A or 7	N/A (therapist) or Physiotherapy Board of Australia (physiotherapist)	No (therapist) or yes (immediately after degree is complete) (physiotherapist)
Music therapist	Master's degree (2 years — this does not include a relevant undergraduate degree)	9	Australian Music Therapy Association	No
Myotherapist	Advanced Diploma (1 year — this does not include relevant prerequisite diploma)	6–7	Massage & Myotherapy Australia or Myotherapy Association Australia	No
Naturopathist	Bachelor's degree (4 years)	7	Australian Natural Therapists Association	No
Nuclear medicine technologist	Bachelor's degree (4 years)	7	Medical Radiation Practice Board of Australia	Yes (immediately after degree is complete)
Occupational therapist	Bachelor's degree (4–5 years)	7	Occupational Therapy Board of Australia	Yes (immediately after degree is complete)
Oral health therapist	Bachelor's degree (3 years)	7	Dental Board of Australia	Yes (immediately after degree is complete)
Orthoptist	Bachelor's degree with Honours (4 years)	8	Australian Orthoptic Board	No
Osteopath	Master's degree (1.5–2 years — this does not include the relevant undergraduate degree)	9	Osteopathy Board of Australia	Yes (immediately after degree is complete)
Pastoral carer (spiritual carer)	Bachelor's degree (3 years)	7	Spiritual Care Australia	No
Pharmacist	Bachelor's degree (4 years)	7	Pharmacy Board of Australia	Yes (after 1575 hours' supervised practice, plus written and oral examination)
Physiotherapist	Bachelor's degree (4 years)	7	Physiotherapy Board of Australia	Yes (immediately after degree is complete)

[132] Medical Technician/renal technician is categorised under ANZSCO 311299 Medical and Dental Technicians nec [not elsewhere classified] and assigned Skill Level 2.

Occupation	Minimum tertiary qualification[126] (length)	AQF level	Relevant body[127]	Mandatory registration[128] (when?)
Play therapist (child life therapist)	Bachelor's degree (3–4 years)	7	Association of Child Life Therapists Australia	No
Podiatrist	Bachelor's degree (3–4 years)	7	Podiatry Board of Australia	Yes (immediately after degree is complete)
Prosthetist / orthotist	Bachelor's degree (3years)	7	The Australian Orthotic Prosthetic Association Ltd	No
Psychologist	Master's degree (2 years — this does not include a relevant undergraduate degree)	8	Psychology Board of Australia	Yes (several pathways)
Radiation therapy technologist / radiation therapist	Bachelor's degree (4 years)	7	Medical Radiation Practice Board of Australia	Yes (immediately after degree is complete)
Reflexologist	No Nationally Recognised Training (NRT) qualification	N/A	Reflexology Association of Australia	No
Scientist, medical	Bachelor's degree (3 years)	7	Australian Institute of Medical and Clinical Scientists	No
Social worker	Bachelor's degree (4 years)	7	Australian Association of Social Workers	No
Sonographer (ultrasonographer)	Graduate Diploma (1 year — this does not include a relevant undergraduate degree)	8	Australian Sonographer Accreditation Registry	No
Speech pathologist	Bachelor's degree (4 years)	7	Speech Pathology Australia	No
Welfare worker	Diploma (2 years)	5	Community Work Australia	No
Youth worker[133]	Diploma (2 years)	5	Youth Workers Australia	No

Note: Research Technologist is included in Schedule B of the HPSS Award, however, there is no corresponding Australian and New Zealand Standard Classification of Occupations code or AQF course. This occupation has not been included in the table.

[124] The qualification and period of training/education needed to enter an occupation is fundamental to an assessment of its work value, since this is necessarily indicative of the intellectual demands, complexity and the degree of autonomous judgment required in the conduct of the occupation. The differences in work value between the various health profession

[133] The unions' position is that since Youth Workers Australia requires associate members to have a Diploma and extensive youth work experience, and full members to hold a Bachelor of Youth Work, the minimum qualification is a Diploma. The Private Hospitals' position is that the minimum qualification to work as a youth worker is a Certificate IV.

occupations which the table above indicates exist is not properly reflected in the minimum pay rate structure for health professionals under the HPSS Award.

[125] The minimum rates of pay do not align with the C10 Metals Framework. For example, the entry-level weekly rate for a health professional requiring a four-year degree is, at $1174.60, lower than the C6 rate ($1183.50) for which only a level of study towards a diploma is required. Such a professional does not reach the C1(a) benchmark rate of $1525.90 until they reach the top pay point in Level 2 ($1541.60), which requires a minimum of seven years in employment in their occupation. The position of a health professional with a four-year degree under the HPSS Award may be compared to that of a teacher with a four-year degree under the EST Award, which has properly-fixed minimum rates of pay as a result of the *Teachers decision*:

HPSS Award — 4 year degree		**EST Award — teacher**	
Classification criteria	$ per week	Classification criteria	$ per week
1st year — Level 1 pay pt 3	1174.60	Level 1: Provisional registration	1396.10
2nd–4th year — Level 1 pay pt 4–6	1215.00 1323.60 1370.50	Level 2: Registered	1525.90
5th–7th year — Level 2 pay pt 1–3	1378.00 1428.10 1482.60	Level 3: after 3 years at Level 2	1661.20
8th year — Level 2 PP 4	1541.60	Level 4: after 3 years at Level 3	1796.50

[126] Even in respect of health professionals requiring only a UG2 qualification, there is no alignment with the C10 Metals Framework. Such an employee will only reach the C5 rate in the Manufacturing Award ($1207.80), for which a diploma is required, in the fourth year of employment.

[127] The internal relativities in the HPSS Award as between support services employees and health professional employees are also distorted. For example, the entry-level minimum weekly wage rate for a health professional with a three-year degree ($1124.80) is the same as for a Support Services employee Level 6, for which the only qualification requirement is: 'may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience'. For a UG2-qualified health professional, who is required to have at least a diploma, the entry-level rate is lower ($1082.90). Similarly, the first-year minimum wage rate for a health professional with a Master's degree ($1215.00) is the same as for a Support Services employee Level 8, pay point 2, for whom '[t]he possession of relevant post[-]secondary qualifications may be appropriate but not essential'.

4.1.2 Award history

[128] The history of the development of the HPSS Award is outlined in the Stage 2 Report. With respect to the health professional employee classifications, the classifications and rates of pay established by the AIRC award modernisation Full Bench appear to have been drawn from, or at least influenced by, a number of pre-existing awards principally including the federal *Health Services Union of Australia (Health Professional Services – Private Sector Victoria) Award 2004*[134] and the *Health Services Union of Australia (Victoria - Private Sector - Medical*

[134] AP835426.

Scientists, Psychologists and Pharmacists) Award 2004,[135] as well as the *Medical Scientists (South Australian Public Sector) Award*[136] and the NSW *Private Hospital Employees (State) Award*.[137] The first two of these awards had their origin in the *Health Services Union of Australia (Victoria – Private Sector) Interim Award 1993*.[138] The circumstances in which this award was made are described in the *Stage 3 Aged Care decision* at [98]. In short, this award was made on an interim basis following the abolition of the Victorian arbitration and award system, and it required the employer respondents to it, which were private health sector employers in Victoria, to continue to pay the rates prescribed by a number of previous Victorian-system awards. This included, in respect of allied health professionals, the Victorian *Health Professional Services Award*, the *Hospital Pharmacists Award*, the *Medical Scientists Award* and the *Psychologists Award*. In respect of professional employees, the interim award continued in operation until 2004, and was adjusted in line with national wage movements over that period. The two 2004 awards were made as a result of the award simplification process mandated by item 51 of Part 2 of Schedule 5 to the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth). They appear to have been made by consent, without any accompanying decision of the AIRC which provides insight into the process by which they were made or the considerations which informed the setting of the wage rates in them.

[129] We note that none of these predecessor awards treated differently-qualified health professionals indiscriminately in the wage rate structure in the way that the HPSS Award does. None was the product of a proper consideration of the work value of the occupations covered by the award. Nor were any of the awards aligned with the C10 Metals Framework.

[130] When it published the exposure draft for the HPSS Award on 23 January 2009, the AIRC award modernisation Full Bench said: [139]

> The exposure draft of the *Health Professionals and Support Services Industry and Occupational Award 2010* is a generic exposure draft to cover professional and technical classifications together with clerical and administrative classifications. We have sought, in the salary structure and level of salaries, to accommodate all health professionals (except doctors and nurses) employed in both the health industry and industry generally. At this stage we have not attempted to attach particular professions or skills to any particular pay point. We invite the parties to examine this and provide advice during the consultations. We have attached as Schedule B to the award a list of common occupation names which should also be considered.
>
> The draft awards covering nurses and health professionals have a common entry rate for a three[-]year degree. We have struck the minimum wage for both classifications at $697.00 per week.
>
> We have not included qualifications allowances in the draft awards for nurses or health professionals. Our provisional view is that the classification structure should deal with qualifications in two ways. The first is the entry rate, which the drafts provide for, and the second is the level at which people are classified…

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[135] AP833755.

[136] AN150080.

[137] AN120434.

[138] AW783559, [1993] AIRC 1711, Print L0831.

[139] [2009] AIRCFB 50, 180 IR 124 [78]–[80].

[131] We infer that the 'common entry rate' of $697.00 was set as a rough average of the existing entry rates in the pre-modern awards to which we have referred. It certainly did not reflect any independent assessment of the work value of the health professions in question.

[132] No further issues arose with respect to the exposure draft relevant to the classifications and rates of pay for health professionals, and the HPSS Award was published on 3 April 2009.[140] There has been no further consideration of the classifications and rates of pay for professional employees under the HPSS Award since that time, apart from adjustments to the indicative list of health professionals in Schedule B.

4.1.3 Gender profile

[133] Health professionals as an occupation group (Australian and New Zealand Standard Classification of Occupations[141] (ANZSCO) code 25), including Health Diagnostic and Promotion Professionals, Health Therapy Professionals, Medical Practitioners, and Midwifery and Nursing Professionals) are female-dominated: 74.5 per cent are women. Particular professions within this group which are covered by the HPSS Award are similarly female-dominated. These include:[142]

Occupation	**Percentage that are female**
Nutrition Professionals (incl. dietitians, nutritionists)	93.6
Audiologists and Speech Pathologists/Therapists	93.2
Occupational Therapists	91
Other Health Diagnostic and Promotion Professionals (incl. orthotists, prosthetists)	78.3
Complementary Health Therapists (incl. acupuncturists, homeopaths, naturopaths)	73.2
Health Therapy Professionals, not further defined	72.1
Medical Imaging Professionals	71.6
Physiotherapists	64.3
Optometrists and Orthoptists	62.8

[134] Psychologists, who are classified as Legal, Social and Welfare Professionals (ANZSCO code 2723) are 81.6 per cent female. Medical Laboratory Scientists are classified as Design, Engineering, Science and Transport Professionals (ANZSCO code 2346) and are 69.9 per cent female.[143]

[135] Within the 'hospitals (except psychiatric hospitals)' industry class (Australian and New Zealand Standard Industrial Classification (ANZSIC) code 8401), the proportion of female health professionals is often even higher. For example, 96.6 per cent of Audiologists and Speech Pathologists/Therapists, 95.7 per cent of Nutrition Professionals, 92.9 per cent of

[140] [2009] AIRCFB 345 [145].

[141] The Occupation Standard Classification for Australia replaced the Australian and New Zealand Standard Classification of Occupations from 6 December 2024: Australian Bureau of Statistics, *OSCA – Occupational Standard Classification for Australia* (6 December 2024). This occurred partway through the substantive proceedings in the Review. Accordingly, we have retained ANZSCO codes in this decision.

[142] Derived from Tables A.3, A.4 and A.5 of the Stage 1 Report.

[143] Derived from Tables A.3 and A.5 of the Stage 1 Report.

Occupational Therapists, 84.7 per cent of Psychologists, 78.1 per cent of Physiotherapists and 72.1 per cent of Medical Laboratory Scientists employed in hospitals are female.[144]

4.1.4 Parties' positions

[136] The ACTU, together with the HSU, the UWU and the ASU, submitted that health professionals under the HPSS Award had been the subject of gender-based undervaluation, on the basis that they were highly feminised, had not been the subject of any systematic work value assessment, and their minimum rates of pay had not been properly aligned with the C1 rate in the C10 Metals Framework. The ACTU also submitted that health professionals exercised 'invisible' skills, including interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination. These matters, it submitted, constituted work value reasons justifying the variation of the classifications and rates of pay for health professionals under the HPSS Award. The ACTU proposed that this be rectified by modifications to the existing classification and rate structure. In respect of Level 1, the proposal is that there would be two pay points for each of five categories of qualifications based on their AQF level (encompassing AQF Levels 6 to 10), with the C1(a) benchmark rate of $1525.90 per week applying to the second pay point for an employee with an AQF Level 7 qualification (i.e. a Bachelor's degree). The other rates in Level 1, and in Levels 2, 3 and 4 are proposed to be adjusted proportionately to maintain existing internal relativities.

[137] The Private Hospitals Group submitted that, unlike in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*, there is not a sufficient evidentiary basis for a finding that there has been an increase in the work value of health professionals. There have not been any significant increases in the skills required for many occupations of health professionals over the last 20 years and, in some occupations the complexity of the role has reduced because of increased efficiencies. In respect of gender-based undervaluation, the Private Hospitals Group submitted that s 157(2B)(b) required consideration of whether there was a causal connection between undervaluation and assumptions based on gender and that the Stage 1 and Stage 2 Reports had not demonstrated any such causal connection. It was also submitted that the health professional occupations covered by the HPSS Award are not in any event uniformly female-dominated. The Private Hospitals Group submitted that the work of the health professional classifications did not involve the exercise of 'invisible' skills at all or at least not to the same degree as described in the *Stage 3 Aged Care decision*, which was a fundamental element of the finding of gender-based undervaluation in that case, and that mere non-alignment with the C1 rate was not a sufficient basis to find that there were work value reasons justifying changes to the minimum award rates in the absence of any demonstration of work value change or the non-recognition of 'invisible' or caring skills.

[138] The Private Hospitals Group also made submissions about the financial position of the private health sector and the likely business impact of the cost of increases to the rate of pay in the HPSS Award. We deal with those submissions in part 4.6 of our decision.

[139] ABI, the NSWBC and the Aged & Community Care Providers Association (ACCPA) accepted that the relevant classifications in the HPSS Award had never been the subject of any comprehensive work value assessment, and submitted that it did not intend to prosecute a case

[144] Derived from Tables B.1, B.2 and B.3 of the Stage 1 Report.

that historical assessments of the relevant work had been free from assumptions based on gender and that, as such, the work had been properly valued. Nonetheless, it submitted that the breadth and diversity of the professional occupations covered by the HPSS Award made an approach of the type taken in *Stage 3 Aged Care decision* unavailable in this case, and that any variation to the minimum wage rates and classifications needed to properly reflect the diversity of the work covered by the award. In particular, it was submitted, it could not be said that the work of all employees under the professional classifications in the HPSS Award involved the exercise of 'invisible' skills or constituted 'caring work'. Further, it was submitted that a simple alignment between the C1(a) benchmark rate and the HPSS Award is unlikely to be appropriate having regard to the different qualifications and registration requirements for each occupation group.

[140] The Australian Association of Massage Therapists Limited, which operates under the name of Massage & Myotherapy Australia (MMA) and represents qualified remedial massage therapists, therapeutic massage therapists and myotherapists, submitted that the professional massage sector was female-dominated by a factor of 4:1, and that based on survey evidence 75 per cent of practitioners in the sector held a diploma qualification and 19 per cent held an advanced diploma or Bachelor's degree. MMA submitted that the work of massage therapists was undervalued, but its proposed remedies for this broadly related to the proper recognition and regulation of the profession of massage therapist and not to the terms of the HPSS Award.

[141] The Australian Diagnostic Imaging Association (ADIA) is an organisation which represents private radiology practices employing radiology professionals including radiographers, sonographers, MRI technologists and nuclear medicine technologists. The ADIA accepted that radiology professionals are predominantly female, with the 2022–23 AHPRA annual report identifying that 68.85 per cent of registered medical radiation practitioners are women. The ADIA submitted that the cost of radiology services was increasing faster than the Medicare funding for such services, which meant that bulk billing was declining while demand for radiology services was increasing. Consequently, it was submitted, the Review insofar as it concerned health professionals under the HPSS Award should take into account these factors and their implications for accessibility to and the provision of radiology services.

4.1.5 Evidence

[142] The ACTU and the HSU relied on evidence given by the following witnesses in relation to health professional employees covered by the HPSS Award:

(1) Sarah Durran[145] is a Pharmacy Manager employed by Barwon Health. She holds a Bachelor of Pharmacy (Honours), a Graduate Certificate of Pharmacy Practice and a Master of Clinical Pharmacy. Ms Durran primarily works at St John of God Geelong Hospital, with some weekend shifts at the University Hospital, Geelong. She is currently employed as a part-time pharmacist, but works full-time hours. Ms Durran previously worked as a Clinical Pharmacist at Barwon Health for eight years, from 2012. She gave evidence about the increasing complexity of her work, work responsibilities and the training, skills and knowledge used at work.

[145] Exhibit HPSS7 (witness statement of Sarah Durran, 2 October 2024, as amended and refiled on 11 December 2024).

(2) Elizabeth Muir[146] is a full-time radiation therapist and is currently employed by the Peter MacCallum Cancer Centre. She works at the Sunshine Hospital Radiation Therapy Centre. She holds a Bachelor of Allied Science (Medical Radiation Science) – Radiation Therapy. Ms Muir has been working for Peter MacCallum Cancer Centre since graduating in 2002. She gave evidence regarding the position itself, the increasing complexity of the work, work responsibilities and the training, skills and knowledge used at work.

(3) Alex Leszczynski[147] is a Senior Industrial Officer with the HSU Victoria No. 3 Branch, also known as the Victorian Allied Health Professionals Association (VAHPA). Mr Leszczynski gave evidence about the allied health professionals that VAHPA is entitled to represent, including medical imaging technologists, physiotherapists, occupational therapists, social workers, radiation therapists and speech pathologists, and the various settings in which they work. He also gave evidence about typical features of the enterprise bargaining processes VAHPA engages in on behalf of its members and the factors informing the wages and conditions that it seeks in those processes, including the allied health professionals' qualifications, skills, experience and knowledge, the significance of their work to society generally, the heavy workload and unsociable rostering arrangements they may experience and their increased exposure to illnesses in some workplace settings. Mr Leszczynski further discussed the qualifications VAHPA's members hold and how these have changed over time, partly because of the 'professionalisation' of their roles. He also discussed the National Registration and Accreditation Scheme (NRAS), which AHPRA administers and which applies to dental practitioners, medical radiation practitioners, occupational therapists, physiotherapists and podiatrists. Mr Leszczynski further gave evidence about the professional registration requirements that apply to certain allied health professionals to whom NRAS does not apply, and the common requirement for clinical supervision of and/or supervised practice by newer allied health professionals. Finally, he gave evidence about the changing nature of the work of VAHPA's members, particularly their expanding scope of practice, the requirement for them to work as part of a multi-disciplinary team, the increasing workload and the emotional impact of the work.

(4) Paul Elliott[148] is an Industrial Officer and former Secretary of the Medical Scientists Association of Victoria, a component association of the HSU Victoria No. 4 Branch (HSU4). Mr Elliott gave evidence about the growing number of health professionals that HSU4 is entitled to represent, including audiologists, clinical perfusionists, dieticians, genetic counsellors, medical scientists, pharmacists and psychologists, the various settings in which they work and his experience of enterprise bargaining on behalf of those employees. In particular, he deposed that while the rates in enterprise agreements that cover the majority of HSU4 members are significantly above the minimum rates of pay for their

[146] Exhibit HPSS8 (witness statement of Elizabeth Muir, 2 October 2024).

[147] Exhibit HPSS9 (witness statement of Alex Leszczynski, 18 October 2024).

[148] Exhibit HPSS10 (witness statement of Paul Elliott, 18 October 2024, as amended and refiled on 11 December 2024).

corresponding award classifications, that outcome is not easily obtained because 'employers treat the [a]ward rates as "market" rates and argue the rates in their enterprise agreements are already above the "market" rate'.[149] Mr Elliott gave evidence about the most common entry-level qualifications that HSU4 health professional members hold, and their professional development and (where applicable) official registration requirements. He also provided his observations of how the nature of HSU4 members' work has changed in his time representing them.

(5) Toni Franklin[150] is a dietician currently employed full-time by Healthscope Operations Pty Ltd (Healthscope). Ms Franklin holds a Bachelor of Science and a Postgraduate Diploma in Dietetics. She has also completed several accreditations and courses, most recently in 2017. She has worked at Knox Private Hospital since 2019 and has worked for Healthscope for seven years. Ms Franklin has also worked as a Sport Dietician in a sole trader capacity, and in other roles as a Clinical Dietician in the United Kingdom (UK) and New Zealand. She gave evidence about her work and responsibilities, the increasing complexity of the work, the training, skills and knowledge used at work and the difficult aspects of the job and its demands.

(6) Sarah Lloyd[151] is a transplantation and immunogenetics scientist. Ms Lloyd holds a Bachelor of Biomedicine (Honours) and a PhD in microbiology and immunology. She is currently employed by Australian Red Cross Lifeblood and has worked at its Melbourne Processing Centre for seven-and-a-half years. Ms Lloyd gave evidence regarding her duties, responsibilities, the workload, the training, skills and knowledge used at work and work demands.

(7) Catherine Durkin[152] is a medical scientist employed by the Pathology Department at Peter McCallum Cancer Centre. She holds a Bachelor of Science (Medical Laboratory) with first-class Honours and a Certificate of Medical Laboratory Science. Ms Durkin is employed as a part-time medical scientist and also teaches undergraduate and postgraduate medical laboratory science students at the Royal Melbourne Institute of Technology. She has been working in laboratories for 50 years. Ms Durkin gave evidence regarding the nature of her role and the work itself, duties and responsibilities, the difficult aspects of the job and its increasing complexity, work demands and training, skills and knowledge used at work.

(8) Rute Ribeiro[153] is a Senior Social Worker currently employed at Silverchain Group. Ms Ribeiro holds a Bachelor of Social Work from the University of

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[149] Ibid [27].

[150] Exhibit HPSS11 (witness statement of Toni Franklin, 11 October 2024, as amended and refiled on 12 December 2024); exhibit HPSS12 (reply witness statement of Toni Franklin, 28 November 2024, as amended and refiled on 12 December 2024).

[151] Exhibit HPSS13 (witness statement of Sarah Lloyd, 1 October 2024).

[152] Exhibit HPSS14 (witness statement of Catherine Durkin, 29 September 2024, as amended and refiled on 12 December 2024); exhibit HPSS15 (supplementary witness statement of Catherine Durkin, 18 November 2024).

[153] Exhibit HPSS18 (witness statement of Rute Ribeiro, 2 October 2024); exhibit HPSS19 (reply witness statement of Rute Ribeiro, 28 November 2024).

Madeira in Portugal, which was recognised by the Australian Association of Social Workers in 2014, as well as a Master of Advanced Social Work. She was also due to complete a Graduate Certificate in Health Leadership by December 2024. Ms Ribeiro gave evidence regarding her role and position, responsibilities, training, skills and knowledge used at work, the increasing complexity of work and difficult aspects of the job.

(9) Marni Jackson[154] is a Senior Physiotherapist currently employed by West Gippsland Healthcare Group. She holds a Bachelor of Physiotherapy (Honours). Ms Jackson currently works as a part-time physiotherapist across two worksites, the West Gippsland Hospital and the Allied and Community Health Centre. She gave evidence regarding the position and work undertaken, responsibilities, the clients she sees, training, skills and knowledge used at work, the difficult aspects of the job and work demands.

(10) Kim Phipps[155] is an occupational therapist employed by Eastern Health. She also practises as a sole practitioner seeing home care package clients. Ms Phipps holds a Bachelor of Health Sciences (Occupational Therapy) and a Master of Health Sciences (Occupational Therapy). Her role with Eastern Health is currently based at Box Hill Hospital but she can be directed to work at any Eastern Health service. She has previously worked for other private health service providers (Austin Health and Donvale Rehabilitation Hospital). She gave evidence about her duties in both her current and previous roles.

(11) Bronwyn Rademaker[156] is a Senior Speech Pathologist, currently employed by Grampians Health Ballarat. She holds a Bachelor of Health Science (Speech Pathology). Ms Rademaker has been a speech pathologist for around 18 years, and has previously worked at St Vincent's Hospital, Melbourne. She has been with her current employer since 2019. Ms Rademaker is currently based in the Queen Elizabeth Centre, a site of Ballarat Base Hospital. She gave evidence about her role and position, the work and skills used in the work, the difficult aspects of the job and the increasing complexity of the work.

(12) Samantha Holmes[157] is a medical scientist employed by Melbourne Pathology. She holds a Bachelor of Biomedical Science and a Master of Laboratory Medicine. Ms Holmes works at various laboratories that service private hospitals in and around Melbourne. She gave evidence about her duties, workload and how she uses her training, skills and knowledge in the course of her role.

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[154] Exhibit HPSS23 (witness statement of Marni Jackson, 29 September 2024, as amended and refiled on 12 December 2024); exhibit HPSS24 (reply witness statement of Marni Jackson, 27 November 2024).

[155] Exhibit HPSS27 (witness statement of Kim Phipps, 5 October 2024); exhibit HPSS28 (reply witness statement of Kim Phipps, 28 November 2024).

[156] Exhibit HPSS29 (witness statement of Bronwyn Rademaker, 1 October 2024, as amended and refiled on 12 December 2024); exhibit HPSS30 (reply witness statement of Bronwyn Rademaker, 26 November 2024).

[157] Exhibit HPSS41 (witness statement of Samantha Holmes, 1 October 2024).

(13) Sarah Backhous[158] is a speech pathologist currently employed by the Royal Institute for Deaf and Blind Children (NextSense). She holds a Bachelor of Health Science and Master of Speech Pathology. Previously, Ms Backhous worked as a speech pathologist in the public health system, at Bass Coast Health and Gippsland Southern Health Services from 2014 to 2019. She currently works part-time at NextSense, with varied hours to meet the clients' needs, and works one day a week privately as a sole trader. Ms Backhous gave evidence regarding the work and her role, responsibilities, overview of clients, training, skills and knowledge used in the work, the increasing complexity of the work, and the problems and challenges of the job.

(14) Elizabeth Cobbledick[159] is an oral health therapist employed by Dental Health Services Victoria. She holds a Bachelor of Oral Health and a Graduate Certificate in Dental Therapy (Advanced Clinical Practice). Ms Cobbledick has been an oral health therapist for 13 years and spent the majority of her career working in the community and public health sectors. In 2015 and 2016, she worked as an oral heath therapist demonstrator at La Trobe University. Ms Cobbledick provided evidence about her role, the patients she works with, the training, skills, and knowledge required, and the expanded scope of oral health therapy practice.

(15) Georgia Craigie[160] is a psychologist currently employed by the Child and Adolescent Mental Health Service (CAMHS) which is a sub-branch of Barwon Health. She also works as a Research Fellow at Deakin University. She has been a registered psychologist for approximately 18 months and performs work for the CAMHS in a part-time capacity. She holds a Bachelor of Psychology (Honours) and a Doctor of Psychology (Clinical). As a psychologist, she shared insights into her work, the clients she assesses and treats helps, the skills, training and knowledge involved, and the challenges and emotional demands she faces.

(16) Shaani Graves[161] is the Head of Audiology at Monash Health. She holds a Bachelor of Arts majoring in English and Linguistics, a Postgraduate Diploma in Audiology and an Advanced Diploma of Business Management. Ms Graves gave evidence about her role and the field of audiology, including a broad overview of the work performed by audiologists. This encompassed a description of her patients, the training, skills and knowledge used in her work and the increasing complexity of the work.

(17) Helen Jeges[162] is a Senior Paediatric Neuropsychologist employed by Latrobe Regional Health who has 21 years of experience working in paediatric neuropsychology. She is primarily based at Latrobe Regional Hospital in Traralgon, Victoria. Ms Jeges sometimes performs work at Sale Hospital, the

[158] Exhibit HPSS52 (witness statement of Sarah Backhous, 17 October 2024); exhibit HPSS53 (reply witness statement of Sarah Backhous, 29 November 2024).

[159] Exhibit HPSS54 (witness statement of Elizabeth Cobbledick, 7 October 2024).

[160] Exhibit HPSS55 (witness statement of Georgia Craigie, 1 October 2024).

[161] Exhibit HPSS56 (witness statement of Shaani Graves, 3 October 2024).

[162] Exhibit HPSS57 (witness statement of Helen Jeges, 2 October 2024); exhibit HPSS58 (reply witness statement of Helen Jeges, 26 November 2024).

Bairnsdale Community Mental Health Service, the Warragul Community Mental Health Service and Latrobe Valley Community Mental Health Services. She holds a Bachelor of Applied Science with first-class Honours and a Doctor of Psychology in Clinical Neuropsychology. In her evidence, Ms Jeges canvassed a description of her role as a paediatric neuropsychologist, her clients, her training, skills and knowledge which she relies upon, and the difficulties associated with her job.

(18) Karl Little[163] is a medical imaging technologist employed by Bairnsdale Regional Health Service. He holds a Diploma in Medical Diagnostic Imaging from Christchurch Polytechnic in New Zealand, which was recognised by AHPRA when he moved to Australia. As a medical imaging technologist, he gave evidence about his work, the clients he sees, the training, skills and knowledge he requires, the challenges he faces, and how the job has become more complex.

(19) Karen Ponza[164] is a podiatrist employed by EACH. She holds a Bachelor of Podiatry. She gave evidence regarding her work as a podiatrist, including the types of clients she serves, the increasing complexity of her role, the training and skills required, the challenges she faces, and the demands of the job.

(20) Ella Sexton[165] is a clinical psychologist employed by the Peter MacCallum Cancer Centre. She holds a Bachelor of Science (Honours) in Psychology and a Master of Clinical Psychology. Ms Sexton gave evidence about the nature of her role, the education, skills and knowledge utilised when discharging her duties and the difficulties and demands associated with doing so.

(21) Samantha Splatt[166] is a Principal Psychology Educator employed by Barwon Health. Prior to this, she was Barwon Health's Chief Psychologist and had worked as a psychologist for 25 years. Ms Splatt holds a Bachelor of Arts (Psychology and Sociology), a Graduate Diploma of Educational Psychology and a Master of Psychology (Counselling Psychology). She gave evidence describing the work of psychology educators, her clients, the complexity of her work, the training, skills and knowledge used in her work and the demands associated with her role.

(22) Kirsten Martin[167] is a part-time physiotherapist employed by Healthscope. She holds a Bachelor of Physiotherapy and a Graduate Certificate in Sports Physiotherapy. Ms Martin gave evidence detailing the nature of her role, the people she works with, the skills she deploys and the difficulties she encounters as a physiotherapist.

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[163] Exhibit HPSS59 (witness statement of Karl Little, 7 October 2024).

[164] Exhibit HPSS60 (witness statement Karen Ponza, 3 October 2024).

[165] Exhibit HPSS61 (witness statement of Ella Sexton, 7 October 2024).

[166] Exhibit HPSS62 (witness statement of Samantha Splatt, 1 October 2024).

[167] Exhibit HPSS64 (witness statement of Kirsten Martin, 2 October 2024); exhibit HPSS65 (reply witness statement of Kirsten Martin, 26 November 2024).

[143] Ten of the above witnesses (Ms Durran, Ms Muir, Ms Franklin, Ms Durkin, Ms Ribeiro, Ms Jackson, Ms Phipps, Ms Rademaker, Ms Holmes and Ms Martin) were cross-examined by the Private Hospitals Group. We have taken Mr Elliott's and Mr Leszczynski's evidence on enterprise bargaining for health professional employees into account in our consideration of cost issues at part 4.6 of our decision, below.

[144] The ACTU also relied upon the expert report annexed to the witness statement of Sara Charlesworth[168] (Charlesworth Report) as to the work of health professional employees. In her report, Dr Charlesworth analysed a number of the above witness statements (as well as those relating to support services employees under the HPSS Award and dental employees under the ATSIHW Award) for the purpose of identifying gender-based undervaluation using a variety of criteria. The ACTU additionally relied upon an expert report of Stephen Duckett, Emeritus Professor of Health Policy at La Trobe University[169] (Duckett Report) and an expert report of James Stanford, the Director of the Centre for Future Work in Canada.[170] The Duckett Report concerned the financing and regulation of the health system and, in that context, he described the evolution of the training and work of health professionals in the health sector. In this respect, his report is relevant to our consideration in this part of the decision. His report is otherwise considered in the context of our consideration in part 4.6 of this decision. Dr Stanford's report concerned (among other things) the capacity of the private health sector to fund wage increases in the HPSS Award and is dealt with in part 4.6 of this decision below. Both Dr Duckett and Dr Stanford were cross-examined by the Private Hospitals Group.

[145] The Private Hospitals Group relied on evidence concerning the work of health professional employees in the private health sector under the HPSS Award given by the following witnesses:

(1) Ms Lynch,[171] though she primarily gave evidence in relation to the Pharmacy Award, also gave evidence about the hospital pharmacists employed by Ramsay, who are covered by the HPSS Award but all have enterprise agreements that apply to them. She described their duties and opined that their work in private hospitals 'has not fundamentally changed… over the past 20 years'.[172] Ms Lynch gave specific evidence in reply to Ms Durran's evidence about her work as a hospital pharmacy manager. She also gave evidence about the psychologists Ramsay employs, including that they comprise approximately equal numbers of men and women and work in both hospital and community settings.

(2) Matthew Knight[173] is the General Manager, Victorian Rehabilitation Hospitals at Healthscope. He holds a Bachelor of Physiotherapy (Honours) and a Master of Business Administration. Mr Knight last practised as a physiotherapist in 2016;

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[168] Exhibit HPSS112 (witness statement of Dr Sara Charlesworth, 18 October 2024) annexure SC-1.

[169] Exhibit HPSS116 (witness statement of Dr Stephen Duckett, 18 October 2024) annexure SD-1.

[170] Exhibit HPSS111 (witness statement of Dr James Stanford, 30 November 2024) annexure JS-1.

[171] Exhibit PH2 (witness statement of Michelle Lynch, 18 October 2024); exhibit PH3 (supplementary witness statement of Michelle Lynch, 29 November 2024).

[172] Exhibit PH2 (witness statement of Michelle Lynch, 18 October 2024) [31].

[173] Exhibit HPSS66 (witness statement of Matthew Knight, 18 October 2024); exhibit HPSS67 (second witness statement of Matthew Knight, 2 December 2024).

he has subsequently managed practising physiotherapists.[174] He gave evidence about the work of allied health workers, including physiotherapists, occupational therapists, social workers and dieticians, at the hospitals he manages.

(3) Dylan Rowley[175] has been the National Manager of Ramsay Health Plus since 2019. He holds a Bachelor of Applied Science – Physiotherapy. Mr Rowley last practised as a physiotherapist for a number of weeks in 2021; before that, he practised for approximately 12 months ending some time in 2019.[176] He gave evidence about the work of physiotherapists, occupational therapists, exercise physiologists and dieticians employed by Ramsay Health Plus.

(4) Kirby Young[177] is the Chief of Allied Health and Ambulatory Services at Cabrini Health, a role he has held since February 2018. By way of a separate engagement to his current employment at Cabrini Health, Mr Young continues to practise as a physiotherapist in a casual capacity on weekends once every three months.[178] He holds a Bachelor of Physiotherapy, a Post-Graduate Certificate in Musculoskeletal Physiotherapy, and a Master of Health Administration. Between December 2006 and March 2011, he practised as a physiotherapist at Angliss Hospital (a public hospital) as well as in private practice. Since April 2011, he has held a variety of leadership and managerial roles involving the provision of allied health services. Following his employment with Cabrini Health in 2013, he has practised as a physiotherapist periodically in his roles as Team Leader, Physiotherapy Rehab Outpatients (September 2013 – October 2014), Program Manager, Cabrini Allied Health Centre (January 2014 – November 2014), Program Director, Allied Health and Ambulatory Services, Cabrini Brighton (November 2014 – January 2017) and Program Director, Allied Health (Acute) and Ambulatory Services (January 2017 – February 2018).[179] In his current role, Mr Young manages (albeit not in a direct clinical supervisory capacity)[180] allied health professionals and ambulatory services at Cabrini Health. Mr Young gave evidence about the work performed by physiotherapists, occupational therapists, speech pathologists, dieticians, social workers, exercise physiologists, and art and music therapists who are employed by Cabrini Health and are often solely represented by Mr Young on high-level committees.

(5) Stephanie Price[181] is the Group Director of Radiation Therapy for Icon Group. She holds a Master of Health Management, a Graduate Certificate in Health Professional Education and a Diploma of Applied Science (Medical Radiation

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[174] Transcript, 16 December 2024 PNs 6240–6253.

[175] Exhibit HPSS76 (witness statement of Dylan Rowley, 18 October 2024).

[176] Transcript, 16 December 2024 PNs 6535–6542, 6550–6551.

[177] Exhibit HPSS70 (witness statement of Kirby Young, 18 October 2024); exhibit HPSS71 (supplementary witness statement of Kirby Young, 27 November 2024).

[178] Transcript, 16 December 2024 PNs 6394–6397.

[179] Ibid PNs 6403–6404.

[180] Ibid PNs 6407–6408.

[181] Exhibit HPSS82 (witness statement of Stephanie Price, 19 October 2024); exhibit HPSS83 (supplementary witness statement of Stephanie Price, 29 November 2024).

Technology) Therapeutic Radiography. Ms Price practised as a radiation therapist approximately monthly in her previous role ending in May 2024. She last practised full-time in December 2016.[182] Ms Price gave evidence about the work of radiation therapists and medical physicists employed by Icon Group.

(6) Leanne Hawke[183] is the National Health Information Manager for Healthscope. She holds a Bachelor of Health Information Management and has worked as a health information manager since 1997. Ms Hawke gave evidence about the role and duties of health information managers both at Healthscope and outside that organisation.

[146] All of the above witnesses were cross-examined by the ACTU. In addition to the evidence of these witnesses, the Private Hospitals Group relied on the following witnesses concerning the cost impact of increases to the minimum wage rates in the HPSS Award:

- Jane Griffiths, the Chief Executive Officer of Day Hospitals Australia;
- Christine Gee AM, the Chief Executive Officer of Toowong Private Hospital and President of the Australian Private Hospitals Association (APHA);
- David Kennedy, a Partner at Ernst and Young and chartered accountant;
- Katharine Bassett, the Director of Health Policy and Catholic Health Australia;
- Mark Nelson, the General Manager, Workplace Relations of Healthscope;
- Michelle Lynch, the Chief Executive Officer of the Ramsay Pharmacy and Psychology Group, a subsidiary of Ramsay;
- Conrad Truscott, the Director of Payor Relations at Ramsay; and
- Peter Ryan, the Director of Employee Relations and Policy at Ramsay.

[147] The evidence of these witnesses is considered in part 4.6 of this decision.

4.1.6 Consideration re gender-based undervaluation

[148] At the outset, we accept the submission made by the Private Hospitals Group that the evidence relied upon by the ACTU does not demonstrate, with respect to *each* health profession covered by the HPSS, that there has been significant work value *change* from a specified datum point (whether 20 years ago or otherwise). However, as the ACTU submissions made clear, the evidence was not adduced to establish a case of that nature. The inclusion of HPSS Award health professionals in this Review as a result of the *AWR 2024 decision* was, as earlier explained, founded on the fact that the minimum wage rates for degree-qualified health professionals in the award had never been aligned with the C1 rate.

[149] A work value change case for an award proceeds on the premise that, as at a given date, the wage rates for that award were properly fixed, but need to be adjusted for work value change that has occurred since that date. However, in respect of health professionals, the fundamental question which arises in is not whether, for each profession or any of them, there has been work value change from any specified datum point, but rather whether the minimum rates of pay in the HPSS Award have ever properly reflected the work value of such health professionals.

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[182] Transcript, 16 December 2024 PNs 6819–6823.

[183] Exhibit HPSS92 (witness statement of Leanne Hawke, 18 October 2024).

[150] We start with the uncontentious proposition that the wage rates for health professionals, at least in the federal sphere, were never determined by reference to a proper consideration of their work value. As earlier stated in our outline of the relevant award history, there are three relevant steps in that history: *first*, the interim award which operated from 1993 to 2004 simply incorporated wage rates from former awards of the Victorian industrial relations system; *second*, in 2004, new federal awards were made by consent without any transparency as to what considerations informed the agreement reached about those awards; and, *third*, the modern HPSS Award was made in the award modernisation process in 2009 drawing on classifications and pay rates in the existing federal awards as well as other State awards in a way which is not now ascertainable. There is no basis to conclude therefore that the rates of pay for health professionals in the HPSS Award were ever properly fixed in accordance with the principles stated in the *Paid Rates Review decision*. A simple comparison between the wage rates for health professionals in the HPSS Award and those in the C10 Metals Framework (as currently found in the Manufacturing Award or, in the case of the C1 classification, the notional rates we have referred to earlier) as set out above, disclose that at no point is there any alignment based on equivalent qualifications, with the HPSS Award rates being significantly lower at every comparable point.

[151] Further, the award history gives no basis for confidence that fundamental developments affecting the work value of the categories of professionals covered by the HPSS Award which have occurred in recent decades have ever been comprehended in the setting of the rates of pay in the HPSS Award or its federal award predecessors. Some of these fundamental changes were described at an overarching level in the Duckett Report, and they include:

- the establishment of regulatory schemes governing the entry, conduct and practice standards for a wide range of allied health professions, either by AHPRA and its associated boards pursuant to the *Health Practitioner Regulation National Law* or by self-regulation through professional organisations and codes of conduct and the like;

- from the 1980s, the shift in the education of allied health professionals from hospital-based training and college-based training to university degree courses, with the incorporation of health professional education into universities leading to a new focus on research in these professions;

- since the 1990s, development of advanced specialisations in many of the professions paralleling the specialities in medicine and the development of advanced practitioner roles with new educational pathways to these through university graduate diplomas and Master's degrees;

- the development since the 2000s of graduate-entry university programs whereby graduates with generalist undergraduate degrees could enter health professions via (typically) two-year Master's degrees;

- the expansion since the early 2000s of roles across all health professions, with most professions taking on roles previously the responsibility of medical

practitioners, in the context of greater recognition of the skills and knowledge of the health professionals and their ability to practise independently;

- the growth of private practice in many allied health professions, affecting the recruitment of practitioners;

- increasing complexity of practice due to an ageing population with more people living with multiple morbidity and chronic diseases; and

- a shift to an emphasis on multi-disciplinary teams, and a change in the conceptualisation of what such teams are, leading to a significantly more complex way of working.

[152] The point may further be illustrated in relation to one of the professions covered by the HPSS Award, that of psychologist. The lack of any transparent consideration of the work value of psychologists in the federal system may be contrasted to the position of NSW public sector psychologists, who have been the subject of comprehensive work value assessments by the NSW Commission. In 2001, the work value of psychologists in the NSW public health system was the subject of extensive consideration in the NSW Commission's decision in *Re Health and Community Employees Psychologists (State) Award*.[184] In its decision, the NSW Commission rejected the proposition that, because the award in question had been adjusted in recent decades in line with general wage movements, its wage rates met the statutory prescription of being 'fair and reasonable':[185]

> The fact that agreed rates of pay followed movements in other awards for other classifications may reflect little more than a convenient means of adjusting rates but without any regard at all for the inherent value of the work or the conditions under which it be performed.

[153] The NSW Commission found that there had been significant work value changes in the profession of psychologist which had not previously been taken into account in the fixation of wages, which it summarised as follows:[186]

> Our assessment of the overall evidence in the case, including the documentary material presented, may conveniently be summarised as leading to the following conclusions —
>
> > (1) The profession of psychology has undergone significant developments in recent years. Dr Wagner described it as an 'explosion of knowledge' in the last 20 years and the evidence of Ms Sawtell and Ms Spilsbury was to a similar effect. In the result, psychologists are required to continually maintain and develop their knowledge in light of developments and research; the application of such knowledge is effected often in a clinical setting and in conjunction with other health professionals.
> >
> > (2) The practice of psychology has become increasingly specialised whereas Dr Wagner described specialisation in the past as a 'rarity'. This trend has necessitated a greater focus on updating knowledge, particularly having in mind the pace and depth of research, and has emphasised the application of more detailed skills and expertise in the chosen

[184] [2001] NSWIRComm 302, 109 IR 458.

[185] Ibid [53].

[186] Ibid [58].

> specialised field be it in paediatric brain injury, epilepsy, neonatology, substance abuse, rehabilitation or counselling.
>
> (3) There is a significant emphasis on the achievement by psychologists of academic excellence and high standards of professional expertise.
>
> (4) To be eligible for, and to retain membership of, the relevant professional body, the Australian Psychological Society and its various Colleges, a psychologist must demonstrate on-going professional development through recognised programmes, conferences or additional qualifications.
>
> (5) The qualification for appointment as a Psychologist in the public health system at the entry level requires a three-year degree with a fourth year [of] honours in psychology. To qualify as a registered psychologist requires a further two years of supervision in the practice of the profession.
>
> (6) Appointment as a Clinical Psychologist requires a minimum of six years' training at the [M]aster's degree level with a mandatory component of supervision.
>
> (7) Senior psychologists are required to be involved in the training and supervision of students and other but less experienced psychologists. This involves practical supervision together with formal teaching sessions and acting as tutors, often in a tertiary institution.
>
> (8) There is an increased focus on multi-disciplinary diagnosis, treatment and follow-up by psychologists usually as part of a clinical team involving medical practitioners, nurses, therapists and social workers.

[154] In 2006, the NSW Commission made findings as to similar work value changes affecting psychologists in public sector community, corrective, juvenile, aged care and disability services in *Re Crown Employees (Psychologists) Award*.[187] It may be noted that a number of the described changes correspond to the overarching changes described in the Duckett Report.

[155] There is no basis to conclude that equivalent changes to the work value of private sector psychologists have ever been taken into account in the minimum wage rates prescribed by the HPSS Award. Even taking into account that the NSW *Health and Community Employees Psychologists (State) Award*[188] (HCEP Award) and the *Crown Employees (Psychologists) Award*[189] (CEP Award) are paid rates awards, the disparity between the wage rates in those awards and in the HPSS Award is marked and are likely explicable by the lack of any historical work value consideration in the HPSS Award or its predecessors. The table below compares the wage rates under the three awards for the first three years of employment for a psychologist entering the profession with a Master's degree (with the annualised salaries prescribed by the NSW awards expressed as weekly amounts):

	HPSS Award **$ per week**	**HCEP Award** **$ per week**	**CEP Award** **$ per week**
1st year	1215.00	1487.70	1471.80

[187] [2006] NSWIRComm 315, 156 IR 434.

[188] Serial C4298, 357 NSWIG 970.

[189] Serial C5356, 362 NSWIG 170.

	HPSS Award **$ per week**	**HCEP Award** **$ per week**	**CEP Award** **$ per week**
2nd year	1323.60	1564.30	1551.40
3rd year	1370.50	1641.00	1630.90

[156] Four psychologists — Ms Jeges, Ms Sexton, Ms Craigie and Ms Splatt — gave evidence via witness statements which was not the subject of any contest. Their evidence confirms the position that the work value changes described in the Duckett Report and in the NSW Commission decisions referred to above are all fundamental features of the current work of psychologists covered by the HPSS Award. Thus, the witnesses said that they:

- hold high-level qualifications, with Ms Jeges holding a doctoral degree and Ms Sexton and Ms Splatt holding Master's degrees;
- engage in specialised practice areas endorsed by AHPRA, with Ms Jeges practising clinical (paediatric) neuropsychology, Ms Sexton clinical psychology and Ms Splatt clinical and counselling psychology;
- work in multi-disciplinary teams;
- engage in supervision and training of students, interns, registrars, and psychology colleagues and more generally in professional education activities as well as participating in research;
- are required to conform with the ethical and professional practice standards established by the Psychology Board of Australia to maintain AHPRA registration, with a high level of accountability for any failure to meet those standards; and
- undertake self-directed ongoing professional development activities as a condition of AHPRA registration as well as keeping abreast of developments in research and best practice.

[157] In addition, the evidence of Ms Jeges, Ms Sexton, Ms Craigie and Ms Splatt disclosed further developments of work value significance since the NSW Commission decisions. The most significant of these is that the academic requirements for entry into the profession of psychologist have become more rigorous, in that the former '4 + 2' pathway requiring an AQF Level 8 qualification (Bachelor's degree plus honours or a graduate diploma) has been retired. It is now necessary to enter the profession by either a '5 + 1' pathway or a six-year pathway, both of which require an AQF Level 9 qualification (Bachelor's degree plus honours or a graduate diploma, plus a one- or two-year Master's degree). We conclude that the wage rates for psychologists in the HPSS Award have never comprehended the work value considerations referred to above.

[158] As explained earlier in this decision, the proper fixation of award wage rates for degree-qualified employees proceeds on the basis that, *prima facie*, there should be an alignment between a benchmark wage rate and the C1(a) benchmark rate in the absence of a work value assessment justifying any departure from this.

[159] In the case of health professional employees covered by the HPSS Award, the *prima facie* position has never applied. The question is therefore whether the evidence before us is sufficient to demonstrate any reason why, on work value grounds, the wage rates for such employees should be *lower* than would apply based on an alignment with the C10 Metals

Framework. The Private Hospitals Group did not in terms attempt to advance a case to justify this, and the evidence did not support such an outcome. In terms of the health professions requiring a university degree or higher that were the subject of witness evidence, that evidence demonstrates generally that the professions have the common characteristics of requiring high-level tertiary qualifications, autonomous practice based on the application of a body of skills and knowledge, regulatory accountability, the capacity to work as part of interdisciplinary teams, participation in training and supervision, and self-directed professional development.

[160] Much of the Private Hospitals Group's own evidence demonstrated this. For example, Mr Knight gave evidence about the work performed by physiotherapists, occupational therapists, social workers and dieticians at Healthscope's rehabilitation hospitals. The Healthscope position descriptions attached to his witness statement for these professions are instructive. For example, the position description for a base-level physiotherapist provides that the position's purpose is as follows:[190]

> This role will deliver exceptional Physiotherapy services to our Inpatient and/or Day Programs (Outpatients) and to ensure excellent clinical outcomes and an industry leading patient experience.
>
> Grade 1 clinicians will provide high quality assessment and intervention, to maximise functional independence, safety and quality of life of our rehabilitation patients, developing their skills, knowledge and experience from a base core competency level.
>
> Additional responsibilities may include participating in/assisting with training and quality improvement activities, assuming responsibility for appropriate clinical portfolios with the support of senior clinicians and allied health management, and assisting in the supervision of students and allied health assistants.

[161] Under the heading 'Improve the Experience', the position description describes the duties of the role as follows:[191]

- Provide an excellent standard of evidence based and person centred Physiotherapy care by establishing treatment plans, performing physiotherapy treatments, assessing and monitoring treatments plans, assessing environmental needs and identifying (and where relevant organising) equipment needs. Advocates for and involves patients, their families and significant others to participate in care, goal setting, discharge planning and preparation for home care.
- Demonstrates professional practice by adhering to AHPRA professional standards, code of ethics and conduct, legislative requirements, Healthscope's polices and processes, required registration, scope of practice and patient confidentiality and privacy.
- Fosters a learning environment by maintaining own professional learning and continuous professional development and providing supervision and teaching to student physiotherapists and Allied Health Assistants.
- Prioritises Healthscope's patient safety and quality frameworks by identifying areas of improvement, conducting clinical audits, initiating quality improvement projects, and when required participating in National Safety & Quality Healthcare Standards and risk committees/meetings.

[190] Exhibit HPSS66 (witness statement of Matthew Knight, 18 October 2024) annexure B.

[191] Ibid.

- Acts as a valued member of an inter-disciplinary team, including Nursing teams, Allied Health teams, and medical personnel to provide exceptional patient care by liaising with both medical nursing teams, participating in case conferences and family conferences and actively contributing to team processes and practices.
- Collaborate with external partners to ensure patients receive a high quality of care across the health care continuum.
- Maintains a professional and constructive working relationships with our VMO partners, using a customer service mindset, to enable high quality patient outcomes.
- Demonstrate operational efficiency by engaging in value added delivery processes.

[162] The mandatory qualifications for the role are a recognised degree in Physiotherapy and registration with AHPRA. The personal attributes of the role are:[192]

- Empathetic and caring
- Team player
- Continuous learner
- Positive approach
- Flexible and adaptable.

[163] The position description also refers to requirements for the demonstration of operational efficiency, service excellence ('Taking actions and developing relationships necessary to meet and exceed patient needs; holding self and others accountable; using appropriate interpersonal techniques'), safety advocacy, involving patients in decision-making, collaboration and continuous improvement.

[164] Healthscope's position descriptions for base-level occupational therapists, social workers and dieticians are similarly structured and have the same fundamental characteristics. For the occupational therapist, the purpose of the position is described as:[193]

> The Occupational Therapist - Grade 1 is responsible for the provision of Occupational Therapy services to patients engaging with our inpatient rehabilitation and/or day rehabilitation and/or rehab at home services.
>
> The Grade 1 Occupational Therapist will provide high quality assessment and intervention, to maximise functional independence, safety and quality of life of our rehabilitation patients, developing their skills, knowledge and experience from a baseline core competency level.
>
> Additional responsibilities may include participating in/assisting with training and quality improvement activities, assuming responsibility for appropriate clinical portfolios with the support of senior clinicians and allied health management, and participating in the supervision of students and allied health assistants —where appropriate to level of experience

[165] The mandatory qualifications for the position are a tertiary qualification in occupational therapy recognised by the Occupational Therapy Board of Australia and AHPRA, current registration with AHPRA and eligibility for membership with Occupational Therapy Australia.

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[192] Ibid.

[193] Ibid annexure C.

[166] For social workers, the position purpose is:[194]

> This role is responsible for providing a high standard of Social Work care to individuals/patients of varying ages and cultural groups within the Victorian Rehabilitation Hospitals. The Grade 1 Social worker will support patients where indicated in collaboration with individuals/patients/their families and the multidisciplinary team so as to achieve the comprehensive and coordinated rehabilitation of patients.
>
> Additional responsibilities may include participating in/assisting with training and quality improvement activities, assuming responsibility for appropriate clinical portfolios with the support of senior clinicians and allied health management.

[167] The mandatory qualifications for the position are a Bachelor's degree in social work or equivalent recognised by the Australian Association of Social Workers (AASW) and eligibility for membership of the AASW.

[168] For a base-level dietician, the position purpose is:[195]

> The Dietitian - Grade 1 is responsible for the provision of dietetic services to patients engaging with our inpatient rehabilitation and/or day rehabilitation and/or rehab at home services.
>
> The Grade 1 Dietitian will provide high quality nutritional assessment and management of patients referred to the dietetics service, demonstrating sound clinical reasoning and best practice dietary prescription, supporting the meeting of patient nutritional requirements and contributing to multidisciplinary care.
>
> Additional responsibilities may include participating in/assisting with training and quality improvement activities, assuming responsibility for appropriate clinical portfolios with the support of senior clinicians and allied health management, and participating in the supervision of students and allied health assistants — where appropriate to level of experience.

[169] The mandatory qualifications for a dietician are a 'Tertiary Dietetics qualification recognised by Dietitians Australia' and eligibility for membership with Dietitians Australia.

[170] The position descriptions for occupational therapists, social workers and dietitians all have the same or similar 'Improve the Experience' duties, personal attributes and other requirements as described above for physiotherapists.

[171] Similarly, Ms Price described in some detail the work of radiation therapists employed by Icon Group (and briefly described the work of medical physicists). She said that Icon Group employed 314 radiation therapists, of whom 229 were female, and that:

- radiation therapists have, since 1992, been required to have a four-year Bachelor's degree in radiation therapy or medical radiation sciences (prior to this, a diploma was required);
- they work in a team environment where they interact with doctors, nurses, medical physicists and other radiation therapists;

[194] Ibid annexure D.

[195] Ibid annexure E.

- their role is to plan radiation treatment as prescribed by a specialist doctor and physically administer radiation treatment to patients in accordance with that plan;
- at Icon Group, radiation therapists treat a high incidence of prostate, breast, lung and skin cancer;
- there are two distinct aspects of the role: (1) planning and preparing to provide treatment (with a doctor signing off on the treatment plan), and (2) delivering treatment;
- radiation therapists also perform quality assurance tasks;
- the role of radiation therapists had adapted to changes in the technology available for diagnosis and radiation treatment of cancer patients, with more advanced digital skills and understanding of technology being required as a result;
- the number of clinical conditions that radiation is used to treat, and the number of protocols to be followed as a consequence, has increased;
- radiation therapists are required to remain up to date on new techniques and technology, with some additional training and upskilling required, as a standard feature of maintaining professional registration; and
- radiation therapists have interaction with patients experiencing cancer every day, with patients often being upset and emotional, and this can be one of the most demanding aspects of the role.

[172] Apart from the health professions already discussed, the evidence described the skills and duties of medical scientists, speech pathologists, oral health therapists, audiologists, podiatrists, health information managers, hospital pharmacists, exercise physiologists and art and music therapists. It is not necessary to recount this evidence in detail. We are satisfied that in each case, the profession has the fundamental characteristics referred to in paragraphs [122] and [159] above.

[173] We conclude therefore that there was never any basis for departure from the *prima facie* position that the health professional classifications in the HPSS Award for which an AQF Level 7 (Bachelor's degree) qualification is required should align with the C1(a) rate in the C10 Metals Framework. It may be added that there is similarly no apparent basis for the UG2 health professional classifications in the HPSS Award, for which an AQF Level 5 qualification (Diploma) or an AQF Level 6 qualification (Advanced Diploma) is required, having significantly lower minimum rates than the C5 and C3 rates in the C10 Metals Framework respectively for which equivalent qualifications are required. The minimum wage rates for health professional employees in the HPSS Award do not properly reflect their work value, and we consider that this by itself constitutes work value reasons, within the meaning of s 157(2A) of the FW Act, justifying the variation of those minimum wage rates (see s 157(2)(a)).

[174] The undervaluation we have identified is clearly gender-related, since it detrimentally affects a workforce which, on the basis of the data previously identified, is plainly female-dominated. We reject the Private Hospitals Group's submission that health professional employees covered by the HPSS Award should not be regarded as being in 'highly feminised' occupations because the workforce as a whole, or particular professional occupations listed in Schedule B, do not meet the threshold of 80 per cent female within highly-feminised industry classes utilised in the Stage 1 Report. The criteria used in the Stage 1 Report were for the purpose of identifying priority areas for attention in the review of gender-based undervaluation; this should not be confused with the well-established 'female-dominated' criterion of 60 per

cent. Some of the smaller professional occupations may not meet the 60 per cent threshold, but this does not gainsay the proposition that those affected by the undervaluation of the work of health professionals are predominantly female.

[175] We have earlier set out the historical process by which the current health professional minimum wage rates were arrived at. The lack of any transparent record as to the considerations which founded the setting of those wage rates makes it difficult to find, for the purpose of s 157(2B)(b) of the FW Act, that the undervaluation of the work which has occurred was *because* of assumptions based on gender. However, the 'indicia' approach to gender-based undervaluation was adopted for the very reason that explicit gender assumptions in wage-setting are often difficult to detect from the public record. In any event, the making of a finding under s 157(2B)(b) that historical undervaluation has occurred because of assumptions based on gender is not a precondition for the variation of modern award minimum wages for work value reasons under s 157(2). Nor does the fact that such a finding may not be available in respect of health professional employees under the HPSS Award vitiate our conclusion that such employees have been the subject of gender-based undervaluation.

4.1.7 Rectification of gender-based undervaluation — provisional views

[176] We next set out our *provisional* views as to how the identified gender-based undervaluation should be rectified in a manner that is consistent with the work value considerations we have identified and which ensures, consistent with s 157(2B) of the FW Act, that we have dealt those considerations in a manner which is free of assumptions based on gender. Our *provisional* views are based on the following propositions:

(1) A new classification and pay structure should be established which is based on alignment of a benchmark classification with the C10 Metals Framework for equivalent qualifications.

(2) The existing classification structure is not adaptable to meet the objective in (1) because, apart from entry-level rates (and the consequential time at which an employee moves through the annual increments), the existing structure makes no distinction between different types of qualification.

(3) The current annual incremental pay structure is not consistent with proper conceptions of work value, for the reasons discussed in the *Teachers decision*, the *Stage 3 Aged Care decision* and the *Aged Care Nurses decision*.

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

(5) The new pay structure should be simplified and structured in a way broadly consistent with the classifications for teachers under the EST Award established

in the *Teachers decision* and for aged care nurses under the *Nurses Award 2020*[196] (Nurses Award) established in the *Aged Care Nurses decision*.

(6) The C1(a) benchmark rate (currently $1525.90 per week) will apply to professions requiring an AQF Level 7 qualification — that is, a Bachelor's degree (whether three or four years in duration) — after one year's employment post-graduation. Consistent with this approach, the equivalent for current UG2 professions would be the C5 or C3 rate, as applicable for the qualification required.

[177] Based on these principles, our *provisional* view is that a benchmark classification for health professionals at 2–3 years' service should be established, with pay increments broadly aligning with those established for teachers under the EST Award as a result of the *Teachers decision*, and with differential minimum rates based on the AQF level of the employee's qualification for the health profession in which they work:

Classification criteria	**Qualification for profession—AQF Level**				
	AQF 5 $ per week	**AQF 6** $ per week	**AQF 7** $ per week	**AQF 8** $ per week	**AQF 9** $ per week
Entry level – 1st year	1147.80	1239.90	1449.20	1493.10	1593.60
2nd – 3rd year	1207.80	1305.10	1525.90	1571.70	1677.50
4th – 6th year	1315.30	1421.30	1661.20	1711.10	1760.90
7th year +	1421.60	1536.10	1796.50	1894.40	1903.20

[178] Our further *provisional* view is that there should be higher classifications for health professionals in specialist, supervisory and managerial roles, with rates of pay derived from those established in the *Aged Care Nurses decision* for equivalent roles for aged care nurses under the Nurses Award as follows:

Classification	**Criteria**	**$ per week**
Level 2.1	Specialist with additional post-graduate qualification or Supervisor	1931.70
Level 2.2	After 5 years at Level 2.1	2050.10
Level 3	Manager/senior specialist	2204.80
Level 4	Senior manager	2500.70

[179] In order to indicate the effect of the introduction of the above classification structure, we set out the translation table below using the examples of a biomedical technologist (AQF Level 5 qualification), a physiotherapist (AQF Level 7) and a psychologist (AQF Level 9). Where, in respect of AQF Level 5 qualifications, the translation would result in a reduction in the minimum wage rate (shown in brackets), transitional provisions would protect the existing rate for existing employees so that no reduction would result.

AQF Level 5 qualification (e.g. biomedical technologist)		
Current classification	**Proposed new classification**	**Increase (%)**
Level 1 pay point 1 (UG 2 qualification)	Entry level – 1st year	5.99
Level 1 pay point 2	2nd – 3rd year	7.38

[196] MA000034.

AQF Level 5 qualification (e.g. biomedical technologist)		
Current classification	**Proposed new classification**	**Increase (%)**
Level 1 pay point 3	2nd – 3rd year	2.83
Level 1 pay point 4	4th – 6th year	8.26
Level 1 pay point 5	4th – 6th year	0 (-0.63)
Level 1 pay point 6	4th – 6th year	0 (-4.03)
Level 2 pay point 1	7th year +	3.16
Level 2 pay point 2	7th year +	0 (-0.46)
Level 2 pay point 3	7th year +	0 (-4.11)
Level 2 pay point 4	7th year +	0 (-7.78)

AQF Level 7 qualification (e.g. physiotherapist)		
Current classification	**Proposed new classification**	**Increase (%)**
Level 1 pay point 2 (3-year degree entry)	Entry level – 1st year	28.84
Level 1 pay point 3	2nd – 3rd year	29.91
Level 1 pay point 4	2nd – 3rd year	25.59
Level 1 pay point 5	4th – 6th year	25.51
Level 1 pay point 6	4th – 6th year	21.21
Level 2 pay point 1	4th – 6th year	20.55
Level 2 pay point 2	7th year +	25.80
Level 2 pay point 3	7th year +	21.17
Level 2 pay point 4	7th year +	16.53

AQF Level 9 qualification (e.g. psychologist)		
Current classification	**Proposed new classification**	**Increase (%)**
Level 1 pay point 4 (Master's degree entry)	Entry level – 1st year	31.16
Level 1 pay point 5	2nd – 3rd year	26.74
Level 1 pay point 6	2nd – 3rd year	22.40
Level 2 pay point 1	4th – 6th year	27.79
Level 2 pay point 2	4th – 6th year	23.30
Level 2 pay point 3	4th – 6th year	18.77
Level 2 pay point 4	7th year +	23.46

[180] As discussed further in part 4.6 of this decision, the parties will be given an opportunity to be heard in relation to the above *provisional* views, including as to their cost implications and the issues of operative date and phasing-in, at a subsequent stage in the proceedings. It is therefore not necessary or appropriate at this stage for us to make findings about whether variations to the HPSS Award to give effect to the *provisional* views would be necessary to achieve the modern awards objective or the minimum wages objective.

4.2 Support Services employees

4.2.1 Classifications and minimum wage rates

[181] The HPSS Award provides for nine classification levels for support services employees, which are defined in clause A.1 of Schedule A. Each classification is primarily defined by way of generic descriptions of the degree of responsibility and supervision and the skills exercised at each level. In broad terms, the classifications may be characterised as follows:

- Level 1 is an entry-level classification for employees with less than three months' work experience in the industry.
- Levels 2 and 3 provide for the performance of duties requiring only limited autonomy and training.
- Level 4 is largely the same as Level 3 except that an employee at level 4, in addition to on-the-job training, 'may require formal qualifications and/or relevant skills training or experience at Certificate III level'.
- At Level 5, an employee is 'capable of functioning semi[-]autonomously, and prioritising their own work within established policies, guidelines and procedures.' In addition to on-the-job training, the employee 'may require formal qualifications at trade or certificate level and/or relevant skills training or experience'.
- A Level 6 employee is capable of functioning 'with a high level of autonomy' and may require 'formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience'.
- Level 7 is largely the same as Level 6 except that the employee 'is capable of functioning autonomously' and may supervise the work of others.
- Level 8 covers specialist, training and supervisory roles in medical administration, for which the 'possession of relevant post[-]secondary qualifications may be appropriate but not essential'.
- Level 9 is for a more senior specialist/supervisory role in medical administration/management, requiring knowledge which may be gained 'through previous experience in the discipline or from post[-]secondary or tertiary study'.

[182] The application of these classification definitions to specific employment positions requires the employer to make an evaluative judgment. This may present some difficulty given the broad terms in which the skills, duties and responsibilities of each classification are described and, in addition, the fact that it is difficult to distinguish between a number of the classification definitions. For example, other than for administrative/clerical employees, the only differences between Levels 2 and 3 is the former requires a 'limited level of accountability or discretion' and 'sound communication skills' and the latter requires a '<u>medium</u> level of accountability or discretion' and 'sound communication <u>and/or</u> arithmetic skills' (underlining added). There is no clear hierarchy of qualification requirements. For example, while Level 4 may require a Certificate III qualification, any 'certificate-level' qualification — including, presumably, a Certificate II — might satisfy Level 5, and while 'post-trade or Advanced Certificate or Associate Diploma level' qualifications may be required for Levels 6 and 7, Level 8 provides that post-secondary qualifications 'may be appropriate but not essential' and Level 9 contains no qualifications requirement as such.

[183] The process of classifying employees is intended to be aided by the identification of 'indicative roles' for Levels 1–7. These roles are divided into three classes, namely 'General and administrative services', 'Food services' and 'Technical and clinical', and are assigned to classification levels as follows:

General and administrative services	Food services	Technical and clinical
LEVEL 1		
Assistant gardener Car park attendant Cleaner General clerk Hospital orderly Incinerator operator Laundry hand Seamsperson	Food and domestic services assistant	Animal house attendant CSSD attendant Darkroom processor Dental assistant (unqualified) Laboratory assistant Medical imaging support Orthotic technician Recording attendant (including EEG & ECG) Social work/Welfare aide Theatre attendant
LEVEL 2 (in addition to the indicative roles set out at Level 1, after the first three months of service)[197]		
Driver (less than 3 tonne) Gardener (non-trade) General clerk/Typist (between 3 months and less than 1 year's service) Housekeeper Maintenance/Handyperson (unqualified) Storeperson	Diet cook[198]	Instrument technician Personal care worker grade 1
LEVEL 3		
Driver (less than 3 tonne) who is required to hold a St John Ambulance first aid certificate General clerk/Typist (second and subsequent years of service) Receptionist	Food monitor[199]	Instrument technician Laboratory assistant Personal care worker grade 2 Theatre technician
LEVEL 4		
Clerk (ward, casualty, medical records etc.) Driver (3 tonne and over) Gardener (trade) Medical imaging administration Printer (trade) Security officer	Trade cook	Dental assistant (qualified) Dental technician Instrument technician (qualified) Orthotic technician Pathology collector Pathology technician Personal care worker grade 3 Theatre technician (qualified)
LEVEL 5		
Interpreter (unqualified) Medical audio typist Medical imaging administration Medical stenographer Secretary	Senior cook	Dental assistant Orthotic technician Pathology collector Personal care worker grade 4 Pharmacy technician Theatre technician

[197] See HPSS Award clause A.1.2(b).

[198] Full description not included.

[199] Full description not included.

General and administrative services	Food services	Technical and clinical
LEVEL 6		
Computer clerk (advanced) Gardener (advanced) Pay clerk (advanced) Library technician Medical imaging administration Printer (advanced)	Chef	Anaesthetic technician Pathology collector Pathology technician Pharmacy technician
LEVEL 7		
Gardener superintendent General clerical supervisor General services supervisor Interpreter (qualified) Medical imaging administration	Food services supervisor Senior chef	Personal care worker grade 5 Technical and therapy supervisor

[184] There are some difficulties with the above assignment of indicative roles to classifications. For example:

- A number of roles appear at multiple levels with no apparent distinction between them, such as Instrument technician, Pharmacy technician, Orthotic technician and, as we discuss below, Pathology collector. The generic classification descriptors must presumably be used to distinguish between these.
- Some indicative roles contain inconsistencies as to requirements for qualifications. For example, a Theatre technician is referred to as '(Qualified)' at Level 4 but not at Level 5. As discussed below, the same applies to Dental assistants.
- There are some roles which appear to have no current purpose. In particular, the role of PCW, which is divided into five grades that are not defined, appears (as the award history below demonstrates) to relate to aged care facilities covered by the Aged Care Award.

[185] Notwithstanding these difficulties, it appears that employers use the indicative roles as the primary method for applying the classification structure in practice. However, the description of the roles as 'indicative' suggests that their inclusion in the classification structure is intended to operate subject to the overriding generic criteria, so that it may be the case that a particular position may be classified higher or lower than the indicative roles indicate if the generic criteria for a classification level more closely match the duties, skills and responsibilities of the position.

[186] The minimum wage rates for Support Services employees are set out in clause 16.2. The weekly rates for full-time employees are as follows:

Classification	Weekly rate ($)
Level 1	945.10
Level 2	982.50
Level 3	1020.30
Level 4	1032.30
Level 5	1067.30
Level 6	1124.80

Classification	Weekly rate ($)
Level 7	1145.00
Level 8—pay point 1	1183.90
Level 8—pay point 2	1215.00
Level 8—pay point 3	1300.30
Level 9—pay point 1	1323.60
Level 9—pay point 2	1370.50
Level 9—pay point 3	1381.50

[187] The Level 4 wage rate is aligned with the C10 rate. Clause 16.1 provides that progression through each pay point in Levels 8 and 9 is by annual movement or, for part-time and casual employees, after each 1824 hours of experience.

4.2.2 Award history

[188] The history of the making of the HPSS Award in the Stage 2 Report briefly outlines the origin of the Support Services employees classifications and wage rates. It is apparent that, in the development of these classifications and wage rates, the AIRC award modernisation Full Bench drew upon a range of federal awards, generally applicable in particular states, and State awards.[200] However, the Full Bench's decisions disclose little in express terms beyond this. The initial exposure draft for the HPSS Award was published on 23 January 2009. In an accompanying statement,[201] the Full Bench said nothing relevant about the development of the Support Services employees classifications and wage rates beyond describing the draft award as 'a generic exposure draft to cover professional and technical classifications together with clerical and administrative classifications'.[202] It is noted in the Stage 2 Report that the exposure draft substantially reflected a draft prepared by the HSU, except that the HSU had included classifications for nurses and medical officers consistent with its position that one modern award should cover the entire health sector (including nurses and medical officers) as well as aged care. The HPSS Award was made on 3 April 2009 and, in its accompanying decision,[203] the Full Bench noted that the award had been changed since the release of the exposure drafts[204] but said nothing relevant beyond this.

[189] One of the source awards was the *Health and Allied Services – Private Sector – Victoria Consolidated Award 1998*[205] (HAS Victorian Award 1998) and it is reasonably apparent to us, from a comparison of that award and clause A.1 of the HPSS Award, that Levels 1–7 of the classification structure for Support Services employees were substantially based on this award.

[190] The history of the HAS Victorian Award 1998 is set out in the *Stage 3 Aged Care decision* at [96]–[103] (because the modern Aged Care Award was also substantially based upon it). In short, it had its origin in the *Health Services Union of Australia (Victoria – Private*

[200] See [2008] AIRCFB 708, 177 IR 5, Attachment B.

[201] [2009] AIRCFB 50, 180 IR 124.

[202] Ibid [78].

[203] [2009] AIRCFB 345, 181 IR 19.

[204] Ibid [146].

[205] AP783872.

Sector) Interim Award 1993,[206] which was made largely by consent on 20 December 1993 to provide award coverage for the private health sector in Victoria after the abolition of the State award system by the Victorian Government. It was replaced by the *Health and Allied Services – Private Sector – Victorian Consolidated Award 1995*[207] and then the HAS Victorian Award 1998. These were also consent awards. No independent work value assessment was ever carried out by the AIRC. As stated in the *Stage 3 Aged Care decision*:[208]

> The HAS Victorian Award 1998 contained an extensively-modified classification structure which separated aged care from hospitals, and further separated both the hospital and aged care classifications into four streams each: Administrative/Clerical, General Services, Food Services, and Technical, Clinical and Personal Care. The classification structure was integrated however to the extent that all classifications remained aligned to the same 11 'Wage/Skill Group' levels which had existed in the HAS Victorian Award 1995.
>
> (citations omitted)

[191] The technical stream for the health sector classifications in clause 19.1 of the HAS Victorian Award 1998 contained nearly all the indicative roles now found in clause A.1 of the HPSS Award, with the notable omission of dental assistants and PCWs. The five PCW grades in the HPSS Award appear to have been taken from the separate aged care classification structure in clause 19.2 of the HAS Victorian Award 1998. Their inclusion, via the HSU draft upon which the HPSS Award exposure draft was based, appears to reflect the HSU's initial ambition for the aged care and the health industries to be covered by one award, with the ultimate retention of those classifications in the final HPSS Award being an error.

[192] The role of pathology collector was assigned to three classification levels in the HAS Victorian Award 1998, as is the case with the HPSS Award. However, in the HAS Victorian Award 1998, the role was divided into three grades with defined meanings at each classification level. The definitions (in Appendix A) showed that the lowest grade applied to a pathology collector in training for the first three months. An employee at the next grade was one:[209]

> … engaged in collecting pathology specimens and performing procedures in accordance with practice instructions; the care, storage and processing of all such pathology specimens; the timely dispatch of pathology specimens to the laboratory; the accurate recording of information relating to patients/clients and specimens in accordance with practice instructions; operating VDUs; attending to the well[-]being of patients; liaising with referrers/referees; receiving payments of accounts.

[193] The highest grade was for a pathology collector with additional supervisory duties, qualifications or experience. Significantly, a pathology collector at each grade was defined as meaning a person who:[210]

> …is a State Enrolled Nurse (or has obtained qualifications equivalent thereto) employed as a Pathology Collector under the general supervision of a Registered General Nurse or equivalent…

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[206] AW783559, [1993] AIRC 1711, Print L0831.

[207] H0488, Print M6132.

[208] [2024] FWCFB 150, 331 IR 137 [100].

[209] AP783872 clause 2.1.

[210] H0488, Print Q2805, clause 2.1.

[194] The same was true in the separate *Health Services Union of Australia (Private Pathology - Victoria) Award 2003*,[211] which applied to private pathology clinics outside the hospital system.

[195] In the development of the HPSS Award, it appears that dental assistants were placed into the classification structure derived from the HAS Victorian Award 1998 even though they had not been covered by that award. The Stage 2 Report indicates that the HSU draft award upon which the exposure draft for the HPSS Award was based referenced a NSW award, the *Dental Assistants and Secretaries (State) Award*,[212] and a federal award applicable in Victoria, the *Dental (Private Sector Victoria) Award 1998*.[213] The latter award, which had its origin in a 1996 consent award, appears to have been the primary source. It contained three relevant classifications. The lowest classification, 'Dental Assistant – Unqualified',[214] was for a dental assistant who did not hold a Certificate-level qualification and was undergoing on-the-job experience and training. The next was 'Dental Assistant Level 1',[215] which required a Certificate in Dental Assisting. The highest classification was 'Dental Assistant Level 2',[216] which required a qualification and also performance of receptionist duties or five years' experience as a Dental Assistant Level 1.

[196] It is important to note that, in developing the dental assistant classifications and wage rates in the HPSS Award, the AIRC award modernisation Full Bench did not reference the total award rates of pay in the Queensland *Dental Assistants (Private Practice) Award - State 2006*,[217] which were made up of a base rate of pay plus an equal remuneration component (ERC) that had been determined in the *Queensland Dental Assistants decision* in 2005. These total award rates of pay were significantly higher than the rates of pay which the AIRC established for dental assistants in the award modernisation process. We discuss the significance of this in part 4.5 of our decision.

4.3 Medical technicians

[197] As explained in the introduction to this decision, the Stage 1 Report identified medical technicians covered by the HPSS Award as one of 29 occupations that were large in size, over 80 per cent female, and located in a highly-feminised industry class. The ANZSCO occupation group 'Medical Technicians'[218] is 85.3 per cent female, and falls within the 'Pathology and Diagnostic Imaging Services' ANZSIC industry class, which is 74.9 per cent female. On this basis, medical technicians covered by the HPSS Award were selected as a priority group to be considered in this Review.

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[211] AP830802.

[212] AN120179.

[213] AP779110.

[214] Ibid clause 17.3.1.

[215] Ibid clause 17.3.2.

[216] Ibid clause 17.3.3.

[217] RA140090.

[218] ANZSCO Code 3112.

[198] On 20 September 2024, the Commission published a document[219] intended to clarify the scope of the Review as it related to medical technicians. This document mapped the occupations included in the ANZSCO occupation group 'Medical Technicians' to the following support services classifications in the HPSS Award:

Level 3
- Laboratory assistant.
- Theatre technician.

Level 4
- Orthotic technician.
- Pathology collector.
- Pathology technician.
- Theatre technician (qualified).

Level 5
- Orthotic technician.
- Pathology collector.
- Pharmacy technician.
- Theatre technician.

Level 6
- Anaesthetic technician.
- Pathology collector.
- Pathology technician.
- Pharmacy technician.

[199] As we set out further below, we received an extensive amount of evidence concerning pathology collectors, who constitute over two-thirds (68.6 per cent) of all employed persons in the Medical Technicians occupation group. That has enabled us to reach firm conclusions as to whether pathology collectors have been the subject of gender-based undervaluation. However, we received very little evidence about the other occupations in that group. The ACTU/HSU called evidence from only one employee arguably falling within these occupations. That witness was Hannah Morgan,[220] a Senior Anaesthetic Technician employed by St John of God Health Care, currently working at Midland Hospital in Perth. She holds a Higher Diploma in Operating Department Practice, a qualification obtained in the UK. Ms Morgan gave evidence that most of her colleagues hold a two-year Diploma in Anaesthetic Technology. Ms Morgan gave evidence about her duties, the workplace environment at the hospital, her supervision of anaesthetic assistants and the challenges and increasing complexity she experiences in her role. However, it is unclear whether Ms Morgan herself is an 'Anaesthetic technician' falling within the Support Services Level 6 classification or whether, by reason of her diploma-level qualification, she is in fact to be classified as a Health Professional under the HPSS Award. Some of her evidence touched upon the work of 'anaesthetic assistants' whom she supervised, who may be Support Services employees, but this was somewhat sparse.

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[219] Pay Equity and Awards Team, Fair Work Commission, *Medical Technicians under the HPSS Award* (Report, 20 September 2024).

[220] Exhibit HPSS17 (witness statement of Hannah Morgan, 29 September 2024, as amended and refiled on 12 December 2024).

[200] There was some employer evidence which touched upon some of the groups:

(1) Matthew Brumby[221] is the Chief Commercial Officer for Healius Limited (Healius) and a director of Australian Pathology. He holds a Bachelor of Biomedical Science, a Postgraduate Certificate in Medical Science (Pathology) and a Master of Business Administration. Mr Brumby has previously performed pathology collection duties, managed pathology collectors and run medical laboratories. He gave some evidence about the duties of, among others, laboratory technicians and laboratory assistants employed by Healius. He said that Healius requires its laboratory assistants to have a high school diploma or equivalent, but acknowledged that some laboratories may require them to hold a certificate in laboratory technology. He also said that laboratory assistants have 'minimal to no direct patient interaction'.[222]

(2) Kaylene Elliott[223] is the National Hospitals Operation Manager at Cura Day Hospitals Group (Cura). She is a hospital-trained registered nurse who also holds a Certificate in Perioperative Nursing and a Certificate in Day Surgery Nursing. Ms Elliott gave evidence about the work of anaesthetic technicians employed by Cura. She said that Cura requires its anaesthetic technicians to hold either an Associate Diploma of Health (Anaesthetic and Operating Theatre Technicians) or a Certificate IV in Medical Technicians and [Assistants]. Ms Elliott described anaesthetic technicians' typical tasks and said that the skills they require have not increased since 2000, nor has the technicians' scope of work increased significantly in the last 20 years. She said they have limited interaction with patients.

(3) Pauline Fogarty[224] is the Theatre Optimisation Work Stream Lead for Healthscope. Ms Fogarty is a registered nurse with over 35 years of experience, predominantly in perioperative nursing. She gave evidence about the work of theatre technicians employed by Healthscope. Ms Fogarty's evidence was that theatre technicians traditionally did not require any formal education or training, but that they can now be trained in TAFE colleges. She further said that their work has largely not changed over the last 35 years, that they do not have any clinical responsibility for the patients with whom they interact and that any interaction beyond talking to the patients about how to position themselves is 'incidental'.[225]

[201] There was no evidence at all about orthotic technicians, pathology technicians or pharmacy technicians apart from some short statements in agreed statements of fact which, as we explain below, cannot be given significant weight.

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[221] Exhibit HPSS34 (witness statement of Matthew Brumby, 29 November 2024).

[222] Ibid [49].

[223] Exhibit HPSS44 (witness statement of Kaylene Elliott, 18 October 2024); exhibit HPSS45 (supplementary witness statement of Kaylene Elliott, 28 November 2024).

[224] Exhibit HPSS81 (witness statement of Pauline Fogarty, 18 October 2024, as amended and refiled on 18 December 2024).

[225] Ibid [11].

[202] Apart from pathology collectors, with whom we deal as a separate occupation below, the evidence is not such as to allow us to conclude that medical technicians falling within the Support Services employees have been generally the subject of gender-based undervaluation. There is too little information before us to permit any proper assessment of the value of the work. The limited evidence that is before us does not establish that, leaving aside pathology collectors, medical technicians exercise 'invisible' skills to any significant degree. That is not to say, however, that we foreclose any future consideration of the work value of medical technicians under the HPSS Award. Having regard to the observations we have earlier made about various deficiencies in the 'Technical and clinical' stream indicative roles in the Support Services employees classification structure, we consider that a wider review of the way in which these roles are fitted into the structure would be appropriate in the future and, further, that consideration should be given to a separate structure for the 'Technical and clinical' roles. The work value of medical technicians could be the subject of more intensive consideration in such a review.

4.4 Pathology collectors

[203] As set out above, the classification definitions for Support Services employees in clause A.1 place, as indicative roles, the occupation of pathology collector at Levels 4, 5 and 6. There is no distinction made between the indicative role of pathology collector at any of those levels, so an employer would be required to evaluate what level applies based on the generic criteria in the classification descriptors. However, the working assumption must be that Level 4 ($1032.30 per week) is the effective minimum rate for pathology collectors under the HPSS Award.

4.4.1 Gender and qualifications profile

[204] It is not in dispute that the occupation of pathology collector (who are also referred to as 'phlebotomists') is female-dominated. The available data[226] indicates that approximately 91 per cent of pathology collectors within the Pathology and Diagnostic Imaging Services industry class (ANZSIC code 8520) are female.

[205] There is no regulatory requirement for a pathology collector to hold any minimum qualification in order to be employed. Available data[227] concerning the qualifications held by pathology collectors indicate that the highest educational attainments of pathology collectors, where ascertainable, are approximately as follows:

Highest qualification	Percentage
Bachelor's degree or higher	25.8
Advanced Diploma and Diploma	17.2
Certificate IV	13.4
Certificate III	28.3
Below Certificate III	15.2

[206] Some aspects of the above data are problematic. In particular, the data indicates that a large proportion of pathology collectors hold diploma or degree qualifications in circumstances

[226] The August 2021 ABS Census of Population and Housing.

[227] Ibid.

where there are no such qualifications concerned *exclusively* with pathology collection. It may be that many pathology collectors hold qualifications or are qualified to work in fields/occupations other than pathology collection, such as nursing or medical science. If so, this may have skewed the data. Additionally, the data shows that a significant proportion of pathology collectors hold a Certificate IV qualification, when the Certificate IV in Pathology qualification has been discontinued (although, as we discuss later, it is likely that the Certificate IV will be offered again in the near future). However, the data may simply reflect the fact that persons who obtained a Certificate IV qualification before it ceased being offered remain in the occupation or that pathology collectors may hold a related Certificate IV in Laboratory Techniques. In any case, we are satisfied that the data establishes that, notwithstanding that there is no regulatory requirement for a qualification, the majority of pathology collectors do in fact hold a relevant qualification.

4.4.2 Parties' positions

[207] The ACTU (together with the HSU, the UWU and the ASU) submitted that medical technicians generally, including pathology collectors, have been subject to gender-based undervaluation by reason of their wage rates not having been the product of a proper work value assessment, but rather having been constructed on the basis of an alignment with the masculinised C10 benchmark. It submitted, based on the Charlesworth Report, that medical technicians generally exercise a range of 'invisible' skills including critical thinking, adaptability, and effective communication, and work closely with patients and health professionals providing emotional support, solving problems in real time and ensuring patient comfort during challenging procedures. In relation to pathology collectors specifically, the ACTU submitted that they adapt practices to meet the needs of a wide range of patients, including newborns, those in palliative care, individuals with drug and alcohol dependencies, and those with complex medical conditions. The union parties' position as to the rectification of the asserted gender-based undervaluation is that there should be a new wage rate structure for medical technicians based on an alignment with the Caring Skills benchmark rate. The structure it proposed is based on the existing structure for support services employees, but with Level 4 employees being entitled to the Caring Skills benchmark rate and the wage rates for all other classifications being increased by a proportionate amount.

[208] The Phlebotomists Council of Australia (PCA), which describes itself as the professional peak body for individuals working in the pathology sector, likewise took the position that the minimum wage rates in the HPSS Award for pathology collectors undervalued their work for reasons including the gendered segregation of the workforce, the history of wage-setting in the HPSS Award and the historical failure to properly recognise and value the 'invisible' skills exercised by workers within the pathology sector. It submitted that the informality of qualifications and skills recognition of pathology collectors left them at the 'mercy of employers'[228] — specifically, whether employers were willing or able to recognise skills development or provide opportunities for upskilling or higher-value work involving skills performed at higher classification levels.

[209] Australian Pathology, which describes itself as the national peak body for private pathology services in Australia, submitted that there were no work value reasons justifying a

[228] PCA submission, 23 October 2024 [5].

variation to the award wage rates for medical technicians employed in pathology businesses, including pathology collectors. Australian Pathology submitted that it did not dispute that pathology collectors exercise *some* of the 'invisible' skills which 'lie at the heart of the gendered undervaluation of work',[229] including the exercise of empathy and communication skills in dealing with patients. However, it submitted, pathology collectors do not exercise 'invisible' skills to nearly the same extent as, for example, nurses and teachers considered in the Aged Care decisions and the *Teachers decision* respectively. Pathology collectors typically see large numbers of patients for a short period each, and the basic communication and human empathy skills they are required to exhibit are those required in almost every customer-facing role in Australia. Australian Pathology submitted that, while it is true that patients may occasionally be anxious or in a heightened state of emotion in respect of a pathology collection, this is the exception rather than the norm. Pathology collectors are not required to, and do not, counsel patients or spend long periods comforting them. Accordingly, it was submitted, 'invisible' skills are not a fundamental part of the role of pathology collectors, nor do they perform caring work as such. As for their qualifications, while holding a Certificate III is considered desirable, pathology employers do not require it.

[210] Australian Pathology submitted that the evidence did not disclose that the work of pathology collectors has changed significantly over time, nor has it increased to any significant degree in intensity or complexity. Its position is therefore that the existence of gender-based undervaluation has not been demonstrated and that no adjustments to the pay rates or classification structures in the HPSS Award are appropriate. As detailed below, Australian Pathology also made extensive submissions about the cost implications of any increase to the wage rates for pathology collectors. We deal with those submissions separately in part 4.6 of this decision.

[211] The Private Hospitals Group submitted that the work of pathology collectors typically involved responsibility for receiving requests for tests for patients, collecting samples required for the tests, labelling the test samples, performing correct patient identification and sending the test samples to the laboratory, with pathology collectors working at hospitals also using point-of-care devices for rapid diagnostic testing and providing intravenous cannulation. The performance of caring work or the exercise of 'invisible' skills was not fundamental to the role, or at least not to the same degree as for Certificate III-qualified direct care workers in an aged care setting). For this reason, and because pathology collectors are not required to hold a Certificate III qualification, it was submitted that the application of the Caring Skills benchmark rate to pathology collectors was not appropriate.

4.4.3 Evidence

[212] A number of persons gave evidence about the work of pathology collectors and the pathology industry generally via witness statements. The ACTU, HSU, UWU and the ASU relied on evidence filed by the HSU from the following two witnesses:

(1) Tracey Giblett[230] is a pathology collector employed by Western Diagnostic Pathology. She holds a Certificate III in Pathology Collection but notes in her

[229] Australian Pathology closing submission, 20 December 2024 [30].

[230] Exhibit HPSS21 (witness statement of Tracey Giblett, 2 October 2024, as amended and refiled on 12 December 2024).

evidence that this qualification was not required (nor was it even available) when she commenced work as a pathology collector. Ms Giblett gave evidence about her duties, the range of people with whom she works, the wide range of clients or patients she sees, the difficulties faced at work, the skills she uses in her daily work and the increasing complexity of the work.

(2) Patricia Goodman[231] is a pathology collector employed by Australian Clinical Laboratories (ACL). She holds a Certificate III in Pathology Collection and a Certificate IV in Laboratory Techniques. Ms Goodman gave evidence that she was not required to hold a Certificate III when she started working for ACL around six-and-a-half years ago, but that now pathology collectors do have that qualification when commencing. She also gave evidence about her duties and responsibilities at work, the training, skills and knowledge she uses in her role and the increasing complexity of her work. Ms Goodman further gave evidence in reply to the evidence of Private Hospitals Group witnesses Debra Hornsby and Jennifer Chambers.

[213] The PCA filed witness statements from the following persons:

(1) Bec Luxton[232] is the founding Chief Executive Officer of the PCA. In her first witness statement, she gave evidence about the additional on-the-job training and assessment that pathology collectors may undertake to be signed off as able to exercise particular skills (e.g. collecting pathology samples from children, fitting Holter monitors) over and above what is taught in the standard Certificate III in Pathology Collection. Ms Luxton also annexed to that statement various documents apparently relevant to pathology collectors' on-the-job training, their employment conditions, pathology companies' revenue during the COVID-19 pandemic, the significance of pathology results in medical decision-making, pathology accreditation standards and guidelines and what proportion of medical technicians are women, along with a copy of the federal government's Women's Budget Statement 2024–25. She also gave specific evidence replying to Australian Pathology's evidence of Liesel Wett and submissions, relating to how the federal government funds pathology services and the prospect of reintroducing a Certificate IV in Pathology.

(2) Jayne Holmes[233] is a pathology collector who holds a Certificate III in Pathology Collection and has 15 years of experience. She gave evidence about her daily duties, the skills she exercises and the challenges she faces in her role. Ms Holmes also deposed that she had gained on-the-job certification of certain advanced skills including in relation to paediatrics, drugs of abuse and Holter monitors.

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[231] Exhibit HPSS32 (witness statement of Patricia Goodman, 4 October 2024, as amended and refiled on 12 December 2024); exhibit HPSS33 (reply witness statement of Patricia Goodman, 29 November 2024, as amended and refiled on 12 December 2024).

[232] Exhibit HPSS35 (witness statement of Bec Luxton, 18 October 2024); exhibit HPSS36 (reply witness statement of Bec Luxton, 29 November 2024).

[233] Exhibit HPSS37 (witness statement of Jayne Holmes, 18 October 2024).

(3) Summer George[234] is a pathology collector who holds a Certificate III in Pathology Collection. She gave evidence about her working environment, responsibilities and skills. Ms George also gave evidence about the training needed to perform her role and that she has gained skills in 24-hour blood pressure monitoring and Holter monitoring.

(4) Michelle Brien[235] is a pathology collector who holds a Certificate III in Pathology Collection and has worked full-time in her current role since July 2005. She gave evidence about the skills she exercises in her day-to-day duties and how the pathology collector role has changed over time. Ms Brien also gave evidence that she has passed written, verbal panel and practical examinations required to perform advanced collection techniques after completing her Certificate III, including in relation to Mantoux testing, oncology patients and hair drug screen collections.

(5) Daniel Simms[236] is a learning and development consultant, as well as a university lecturer in business, leadership and management at both undergraduate and postgraduate levels. He has worked in emergency services, including eight years as a paramedic, has lectured at a school of nursing and previously managed the training arm of the Australian Medical Association Queensland. Mr Simms gave evidence about the training that pathology collectors are required to undertake to perform their role and whether a formal qualification is required.

[214] All the ACTU/HSU and PCA witnesses were cross-examined except for Ms Luxton and Mr Simms. The ACTU and the PCA also sought to rely upon two statements of agreed facts pertaining to pathology collectors[237] but, because they were not the subject of agreement with any interested employer party, they can only be assigned very limited weight.

[215] Australian Pathology relied on evidence from the following persons about the work of pathology collectors:

(1) Mr Brumby[238] gave evidence about the duties of pathology collectors employed by Healius. In particular, he said that Healius does not require pathology collectors to hold a Certificate III in Pathology Collection or any particular qualification when commencing in their role.

(2) Boon-Kiang Tan[239] is the Operations Manager, Customer Service for ACL in Western Australia. She holds a Bachelor of Science with first-class Honours, a PhD in osteoporosis and falls in community-dwelling older persons, is a certified

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[234] Exhibit HPSS38 (witness statement of Summer George, 18 October 2024).

[235] Exhibit HPSS40 (witness statement of Michelle Brien, 17 October 2024).

[236] Exhibit HPSS63 (witness statement of Associate Professor Daniel Simms, 16 October 2024).

[237] Exhibits HPSS120 (statement of facts agreed between Australian Council of Trade Unions, Phlebotomists Council of Australia and Dental Assistants Professional Association, 18 October 2024); exhibit HPSS121 (additional statement of facts as agreed between Phlebotomists Council of Australia and Australian Council of Trade Unions, 18 October 2024).

[238] Exhibit HPSS34 (witness statement of Matthew Brumby, 29 November 2024).

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

drug and alcohol test collector and is currently studying towards a Certificate III in Pathology Collection. Dr Tan is also a trained physiotherapist. Dr Tan gave evidence about the pathology collectors ACL employs. She described the process that ACL's pathology collectors are expected to follow when collecting samples for tests. She said that holding a Certificate III in Pathology Collection is a 'desirable, but not mandatory requirement'[240] for pathology collectors employed by ACL, and that they also do not need to have a Certificate IV in Laboratory Techniques, but that some did complete that qualification while employed in response to a federal wage subsidy offer. Dr Tan also gave specific evidence in response to the evidence of Ms Goodman, who works for ACL.

(3) Liesel Wett[241] is the Chief Executive Officer of Australian Pathology. Ms Wett gave evidence about Australian Pathology's membership, the scope of pathology practice and how private pathology companies operate. She gave specific evidence in reply to Ms Luxton's and Ms Brien's evidence about pathology collectors' duties. She also gave evidence about the sector's financial viability, but we discuss this at part 4.6 below.

[216] Finally, the Private Hospitals Group relied on evidence from two witnesses:

(1) Debra Hornsby[242] is the General Manager of Mater Pathology (Mater). She holds a Master's degree in eHealthcare, Business Administration and Project Management and a Graduate Degree in Information Technology and Teaching. Ms Hornsby gave evidence about the work of pathology collectors employed by Mater in both hospitals (inpatient services) and collection centres that are not part of a hospital (outpatient services). She said that pathology collectors employed by Mater are required to hold a Certificate III in Phlebotomy. Ms Hornsby further said that apart from the implementation of assistive technology, the work pathology collectors perform at Mater has largely not changed in the last 20 years. Ms Hornsby also gave specific evidence in reply to the evidence given by the HSU and PCA pathology collector witnesses.

(2) Jennifer Chambers[243] is the Director of Nursing and General Manager at Concept Fertility Centre and Day Hospital (Concept). She holds a Bachelor of Science (Nursing) and a Graduate Certificate in Human Resource Management. Ms Chambers gave evidence about the work of pathology collectors employed by Concept. Her evidence was that the pathology collector's scope of work and required skills have not changed in the last 20 years. Ms Chambers also gave specific evidence in reply to the evidence given by the HSU and PCA pathology collector witnesses in the proceedings.

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[240] Ibid [12].

[241] Exhibit HPSS47 (witness statement of Liesel Wett, 18 October 2024); exhibit HPSS48 (supplementary witness statement of Liesel Wett, 29 November 2024).

[242] Exhibit HPSS86 (witness statement of Debra Hornsby, 18 October 2024); exhibit HPSS87 (supplementary witness statement of Debra Hornsby, 29 November 2024).

[243] Exhibit HPSS88 (witness statement of Jennifer Chambers, 20 October 2024, as amended and refiled on 18 December 2024); exhibit HPSS89 (supplementary witness statement of Jennifer Chambers, 28 November 2024, as amended and refiled on 18 December 2024).

[217] Of these employer witnesses, only Mr Brumby, Dr Tan and Ms Wett were cross-examined.

4.4.4 The work of pathology collectors

[218] Based on the evidence outline above, we make the following findings about the work of pathology collectors. The basic function of pathology collectors is to collect samples from patients for testing by pathologists. These may be blood, urine or respiratory samples (such as COVID-19 and other respiratory swabs). Generally, pathology collectors are the primary patient-facing roles associated with pathology work. A more detailed description of the duties of a pathology collector can be found in the witness statement of Ms Giblett as follows:[244]

> My role involves the following duties:
>
> (a) Collecting blood samples.
> (b) Accepting stool, urine and sputum samples.
> (c) Accepting samples that doctors have taken (like cervical smears, histology samples, swabs).
> (d) Accepting patient collected swabs (including cervical smears).
> (e) Conducting urine drug and alcohol screening.
> (f) Centrifuging specimens in the collection room.
> (g) Aliquoting samples that need to be split and frozen, including urine.
> (h) Interacting with patients with a high degree of professionalism and empathy.
> (i) Verifying patients' identity and other patient information. Ensuring patient information remains confidential.
> (j) Completing computer data entry of patient information, tests referred, and printing labels, and taking payment if necessary.
> (k) Wiping down chairs and equipment after every patient.
> (l) Cleaning equipment including cleaning the centrifuge.
> (m) Checking stock and making orders for materials needed like tubes, needles, cotton wool, and paper.
> (n) Maintaining clean rooms and often conducting cleaning duties like mopping floors and cleaning toilets and emptying rubbish bins.
> (o) Liaising with doctors and other healthcare professionals about patient safety, appropriate testing and other matters.
> (p) Packing the specimen collections. Ensuring all specimens are labelled and processed properly.
> (q) Answering email and telephone enquiries from internal and external stakeholders.

[219] Some pathology collectors will also undertake testing of hair and urine samples.

[220] Mr Brumby summarised the steps required to undertake the sample collection function at the Healius business in the following way:[245]

> The sample collection process commences when the patient presents at an Approved Collection Centre (ACC) for testing.

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[244] Exhibit HPSS21 (witness statement of Tracey Giblett, 2 October 2024, as amended and refiled on 12 December 2024) [11].

[245] Exhibit HPSS34 (witness statement of Matthew Brumby, 29 November 2024) [9]–[15].

A pathology collector collects blood and other sample types such as urine and hair from patients and ensures that samples are correctly labelled and handled in a hygienic manner in accordance with documented processes and procedures.

In a typical collection, the pathology collector will greet the patient, and look at the referral form that the patient gives them, which specifies the test(s) that are required.

The pathology collector will review the referral or request form, and type in the tests listed on the form in the collections manual maintained by Healius, which is an online resource accessible through the staff intranet. The collections manual will tell the pathology collector what specimen to collect, any special requirements for the test, and the specific specimen handling requirements for that particular specimen. This is a very prescriptive document and procedure that the pathology collector follows to collect the sample. Healius is also introducing a collections portal across our network which will be able to handle electronic referrals for pathology in a more efficient and timely manner.

The pathology collector will ensure that the patient meets the criteria for collection on that day (for example, if a test requires fasting, the pathology collector will confirm with the patient that they have followed the process for the test on that day).

Essentially the role involves greeting a patient, identifying from the referral form which test is to be conducted, following the process for that test as set out in a written/online collections manual (including identifying any special patient preparation required for that test such as fasting and confirming with the patient that they have followed that process), and then preparing the sample for dispatch to the laboratory. Pathology collectors exercise autonomy, working within published procedures, in deciding what kind of container to use for collection — for example, a syringe, a vacutainer (which is the most common) or a butterfly needle. A pathology collector may need to use judgment to determine which process is most appropriate for a particular patient and their veins. However, they are still required to follow relevant guidance and procedures which are in place and they otherwise have very limited discretion or decision-making to do. For example, our procedure places limits on how many times a pathology collector is to attempt collection if they are having trouble locating an appropriate vein or collecting the sample, before seeking support from a colleague or asking the patient to return at a later date.

As collectors are taking samples from patients, these roles involve a direct patient interaction. Those interactions are aimed at ensuring that the process is comfortable for patients. A typical pathology collector might collect samples from 4–6 patients per hour (though this varies). Once the sample is collected correctly, and all details are captured, the patient leaves the centre and the pathology collector is not involved with any further interaction with the patient relating to this referral.

[221] The function that pathology collectors undertake requiring the highest level of skill is venepuncture — that is, withdrawing blood from a vein with a needle. The complexity of venepuncture can vary: early in their development, pathology collectors have only limited collection skills and training, and are only competent to complete standard and routine tests on easily accessible veins, but more experienced pathology collectors may be required to undertake more complex blood collection, including from newborns, oncology patients, frail patients, those receiving palliative care and those with drug and alcohol dependence. Ms Giblett gave

evidence that pathology collectors must make an evaluative judgment about the best method of extracting blood from a patient:[246]

> This involves assessing the quality of the vein and the appropriate method for blood extraction depending on the patient's age and circumstances (for example, whether to utilise a vacutainer system (a blood collection tube with a coloured rubber stopper) or a needle and a syringe). I am able to use a needle and syringe on a baby because I have good control over the suction, which is not possible on a vacutainer system. This involves an assessment of how much blood needs to be taken for the tests required.

[222] Ms Holmes gave evidence to similar effect:[247]

> Blood samples are taken from the patients using a variety of equipment — vacutainer needle system, needle & syringe or winged infusion set, also known as a "butterfly". Many patients have veins that are difficult to locate because of scarring, bruising from medications or surgery, lack of fluids, tension or fear but over many years of experience I have learned to assess each patient with the skill and care to overcome most circumstances.

[223] Ms Holmes also gave evidence about the variable and dynamic nature of the work of pathology collectors:[248]

> A typical day for a pathology collector can include time-pressed, fasting patients eager to get in and out as quickly as possible, scared and vulnerable patients who need time and careful treatment to have their samples taken with the least amount of stress and trauma, reluctant and often aggressive patients requiring legal testing for court, child safety cases, work-cover and employment which involves the direct observation of passing urine samples from the private area enclosed one on one inside the toilet cubicle with the patient.

[224] Although a Certificate III in Pathology Collection qualification is available (and a Certificate IV in Pathology was previously available until about 2017), as previously stated there is no regulatory requirement for pathology collectors to hold this qualification. Mr Brumby said in respect of the Healius business:[249]

> Healius does not require pathology collectors to have any set qualification when commencing in the role, and does not require pathology collectors to have a certificate III in pathology collection as a prerequisite of the role. Healius regularly hires pathology collectors without a relevant certification or base knowledge of pathology and train[s] them to do the job. The key requirements are an ability to engage with patients and to follow procedures and protocols to collect the samples.
>
> The role of pathology collector does not require any prior clinical knowledge. Phlebotomy, or drawing blood, is a task that can be learned. Proficiency as a phlebotomist is learned from on the job experience collecting samples after having completed theoretical training in a class room environment.

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[246] Exhibit HPSS21 (witness statement of Tracey Giblett, 2 October 2024, as amended and refiled on 12 December 2024) [40].

[247] Exhibit HPSS37 (witness statement of Jayne Holmes, 18 October 2024) [13].

[248] Ibid [10].

[249] Exhibit HPSS34 (witness statement of Matthew Brumby, 29 November 2024) [16]–[17].

[225] Nonetheless, a large majority of pathology collectors do hold a Certificate III qualification or higher. The current version of the Certificate III qualification (HLT37215) is described in the following terms:[250]

> This qualification reflects the role of pathology collectors. Workers in this role follow known routines and procedures, taking responsibility for their own work under general supervision. They combine communication, customer service and technical skills, and use discretion and judgment to adapt and transfer their skills to different situations.
>
> To achieve this qualification, the candidate must have completed at least 35 hours of work as detailed in the Assessment Requirements of units of competency.
>
> *No licensing, legislative, regulatory or certification requirements apply to this qualification at the time of publication.*
>
> (italics in original)

[226] Additional skills or duties outside the Certificate III course that are being taught on the job include paediatrics collection, respiratory swab collection, arterial blood gases, urea breath testing, NIPT testing, venesections, ambulatory blood pressure and the use of ECG/24-hour Holter Monitors.

[227] A Certificate IV in Pathology has not been offered since about 2017. However, the introduction of a new Certificate IV in Pathology is anticipated in about June 2025.

[228] The environment in which pathology collectors work may vary considerably. Pathology collectors may work in a range of environments including public and private hospitals, urgent care clinics, collection centres, and as mobile collectors visiting residential aged care facilities, mental health facilities and private homes. However, pathology collectors predominantly work at 'single-staffed' 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.

[229] The evidence indicates that pathology collectors are exposed to biological hazards by the nature of their work — by way of example, when a patient improperly self-collects a urine or faecal sample and the pathology collector is then required to handle a sample which is externally contaminated with the content of the sample. Whilst the frequency of vomiting was contested by some of the employer witnesses, pathology collector witnesses referred to dealing with patients vomiting during the collection process and that pathology collectors are expected to clean up other bodily fluids in the course of their duties such as urine.

[230] Patients themselves may also constitute a safety hazard, in that the patients who present for pathology collection sometimes become aggressive, threatening, and/or engage in sexually harassing or inappropriate conduct towards (predominantly female) pathology collectors. For example, one witness recounted having a container of urine thrown at her by an agitated patient. Mobile collection or 'domiciliary' duties conducted in nursing homes can present further challenges as dementia patients can react violently to having pathology samples collected. Ms Giblett's evidence was that she had experienced a needle-stick injury in the process of such a collection.

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[250] Australian Government, *HLT37215 Certificate III in Pathology Collection*, Release 4 (Qualification, 1 July 2023).

[231] The evidence indicates that the nature of the work of a pathology collector has changed over time, in relation to the breadth of duties, the types of duties performed, and the amount of time required to complete those duties. The evidence about these changes includes the following:

- From Ms Goodman's evidence, pathology collectors are responsible for collecting a wider variety of samples for pathology testing than they used to be, with the role expanding over time to include breath testing, drug and alcohol testing, stool sampling, COVID-19 swabs, nail clippings and skin scraping. Ms Giblett's evidence indicated that pathology collectors have also started to fit blood pressure monitors and Holter monitors in addition to their collection duties.

- The work of pathology collectors has also become more computerised over time, and their duties require the handling of increasing amounts of digital information, increasing wait times for patients while data is entered into the computer system and for which no or minimal training has been provided. The failure of these systems (arising from computers not working, or the input of incorrect data) may delay processing.

- Pathology collectors at suburban collection centres have become responsible for duties which were previously performed by employees in other classifications in drug and alcohol screening centres or laboratories. For example, drug and alcohol screening used to be done at specific centres and specimen preparation and sorting of samples and handling of samples used to be done in laboratories. The evidence of Ms Giblett indicates that if a duty is capable of being performed in a collection centre, a pathology collector is expected to do it as it is likely cheaper to do so than it is to have a laboratory worker do it. Ms Giblett's evidence also indicated that the same was true for billing practices and contacting patients to schedule recollections of samples, both of which were duties previously performed by separate departments. In some workplaces, receptionists or cleaners previously performed administrative tasks, patient intake, stock control and cleaning and now these duties fall to pathology collectors.

- Ms Giblett's evidence was that the practices around packing specimens for pickup by a courier now involves a higher level of complexity and the completion of more paperwork, which has increased the amount of time she spends packing samples by 30 to 45 minutes per shift. Ms Giblett indicated that despite these increases in the amount of work to be performed by pathology collectors, they are expected to see the same number of patients per day as they were previously.

4.4.5 Existence and extent of gender-based undervaluation

[232] We are satisfied that pathology collectors covered by the HPSS Award have been the subject of gender-based undervaluation. This is the result of the wages structure for pathology collectors having been structured on the basis of an alignment (at Level 4) with the masculinised C10 rate without any proper consideration of the work value of this historically female-dominated occupation. This in turn has meant that the following fundamental features

of the work of pathology collectors, which are not characteristics of the work of the metal industry tradesperson with whom they have been aligned, have not been taken into account in the setting of their minimum wages:

(1) A core duty and skill of pathology collectors is to obtain blood samples by means of venepuncture. This is an invasive medical procedure required to be performed on a human patient and, as such, involves a level of responsibility which is simply not a usual characteristic of work at the C10 level. The need to ensure sterilisation, make an evaluative judgment regarding the appropriate method of blood extraction based on the age and circumstances of the patient, identify the vein from which the blood is to be drawn, puncture the skin, enter the vein in a way which is safe, precise and minimises the patient's pain and distress, draw the blood efficiently, and then ensure the sample is stored in a sterile and properly-identified container has no analogue in most forms of work for which a Certificate III qualification is required or appropriate. Significant risks attach to this procedure if carried out incorrectly, including the risk of hitting a nerve and causing nerve damage, or hitting an artery or a vein that has had lymph nodes removed.

(2) Pathology collectors work in a highly autonomous and self-directed way and in a high proportion of workplaces work alone without any in-person supervision, guidance or assistance. Responsibility for the accuracy of patient information, pathology sample collection and processing therefore rests exclusively with the pathology collector.

(3) The work of a pathology collector is substantially performed in the presence of and in interaction with patients. A pathology collector must also coordinate their work efficiently in order to deal with large numbers of patients with differing age and health circumstances and requiring different samples across the course of a working day. This requires the exercise of 'invisible' skills, including highly-developed communication skills, empathy, organisation and patience in order to deal effectively and sensitively with the wide variety of patients of varying ages, states of health, English proficiency and levels of distress about their diagnoses and/or having their blood taken. In this respect, we do not accept the submission made by Australian Pathology that the role of pathology collector involves no more than the basic skills of communication and empathy found in all customer-facing jobs. The regularity of patient interaction and the need to manage patients through a medical procedure which may have significant life consequences plainly requires the exercise of 'invisible' skills to a higher level and degree than, for example, in a retail or hospitality role. In addition, pathology collectors must have the capacity to deal with unusual circumstances such as a patient fainting or vomiting in reaction to a blood sample being taken or patients who behave in an aggressive or threatening manner because of drug, alcohol or other problems.

(4) The general level of responsibility attaching to the proper performance of the totality of the role of pathology collectors which, as earlier stated, rests exclusively with the pathology collector, is significant. Any mistakes in patient identification, or the conduct of the incorrect test, or the delivery of the incorrect results for the

patient, may result in delays in treatment, significant distress to a patient or even death and can impact the care received by patients and the organisation's overall service delivery.

[233] We therefore conclude that there are work value reasons, within the meaning of s 157(2)(a) of the FW Act, justifying an increase to the wage rates of pathology collectors covered by the HPSS Award.

4.4.6 Rectification of gender-based undervaluation — provisional view

[234] We do not consider that the wage rates for pathology collectors should be aligned with the Caring Skills benchmark rate, as proposed by the ACTU, the HSU, the UWU, the ASU and the PCA. As we discuss later in this decision in relation to the CS Award, it was fundamental to the establishment of the Caring Skills benchmark rate in the *Stage 3 Aged Care decision* that the exercise of historically undervalued 'invisible' skills was considered to be a constant requirement of the role that was wholly integrated with the exercise of all of the technical skills of the work. This cannot be said to be the case for pathology collectors, for whom a portion of their technical tasks do not require high-level interaction with the patient (for example, after the sample has been taken and the pathology collector proceeds to the preparation, labelling and despatch of the sample).

[235] We do not consider that it is necessary or desirable to create a whole new classification structure for pathology collectors at this time, having regard to our earlier observation concerning the desirability in the future of undertaking a holistic review of the 'Technical and clinical' roles in the Support Services employee classification structure. The better course, at the current time, is to reclassify pathology collectors within the existing structure for Support Services employees, as was done with certain categories of indirect care workers under the Aged Care Award in the *Stage 3 Aged Care decision*. We consider that an experienced pathology collector belongs most appropriately in Level 7. On the basis of our earlier findings, they fit most closely with the criteria in the Level 7 classification structure because they are 'capable of functioning autonomously, and prioritising their work… within established policies, guidelines and procedures', are 'responsible for work performed with a substantial level of accountability and responsibility', and possess 'well developed communication [and] interpersonal… skills'. Our *provisional* view is that pathology collectors should therefore be classified within the existing structure as follows:

Support services classification	**Criteria**	**$ per week**
Level 5	Entry level Unqualified and 1st year of industry experience	1067.30
Level 6	Qualified Certificate III **or** equivalent training and experience and one year or more of industry experience	1124.80
Level 7	Experienced Certificate III or equivalent training and experience	1145.00

Support services classification	Criteria	$ per week
	and four years or more of industry experience or required to work in a 'single-staffed' collection centre.	

[236] This will produce minimum wage rate increases in the range of 1.8 to 10.9 per cent dependent on an employee's current classification level. In respect of the proposed criteria for pathology collectors at Level 7, we consider it likely, given the evidence of the work environment, the nature of the work, and the breadth and level of the skills utilised by pathology collectors in single-staffed collection centres, that their training and experience would be considered to be equivalent to a Certificate III qualification. We will not at this stage attempt to classify a pathology collector who might in future be required to hold a Certificate IV qualification because we do not have a sufficient understanding of what the role and duties of such an employee might entail. This issue may be dealt with on application in the future. However, existing pathology collectors who hold a relevant Certificate IV qualification will translate to Level 7.

[237] We discuss further the cost implications of our *provisional* view in part 4.6 of our decision.

4.5 Dental assistants

[238] As earlier set out, clause A.1 of the HPSS Award provides that, as an indicative role, the occupation of dental assistant is distributed amongst three Support Services employee classifications:

- Level 1 — Dental assistant (unqualified) — less than 3 months' industry experience.
- Level 2 — Dental assistant (unqualified) — 3 months' or more industry experience.[251]
- Level 4 — Dental assistant (qualified).
- Level 5 — Dental assistant.

[239] It may be noted that the reference to the indicative role of dental assistant at Level 5 identifies no criteria for progression to that level other than by application of the generic criteria in the classification definition. This makes it unlikely, in practice, that Level 5 operates as an effective minimum wage rate for any category of dental assistant.

4.5.1 Gender and qualifications profile

[240] The occupation of dental assistant is overwhelmingly female, with 97.5 per cent being women. No formal qualification is required to be employed as a dental assistant, but the majority of dental assistants do in fact hold a qualification. The following table, extracted from Table 7.1 in the Stage 1 Report, shows the highest qualifications held by dental assistants:

[251] See clause A.1.2(b) of the HPSS Award.

Highest education qualification	Dental Assistants
Bachelor's degree or above	17.3%
Advanced Diploma and Diploma	11.4%
Certificate III & IV	41.2%
Below Certificate III	30.1%

[241] The proportion of dental assistants holding a Bachelor's degree or higher is problematic since there are no such qualifications for this occupation. This might indicate the erroneous identification of persons as dental assistants in the data source[252] and/or the holding of qualifications not relevant to the occupation of dental assistant. However, the Stage 1 Report at least identifies that a substantially greater proportion of dental assistants hold at least a Certificate III or IV qualification than those that do not. The proportion of employees holding diploma qualifications is likely referable to the Diploma of Dental Technology or the Advanced Diploma of Dental Prosthetics. However, persons who require qualifications of this type would not be dental assistants within the meaning of the HPSS Award and, if covered by that award, would fall into the Health Professional classifications.

4.5.2 Parties' positions

[242] The ACTU contended that the work of dental assistants had been the subject of historical gender-based undervaluation because of a gendered division of labour whereby a female auxiliary workforce supported male dentists, a continued perception that dental assistant work is low-status and unofficially restricted to women, and the failure to carry out any proper work value assessment in setting minimum award wages. The ACTU submitted that, on a proper assessment of their work, dental assistants played a key role in supporting the clinical practice of dentistry by providing 'hands-on care', having close contact with patients and helping to maintain dentists' practices. It was submitted that the role of dental assistants was multi-faceted and included preparing patients, organising instruments, and assisting with dental procedures, as well as infection control, equipment maintenance, and post-operative patient care. They also manage data, handle clerical work, and perform reception duties, demonstrating a broad skill set that is essential to the smooth functioning of dental practices. The ACTU submitted that while many of these tasks may be delegated differently by various dentists, the complexity and range of dental assistants' duties reflected a high level of professional competency.

[243] Additionally, the ACTU submitted that the work of dental assistants involved the exercise of 'invisible' skills. Their work includes the need to anticipate the needs of dentists, follow their cues, and work as an adjunct to them by providing 'another pair of hands, and eyes'.[253] The ACTU relied upon the description of dental assistants' work in the Charlesworth Report as requiring 'relevant knowledge, problem-solving, interpersonal (including cultural skills), and physical skills … in their work both in their responsive interactions with dentists as well as patients and families'.[254] The ACTU submitted that dental assistants are ordinarily expected to have skills such as anticipating the dentist's needs, demonstrating excellent manual dexterity, reading both patients and the room to ensure appropriate communication, alongside time management and maintaining a calm, cheerful demeanour under pressure.

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[252] The August 2021 ABS Census of Population and Housing.

[253] ACTU submission, 18 October 2024 [82].

[254] Ibid [83].

[244] As with medical technicians, the ACTU proposed that the asserted gender-based undervaluation should be remedied by the establishment of a new classification structure applying to dental assistants which reflected the existing structure for Support Services employees but was aligned with the Caring Skills benchmark rate at Level 4, with the wage rates for all other levels adjusted proportionately.

[245] Dental Assistants Professional Association Incorporated (DAPA), an incorporated association representing the interests of dental assistants as an occupation, submitted that the HPSS Award fails to recognise the complexity and value of the work of dental assistants, especially those with more experience because it does not recognise the significant skills gap between inexperienced dental assistants and those who have undertaken further qualifications and have significant experience, the years of experience at each level or the significance of the Certificate III qualification. DAPA also submitted that the HPSS Award does not recognise the acquisition of the Certificate IV qualification, which encompasses advanced knowledge and skill sets such as general anaesthesia, sedation and practice management. It was submitted that the work of dental assistants had historically been undervalued because of assumptions based on gender in that the occupation was highly feminised, was created and developed based on a gendered division of labour, remained gender-segregated, and involved the exercise of 'invisible' skills which had not been recognised. These 'invisible' skills included the exercise of compassion and empathy to drive interactions with patients, attention to detail, efficient time management, critical thinking in responding to patients and managing unplanned changes in treatment, interpersonal skills, adaptability in response to changes in scheduled treatment procedures, problem solving, organisational skills, learning agility and communication and social intelligence. In addition, it was submitted, changes in work value in the nature of advancement in and complexity of technology and equipment, increased emphasis on infection prevention and control (IPC) measures, and a move from a passive to an active role in patients' treatment had never been taken into account in the setting of minimum award wages.

[246] DAPA submitted that the skills, including 'invisible' skills, exercised by dental assistants are far greater than those exercised by PCWs, aged care HCWs and AINs, as dental assistants are required to, in addition to providing 'caring work', possess the clinical knowledge of a broad range of complex dental procedures, including surgical procedures and highly advanced equipment and software systems used in these procedures. It was submitted that no such equivalent skills and responsibilities are exercised by PCWs, aged care HCWs or AINs. On this basis, DAPA's position was that the minimum award wages of dental assistants should be increased by 25 per cent to properly reflect the value of their work. DAPA also proposed the introduction of cleaning and study allowances for dental assistants.

[247] The Australian Dental Association (ADA), a professional organisation representing employer and employee dentists, made a brief submission to the effect that it was concerned that higher costs associated with increased wages for dental assistants would be passed on to patients as higher treatment costs, which would lead to patients foregoing necessary treatment due to affordability constraints and lead to worsening oral health outcomes for lower income earners. The ADA expressed concerns about the use of the Spotlight tool[255] to assess gender-based undervaluation, including that it could be subjective and lead to inconsistent

[255] The Spotlight tool was described in detail in the *Stage 1 Aged Care decision*: [2022] FWCFB 200, 319 IR 127 [410]–[412].

outcomes, and might not adequately capture the specific skills and experience required for dental assistant roles.

[248] In respect of dental assistants specifically, the Private Hospitals Group submitted that their primary role is to assist dentists in undertaking procedures, and they generally have limited patient interaction. As such, it was submitted, they do not exercise 'invisible' skills to the same degree as for Certificate III-qualified direct care employees dealt with in the *Stage 3 Aged Care decision*. The Private Hospitals Group opposed the award variations proposed by the ACTU and DAPA as not being justified by work value reasons. The Private Hospitals Group noted that in the *Queensland Dental Assistants decision*, the QIRC had found, following a consideration of the skills of dental assistants, including their soft skills, that the work of those who held a Certificate III qualification was appropriately valued by the C10 rate. The Private Hospitals Group pointed to the facts that it was not mandatory that dental assistants hold a Certificate III qualification and that there was no clear division of duties between qualified and unqualified dental assistants, and consequently submitted that it was not appropriate to align the pay rates of dental assistants with the Caring Skills benchmark rate.

4.5.3 Evidence

[249] The ACTU, the UWU and the HSU relied on witness statements made by two employees as to the work of dental assistants:

(1) Lily Robertson[256] is a dental assistant employed by Bupa Dental. She is enrolled in a 12-month course to complete a Certificate III in Dental Assistance. Ms Robertson gave evidence about her duties and scope of responsibility at work, the variety of clients she sees and the training, skills and knowledge she uses in her role. She also said that she was 'expected to get qualified'[257] after six months with Bupa Dental.

(2) Emmily Medwin[258] is a dental assistant employed casually by Attention to Dental and also by Dental Flossophy. She holds a Certificate III in Dental Assisting. Ms Medwin gave evidence about her duties and responsibilities at various workplaces, her interaction with co-workers and patients, the training, skills and knowledge she uses in her role, and the increasing complexity of her work.

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

(1) Barbara Hayes[259] is the Chairperson of the Board of DAPA. She holds a Certificate III in Dental Assisting, a Certificate IV in Work Health and Safety and a Certificate in Training and Assessment. Ms Hayes practised as a dental assistant for over 50 years before retiring in 2021. She gave evidence about dental assistants' qualification and occupational pathways, the various contexts in which

[256] Exhibit HPSS16 (witness statement of Lily Robertson, 3 October 2024).

[257] Ibid [32].

[258] Exhibit HPSS25 (witness statement of Emmily Medwin, 10 October 2024).

[259] Exhibit HPSS26 (witness statement of Barbara Hayes, 11 October 2024).

they work, their clinical, hygiene and administrative duties, changes to those duties and the dental industry over time, and the skills they exercise.

(2) Rebecca VanZutphen[260] is the owner and founder of Staged Dental Coaching, a consulting business that 'coach[es] dental practice owners and their teams to improve communication, patient engagement, and leadership'[261]. Before founding that business, Ms VanZutphen worked as a dental practice manager for over 10 years, and as a dental assistant for around seven years prior to that. She holds a Certificate III in Dental Assisting, a Certificate IV in Training and Assessment in Dental and a Certificate IV in Practice Management in Dental. Ms VanZutphen gave evidence about typical dental assistant duties, the skills they exercise and how these have changed over time.

(3) Cheryl Gomez[262] is a full-time dental assistant in a private practice in Melbourne. She holds a Certificate III in Dental Assisting, a Certificate IV in Dental Assisting (Dental Radiography) and a Diploma in Dental Technology. Ms Gomez has been a dental assistant for 13 years. She gave evidence about her experience of shifting pay rates while obtaining her qualifications, her duties, responsibilities and working conditions and changes in the dental assistant role and dental industry over time.

[251] Of the above witnesses, only Ms Robertson, Ms VanZutphen and Ms Gomez were cross-examined. The ACTU and DAPA also sought to rely upon a statement of agreed facts pertaining to dental assistants.[263] This was not the subject of agreement with any interested employer party. However, it can be given somewhat greater weight than in the case of pathology collectors because of the very limited factual contest concerning the work of dental assistants.

[252] As indicated above, Ms Elliott[264] gave evidence for the Private Hospitals Group. Her evidence in part concerned one dental assistant employed by Cura at the Sydney Surgical Centre. She said Cura prefers dental assistants to hold a Certificate IV in Dental Assisting, but it is not compulsory, and that they have 'limited patient interaction'[265] because the patient is asleep while the dental assistant is performing their role. Ms Elliott further deposed that the skills, scope of work and responsibilities of dental assistants have largely not increased in the last 20–25 years. Ms Elliott was cross-examined by the ACTU.

4.5.4 Factual findings

[253] The evidence concerning the typical duties, skills and responsibilities of dental assistants was largely uncontested, with the areas of disagreement being primarily concerned

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[260] Exhibit HPSS20 (witness statement of Rebecca VanZutphen, 11 October 2024).

[261] Ibid [4].

[262] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024).

[263] Exhibit HPSS120 (statement of facts agreed between Australian Council of Trade Unions, Phlebotomists Council of Australia and Dental Assistants Professional Association, 18 October 2024).

[264] Exhibit HPSS44 (witness statement of Kaylene Elliott, 18 October 2024); exhibit HPSS45 (supplementary witness statement of Kaylene Elliott, 28 November 2024).

[265] Exhibit HPSS44 (witness statement of Kaylene Elliott, 18 October 2024) [28].

with the proper characterisation of certain skills and different emphases on certain aspects of dental assistants' work. The fundamental role of the dental assistant is to assist dentists and dental/oral therapists in providing treatment of teeth, mouths, and oral structures in all stages of dental treatment other than clinical diagnoses and consultations or treatment planning. This work is predominantly undertaken in private, for-profit dental practices. In undertaking this role, dental assistants undertake a mixture of clinical, administrative and cleaning duties throughout a typical day of work. The role of assisting dental practitioners with dental procedures will typically involve the following specific duties and responsibilities:

- preparing for and cleaning up after procedures, including hand hygiene, putting on personal protective equipment, and the cleaning and sterilisation of materials, instruments and equipment used in these treatments through the operation of ultrasonic cleaning baths, thermal washer/disinfector and benchtop steam sterilisers;
- assisting during procedures chairside, including passing instruments, operating suction apparatus, mixing and passing materials, protecting the tongue and associated tissue, and maintaining a dry and clean field within which to operate;
- explaining the procedures and courses of prescribed treatments to the patient;
- processing and uploading X-rays or digital images using the requisite software;
- reviewing and recording findings from the dental practitioner's oral examination into electronic patient records, charting, recording clinical notes of the procedure and the treatment plan, and uploading documentation including consent forms and quotes;
- completing work health and safety checks;
- observing and monitoring patient comfort and safety; and
- managing sterilisation processes in the practice.

[254] Certificate IV-qualified dental assistants will also undertake more advanced duties including operating and troubleshooting digital imaging equipment such as scanners or digital X-rays, providing oral hygiene instruction to members of the public, taking impressions for study models, constructing bleaching trays and bite rims, articulating models, and assisting in general anaesthesia and conscious sedation procedures.

[255] Dental assistants will also usually perform a range of administrative duties including attending to telephone calls and emails and managing patient inquiries, making appointments (including emergency appointments), and operating dental patient management software including for invoicing, accounts receivable and payable, scheduling, confirmation and reminders of appointments, processing health fund claims and maintaining and replenishing stock by placing orders with suppliers. Dental assistants may also be engaged in the triaging of emergencies. Certificate IV-qualified dental assistants may also be engaged in practice management activities and business administration.

[256] The competencies expected from dental assistants are evidenced by a position description provided by one witness, Ms Medwin. This position description identified ten 'technical competencies' of her position, being the 'key outcomes that are to be achieved in the

role and a performance standard against [which] the employee will be assessed', as consisting of the following:[266]

> **Clinical treatment**
> Assists dental operators in clinical treatment.
> **Prepare treatment room**
> Prepares treatment room for daily procedures.
> **Patient greeting**
> Welcomes patients and accompanies them into the treatment room.
> **Materials**
> Prepares and delivers materials under the direction of the dental operator. Pour up impressions, make bleaching trays/MG or other in-lab procedures. Prepare and deliver CADCAM restorations from preparation to cementation.
> **Clean & prepare treatment room**
> Cleans and prepares treatment rooms ready for the next patient in line with the practice's infection control protocol.
> **Contaminated instruments**
> Responsible for processing of contaminated instruments and equipment in line with the practice's infection control protocol.
> **X-rays**
> Download, develop and accurately file patient's X-rays.
> **Supplies**
> Monitors and orders supplies as needed or at least tells the person responsible that stock needs replenishing.
> **Dental team**
> Develops working relationships with the dental team, focussing on coordinating team at back with start times/finish times and breaks as well as lab/steri[lisation] and back area duties. Manages infection control processes. Reports back to the owner.
> **Office staff**
> Assists office staff when required and passes on information to owner.

[257] The same position description also lists 10 'personal competencies', being the 'personality traits and characteristics that are considered to be most important in the carrying out of the function and the achieving the objectives' (underlining added), as follows:[267]

> **People management skills**
> The ability to interact appropriately and successfully with people of all different types and at different levels.
> **Accuracy/eye-for-detail**
> Demonstrates a concern for accuracy at every stage and in every aspect of a task. Being able to attend to all requirements of a task and implement processes of checking and follow-up.
> **Handles pressure & stress**
> The ability to continue to perform well under pressure or in stressful situations
> **Teamwork**
> The ability to work with other people towards a common goal. To establish effective collaborative relationships with other people in the practice.
> **Initiative**
> An ability to take action when required. Actively seeking out opportunities to make extra contributions to benefit the practice.

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[266] Exhibit HPSS25 (witness statement of Emmily Medwin, 10 October 2024) annexure EM-4.

[267] Ibid.

> **Sense of urgency**
> An appreciation of priorities and the ability to perceive the relative importance of individual tasks and to act on these with appropriate speed and urgency.
> **Tact & diplomacy**
> Skill in dealing appropriately with different social exchanges, particularly in difficult or embarrassing situations.
> **Empathetic**
> The ability to perceive and understand the feelings of others.
> **Flexibility to cope with change**
> Not rigid; supports change and is able to adjust to changes in the practice quickly.
> **Work ethic**
> An attitude that when at work you are focused on your work and not easily distracted. In addition, be prepared to put in extra hours as required either early in the morning or after work. [Being p]repared to put the extra effort in.

[258] The position description 'scores' each of the above competencies as constituting 5 per cent of the 100 per cent total for the job, with the technical and personal competencies both constituting 50 per cent of the total.

[259] It is apparent that a number of the above 'personal competencies', which are classically mislabelled as 'personality traits' rather than skills, are in fact 'invisible' skills of the type discussed in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. Certainly, 'People management skills', 'Tact & diplomacy' and 'Empathetic' are encompassed by the 'invisible' skills of interpersonal and contextual awareness, verbal and non-verbal communication and emotion management, and 'Handles pressure & stress', 'Teamwork', 'Initiative', 'Sense of urgency' and 'Flexibility to cope with change' would likely all involve elements of dynamic workflow coordination. Thus, the position description is evidence that these are a significant aspect of the role of a dental assistant.

[260] The witness evidence before us amply confirms this. It is clear that it is a basic expectation of dental assistants that they exercise effective interpersonal and communications skills to manage the emotions and reactions of patients before, during and after dental treatment. For example, Ms Medwin gave the following evidence:[268]

> I have found that the expectation in most, if not all, practices is that dental assistants welcome patients into the room and make them feel comfortable throughout their treatment. We do this by speaking with patients and monitoring them for discomfort. Dentists have different expectations. For example, one dentist expects me to speak to members about after treatment care. If a patient had a question that is within my training and I am comfortable with answering, I will answer questions verbally. When patients ask a question I cannot answer, I will direct their question to the dentist.
> . . .
> My work with patients occurs on a daily basis. It is an integral part of my job and includes:
>
> (a) welcoming patients to the treatment room and trying to make them feel as comfortable as possible through polite and calm communication. This will include calling the patient into the room, depending on practice;
> (b) providing support throughout the treatment or procedure. This can include holding a patient's hand. Some dentists will treat two patients at once and when I am in the

[268] Ibid [16], [33]–[34].

room alone with a patient, I will make small talk and answer questions that I can answer;

(c) monitoring patients for pain and letting them know that they can ask us to stop if the pain is too much. Sometimes patients won't tell me that they are in a lot of pain so watching their body reaction is important; and

(d) providing patients with leaflets and other items necessary for after care such as dental gauze.

Overall, I estimate that 40% of patients who I work with are elderly, 40% of patients are adults and the other 20% are children, including babies.

[261] The communications skills required to be exercised can include non-verbal skills and emotion management techniques. For example, Ms Medwin said:[269]

> …I use my communication skills to help patients feel comfortable. I identify nervous patients by observing them and support them through conversation. I can tell a patient is nervous by watching the body for twitches, leg jolting, squinting or scrunching eyes, and shaking legs. Sometimes patients will start crying after entering the room or sitting down, which shows me they are very nervous or anxious. I use a calm voice and supportive words to calm patients in these circumstances.

[262] Ms Robertson similarly said:[270]

> I need to exercise empathy, compassion, and emotional intelligence. For example, I have to be aware of the patient's mood (agitated or anxious). There are nonverbal cues like fidgeting, restlessness, frustration, mumbling, sweating, pinching themselves, or wringing their hands. Sometimes patients are open and tell you. Sometimes they don't talk to you or look at you at all, they can be rude and/or short in their responses. One patient was very anxious, and through distraction and explanation we were able to calm them down enough to administer gas which then allowed us to complete the procedure.
> . . .
> I need to be able to communicate openly and clearly. I adjust my language according to the situation, for example, I might refrain from using excessive dental terminology. I utilise communication techniques, such as asking open ended questions, and/or using reflections to ascertain whether the information I have and how I have interpreted it from what the patient has said is correct. I use measured and accessible language. I have utilised written communications and diagrams to help to a hard of hearing patient.
>
> I have to be able to read or understand non-verbal communication. I've had to learn how to read non-verbal cues from patients and have a level of understanding of how to communicate to a hard of hearing patient.

[263] Ms Gomez likewise gave the following evidence:[271]

> I notice a patient's facial expressions. If a patient does not understand the jargon that a dental practitioner uses in their explanation, I notice the change in their eyebrow movement. I will then ask the patient: 'Is there a specific question that you are not understanding that you need more

[269] Ibid [60].

[270] Exhibit HPSS16 (witness statement of Lily Robertson, 3 October 2024) [38], [41]–[42].

[271] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024) [82]–[83].

> clarity on?' or 'Is there anything in particular that you'd like explained again?' I need to gently prompt the patients with these questions because sometimes they may be too nervous or scared to ask the dental practitioner questions. If a patient's face looks tense and uncomfortable, I will gently remind them to breathe and make sure they do not breathe through their mouths. I will say to patients, in an encouraging and supportive tone: 'Make sure you take deep breaths slowly in through your nose and slowly out. Just focus on your breathing and I will give you a break.'
>
> I monitor the emotional wellbeing [of] the patient by asking the patient open-ended questions such as: 'How are you feeling about this appointment?' to draw out how they may be thinking or feeling. When a patient arrives for a procedure, I will ask them: 'Have you had this procedure done before?' The patient may respond: 'Yeah I have and I didn't like it' or 'I liked it but didn't' like the needle.' I will then offer: 'We will give you some numbing cream to help numb[] the area before the needle goes in. You are more than welcome to close your eyes', 'Would you like to hold my hand? Would that give you some comfort?' I can observe that the tension in the patient's face ease when I offer them these options.

[264] The exercise of interpersonal skills by dental assistants will need to be adjusted to account for the age of patients, neurodivergence and cultural sensitivities. Ms Medwin gave evidence about the specific skills she exercises depending on the particular characteristics of patients:[272]

> If a dentist can speak another language, often people who also speak that language will book with the dentist. When I worked at National Dental Care, I worked with a Korean dentist and over half the patients were Korean. I do not speak Korean; however, I was able to learn what certain phrases meant with time. For example, I understood the Korean term for X-ray and was able to begin setting the room up accordingly without instruction from the dentist.
>
> When I work at the Institute for Urban Indigenous Health, I work with First Nations communities and their family. Elderly Indigenous patients attend this clinic. Elderly Indigenous patients are more prone to illness and strict sterilisation protocols must be followed. For example, rooms must be wiped down twice between patients and dental assistants must wear full PPE including glasses, mask, gloves, hair net and full body gown.
>
> I need to be aware of cultural differences and expectations, and if I am unsure, ask patients what they are comfortable with. For example, Muslim patients do not like being touched and I need to be cautious about making physical contact. I need to be mindful to not place any tools on the patient's chest. Placing tools on patients' chests, where there is consent, is a common practice. Another example related to Muslim patients is often female patients will request that females only provide dental treatment. Otherwise, it is common practice for a male member of their family to attend. As a dental assistant, we need to also ensure that they feel welcomed and respected in the dental clinic.
> …
> When children come in with their guardian, as well as communicating with parents, I also need to assist the dentist to speak to the parents by focusing on the child to keep them entertained. During a recent appointment in early October, a one year old attended the dental clinic I was working at. Both parents wanted to listen to the dentist and ask questions. To allow the parents to do this, I played with the child so the parents could focus on the dentist.
> …
> When working with neurodivergent children and adults, I adjust my work accordingly. In cases of autism, I change the way [I] approach work and will communicate more. The dentist and I

[272] Exhibit HPSS25 (witness statement of Emmily Medwin, 10 October 2024) [49]–[51], [64], [68].

> will work as team to talk the patient throughout the process and explain each step in greater detail. For example, I will clearly tell a patient that I will use the suction tube in their mouth before doing so.

[265] An important aspect of the 'invisible' skills involves the dental assistant acting as a disguised interlocutor and coordinator between the dentist and the patient. Ms Robertson described this in the following way:[273]

> I have to be able to hold positions for a really long time and speak with the client and listen to the dentist all at once. I listen to dentists as they talk to know what they are saying to the patient and to know what they and the patient might need. Dentists generally talk through the procedures, but I sometimes need to explain to the patient afterwards with less 'jargon' if the patient hasn't understood. For example, explaining to a patient the process of a buccal filling, by breaking it down into stages and trying to use analogies to help explain the process.

[266] Ms VanZutphen explained that this aspect of the role involved the skill of anticipating the needs of both the dentist and patient:[274]

> Another key invisible skill is intuition. When preparing the surgery or assisting during an appointment, dental assistants must anticipate the needs of both the patient and the dentist. For example, when assisting with an emergency patient, the assistant must stay fully engaged, actively listening to the patient's symptoms and the conversation between the dentist and the patient. They need to predict what the dentist will require next, such as preparing the X-ray machine before the dentist requests it. This ability to anticipate and act quickly improves the efficiency of the appointment and reduces patient wait time. The ability to anticipate needs is highly valued and is a skill that not all dental assistants naturally possess but are expected to develop.

[267] The exercise of the 'invisible' skill of dynamic workflow coordination is apparent in the way that dental assistants will often be required to deal with, and even manage, evolving situations arising from the different circumstances of patients and scheduling issues. Ms VanZutphen said:[275]

> Flexibility and adaptability are also critical invisible skills. If the circumstances of an appointment change, such as a patient deciding to extract a tooth rather than proceeding with a planned root canal, the dental assistant must quickly shift gears. After spending time preparing for one procedure, they must immediately adjust and prepare for another, all while maintaining a positive attitude. They must continue to provide emotional support to the patient, demonstrating understanding and professionalism in the face of these changes.

[268] This may extend to triaging of patients, as Ms Gomez explained:[276]

> I must possess a superior level of clinical knowledge and skill as I may be required to triage a patient. If a patient presents to the practice for an emergency treatment, I need to recognise their symptoms and identify the appropriate treatment so I can prepare the correct equipment for the patient.

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[273] Exhibit HPSS16 (witness statement of Lily Robertson, 3 October 2024) [40].

[274] Exhibit HPSS20 (witness statement of Rebecca VanZutphen, 11 October 2024) [52].

[275] Ibid [53].

[276] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024) [53].

[269] The evidence also indicates that there have been changes to the work of dental assistants over the last decade or so which has increased the quantity and complexity of the work. This has included changes in work due to the introduction of new technology such as:

- sterilisation units which are more complex to run, clean and maintain;
- the increasing digitalisation of dental technologies, including the operation of X-ray machines and intra-oral cameras (which now exclusively involve digital imaging), and artificial intelligence-enhanced X-ray and imaging analysis;
- the use of 3D scanning and printing of patients' teeth for study and diagnostics;
- the use of 3D scanning equipment to create dental crowns within a single day — a process previously outsourced to offsite labs which took weeks to complete;
- Invisalign or clear aligner treatment, now commonly available in general dentistry; and
- new financial and administrative technologies including operating HICAPS and PRODA (electronic health claims systems) and point of sale terminals.

[270] Ms Hayes described some of the changes to dental assistants' duties and responsibilities arising from technological change in the following terms:[277]

> Over the past 10 years, there have been significant technological advances in digital imaging equipment including but not limited to intraoral cameras, scanning equipment, and digital dental X-ray systems. These technologies are increasingly utilized in many private dental practices. Dental assistants require education and training on the operation and safe use of this equipment. This includes operating the software, producing acceptable images, modifying settings for image intensity and clarity, uploading and storing images, and adhering to IPC measures of these items, as well as cleaning and routine maintenance protocols in accordance with the manufacturer's instructions. In the interests of IPC, the dental assistant would generally operate the computer to display an acceptable image, thus avoiding potential contamination from practitioners' gloved hands. Dental Assistants can be utilised to assist in the operation of and collection of digital images for patient records using oral cameras and scanning equipment. A dental assistant holding a license to operate radiographic equipment may also take radiographs on patients as prescribed by the registered practitioner, further utilising the skills of dental assistants.
>
> Technology advancements to dental equipment also requires the dental assistant to familiarise themselves with the supplies required to operate these items and the stock needed (including barriers for infection control) to ensure reliable continuity of use and prevention of cross infection between patients. 3D printing is increasing in availability and its capacity to reproduce dental prosthetic items places it in high demand. Dental assistants need a high level of knowledge and additional time to care for and clean this type of dental equipment.

[271] As Ms Gomez explained in her evidence, a number of the technological changes referred to above have allowed standard dental practices to undertake complex procedures that are new or previously the domain of dental specialists, with consequences for the complexity of the work of dental assistants:[278]

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[277] Exhibit HPSS26 (witness statement of Barbara Hayes, 11 October 2024) [52]–[53].

[278] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024) [69]–[71].

> When I first started dental assisting in 2011, many procedures were referred to dental specialists. Nowadays, many of these procedures can be performed by general dental practitioners, which means that I need to expand my knowledge on complex dental procedures.
>
> The most common treatment that is now available in general dentistry is Invisalign/aligner treatment. Since this was introduced into general dentistry, I have had to familiarise myself with 3D scanning machines, which starts by knowing how to operate the scanners, inputting the patient's information including their name, last name, date of birth and what scans are being done on the patient. I then have to make sure that these machines have the correct barriers or covers on them before the procedure in order for the 3D scanner to work properly. Unfortunately, I am aware that there are no specific courses for dental assistants to attend and learn the technology for using Invisalign scanners. The supplier does come to the clinic to provide a demonstration, but the demonstration is catered for dental practitioners rather than dental assistants. I also had to learn by myself how to clean these 3D scanners according to the manufacturer's instructions.
>
> Compared to 13 years ago, I am now required to assist the dental practitioner perform high-risk surgical procedures, including implantology which is a major development in recent years. Implantology is the permanent implantation of artificial teeth into the jawbone. I am responsible for making sure that all the parts needed for the procedure have arrived at the clinic, including the implant machine, implant drills, handpieces, drapes, salines and ensure that all these parts have been processed correctly before use. Once all the equipment and materials are available for this procedure, I follow aseptic technique in the set-up of this procedure, which is a specific method that is used in a surgical procedure to prevent the cross-contamination of harmful bacteria at surgical sites. It is one of the most important steps taken during an implant procedure, as this is critical in the patient's healing and success of the surgery.

[272] In addition, the work of dental assistants now has a greater emphasis on IPC in accordance with the new Australian Standard AS 5369:2023, *Reprocessing of reusable medical devices and other devices in health and non-health related facilities*, which was issued in December 2023. This has required dental assistants to use aseptic techniques to protect patients from healthcare related infections associated with contact with blood, body fluid and body tissue, especially when working on emerging procedures involving dental implants. The new Australian Standard has resulted in the Australian Commission on Safety and Quality in Health Care revising its version of the *Australian Guidelines for the Prevention and Control of Infection in Health Care*. The guidelines are comprehensive (409 pages) and deal with a wide range of new or more rigorous procedures which must be applied by dental assistants in their work. Failure to meet standards of IPC can result in serious health risks for patients and staff and lead to penalties or other disciplinary actions for the practice by regulatory authorities. The ADA has also published *Guidelines for Infection Prevention and Control* arising from the new Standard. The ADA's guidelines cover the matters in the *Australian Guidelines for the Prevention and Control of Infection in Health Care* and are specific to dental practices. Dental assistants are identified in the guidelines as 'clinical support staff'.[279] While the guidelines make clear that dental practitioners hold ultimate responsibility for IPC, they require dental practitioners to ensure that clinical support staff follow dedicated IPC procedures in line with the guidelines and are provided ongoing training.

[279] Ibid annexure CG-1.

[273] The importance of the role of appropriately-trained dental assistants in ensuring IPC in dental practices was emphasised by Ms Hayes:[280]

> The mouth contains over 700 micro-organisms, so it is extremely important for dental practices to implement high-level IPC processes to reduce any potential of contamination between patients. Disinfection and sterilisation processes are processes undertaken by most dental assistants. Disinfection is a process to inactivate viable micro-organisms to a level previously specified as being appropriate for a defined purpose. Sterilisation is a validated process used to render a product free from viable micro-organisms.
>
> The dental assistant is responsible for cleaning, decontaminating (and if required, disinfecting) the surfaces in the dental treatment area as well as the equipment used, which may be located within distance of the zone of contamination by aerosolization. The importance of thorough cleaning and treatment of the surfaces involved in clinical treatment is essential to providing a safe health care facility and environment. This procedure is undertaken by dental assistants following every patient treatment so training and knowledge and a clear understanding of patent safety is essential to this role.
> …
> After a patient completes their treatment, the dental assistant safely transports the dental instruments to the reprocessing area to be cleaned then undergo a cycle of sterilisation in the sterilising unit. After a completed sterilisation cycle of approximately 45 minutes, a dental assistant performs a check on the steriliser parameters and the contents of the load, and ensures these results are documented. Each sterile instrument used on a patient must be linked to a validated sterilisation cycle and recorded on the patient's file, either through a cycle identification number or barcode-scanned identification. The dental assistant completes the sterilisation process (provided it has passed the required parameters) by signing off the items for release into circulation ready for use. All critical items (such as dental forceps, flap retractors and surgical burs) are required to be sterile at the point of use and stored in sterile packaging prior to use. Each item must be labelled and tracked to a validated sterilisation cycle. The accuracy of the documentation is necessary to ensure the highest standards of IPC are met. The required documentation is listed in the Reprocessing Standard at paragraphs 2.3.3 – Records and 2.3.4 [–]Management of Records on pages 21–22. …
>
> The current Reprocessing Standard stipulates that only a competent person shall load items into a benchtop steriliser and release those items, check the items and allow them to be placed back into circulation. A competent person is described in the Reprocessing Standard as a person who has received acceptable training which is further defined as a person who has been formally trained in standards of IPC.

[274] Ms Gomez gave evidence that the role of the dental assistant has significantly evolved due to the interplay of the exercise of 'invisible' skills and the introduction of new procedures and technologies:[281]

> The industry has evolved such that I am no longer a passive player in the patient's treatment but an active player, which has required a more significant exercise of invisible skills in my interactions with patients, including empathy, compassion, building a rapport with patients, high-level verbal and non-verbal communication skills, being flexible, showing initiative and exceeding the expectations of the dental practitioner, possessing a kind demeanour and positive

[280] Exhibit HPSS26 (witness statement of Barbara Hayes, 11 October 2024) [37]–[38], [43]–[44].

[281] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024) [73]–[74].

> attitude, interpersonal skills, critical thinking, multi-tasking and clinical knowledge, which I will explain below.
>
> Compared to when I started as a dental assistant 13 years ago, I must exercise a greater degree of critical-thinking because I am involved in and must be proficient in assisting a broader range of procedures, including surgical procedures which are more complex. With the advance of technology and new materials and procedures, I also need to know how to operate and maintain the technology, use the new materials and do the new procedures. In the case of a complication during the treatment of a patient, I need to know what the dental practitioner may ask for next, such as x-ray unit or certain equipment or material, and prepare these in case the procedure will change, such as a filling procedure turned root canal treatment.

[275] The evidence of Ms Elliott, upon which the Private Hospitals Group relied, does not displace any of the findings above based on the largely uncontradicted evidence of the other witnesses. Ms Elliott's evidence concerned the skills, duties and responsibilities of a single dental assistant employed by Cura at its Sydney Surgery Centre. The duties of that employee may be considered atypical of the work of dental assistants, since it involves assisting in dental surgery conducted upon patients under general anaesthetic, in the context of a hospital environment. In terms of the skills involved, the technical skills may arguably be at a more advanced level since Cura regards it as desirable that such a dental assistant hold a Certificate IV qualification and the dental assistant works as part of a surgical team performing, among other things, wisdom teeth extraction, dental implants and full dental clearances. However, the dental assistant does not perform the ancillary administrative and cleaning duties typically required in a dental practice because of the performance of the work in a hospital environment. Nor does the dental assistant engage in significant interaction with patients because they are asleep during the procedure. Ms Elliott said that the skills required in this single position had not increased or expanded since 2000, but she acknowledged that some change to clean-up and disposal of instruments by dental assistants had occurred due to changes in infection control standards, and that dental assistants are required to comply with various accreditation standards including in relation to hand hygiene, handling of instrumentation, counts for patient records, patient identification, participation in clinical handover, time out procedures and mandatory training.

[276] As earlier stated, there is no regulatory requirement for dental assistants to hold any particular qualification, and employers' training and qualification requirements for dental assistants varies greatly between different practices. Ms Robertson, who is employed by Bupa Dental, described her training experience there as involving initial on-the-job training followed by a requirement to obtain a Certificate III qualification:[282]

> I was given training when I started my current role; it lasted for about a week and revolved around shadowing other dental assistants and some hands-on run overs of how to do my role. I was told what do to and where to find things, for example. From here it was learning as I went.
>
> The Certificate III is a requirement for the role. Once I had been with Bupa 6 months, I was expected to get qualified. This was communicated to by the practice manager who provided options of obtaining the qualification either through Bupa or through TAFE.

[282] Exhibit HPSS16 (witness statement of Lily Robertson, 3 October 2024) [31]–[33].

> I have also received some training in working with people from diverse backgrounds. I completed internal employer-based modules. The internal modules are mostly about being respectful within the workplace and following company bullying and discrimination policies.

[277] Ms Gomez gave evidence that the dental practice in which she worked was highly diverse as to the qualifications and training undertaken by dental assistants:[283]

> I work in a team where there are five dental practitioners, six dental assistants and one receptionist in the practice. Three of the dental assistants, including myself, hold a Certificate III in Dental Assisting qualification while the three other dental assistants do not. I am the only dental assistant who also holds a Certificate IV in Dental Assisting (Dental Radiography). The dental assistants have all been trained in the front desk/receptionist duties and are competent to do both clinical and receptionist duties if required.

[278] The evidence indicates that, as a matter of practice, the basic duties of dental assistants may equally be performed by qualified and unqualified dental assistants, but more complex and advanced duties are generally, but not always, undertaken by dental assistants with qualifications. Ms VanZutphen said:[284]

> The duties performed by unqualified dental assistant[s] are the same as those performed by qualified dental assistants, especially the duties that do not require expert technical training or knowledge. Even in these cases, if the dental assistant has received on the job training and can competently perform the relevant duties, that may otherwise be performed by dental assistants with more formal qualification, this is accepted by the industry. This lack of differentiation in responsibilities highlights the undervaluation of formal qualifications within the dental assistant profession.

[279] Ms Gomez confirmed that dental employers' work expectations generally do not distinguish between qualified and unqualified dental assistants:[285]

> It is my experience that there is not a clear division of duties between qualified and unqualified dental assistants. Most dental practitioners assume that the unqualified dental assistants know how to perform the same duties as a qualified dental assistant.

[280] However Ms Gomez herself, who holds a Certificate IV classification, made it clear that she in fact performed duties at a more advanced level:[286]

> As a dental assistant with my qualifications, I perform different duties to those of unqualified dental assistants, purely because I have a broader understanding of dental procedures and policies which apply at dental practices. This includes but is not limited to, the importance of keeping patient information confidential, how to operate dental ultrasonic machines and scalers, what tests dental assistants need to do, how to operate sterilisation machines such as autoclaves (the old name for steam sterilisers), and for example, what temperature and pressure to set and which instruments you can place in the autoclave.

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[283] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024) [4].

[284] Exhibit HPSS20 (witness statement of Rebecca VanZutphen, 11 October 2024) [20].

[285] Exhibit HPSS22 (witness statement of Cheryl Gomez, 14 October 2024) [24].

[286] Ibid [21]–[22].

> This means that as a qualified dental assistant, I am often required to double-check the work of unqualified dental assistants and ensure that they have performed their duties correctly, including if they have washed their hands, wiped down the surgery and performed the tests on the sterilisation machines. I provide a significant amount of training and explanation to unqualified dental assistants. I supervise and mentor unqualified dental assistants with respect to new procedures or tasks they have not done before. I am also responsible for ordering dental materials, components or instruments which unqualified dental assistants do not do. Given I have more clinical knowledge, I also do more administrative tasks such as organising the next appointment time for the patient because I know the next treatment and required time for the appointment and provide the patient with explanations of the treatment.

[281] Finally, as to the distinction between the Certificate III and Certificate IV qualifications, Ms VanZutphen said:[287]

> Certificate III and IV in Dental Assisting are the core qualifications for dental assistants in Australia, and there is a distinct difference between the two:
>
> a. Certificate III in Dental Assisting: This entry-level qualification provides foundational skills such as chairside assisting, infection control, sterilisation of instruments, patient care, and administrative duties. It equips dental assistants to support dentists during procedures and manage essential tasks in a dental practice.
>
> b. Certificate IV in Dental Assisting: Building on the skills learned in Certificate III, this advanced qualification covers more specialised areas such as dental radiography, oral health promotion, and advanced chairside assisting. Certificate IV also prepares dental assistants for supervisory roles, enabling them to take on greater responsibility within the practice, including taking x-rays and managing other staff.

4.5.5 Gender-based undervaluation

[282] The occupation of dental assistant presents a paradigmatical case of undervaluation arising from gender segregation and gender assumptions. The Stage 1 Report explains, by reference to academic literature, how the occupation of dental assistant was one constructed on the basis that it consisted of entirely female employees attending upon male dentists:[288]

> Adams (2010, 2003) documents the way dental assisting, nursing and hygiene developed through the nineteenth century in the context of gender inequality. Dental Assistant work was developed as part of a gender division of labour whereby a female auxiliary workforce would support and enable the male profession of dentistry, under male dentists' authority (Adams, 2010, 2003; Rayman, 2002). Hiring women in support roles to provide hands-on care, have close contact with patients and help maintain a practice is argued to have enabled men to adopt more authoritative professional roles and to achieve professional status through excluding women from their professional knowledge and credentials, and dominating women's labour through creation of a subordinate and subservient occupation (Adams, 2010, 2003; Thomson, 2015). While there are few studies of Dental Assistants' experiences and perspectives on their work, Freeman et al (2004) noted that Dental Nurses felt they were treated like 'housewives' by male dentists.

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[287] Exhibit HPSS20 (witness statement of Rebecca VanZutphen, 11 October 2024) [71].

[288] Stage 1 Report 69.

[283] The process by which the work of dental assistants was historically undervalued in the Queensland award system was outlined by the QIRC in the *Queensland Dental Assistants decision*. In short, the initial award regulation of dental assistants in the 1950s proceeded on the premise that they constituted a wholly female occupation and their work was valued based on that assumption. No proper work value assessment of their work was ever undertaken. The occupation did not benefit from the *1969 Equal Pay Case* because of the lack of any male dental assistants. As with many other exclusively female low-paid occupations, a comparative work value assessment of the type contemplated by the 'equal pay for work of equal value' principle established in the *1972 Equal Pay Case*, which might have led to a proper valuation of the work of dental assistants, never occurred. After the adoption of the C10 Metals Framework Alignment Approach as the guiding principle of wage fixation, a certificate-qualified dental assistant was aligned with the C10 rate, but dental assistants without this qualification, which was not an occupational requirement, had their rate set at 92 per cent of the C10 rate. This was found in the *Queensland Dental Assistants decision* not to constitute a proper valuation of their work. The QIRC undertook a full work value assessment of dental assistants involving a full analysis of both their technical or 'hard' skills and their 'soft' skills and, in respect of the latter, made the following findings:[289]

> Evidence was also given by [dental assistants] and Dentists as to the 'soft skills' which are used by [dental assistants] and which in the past may not have been recognised or adequately recognised. Soft skills are ones that may have been previously considered to be aptitudes or attributes and are often found in many caring occupations. They include:
>
> - communication and interpersonal skills such as putting patients at ease before, during and after procedures, caring and comforting patients;
> - dexterity — being able to manipulate equipment and work with and around the Dentist in the confined space of the patient's mouth;
> - close concentration and accuracy — for example, in dental charting, chair side assisting;
> - multi-tasking — both in chair side assisting and responding to interruptions;
> - anticipatory skills — to anticipate the needs of the Dentist often without a verbal request;
> - organisational skills — to pre-plan instrument trays; and
> - domestic skills — cleaning up the surgery and patients, if necessary.

[284] The QIRC determined the matter before it at two levels. First, it determined what it characterised as the 'base rates'[290] for dental assistants. In respect of unqualified and Certificate III-qualified dental assistants, the QIRC broadly maintained the existing relativities to the C10 rate. In this respect, it is apparent that the QIRC considered itself bound to strictly apply the C10 Metals Framework Alignment Approach. However, the QIRC added to this an 'Equal Remuneration Component' (ERC) of 11 per cent to remedy what it characterised as 'unequal remuneration'[291] or 'pay inequity'[292] for dental assistants, resulting in a 'total award rate' under the Queensland *Dental Assistants' (Private Practice) Award - State*[293] which, for a Certificate III-qualified dental assistant, had a relativity of 111 per cent to the C10 rate. It also

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[289] [2005] 180 QGIG 187 [83].

[290] Ibid [198].

[291] Ibid [181].

[292] Ibid [192].

[293] AN140090.

determined that there should be future adjustments to the ERC of 1.25 per cent per annum, calculated on the base rate.

[285] We have earlier outlined the history of the federal award regulation of dental assistants. There are three key aspects of this. *First*, the rates had their origin in a former award from the Victorian industrial relations system, and have never been the subject of a proper, gender-neutral work value assessment. *Second*, the rates of pay have been set on the basis of an automatic alignment of Certificate III-qualified dental assistants with the C10 rate. *Third*, when the HPSS Award was made during the award modernisation process, no consideration was given to the adoption in the modern award of the 'total award rates' in the Queensland *Dental Assistants' (Private Practice) Award - State*[294] established in the *Queensland Dental Assistants decision* — the only proper work value assessment of dental assistants which had ever been undertaken to that point.[295]

[286] Our own assessment of the work of dental assistants based on the evidence before us is that the minimum wage rates in the HPSS Award do not properly value the work of dental assistants. There are three principal reasons for this:

(1) We have earlier made findings about the required exercise of 'invisible' skills by dental assistants and the significance of this in the proper discharge of the duties and role of the dental assistant. Our findings about this are broadly consistent with those made by the QIRC in the *Queensland Dental Assistants decision* concerning the 'soft' skills of dental assistants, albeit that we consider that the development of the concept of 'invisible' skills since that decision has become more sophisticated and better distinguishes these skills from the more obvious 'hard' or technical skills. The duties of dental assistants involving the exercise of skills falling in the latter category, which we have attempted to describe in paragraphs [253]–[256] above, might considered in isolation justify an alignment with the C10 rate. However, we do not consider that, once the 'invisible' skills about which we have made findings in paragraphs [257]–[268] above are properly taken into account, that an automatic alignment with the C10 rate is justifiable. There is no basis to consider that the C10 rate was ever intended to properly value and remunerate the exercise of skills of this nature.

(2) Although the evidence establishes that at least the basic duties and employer expectations of dental assistants are largely the same as between unqualified and Certificate III-qualified dental assistants, those in the former category are, under the Level 2 classification in the HPSS Award, assigned a minimum wage rate which is approximately 95 per cent of the C10 rate. Having regard to our earlier findings about the work of dental assistants, this represents a clear undervaluation of the work of unqualified dental assistants who have received on-the-job training and have the benefit of work experience.

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[294] Ibid.

[295] The amount of the ERC was preserved for Queensland dental assistants employed by non-incorporated employers via a transitional pay equity order taken to have been made under item 30A of Schedule 3A to the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth). This is noted in clause 16 of the HPSS Award. We received no submissions as to the current effect, if any, of this order.

(3) The HPSS Award wage rates for dental assistants, which have not been the subject of any further consideration prior to this Review since that award was made (outside of the AWR), do not comprehend the changes in work value which we have found to have occurred in paragraphs [269]–[274] above.

[287] Accordingly, we consider that there are work value reasons within the meaning of s 157(2A) of the FW Act justifying a variation of the minimum wage rates for dental assistants covered by the HPSS Award.

4.5.6 Rectification of gender-based undervaluation — provisional view

[288] For reasons similar to those stated earlier in respect of pathology collectors, we do not consider that the award minimum wage rates for dental assistants should be restructured on the basis of an alignment with the Caring Skills benchmark rate (as proposed by the ACTU) or set above the Caring Skills benchmark rate (as proposed by DAPA). Although, as we have found, the exercise of 'invisible' skills is clearly of considerable significance in the role of dental assistants, we do not accept that the position here matches or approaches the quality or degree of the 'invisible' skills considered in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. The approach we consider is appropriate is based on the following principles:

(1) The most convenient course for the rectification of the gender-based undervaluation we have identified is to re-classify dental assistants within the existing structure for Support Services employees (as with pathology collectors).

(2) Our findings concerning the work value of dental assistants justify them being placed above Level 4, which is aligned with the C10 rate. This includes unqualified dental assistants, who perform the basic duties and are subject to the employer expectations we have earlier identified.

(3) Certificate III-qualified dental assistants should be classified higher than unqualified dental assistants because, even though they may be the subject to the same basic work requirements, the evidence indicates that they have the capacity to and often do perform more advanced duties. In addition, it is necessary that the minimum wage rate structure recognises the acquisition of qualifications in response to historical gender-based undervaluation which has involved a failure to recognise skills acquisition by dental assistants.

[289] Consistent with the above principles, our *provisional* view is that the role of dental assistant should be re-classified within the existing classification structure for Support Services employees as follows:

Support services classification	**Criteria**	**$ per week**
Level 1	Entry level Less than three months' experience	945.10
Level 5	Unqualified Has undertaken on-the-job training	1067.30

Support services classification	Criteria	$ per week
Level 6	Qualified Holds Certificate III or equivalent qualification or experience	1124.80
Level 7	Advanced Holds Certificate IV or equivalent qualification or experience	1145.00

[290] Consistent with the above *provisional* view, existing employees would translate to the new classification structure as follows:

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

[291] We recognise that there are some imperfections in the above outcome that are the result of rectifying gender-based undervaluation within the constraints of the existing classification structure. In particular, because the margin between the minimum wage rates for Levels 6 and 7 is small, the remuneration reward for a Certificate IV-qualified dental assistant may be perceived as inadequate. This is a matter which may require further attention upon a more fundamental review of the classification structure for Support Services employees in the 'Technical and clinical' stream. Nonetheless, we consider that the outcome we propose would result in wages set on a basis which is free of assumptions based on gender.

[292] There was only very limited employer evidence and submissions going to the cost implications for adjustments to the minimum wage rates for dental assistants. To the extent that any cost issues arise, we discuss them further in part 4.6 of our decision.

4.6 Cost issues

[293] The Private Hospitals Group advanced a substantial case concerning the cost implications for its constituent parties if the minimum wage rates for health professionals and Support Services employees covered by the HPSS Award were increased arising out of this Review. The case was articulated at a number of levels. In the first instance, the Private Hospitals Group opposed generally any increases to award minimum wage rates on a gender-based undervaluation basis, not only as a matter of principle but also because of the costs consequences for affected employers. In this respect, the Private Hospitals Group contended that such increases would not be consistent with the modern awards objective in s 134(1) and the minimum wages objective in s 284(1), having regard in particular to the consideration in s 134(1)(f) ('the likely impact of any exercise of modern award powers on business, including on … employment costs…') as well as s 134(1)(h). Secondly, the Private Hospitals Group's case focused on the ACTU claims that the wage rates for health professionals and medical technicians/dental assistants should be increased based on alignments with the C1(a) benchmark rate and the Caring Skills benchmark rate respectively, and addressed the detriment to employers which this would cause. Thirdly, the Private Hospitals Group advanced a case in the alternative that if wage rates were increased by the amounts claimed by the ACTU

or at all, we should consider ordering a delayed operative date and a phasing-in process. In support of its case, the Private Hospitals Group called evidence from the following witnesses:

(1) Peter Ryan,[296] the Director of Employee Relations and Policy at Ramsay gave evidence about the industrial instruments that set the terms and conditions of employment for Ramsay's employees, and the likely impact of any increase in wage rates in the HPSS Award on Ramsay's financial viability and future enterprise bargaining. In support of this, he prepared a spreadsheet[297] setting out wage calculations pertaining to each of Ramsay's current enterprise agreements.

(2) Conrad Truscott[298] is the Director of Payor Relations at Ramsay. He holds a Bachelor of Biomedical Science. Mr Truscott gave evidence about the agreements Ramsay has with private health funds which regulate how those funds pay its hospitals for services rendered to fund members, and how Ramsay derives revenue from federal and State governments.

(3) Mark Nelson[299] is the General Manager, Workplace Relations of Healthscope. In this role, he also provides workplace relations advice and enterprise bargaining support to the Adelaide Community Healthcare Alliance (ACHA). He was called by the Private Hospitals Group to give evidence about Healthscope's operation of private hospitals nationally, the extent to which Healthscope's and ACHA's employees are covered by awards and/or have enterprise agreements that apply to them and the impact that any increase to HPSS Award wage rates would have on Healthscope's and ACHA's financial viability. In support of the latter, Mr Nelson instructed the preparation of a spreadsheet[300] purporting to model both the immediate and potential financial impact upon on Healthscope. After the hearing of these matters had concluded, the Private Hospitals Group also filed a confidential note[301] addressing questions raised in cross-examination about the financial modelling Mr Nelson had caused to be prepared, and a further spreadsheet[302] comparing the original modelling and updated modelling.

(4) Jane Griffiths[303] is the Chief Executive Officer of Day Hospitals Australia (DHA). She was called by the Private Hospitals Group to give evidence about the operations of day hospitals including the usual procedures performed there, length of admission, types of employees and sources of revenue. Ms Griffiths gave detailed evidence about the typical contractual and other arrangements between day hospitals and private health insurers for funding of the hospitals' services. She

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[296] Exhibit HPSS1 (witness statement of Peter Ryan, 18 October 2024, as amended and refiled on 19 December 2024).

[297] Exhibit HPSS2 (confidential exhibit to witness statement of Peter Ryan, 18 October 2024 – spreadsheet, 'FWC work value modelling – Ramsay Enterprise Agreements', as amended and refiled on 19 December 2024).

[298] Exhibit HPSS31 (witness statement of Conrad Truscott, 18 October 2024).

[299] Exhibit HPSS97 (witness statement of Mark Nelson, 18 November 2024).

[300] Exhibit HPSS98 (confidential spreadsheet prepared by Mark Nelson, 18 October 2024).

[301] Exhibit HPSS123 (confidential explanatory note about the financial modelling in the evidence of Mark Nelson, 23 December 2024).

[302] Exhibit HPSS124 (confidential comparison spreadsheet to HPSS98 (confidential spreadsheet prepared by Mark Nelson, 18 October 2024), referred to in HPSS123, 23 December 2024).

[303] Exhibit HPSS105 (witness statement of Jane Griffiths, 17 October 2024, as amended and refiled on 18 December 2024).

further gave evidence that 'the vast majority of DHA's members will not be able to absorb [the] increases in labour costs [that she understood would flow if the HPSS Award wage rate for degree-qualified health professionals were increased to accord with that determined for registered nurses in the *Stage 3 Aged Care decision*]'.[304]

(5) Katharine Bassett[305] is the Director of Health Policy at Catholic Health Australia (CHA). She was called by the Private Hospitals Group to give evidence about the financial performance of CHA's member hospitals, the impact of the COVID-19 pandemic on those hospitals, their operating costs and how they are funded. Dr Bassett deposed that '[a]ny further increases to labour costs… will largely need to be absorbed by private hospitals'[306] because their ability to obtain increased funding from private health insurers and government is limited. In her supplementary statement, Dr Bassett gave specific evidence in reply to the Duckett Report.

(6) Christine Gee AM[307] is the Chief Executive Officer of Toowong Private Hospital (TPH) and President of the APHA. She holds a Master of Business Administration. Ms Gee was called by the Private Hospitals Group to give evidence about APHA's membership, TPH's operations including the enterprise agreements that apply to its employees, factors affecting the private hospital sector's financial performance, that sector's ability to absorb increased labour costs and the impact that any increase to HPSS Award wage rates would have on TPH's financial viability. She annexed to her supplementary statement various data on the number of patients treated by, and admissions to, APHA's member hospitals, as well as on other medical care services they provided.

(7) David Kennedy[308] is a partner in Ernst & Young's Strategy and Transactions Practice. He prepared an expert report which addressed the financial performance of private hospitals, their revenue sources, the adequacy of their capital expenditure and reasons they may become insolvent. Mr Kennedy also set out his opinion that the private hospital sector has underperformed recently and that this is in part attributable to increased labour costs. Mr Kennedy also prepared a supplementary expert report[309] in which he addressed the parts of the Duckett Report that addressed the financial health of the private hospital sector.

[294] A substantial part of Australian Pathology's case was also concerned with the cost consequences of increases to the minimum wage rates for pathology collectors, particularly if

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[304] Ibid [44]–[45].

[305] Exhibit HPSS107 (witness statement of Katharine Bassett, 18 October 2024); exhibit HPSS108 (supplementary witness statement of Katharine Bassett, 29 November 2024).

[306] Ibid [40].

[307] Exhibit HPSS103 (witness statement of Christine Gee AM, 18 October 2024, as amended and refiled on 18 December 2024); exhibit HPSS104 (supplementary witness statement of Christine Gee AM, 16 December 2024).

[308] Exhibit HPSS118 (expert report of David Kennedy, 18 October 2024).

[309] Exhibit HPSS119 (supplementary expert report of David Kennedy, 28 November 2024).

this was based on an alignment with the Caring Skills benchmark rate. In this respect, Australian Pathology relied on evidence from the following witnesses:

(1) Ms Wett[310] gave evidence about how private pathology companies are funded. She also gave specific evidence in reply to the Duckett Report, and commented on the expert report of Mr Browne. Ms Wett deposed that she believed any increase to the HPSS Award wage rates for pathology collectors and laboratory staff employed by Australian Pathology's members would 'dramatically impact the viability of what is already a low margin sector'.[311]

(2) Oliver Browne[312] is the Chief Economist at the Pragmatic Policy Group. Mr Browne prepared an expert report in which he set out his opinion on the current funding model for private pathology services in Australia and the viability of the sector if relevant HPSS Award wage rates were increased, based on certain assumptions he was directed to make. Mr Browne's report specifically addressed, inter alia, particular comments in the Duckett Report.

[295] The ACTU cross-examined all of the above witnesses. The ACTU also relied on the Duckett Report and the Stanford Report as to the capacity of health industry employers to pay the wage increases it was claiming. As indicated above, we have also taken into account the evidence given by the HSU's witnesses, Mr Elliott and Mr Leszczynski, in relation to enterprise bargaining on behalf of health professionals.

[296] For the most part, full consideration of this aspect of the respective cases of the Private Hospitals Group and Australian Pathology would be premature. Of necessity, these parties advanced cases that were effectively anticipatory of the worst-case outcomes (for them). For example, Mr Nelson attempted to model the financial impact of the potential effect of the outcome of the Review on the Healthscope business, both in terms of the immediate financial impact and the future effect on enterprise bargaining. In doing so, Mr Nelson proceeded on the basis that the ACTU claims would be awarded in full and with immediate effect. Similarly, Mr Browne attempted to model the financial impact of wage increases upon the private pathology sector on the assumption that, again, the ACTU claims would be awarded in full and with immediate effect and, in addition, that the increases claimed would apply to all relevant employees even if they were currently paid above the minimum award rate and that there would be no additional Commonwealth funding to assist in paying for this. Mr Browne's and Mr Nelson's evidence was the subject of extensive cross-examination and submissions, and the ACTU successfully identified a number of flaws in their modelling. However, ultimately this evidence has become irrelevant because, having regard to our findings and the *provisional* views we have expressed, it does not address any of the actual outcomes which will flow from the Review. It is therefore not necessary for us to make findings about their analyses.

[310] Exhibit HPSS47 (witness statement of Liesel Wett, 18 October 2024); exhibit HPSS48 (supplementary witness statement of Liesel Wett, 29 November 2024).

[311] Exhibit HPSS48 (supplementary witness statement of Liesel Wett, 29 November 2024) [13].

[312] Exhibit HPSS113 (expert opinion of Oliver Browne, 29 November 2024).

[297] It is possible to make some limited findings about the private health sector's capacity to pay wage increases generally. In respect of private hospitals, it may be accepted that:

- Labour costs are the largest operating expense of private hospitals.
- Private hospitals are substantially constrained in their capacity to increase charges in response to increases in labour costs because the large majority of their revenue is paid pursuant to multi-year agreements with private health insurers which prescribe their pricing arrangements. Private health insurers are themselves constrained by Commonwealth control over the premiums they can charge.
- At least in the immediate post-pandemic period, the private hospital sector has suffered from reduced profit margins and from costs rising faster than revenue.

[298] However, we also accept that, in the longer term, the private hospitals sector will benefit from growing demand for health services from an ageing population, and this is likely to improve revenue and profits. It is also important that the direct effect of increases to award minimum wage rates on the sector is significantly limited by the fact that a large proportion of employees in the sector are paid above award rates, either pursuant to enterprise agreements or individual arrangements.

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

[300] Having regard to the outcomes we have earlier proposed for health professionals and pathology collectors, our *provisional* view is that these findings are not sufficient to deter us from varying the HPSS Award to remedy the gender-based undervaluation we have found to have occurred, but they would necessitate consideration of an appropriate timetable for the phasing-in of the wage rate increases involved. In respect of dental assistants, we have received virtually no evidence about the cost base, revenue sources, profitability or price adjustment capacity of dental practices which would permit us to make any findings about their capacity to pay the award wage rate increases we propose. The limited evidence and submissions advanced by the Private Hospitals Group about dental assistants was concerned with the atypical context of dental surgery in day hospitals and was therefore of limited assistance in this regard. We do not propose therefore to express any *provisional* view about the implementation of the proposed increases for dental assistants.

[301] As we detail in part 8 of this decision, interested parties will be given an opportunity to advance further submissions and, if necessary, evidence in response to the *provisional* views which we have expressed. That will allow the parties to, among other things, provide us with more concrete modelling about the cost implications of the implementation of the *provisional* views and advance any proposals they wish to make about appropriate phasing-in arrangements. We will then be in a position to make findings about whether variations to the HPSS Award consistent with the *provisional* views (either as expressed above or as may be modified in response to the parties' further submissions) are necessary to achieve the modern awards objective and the minimum wages objective.

5. SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010

5.1 Classifications, minimum wage rates and the ERO

[302] Clause 4.1 of the SCHADS Award provides that it covers employers, and their employees in the classifications in the award, in the following sectors:

(a) crisis assistance and supported housing sector;
(b) SACS sector;
(c) home care sector;
(d) family day care scheme sector.

[303] Each of the sectors referred to in clause 4.1 is the subject of a definition in clause 3.1. The definitions (in the order set out in clause 4.1 above) are:

> **crisis assistance and supported housing sector** means the provision of crisis assistance and supported housing services
>
> **social and community services sector** means the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of social, community or disability services including the provision of personal care including therapeutic care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services
>
> To avoid doubt, an employee will not be precluded from being engaged under Schedule B, instead of another schedule, merely because they provide services in a private residence or in outreach.
>
> **home care sector** means the provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence
>
> **family day care scheme sector** means the operation of a family day care scheme for the provision of family day care services

[304] Fundamental to our consideration of this award is that there are different classification structures and rates of pay for the different sectors defined above. First, clause 15 provides for a classification structure which applies to employees in both the SACS sector and the crisis assistance and supported housing sector. The classifications and minimum rates provided for in clause 15 are as follows:

Classification and pay point	**$ per week**
Social and community services employee level 1	
Pay point 1	965.60
Pay point 2	996.70
Pay point 3	1032.30

Classification and pay point	$ per week
Social and community services employee level 2	
Pay point 1	1032.30
Pay point 2	1064.70
Pay point 3	1097.10
Pay point 4	1126.30
Social and community services employee level 3 Crisis accommodation employee level 1	
Pay point 1 (associate diploma/advanced certificate)	1126.30
Pay point 2	1158.70
Pay point 3 (3 year degree)	1183.50
Pay point 4 (4 year degree)	1207.80
Social and community services employee level 4 Crisis accommodation employee level 2	
Pay point 1	1240.10
Pay point 2	1272.50
Pay point 3	1305.20
Pay point 4	1334.30
Social and community services employee level 5 Crisis accommodation employee level 3	
Pay point 1	1366.90
Pay point 2	1396.30
Pay point 3	1428.80
Social and community services employee level 6 Crisis accommodation employee level 4	
Pay point 1	1461.40
Pay point 2	1493.60
Pay point 3	1526.00
Social and community services employee level 7	
Pay point 1	1558.30
Pay point 2	1591.00
Pay point 3	1623.40
Social and community services employee level 8	
Pay point 1	1655.70
Pay point 2	1688.20
Pay point 3	1720.90

[305] The ERO applies to employees in the classifications for the SACS sector and the crisis assistance and supported housing sector. The current operative provision of the ERO[313] is clause 6.2, which provides:

> **6.2** From the first full pay period on or after 1 December 2020, the employer must pay an employee in a classification listed in Schedules B and C of the Award:
>
> **(a)** the applicable minimum wage in clause 15 of the Award, and
>
> **(b)** a Final Equal Remuneration Payment equal to the following percentage of the applicable minimum wage in clause 15 of the Award:

[313] *Social, Community and Disability Services Industry Equal Remuneration Order 2012* PR525485.

Classification in Schedules B and C of the Award	Final Equal Remuneration Payment Percentage
Social and community services employee level 2	23%
Social and community services employee level 3 Crisis accommodation employee level 1	26%
Social and community services employee level 4 Crisis accommodation employee level 2	32%
Social and community services employee level 5 Crisis accommodation employee level 3	37%
Social and community services employee level 6 Crisis accommodation employee level 4	40%
Social and community services employee level 7	42%
Social and community services employee level 8	45%

[306] The current minimum wage rates produced by operation of the ERO on the weekly wage rates in clause 15 of the SCHADS Award are:

Classification and pay point	$ per week
Social and community services employee level 1	
Pay point 1	965.60
Pay point 2	996.70
Pay point 3	1032.30
Social and community services employee level 2	
Pay point 1	1269.73
Pay point 2	1309.58
Pay point 3	1349.43
Pay point 4	1385.35
Social and community services employee level 3 Crisis accommodation employee level 1	
Pay point 1 (associate diploma/advanced certificate)	1419.14
Pay point 2	1459.96
Pay point 3 (3 year degree)	1491.21
Pay point 4 (4 year degree)	1521.83
Social and community services employee level 4 Crisis accommodation employee level 2	
Pay point 1	1636.93
Pay point 2	1679.70
Pay point 3	1722.86
Pay point 4	1761.28
Social and community services employee level 5 Crisis accommodation employee level 3	
Pay point 1	1872.65
Pay point 2	1912.93

Classification and pay point	$ per week
Pay point 3	1957.46
Social and community services employee level 6 Crisis accommodation employee level 4	
Pay point 1	2045.96
Pay point 2	2091.04
Pay point 3	2136.40
Social and community services employee level 7	
Pay point 1	2212.79
Pay point 2	2259.22
Pay point 3	2305.23
Social and community services employee level 8	
Pay point 1	2400.77
Pay point 2	2477.89
Pay point 3	2495.31

[307] The classification definitions for SACS employees and crisis accommodation employees are set out in Schedules B and C to the SCHADS Award respectively. The Schedule B definitions are lengthily expressed and describe the characteristics, responsibilities and requirements of each classification in generic terms. Employees who hold a certificate qualification and are required to undertake work related to that certificate must be paid at Level 2, with employees holding a Certificate IV or a diploma starting at pay point 2. Level 3 involves supervisory responsibilities. A person holding a relevant three-year degree must be paid no less than Level 3 pay point 3, and for a four-year degree the minimum rate is Level 3 pay point 4. Level 3 employees otherwise require an associate diploma or certificate with relevant experience or equivalent experience and expertise. Level 4 employees are required to exercise a greater degree of autonomy and judgment, with the educational requirements being similar to Level 3 albeit with a higher level of experience. Level 5 employees generally are required to have a broader scope of responsibilities, with the educational requirements being essentially the same as Level 4. Levels 6, 7 and 8 employees exercise managerial functions at variously-described levels.

[308] The classification definitions for crisis accommodation employees in Schedule C are expressed in a similar way to those in Schedule B. The same entry pay rates apply to degree-qualified employees.

[309] Clause 13.3(a) provides generally that progression between pay points occurs at the end of each 12 months of continuous employment if the employee has demonstrated competency and satisfactory performance over a minimum period of 12 months at each level. Clause 13.3(b) provides that movement to a higher classification will only occur by way of promotion or re-classification.

[310] Clause 16 provides for the classification and pay structure for family day care employees as follows:

Classification and pay point	$ per week
Family day care employee level 1	
Pay point 1	966.80
Pay point 2	997.80

Classification and pay point	$ per week
Pay point 3	1034.00
Pay point 4	1068.70
Family day care employee level 2	
Pay point 1	1099.10
Pay point 2	1135.00
Pay point 3	1170.90
Pay point 4	1198.80
Family day care employee level 3	
Pay point 1	1229.30
Pay point 2	1267.50
Pay point 3	1306.60
Pay point 4	1342.50
Family day care employee level 4	
Pay point 1	1381.40
Pay point 2	1395.90
Pay point 3	1428.60
Pay point 4	1452.20
Family day care employee level 5	
Pay point 1	1556.10
Pay point 2	1599.10
Pay point 3	1642.60
Pay point 4	1685.70

[311] The classification definitions for family day care employees in Schedule D describe in generic terms the responsibilities at each level. There are no prescribed qualifications at any level except as may be required by statute.

[312] The classifications and pay structures for HCWs are set out in clause 17. There was, prior to the aged care work value proceedings, a single structure for all HCWs. However, following the *Stage 1 Aged Care decision*, which for relevant purposes determined that an interim 15 per cent wage increase should be awarded to HCWs in aged care, a separate pay scale was established for such employees. In the *Stage 3 Aged Care decision*, as we discuss further below, the Expert Panel determined, as part of the final outcome for aged care workers, to establish a new classification structure for HCWs in aged care.

[313] The classification structure and pay rates for HCWs in disability care is set out in clause 17.1:

Classification and pay point	$ per week
Home care employee level 1 — disability care	
Pay point 1	956.30
Home care employee level 2 — disability care	
Pay point 1	1011.50
Pay point 2	1018.40
Home care employee level 3 — disability care	
Pay point 1 (certificate 3)	1032.30
Pay point 2	1064.20
Home care employee level 4 — disability care	
Pay point 1	1126.20

Classification and pay point	$ per week
Pay point 2	1148.70
Home care employee level 5 — disability care	
Pay point 1 (degree or diploma)	1207.50
Pay point 2	1255.20

[314] The classification definitions for HCWs in disability care in Schedule E (which also applied to HCWs in aged care prior to the *Stage 3 Aged Care decision*) set out, in generic terms, the accountability and extent of authority, judgment and decision-making, specialist knowledge and skills, interpersonal skills and qualifications and experience required at each level. A Certificate III is an indicative qualification for Level 3. At Level 5, qualifications and/or experience beyond a TAFE certificate or associate diploma are required, which might include a diploma or degree qualification.

[315] The classifications and minimum wage rates for HCWs in aged care are set out in clause 17.2. They are:

Classification	$ per week
Home care employee level 1 — aged care	1132.60
Home care employee level 2 — aged care	1202.20
Home care employee level 3 — aged care	1241.60
Home care employee level 4 — aged care	1320.60
Home care employee level 5 — aged care	1347.30
Home care employee level 6 — aged care	1422.20

[316] It is important to note that the above wage rates represent a transitional phase towards the final outcome determined in the *Stage 3 Aged Care decision.* The final rates will be applicable from 1 October 2025. The final outcome, not including any wage increase which may flow as a result of the upcoming 2025 AWR, is as follows:

Classification	$ per week
Home care employee level 1 — aged care	1142.80
Home care employee level 2 — aged care	1206.30
Home care employee level 3 — aged care	1269.80
Home care employee level 4 — aged care	1320.60
Home care employee level 5 — aged care	1371.40
Home care employee level 6 — aged care	1422.20

[317] The classification definitions for home care employees in aged care, which were determined in the *Stage 3 Aged Care decision* and the *Stage 4 Aged Care decision*[314] are set out in Schedule F. The definitions are as follows:

> **Home care employee level 1—aged care—Introductory**
> An employee whose primary role is to provide home care to aged care clients and who has less than 3 months' aged carer experience.

[314] *Aged Care Award 2010; Nurses Award 2020; Social, Community, Home Care and Disability Services Industry Award 2010* [2024] FWCFB 298.

Home care employee level 2—aged care—Home Carer
An employee whose primary role is to provide home care to aged care clients and who has 3 months' or more aged carer experience.

Home care employee level 3—aged care—Qualified
An employee whose primary role is to provide home care to aged care clients and who has obtained a Certificate III in Individual Support (Ageing) or equivalent qualification.

Home care employee level 4—aged care—Senior
An employee whose primary role is to provide home care to aged care clients and who has obtained a Certificate III in Individual Support (Ageing) or equivalent qualification and has obtained 4 years' experience classified at level 3 after 1 January 2025.

Home care employee level 5—aged care—Specialist
An employee whose primary role is to provide home care to aged care clients and who has obtained a Certificate IV in Ageing Support or equivalent qualification as a requirement for the performance of their duties by the employer.

Home care employee level 6—aged care—Team Leader
A home care employee who has obtained a Certificate IV in Ageing Support or equivalent qualification as a requirement for the performance of their duties by the employer and is required to supervise and train other home care employees—aged care.

[318] There are transitional provisions made necessary by the implementation of the new classification structure for home care employees in aged care set out in Schedule G.

5.2 Award history

[319] The development of the SCHADS Award during the award modernisation process involved work previously the subject of different streams of award regulation being joined into a single award but with different classification structures and wage rates. In a statement published on 25 September 2009[315] together with an exposure draft for the SCHADS Award, the AIRC award modernisation Full Bench identified the primary sources of the classifications and wage rates in the exposure draft. In relation to SACS employees, the classifications and wage rates adopted 'largely reflect[ed]' the federal *Social and Community Services (Queensland) Award 2001*[316] (in preference to other federal and State awards applying in the other states and the Australian Capital Territory (ACT)).[317] The history of this award is outlined in the Stage 2 Report. In short, the award was first made in 1996 on the application of the ASU, and its terms were largely agreed upon by the parties. The 2001 award was made pursuant to the award simplification process as a result of two decisions issued by the AIRC (Cartwright SDP) on 23 November 2001[318] and 5 March 2002[319] respectively. In the first of these decisions, the AIRC determined that the 'key classification' for the purpose of fixing appropriate minimum rates in accordance with the award simplification principles was the entry level for a

[315] [2009] AIRCFB 865, 188 IR 23.

[316] AP808848.

[317] [2009] AIRCFB 865, 188 IR 23 [101].

[318] [2001] AIRC 1236, PR911777.

[319] [2002] AIRC 235, PR914950.

social worker with a four-year degree qualification.[320] The relativity of this classification was fixed at 130 per cent of the C10 rate (representing an increase to the previous relativity of 120 per cent). This determination represented a preference for the position of the ASU over that of the relevant employer groups, who had pressed for the existing position to be retained. In the second decision, subject to some exceptions which were agreed, the AIRC explained that it had adjusted the wage rates for all classifications according to their original 1996 relativities and for subsequent safety net adjustments. In relation to the annual increments for each classification, the AIRC said:[321]

> The award contains increments. I have reviewed the form of the mechanism for progression and I am satisfied that it is not simply service[-]based but rather includes the element of work-value required by the Full Bench in the *Paid Rates Decision*. On this basis, I accept that the incremental paypoints in the award may be maintained.

[320] There was no subsequent consideration of the work value of employees covered by the *Social and Community Services (Queensland) Award 2001*[322] prior to the award modernisation process.

[321] It is apposite to note at this point that the rates of pay in the *Social and Community Services (Queensland) Award 2001*,[323] and therefore as picked up in the draft SCHADS Award, were significantly lower than in the equivalent QIRC award, the *Queensland Community Services and Crisis Assistance Award – State 2008*,[324] as a result of the *Queensland CSCA Award decision* delivered on 6 May 2009. Notwithstanding that, as explained in the introduction to this decision, the QIRC found in the *Queensland CSCA Award decision* that the work of SACS workers covered by the Queensland award had been undervalued on a gender basis, and that a proper consideration of work value required a significant adjustment to minimum rates of pay, the AIRC award modernisation Full Bench did not give consideration to whether the rates of pay determined by the QIRC should be incorporated into the draft SCHADS Award.

[322] In respect of crisis accommodation employees, the AIRC award modernisation Full Bench stated that they 'have been integrated into the SACS employee wage rate structure taking into account qualification levels',[325] with the wage rates and classification levels reflecting the federal *Crisis Assistance Supported Housing (Queensland) Award 1999*.[326] As explained in the Stage 2 Report, this award had its origins in the *Crisis Assistance Supported Housing Award 1991*,[327] which was made in 1991 as a conditions-only award on the basis (as recorded in clause 5.2(b) of the award) that the parties agreed that an award classification structure 'which [would] truly reflect the work requirements and skill levels of employees in the industry' would later be established. However, the 1999 award, which was made by consent, was the first to contain a classification structure and wage rates. There is no decision of the AIRC which

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[320] [2001] AIRC 1236, PR911777.

[321] [2002] AIRC 235, PR914950 [22].

[322] AP808848.

[323] Ibid.

[324] RA140348.

[325] [2009] AIRCFB 865, 188 IR 23 [102].

[326] C6137, Print S8406.

[327] C0298, Print J8212.

exposes what considerations informed the setting of the wage rates or the basis of the classification structure in the 1999 award.

[323] The classifications and wage rates for family day care employees were derived from the federal *Family Day Care Services Award 1999*[328] which, despite its title, was made arising from the award simplification process on 10 December 2001.[329] The first federal award preceding this award was the *Family Day Care Services Award 1993*.[330] The decision which records the making of the 1993 award[331] makes it apparent that the classifications and wage rates were established by agreement between the parties and otherwise gives no insight as to the basis upon which they were made. The evidence of Ms Michelle Robertson, an ASU industrial officer, in the present proceedings (discussed further below) was that the 1993 award was made 'in a big rush' to facilitate a Commonwealth scheme for additional funding to community services to top up wages.[332] There appears to have been no alteration to the wage rates or classification structure when the 1999 award was made.[333]

[324] The exposure draft for the SCHADS Award contained a separate stream of classifications and wage rates for the residential 'disability services sector', defined as meaning:

> … the provision of personal care and domestic and lifestyle support to a person with a disability in a community residential setting excluding a private residence[.]

[325] These classifications and wage rates were largely derived from the federal *Residential and Support Services (Victoria) Award 1999*.[334] The history of this award and its predecessor is recited in the Stage 2 Report. It is sufficient to note that the 1999 award emanated from an AIRC Full Bench decision made on 16 December 1999[335] as part of the award simplification process. That decision recorded that the rates of pay were set on the basis of an alignment between the Residential/Support Services Worker Grade 3 classification and the C10 rate but also involved a degree of consideration, based on evidence, of the work value of the employees concerned.[336]

[326] Finally, the AIRC award modernisation Full Bench identified[337] that the source of the classification structure and wage rates for the home care sector was the federal *Home and Community Care Award 2001*.[338] The relevant history of this award was detailed in the *Stage 3 Aged Care decision* as follows:[339]

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[328] AP812580.

[329] [2001] AIRC 1319, PR912398.

[330] AW781159.

[331] [1993] AIRC 206, Print K6923.

[332] Exhibit SCH9 (witness statement of Michelle Robertson, 26 September 2024) [21].

[333] See [2001] AIRC 1319, PR912398.

[334] AP795711.

[335] [1999] AIRC 1448, Print S1841.

[336] Ibid [15]–[21].

[337] [2009] AIRCFB 865, 188 IR 23 [106].

[338] AP806214.

[339] [2024] FWCFB 150, 331 IR 137 [110].

> The *Home and Community Care Award 2001* was an award which applied to only a single employer. It was initially made in 1995 by consent following the finding of a dispute, and the rates of pay never involved any work value assessment. As the Full Bench statement above indicates, the benchmark rate was that for a Certificate III-qualified employee, which was same rate as for Level 4 in the Aged Care Award — that is, the C10 rate. This involved the same automatic application of the C10 Metals Framework Alignment Approach as described above for the Aged Care Award to a female-dominated occupation without any further consideration of the skills, responsibilities and working environment involved.

[327] In response to the SCHADS Award exposure draft, the ASU, ABI and other employer interests made submissions opposing residential disability service workers having a classification and wage structure separate to that of SACS workers. The ASU also foreshadowed that, in light of the *Queensland CSCA Award decision*, it intended to pursue a case in the near future to establish new wage rates for SACS workers on pay equity or work value grounds, and submitted that as a consequence the AIRC should defer the operation of classifications and wages in the SCHADS Award.

[328] In a decision issued on 4 December 2009,[340] the AIRC award modernisation Full Bench determined to make the SCHADS Award in terms which, in respect of classification and wage rates, were the same as the exposure draft. However, the Full Bench acceded to the ASU's submission about a delayed date of operation for wages and classifications and determined that they would not take effect until 1 July 2011.[341] The delayed date of operation was later extended to 1 February 2012.[342] The SCHADS Award otherwise commenced operation on 1 January 2010.

[329] On 23 December 2009, ABI applied to vary the SCHADS Award to delete the separate classification and wages structure for residential disability service employees and integrate them into the classification structure for SACS employees. This application was granted, largely by consent, by a Full Bench in a decision issued on 26 March 2010.[343] The definition of 'disability services sector' set out in paragraph [324] above and the classifications and wage rates applicable to this sector were removed from the SCHADS Award, and the definition of 'social and community services sector' was modified by adding the following:[344]

> and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services.

[330] It may be noted that the exclusion pertaining to private residences which was contained in the previous definition of 'disability services sector' was not carried over into the 'social and community services sector' definition. The decision discloses that this occurred in the following context:[345]

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[340] [2009] AIRCFB 945, 190 IR 370.

[341] Ibid [80].

[342] Decision in transcript (matter AM2011/20), 11 April 2011 PN78 (see also PN45). This decision was subsequently noted in [2011] FWAFB 2700 [4].

[343] [2010] FWAFB 2024.

[344] PR995399.

[345] [2010] FWAFB 2024 [5]–[6], [9].

> In addition, the AWU, ASU and [HSU] proposed minor amendments to the application. The principal change was a variation to the definition of the disability services sector to delete the words 'but excluding a private residence'. The unions argued that some disability services are provided to individuals in the home and that this work was distinguishable from home care work. …
>
> While the aged care employers supported ABI's application they were strongly opposed to removal from the definition of the words 'but excluding a private residence'. It was argued that the definitions in the modern award of disability services sector and home care sector clearly define who performs work for a person with a disability in a private residence. It was submitted that the variation proposed by the unions would cause confusion as there would be two separate classifications of employees with different entitlements potentially able to provide care to disabled clients in their own home.
> . . .
> In the course of their submissions on the ABI application, the [HSU] also suggested that the proposed definition of the disability services sector should be amended to read 'in a community and/or residential setting'. We think that alteration would be appropriate and it will be included in the variation necessary to give effect to this decision.

[331] We observe that it is not apparent how the Full Bench's adoption of the wording proposed by the HSU was intended to resolve the conundrum identified by the aged care employers.

[332] On 1 March 2010, the ASU and other unions lodged the application foreshadowed in the award modernisation process. The application was for an equal remuneration order under Part 2-7 of the FW Act applicable to employees of non-government employers in the social, community and disability services industry throughout Australia. It is important to note that the application did not seek any variation on work value grounds to the SCHADS Award itself. Nonetheless, it is apparent from the first Full Bench decision in the matter issued on 16 May 2011[346] that there was an extensive consideration of work value in the matter. For example, the Full Bench heard extensive evidence from some 45 employees in the sector about the nature and responsibilities of their work[347] and 10 senior managers,[348] and also engaged in a number of site visits:[349]

> The visits assisted the Full Bench in gaining a better understanding of the nature and range of [social, community and disability services industry] services and the environments in which services are provided. The tribunal met and spoke with many dedicated people in a variety of roles, many of whom also provided statements as to their duties and responsibilities. …

[346] [2011] FWAFB 2700, 208 IR 345.

[347] Ibid [181], Appendix A.

[348] Ibid [183], Appendix B.

[349] Ibid [182].

[333] In its determination of the matter, the Full Bench declined to make a finding that the SCHADS Award wage rates did not properly reflect work value:[350]

> We deal first with the applicants' submission that the minimum wages in the modern award do not properly reflect the value of the work. Given the basis on which minimum rates are fixed, it is not possible to demonstrate that modern award wages are too low in work value terms by pointing to higher rates in enterprise agreements, or in awards which clearly do not prescribe minimum rates. In order to succeed in their submission it would be necessary for the applicants to deal with work value and relativity issues relating to the classification structure in the modern award and potentially to structures and rates in other modern awards. No real attempt has been made to deal with those important issues.

[334] However, it is apparent that the ultimate determination of the Full Bench to make an equal remuneration order, while founded on its satisfaction as to the statutory test in s 302 of the FW Act, took into account work value considerations. Of particular importance are the following findings made by the Full Bench:[351]

> We have already recorded our view that the workforce is predominantly female. We deal next with the female characterisation of work. There is much to be said for the view that work in the industry bears a female characterisation. In our view the applicants have established the following propositions:
>
> (a) much of the work in the industry is 'caring' work
>
> (b) the characterisation of work as caring work can disguise the level of skill and experience required and contribute, in a general sense, to a devaluing of the work
>
> (c) the evidence of workers, managers and union officials suggests that the work, in the SACS industry, again in a general sense, is undervalued to some extent, and
>
> (d) because caring work in this context has a female characterisation, to the extent that work in the industry is undervalued because it is caring work, the undervaluation is gender-based.

[335] These findings caused the Full Bench (by majority) in its second decision of 1 February 2012[352] to refer to 'caring work as a proxy for gender-based undervaluation'.[353] The ERO ultimately made by the Full Bench took effect on 1 July 2012 and provided for phasing-in of the wages outcome over a period ending on 1 December 2020.

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[350] Ibid [261].

[351] Ibid [253].

[352] [2012] FWAFB 1000, 208 IR 446.

[353] Ibid [63].

[336] There were two subsequent developments of note. First, on 21 November 2012, the definition of 'social and community services sector' in the SCHADS Award was varied by consent to add the following words currently appearing at the end of the definition:[354]

> To avoid doubt, an employee will not be precluded from being engaged under Schedule B, instead of another schedule, merely because they provide services in a private residence or in outreach.

[337] No reasons were given for this variation. It seems to have arisen from a conference of the parties which occurred in the course of the 2 yearly review of modern awards conducted pursuant to item 6 of Schedule 5 to the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Cth).

[338] Second, during the 4 yearly review of modern awards, a Full Bench of the Commission considered a proposal to incorporate the rates of pay prescribed by the ERO into the SCHADS Award. It initially expressed a provisional view that it should do so, but ultimately did not because of 'a reason to doubt our power to include the ERO rates in a way that creates an award[-]derived entitlement to be paid the relevant rates'[355] and instead inserted a note setting out the rates of pay produced by the ERO in clause 15.[356]

5.3 Gender profile

[339] Data contained in the Stage 1 Report discloses that, in the Aged Care Residential Services industry group, 86.5 per cent of 'Aged and Disabled Carers' (who 'provide general household assistance and support for aged and disabled people in their own homes, including assistance with daily activities, hygiene, dressing and mobility; food preparation and eating; and social activities, errands and emotional support') are female.[357] In the Other Social Assistance Services industry group, the female proportions of the following occupations are:[358]

- 83.1 per cent of Social Workers;
- 80.9 per cent of Contract, Program and Project Administrators;
- 78.6 per cent of Welfare, Recreation and Community Arts Workers;
- 73.8 per cent of Health and Welfare Services Managers; and
- 72.0 per cent of Aged and Disabled Carers.

[340] The above occupation groups represent the main categories of employees covered by the SCHADS Award. We therefore conclude that the workforce covered by the award is female-dominated.

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[354] PR531544.

[355] [2021] FWCFB 2383 [1251].

[356] Ibid [1238]–[1256].

[357] Stage 1 Report 37.

[358] Ibid 92–93.

5.4 Parties' positions in the Review

[341] The ASU submitted that the classifications in the SCHADS Award applying to the occupation of disability carer and other classifications applying to SACS, home care and family day care workers generally have been historically undervalued due to assumptions based on gender. This gender-based undervaluation has been, in respect of SACS work, at least partially rectified by the ERO and, in relation to home care employees in aged care, by the *Stage 3 Aged Care decision*. The ASU submitted that if any employee were to be paid the minimum wage rates applying to 'Home care employees — disability care' in clause 17.1 then their work would be undervalued including for reasons related to gender, but these minimum rates are now an 'artefact' of the aged care work value proceedings and the undervaluation of this work should be addressed by granting the variation sought in matter AM2024/25.[359] In respect of family day care work, the ASU submitted that this has been historically undervalued because of assumptions based on gender and has never been subject to a substantive work value assessment, and that this undervaluation should be rectified by aligning their pay rates in clause 16 with those applicable to SACS and crisis accommodation employees in clause 15.

[342] The position of the UWU and the HSU was substantially the same as that of the ASU except that their submissions did not address in detail the position of family day care employees.

[343] ABI, the ACCPA, the NSWBC and National Disability Services (NDS) submitted that it is likely that the work undertaken by direct care employees covered by the SCHADS Award has been historically undervalued because of assumptions based on gender given the findings in the *Stage 3 Aged Care decision* and the similarity of work between home care employees in aged care and other direct care employees covered by the SCHADS Award. In respect of employees in the SACS sector and the crisis accommodation sector, ABI, the ACCPA, the NSWBC and NDS submitted that historical gender-based undervaluation of work would be remedied by the inclusion of the ERO payments into the award's minimum wage rates. They also submitted that the findings in the *Stage 3 Aged Care decision* concerning home care employees in aged care would be apposite in respect of HCWs in disability care because:

- many home care providers offer home care services to clients across both the aged care and disability fields;
- many home care workers provide home care to both aged clients and clients with a disability (and sometimes an employee will work with both categories of clients within the same day); and
- while the specific tasks might differ from client to client (based on each client's unique characteristics, preferences and needs), the core work duties of a home care worker are substantially similar and not meaningfully different whether they are providing home care services to a client with disability or to an aged client.

[344] ABI, the ACCPA, the NSWBC and NDS therefore submitted that there was a 'reasonably compelling' basis to align the minimum wages of HCWs in disability care with those in aged care.[360] In respect of family day care, ABI, the ACCPA, the NSWBC and NDS submitted that there was a lack of evidence about the gender profile or work of this sector and

[359] ASU submission (matter AM2024/21), 27 September 2024 [11].

[360] ABI, ACCPA, NSWBC and NDS submission, 27 September 2024 [86].

it was unclear as to whether it involved 'caring' work as distinct from merely administrative work.

[345] In respect of the classification structure generally, it was submitted that the division of work into five classification structures, and the lengthy classification definitions, are problematic in various respects, and should be rationalised and consolidated to the extent this can practicably be done without disturbing existing entitlements. Finally, ABI, the ACCPA, the NSWBC and NDS emphasised that employers covered by the SCHADS Award had little capacity to absorb cost increases due to funding arrangements, and any implementation arrangements for variations to the award in respect of minimum wages would need to take this into account through deferred commencement dates and phasing-in of any increases.

[346] The Australian Industry Group (Ai Group) submitted that it 'does not contend' that the classifications in the SCHADS Award have been historically undervalued because of assumptions based on gender or that there should be any adjustments to minimum wage rates.[361] In respect of disability support work funded through the NDIS, the Ai Group emphasised that employers in this sector were already under financial strain because of the tightness of the funding model and submitted that there should not be any increases to minimum wages in the disability services sector in the absence of a firm commitment from the Commonwealth as to funding. The Ai Group advanced no proposals as to the modification of the classification structure in the SCHADS Award and expressed no clear position concerning the incorporation of the ERO rates into the award beyond referring to the 'concerns' expressed by an earlier Full Bench about this in the 4 yearly review[362] and the need for the relevant statutory criteria to be satisfied.

[347] The Queensland Alliance for Mental Health (QAMH), which is the peak body for the community mental health and welfare sector and people with experiences of psychosocial disability in Queensland, made submissions which focused on the position of HCWs in disability care. The QAMH submitted that the Commission should apply the same principles as in the *Stage 3 Aged Care decision* to align the wages of HCWs in disability care with those in aged care. These two groups of workers, it was submitted, engaged in caring work and exercised 'invisible' skills in the same way. In relation to the issue of a new classification structure and the potential revocation of the ERO, the QAMH submitted that this should be done with caution and be based on a thorough assessment of whether the new award provisions fully addressed the pay equity concerns that the ERO sought to remedy.

5.5 Variation application by the ASU, the AWU, the HSU and the UWU — matter AM2024/25

[348] In the introduction to this decision, we briefly described the two applications to vary the SCHADS Award which were heard together with the Review. In matter AM2024/25, the joint union application, as amended on 1 August 2024, sought that the definition of 'home care sector' in clause 3.1 be varied as follows:

> **home care sector** means the provision of personal care, domestic assistance or home maintenance to an aged person ~~or a person with a disability~~ in a private residence.

[361] Ai Group submission, 3 October 2024 [14], [17].

[362] *Re Social, Community, Home Care and Disability Services Industry Award 2010* [2021] FWCFB 2383.

In addition, and as a corollary of the above, the joint union application sought that clause 17.1—Minimum weekly wages for home care employees—disability care in clause 17 be deleted.

[349] The applicant unions submitted in support of this application that the variation sought should be made pursuant to s 160(1) of the FW Act to remove an ambiguity or uncertainty in the SCHADS Award, namely that provision of services to persons with a disability in a private residence is currently included in the definitions of in clause 3 of the Award of both the SACS sector ('in a … residential setting') and the home care sector ('in a private residence'). This, it was submitted, had led to disputation as to whether employees performing this work were entitled to the wage rates in clause 15, upon which the ERO operates, or the lower wage rates in clause 17. The applicant unions submitted that the history of the SCHADS Award, including its development, demonstrated that the definition of the SACS sector had never been intended to exclude work performed in a private residence. They also noted that NDIS funding was calculated using a cost model which was based on the Schedule B classifications and the wage rates in clause 15, as adjusted by the ERO. The unions submitted that the variation was appropriate because the classification of disability support work within the SACS sector reflects how such services are provided in contemporary Australia, and under the NDIS employers are funded to pay the wage rates prescribed by the SCHADS Award for that sector.

[350] ABI, the ACCPA, NSWBC and NDS opposed the application on the basis that, first, there was no ambiguity or uncertainty as alleged and, second, if the Commission found that there was, it should not vary the SCHADS Award in the manner proposed. As to the first proposition, they submitted based upon an analysis of the history of the award that it was to be read on the basis that where an employee is engaged to provide personal care and domestic assistance to a person with disability in their private residence, it is to be regarded as home care work unless it has the character of SACS work. ABI, the ACCPA, the NSWBC and NDS did not accept the proposition that all provision of NDIS services fell within the SACS sector, and submitted that NDIS-funded work to provide supports in the home such as personal care and domestic assistance, cleaning and household maintenance has always been home care work under the award. They also submitted that the effect of the variation sought would be to draw a distinction in classifications and pay rates based on the attributes of the client (that is, whether they are aged or live with disability) rather than the nature of the work.

[351] The Ai Group similarly opposed the unions' application, submitting that there was no ambiguity or uncertainty requiring rectification and that the question of whether an employee's work fell within the SACS sector or the home care sector was answerable by application of the principal purpose test to the employee's work and the circumstances of their employment. In the alternative, the Ai Group submitted that that the Commission should not make the variation sought by the unions even if ambiguity or uncertainty were found because it would go beyond mere rectification of this and lead to large cohorts of employees being reclassified at substantially higher rates of pay for which no funding commitment has been made by the Commonwealth.

5.6 Variation application by the ASU — matter AM2024/27

[352] As explained in the introduction to this decision, two 'phases' of the ASU's application in matter AM2024/27 have been heard together with the Review. The first 'phase' variation

proposed by the ASU is that the current wage rates in clause 15 applicable to social and community care employees and crisis accommodation employees be replaced by wage rates reflecting the current effect of the ERO. This would mean that the wage rates set out in paragraph [306] above would become the wage rates prescribed by clause 15. Consequential upon this occurring, the ERO would be revoked. The second 'phase' proposed variation involves the addition of indicative job titles to the classification definitions in Schedules B and C. In respect of Schedule B, the indicative job titles for each level would be:

Level 1
Trainee with direct supervision

Level 2
Administrative assistant
Disability support worker

Level 3
Administration and finance worker
Experienced disability support worker
Entry-level case worker

Level 4
Administrative and finance officer
Sole employee
Community Development Worker
Caseworker with experience
Supervisor of a small team, outlet or specific project
Youth worker
Outreach worker
Family support worker

Level 5
Counsellor
Family and domestic violence counsellor
Tenancy advice worker
Advocacy worker
Experienced or intensive family support worker
Family dispute practitioner
Experienced outreach worker
Court support advocate
Caseworker with significant experience
Complex case manager
Senior administrative officer
Specialist employee in a relevant discipline

Level 6
Coordinator of a small service
Project manager
Program manager
Team leader in a complex social welfare setting
Program coordinator
Advanced specialist in a professional discipline
Family dispute practitioner

Level 7
Senior specialist expert/employee
Manager
Coordinator
Director

Level 8
Chief executive officer
Senior Manager
Service manager
Senior specialist providing multi-functional advice to other employees, the employer, the committee or board of management

[353] For Schedule C, the indicative job titles would be:

Level 1
Administration and finance worker
Entry-level case worker

Level 2
Administrative and finance officer
Caseworker with experience
Outreach worker
Supervisor of a small team, outlet or specific project
Youth Worker

Level 3
Senior administrative officer
Caseworker with significant experience
Senior outreach worker
Specialist employee in a relevant discipline
Specialist Support worker

Level 4
Coordinator of a small service
Project manager
Program manager
Team leader in a complex social welfare setting
Program coordinator
Advanced specialist in a professional discipline

[354] The ASU submitted in support of its application that the classification structure in the SCHADS Award is 'archaic, complex and ambiguous', that the absence of adequate classification descriptors and indicative classifications means that job roles are routinely devalued and regress through structure, and that its application was intended to remedy this. However, it submitted, the Commission must assess work value changes since 2008 and 2012 before determining a final classification structure for the 'community and disability sector'[363] — matters which would not be addressed in the Review. 'Phases' 1 and 2 of the ASU

[363] The ASU used this term to collectively refer to employees covered by Schedules B, C and D to the SCHADS Award: ASU position paper, 8 July 2024 [2].

application would, it was submitted, provide for an interim solution until 'phase 3' of the application could be heard and determined.

[355] ABI, the ACCPA, the NSWBC and NDS did not oppose the incorporation of the ERO rates into the SCHADS Award, and the revocation of the ERO, provided that this did not operate to increase allowances via the 'standard rate' mechanism. They expressed 'concerns' about the inclusion of indicative job titles as proposed by the ASU, including that some of the proposed job titles are themselves ambiguous, overly generic, capable of being given different interpretations in different organisations and are of little practical significance. They also noted that the proposed variation implied that all disability support workers would be classified at Level 2 as a minimum, which position the ABI, the ACCPA, the NSWBC and NDS disagreed with.

[356] The Ai Group opposed the insertion of the proposed indicative job titles because this would introduce new terminology into the SCHADS Award which would be likely to create further confusion, ambiguity, disruption and potential disputation.

5.7 Evidence

[357] The union parties to the SCHADS Award proceedings filed witness statements made by the following persons:

(1) Fiona Macdonald[364] is the Acting Director of the Centre for Future Work at the Australia Institute. Dr Macdonald holds a Doctor of Philosophy in Political Science (Industrial Relations), a Master of Social Science (Social Policy), a Graduate Diploma in Counselling Psychology and a Bachelor of Behavioural Science (Psychology). She prepared an expert report in support of the joint union application (matter AM2024/25). Dr Macdonald's evidence addressed what disability support work involves and whether and how it has changed since the NDIS commenced.

(2) Michelle Robertson[365] was a Senior Industrial Officer of the ASU Queensland Services and Northern Administrative Branch until her retirement on 29 November 2024. Ms Robertson holds a Bachelor of Arts (Honours), a Graduate Diploma of Industrial Relations and a Master of Labour Studies, and has also participated in the Harvard Trade Union Training Program. Ms Robertson was called by the ASU in the gender-based undervaluation proceedings relating to the SCHADS Award (matter AM2024/21). She gave evidence about the ASU's and its predecessors' coverage of family day care coordinators and the history of award-making for these workers.

(3) Stefi Clough[366] is a disability support worker (DSW) employed by SA Care. She holds a Certificate III in Individual Support. Ms Clough was called by the applicants for the joint union application (matter AM2024/25) to give evidence

[364] Exhibit SCH1 (witness statement of Dr Fiona Macdonald, 25 September 2024).

[365] Exhibit SCH9 (witness statement of Michelle Robertson, 26 September 2024).

[366] Exhibit SCH10 (witness statement of Stefi Clough, 27 September 2024).

about her work pattern, the residential palliative care facility where she works and the clients who live there. She provided detailed information on her work in relation to one particular client who lives with Huntington's disease. Ms Clough also gave evidence about the work she undertook with a client with partial quadriplegia for a former employer and the impact her pay has on her standard of living.

(4) Jennifer Duscher[367] is a DSW who currently works for three different NDIS-funded organisations — Enhanced Lifestyles, Go Getter and CARA. She holds a Certificate III in Disability, Community Support and the Ageing Community. Ms Duscher was called by the applicants for the joint union application (matter AM2024/25) to give evidence about her working pattern and her experience of working with people with disability who have high support needs in supported independent living facilities. She also gave evidence about querying Enhanced Lifestyles' decision to classify her under Schedule E to the SCHADS Award (relating to HCWs providing disability care) instead of Schedule B (relating to SACS employees).

(5) James Eddington[368] has been a Legal and Industrial Officer of the HSU's Health & Community Services Union Tasmania Branch since 2010. He was called by the applicants for the joint union application (matter AM2024/25) to give evidence about disability sector employers in Tasmania, enterprise bargaining in the disability sector and industrial disputes that have arisen about whether employees providing disability services should be classified under Schedule B (SACS employees) or Schedule E (HCWs providing disability care).

(6) Melissa Hall[369] is a DSW currently employed by The Junction Works. She is studying towards Certificates III and IV in Disability Services. Ms Hall was called by the applicants for the joint union application (matter AM2024/25) to give evidence about the duties of her current role as well as her roles with previous employers Network Nursing Agency (as a Community Care worker) and Riverlands Disability Support (as a DSW).

(7) Natalie Haylett[370] is a DSW employed by LiveBetter. She holds a Certificate IV in Disability and is required to undertake monthly training modules through her work. Ms Haylett was called by the applicants for the joint union application (matter AM2024/25) to give evidence about her pattern of work, location of work, duties and the range of clients she supports.

(8) Martin Laverty[371] is the Chief Executive Officer of Aruma, a disability service provider. Dr Laverty holds a Diploma of Laws, a Master of Laws and a Doctor of Philosophy in corporate governance. He was also an inaugural director of the

[367] Exhibit SCH11 (witness statement of Jennifer Duscher, 26 September 2024).

[368] Exhibit SCH12 (witness statement of James Eddington, 25 September 2024).

[369] Exhibit SCH13 (witness statement of Melissa Hall, 26 September 2024).

[370] Exhibit SCH14 (witness statement of Natalie Haylett, 20 September 2024).

[371] Exhibit SCH15 (witness statement of Dr Martin Laverty, 27 September 2024).

National Disability Insurance Agency (NDIA). Dr Laverty was called by the applicants for the joint union application (matter AM2024/25) to give evidence about Aruma's support services and the employment conditions of its DSWs. In particular, he stated that the NDIA's DSW cost model 'fully funds the cost of labour for disability support work at rates stipulated in Schedule B [SACS employees] [to] the SCHADS Award'[372] and that Aruma does not employ any workers under Schedule E to the SCHADS Award or instruments with wage rates derived from that schedule.

(9) Sarah Lenhard[373] is a DSW who has worked in the disability services industry for approximately 44 years. She does not hold formal qualifications in relation to working with people with disability because they did not exist when she started working in the industry, and by the time relevant Certificates III and IV were available, she had already accrued extensive experience. Ms Lenhard was called by the applicants for the joint union application (matter AM2024/25) to give evidence about her previous roles with Ability WA working in a group home and later as a Learning & Development Workplace Trainer, as well as her current role in supported accommodation operated by Rocky Bay. She also gave evidence about her observations of how the commencement of the NDIS changed her work as a DSW.

(10) Chantel Moffat[374] is a DSW employed by Aruma. She holds a Certificate III in Disability Services, Certificates III and IV in Aged Care and has partially completed a Certificate IV in Community Services. Ms Moffat also undertakes ongoing training in her role. She was called by the applicants for the joint union application (matter AM2024/25) to give evidence about the range of duties she undertakes in her role and the differing needs of the clients with whom she works.

(11) Michael Robson[375] is the National Industrial Coordinator of the ASU National Office. He holds a Bachelor of Arts and a Juris Doctor. Mr Robson's evidence was filed in relation to all three matters (AM2024/21, AM2024/25 and AM2024/27) relating to the SCHADS Award. He gave evidence about how SACS (and in particular disability services) were regulated before the SCHADS Award commenced in 2010. Mr Robson also gave evidence about various applications and reviews that have varied the SCHADS Award since it was made (including the application that led to the making of the ERO). In particular, he highlighted aspects of those proceedings that suggested that employees performing disability support services could still be classified under Schedule B (SACS) to the SCHADS Award even if the work was performed in a client's private home.

(12) Tin Sit[376] is a DSW employed by Home@Scope. He holds a Certificate IV in Disability Support and is studying towards an Advanced Diploma of Community

[372] Ibid [32].

[373] Exhibit SCH16 (witness statement of Sarah Lenhard, 25 September 2024).

[374] Exhibit SCH17 (witness statement of Chantel Moffat, 25 September 2024).

[375] Exhibit SCH18 (witness statement of Michael Robson, 25 September 2024).

[376] Exhibit SCH19 (witness statement of Tin Sit, 25 September 2024).

Sector Management. Mr Sit has also completed additional training through his employer and the University of Tasmania. He was called by the applicants for the joint union application (matter AM2024/25) to give evidence about his duties and employment conditions in both his current position and former role working for Perfect Care. In particular, Mr Sit deposed that the work he performed for both employers was the same, the context in which he worked (supported independent living houses with clients with high support needs) was the same and the skills he exercised were 'directly equivalent'.[377] He said that despite this, his role with Home@Scope is classified as being equivalent to Level 2.4 under Schedule B to the SCHADS Award, while he was classified as a home care employee under the SCHADS Award while working for Perfect Care.

(13) Madeleine Tapley[378] is a DSW employed by Programmed Care. She holds a Bachelor of Behavioural Science with a major in Disability and Developmental Education and has also completed training relevant to her role, part of which took place in a previous role with Minda, a different disability support organisation. Ms Tapley was called by the applicants for the joint union application (matter AM2024/25) to give evidence about the duties of her current role with Programmed Care, her employment conditions and work patterns and the different needs of clients with whom she worked. She said that she is currently paid as a disability care HCW under Schedule E to the SCHADS Award, but that the skills of a DSW are the same whether the client is supported in their own home or in community-based housing.

(14) Natasha Wark[379] is the Branch Secretary of the ASU's Victorian and Tasmanian Authorities and Services Branch. She was previously the branch's Deputy Secretary and an organiser. Prior to her employment at the ASU, which commenced in 2006, she was employed in the SACS sector, where she was an ASU member and delegate. In May 2012, Ms Wark was seconded to the ASU's national office to oversee the implementation of the Social and Community Services Education and Information Program (SACS EIP), a project designed to 'provide information, education and assistance to employees affected by the [ERO] in the social and community services case'.[380] She was responsible for administering the SACS EIP and liaised with ASU Branches about delivery and reporting requirements. She was called by the ASU to give evidence in its application to vary clause 15, Schedule B and Schedule C of the SCHADS Award (matter AM2024/27). She gave evidence about the establishment of and the ASU's role in the SACS EIP, as well as the program's two phases. She described the first phase, which commenced in May 2012, as concerning the transition to the SCHADS Award's eight-level classification structure, and the second phase, which commenced in August 2012, as being focused on the application of the ERO.

[377] Ibid [42].

[378] Exhibit SCH20 (witness statement of Madeleine Tapley, 26 September 2024).

[379] Exhibit SCH21 (witness statement of Natasha Wark, 27 September 2024).

[380] Ibid 4.

(15) Angus McFarland[381] is the Branch Secretary of the NSW and ACT (Services) Branch of the ASU. He holds a Bachelor of Arts and Bachelor of Laws. Mr McFarland's three witness statements were filed by the joint applicants in the joint union application (matter AM2024/25). He gave evidence about the ASU's consultation with disability sector members, the employment instruments which cover DSWs and how the ASU deals with industrial disputes involving DSWs. Mr McFarland also provided evidence about the origins of disability support work prior to the introduction of the NDIS, the characteristics of the NDIS and the nature of disability support work in the NDIS. He also supplied evidence about matters concerning the disability sector work force arising from the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, including how the Commonwealth, in response to Recommendation 10.9, noted the proceedings commenced by the joint union applicants in matter AM2024/25. He also gave evidence about funding arrangements and services outside of the NDIS.

(16) Melissa Coad[382] is currently the Public Sector National Campaigns, Policy and Stakeholder Co-ordinator at the UWU, a role she has held since 2020. In this role, Ms Coad is responsible for the national coordination of policy, stakeholder management and campaigning in respect of the disability, health and education sectors. Called by the joint applicants in the joint union application (matter AM2024/25), Ms Coad gave evidence about how the introduction of the NDIS changed the nature of the work in the disability sector as well as evidence concerning the classification of DSWs under the SCHADS Award.

[358] The ASU also relied on the expert report of Associate Professor Natasha Cortis and Dr Megan Blaxland[383] (Cortis/Blaxland Report), primarily in support of its application in matter AM2024/27 but also as informing the application in matter AM2024/25 and the Review. The report sets out and analyses data obtained via a survey of over 3000 employees about what they do in their work and how social and community service work (predominantly under the SCHADS Award, but also under relevant enterprise agreements) is characterised, classified and paid. It identifies common themes and concerns from the survey responses, including that many respondents were highly qualified and experienced, felt they were underclassified and were dissatisfied with the lack of pay progression in their roles.

[359] ABI, the ACCPA, the NSWBC and NDS relied upon a witness statement made in relation to all matters by Karen Stace,[384] who is the Director of Policy and Advocacy (Acting) of NDS. Ms Stace holds a Bachelor of Social Science (Welfare Studies), a Graduate Diploma of Health Sciences (Clinical Drug Dependence Studies), a Master of Business Leadership and a Diploma of Quality Auditing. She gave evidence about NDS' functions and membership, how the disability sector is particularly reliant on government funding, issues with the assumptions in the NDIS cost model and concerns raised by NDS members about the disability sector. Ms

[381] Exhibit SCH22 (witness statement of Angus McFarland, 26 September 2024); exhibit SCH23 (witness statement of Angus McFarland, 26 September 2024) and exhibit SCH24 (third witness statement of Angus McFarland, 19 November 2024).

[382] Exhibit SCH25 (witness statement of Melissa Coad, 26 September 2024).

[383] Exhibit SCH26 (expert report of Associate Professor Natasha Cortis and Dr Megan Blaxland, 19 April 2024).

[384] Exhibit SCH5 (witness statement of Karen Stace, 27 September 2024); exhibit SCH6 (further witness statement of Karen Stace, 22 November 2024).

Stace also made observations in reply regarding the joint union application (matter AM2024/25) and Dr Macdonald's expert report.

[360] Only Dr Macdonald and Ms Stace were cross-examined.

5.8 Factual findings

[361] On the basis of this body of evidence, most of which was not the subject of contest, we make the following findings.

[362] *First*, the work of employees covered by the SCHADS Award who undertake direct personal care work for people with disabilities involves the same or equivalent skills, responsibilities and working environments as those who undertake personal care work for the aged, including in-home care under the SCHADS Award, as assessed in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. Disability support work is fundamentally caring work of the same nature involving the exercise of the 'invisible' skills described in the *Stage 3 Aged Care decision* as the 'skills of interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination'.[385] The evidence amply demonstrates that disability support workers deal with persons with a wide range of conditions and are required in each case not merely to engage in functions associated with the direct physical care of clients but also to be constantly engaged in verbal and non-verbal communication with clients in order to be responsive to and meet their ongoing physical, intellectual and emotional needs.

[363] For example, Ms Haylett, a disability support worker, described her interactions with the full range of her regular clients, who have varying physical and intellectual disabilities including autism, cerebral palsy, ageing disabilities combined with intellectual disability and mental health issues, and non-verbal disability. In each case, Ms Haylett's duties require her not only to attend to the immediate physical care of her clients but also to assist them in engaging in life activities in a way that maximises their capacity for self-determination and freedom of expression. This requires a constant level of engagement with the client. She described her work with one client ('Client 3') as follows:[386]

> At 5:00 pm I attend Client 3's home. Client 3 is in his early 20s and lives with his parents. Client 3 is non-verbal and uses a wheelchair. Client 3 receives NIL by mouth and eats by percutaneous endoscopic gastrostomy (PEG) feeding. PEG feeding involves eating through a tube which has been inserted through the skin and the stomach wall. Client 3 has high level needs and requires myself and another worker for disability support. While in his wheelchair, Client 3 uses an Eyegaze — a device through which Client 3 looks at words and phrases, and pictures on a tablet by looking at them. When I arrive, we meet and greet each other by talking and communicating through the Eyegaze. This takes time and is also how I establish rapport and carry out my work with Client 3, recognising his right of respect and freedom of expression under the Code of Conduct.
>
> Using a lifter and sling we lift Client 3 onto a change table, undress him, and transfer him onto a shower bed. Once Client 3 is strapped into the shower bed we take him to the shower, check the water temperature and shower Client 3. We then transfer Client 3 back to the change table

[385] *Stage 3 Aged Care decision* [2024] FWCFB 150, 331 IR 137 [156(1)].

[386] Exhibit SCH14 (witness statement of Natalie Haylett, 20 September 2024) [29]–[32].

> and dry and dress him. While Client 3 is on the change table the Care Plan requires me to take particular care to clean Client 3's PEG site. We then transfer Client 3 back to his wheelchair.
>
> While we are performing this work Client 3 is unable to use his Eyegaze, so I pay careful attention to Client 3's non-verbal vocal sounds and facial expressions. I take care to keep communicating with Client 3 throughout the showering process so I can prompt him as we move to the next stage and listen and keep an eye out for any concerns. Client 3 regularly has seizures. I keep on the lookout for a seizure or potential seizure, particularly while transferring Client 3 from the wheelchair to the change table, and from the change table to the showing bed. If Client 3 is having or about to have a seizure I wait and speak calmly with him until the seizure passes and it is safe, and Client 3 is ready to continue showering. During this part of my work, I must be attentive and carry out my duties in a safe, competent and respectful way as required by the Code of Conduct.

[364] As another example, Ms Haylett described her work with 'Client 11':[387]

> Client 11 is a man in his late 60s who lives on his own and has with mental health concerns. On arrival I prompt client 11 to take his medication and prompt him to have a shower. In accordance with the principle of choice and control I do not tell client 11 to take his medication and have a shower and instead prompt and encourage him to do these daily activities.
>
> Client 11's behaviours are challenging, he is sometimes aggressive and may refuse to wash or shower. I have to keep a look out for client behaviour that may be dangerous, I have been assaulted several times at work and so this is for my own safety. Helping clients manage their emotions also helps me do my job. With Client 11 this can be difficult as I have to meet two competing Code of Conduct obligations — the requirement to respect Client 11's right of choice and control *not* to shower and wash — and my obligation to *ensure* that, as a vulnerable person, Client 11 does not suffer from neglect. I use various strategies to solve this problem. Firstly, I make a strong cup of coffee the way Client 11 likes it. While he is having coffee I do some house cleaning, we chat together and Client 11 gradually becomes more approachable. When I judge the time is right I ask, 'What would you like to do today, would you like a quick haircut or shave?' If Client 11 says. 'Yes', I have the opportunity to wash his face, neck and head while giving him a haircut and shaving his beard. I may also have the opportunity to give him clean clothes and put on some aftershave. I stay alert to Client 11's mood and capabilities and act accordingly.
>
> I then take Client 11 shopping. While shopping Client 11's behaviours can be challenging, he can be fast paced and difficult to keep up with. I am mindful of my requirement under the Code of Conduct to support Client 11 being financially responsible. Client 11 is fond of his cats, and I take care he does not spend too much money on cat food. I use active support skills by suggesting healthy food he may wish to purchase for himself.

[365] An important additional feature of the work Ms Haylett described is that, like HCWs in aged care, she works almost entirely unsupervised and autonomously.

[366] Ms Lenhard described her work as a disability support worker working in a group home setting. Importantly, it is clear that her work involves a combination of aged and disability care. Of the six residents in the group home, three are on NDIS plans, but the other three have 'aged out' of the NDIS because they are in their 70s. The range of physical and intellectual disabilities and medical conditions across her six clients may be summarised as follows:

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[387] Ibid [75]–[77].

(1) Intellectual disability, obsessive compulsive disorder, agoraphobia, non-verbal, aggression and anger, self-abuse and incontinence.

(2) Intellectual disability, cerebral palsy, osteoporosis, wheelchair-bound, self-abuse and incontinence.

(3) Intellectual disability, blind/vision impaired, digestive problems and incontinence.

(4) Intellectual disability, facial skin cancer, wheelchair-bound, requires full meal-time management, and incontinence.

(5) Down syndrome, dementia/Alzheimer's and incontinence.

(6) Down syndrome, sleep apnoea and incontinence.

[367] Ms Lenhard generally performs her work together with two other support workers because of the high needs of her clients. She described in detail her daily duties and responsibilities, and this includes in very general terms the provision of direct physical care, which includes medication management, the implementation of personal care, transfer, mealtime and communication plans, the preparation and delivery of meals (including feeding where necessary), and undertaking community activities with clients. She also described record-keeping for compliance purposes. In her activities with all clients, Ms Lenhard is required to engage in what is known as 'Active Support', which she described as:[388]

> … the idea that I am not supposed to do anything without having a customer with me so that they can participate in whatever I am doing, learn new skills and be engaged socially and emotionally. This means that I am to try and do everything *with* customers, rather than doing work *for* customers.
>
> Active Support creates another layer of work as because of the customer's disabilities, it is not easy to include them in tasks. It requires me to navigate, negotiate and plan how to include them each time I do something. The positive benefits of Active Support, however, are immense and are a huge improvement on the ways in which people with disabilities used to be treated.

[368] Ms Lenhard's evidence was that although she had not worked providing care to people in their private homes, she had trained staff who were going to provide support to people at their private homes. She said that the training was effectively the same as that provided for disability support workers in supported accommodation, with the same expectations and duties (including the underlying philosophy of Active Support), with the only difference being training as to specific risks that might arise in private homes.

[369] In her witness statement, Ms Moffat described working in a variety of disabled support settings. She currently works at a 'Community Hub', which facilitates persons with disability engaging in community, learning and recreation activities. Ms Moffat described in detail her duties and responsibilities in respect of both group activities and particular clients. For example,

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[388] Exhibit SCH16 (witness statement of Sarah Lenhard, 25 September 2024) [62]–[63].

in respect of one client 'P1', Ms Moffat related her working day with him as a complex combination of direct personal care, constant monitoring of his physical needs and emotional state, encouragement of him to engage in daily life activities and functions, and the need to respect his dignity, personal choice and human rights. Part of her account was as follows:[389]

> P1 is a man in his early 40s. I work with P1 one on a one-on-one basis each Monday and have supported him for about eight years. P1 has an intellectual disability and lives with early dementia.
>
> On arriving at the home, I greet P1 and ask him how he is. P1 has complex bowel health concerns. I ask P1 how he is feeling and if he has any discomfort. If necessary, I support P1 going to the toilet and with personal care.
>
> We discuss what P1 wishes to do with the day. I check P1's backpack for incontinence aids and make sure a lunchbox has been packed. I then drive him to the community hub.
>
> I ask P1, 'Have you had morning tea?', and support him to sit at the table and get his lunch out. P1 [] has difficulty drinking and feeding himself. Under the NDIS Code of Conduct I am required to support P1 to practice and retain these skills. If he does not continue to practice these skills, he is at risk of losing them further. I encourage P1 to feed himself morning tea, however if he becomes tired or confused I use a 'hand over hand' technique through which I use my hand to help P1 place food in his spoon and place the spoon in his mouth to eat.
>
> It is also my responsibility to ensure P1 maintains dignified social relationships with his peers in the [Supported Independent Living facility], and whenever possible I ensure P1 [] sits and eats together with his peers.
>
> Morning tea goes until about 10:00 am. Respecting P1's right of choice and control means it is not up to me to tell P1 when morning tea is over. I wait for P1 to let me know when he has finished which he often does by standing up and saying, 'I'm done.' Sometimes this means that P1 has become tired while eating and actually wants a break. It is my responsibility to ensure P1 has the choice to have a break from this activity and is also able to come back to it later.
>
> I cover and store the meal if it is not finished. P1 may then let me know he is ready to come back to it. Morning tea can last [] between 5 to 10 minutes or up to 45 minutes, and may involve up to four separate eating sessions. Each time P1 takes a break, I pack up the meal and after a while ask, 'Would you like some more morning tea?'. I then help P1 back to the table and make sure he is in the right position so that he can eat safely and exercise his right of choice about continuing the meal. My work with P1 is driven by a human rights framework focused on choice and the freedom that applies to each daily activity, no matter how ordinary the activity may be.
>
> After morning tea, I check if P1 is due for a bowel movement. I encourage him to go to the bathroom. I stay with him for a few minutes to see if he opens his bowels. Often, he will say 'No' and stand up. I ensure his incontinence aid is pulled up and encourage him to wash and dry his hands. If P1 does open his bowels, I assist him with personal care including protecting against rashes. This activity is repeated often throughout the day.

[389] Exhibit SCH17 (witness statement of Chantel Moffat, 25 September 2024) [15]–[22].

[370] Ms Tapley similarly detailed her work as a disability support worker with a variety of clients with different conditions, and described the non-physical support she is required to provide in the following terms:[390]

> A very large part of my work is providing emotional and psychological support. Sometimes, I feel like a low-paid counsellor. I am constantly listening to clients, helping them understand and dissect the problems they are facing, helping them to put a name to or identify the feelings or circumstances that they are going through. I talk with clients, discuss their problems and work with them to better understand, mediate and navigate what are often complex interpersonal relationships and life experiences that they are going through and how these intersect with and are affected by my client[']s disabilities.
>
> Providing emotional and psychological support to clients is a very significant part of what I do in my role. If I am cleaning a house, preparing food, transferring a client, transporting a client, doing any other activity in my role, I am almost always simultaneously providing emotional or psychological support.
>
> I also provide support and planning for life transitions and broader 'life-coaching'. This involves knowing how to build rapport and trust with clients so that they can open up about what they want in life. I then help them develop habits and skills to live the lives they want to live…
>
> Relatedly, I also use my skills to develop my clients' independent living. This means I need to know how to communicate, teach, and encourage clients to develop skills such as cooking and financial management so that they can live more independently. It also means I work with my clients, rather than just doing things for them.
>
> Another skill that is very important is knowing how to adapt and make modifications to achieve different tasks. Due to my clients' disabilities, I need to help them implement changes to accommodate their needs… By breaking down tasks, I help clients understand what they need to do to achieve their goal in a way that actually takes into account their disability and makes their goal achievable.
>
> Another essential skill is knowing how to learn what clients need. This is not something that is simply given to me by my employer. Sometimes, I am not even told what disability a client has, I am just told generally what they need support with.
>
> I need to know how to listen to my clients, observe them and notice what things they have difficulty with in order to provide the proper support…
>
> Similarly, my role involves knowing how to anticipate what problems a client may face, and deeply understanding a client's needs/abilities so that if we do plan something, it is effective and does not cause them any harm…
>
> I also use skills to help facilitate clients' own self-advocacy, and also to advocate on their behalf. This involves knowing how to facilitate clients to advocate for themselves (e.g. knowing how to encourage and help them make calls to health services and engage in new services). And it also involves knowing how to communicate my client's needs to various administrative, retail and health staff when my clients are unable to communicate this themselves.

[390] Exhibit SCH20 (witness statement of Madeleine Tapley, 26 September 2024) [97]–[106].

> When I have been talking about my duties, I have often said that I have been helping clients 'manage' issues or 'navigate' issues. What I mean when I say these things is that it involves me sitting down and talking with them about the problems and difficulties they are facing. I am actively listening, empathising and strategizing how they can best get the support and outcomes they want and need.

[371] Both on the basis of her own experience and expertise and by reference to the evidence of the witnesses directly engaged in disability support work, we accept as accurate the general description of the skills, including 'invisible' skills, and responsibilities of disability support workers ('DSWs') given by Ms Coad:[391]

> DSWs perform a range of duties, including working with participants to meet the outcomes and goals of their individual NDIS plan[s]. They provide support to participants with aspects of daily living; assisting and overseeing medication management; supporting participants at mealtimes; supporting participants in the community; liaising with family and guardians; implementing behaviour support plans; managing complex behaviours, and supporting participants with health and allied health plans. DSWs engage in advocacy on behalf [of] participants.
>
> The work that DSWs do is highly skilled, and requires high level communication skills, including the capacity to read body language and communicate with people who are non-verbal. It requires empathy, a non-judgemental approach, the capacity to remain calm in stressful and distressing situations, and the ability to develop strong relationships. DSWs develop skills in recognising and referring physical and mental health issues. DSWs are required to multi-task, providing emotional support as well as practical, physical support at the same time, while also ensuring the participant's safety and their own safety.
>
> The emphasis in the NDIS on individual, person-centred disability support provided in the participant's own home where possible means that DSWs are now more likely to work with a person with disability on a one-on-one basis than was the case before the advent of the NDIS. DSWs are also more likely to be providing support to people with disability living in their own homes or in supported accommodation with fewer other staff. To provide support to people with disability in a way that respects their right to choice and control, DSWs are increasingly required to engage with participants in problem-solving and in decision-making. Many DSWs are doing this work with very limited supervision and support from other workers in their field…

[372] *Second*, and overlapping with the previous finding, the requirements of the NDIS have made disability support work more varied and complex than previously, in a way that is substantially equivalent to the changes in the work value of aged care workers identified in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. These changes were discussed in the evidence of the witnesses referred to above but are best summarised in the report of Dr Macdonald as follows:[392]

> In the NDIS person-centred support and individualised funding arrangements the disability support worker role is more varied and more complex than previously. Changes to the DSW role required by the NDIS include greater responsiveness, greater complexity, less routine work, increased knowledge requirements and expanded scope for the exercise of judgement and initiative. …these increased expectations and requirements are clearly articulated in NDIS policy and regulatory standards for workers.

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[391] Exhibit SCH25 (witness statement of Melissa Coad, 26 September 2024) [10]–[12].

[392] Exhibit SCH1 (witness statement of Dr Fiona Macdonald, 25 September 2024) annexure FM-1 [25]–[26].

> With [the] advent of the NDIS, the work environment of disability support work has expanded and, in any individual disability support job, the environment is likely to be more complex and more variable. Disability support work is often undertaken in private and public settings without close oversight and without the sorts of environmental controls typically found in institutional settings. …

[373] *Third*, the classification structures in the SCHADS Award are productive of disputation, confusion and potential non-compliance in relation to disability support workers covered by the award. The disputation and confusion fall into two categories. The first involves disputes about whether disability support work performed in a private residence is covered by the SACS classification structure in Schedule B and the minimum wage rates in clause 15 together with the ERO, or the Home care employees — disability care classification structure in Schedule E and the minimum wage rates in clause 17.1. As described by Ms Coad, these disputes tend to arise when a disability services worker who has been employed by an employer who classifies them under Schedule B changes to a new employer who classifies them under Schedule E. In respect of one employer, the Paraplegic and Quadriplegic Association of South Australia, disputation of this nature has led to proceedings in the Federal Court of Australia. Mr McFarland's evidence was that the NSW/ACT branch of the ASU had been involved in disputes with about 30 employers about this issue over the last few years. Mr Eddington reported a dispute with one employer that applies the Schedule B classifications to employees who support clients in the clients' own homes, but applies the Schedule E classifications to employees who support clients in supported independent living homes. Ms Duscher and Mr Sit gave evidence as disability support workers of being directly involved in disputes of this nature. For example, Mr Sit said:[393]

> The work I perform as a DSW with Scope is the same as the work I performed as a DSW with Perfect Care. With both employers, my work took place in [supported independent living] houses with clients with high support needs. The tasks I perform with residents in both jobs, and the skills I use, are directly equivalent.
>
> Apart from the fact that I also performed House Supervisor duties with Perfect Care, my disability support work with both employers was the same. My work as a DSW for both employers is and was focussed on supporting the independent living of residents, to empower them so they can become as independent as possible. I cannot understand why I was paid less working for Perfect Care than I am with Scope, for the same work.
>
> Before I left my employment with Perfect Care, I raised a dispute about the fact that I was being paid as a Home Care Employee under the Award. It was my view my work more closely aligned with the work of a SACS employee under the Award. Perfect Care had engaged a consultancy company to implement new contracts and job descriptions at the time, and I was informed by a representative from the consultancy group that my work was Home Care work because the residents in these houses had signed tenancy agreements, therefore the houses were their own homes.
>
> I lodged a dispute with the Fair Work Commission on 14 July 2023 about my classification… Perfect Care did not agree for the dispute to be arbitrated and [the] matter was discontinued.

[393] Exhibit SCH19 (witness statement of Tin Sit, 25 September 2024) [42]–[46].

> I subsequently raised a dispute with the Fair Work Ombudsman about what I think was my incorrect classification. The Ombudsman is currently investigating the matter, and I am yet to receive an outcome.

[374] Even where disputation has not yet arisen, the evidence points to the potential for future disputes and claims of non-compliance. For example, Ms Tapley, who is a degree-qualified disability support worker, performs home-based care for an employer that is a NDIS provider. She is classified as a 'Home Care Employee' under Schedule E of the SCHADS Award at Level 3.1 rather than under Schedule B. Her evidence was that 'the skills to be a DSW in terms of implementing clients['] plans, guidance and support [and] mentoring, are the same regardless of where the support work is provided'[394].

[375] The second category of dispute concerns the classification of employees under Schedule B of the SCHADS Award. The Cortis/Blaxland Report indicates that, based on survey evidence, a large proportion of such employees consider that they are under-classified and that, based on employees' reports of their qualifications, experience and provision and receipt of supervision, that this in fact appears to be the case. Associate Professor Cortis and Dr Blaxland substantially attribute this to the drafting of the classification descriptors in Schedule B:[395]

> … employers and employees find it difficult to use the Award to classify (and reclassify) SACS roles, as the wording fails to characterise typical work activities, responsibilities and skills, and ambiguous language makes it difficult to map roles to appropriate levels.

5.9 Conclusions regarding gender-based undervaluation

[376] We are satisfied that the minimum wage rates prescribed by the SCHADS Award for employees within the classifications in Schedules B, C and E do not properly reflect the value of the work to which those classifications apply and that this is the case for reasons related to gender. The work to which the classifications apply is caring work involving the exercise of 'invisible' skills. This is established, in respect of disability support work covered by Schedules B and E, by the evidentiary findings we have earlier made. Insofar as Schedules B and C also apply to other forms of what may broadly be characterised as social work, it is established by the findings made by the QIRC in the *Queensland CSCA Award decision* and by this Commission in the *SACS Equal Remuneration decisions*. The workforce which performs this work is, and has historically been, female-dominated. The rates of pay applying to the classifications in Schedules B, C and E are not the product of any proper work value assessment by this Commission or the AIRC of the skills utilised in undertaking work of this nature, but are the result of non-transparent consent arrangements in which the assumption of an alignment with the masculinised C10 rate at the Certificate III level may be inferred to have played a major role. In sum, there has never been proper recognition of the skills involved in undertaking the work covered by Schedules B, C and E when setting award wage rates and this has operated to the disadvantage of a highly-feminised workforce.

[377] The extent of this gendered undervaluation of the relevant work is plainly apparent on the face of the SCHADS Award in two ways. First, there is the difference between the rates prescribed by the SCHADS Award for the Schedule B and C classifications set out in clause 15,

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[394] Exhibit SCH20 (witness statement of Madeleine Tapley, 26 September 2024) [116].

[395] Exhibit SCH26 (expert report of Associate Professor Natasha Cortis and Dr Megan Blaxland, 19 April 2024) 82.

and the rates produced by the ERO for these classifications as set out in the note to clause 15. As stated in the *Stage 3 Aged Care decision* at [171]–[172], although the ERO rates were not made in the exercise of the award-making and variation powers under the FW Act, the way in which the rates were set essentially proceeded on what may be characterised as work value grounds within the meaning of s 157(2A). They were fixed on the basis that they ensure equal remuneration for work of equal or comparable value and can therefore be relied upon as being free of assumptions based on gender. The ERO rates are therefore broadly indicative of what the SCHADS Award rates would be if they were properly based on a gender-neutral assessment of work value. The quantitative difference between the award rates and the ERO rates ranges from 23 per cent at Level 2 to 45 per cent at Level 8.

[378] Second, there is the difference between the award wage rates for the Schedule E Home care — disability care classifications, which are not the result of any work value assessment, and the wage rates for the Schedule F home care — aged care classifications, which have been significantly increased as a result of the aged care work value proceedings. As earlier stated, prior to the aged care work value proceedings, the same minimum wage rates applied to all forms of home care based on an assumed equivalence in work value. The rates for the Schedule F classifications will be 20 per cent or more above their corresponding Schedule E classifications upon full implementation.

5.10 Conclusions re the SCHADS Award classification structures and rectification of gender-based undervaluation — *provisional* views

[379] The evidence and submissions before us make it amply clear that the current system of classifications and rates of pay in the SCHADS Award is not fit for purpose. This is the case in two major respects. First, the division of the coverage of the SCHADS Award into different classification streams with different rates of pay sourced from different pre-modern awards has resulted in an outcome which is complex, does not value work equally across the classification streams, and is conducive of disputation and potential non-compliance. This can most clearly be seen in the way the SCHADS Award divides residential disability service work between Schedules B and E in a way that is not readily explicable. It is reasonably clear, we consider, that at the time the SCHADS Award was made in December 2009, the care of clients in their private residences was 'home care', and that care in other type of residential settings (such as group homes or supported independent living facilities) fell into the 'disability services sector', which was subsequently incorporated into the 'social and community services sector'. However, changes to the sectoral definitions since the award was made, as described in our outline of the award history, have confused the position. The outcome is that some employers are paying disability support workers under Schedule B (to which the ERO applies) and others are paying them under Schedule E. This is work primarily funded by the NDIS, whose cost model assumes the payment of wages under Schedule B and the ERO.

[380] This position is obviously unsatisfactory. Modern awards should make clear the minimum wage rate obligations of an employer and entitlements of an employee and should not be productive of disputation and litigation. We note that the union applicants in matter AM2024/25 contend that whether an employer falls under Schedule B or Schedule E may be determined by the 'principal purpose test'. Without expressing a view about this, it should not be necessary to make an evaluative judgment of this nature in order to determine which minimum wage rate obligations apply. More fundamentally, as the evidence in these

proceedings demonstrates, there was never any logical basis for the work of caring for people with disabilities in different settings, and aged people in residential settings, to be divided into different classification structures with different rates of pay, since the work is fundamentally the same in all settings.

[381] Second, the classification structures in Schedules B and C are expressed in terms which makes it very difficult to determine at what level an employee should be classified and paid. The definitions of the classification levels contain descriptions of the applicable characteristics, responsibilities and requirements which are so broadly expressed that it is often difficult to distinguish one classification from the next. We accept the submissions of the ASU which characterised the classification structures in Schedules B and C in the following terms:[396]

> … the descriptors are extremely lengthy, spanning multiple pages, and attempt to capture a wide range of skills, potential duties, qualification levels and otherwise describe a range of positions.
>
> Where concrete descriptors — for example, qualification levels — are used, a high degree of discretionary language remains…
>
> In short, the classification structure requires an extremely broad evaluative exercise to be undertaken by the employer in assessing the level of skill and the nature of the duties (and their level) it requires of a particular position or of a particular employee: a bespoke work value exercise for every workplace. This is generally undesirable but more so in female-dominated industries involving work which has historically been undervalued by persons conducting such assessments.

[382] The result, as the Cortis/Blaxland Report indicates, is the widespread misclassification of employees.

[383] It is necessary therefore to find an appropriate remedy for the intersecting problems of the gender-based undervaluation we have found to exist and the above difficulties in the classification structures in the SCHADS Award.

[384] We do not consider that the variations proposed in matters AM2024/25 and AM2024/27, either individually or in combination, constitute an appropriate remedy. The variation sought in matter AM2024/25 constitutes at best a 'fix' for the problem of some employers paying their employees undertaking NDIS-funded work under Schedule E rather than Schedule B without resolving the broader issues of the relative work value of SACS and home care work, the problematic nature of the classification structures in Schedules B and C and the gender-based undervaluation in the minimum award wage rates we have identified.

[385] The first variation sought in matter AM2024/27, which would 'incorporate' the ERO rates into the SCHADS Award, is predicated on the retention of the five separate classifications streams in Schedules B through F to the award and the classification definitions in Schedules B and C. Further, while it would remedy the gender-based undervaluation in the wage rates applicable to the Schedule B and C classifications, it would not remedy the gender-based undervaluation in the Schedule E wage rates. As to the second variation, which seeks to add indicative job titles to the Schedule B and C classification definitions, we are not satisfied that

[396] ASU submission (matter AM2024/27), 2 October 2024 [17]–[19].

that there is a proper evidentiary basis for such a variation to be made. The ASU adduced no evidence as to the duties, skills and responsibilities of many of the specified jobs, so there is no basis for us to conclude that they can be assigned to the existing classification levels in the way proposed by the ASU. Further, we do not consider that the proposed indicative job titles would necessarily add any clarity to the Schedule B and C classification definitions, since the job titles themselves are expressed in general terms which in many cases would still require an evaluative judgment to be made as to the employment roles to which they apply.

[386] Accordingly, we do not consider that either application is necessary to meet the modern awards objective or, to the extent they would alter or have the effect of altering the minimum wage rates in the SCHADS Award, the minimum wages objective. In respect of the modern awards objective in s 134(1) of the FW Act, we consider for the reasons stated that the variations would not result in the elimination of gender-based undervaluation of work under the SCHADS Award, nor would they ensure that the SCHADS Award is simple, easy to understand, stable and sustainable. The considerations in paragraphs (ab) and (g) of s 134(1) therefore weigh heavily against the variations, with the other considerations being largely neutral, with the result being that we do not consider that the variations would provide a fair and relevant minimum safety net of terms and conditions. In respect of the minimum wages objective in s 284(1), the variations would not establish a safety net of fair minimum wages because, again, they do not meet the 'need' in paragraph (aa) of eliminating the gender-based undervaluation of work, with the other considerations being neutral.

[387] The application in matter AM2024/25 is therefore dismissed. As to matter AM2024/27, we decline to make the variations proposed in the first two 'phases' of the application and dismiss the application to that extent.

[388] We consider that the preferable course is to replace the classification structures in Schedules B to F, and their accompanying wage rates in clauses 15 to 17, with a single new classification structure for the SCHADS Award which rectifies gender-based undervaluation, is simple and easy to understand, and which provides common minimum wage rates for work of equal or comparable value that apply to all of the types of work covered by the award. We consider that this new classification structure should be based on four fundamental principles. The first is that the classifications should be defined in terms which render compliance, as far practicable, a straightforward matter not requiring any complex evaluative judgments to be made. Unlike the current classification definitions in Schedules B and C, they should not attempt to completely describe the skills, duties, responsibilities and working environment of individual job roles. In this respect, we repeat what was said in the *Stage 3 Aged Care decision* as to the proper role of classification definitions:[397]

> They are not 'position descriptions' of the type which might apply to individual employment arrangements. Their purpose is to identify to which categories of employees the minimum pay rates prescribed by the award are payable. They are the means of expressing the legal prescription of the minimum pay obligations of employers and entitlements of employees. Except insofar as it is necessary to serve this purpose, there is no need for classification descriptors to give a total description of the skills, duties and incidents of the jobs to which they apply. Indeed, it is undesirable for this to be attempted. The changing nature of modern work means that a classification descriptor of this nature would rapidly become outdated. Further, the

[397] [2024] FWCFB 150, 331 IR 137 [184].

> type of comprehensive description contemplated would be excessively lengthy and require complicated judgments to be formed as to how each employee is to be classified and paid, thus constituting an onerous regulatory burden on employers. …This degree of complexity does not aid award compliance. The proper assessment of work value, including the proper recognition of the 'invisible' skills that characterise these female-dominated jobs, is not to be found in the award classification descriptor for a position but rather in its minimum rate of pay.

[389] The second principle is that the new classification structure should be structured on the Caring Skills benchmark rate and C1(a) benchmark rates respectively identified at paragraphs [170] and [204] of the *Stage 3 Aged Care decision* — namely (as adjusted by the *AWR 2024 decision*), $1269.80 per week for a Certificate III-qualified employee and $1525.90 for a degree-qualified employee. The Caring Skills benchmark rate was itself originally derived from the ERO and aligns (subject to some rounding differences) with the ERO rate for a SACS employee Level 2, pay point 1. It was also adopted in the *Stage 3 Aged Care decision* as the benchmark rate for home care employees in aged care, and will be the final rate (subject to future AWR adjustments) for the Schedule F classification of Home care employee level 3—aged care. Having regard to our findings as to the equivalence of work value in all direct care functions in the classification streams in the SCHADS Award, including that the NDIS has made disability support work more varied and complex, the Caring Skills benchmark rate is appropriate to be applied to all Certificate III-qualified employees under the new classification structure. It appropriately reflects the work value of these employees. The C1(a) benchmark rate approximately aligns with the ERO rate for a four-year degree-qualified SACS employee level 3 and a Crisis accommodation employee level 1 at pay point 4. Noting that a degree in social work takes a minimum of four years to complete (see the table in paragraph [123] above), this is, effectively, the current minimum rate for degree-qualified employees under the award.

[390] Third, the new classification structure should appropriately recognise the acquisition of relevant qualifications at each level, whilst making allowance for the recognition of equivalent experience and training, obtained for example through 'lived experience' which is a particular feature of SACS work.

[391] Fourth, the current annual pay increments which are a feature of the classification structures in Schedules B, C, D and E should not be retained as they are not properly based on work value for the reasons discussed in the *Teachers decision*,[398] the *Stage 3 Aged Care decision*[399] and the *Aged Care Nurses decision*.[400]

[392] Having regard to our earlier findings and these principles, our *provisional* view is that the SCHADS Award should be varied to replace the existing classification and wages structures with a single new classification structure, set out below. We consider that this is justified by work value reasons, within the meaning of s 157(2A) of the FW Act, and that these new wage rates would properly reflect work value in a way that is free from assumptions based on gender. The new structure is substantially based on, and incorporates, the classification structure in Schedule F, which was formulated in the *Stage 3 Aged Care decision* based on the principles set out above. Additional classifications have been added above and below the Schedule F

[398] [2021] FWCFB 2051 [645]–[659].

[399] [2024] FWCFB 150, 331 IR 137 [207].

[400] [2024] FWCFB 452 [57]–[58].

classifications to encompass the broader scope of work and qualifications captured in current Schedules B and C.

Classification	Criteria	Relativity	$ per week
Level 1 Introductory administrative/clerical employee	An employee whose primary role is to provide basic administrative or support activities which do not include home care, social and community services or crisis assistance and supported housing work.		
	Level 1.1—less than 3 months' relevant industry experience	76% of Level 3.1	965.60
	Level 1.2—3 months' or more relevant industry experience.	78.5% of Level 3.1	996.70
Level 2 Introductory home care/social and community services employee	An employee without a qualification whose primary role is to: • provide basic home care; or • undertake basic social and community services work.		
	Level 2.1—less than 3 months' relevant industry experience	90% of Level 3.1	1142.80
	Level 2.2—3 months' or more relevant industry experience.	95% of Level 3.1	1206.30
Level 3 Qualified home care/ social and community services employee	An employee whose primary role is to: • provide home care; or • undertake social and community services work; or • undertake administrative or support activities **and** who has obtained a relevant Certificate III qualification or equivalent.		
	Level 3.1	100%	1269.80
	Level 3.2 — a Level 3 employee who has obtained 4 years' experience* at Level 3. *For employees currently classified under Schedule B or C, prior experience as an employee holding a Certificate III will count towards this requirement. For employees currently classified under Schedule E or F, the relevant experience must be on or after 1 January 2025.	104% of Level 3.1	1320.60

Classification	Criteria	Relativity	$ per week
Level 4 Senior home care/social and community services employee	An employee whose primary role is to: • provide home care; or • undertake social and community services work **and** who has obtained a relevant Certificate IV qualification or equivalent as a requirement for the performance of their duties by the employer.	108% of Level 3.1	1371.40
Level 5 Specialist/supervisory employee	An employee whose primary role is to: • provide home care; or • undertake social and community services work; • undertake crisis accommodation and supported housing work; **and**: • is required to supervise and/or train other employees covered by this award; or • has obtained a relevant diploma qualification or equivalent as a requirement for the performance of their duties by the employer.	112% of Level 3.1	1422.20
Level 6 Professional employee	An employee who has obtained an undergraduate degree as a requirement for the performance of their duties, or who has equivalent expertise and experience.		
	Level 6.1 — First year of experience at Level 6.	95% of Level 6.2	1449.60
	Level 6.2 — A Level 6 employee with 1 year's experience at Level 6.	100%	1525.90
	Level 6.3 — A Level 6 employee with 4 years' experience at Level 6.	108.9% of Level 6.2	1661.20
	Level 6.4 — A Level 6 employee with 7 years' experience at Level 6.	117.7% of Level 6.2	1796.50
Level 7 Senior professional employee	Professional employee with a supervisory or leadership role over other professional employees. Employees at this level may be required to have obtained a relevant post-graduate qualification.		
	Level 7.1	126.6% of Level 6.2	1931.70
	Level 7.2 — A Level 7 employee with 5 years' experience at Level 7.	134.4% of Level 6.2	2050.10

Classification	Criteria	Relativity	$ per week
Level 8 Manager/Senior specialist	An employee who has been appointed as: • a manager of an organisational unit or a project; • part of a management team; • a senior specialised expert; • a coordinator of services; or • leader of a multi-disciplinary team of professional employees. Employees at this level may be required to have obtained a relevant post-graduate qualification.	144.5% of Level 6.2	2204.80
Level 9 Senior Manager	An employee who has been appointed to a senior managerial role. Employees at this level may be required to have obtained a relevant post-graduate qualification.	163.9% of Level 6.2	2500.70

[393] For the purpose of the above classifications, the expressions 'home care', 'social and community services work' and 'crisis accommodation and supported housing work' will be defined as follows (adapting the current sector definitions in clause 3.1):

> **home care** means the provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence.
>
> **social and community services work** means the work of
> (a) providing social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work; and
> (b) the provision of disability services including the provision of social, community or disability services, which includes the provision of personal care including therapeutic care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services.
>
> **crisis assistance and supported housing work** means the work of providing crisis assistance and supported housing services.

[394] We do not anticipate that the new classification structure proposed above would require any significant additional NDIS funding on the part the Commonwealth. That is because, as earlier explained at paragraph [389], the structure aligns with, and is built around, the Caring Skills benchmark rate as produced by the operation of the ERO upon the rates prescribed by clause 15 of the SCHADS Award, and the C1(a) benchmark rate approximately aligns with the four-year degree-qualified ERO rate. The new structure is not intended to produce, except perhaps at the margins upon translation, any significant increase to the current ERO rates which form the basis of the funding model for NDIS providers.

[395] We have not incorporated family day care services into the above classification structure. There was no evidence in these proceedings concerning the work currently performed by employees covered by the Schedule D classifications. The work does not involve any direct care, since it is concerned with the support, recruitment and training of family day carers, the

arrangement of the placement of children according to the needs of families and carers, monitoring the care provided and undertaking its administration. Accordingly, it is not possible to say, on the material before us, that the work is equivalent in work value to that of employees engaged in disability support or the in-home care of aged persons or persons with disabilities, or that it has been the subject of gender-based undervaluation. Our *provisional* view is that the inclusion of family day care work in the SCHADS Award is an anomaly, and that all such work should be covered by the CS Award (a matter we discuss further in relation to that award later in this decision).

[396] Because the above classification structure would implement minimum wage rates which will eliminate the gender-based undervaluation of work and ensure equal remuneration for work of equal or comparable value, it would render the ERO redundant. It is therefore our *provisional* view that the ERO should be revoked upon implementation of the above classification structure.

[397] Parties will be given an opportunity to make further submissions in response to the *provisional* views expressed above concerning a new classification structure. Without limiting the matters about which parties may wish to make submissions, we invite submissions about the following matters in particular:

(1) Whether the classification descriptors provide a sufficient level of prescription to allow all employees covered by the SCHADS Award to be classified.

(2) What transitional arrangements should be implemented to translate employees from the current classifications to the new structure and ensure that no employee has their wage rate reduced because of the transition?

(3) What should the operative date for the new structure and the revocation of the ERO be, and what (if any) phasing-in arrangements should apply, having regard to the need to rectify gender-based undervaluation and the funding constraints on employers covered by the SCHADS Award?

(4) What provisions of the SCHADS Award might require modification if the new structure is implemented?

[398] It is not necessary for us to make any findings about whether the implementation of the *provisional* views above would be necessary to achieve the modern awards objective or the minimum wages objective until we have received and considered any submissions that might be made in response to those *provisional* views.

6. ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKERS AND PRACTITIONERS AND ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES AWARD 2020

6.1 Classifications and minimum wage rates

[399] The ATSIHW Award covers employers in the 'Aboriginal community controlled health services industry'[401] and their employees in the classifications set out in the award, and any employers of Aboriginal and/or Torres Strait Islander Health Workers or Health Practitioners in those classifications. The expression 'Aboriginal community controlled health services' is defined in clause 4.2 to mean:[402]

> … incorporated Aboriginal organisations, initiated and based in an Aboriginal community. They are governed by a representative Aboriginal Board of Management which is elected by the local Aboriginal community. They deliver holistic and culturally appropriate health and well-being services to the Aboriginal community which controls them.

[400] Clause 16.1 of the award sets out adult minimum rates of pay for classifications in four streams. The first, in clause 16.1(a), is for 'Aboriginal and/or Torres Strait Islander Health Worker/Aboriginal and/or Torres Strait Islander Community Health Worker employees' (Health Workers). The classifications and current minimum rates of pay are:

Classification	Full-time weekly rate ($)	Hourly rate ($)
Grade 1		
Level 1	985.20	25.93
Grade 2		
Level 1	1055.10	27.77
Level 2	1091.20	28.72
Grade 3		
Level 1	1148.20	30.22
Level 2	1208.30	31.80
Level 3	1267.00	33.34
Grade 4		
Level 1	1302.40	34.27
Level 2	1337.40	35.19
Level 3	1368.20	36.01
Grade 5		
Level 1	1400.90	36.87
Level 2	1433.80	37.73
Level 3	1468.60	38.65

[401] *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* [MA000115] ('ATSIHW Award') clause 4.1(a).

[402] ATSIHW Award clause 4.2.

[401] Each grade is defined in clause A.2 of Schedule A by way of broad descriptions of the skills, responsibilities, duties and qualifications required. Broadly speaking:

- Grade 1 is an entry-level trainee role for 12 months.
- Grade 2 is also a trainee role for an employee in their second year of service or who has obtained a Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care (ATSI Primary Health Care) or equivalent.
- Grade 3 is an employee who has completed a Certificate III in ATSI Primary Health Care or equivalent or has other qualifications or experience deemed equivalent through a Registered Training Organisation (RTO).
- Grade 4 applies to a person holding a Certificate IV in ATSI Primary Health Care Practice or ATSI Primary Health Care or equivalent. There are three roles: (1) Advanced Health Worker – Practice, (2) Health Practitioner, who is required to hold current registration as such with the AHPRA Aboriginal and Torres Strait Islander Health Practice Board and (3) Advanced Health Worker – Care. Employees at this grade work at advanced levels with minimum supervision.
- Grade 5 covers the roles of Senior Health Worker, Senior Health Practitioner and Health Worker Coordinator. Employees at this level are required to hold at least a Diploma in ATSI Primary Health Care or ATSI Primary Health Care Practice or equivalent. Senior Health Practitioners and Health Worker Coordinators may also possess experience deemed to be equivalent. Senior Health Practitioners must hold current registration as such with the AHPRA Aboriginal and Torres Strait Islander Health Practice Board. Employees at this grade operate at a complex and specialist level and may be required to undertake some management-type duties.

[402] Progression through the levels in each grade occurs at the end of each 12-month period of continuous employment subject to the demonstration of competence and satisfactory performance: clause 12.3(a).

[403] The second classification stream, for Administrative employees, is not relevant to this proceeding. The third stream is for Dental employees. The classifications and minimum rates prescribed by clause 16.1(c) are:

Classification	Full-time weekly rate ($)	Hourly rate ($)
Dental Assistant		
Grade 1	934.80	24.60
Grade 2	953.20	25.08
Grade 3	971.80	25.57
Grade 4	1032.30	27.17
Grade 5	1067.30	28.09
Dental Therapist Grade 1		
Level 1	1116.70	29.39
Level 2	1146.00	30.16
Level 3	1182.80	31.13
Level 4	1228.40	32.33
Level 5	1289.00	33.92
Level 6	1348.50	35.49
Level 7	1394.20	36.69

Classification	Full-time weekly rate ($)	Hourly rate ($)
Dental Therapist Grade 2		
Level 1	1414.00	37.21
Level 2	1445.90	38.05
Level 3	1476.70	38.86
Level 4	1503.00	39.55
Level 5	1537.10	40.45

[404] Progression through the levels in each grade for Dental Therapists is also as per clause 12.3(a).

[405] The Dental employee classifications are defined in clause A.4. In summary, the Dental Assistant grades are defined as follows:

- Grade 1 is an entry-level classification applicable for three months.
- Grade 2 is for an employee performing only dental assistant duties and who has no formal qualifications.
- Grade 3 is for an employee who has either completed a dental assistant qualification and performs only dental assistant duties, or is unqualified but performs a combination of duties including routine clerical, reception duties and dental assistant duties, or is unqualified, performs only dental assistant duties and has 12 months' experience at Grade 2.
- Grade 4 is for an employee who is:
  - unqualified, has 12 months' experience at Grade 3 and has demonstrated competence in respect of knowledge of dental equipment, sterilisation techniques and infection control, a basic understanding of techniques and procedures, and an understanding of the set-up prior to procedures; or
  - unqualified and performs a combination of dental assistant, clerical and reception duties and has 12 months' experience at Grade 3;
  - qualified and performs solely dental assistant duties and has 12 months' experience at Grade 3; or
  - qualified and performs a combination of dental assistant, clerical and reception duties.
- Grade 5 covers unqualified employees who perform a combination of dental assistant, clerical and reception duties and have 12 months' experience at Grade 4, or who are qualified and have 12 months' experience at Grade 4 (regardless of their range of duties).

[406] The Dental Therapist Grade 1 classification is defined in clause A.4.6 and, broadly speaking, is a professional practitioner who works under the supervision of a higher-grade professional officer. A Dental Therapist Grade 2, defined in clause A.4.7, performs their work only under general professional guidance unless it is novel, complex or critical professional work. Dental Therapists are an ANZSCO-defined occupation. While the occupation is titled as 'Dental Therapist' it also includes 'Oral Therapists' as a specialisation. Accordingly, our conclusions below will apply to any dental therapist or oral therapist within the coverage of the ATSIHW Award.[403]

[403] Fair Work Commission, *Gender Undervaluation: ACTU Data Request — ATSIHW Award* (Information Note, 19 November 2024) 2.

[407] The fourth classification stream consists of ancillary staff who are not relevant to the current matter.

[408] An important feature of the classification definitions in Schedule A is that a number of them refer to the exercise of 'Aboriginal and/or Torres Strait Islander knowledge and cultural skills'. This expression is defined in clause A.1 by reference to three levels of knowledge and cultural skills. Level 1, the lowest level, is defined in clause A.1.1 as follows:

> **Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 1** means:
>
> (a) an understanding, awareness and sensitivity to Aboriginal and/or Torres Strait Islander culture and lore, kinship and skin relationships, local cultural values, the ability to conduct oneself in a culturally appropriate manner and an understanding that Aboriginal and/or Torres Strait Islander culture is not homogenous throughout Australia;
>
> (b) where relevant, a knowledge of one or more relevant Australian Aboriginal and/or Torres Strait Islander language groups;
>
> (c) an ability to deliver or assist in the delivery of effective and appropriate services to an Aboriginal and/or Torres Strait Islander clientele through knowledge of the relevant Australian Aboriginal and/or Torres Strait Islander community, the ability to effectively communicate with Aboriginal and/or Torres Strait Islander people, and a knowledge of cultural conventions and appropriate behaviour;
>
> (d) an awareness of the history and role of Aboriginal and/or Torres Strait Islander organisations in the relevant region, an understanding of the organisations and their goals and the environment in which the organisations operate;
>
> (e) the ability to function effectively at work in an Aboriginal and/or Torres Strait Islander organisation; and
>
> (f) an understanding and/or awareness of the concepts of Aboriginal and/or Torres Strait Islander self determination and Aboriginal and/or Torres Strait Islander identity.

[409] The classification definitions for Dental Assistant Grades 2–5 and Dental Therapist Grades 1 and 2 all provide that it is 'desirable' that staff have Aboriginal and/or Torres Strait Islander knowledge and cultural skills—Level 1.

[410] A full comparison between the current minimum rates of pay for dental assistants and dental therapists under the HPSS Award and the ATSIHW Award is problematic because of the lack of correspondence between the awards' respective classification definitions. However, it is possible to compare the rates of pay at key levels. As the table below shows, at these key levels the rates of pay in the ATSIHW Award are either lower than or the same as under the HPSS Award.

Role	HPSS Award		ATSIHW Award	
	Classification	**Current $ per week**	**Classification**	**Current $ per week**
Dental Assistant — entry level	Support Services Level 1	945.10	Grade 1	934.80

Role	HPSS Award		ATSIHW Award	
	Classification	**Current $ per week**	**Classification**	**Current $ per week**
Dental Assistant — Certificate III-qualified	Support Services Level 4	1032.30	Grade 3 1st 12 mths Grade 4	971.80 1032.30
Dental Assistant — highest rate	Support Services Level 5	1067.30	Grade 5	1067.30
Dental Therapist — entry level	Health Professional Level 1 — 3-year degree entry	1124.80	Grade 1 Level 1	1116.70
Dental Therapist working independently — highest rate	Health Professional Level 2 — pay point 4	1541.60	Grade 2 Level 5	1537.10

[411] The Dental Assistant Grade 4 rate in the ATSIHW Award aligns with the C10 rate in the Manufacturing Award. The entry-level rate for a Dental Therapist holding a three-year undergraduate degree is lower than the C7 rate in the Manufacturing Award, for which a Certificate IV or 60 per cent completion of a diploma qualification is required. A Grade 1 Level 7 Dental Therapist has a minimum weekly rate of $1394.20, which is below the C2(b) rate in the Manufacturing Award for which an Advanced Diploma is required. It is also below the C1(a) benchmark rate of $1525.90, as are all rates for the Dental Therapist Grade 2 classification except for the highest (Level 5) rate.

6.2 Award history

[412] The history of the development of the ATSIHW Award is set out in the Stage 2 Report. As the report explains, the classification structure and rates of pay in the award had their origin in the *Health Services Union of Australia (Aboriginal Health Services) Award 1992*[404] (1992 Award), which was the first federal instrument to regulate the Aboriginal healthcare sector in more than one state. The 1992 Award arose from an interstate dispute generated by a letter of demand and log of claims served by the HSU upon a number of employers in NSW, Queensland and Victoria. The 1992 Award was made in a decision of the AIRC (Turbet C) on 6 May 1992.[405] In this decision, the union and employer parties proposed the making of an award which contained the rates prescribed in the *Victorian Aboriginal Health Service Agreement*, an agreement registered under Victorian State law. The Commissioner determined that these rates were appropriate to be adopted for a first award, subject to a short period of phasing-in. The 1992 Award included classifications for dental officers (i.e. dentists) and dentists' nurses (i.e. dental assistants), as well as Aboriginal health workers and a range of managerial, administrative and clerical roles. Importantly, the decision refers to evidence that a majority of the employees who would be covered by the award were female.

[413] The 1992 Award was restructured in 1995 as a result of an application made by the HSU to complete the structural efficiency process.[406] The major part of this restructure was a new classification structure, which was proposed by the HSU, not opposed by the employers, and adopted by the AIRC (O'Shea C).[407] It included classification structures and definitions for dental assistants and dental therapists which were essentially the same as those now appearing in the current ATSIHW Award except that they omitted any reference to the exercise of

[404] AW783526.

[405] [1992] AIRC 342, Print K2782.

[406] [1995] AIRC 626, Print M0885.

[407] Print M0886.

Aboriginal and/or Torres Strait Islander knowledge and cultural skills. The restructured award also included classifications for dental officers, Aboriginal health workers, and administrative and ancillary staff. The award was consolidated in 2002 and renamed as the *Health Services Union of Australia (Aboriginal and Torres Strait Islander Health Services) Award 2002*[408] (2002 Award).

[414] During the award modernisation process, the AIRC Full Bench determined in 2009 that it was appropriate to create a separate modern award for Aboriginal community controlled health organisations (ACCHOs):[409]

> We have decided, however, that the operation of [A]boriginal community controlled health organisations should be regulated by a separate modern award. We are satisfied that the nature of health services that are delivered in a culturally appropriate way is sufficiently different to justify a separate award. The difference is not only about the way the services are established and controlled but is critically seen in the way that employees of the services operate. We accept that the [A]boriginal health worker within [A]boriginal community controlled health services is critical. No equivalent health care worker operates in what we might describe as mainstream services. We publish a draft Aboriginal Community Controlled Health Services Award 2010.

[415] The draft award published was one largely based on a draft provided by the National Aboriginal Community Controlled Health Organisation (NACCHO), with the exception that coverage of doctors, nurses and dentists was excluded. The classification definitions and rates of pay were otherwise derived from the 2002 Award.[410] The exposure draft introduced the definitions and classifications requirements for Aboriginal knowledge and cultural skills.

[416] In response to the exposure draft, the HSU submitted that there was an unjustified disparity in rates for dental assistants compared to the rates determined for the HPSS Award. This submission was dealt with in a subsequent decision in which the AIRC Full Bench said:[411]

> The Health Services Union drew attention to the rates for dental assistants which it said were less than those applying to dental assistants in the [HPSS Award]. In our statement of 25 September 2009 we explained that the services provided by [A]boriginal community controlled health organisations are notably different from what might be called mainstream health services, including as to the work that is performed by its employees. A ready comparison with the HPSS Award is not easily made. However, on closer examination of the definitions, we have decided to adjust the higher grades (4 and 5) so that the rates accord with those found in the HPSS Award.

[417] Critically, this amendment resulted in the Grade 4 dental assistant classification being aligned with the C10 rate in the Metals Framework (which had not hitherto been the case). The AIRC Full Bench also modified the classification definitions for Aboriginal health workers, and made brief reference to the issue of Aboriginal knowledge and cultural skills:[412]

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[408] AP819920.

[409] [2009] AIRCFB 865, 188 IR 23 [125].

[410] Ibid [126], [128].

[411] [2009] AIRCFB 945, 190 IR 370 [98].

[412] Ibid [102]–[103].

> There was some difference between the unions and NACCHO concerning the definition of [A]boriginal health worker. On the basis of those submissions we have revised the definitions to incorporate the draft of NACCHO as well as the suggestions of the [Liquor, Hospitality and Miscellaneous Union]. In particular we have limited Grade 1 to the first year (and not up to the third year) of employment. We have incorporated the emerging occupations of [A]boriginal community health worker (albeit limiting it to Grades 1 and 2 for now) and finally, have made it clear that Grade 2 is applicable to employees with Certificate III training while Certificate IV trained persons would be classified at Grade 3.
>
> There was disagreement as to how [A]boriginal knowledge and cultural skills (Levels 1, 2 and 3) would apply to the classifications and concern that they might unfairly impact on progression. We have decided to apply the relevant skill to each but as a desirable rather than a necessary skill.

[418] With these modifications, the *Aboriginal Community Controlled Health Services Award 2010*[413] took effect on 1 January 2010. The award was subsequently the subject of some major modifications to the classification structure and definitions made as part of the 4 yearly review of modern awards and in response to a number of claims made by the National Aboriginal and Torres Strait Islander Health Worker Association and the HSU. Of most relevance are proposed changes which were sought to the coverage and classification structure by:

- extending the coverage to all employers of Health Workers and health practitioners, with consequential changes to the classification definitions;
- dividing the existing Health Worker Grade 1 classification into two grades;
- reclassifying persons engaged as 'Advanced Health Worker – Practice' and 'Health Practitioners' (previously in Grade 3) to Grade 5 with associated increases to remuneration; and
- establishing a new Grade 6, to align with the SACS employee level 8 classification in the SCHADS Award.

[419] The last two claims were advanced on work value grounds. In a decision issued in 2020,[414] a Full Bench granted the first two claims but rejected the last two. The Full Bench also, relevantly, added new provisions relating to progression between classifications (including current clause 12.3(a)), and changed the name of the award to its current name to reflect the expansion in its coverage.

6.3 Data profile

[420] Data from the Australian Institute of Health and Welfare shows that 48 of 146 ACCHOs employ just over 129 FTE dental assistants. The NHWDS shows that there are 14 dental or oral therapists employed in Aboriginal Health Services or ACCHOs. There is no data indicating the gender makeup of dental assistants and therapists employed by ACCHOs. However, the witness evidence does not indicate that the position is other than that for dental assistants and therapists generally, namely that they are overwhelmingly female. As a whole, ACCHO workforces are female-dominated, with approximately 73 per cent of employees of the organisations affiliated

[413] MA000115. Note that this was later replaced by the ATSIHW Award the subject of this Review, which retained the same award code.

[414] [2020] FWCFB 3827.

with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) being female.

[421] Of all dental assistants employed by ACCHOs, about 41 per cent are Aboriginal or Torres Strait Islander people. Fifty-four per cent of all ACCHO employees are Aboriginal or Torres Strait Islander.[415]

6.4 Parties' positions

[422] The ACTU, together with the HSU, the UWU and the ASU, contends that the work of dental assistants and dental therapists covered by the ATSIHW Award has been the subject of gender-based undervaluation in that:

- these occupations are highly feminised;
- they had not been the subject of a proper work value assessment;
- dental assistant rates of pay under the ATSIHW Award are lower than for their counterparts under the HPSS Award despite equivalent skill requirements and job responsibilities;
- the degree-qualified occupation of dental therapist had never been aligned with the C1 classification; and
- there is a real risk that past pay-setting for these occupations has been affected by assumptions about gender.

[423] The ACTU submitted that, in addition to the skills (including 'invisible' skills) exercised by dental assistants and dental therapists generally, those employees covered by the ATSIHW Award generally exercised a variety of cultural knowledge and skills, for which many received training.

[424] The ACTU contends that the weekly pay rate for a Dental Assistant Grade 4 under the ATSIHW Award, who is Certificate III-qualified, should be increased from $1032.30 to the Caring Skills benchmark rate, with the other rates adjusted to maintain internal relativities, and that the Grade 4 and Grade 6 definitions should be varied to properly recognise them as the Certificate III and Certificate IV rates respectively. In respect of dental therapists, the ACTU identified the classification of Grade 1 Level 2 Dental Therapist as being the appropriate benchmark rate to be adjusted from the existing rate of $1146.00 to the C1(a) benchmark rate of $1525.90, with the other rates adjusted to maintain existing internal relativities.

[425] The VACCHO and the NACCHO supported the position of the ACTU. The VACCHO and NACCHO also made submissions that cultural skills and the level of necessity or desirability of those skills are not adequately or properly described in the ATSIHW Award and that allowances should be introduced recognising cultural load and cultural responsibility and the use of languages.

[426] No party advanced any position contrary to that of the ACTU, VACCHO and NACCHO. The Commonwealth supported the proposition that it was vital to take into account, as part of the concept of 'invisible' skills, whether employees exercised indigenous cultural

[415] Exhibit ATSIHW1 (witness statement of Dr Dawn Casey, 16 October 2024) [16].

skills. Evidence of employees utilising particular cultural competencies is capable of forming part of 'work value reasons' in s 157(2A) of the FW Act, regardless of whether it forms part of the mandatory considerations under s 157(2B).

6.5 Evidence and factual findings

[427] The evidentiary material concerning the work of dental assistants and dental therapists under the ATSIHW Award was uncontested. The Commission itself commissioned a literature review from the Jumbunna Institute for Indigenous Education and Research and University of Technology Sydney Business School (Jumbunna Report) that examined the intersection of gender-based skills and cultural skills under the award and the history of the ACCHO sector and domestic and caring work performed by Aboriginal and Torres Strait Islander women.[416] The VACCHO filed four witness statements as follows:

(1) Jill Gallagher AO[417] is the Chief Executive Officer of the VACCHO since 2001. Dr Gallagher is a proud Gunditjmara woman.

(2) Richelle Johnson[418] is employed as an Aboriginal Health Worker with the Bubup Wilam Aboriginal Child and Family Centre. Ms Johnson is a proud Gunditjmara /Wiradjuri woman. She was previously employed as a dental assistant with the Victorian Aboriginal Health Service (VAHS) from 1990 to 1996 and in private practice from 2002 to 2003, and holds a dental assistant certificate qualification.

(3) Alita Thorpe[419] is a Medical Administrator employed by the VAHS. Ms Thorpe is a proud Gunnai woman from Gippsland and Bindal from North Queensland. She was previously employed by the VAHS as a Dental Assistant from 2016 to 2019. She holds a Certificate III in Dental Assistance.

(4) Stephanie Thow-Tapp[420] is the Executive Manager for Healthy Communities at the VACCHO. Ms Thow-Tapp is a proud Pennemuker/Ngāti Porou woman. Ms Thow-Tapp previously worked as a dental assistant from 2006 to 2012 with the Gippsland and East Gippsland Aboriginal Co-operative (GEGAC) and completed a Certificate III in Dental Assisting in 2008. She subsequently worked for GEGAC as an Aboriginal Health Worker and Practitioner from 2012 to 2018 (during which period she continued to support the Dental team).

[428] The NACCHO filed a witness statement of Dawn Casey,[421] its Deputy Chief Executive Officer since 2016. Dr Casey is a Tagalaka traditional owner from North Queensland. These five witness statements were received into evidence, and none of the witnesses was required for cross-examination. The ACTU also relied on the Charlesworth Report, as relevant to the

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[416] Nareen Young et al, Jumbunna Institute for Indigenous Education and Research and University of Technology Sydney, *A Hidden History of Aboriginal Women's Work in the Community Controlled Health Sector* (Report, 19 November 2024).

[417] Exhibit ATSIHW2 (witness statement of Dr Jill Gallagher AO, 17 October 2024).

[418] Exhibit ATSIHW3 (witness statement of Richelle Johnson, 9 October 2024).

[419] Exhibit ATSIHW4 (witness statement of Alita Thorpe, 9 October 2024).

[420] Exhibit ATSIHW5 (witness statement of Stephanie Thow-Tapp, 7 October 2024).

[421] Exhibit ATSIHW1 (witness statement of Dr Dawn Casey, 16 October 2024).

ATSIHW Award, and the statement of agreed facts it jointly filed with DAPA and the PCA insofar as it described the work, skills and responsibilities of dental assistants generally.[422]

[429] On the basis of this material, we find at the outset that dental assistants and dental therapists covered by the ATSIHW Award exercise the same core duties, skills and responsibilities as their counterparts under the HPSS Award. For the ATSIHW Award we adopt, without repeating, the findings already made in this regard in relation to the HPSS Award.

[430] In addition, it is clear that the roles of dental assistants and dental therapists covered by the ATSIHW Award involve, either explicitly or implicitly, the exercise of Indigenous cultural skills. We have earlier detailed how the classifications of Dental Assistant Grades 2–5 and Dental Therapist Grades 1 and 2 expressly provide that the possession of Aboriginal and/or Torres Strait Islander knowledge and cultural skills—Level 1 is 'desirable'. The labelling of the possession of such skills as being 'desirable' suggests either that, all other things being equal, preference in employment would be given to persons possessing such knowledge and cultural skills, or that employers would place an emphasis on providing training in such skills for those who do not have them. The categories of persons who might possess these skills would include Aboriginal and Torres Strait Islander persons who have acquired them through lived experience, those who have acquired such skills through previous employment in the Aboriginal and Torres Strait Islander health or care sectors, and those who have acquired them through training and experience in their current employment. It may be inferred that employees who have such skills or acquire them in the course of employment would, under the ATSIHW Award, be expected to exercise them as a significant part of the discharge of their employment duties.

[431] The evidence shows that the possession and exercise of Aboriginal and Torres Strait Islander cultural skills, both within the award definition at Level 1 and beyond this, is in fact a common and expected feature of the work of dental assistants under the ATSIHW Award. Without attempting an exhaustive description, such skills include:

- the ability to provide 'culturally safe' care to Aboriginal and Torres Strait Islander people;
- assessing the social and cultural needs, as well as the health needs, of patients;
- advocacy for the cultural, dental and health needs of Aboriginal and Torres Strait Islander people;
- the capacity to train, guide and advise non-Aboriginal and Torres Strait Islander employees on matters concerning Indigenous cultures and sensitivities;
- understanding Aboriginal and Torres Strait Islander concepts of health;
- explaining mainstream concepts of health to Aboriginal and Torres Strait Islander people;
- awareness and understanding of important concepts such as women's business, men's business, sorry business, kinship care, and care for Elders;

[422] Exhibit HPSS120 (statement of facts agreed between Australian Council of Trade Unions, Phlebotomists Council of Australia and Dental Assistants Professional Association, 18 October 2024), especially [49]–[58].

- providing moral and cultural support to Aboriginal and Torres Strait Islander people, including de-escalating tensions between community members in the dental practice;
- awareness of Aboriginal and Torres Strait Islander community politics, family structures and relationships, and community connections and dynamics which may play out at the dental clinic; and
- building trust and relationships with community members.

[432] In addition, the evidence demonstrates that, leaving aside specific cultural skills, dental employees under the ATSIHW Award typically provide a range of support services to patients and their communities in a way which is not a feature of the work of dental employees generally. This may include engagement with community members outside of the workplace regarding health and dental issues, developing culturally appropriate educational resources, arranging transport for patients to and from the dentist and other appointments or services, looking after families and children who attend the dentist with the patient, oral health and preventative care promotion in waiting rooms, responding to patients' 'whole of life' challenges which present on a day-to-day basis, providing food to patients, in addition to, liaising with and providing advice about other medical, mental health or specialist care available to patients as part of the provision of holistic and continuous medical care to Aboriginal and/or Torres Strait Islander people.

[433] The exercise of these skills and responsibilities must be understood in the context of the 'business model' by which ACCHOs operate. Dr Gallagher, the CEO of the VACCHO, described this as follows:[423]

> VACCHO was established 27 years ago in 1996 with the goal of delivering high quality culturally safe health and social services to Aboriginal and Torres Strait Islander communities around Victoria. …
>
> Our 'work' at VACCHO is rooted in an Indigenous worldview that privileges Aboriginal ways of Knowing, Being and Doing. Our work is always undertaken in partnership and rooted in an Indigenous world view[.]
>
> Our role is to support our Members in the delivery of high-quality, culturally safe health and social services to the Aboriginal and Torres Strait Islander Community across the state. We do this by:
>
> (a) Advocating on issues related to Community health and wellbeing;
> (b) Strengthening support networks;
> (c) Increasing workforce development opportunities;
> (d) Partnering with government; and
> (e) Working with mainstream health and wellbeing organisations to embed self-determination and culturally informed approaches across health services and systems.
>
> 'Aboriginal Health' does not simply mean the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community. The health of the individual, family and community are intertwined (see JG-1 p.33). Each Aboriginal community has a unique culture, distinct protocols and practices, language group and history. Under a

[423] Exhibit ATSIHW2 (witness statement of Dr Jill Gallagher AO, 17 October 2024) [25]–[28].

> community-controlled model, the local community identifies its needs, sets its own goals, and makes decisions for the health of that Community.

[434] Dr Gallagher explained that, as part of this model, all employees are expected to be involved in community engagement and outreach:[424]

> Being able to link in with the local Community and contact people's families, contact Aboriginal health work[er]s and practitioners and other supports as needed when someone is in crisis, regardless of your role in an [Aboriginal Community Controlled Organisation] is also what our workers do. This all requires problem solving, interpersonal and good communication skills and often involves extra support after hours, for example chatting to local community members in the supermarket when you are doing your shopping, having people come up to you on the street for help after hours. All this is part of what our workers do to help support Mob. Generally they go well over and above what is written in their position description. This work is about caring for others, having empathy, assessing where someone is at, knowing what they might need and how to get them the support they need.
>
> Workers at our Member organisations are often 'on' 24/7 helping out people in vulnerable and complex situations, particularly when the workers themselves are a part of that local community. Being able to build trust and build relationships with Aboriginal Community is so important and so is being mindful of family structures and relationships.

[435] Dr Gallagher made clear that the above expectations apply equally to dental assistants:[425]

> Dental assistants are an important entry pathway into our sector. These roles extend far beyond oral health. Not only do they do chair-side dental-assisting work, but their role often extends far beyond what is outlined in their CVs. Our dental assistants work in a holistic way which is consistent with the [Aboriginal Community Controlled Organisation] way of working and Aboriginal ways of Knowing, Being and Doing (see JG-1 p.61). They help to make people feel comfortable when they access our services. They support Community needs in all sorts of ways, for example getting them food vouchers when they have no food, or taxi vouchers so they can get to the dentist. They look after families and children when they come to the dentist, having a yarn and helping the patients feel more at ease. They do oral health promotion in the waiting rooms. They help provide a trusting, and culturally safe environment for our Mob. This in turn means our Community will come back, because they feel safe.

[436] Dr Casey's evidence was to similar effect. Ms Thow-Tapp explained how, from her perspective as a Pennemuker/Ngāti Porou woman, she exercised cultural skills when she was a dental assistant:[426]

> My lived experience as an Aboriginal and Torres Strait Islander was important in my role as a dental assistant. Mob working with mob is what ACCOs do well in our in-house services. Being an Aboriginal Community member helps with getting people into the dental service who might not come otherwise. Coming to the dentist is not everyone's favourite thing so having that level of comfort around who is going to be working on their mouth and having that level of trust helps. It's like an extra connection you have with someone, and trust is important.

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[424] Ibid [36]–[37].

[425] Ibid [59].

[426] Exhibit ATSIHW5 (witness statement of Stephanie Thow-Tapp, 7 October 2024) [28]–[31].

> For example, without being an Aboriginal Community member I could not provide the service in the same way because I wouldn't have those relationships built up over time between families and or the same shared experiences of living as Aboriginal people in Bairnsdale.
>
> At GEGAC it helped to know the mob that was from up that way and where they lived and what was important to them. This knowledge came from being Aboriginal and being able to connect with mob on that level. We're all next-door neighbours, we're family and come friends. We also know these things because Bairnsdale is a small town. Being able to build trust and relationships with Community not just in the dental chair, but in the wider community was also key for me. I could do the work that I wanted to do anywhere, not just in any dental clinic— having that strong connection to Community kept me going every day, doing my job.
>
> It was important to be mindful of the different dynamics that were happening in Community. And to be respectful, like if we had our male dentist on and somebody who was a woman wanted only to see the woman dentist, maybe swapping appointments around. Or if an Auntie had a blue with another Auntie, not having them both coming into the waiting room at the same time.

[437] More pithily, Ms Thorpe said:[427]

> Approximately every two months we had people ring up with a bad toothache who would say I've got no way to get into the dentist, but I also don't have any food in the house. And I would say, ['*All right, come in and we'll get this sorted, I'll speak to this person, and I'll speak to that person before you come in, so we have a plan for you for when you come in.*' The people I would speak to included. I might be the first one to speak to the patient, and I'd have to get vouchers, get a taxi if they had kids come in too, go out to the play area and keep the kids occupied. I was a support person.
> …
> Black dental assisting isn't just being at the chair-side. It's about being the communicator, sometimes being a social worker; it's[] not just dental. You have to be a human and not a robot.
>
> It's about knowing how to speak to patients and knowing that they're there to get some treatment and it might be something that they don't fully understand. Teaching the Community about how important it is to look after your teeth and that they should be a part of our holistic health model.

[438] During the proceedings, Dr Gallagher gave evidence that there is an inextricable intersection between Aboriginal and Torres Strait Islander cultural skills and gender-based skills. This was consistent with the findings of the Jumbunna Report, as follows:[428]

> Aboriginal and Torres Strait Islander female health workers and practitioners operate at the intersection between gender-based skills and Aboriginal and Torres Strait Islander cultural skills. Their roles demand both cultural skills for the delivery of safe and culturally appropriate health services to the communities they serve and the gender-based skills that have come to be expected in health and other caring work.

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[427] Exhibit ATSIHW4 (witness statement of Alita Thorpe, 9 October 2024) [25], [31]–[32].

[428] Nareen Young et al, Jumbunna Institute for Indigenous Education and Research and University of Technology Sydney, *A Hidden History of Aboriginal Women's Work in the Community Controlled Health Sector* (Report, 19 November 2024), 22.

[439] The Jumbunna Report also identified that:[429]

> Cultural skills are a valuable asset that Aboriginal health workers bring to prevention and treatment work because they are the bridge between cultural protocols and clinical standards. Further, they 'provide links between communities and health services, and build trust, relationships and culturally appropriate education and care systems'.
>
> (citations omitted)

[440] Ultimately, the Jumbunna Report found that even though there is an expectation that Aboriginal and Torres Strait Islander health and care workers will draw on both cultural and gender-based skill sets, there is great ambivalence around the value of these skills. As we discuss later, these skills, duties and responsibilities make the role of dental assistants under the ATSIHW Award distinct from those of dental assistants under the HPSS Award.

6.6 Gender-based undervaluation

[441] We are satisfied that the dental assistant and dental therapist classifications in the ATSIHW Award have been the subject of historical gender-based undervaluation. As we have found in relation to the HPSS Award, these occupations generally are overwhelmingly female in composition and are thus gender-segregated, their 'invisible' skills have not been taken into account in the fixation of minimum award rates of pay, and assumptions based on gender and the C10 Metals Framework Alignment Approach have been applied in a way which has resulted in an undervaluation of their work. For the ATSIHW Award, the position is even clearer. The award history outlined earlier makes it clear not only that the rates in this award have never been the subject of any proper work value exercise but also that work value considerations critical to employees under this award have been identified without ever having been taken into account in the setting of minimum rates of pay. In particular, when the ATSIHW Award was established in the award modernisation process, the AIRC Full Bench expressly recognised that health services to Aboriginal and/or Torres Strait Islander communities must be delivered in a 'culturally appropriate way'[430] (thus justifying a separate award) and that Health Workers delivering such services are not in the mainstream. Additionally, the AIRC Full Bench added to the classification definitions for dental employees (except for an entry-level dental assistant) reference to the desirability of holding Level 1 Aboriginal and/or Torres Strait Islander knowledge and cultural skills, without ever exploring what this meant for the work value of such employees or taking this into account in setting their minimum rates of pay.

[442] The gendered and racial dimension of this historical undervaluation is well-described in the Charlesworth Report, drawing on research concerning the intersection between income inequality for women and Aboriginal and/or Torres Strait Islander people. Dr Charlesworth said:[431]

> Gender-based undervaluation may be experienced differently by different cohorts of workers creating compounded forms of undervaluation. Inequalities, such as those on the basis of race and migration status, can intersect with gender inequality 'creating overlapping and interdependent systems of discrimination or disadvantage' (WGEA ND).The concept of

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[429] Ibid.

[430] [2009] AIRCFB 865, 188 IR 23 [125].

[431] Exhibit HPSS112 (witness statement of Dr Sara Charlesworth, 18 October 2024) annexure SC-1 [19]–[21].

> 'intersectionality', is about intersecting power dynamics — it 'recognises that the causes of disadvantage or discrimination do not exist independently, but intersect and overlap with gender inequality, magnifying the severity and frequency of the impacts while also raising barriers to support' (CGEPS 2022: 3).
>
> A tangible example is where gender undervaluation may be compounded by Aboriginal and/or Torres Strait Islander status. A recent analysis of the gender pay gap in Victoria, using data from the 2021 Census, examined how employed Aboriginal and non-Aboriginal men and women are distributed across the income distribution, calculating average (mean) gender income (rather than pay) gaps (Austen & Preston 2024). They find that within the non-Aboriginal group, the gender income gap is 22.8%, while among First Nations people in Victoria the gender income gap is 18.5%. However, when the benchmark group is non-Aboriginal men, the gender income gap facing Aboriginal women is 31.2% (Austen & Preston 2024: 40–41). A recent survey of workers employed under the SCHADS Award found that many employees who drew on their Aboriginal and Torres Strait Islander cultural knowledge and community connections in their work felt their knowledge and experience was not well-valued (Cortis & Blaxland 2024: 9). Another study found that Indigenous women were more likely to be expected to carry a high cultural load in employment — 'the extra, often invisible, workload attached to Indigenous employees' — with Indigenous men more likely to have a moderate cultural load. Indigenous women with caring responsibilities had the highest cultural load, 'which may also reflect their feeling of [being] unable to turn down this extra workload out of concern for the stability of their position' (Evans 2021: 9).
>
> In today's multi-cultural Australia, many health and care services rely on the bilingual and bi-cultural skills of non-English-speaking background and Indigenous workers, yet these skills may not be acknowledged and remunerated in industry awards. The Migrant and Refugee Health Partnership (MRHP) argues that 'given the added value that the bilingual and bi-cultural health and care workforce brings to the work of their organisations, it is appropriate that they are adequately and proportionately remunerated, in accordance with industry awards where relevant. For bilingual health practitioners and workers in particular, their language skills risk being exploited as a welcome 'free' resource for their employer' (MRHP 2022: 25).
>
> (footnotes omitted)

[443] For dental assistants under the ATSIHW Award, this has meant that their rates of pay have been set on the basis of an alignment of the rate of pay for the Certificate III-qualified level with the C10 rate, without any account having been given to fundamental aspects of their work which are inapplicable to C10-classified employees under the Manufacturing Award. For dental therapists under the ATSIHW Award, as with health professionals under the HPSS Award (including dental therapists), there has never been an alignment with the C1 rate in the Metals Framework, which constitutes gender-based undervaluation for the reasons earlier discussed.

6.7 Award amendments to rectify gender-based undervaluation — *provisional* views

[444] As earlier noted, the ACTU, with the support of the NACCHO and the VACCHO, proposed that, with respect to dental assistants, the identified gender-based undervaluation should be rectified by adjusting the existing Grade 4 minimum rate to align it with the Caring Skills benchmark rate and then adjusting the minimum rates for the other grades to maintain the relativity to Grade 4. This approach would result in a wage increase of 23 per cent for employees at all grades.

[445] We reject this approach for two reasons. The first is that we do not consider that dental assistants exercise 'invisible' or 'caring' skills of a kind or to a degree comparable to PCWs in the aged care sector. We have already discussed this issue with respect to the core skills of dental assistants under the HPSS Award, and it is not necessary to repeat our analysis and conclusions here. The additional cultural skills exercised by dental assistants under the ATSIHW Award undoubtedly include some 'caring' elements, but they are not 'invisible' since they are explicitly described in the definition of 'Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 1' in clause A.1.1. Further, while the exercise of these duties is regularly required and a significant part of the role of dental assistants, the evidence does not demonstrate that it is integral to the entirety of their functions in the same way as for PCWs in aged care. The position is more analogous to some of the categories of indirect care workers discussed in the *Stage 3 Aged Care decision* who are required to exercise 'the skills of interpersonal and contextual awareness, verbal and non-verbal communication and emotion management' as a 'regular and fundamental part of their daily duties'[432] but, unlike PCWs, do not do so 'for nearly the entire duration of their shifts, every shift'.[433]

[446] The second reason is that we do not consider that the current classification structure is fit for purpose. The characterisation of cultural skills in the classification definitions as being 'desirable' does not, for the reasons stated, represent the reality of the work of dental assistants in which the exercise of such skills is a significant feature of their roles. Further, the classification definitions do not appropriately recognise and reward the acquisition of qualifications so that, under the current structure, a dental assistant without qualifications may, on an annual incremental basis, reach the same pay levels as a dental assistant with a Certificate III or IV qualification. More fundamentally, we do not consider the categorisation of dental assistants as such in a manner entirely separate from Health Workers does justice to what the evidence demonstrates about their role in the delivery of holistic community care to Aboriginal and Torres Strait Islander people. This significant feature of their role distinguishes them from dental assistants covered by the HPSS Award and justifies a different approach to remedy the gender-based undervaluation we have found to exist.

[447] Our *provisional* view is that dental assistants should be integrated into the classification structure for Health Workers in a way that properly recognises the acquisition of occupational qualifications and the exercise of cultural skills. We envisage that this would occur as follows:

Health Worker Classification	Criteria	Weekly rate of pay ($)
Grade 2 Level 1	No qualifications – 1st year	1055.10
Grade 2 Level 2	No qualifications – 2nd + years	1091.20
Grade 3 Level 1	Certificate III or assessed equivalent – 1st year	1148.20
Grade 3 Level 2	Certificate III or assessed equivalent – 2nd year	1208.30
Grade 3 Level 3	Certificate III or assessed equivalent – 3+ years	1267.00
Grade 4 Level 1	Certificate IV or assessed equivalent – 1st year	1302.40

[432] [2024] FWCFB 150, 331 IR 137 [267].

[433] Ibid [227].

Health Worker Classification	Criteria	Weekly rate of pay ($)
Grade 4 Level 2	Certificate IV or assessed equivalent – 2nd year	1337.40
Grade 4 Level 3	Certificate IV or assessed equivalent – 3+ years	1368.20

[448] Existing dental assistants would translate from their current classifications to the new classifications as follows:

Current Classification	Proposed Health Worker Classification	Increase (%)
Unqualified		
Grade 1	Grade 2 Level 1	12.9
Grade 2 — less than 12 months' service	Grade 2 Level 1	10.7
Grade 2 — 12 or more months' service	Grade 2 Level 2	14.5
Qualified with a Certificate III or assessed equivalent or unqualified		
Grade 3	Grade 3 Level 1	18.2
Grade 4	Grade 3 Level 2	17.0
Grade 5	Grade 3 Level 3	18.7
Qualified with a Certificate IV		
Grade 3	Grade 4 Level 1	34.0
Grade 4	Grade 4 Level 2	29.6
Grade 5	Grade 4 Level 3	28.2

[449] For dental/oral therapists, our *provisional* view is that we should take the same approach as for their equivalents under the HPSS Award. The current classification structure for dental therapists is overcomplicated for the small numbers involved and is based to an excessive degree on increments for length of service. The utility of the Grade 2 classification, and the practical distinction between it and Grade 1, is unclear. We consider that an appropriate classification structure would be as follows:

Classification	Weekly rate of pay ($)
Level 1: Entry Level–1st year	1449.00
Level 2: 2nd–3rd year	1525.90
Level 3: 4th–6th year	1661.20
Level 4: 7th year +	1796.50

[450] Existing employees would translate to the new classification structure in accordance with the following table:

Current classification	Proposed new classification	Increase (%)
Grade 1 Level 1 (entry)	Level 1	29.76
Grade 1 Level 2 (2nd year)	Level 2	33.15
Grade 1 Level 3 (3rd year)	Level 2	29.01
Grade 1 Level 4 (4th year)	Level 3	35.23

Current classification	Proposed new classification	Increase (%)
Grade 1 Level 5 (5th year)	Level 3	28.88
Grade 1 Level 6 (6th year)	Level 3	23.19
Grade 1 Level 7 (7th year)	Level 4	28.86
Grade 2 Level 1	Level 4	27.05
Grade 2 Level 2	Level 4	24.25
Grade 2 Level 3	Level 4	21.66
Grade 2 Level 4	Level 4	19.53
Grade 2 Level 5	Level 4	16.88

[451] Upon translation, existing dental/oral therapists would then progress through the classification structure in accordance with the service-based progression in the new classification structure.

[452] Finally, some parties have made submissions in these proceedings that an allowance should be introduced recognising the cultural load and cultural responsibility of employees covered by the ATSIHW Award and/or the use of languages. In addition, some submissions have been made that cultural skills and the level of necessity or desirability of those skills are not adequately or properly described in the ATSIHW Award. We consider that these matters are outside of the scope of these proceedings in that they likely relate to all employees covered by the ATSIHW Award and may not be matters that relate to gender-based undervaluation. In any event, we did not have sufficient evidence before us to reach a conclusion on these matters. These claims may be pursued further by separate application.

[453] We propose to provide interested parties an opportunity to comment on the *provisional* views stated above including, if they were implemented, what arrangements should be made for the operative date of any variation and/or any timetable for phasing-in of the outcome, noting that ACCHOs are wholly or primarily funded by the Commonwealth.

7. CHILDREN'S SERVICES AWARD 2010

7.1 Classifications and minimum wage rates

[454] The CS Award covers employers in the 'children's services and early childhood education industry' and their employees in the classifications listed in Schedule B of the award.[434] This coverage operates subject to certain exceptions, including that it does not, in effect, apply to schools, higher education and local government employers. The 'Children's services and early childhood education industry' is defined in clause 3.1 to mean:

> … the industry of long day care, occasional care (including those occasional care services not licensed), nurseries, childcare centres, day care facilities, family based childcare, out-of-school hours care, vacation care, adjunct care, in-home care, kindergartens and preschools, mobile centres and early childhood intervention programs.

[434] Clause 4.1.

[455] The classifications, pay points and weekly and hourly minimum wage rates are set out in clause 14.1 of the CS Award. Not including the hourly rates, they are as follows:[435]

Classification		$ per week
Support Worker		
Level 1.1	On commencement	915.90
Level 2.1	On commencement	944.00
Level 2.2	After 1 year	975.00
Level 3.1	On commencement	1032.30
Children's Services Employee		
Level 1.1	On commencement	915.90
Level 2.1	On commencement	944.00
Level 2.2	After 1 year	975.00
Level 3.1	On commencement	1032.30
Level 3.2	After 1 year	1067.90
Level 3.3	After 2 years	1101.50
Level 3.4 (Diploma)		1162.40
Level 4A.1	On commencement	1101.50
Level 4A.2	After 1 year	1116.90
Level 4A.3	After 2 years	1132.10
Level 4A.4	After 3 years	1148.00
Level 4A.5	After 4 years	1163.30
Level 4.1	On commencement	1216.00
Level 4.2	After 1 year	1234.60
Level 4.3	After 2 years	1253.00
Level 5A.1	On commencement	1271.60
Level 5A.2	After 1 year	1290.00
Level 5A.3	After 2 years	1308.30
Level 5.1	On commencement	1271.60
Level 5.2	After 1 year	1290.00
Level 5.3	After 2 years	1308.30
Level 5.4		1313.00
Level 6A.1	On commencement	1466.30
Level 6A.2	After 1 year	1484.60
Level 6A.3	After 2 years	1502.80
Children's Services Employee—Director		
Level 6.1	On commencement	1466.30
Level 6.2	After 1 year	1484.60
Level 6.3	After 2 years	1502.80
Level 6.4	On commencement	1558.90
Level 6.5	After 1 year	1573.20
Level 6.6	After 2 years	1592.00
Level 6.7	On commencement	1611.00
Level 6.8	After 1 year	1629.40
Level 6.9	After 2 years	1647.80

[435] This table also excludes the classifications and weekly rates for CSE Levels 3A.1 and 3A.2 because they constitute a preserved classification from a pre-modern Western Australian award.

[456] The notes to clause 14.1 explain that:

(1) The references to a year or years of service are to industry service.
(2) Level 5.4 sets the minimum wage rate for an Assistant Director who holds an 'Advanced Diploma (AQF Level 6/3 year qualified)'.

[457] Progression between levels within a classification is not automatic. Clause 14.2(a) provides that progression is subject to:

- competency at the existing level;
- 12 months' experience at that level (or 24 months for employees employed for 19 hours or less per week) plus in-service training as required; and
- demonstrated ability to acquire the skills necessary for advancement to the next pay point.

[458] The definitions for the CSE classifications are set out in clause B.1 of Schedule B. In broad summary:

- Level 1 is an entry-level classification for a new employee in training who has no formal qualifications, is under direct supervision at all times and performs basic children's services.

- Level 2 is an employee who has completed 12 months at Level 1, or holds a Certificate II, or in the opinion of the employer has sufficient knowledge and experience to perform the work within the scope of this level.

- Level 3 is an employee who has completed a Certificate III or equivalent, or in the opinion of the employer has sufficient knowledge and experience to perform the work within the scope of this level. An employee with a Diploma in Children's Services or equivalent and who demonstrates the application of skills and knowledge acquired beyond the competencies required for AQF Certificate III in the ongoing performance of their work must be paid at least the Level 3.4 rate.

- Level 4A is an employee who has not obtained the qualifications required for a Level 4 employee who performs the same duties as a Level 4 employee.

- Level 4 is an employee who has completed a Diploma in Children's Services or equivalent (such as a Certificate IV in Out of School Hours Care (OSHC)) who is appointed as the person in charge of a group of children in the age range from birth to 12 years or an employee who is appointed as an Authorised Supervisor (as defined in the *Children and Young Persons (Care and Protection) Act 1998* (NSW)).

- Level 5A is an employee who has not obtained the qualification required for a Level 5 employee who performs the same duties as a Level 5 employee.

- Level 5 is an employee who has completed a Diploma in Children's Services or equivalent and is appointed as an Assistant Director of a service, a Children's

Services Co-ordinator, a Family Day Care Co-ordinator, a Family Day Care Trainee Supervisor or a School Age Care Co-ordinator.

- Level 6A is an employee who has not obtained the qualification required for a Level 6 employee who performs the same duties as a Level 6 employee.

- Level 6—Director is an employee who holds a relevant degree or a three- or four-year Early Childhood Education qualification, or an Advanced Diploma, or a Diploma in Children's Services, or a Diploma in Out-of-Hours Care, or is otherwise a person possessing such experience, or holding such qualifications deemed by the employer or the relevant legislation to be appropriate or required for the position, and who is appointed as the director of a service or a qualified Co-ordinator. The applicable rate of pay varies depending upon the number of children which a service is licensed to accommodate.

[459] The definitions for the Support Worker classifications are set out in clause B.2 of Schedule B. It is not necessary to set out or summarise the definitions except to say that a person assisting a qualified cook or engaging in basic food preparation or the duties of a kitchen hand will be graded at Level 1 for the first 12 months at the most and thereafter at Level 2, and a Level 3 employee must possess a Certificate III or equivalent skills.

[460] It may be observed that the minimum wage rates for a CSE Level 3.1 and a Support Worker Level 3.1, both of which require a Certificate III qualification or equivalent, are set at the C10 rate. The minimum wage rate for a diploma-qualified CSE (Level 3.4) is, at $1162.40 per week, significantly below the C5 rate in the Manufacturing Award of $1207.80 per week for which a diploma qualification is required.

[461] In addition to the wage rates prescribed by clause 14, clause 15 provides for a number of additional allowances. Most relevantly:

- Clause 15.6 provides for an all-purpose Qualifications allowance of 5 per cent of the weekly rate for CSE Level 5.4 payable to a Director or Assistant Director who holds a Graduate Certificate in Childcare Management or equivalent.
- Clause 15.8 provides for an allowance of $4412.84 per annum (pro-rated on a daily basis for part-time employees) for an employee required to act as Educational Leader.

7.2 Award history

[462] The first federal award applicable to private sector early childhood education and care (ECEC) appears to have been the *Kindergartens and Child Care Centres, etc. (ACT) Award 1974*.[436] This award covered the 'Kindergarten and Child Care Industry', defined in clause 3(b) to include:

> … any centre used for cultivating the normal aptitude for exercise and/or play and/or observation and/or imitation and/or construction including the emphasis on a necessity for social

[436] [1974] CthArbRp 1983, 163 CAR 89, Print C3836.

> training for children of school age or under and/or a centre used for the proper supervision and control of children.

[463] The award contained classifications for a 'Child Care Aide', meaning an employee who had completed a technical college course in childcare or equivalent, an 'Assistant' performing general kindergarten or childcare duties in an establishment without a Child Care Aide, a 'Helper' (only where a Child Care Aide or an Assistant is also employed) and a Kitchen Hand. There is no indication on the record that this award was made on the basis of any work value assessment, and it likely represents a bargained settlement of an industrial dispute.

[464] This award was followed by the *Child Care Industry (Northern Territory) Award, 1982*,[437] This award covered employees:[438]

> …employed in the performance of all work in or in connection with, or incidental to, the industries or industrial pursuits of child minding, day nursery and pre school kindergartens other than persons employed as clerks.

[465] This award likewise contained classifications for child care aides, child care assistants, child care helpers and kitchenhands. Again, this award was not made on the basis of any recorded work value assessment, and it likely represents the bargained outcome of an industrial dispute.

[466] Outside of the Territories, what was then known as the childcare and kindergarten industry was regulated by State awards.

[467] As described in the Stage 2 Report, the ACT and Northern Territory (NT) childcare awards[439] were the subject of a limited work value review in a Full Bench decision of the AIRC issued on 14 September 1990[440] (*1990 Child Care decision*). This followed an Anomalies Conference which occurred in 1988 and an inquiry conducted by a single member of the AIRC (Laing C). The *1990 Child Care decision* records that:[441]

> Although the Inquiry conducted by Commissioner Laing was directly relevant only to the two Federal awards, the ACTU and the FMWU took the view that the issues involved were fundamental to the child care industry in Australia generally. As a consequence of this approach, very lengthy proceedings were necessary to deal with the large number of witnesses who were called and the voluminous written material which was presented; there were also thirteen inspections in Victoria, the Australian Capital Territory and the Northern Territory.

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[437] [1982] CthArbRp 1206, 275 CAR 25, Print E9556.

[438] Ibid 26 (clause 3(a)).

[439] By this point they were the *Child Care Industry (Australian Capital Territory) Award 1985*, Print G0220 and *Child Care Industry (Northern Territory) Award 1986*, Print G4877.

[440] *Re Child Care Industry (Australian Capital Territory) Award 1985; Re Child Care Industry (Northern Territory) Award 1986* [1990] AIRC 996, Print J4316.

[441] Ibid 1.

[468] The Full Bench said in respect of the then-applicable wage rates set by those ACT and NT awards:[442]

> Little comment on [childcare] wage levels is necessary. It is enough to say that members of this industry's workforce, from whom the community expects so much, have been disadvantaged. They form part of that class of lower[-]paid workers whose position was recognised by the decision in the National Wage Case March 1987 and who qualify for special attention according to the principle providing adjustment of minimum rates which was published by the Full Bench in the National Wage Case August 1989. The awards fall into the category to which the national wage Full Bench referred when it stated 'there is no doubt that the current award wage system contains irregularities in rates of pay which must be dealt with.'
>
> A further indication of the unsatisfactory state of the awards may be seen in the fact that rates of pay were never varied to give effect to the adjustment of 4% which was available under the principles published by the Full Bench in the National Wage Case March 1987, although the first increase of 3% as a structural efficiency increase was approved on 22 December 1989…

[469] The Full Bench noted that the ACTU and the relevant union had reached agreement with employer groups about a new classification structure and agreement with some employers about new wage rates. The Full Bench referred to the 'guidance' provided by the *National Wage Case August 1989* as to appropriate relativities in award rates of pay (i.e. the C10 Metals Framework Alignment Approach), and said as to the partial agreement on wages:[443]

> … the agreement generally recognised as appropriate a comparison of the Child Care Worker Level 3 after one year's service with the Engineering Tradesperson Level 1 in the Metal Industry Award. It was not suggested, of course, that these classifications could be 'compared' in the conventional sense, but by reference to the training requirements for each classification, a guide was found to the level of competence which must be attained. Both classes of worker must hold a certificate which is awarded after completion of a course provided by a College of Technical and Further Education.

[470] However, the Full Bench went on to find, in respect of the benchmark classification of Child Care Worker Level 3 after one year's service, that the qualification required at this level was in fact higher than that for C10:[444]

> In order to conform with the National Wage Case guidelines, the parties adopted as a basis for comparison the training experience which the two classifications of worker must undertake. It has been shown that both must have work experience to complement their academic studies and both are taught a range of skills which must be applied in circumstances calling for the exercise of responsibility. The evidence showed also that the student in child care studies will have had approximately twice the number of hours of academic training as will the student pursuing the trade certificate course in the metal and engineering industry. Finally, we note that two[-]year courses in child care studies are rated in the Register of Australian Tertiary Education at levels higher than the levels for which certificate trade courses are accredited. …

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[442] Ibid 2.

[443] Ibid 4.

[444] Ibid 6.

[471] Nonetheless, the Full Bench accepted that the proposed new wages structure based on the alignment of the benchmark rate with the C10 rate was appropriate:[445]

> We consider that the process followed by the parties is an acceptable means of carrying out the exercise required to set appropriate minimum classification rates and supplementary payments; it is to be noted that this exercise was carried out as an integrated process with the exercise in structural efficiency. …
>
> … the classification structure in annexure A and the rates of pay set out above are an appropriate outcome of the exercise which the parties have undertaken to review conditions of employment and to provide proper levels of remuneration for the workers in the industry. We approve the classifications and the wage levels.

[472] The result of this was that childcare employees under the ACT and NT awards who held an Advanced Certificate or Associate Diploma (that is, what are now AQF Level 4 qualifications) were awarded wage rates below the C7 rate in the C10 Metals Framework notwithstanding that their qualifications should have aligned them with that rate.

[473] Following the abolition of the Victorian arbitration and awards system in 1993, the first private sector childcare award for Victoria was made by consent in 1995. The *Children's Services (Victoria) Award 1995*[446] adopted the classification structure and rates of pay from two former Victorian-system awards, the *Mothercraft Nurses Award* and the *Day Child Care Workers Award*. The rates in these former Victorian awards had, in turn, reflected the *1990 Child Care decision* discussed above,[447] and thus incorporated the anomalous application of the C10 Metals Framework Alignment Approach we have identified.

[474] The next significant development was the *ACT Child Care decision*[448] issued on 13 January 2005, which was discussed in the *Stage 3 Aged Care decision* at [90]–[92] and to which we have referred in the introduction to this decision. The *ACT Child Care decision* concerned applications by the Australian Liquor, Hospitality and Miscellaneous Workers Union to vary the classification structure and wage rates in ACT and Victorian childcare industry awards[449] on work value grounds. In determining the matter, the AIRC Full Bench was bound by the then-applicable wage-fixing principles which, in respect of work value, only permitted wage adjustments based on demonstrated change from a datum point not earlier than the second structural efficiency adjustment allowable under the *National Wage Case August 1989* and in accordance with strict criteria. As observed in the *Stage 3 Aged Care decision* at [90], the Full Bench in the *ACT Child Care decision* was not permitted by the wage-fixing principles to engage in an *ab initio* consideration of the value of the work of the employees covered by the two awards. After considering extensive evidence, the Full Bench found that there had been significant changes to the children's services sector and to the work value of employees in the sector, which it summarised as follows:[450]

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[445] Ibid 6, 8.

[446] AP840807.

[447] See *ACT Child Care decision* [2005] AIRC 28, PR954938 [126]–[130].

[448] [2005] AIRC 28, PR954938.

[449] *Child Care Industry (Australian Capital Territory) Award 1998* [AW772250] and *Children's Services (Victoria) Award 1998* [AW772675].

[450] [2005] AIRC 28, PR954938 [364].

6.2 Children's services sector

1. There has been significant growth in the children's services sector since 1999.

2. Between 1999 and 2002 the average number of children per service has increased markedly in all service types. The capacity utilisation of child care services has also increased, and utilisation patterns of the users of long day care have changed over time. For example, in 1997 in Victoria some 63 per cent of child care attendance hours in private long day care centres were less than 30 hours per week. By 2002 this had increased to 73 per cent.

3. The growth in the private long day care component of the children's services sector has been particularly significant in recent years and it is the dominant means of providing long day care in Victoria.

4. In recent years publicly listed corporate chains have become a significant presence in the long day care component of the sector.

6.3 Work value considerations

6.3.1 General

1. The nature of the work of child care workers and the conditions under which that work is performed has changed over time.

6.3.2 Shift in utilisation patterns

1. The utilisation patterns of the users of long day care have changed over time.

2. This change in utilisation patterns has increased the workload of child care workers.

6.3.3 Supervision and training of workers

1. Since the introduction of the AQF system children's services training packages have incorporated on-the-job training and assessment.

2. This development has increased the work of team leaders and others who supervise employees undertaking further study.

6.3.4 Programming

1. Changes in programming and documentation requirements have increased the workload of child care workers and have, to a limited extent, increased their accountability and responsibility.

6.3.5 Children from non-English speaking backgrounds

1. Children from culturally diverse backgrounds comprised 13 per cent of users in long day care schemes as at May 2002 (compared to 11 per cent in August 1997).

2. Dealing with children from differing cultural backgrounds creates particular challenges for child care workers.

6.3.6 Children with special needs or 'at risk' children

1. The evidence suggests that there has been an increase in the number of children with special needs or `at risk' children in childcare centres, and that this has impacted on the work undertaken by childcare employees in all services.

6.4 From child minding to child development

1. The conceptualisation of children's services has changed over time from the notion of child minding or child care to one of early child development, learning, care and education.

2. Recent neuroscience research into brain development supports the fundamental influence of the early years of children's development.

3. The available research supports the proposition that there are clear links between the provision of early childhood programs and children's subsequent achievement. This has implications not just for individual opportunities but also for broad social outcomes such as mental health and crime.

4. The available research supports the proposition that the provision of quality child care is directly related to better intellectual/cognitive and social/behavioural outcomes in children. The quality of care, and hence outcomes for children, is positively related to the level of the qualifications of the staff working with children.

> 5. The available research suggests that money directed to the early years of children's development results in positive long[-]term outcomes and is cost effective.
> 6. The shift in the conceptualisation of children's services towards early childhood development, learning, care and education has increased community expectations of child care workers and has led to changes in their training and development.
>
> **6.5 Accreditation**
> 1. Accreditation has increased the workload of child care workers and has, to a limited extent, increased their accountability and responsibility for their work.
>
> **6.6 Qualifications and training**
> 1. Child care workers have a strong commitment to continuing professional development.
> 2. There have been significant changes to the structure and content of the courses offered in children's services since 1990.
> 3. The current Certificate III in Child Care bears little relationship to the former TAFE Child Care Practices Certificate. A number of new modules have been developed in response to changes in community expectations and the regulatory environment.
> 4. The Diploma of Child Care replaced the Associate Diploma in 1997. It contains a number of new modules and is competency[-]based.
> 5. There is a general preference in the industry for employing qualified staff or staff undertaking further study, and the evidence supports a finding that undertaking further training in children's services has a positive impact on work value.
>
> **6.7 Recruitment and retention**
> 1. The child care sector is facing a critical shortage of qualified staff and this impacts on the ability of child care services to meet minimum legislative and quality standards.
> 2. The shortage of qualified staff has the potential to jeopardise the future of quality child care in Australia.
> 3. Limited career path options and low pay have contributed to the current recruitment and retention problems.

[475] The Full Bench was satisfied that these changes in the nature of the work constituted a significant net addition to work requirements within the meaning of the work value principle.[451] It also stated the following conclusion concerning the proper fixation of rates for the key classifications in the two awards:[452]

> The second broad conclusion concerns the proper fixation of rates for the key classification levels in the child care awards. In our view the rate at the AQF Diploma level should be linked to the C5 level in the *Metal Industry Award*. Further, it is appropriate that there be a nexus between the CCW level 3 on commencement classification in the *ACT Award* (and the certificate III level in the *Victorian Award*), and the C10 level in the *Metal Industry Award*.

[476] In determining this outcome, the Full Bench made it plain that it regarded itself as constrained by the established principles concerning the proper fixation of award minimum wage rates and indicated that, but also indicated that it might have determined a different outcome absent this constraint:[453]

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[451] Ibid [366].

[452] Ibid [367].

[453] Ibid [372].

> Prima facie, employees classified at the same AQF levels should receive the same minimum award rate of pay unless the conditions under which the work is performed warrant a different outcome. Contrary to the employer's submissions the conditions under which the work of child care workers is performed do not warrant a lower rate of pay than that received by employees at the same AQF level in other awards. Indeed if anything the opposite is the case. Child care work is demanding, stressful and intrinsically important to the public interest.
>
> (underlining added)

[477] We repeat and adopt the following statement made in the *Stage 3 Aged Care decision* about the approach taken in the *ACT Child Care decision*:[454]

> A Full Bench of this Commission observed in *Application by United Voice and the Australian Education Union* [[2018] FWCFB 177, 274 IR 1]... that the *ACT Child Care decision*, insofar as it compared the work of [ECEC] workers and employees under the Metal Industry Award, only considered the qualifications and training required and did not purport to otherwise compare the nature of the work or the level of skill and responsibility involved in performing the work. This is, we consider, illustrative of the way in which the C10 Metals Framework Alignment Approach constrained the proper work value assessment of female-dominated work by requiring, as at least as the prima facie position, alignment with the classifications for male-dominated work in the Metal Industry Award based on a bare comparison of training qualifications. The Full Bench in the *ACT Child Care decision* made it tolerably clear, in our view, that unconstrained by the C10 Metals Framework Alignment Approach it would have assessed the key classifications in the [ECEC] awards under consideration as having higher work value than the identified equivalents in the Metal Industry Award.
>
> (citations omitted)

[478] The classifications and wage rates in the ACT and Victorian awards were subsequently varied consistent with the conclusions stated in the *ACT Child Care decision*. The variations included transitional phasing-in arrangements. The phasing-in process was disrupted by the enactment of the Work Choices Act, which meant that the alignment between the Level 4 diploma-level classification and the C5 rate was not fully achieved.

[479] As explained in the Stage 2 Report, in the award modernisation process the AIRC Full Bench derived the classifications and wage rates in the CS Award from the ACT and Victorian awards the subject of the *ACT Child Care decision* to the point that the contemplated phasing-in process had been implemented.

[480] When it published the exposure draft for the CS Award on 25 September 2009, the AIRC award modernisation Full Bench said in relation to family day care:[455]

> We publish a draft Children's Services Award 2010. The classification structures for childcare employees have, in recent times, been the subject of work value assessments by the Commission and this is reflected in the exposure draft. The structure includes family day care co-ordinators. We recognise that these classifications may also be included in the exposure draft for the Social, Community, Home Care and Disability Services Industry Award 2010. Award coverage will depend on the industry of the employer.

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[454] [2024] FWCFB 150, 331 IR 137 [92].

[455] [2009] AIRCFB 865, 188 IR 23 [93]–[94].

> We have not included family day care workers in the draft award. The only award currently covering these workers is confined in its operation to the Australian Capital Territory.

[481] The family day care classifications referred to in the above statement remained in the CS Award when it was made.

7.3 Profile of the ECEC sector

[482] The sector covered by the CS Award is usually described as the ECEC sector. The ECEC sector consists of services operating centre-based day care (CBDC), preschools, long day care, family day care and OSHC. Ninety-seven per cent of ECEC services are CBDC or OSHC services. ECEC services are regulated by the *Education and Care Services National Law Act* as enacted (largely uniformly) in each State and Territory, the *Education and Care Services National Regulations* and the National Quality Framework (NQF). Seventy per cent of CBDC providers are for-profit services, while a lower percentage of other types of ECEC service are for profit. ECEC services are required to be approved by State/Territory regulatory authorities under the NQF. The approval will specify the maximum number of children for which the service can provide care. The quality of ECEC services is assessed in accordance with the National Quality Standards established as part of the NQF.

[483] The NQF sets minimum qualification and educator-to-child ratio requirements for ECEC services; educators that count for ratio purposes are employees working directly with children in that they are physically present with them and directly involved in providing education and care to them. The required ratios vary depending upon the age of the children involved and the state or territory in which the service operates. Educators' minimum required qualifications are different for the various types of ECEC service. For CBDC services, at least 50 per cent of educators who are required to meet the ratio requirements must have or be actively working towards an approved diploma-level ECEC qualification or higher. All other educators must hold or be actively working towards an approved Certificate III ECEC qualification. Services with preschool-aged children are also required to make an early childhood teacher available dependent on the number of children in attendance. Such teachers are covered by the EST Award. There are no national requirements for ratios or qualifications for OSHC services, but there are applicable State and Territory requirements. In family day care, educators must hold an approved Certificate III qualification or higher. Under the CS Award, educators would most commonly be mapped to the classifications of CSE Levels 1–4, and our subsequent references to 'Educators' are to employees classified at those levels only.[456]

[484] ECEC services for children below school age deliver an educational program in accordance with the Early Years Learning Framework (EYLF). The EYLF was first introduced in 2009 and updated in 2022. The educational program under the EYLF operates by providing a structured, evidence-based approach to early childhood education that emphasises play-based learning, intentional teaching, and collaboration with families and communities. The education program incorporates play-based learning and intentionality, five specified learning outcomes, assessment and evaluation, and collaboration between educators, children and families. In

[456] However, we note that Assistant Directors (CSE Level 5) and Directors (CSE Level 6) who hold appropriate ECEC qualifications would also be counted towards the NQF educator-to-child ratio requirements when working 'on the floor' directly with children: see, e.g. exhibit CS25 (witness statement of Gemma Lewis, 9 October 2024) [15]; exhibit CS26 (reply witness statement of Gemma Lewis, 28 November 2024) [7].

OSHC, the 'My Time, Our Place' Framework applies to support educators in extending and enriching learning for school-aged children.

[485] The usual employment roles in CBDC services are those of:

- Director (mapping to CSE Levels 6 and 6A);
- Assistant Director (CSE Levels 5 and 5A);
- Early Childhood Teacher (EST Award);
- Lead Educator—diploma-qualified or equivalent (CSE Level 4);
- Educational Leader (CSE Level 3 or 4 and Educational Leader allowance in clause 15.8);
- Educator with Certificate III or diploma qualification or equivalent (CSE Level 3 or 4);
- Educator without a Certificate III qualification (CSE Level 1 or 2);
- Cook; and
- Other support staff performing clerical, cleaning, laundry, gardening, driving and maintenance functions — although these functions may be outsourced.

[486] The Stage 1 Report found the occupation group of 'Child Carers' within the industry class of 'Preschool Education' is 97.2 per cent female, while the same occupation in the industry class of 'Child Care Services' is 96 per cent female. This is broadly consistent with the 2021 ECEC National Workforce Census, which found that 95.9 per cent of workers in CBDC services and 81.2 per cent of workers in OSHC services are female.

[487] The ECEC sector is significantly reliant on Commonwealth Government funding. The main funding mechanism is the Child Care Subsidy (CCS), which is paid directly to ECEC services, with parents paying any 'gap' between the CCS amount and the service's fee out-of-pocket. The CCS rate varies dependent on household income, the number of children in care, a parental activity test, and an hourly rate cap. There is also an Additional Child Care Subsidy, which provides fee assistance for vulnerable or disadvantaged households and children.

[488] As at September 2023, the ECEC sector was award-reliant to a significant degree. Pay rates for 57.8 per cent of employees in the ECEC sector were derived from the applicable award (the CS Award or the EST Award), and pay rates for a further 20.9 per cent were between 0.01 per cent and 10 per cent above the award rate of pay.[457] However, this position has since altered as a result of two intersecting developments. The first is that, on 27 September 2023, the Commission granted an authorisation for supported bargaining in the ECEC sector.[458] This ultimately led to the Commission approving the *Early Childhood Education and Care Multi-Employer Agreement 2024-2026*[459] (ECEC Agreement) on 10 December 2024, with the ECEC Agreement taking effect from 17 December 2024. The second is that, pursuant to the *Wage Justice for Early Childhood Education and Care Workers (Special Account) Act 2024* (Cth) (Wage Justice Act), which commenced on 11 December 2024, the Commonwealth has established the Early Childhood Education and Care Worker Retention Payment (Retention

[457] *Application by United Workers' Union, Australian Education Union and Independent Education Union of Australia* [2023] FWCFB 176 [47].

[458] Ibid.

[459] [2024] FWCFB 455, AE527165.

Payment) scheme. Under this scheme, employers may access the funding mechanism constituted by the Retention Payment, provided they have entered into a 'compliant workplace instrument' prescribing minimum wage rates at least 10 per cent above the CS Award rates for CSEs (or the EST Award in the case of ECEC teachers) from 2 December 2024 and a further 5 per cent from 1 December 2025. It is also a condition of the Retention Payment that employers adhere to the 'Fee Constraint Condition', the effect of which is to cap the increases in fees which providers can charge. The ECEC Agreement is designed to be a compliant workplace instrument for the purpose of the Retention Payment scheme, and consequently provides for the wage increases required by the scheme. The ECEC Agreement is the primary mechanism giving effect to the Retention Payment scheme, and as at 15 April 2025,[460] applies to 289 employers and approximately 40,000 employees in the sector. It is anticipated that a substantial number of additional employers will, in the near future, seek to be covered by the ECEC Agreement by way of applications under s 216AA of the FW Act. The effect of this will be to substantially reduce award reliance in the ECEC sector.

7.4 Parties' positions

[489] The position of the ACTU and the UWU is that the CS Award has been subject to gender-based undervaluation, and that this should be rectified by increasing the minimum pay rate for a Certificate III-qualified CSE (Level 3.1) to the Caring Skills benchmark rate of $1269.80 (including the subsequent *AWR 2024 decision* adjustment), and by increasing the rate for a degree-qualified Director (Level 6.1) to the C1(a) benchmark rate of $1525.90. They submitted that other classifications should be adjusted accordingly to maintain internal relativities.

[490] The ACTU submitted that gender-based undervaluation has occurred because the pay rates in the CS Award have been aligned with the masculinised benchmarks in the C10 Metals Framework, which undervalued or failed to recognise skills practised in feminised work. In respect of the *ACT Child Care decision*, the ACTU submitted that while this decision examined the work value of children's services workers, it did not properly value their work because:

- it was not permitted to engage in an *ab initio* assessment of their work, but rather was confined by the wage-fixing principles to an examination of work value changes from a 1990 datum point. This meant that the starting point rates considered in the decision may not have been properly set in the first place; and
- because the Full Bench (and the earlier Full Bench in the *1990 Child Care decision*) sought to align children's services classifications with the C10 Metals Framework based on equivalency of qualifications, the rates set in the *ACT Child Care decision* failed to comprehend 'invisible' skills.

[491] The ACTU also referred to the non-implementation of the full wage increases determined in the *ACT Child Care decision*, the carrying-over of the pre-modern wage rates in the award modernisation process and the requirement for a male comparator in *United Voice*[461] as forming part of the history of the gender-based undervaluation of CS Award wage rates. It submitted that CSEs are overwhelmingly female and low-paid, demonstrating the gendered

[460] *Re Ingham Family Centre Inc t/a Ingham Early Learning Centre & Ors* [2025] FWCA 1046.

[461] *Application by United Voice and the Australian Education Union* [2018] FWCFB 177, 274 IR 1.

consequences of the history of undervaluation. A proper work value assessment, free of assumptions based on gender and the other historical constraints to which they referred, would lead to a recognition that children's services work is caring work involving the exercise of 'invisible skills' to a degree warranting wage rates being set on the basis of the Caring Skills benchmark rate.

[492] The UWU submitted that the wage rates in the CS Award have been the subject of gender-based undervaluation for, broadly, the same reasons as the ACTU. It described in detail the way in which it says CSEs and Support Workers exercise, in the conduct of their caring work, the 'invisible' skills of interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination by:

- sensing contexts or situations;
- monitoring and guiding the reactions of children and their families;
- predicting and judging the impact of actions and programs on children and their families;
- negotiating boundaries in interactions with parents;
- working with diverse people and communities;
- sequencing and combining work activities in dynamic situations;
- maintaining and restoring routine workflow in the face of interruptions and unexpected events; and
- interweaving activities smoothly with those of colleagues to establish a collaborative workflow.

[493] The Australian Childcare Alliance's (ACA's) position was that it accepted, based on the reasoning in the *Stage 3 Aged Care decision*, that the minimum wage rates in the CS Award are not properly set, and there may be work value reasons to increase those rates. The ACA further accepted that the work of CSEs was caring work that involves the exercise of the skills described as 'invisible' skills in the *Stage 3 Aged Care decision*. However, the ACA contended that such skills were not 'invisible' in the true sense as many are expressly contemplated in the Certificate III and diploma qualifications held by employees in the sector. The ACA submitted that the Caring Skills benchmark rate was not appropriate to be applied to the Certificate III-qualified classifications in the CS Award. It pointed to differences between aged care work and childcare work, including that the former involved:

- dealing with adults (who are increasingly likely to have comorbidities amplified by dementia);
- larger-scale facilities which often left staff isolated in dealing with residents;
- changes in the nature of aged care whereby residents were less likely to be self-reliant and more likely to have shorter life spans while in care;
- the increasing likelihood that residents have dementia and multiple comorbidities;
- greater exposure to clients palliating with a corresponding impact on the nature of care and dealing with family members and external medical staff;
- unsupervised care in the case of home care;
- the physical and psychological dynamics of caring for often-immobile adults (including showering, toileting and feeding) while maintaining adult dignity;
- exposure to physical abuse and violence occasioned by clients with dementia;

- a lack of regulatory staffing ratios;
- dealing with critical issues such as falls and medically-compromised adults; and
- the compounding pressure of dealing with clients 24/7 involving effective handover and management of the full daily cycle every day.

[494] The ACA ultimately submitted that while the evidence supported an adjustment to the wage rate for CSEs, the quantum of this should sit somewhere between what was awarded in the aged care work value proceedings for Certificate III-qualified direct care workers and for indirect care workers, and should be somewhat below 15 per cent.[462]

[495] The ACA accepted that the C1(a) benchmark rate should be applied to degree-qualified directors, but that it would be necessary to disaggregate diploma-qualified directors. In respect of the current classification structure, the ACA submitted that the annual incremental element of the structure was problematic in that it did not reflect work value on any principled basis. The ACA also submitted and that the Commission should apply the reasoning in the *Teachers decision* to delete the pay points referring to years of service or adopt the outcome in the *Stage 3 Aged Care decision* whereby an additional classification and rate would apply to a Certificate III-qualified employee who has at least four years' post-qualification industry experience.

[496] In relation to the timetable for the implementation of any increases to minimum wage rates, the ACA submitted that this should conform to any unconditional commitment by the Commonwealth to fully fund the increases given the fragile economic state of the sector coupled with its reliance on government funding. It further submitted that the funding for wage increases provided under the Retention Payment scheme only lasted until 30 November 2026. The wage increases which it funded were a 10 per cent increase to the applicable award wage rates, notionally operative from 2 December 2024 for providers that applied for funding by 30 June 2025, and a further increase of 5 per cent from 1 December 2025 upon the award rates as they stand at that point. It was submitted that this funding should not be taken as a commitment to fund the outcome of these proceedings.

[497] ABI and the NSWBC adopted and supported the ACA's submissions.

[498] The Early Learning Association Australia (ELAA), an employer association representing over 1350 early childhood and care services, principally located in Victoria, submitted that the work of CSEs has historically been undervalued because of assumptions based on gender, specifically, different perceptions of feminine traits around caring for young children and technical skills in male-dominated industries that are similar to the stereotypes and cultural norms referenced in the *Stage 3 Aged Care decision*. The ELAA submitted that this had resulted in a highly gender-segregated workforce that receives relatively low rates of pay compared to other sectors, which in turn had led to workforce shortages and unprecedented rates of attrition. The ELAA characterised the work of CSEs as being 'incredibly broad, requir[ing] significant levels of "code switching" and occur[ring] in unpredictable and dynamic work environments'[463] and submitted that it was caring work requiring the exercise of 'invisible' skills in the sense discussed in the *Stage 3 Aged Care decision*. The ELAA supported

[462] Transcript, 19 December 2024 PNs 8505–8509.

[463] ELAA submission, 25 September 2024 [44].

the adoption of the Caring Skills benchmark rate for the CS Award at Level 3.1, and proposed that the other pay points in Level 3 of the CSE stream be adjusted proportionately. In respect of the C1(a) benchmark rate, the ELAA submitted that a degree qualification was not necessary for appointment as a director of an ECEC service classified at CSE Level 6 and so this was not a direct comparator for the CS Award. In respect of CSE Levels 1 and 2, the ELAA submitted that these classifications did not reflect the NQF requirement that all educators working with children must hold or be working towards a Certificate III qualification, and it proposed modifications to rectify this together with increases in wages to properly reflect the value of the work performed. It also proposed a separate classification for diploma-qualified CSEs who are not leading a team. The ELAA submitted that there should be an implementation timetable, taking into account government funding and related issues.

[499] The Ai Group's position is that it 'does not contend'[464] that the work of CSEs has been historically undervalued because of assumptions based on gender or that their award minimum wages should be increased. The Ai Group submitted that neither the Stage 1 nor the Stage 2 Reports supported a finding of gender-based undervaluation and, at its highest, the Stage 2 Report only went to the issue of whether a comprehensive work value assessment had ever been undertaken. Insofar as it might be concluded that the work of CSEs involves the exercise of 'invisible' skills or caring work of the nature described in the *Stage 3 Aged Care decision*, the Ai Group submitted that this had already been taken into account in the current classification structure and compensated for in the prescribed minimum wage rates. It also submitted that the funding dependency and regulatory and pricing constraints on the ECEC sector meant that any wholly- or partially-unfunded wage increases would threaten the viability of many operators and result in increased childcare fees. This would likely diminish access to childcare and constitute a barrier to workforce participation. The Ai Group opposed the adoption into the CS Award of the Caring Skills benchmark rate and the C1(a) benchmark rate and, in respect of the latter, submitted that there was no classification in the CS Award for which a degree or equivalent was required. In respect of any minimum wage rate increases that might be awarded, the Ai Group submitted that it would be necessary for such increases to have a delayed operative date and/or be implemented in phases having regard to the quantum of any increases, the availability of government funding, the capacity of employers to vary service fees, the social and economic consequences of increasing service fees, and the extent to which changes might be required in employers' payroll, information technology and other business systems.

[500] Finally, the Commonwealth made submissions specifically concerned with the Retention Payment scheme funded pursuant to the Wage Justice Act. The Commonwealth submitted that the Retention Payment:[465]

> … has been designed to support a wage increase to eligible ECEC workers, while balancing the impacts of fee increases to families and the economy through an annual fee growth percentage cap intended to keep downward pressure on fees. The Commonwealth submits that it would be appropriate for the Commission to also have due regard to the likely broader economic impact of any exercise of the Commission's modern award powers in considering how it implements any wage increases for the duration of the term of the Payment.

[464] Ai Group submission, 13 October 2024 [14].

[465] Commonwealth of Australia reply submission, 27 November 2024 [8].

[501] The Commonwealth submitted that the Retention Payment scheme had been designed to account for the outcome of this Review, in that:[466]

> … should the wages in the CS Award be increased by less than the wage increase supported by the [Retention] Payment, the above award requirement would be reduced by an amount equivalent to any increases to the award through the proceedings. For example, in January 2025, if the wages in the CS Award increased by 6 per cent, employers would still be required to pay eligible employees 4 per cent above that increase, so the rate paid in January 2025 is 10 per cent above the applicable award rates as at 2 December 2024.
>
> Should wages in the CS Award be increased in line with or above the rates of pay otherwise required for a compliant workplace instrument, the CS Award would become a compliant workplace instrument for the purpose of the grant…

[502] However, the Commonwealth emphasised that the Retention Payment was fixed and would not fund increases exceeding the amounts identified in paragraph [488] above. The Commonwealth said that:[467]

> The Payment is an interim measure while the Priority Review is being finalised and while the Commonwealth considers the Australian Competition Consumer Commission and Productivity Commission reports to chart a course for universal ECEC.

[503] As to further funding, the Commonwealth relied on its general position, which was stated as follows:[468]

> … the Commonwealth has not made any decisions regarding changes to policies or programs in order to fund (directly or indirectly) any wage increases arising from these proceedings. However, it foreshadows to the parties and to the Commission that any such decisions — as well as the Commonwealth's broader position as to appropriate timing — will be informed by responsible fiscal and economic management. If the Commission concludes that pay increases are warranted, the Commonwealth is likely to support a staged or phased process for implementation, particularly for any significant increases. If and when it would assist the Commission, the Commonwealth would address an appropriate phased implementation of any wage increases, at an appropriate stage in these proceedings.

7.5 Evidentiary material

[504] The ACTU and the UWU tendered, without objection, a substantial statement of facts agreed between the UWU, the ACA and the Ai Group[469] (ASF). Our earlier profile of the ECEC sector substantially draws on the ASF. The ACTU and the UWU relied, in addition, on witness statements made by the following persons:

(1) Natalie Dabarera[470] is a Research Coordinator for the UWU. Ms Dabarera gave evidence about various reviews of, and reports on, the ECEC sector.

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[466] Ibid [12.1]–[12.2].

[467] Ibid [14].

[468] Commonwealth of Australia submission, 27 September 2024 [52].

[469] Exhibit CS1 (statement of agreed facts — ACA, Ai Group and UWU, 10 October 2024).

[470] Exhibit CS2 (witness statement of Natalie Dabarera, 11 October 2024).

(2) Kerrie Garnsey[471] is an educator at the St Helens Early Learning Centre. She holds an Associate Diploma of Social Science (Child Care), which she deposed is equivalent to a Diploma of Early Childhood Education today. Ms Garnsey gave evidence that she is the responsible person at her centre when the centre director is absent and that she usually works in the room designated for children under two years of age. She also gave evidence about her day-to-day work routine and duties including the extent to which she is responsible for supervising others, the groups of people with whom she interacts and the training, skills and knowledge she uses in her role.

(3) Sebastian Hand[472] is an educator at Gowrie Victoria Carlton Learning Precinct. Mr Hand holds a Diploma of ECEC and also has on-the-job training. He gave evidence about his daily work routine and duties, and the skills which he exercises in his role.

(4) Tamika Hicks[473] is a self-employed consultant with 23 years' experience in the ECEC sector as an educator and lead educator. Ms Hicks holds a Diploma of Community Services (Children's Services), Advanced Diploma of Community Services (Children's Services) and a Certificate IV in Workplace Training and Assessment. She has also taught several units forming part of Certificate III in ECEC and Diploma of ECEC courses. Ms Hicks gave evidence about the 'invisible skills'[474] she believes are necessary when working in the ECEC sector, and how these are only taught to a limited extent in the Certificate III and Diploma courses: '[y]ou are given "pieces of the puzzle" during the Certificate III and Diploma, but it is not until working that skills are actually learned.'[475]

(5) Sunitha Ranasinghe[476] is a 'Senior Educator' employed by Goodstart Early Learning Centres. She holds a Diploma of Child Day Care obtained overseas, a Certificate III in Children's Services and a Diploma of Children's Services (ECEC), the latter two of which she was able to complete mostly via recognised prior learning. She also holds first aid qualifications that are renewed annually and completes on-the-job training modules. Ms Ranasinghe gave evidence about her typical daily duties and responsibilities, the workplace environment, the groups of people with whom she works and the training, skills and knowledge she uses in her work.

(6) Nicole (Nikki) Graham[477] is the Evaluator and Research Coordinator at the Community Child Care Association (CCC). She holds a Graduate Diploma in Evaluation, a Master of Education (Early Childhood), a Graduate Diploma of

[471] Exhibit CS3 (witness statement of Kerrie Garnsey, 9 October 2024).

[472] Exhibit CS4 (witness statement of Sebastian Hand, 9 October 2024).

[473] Exhibit CS5 (witness statement of Tamika Hicks, 27 November 2024).

[474] Ibid [34].

[475] Ibid [37].

[476] Exhibit CS6 (witness statement of Sunitha Ranasinghe, 9 October 2024).

[477] Exhibit CS7 (witness statement of Nicole (Nikki) Graham, 27 November 2024).

Teaching (Early Childhood) and a Bachelor of Arts. Ms Graham gave evidence about the CCC's work, the responsibilities of her role there, how educators provide inclusion support to children living with disabilities or from diverse backgrounds (and how the CCC supports them to do this) and the changes to the ECEC sector that she has observed since commencing work therein in 2002.

(7) Tania Rodger[478] is a cook employed by Goodstart Early Learning Centre in Blue Haven, NSW. She does not hold formal qualifications but has 35 years of experience as a cook in CBDC and early education. Ms Rodger gave evidence about her duties and responsibilities, including taking eight children at a time for a weekly cooking class and liaising with parents. She also gave evidence about the training and skills she uses in her role and the changes she has observed over her time working in the ECEC sector. Ms Rodger provided specific evidence in reply to the evidence of Brent Stokes and Nina Hefford. She also disagreed with the proposition in the evidence of Karthiga Viknarasah, Majella Fitzsimmons and Jackie Jackman that cooks in ECEC centres have minimal contact with children and parents.

(8) Gemma Lewis[479] is the Centre Director of the Community Kids Pascoe Vale early education centre, a subsidiary of G8 Education Limited (G8). Ms Lewis holds a Certificate III in ECEC and a Diploma of ECEC. She is required to undertake internal training and professional development planning annually. Ms Lewis gave evidence about her duties and typical daily routine, the groups of people with whom she interacts at work and the challenges she faces at work relating to children's difficult behaviours, new computer software in relation to which she said she did not receive training and internet and power outages. She also gave specific evidence in reply to the evidence of Dr Hefford and Ms Viknarasah for the ACA.

[505] All the above witnesses were cross-examined by the ACA except for Ms Dabarera.

[506] The UWU also relied on the expert report of Associate Professor Nikola Balnave and Dr Celia Briar[480] (Balnave/Briar Report) and a supplementary report by Associate Professor Balnave.[481] Associate Professor Balnave holds a Doctor of Philosophy in industrial welfarism in Australia from 1890 to 1965 and a Bachelor of Economics with first-class Honours in Industrial Relations. She currently works at the Department of Management in Macquarie Business School, at Macquarie University. Dr Briar holds a Doctor of Philosophy in sociological studies. She has largely worked as an independent researcher since 2006, primarily in Australia and New Zealand, and specifically with the Spotlight tool since 2011. Associate Professor Balnave's and Dr Briar's report set out their findings in respect of the 'invisible' skills exercised by nine childcare workers covered by the CS Award and explained why they believe the pay rates in that award undervalue the work involved. In her supplementary report,

[478] Exhibit CS8 (witness statement of Tania Rodger, 8 October 2024); exhibit CS9 (reply witness statement of Tania Rodger, 27 November 2024).

[479] Exhibit CS25 (witness statement of Gemma Lewis, 9 October 2024); exhibit CS26 (reply witness statement of Gemma Lewis, 28 November 2024).

[480] Exhibit CS27 (expert report of Associate Professor Nikola Balnave and Dr Celia Briar, filed 11 October 2024).

[481] Exhibit CS28 (supplementary report of A/Prof Nikola Balnave, filed 3 December 2024).

Associate Professor Balnave provided updated versions of Tables M-5, M-6 and M-7 originally included in the Balnave/Briar Report setting out the pay rates, indicative duties and corresponding Spotlight skills of a childcare educator, assistant director and director under the CS Award respectively. Associate Professor Balnave was cross-examined by the ACA.

[507] The ACA relied on evidence given by the following witnesses, all of whom made witness statements and were cross-examined:

(1) Karthiga Viknarasah[482] is the Director of Choice Childcare Holdings Pty Ltd, which operates Choice Preschool Kindergarten. She also teaches the Certificate III in ECEC and Diploma of ECEC courses at TAFE NSW Petersham, and mentors students undertaking placements for the Bachelor of ECEC and Master of ECEC degrees at the University of Sydney. Ms Viknarasah is also an Accreditation Supervisor with the NSW Education Standards Authority and delivers training to childcare centres with Community Early Learning Australia. She holds a Master of Teaching (Early Childhood), Master of Educational Leadership, Graduate Certificate in Education (Early Childhood Leadership), Certificate IV in Training and Assessment and Bachelor of Business, and is completing research towards a Doctor of Philosophy relating to how families with children with additional needs get support in Australia if they are not Australian citizens. Ms Viknarasah gave evidence about the daily operations and curriculum of Choice Preschool Kindergarten, its staff, their qualifications and their various roles (including her own as Director). She gave specific reply evidence identifying where practices at Choice Preschool Kindergarten differ from those set out in the evidence of Ms Ranasinghe, Mr Hand, Ms Lewis and Ms Garnsey.

(2) Brent Stokes[483] is the Approved Provider and Company Director of East Coast Early Learning Pty Ltd (East Coast Learning), which operates three early learning centres. He holds a Certificate III in ECEC. Mr Stokes gave evidence about the various staff roles at East Coast Learning's centres (including the respective extent to which they would interact with parents and children and bear responsibility for supporting children with additional needs), the centres' day-to-day operations, policies and curriculum and the costs involved in running the centres. He also gave specific evidence in reply identifying where East Coast Learning's practices and expectations of staff differ from those described in the evidence of Ms Lewis, Ms Ranasinghe, Ms Garnsey and Mr Hand. Mr Stokes also replied to the childcare workers' accounts of their skills and duties annexed to the Balnave/Briar Report.

(3) Brooke Eerden[484] is the Director of Dandenong Ranges Childcare Centre and has worked at that centre since 2004. She holds a Diploma in Children's Services and a Certificate III in Children's Services and is studying towards a Bachelor of Business Administration. Ms Eerden gave evidence about the daily operations (including support for children with additional needs), staff, curriculum and

[482] Exhibit CS10 (witness statement of Karthiga Viknarasah, 9 October 2024); exhibit CS11 (reply witness statement of Karthiga Viknarasah, 25 November 2024).

[483] Exhibit CS12 (witness statement of Brent Stokes, 9 October 2024); exhibit CS13 (reply witness statement of Brent Stokes, 25 November 2024).

[484] Exhibit CS14 (witness statement of Brooke Eerden, 9 October 2024).

policies of the centre. She also gave evidence about the centre's increased running costs over the last year.

(4) Gregory Hensman[485] is the Chief Executive Officer of Sagewood Early Learning, which operates six early childcare centres in Western Australia. He gave evidence about Sagewood Early Learning's staff (including their respective qualifications, duties, responsibilities and level of interaction with parents and children), daily routines, curriculum and policies. Mr Hensman also gave evidence about how Sagewood Early Learning supports children in its care who have additional needs and what it takes into account in setting its fees.

(5) Megan Sharman[486] is the co-founder and Director of Training at Early Childhood Training Pty Ltd, an RTO that offers Certificate III and Diploma courses in ECEC. Ms Sharman holds a Bachelor of Early Childhood Education, a Certificate in Child Psychology, a Diploma of Children's Development 0–5, an Advanced Diploma of Children's Services and a Certificate IV in Training and Assessment. She is also studying towards a Master of Educational and Developmental Psychology. Ms Sharman gave evidence about her role at Early Childhood Training Pty Ltd and the theoretical and practical course content offered.

(6) Jackie Jackman[487] is the co-founder, Approved Provider and a Company Director of Treetops Early Learning Centres Pty Ltd, which operates five childcare centres in South Australia (SA). She is also the President of the ACA in SA. She holds a Bachelor of Early Childhood Education and is a registered teacher in SA. Ms Jackman gave evidence about the qualifications and duties of Treetops Early Learning Centres Pty Ltd's staff, their respective levels of engagement with children and parents and the centres' daily routines, curriculum and policies. She also gave evidence about the centres' increasing operational costs and how it would manage any increase in award pay rates. Ms Jackman gave specific evidence in reply identifying where practices at those centres differ to those described by Ms Lewis, Ms Garnsey, Mr Hand, Ms Ranasinghe and the Balnave/Briar Report.

(7) Nina Hefford[488] is the Chief Executive Officer of LEAD Childcare Pty Ltd, which operates 16 childcare centres in Queensland and Lead Education and Training Pty Ltd (Lead Institute), an RTO that offers qualifications in ECEC, School Based Education Support and Business. Dr Hefford gave evidence about the ECEC courses available through the Lead Institute. She also gave evidence about the qualifications, duties and responsibilities of LEAD Childcare Pty Ltd's staff, the centres' curriculum, policies and support for children with additional needs and its increasing operational costs. Dr Hefford gave specific evidence in reply to the

[485] Exhibit CS15 (witness statement of Gregory Hensman, 9 October 2024).

[486] Exhibit CS16 (witness statement of Megan Sharman, 9 October 2024).

[487] Exhibit CS17 (witness statement of Jackie Jackman, 9 October 2024); exhibit CS18 (reply witness statement of Jackie Jackman, 26 November 2024).

[488] Exhibit CS19 (witness statement of Nina Hefford, 9 October 2024); exhibit CS20 (reply witness statement of Nina Hefford, 27 November 2024).

Balnave/Briar Report and the evidence of Mr Hand, Ms Lewis, Ms Garnsey and Ms Ranasinghe.

(8) Majella Fitzsimmons[489] is the co-owner, Director, Approved Provider and National Operations Manager of Educating Kids Early Learning Centre, which operates three childcare centres in Queensland. Ms Fitzsimmons is also the President of the ACA in Queensland. She holds an Associate Diploma of Children's Services and an Advanced Diploma of Childcare. Ms Fitzsimmons gave evidence about the qualifications and duties of Educating Kids Early Learning Centre's staff, the extent to which staff in different roles engage with parents and children, the centres' curriculum and policies (especially in relation to supporting children with additional needs) and their increasing operational costs. She also gave specific evidence in reply identifying where practices at Educating Kids Early Learning Centre differ from those described by Mr Hand, Ms Lewis, Ms Ranasinghe and Ms Garnsey.

(9) Linda Carroll[490] is the Chief People Officer at G8. Ms Carroll gave evidence in reply to Ms Lewis' first statement, including issues raised by Ms Lewis concerning overtime, child and staff safety and power and internet outages.

7.6 Has the work of CSEs been the subject of gender-based undervaluation?

[508] As stated in the *AWR 2024 decision*, in the *ACT Child Care decision* the Full Bench accepted evidence about the skills, duties and responsibilities of CSEs which pointed to the likelihood of them exercising caring work involving the exercise of 'invisible' skills of the type the subject of consideration in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. In particular, the *AWR 2024 decision* referred to evidence given by one witness which was accepted in the *ACT Child Care decision* as to the aspects of the role of a CSE which contributed to its complexity.[491] It is useful as a starting point to set out that witness's list again:

- Providing a nurturing environment and interacting with the children in such a way that each individual child's emotional needs are met.
- Providing environments and experiences which are appropriately stimulating and engaging and interacting with the children in such a way that each child's cognitive, language, and creative development is stimulated.
- Providing experiences and environments that are supportive of children's social development and facilitating the interactions of children in such a way that their social development in a diverse environment is encouraged.
- Supporting the needs of children and families from socially, culturally and linguistically diverse backgrounds, facilitating understanding of that diversity and providing an environment where all children and families feel valued and included.
- Observing babies and children sensitively and accurately and using a developmental analysis of those observations to assist in planning and caring appropriately for each child.

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[489] Exhibit CS21 (witness statement of Majella Fitzsimmons, 9 October 2024); exhibit CS22 (reply witness statement of Majella Fitzsimmons, 25 November 2024).

[490] Exhibit CS24 (witness statement of Linda Carroll, 26 November 2024).

[491] [2024] FWCFB 3500, 331 IR 248 [115].

- Planning appropriate programs for individual children and groups of children for all areas of their development and well-being.
- Guiding children's behaviour and managing situations where a child's behaviour is difficult and challenging.
- Communicating appropriately and sensitively with families in a way that is supportive of the child's well-being and development.

[509] There was no contest in this Review that the above list describes many of the fundamental features of the work of CSEs. It is immediately apparent that the list includes many of the features of 'soft' or 'invisible' skills as described in the *Stage 1 Aged Care decision* and the *Stage 3 Aged Care decision*. The references to interacting with children to meet emotional needs and developmental goals, observing behaviour sensitively and accurately, ensuring that children and families feel valued and included, guiding behaviour, managing difficult and challenging behaviour, and communicating appropriately and sensitively with families all plainly fall with the skills of 'interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination'[492] discussed in the *Stage 3 Aged Care decision*.

[510] The submission that these skills cannot be said to be 'invisible' because they were expressly recognised in the *ACT Child Care decision* and taken into account in the setting of award minimum pay rates misses the point made in the *Stage 3 Aged Care decision* and the *AWR 2024 decision* — that the constraints operating upon the AIRC Full Bench in the *ACT Child Care decision* meant that these skills were not able to be assigned their proper work value. There were, as the ACTU submitted, two constraints in this respect. The first was that because the AIRC Full Bench was unable, under the wage-fixing principles, to consider the work value of CSEs *ab initio* as distinct from work value changes from a 1990 datum point, it was unable to assess whether the existing rates of pay had taken into account the identified 'invisible' skills so as to constitute an appropriate starting point for the consideration of work value change. The history of the federal award coverage of CSEs that we have recited earlier indicates clearly enough that indeed these 'invisible' skills had not properly been taken into account: the ACT and NT awards the subject of the *1990 Child Care decision* were consent awards and thus the outcome of bargaining outcomes, and that decision set wages on the basis of a flawed application of the C10 Metals Framework Alignment Approach rather than a proper assessment of work value. Second, as earlier discussed, the Full Bench in the *ACT Child Care decision* was itself constrained by the C10 Metals Framework Alignment Approach, as applied in the *Paid Rates Review decision*, even in its limited consideration of work value change. Those two constraints, operating together, meant that the identified 'invisible' skills were not assigned their proper value in the wages outcome that was determined.

[511] The evidence before us confirms the fundamental importance of the exercise of 'invisible' skills to the performance of children's services work. The authors of the Balnave/Briar Report concluded that work in the CS Award classification categories of Educator (CSE Levels 1–4), Assistant Director (CSE Levels 5A–5), and Director (CSE Levels 6A–6) requires the deployment of a wide range and significant volume of complex 'invisible' skills. The report also made findings about Cooks (SW Level 3), whom we deal with separately later in this decision. The Balnave/Briar Report identified and taxonomised these as Spotlight skills, as follows:

[492] [2024] FWCFB 150, 331 IR 137 [156(1)].

Awareness skills — contextualising, building and shaping awareness
A1. Sensing contexts or situations
A2. Monitoring and guiding reactions
A3. Judging impacts
Communication and interaction skills — connecting, interacting and relating
B1. Negotiating boundaries
B2. Communicating verbally and non-verbally
B3. Working with diverse people and communities
Coordination skills — coordinating
C1. Sequencing and combining activities
C2. Interweaving your activities smoothly with those of others
C3. Maintaining and/or restoring workflow

[512] The Balnave/Briar Report also concluded that:

- work processes and practices in children's services are heavily reliant on the effective deployment of skills of interpersonal and contextual awareness, verbal and non-verbal communication, emotion management and dynamic workflow coordination;
- the exercise of these skills is not an optional extra but a fundamental requirement of the work, assumed within its responsibilities and structured into the working day;
- undervaluation of the work is significantly linked to the invisibility and mischaracterisation of the skills and its responsibility, nature and conditions;
- invisibility is defined in terms of the necessarily hidden nature of aspects of the work, the under-defined (situational, embodied, hard-to-verbalise) aspects of work processes, the under-specified content of interactional and relational work, and the under-codified nature of the coordination of ECEC work processes and workflows; and
- the skills of the work have been disregarded and mischaracterised as natural feminine attributes.

[513] The ACA submitted that we should give only limited weight to the Balnave/Briar Report for a number of reasons, including that the number of educators from whom the primary data were drawn was small, that all held a Certificate III or higher qualification and were therefore not representative of the workforce, and that the methodology by which the educators were interviewed was in some cases flawed. Those criticisms have a degree of substance, with the identified faults primarily attributable to the limited time in which the report had to be prepared. However, we consider nonetheless that the conclusions of the Balnave/Briar Report should be assigned significant weight. The sample of employees who provided data for the report included Directors and Assistant Directors responsible for operations in childcare centres, who according to the ASF are required to have detailed knowledge and understanding of the skills exercised by childcare workers at all levels. It is also likely that some would have worked as Educators during their careers. Additionally, the fact that childcare centres operate in the context of the EYLF and the NQF means that it is likely that the primary evidence about the skills used by CSEs set out in the Balnave/Briar Report can be extrapolated across the sector more generally. Most importantly, the primary evidence upon which the report was based is entirely consistent

with the largely-unchallenged evidence given by other CSEs in their witness statements and with the findings in the *ACT Child Care decision*.

[514] The ACA submitted that we should also deal cautiously with the lay evidence because the UWU's CSE witnesses all held diploma-level qualifications and were therefore also not representative of the CSE workforce as a whole. We do accept this. The witnesses were plainly not in a position to give evidence about the work of CSEs at all levels.

[515] On the basis of the Balnave/Briar Report and the evidence of all the witnesses, we make the following findings about the work of CSEs. At the outset, it is not in dispute that CSEs engage in a range of functions which involve the exercise of what might loosely be characterised as 'hard' or 'technical' skills — that is, skills that are readily visible in the observation of CSEs work. These include:

- developing and delivering educational curricula and activities;
- making and recording observations about children's learning and development processes;
- engaging in feeding activities and signing paperwork relating to food;
- changing nappies and assisting with toileting;
- facilitating rest periods;
- making notes via computer programs detailing when children slept, how much they ate and when, how many nappy changes they had, any notes about their bowel movements and generally what activities they engaged in;
- uploading photographs for parents to observe during the day while maintaining confidentiality;
- observing individual children for signs that they are unwell;
- monitoring play to ensure that children are safe and engaged;
- monitoring and regularly applying sunscreen;
- carrying out head counts;
- ensuring that mandated ratios of educators to children are maintained;
- engaging in active supervision to ensure that children are always in sight;
- actively scanning for safety hazards;
- actively supervising visitors to the service; and
- generally ensuring that all record-keeping and other regulatory requirements are complied with.

[516] In addition, the evidence before us makes plain that discharging the above functions fundamentally requires CSEs at all levels to exercise 'invisible' skills. Those skills may be organised into four broad categories. *First*, CSEs are required to *sense contexts and situations, anticipate, monitor and guide children's reactions, engage in effective communication (verbal and non-verbal) and emotional management strategies with children, and assess the impact of interactions both in the short and longer terms*. CSEs are required to monitor and anticipate children's emotional reactions, adapt their work programming by finding ways to manage emotions and behavioural issues and regulate their own responses while maintaining workflow and educational programming.

[517] The exercise of effective verbal and non-verbal communication skills is essential in managing children's emotions and engaging with them empathetically. Ms Garnsey gave evidence that:[493]

> [a]s the children arrive, I greet them warmly, using my facial expressions and tone of voice to reflect how they feel. If a child is timid, I adjust my approach accordingly to help them feel more comfortable.

[518] Mr Hand said:[494]

> When I communicate with the children, I need to adjust the way I speak so the information I am providing can be understood. Ensuring the children can grasp the concepts I am talking [about] is part of providing access to that information. This allows them to think critically and ask questions. Communicating in a way that children understand is a skill I need to be constantly performing, it is almost like translating the information into another language for the children.
>
> When communicating to the children, the tone used, and the length of the sentence must also be considered to ensure you maintain their attention. Because children do not have the ability to concentrate as well or as long as adults, using tone and emphasising in the right places of a sentence is important to keep children engaged and focused on key points. Sentences need to be short and simple so they can digest the information.

[519] Educators are required to acquire an in-depth understanding of each child's personality, likes and needs. This knowledge is crucial to enable them to keep children happy and settled, prevent disruption to the entire day and avoid increasing their own workload such as by missing cues that make it harder to get the children to sleep, leading to educators needing to carry them around. The witnesses gave evidence about the need to distract, transition and redirect children when they have had an experience that has upset them, while simultaneously ensuring that other children are not impacted by an upset child who may be expressing emotions. The educators in this situation often undertake to help the upset child work through their emotions. Mr Hand gave evidence about this as follows:[495]

> When a child becomes upset when I am packing down an experience, I try to transition the child out of the experience. I do this by trying to re-direct them to a different experience or activity. If this doesn't work, I crouch down to the child's level, so we are eye to eye, and tell them the experience needs to go away because they need to learn about other topics for now. If this doesn't work, I can provide them with sensory toys to play with which will hopefully distract them. If this does not work and the child becomes violent, I will try to move the other children away from the immediate vicinity, so the angry child has a clear area where they can express their emotions. This allows them to do 'big body movements' to help them feel and work through their emotions.
>
> After the child has calmed down, I will have a conversation with them to explain why their response is not okay. I will say something like, 'hey that was not safe, that was very dangerous,' and explain why their actions were very dangerous.

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[493] Exhibit CS3 (witness statement of Kerrie Garnsey, 9 October 2024) [11].

[494] Exhibit CS4 (witness statement of Sebastian Hand, 9 October 2024) [138]–[139].

[495] Ibid [46]–[47].

[520] Emphasis was also placed on the importance of CSEs regulating their own emotions, including by remaining calm when dealing with such behaviour to guide children, modelling appropriate behaviours for children, and mirroring positive emotions displayed by children, even when the employees may not be feeling those emotions themselves. Ms Eerden described the importance of this, and the skills involved, as follows:[496]

> The number one most important factor in supporting a child's emotional regulation and behaviour is an Educator's ability to be aware of and regulate their own emotion[s]. An Educator who is angry, impatient, frustrated, annoyed, fed up etc. will only exacerbate a child's emotional dysregulation and the behaviours that go with it. All Educators must also possess the following skills:
>
> (a) the ability to recognise their own capabilities and if they are not in the right headspace or emotional state be able to make the decision to step away and ask another Educator to take over supporting a child/children in that scenario;
> (b) remain calm, empathetic, and patient when managing all emotions that children experience even when emotions such as anger, fear, tiredness, sadness etc. sometimes trigger behaviours such as physically harming Educators or other children (hitting, kicking, biting, throwing furniture at them etc.), or being upset for a few hours (when they first start care, or when having a meltdown/tantrum);
> (c) be aware of each other's emotional state and triggers for this reason — so they can encourage one another to take a break and provide emotional support and empathy to one another as well as the children;
> (d) when the children experience emotions such as joy, excitement, surprise etc. it is important that Educators mirror and reflect these back to the children even if they aren't feeling those positive emotions themselves; and
> (e) the ability to be empathetic towards children, [and] remain open[-]minded and reflective to ensure they are able to reframe all behaviours & emotions.

[521] CSEs are also required to interact with tired, emotional or angry children undertaking activities such as eating meals, which requires individual attention, while ensuring that other children who do not require the employee to exercise the same degree of focus are also assisted and encouraged to undertake the relevant activity. Witnesses described the need to adapt to the children's constantly-changing emotional and physical needs during the course of a day and the need to respond immediately and take their emotions seriously. This requires careful attention to children's 'cues', and an understanding of what they portend and what the appropriate response should be. For example, Ms Garnsey said:[497]

> Over time, I've learned to recognise when a child is not acting like themselves — such as being unusually quiet or not engaging in play — allowing me to identify potential issues early on. This constant sensory engagement occurs throughout the day as I interact with and care for the children.

[522] Ms Lewis said that she mentored staff:[498]

> … to recognise cues that a child is becoming dysregulated, such as crying or becoming withdrawn, in order to assist the child to regulate and de-escalate the behaviours.

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[496] Exhibit CS14 (witness statement of Brooke Eerden, 9 October 2024) [146].

[497] Exhibit CS3 (witness statement of Kerrie Garnsey, 9 October 2024) [44(b)].

[498] Exhibit CS25 (witness statement of Gemma Lewis, 9 October 2024) [70].

[523] Ms Ranasinghe described the skills involved in greater detail as follows:[499]

> For infants under two years old, I am attentive to various cues, such as crying, which can signal a range of needs from tiredness to discomfort. My approach involves promptly addressing these signs by checking for factors like a wet nappy or signs of being tired. I will check and change the child's nappy and then rock the child in my arms, usually this will settle the child to sleep if they are tired. If these methods don't work, the child may be unwell or unsettled for another reason.
>
> For children over the age of two years, I will observe them for cues which may indicate that they are distressed or tired. These cues vary largely for each child, for some in this age group it may be behaviour such as being quieter than usual or withdrawn and for others it may be they become louder and more disruptive. I am familiar with the personality of each child, this allows me to understand their unique cues. I will hold the child[']s hand or engage them in an activity, such as colouring, that they enjoy to assist them.
> . . .
> I monitor the children throughout the day, attending to both emotional and physical needs of the children. For example, when I recognise a child is missing their parent I will communicate with the child in an empathetic and positive way by first acknowledging the child's feelings about their parent and reassure them that their parents will return. I will then encourage the child to rejoin their friends using a play element or something that the particular child likes such as painting or colouring a drawing for their parents.

[524] CSEs are required to teach children to identify, sit with, communicate and appropriately regulate all their emotions — both the comfortable and uncomfortable ones. Without support, even emotions such as happiness and excitement can be expressed inappropriately, such as by squealing, shouting, jumping on furniture or running inside. This requires constant assessment of situations and use of strategies and centre-prescribed procedures. The skills employed by different levels of CSEs are directed at adapting activities, actions and the environment in the centre around the child.

[525] *Second*, CSEs at all levels *are required to establish relationships with parents and caregivers for the purpose of gathering and conveying information and managing expectations and behaviours*. Information that is gathered is used to understand, predict and respond to the behaviour of children throughout the day. This information is obtained from discussions held between CSEs and parents/carers when children are dropped off at the centre and might include sleep patterns, mealtime, bottle time, nappy rash, that they have had an unsettled night, eating issues, teething, injury and toilet training. It is important that there is at least a brief conversation with every parent to understand what mood the child is in and if there have been issues that day.

[526] CSEs at Educator levels relay the information they collect from parents and caregivers to directors and other CSEs. This informs consideration and decision-making about behavioural management plans to combat aggressive behaviours, the mix of children in rooms and whether it is safe to send a younger child to a room for older children. As described above, while they are gathering information, educators are also helping parents and children to separate using strategies and routines based on individual needs and providing one-on-one comfort to children needing it. They are also required to understand the needs of a variety of parents at drop-off

[499] Exhibit CS6 (witness statement of Sunitha Ranasinghe, 9 October 2024) [17]–[18], [21].

time and to identify any family context that may impact on the child's behaviour including whether the child has any siblings, whether the child's parents are going through a separation or some other family difficulty, or whether there are any illnesses in the family. The witnesses emphasised that it is important to have these conversations with parents and carers about each and every child. These activities are also undertaken at handover when children are collected from the centre, during which CSEs provide information to parents and carers about the child's day. Ms Garnsey described the importance of these interactions in the following terms:[500]

> My interactions with parents are crucial to my job because they provide essential information about their child's needs and care. Additionally, what I do during my time with the child can significantly impact their behaviour at home; if a child doesn't sleep well while in my care, they may be more challenging for their parents later.
> …
> … I often need to explain to parents why a child hasn't slept or eaten well. For example, if a child struggles to settle, I have to recount my efforts, such as rocking them in my arms or in a pram, to reassure parents that I've done everything possible. Gathering information about why a child didn't eat can also be necessary, especially since this situation arises a few times a week. As the responsible person, it's my duty to provide updates even if the staff member who has cared for the child that day has gone home. This responsibility can be stressful, especially when I need to reassure parents that I will follow up the next day.
> …
> … I take accountability for these communications, ensuring that I follow up with parents and assure them that we are committed to their child's well-being. This responsibility can be stressful, but it's essential for building trust with parents and ensuring they know we are making our best efforts.

[527] CSEs must further adapt their communication skills to manage boundaries and have difficult conversations with parents and caregivers about children's behaviour, or to receive parents' feedback. An important part of the engagement with parents and carers is boundary management, whereby CSEs seek to accommodate parental requirements without breaching regulatory requirements or organisational realities. Navigating these difficult issues requires strong communication skills. CSEs must identify appropriate times for these discussions or (if they are at Educator level) direct parents to an appropriate supervisor who can provide support when discussing sensitive topics. They must also deal with parents who are angry or upset. Interactions with such parents requires effective communication and consistency, as Mr Hand explained:[501]

> Parents get angry for a wide range of reasons. I have learned how to deal with angry parents by showing empathy and understanding. I show I am listening by saying things like, 'I understand', and 'it's fine'. I have been trained to be courteous, concede as much as possible and direct the parent to an educational leader. This is to ensure the situation does not escalate.

[528] It is also important that all CSEs are aligned on what information they can share with parents to avoid breaches of confidentiality. All CSEs that engage with parents must also be informed about daily occurrences so they can provide consistent information to parents.

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[500] Exhibit CS3 (witness statement of Kerrie Garnsey, 9 October 2024) [26], [45(c)], [46(a)].

[501] Exhibit CS4 (witness statement of Sebastian Hand, 9 October 2024) [42].

[529] It is necessary for Educators to recognise and implement strategies for dealing with parents who raise topics beyond the scope of the Educator's role or with which the Educator is unable to assist, and when those parents should be referred to a teacher, lead educator or centre director. This can be difficult in circumstances where parents only want to talk to Educators with whom they have a good rapport. For example, Mr Hand described dealing with parents who had an apprehension about their child having autism spectrum disorder (ASD):[502]

> When a topic raised by the parent beyond the scope of my role or that I am otherwise unable to assist with, I refer the parent to the teacher, lead educator or centre director. However, I have found that some parents will only want to talk to certain educators. For example, there is a parent at the centre that I have a good rapport with, who wanted to speak with me about their child's process of being diagnosed with ASD and seeking my opinion on it.
>
> It is beyond the scope of my role to assess a child for ASD or provide my opinion on the diagnosis. I told the parents that I was not qualified to make an assessment but advised the parent generally of the observations I had made of their child. I then recommended to the parent to continue with the process of her child being diagnosed, as she was already mid-way through that process.
>
> I have also had parents come to me where they suspect their child has ASD but they have not yet begun to process of getting a diagnosis. When this occurs, I will direct the parent to the educational leader at the centre or a licenced early education teacher who can assist the parent with information, support and a referral to a doctor.

[530] Parents may also disclose sensitive and confidential issues such as domestic violence, requiring Educators to escalate concerns to the Director.

[531] Sometimes CSEs are required to have difficult conversations with parents about children's behaviour on a daily basis in a manner that requires high-level communication and interpersonal skills. Such conversations may involve telling parents that their child has been injured or hit by another child, has developmental issues, is engaging in biting or similar problematic behaviour, or has anxiety while waiting to be picked up. CSEs at Director and Assistant Director levels are usually required to conduct the most difficult conversations, particularly where children are to be sent home or other similar action is taken. However, the information necessary to inform the conversations is usually collected by CSEs working 'on the floor', and it is likely these CSEs are involved at some level in these conversations.

[532] *Third*, CSEs *must recognise and deal with the diversity of children and families they work with*, including those from culturally and linguistically diverse backgrounds and different socio-economic circumstances, and people with disabilities. This involves understanding the practices, perspectives and needs of families from different backgrounds and integrating that understanding into all interactions with both parents and children. As an example of this in practice, Ms Ranasinghe gave the following evidence:[503]

> In my role, I engage with a diverse range of families, each bringing unique cultural and regional backgrounds that influence their perspectives and needs. My ability to speak multiple languages, including Cantonese, South Indian (Tamil), and Hainanese, allows me to communicate more

[502] Ibid [37]–[39].

[503] Exhibit CS6 (witness statement of Sunitha Ranasinghe, 9 October 2024) [39].

> effectively with families from a variety of cultural backgrounds. When approaching families, I tailor my communication to respect and reflect their cultural values and practices.

[533] She also described dealing with parents and their child, all of whom lacked English language proficiency:[504]

> For example, a family who attends the centre had a significant language barrier, they were unable to understand any of the staff at the centre, including myself. This observation allowed us to coach the child, in accordance with the EYLF, to assist them in developing their English language skills. I additionally observed that due to the child not being able to communicate effectively, they were behind also in their social development skills. Both myself and other educators within the room adapted our learning programme to suit her specific needs. We utilised techniques such as remodelling to bridge the language barrier and build both language and social skills.…

[534] While the proportion of children who have additional needs is relatively low, CSEs are nonetheless required to exercise higher skills and provide higher levels of support for such children. In respect of children with additional needs, Ms Eerden gave detailed evidence as to risk management, communication methods, managing social skills, educational programs, transitions for such children between daily activities, collaborative relationships with treating professionals and other educators, supporting parents, professional education and training for CSEs, and documentation requirements, which we accept. CSEs at all levels are skilled at adapting programs for all children, including those who have additional needs, regardless of whether those needs have been formally diagnosed. Ms Graham described the way in which CSEs practise inclusion of children with additional needs as follows:[505]

> Educators provide for inclusion because they're incorporating it into the program and their teaching practices. Teaching in an early learning setting is not babysitting; it's walking alongside the children in the entirety of their identity and making sure they're supported and getting as much care and support as they need.
>
> It in no way can be compared to parenting in the context of looking after your own children. There is a high degree of skill and professionalism required to perform the role of early educator well. This skill and knowledge is developed both through actual professional development and qualifications, but also through experiences in working with diverse groups of children.
>
> Inclusion support for the most part is not actually about having additional physical support or an external provider coming in, but rather it relies on educators with significant experience to provide the types of inclusion and support required.

[535] *Fourth*, CSEs are expected to *maintain and restore workflow continuity* in the context of a dynamic work environment in which interruptions and unanticipated events and behaviours, including critical incidents, are common. Interruptions can occur, for example, when children are injured or become ill and CSEs are required to take time to comfort the child, administer any first aid required, prepare a report, and possibly call a parent. These situations require CSEs to prioritise tasks and exercise situational awareness, problem-solving abilities

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[504] Ibid [33].

[505] Exhibit CS7 (witness statement of Nicole (Nikki) Graham, 27 November 2024) [21]–[23].

and the capacity to engage in teamwork. Ms Eerden gave evidence that she experiences at least one incidence of injury each day and described:[506]

> …[h]aving to make hundreds of snap decisions about what to prioritise at all times of the day (do I help up the child who is sad and grazed their knee, support and clean up the child [who's] embarrassed because they had [a] toileting accident, continue to supervise the high-risk water play activity, support two children who are yelling at each other and starting to become physically aggressive over sharing a toy or get the child [who's] standing on a table to get down when they all happen at once[?]).

[536] Similarly, Ms Garnsey said:[507]

> Efficient multitasking is crucial. For instance, while preparing meals for a group of children, I must also supervise playtime to ensure safety and engagement. If one child starts to cry or another requires immediate attention, it can be challenging to balance these responsibilities without compromising the quality of care for any child. Being able to shift focus quickly while maintaining a calm environment is essential to keeping the day on track.

[537] It is also necessary to establish a collaborative workflow whereby CSEs are able to step into each other's roles as substitutes for absent colleagues, maintain awareness of how colleagues are faring at any point in the day, and step in where necessary to provide respite. Certificate III- and diploma-qualified CSEs develop cooperative and supportive relationships and collaborate to provide continuity of care in a secure and active environment. Ms Hicks gave the following example of this, which she described as 'multitasking with presence':[508]

> An example of such a situation of multitasking with presence is the following regular occurrence which I experienced multiple times at Cardinia, where there are two staff assigned to 15–22 children and an indoor/outdoor program. One child wets themselves in the bathroom. Suddenly, one of the educators is required to tend to the child in the bathroom, whilst the other needs to look after all the other children and either move them all indoors or all outdoors, so that they can all be in the same space where they can be adequately supervised. Simultaneously, the educators were in the middle of preparing lunch, but they now need to clean the bathroom because the children need to wash their hands before they eat. Whilst this is happening, the educator not cleaning the bathroom has to improvise a group activity to keep the children interested, whilst also managing the specific needs of each child, including certain children who may have a meltdown.
>
> For skilled educators, this scenario can be easily managed because they have access to a 'toolbox' of knowledge and skills, but it is one that new educators and graduates really struggle with.

[538] This completes the picture that CSEs simultaneously manage the care and education of children in accordance with regulatory frameworks while completing administrative work, coordinating with colleagues and communicating with parents.

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[506] Exhibit CS14 (witness statement of Brooke Eerden, 9 October 2024) [147].

[507] Exhibit CS3 (witness statement of Kerrie Garnsey, 9 October 2024) [45(a)].

[508] Exhibit CS5 (witness statement of Tamika Hicks, 27 November 2024) [47].

[539] The 'invisible' skills we have described can only be fully learnt through on-the-job experience and are not immediately exercisable upon completion of an ECEC Certificate III or diploma qualification. We accept the evidence of Ms Hicks to this effect:[509]

> These invisible skills take a long time to learn and often are only realised when an educator is able to develop a longstanding relationship with a child and their family. The theoretical components and limited amount of time spent with children during the Certificate III and Diploma is not able to teach these skills because they require the experience of spending months and even years with children and their families.
> …
> What is not covered, or able to be covered, in the Certificate III or Diploma, is the developed ability to memorise, internalise, juggle and utilise effectively the wide variety of information an educator has had to gather. It is one thing to be aware of all the information the educator needs to learn, it is another to actually apply and internalise this information and draw upon it in 'real time', especially in challenging situations.
>
> An example of this skill being used effectively is one of my educators at Cardinia Lakes who was in charge of the nursery. She had completely internalised each of the children's routines, cultural preferences, allergies, intolerances, sleep routines and developmental plans. She had not only memorised these individual preferences, but was able to call on them quickly and in different situations which then allowed her to multitask with presence. For example, if a child was crying, she didn't need to consult the child's 'All About Me' book to see how they preferred to be comforted, instead, she could immediately provide that care and then continue doing the other things she needed to do for the other children.

[540] The current classification definitions for Directors (Levels 6A and 6) and Assistant Directors (Levels 5A and 5) refer to, but do not require, a range of qualifications, including (for Directors) a relevant degree. Employment at these levels is subject to appointment by an employer, and appointees to the role of Director must be persons 'possessing such experience, or holding such qualifications deemed by the employer or the relevant legislation to be appropriate or required for the position'.[510] The current classification definitions and rates explicitly recognise that Directors and Assistant Directors do not require formal qualifications, by establishing classification levels (Levels 6A and 5A) with rates that are the same as those payable to Directors and Assistant Directors (Levels 6 and 5) who hold qualifications.

[541] As the ASF and the evidence makes clear, persons appointed to the role of Director hold significant responsibilities for the overall management and administration of a service and for compliance with a complex framework of legislation, regulation and standards relating to educational outcomes, the safety of children, the physical environment in a childcare facility, the qualifications, suitability and training of Educators and Support Workers, reporting to a range of authorities and extensive engagement with parents and carers of children. It is also the case that Directors, Assistant Directors and other senior staff provide direct care to children on a routine basis either as they undertake their substantive role or fill in for absent Educators or Support Workers. When the range of skills and competencies required of Directors, Assistant Directors and senior staff is considered, it is immediately apparent that they are required to have a detailed knowledge and understanding of the skills exercised by childcare workers at all levels and the minutiae of activities in a childcare facility.

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[509] Ibid [38], [42]–[43].

[510] CS Award [MA000120] clause B.1.10.

[542] While not undertaking direct care of children to the same level or with the same frequency as Educators, it is clear from the evidence that Directors and Assistant Directors are still required to use 'invisible' skills when interacting with children, staff and parents/caregivers. An example of the use of these skills is in the difficult and sensitive discussions Directors are required to have with parents and caregivers which require awareness of context and situations, monitoring and guiding reactions and judging impacts and communicating effectively within boundaries and to diverse people and communities. These 'invisible' skills are required to be deployed in addition to general communication skills which would be expected of managers in other sectors. A failure to communicate, in the context of responsibility for the welfare and safety of babies and children, has potentially serious implications for a particularly vulnerable group of people.

[543] As we have earlier explained, the current minimum wage rates in the CS Award find their immediate origin in the *ACT Child Care decision*. That decision identified the skills to which we have referred, but was unable to reflect their proper value in the minimum wages set because of the constraints imposed by the C10 Metals Framework Alignment Approach which, as articulated in the *Paid Rates Review decision*, required alignment with the masculinised C10 benchmark and prevented an *ab initio* assessment of work value. That approach was founded on assumptions about gender and has resulted in a situation whereby the historically female-dominated work of CSEs is undervalued in respect of the award minimum wage rates that apply to them. We find therefore that CSEs under the CS Award have been subject to gender-based undervaluation.

[544] In addition, although the case in this respect was not fully articulated, there are strong grounds to consider that there have been changes in the work value of CSEs since the *ACT Child Care decision* — in particular, changes to the educational role of CSEs as a result of the introduction of the NQF and the EYLF. In the *Teachers decision*, these changes were found to have led to increases in the work value of ECEC teachers,[511] and there is evidence before us that there have been analogous developments in the work of Educators. For example, Ms Garnsey, who before her current employment as an ECEC Educator worked a previous stint in the ECEC sector in the 1990s, said:[512]

> Since I've been in the industry, but not always working in this field, I've seen a shift in complexity since the introduction of the Early Years Learning Framework in 2009. …
>
> There's also a greater emphasis on professional development; we are required to complete more courses than before. The focus on education levels has intensified, with a strong emphasis on understanding the principles and practices outlined in the framework. This shift means we must be mindful of each child's developmental milestones and the reasoning behind our chosen activities. Instead of simply implementing tasks, we now have to consider how they align with educational principles, making my work only more demanding.

[511] [2021] FWCFB 2051 [615], [628]–[639].

[512] Exhibit CS3 (witness statement of Kerrie Garnsey, 9 October 2024) [54]–[55].

[545] Ms Graham's evidence was to similar effect:[513]

> The nature of early education and care has changed dramatically over the 20 or so years that I have been involved. It has changed from being predominately care[-]based work, concerned mainly with the physical needs of the child, to now very much being focused on educational outcomes and supporting children's emotional wellbeing.
>
> In 2002, when I first started working in the sector, I didn't have any qualifications, and this was the case for most educators. Now Certificate III is a minimum requirement. The work I did looked a lot more like just taking care of physical needs of a child, and there were certainly no real expectations about children having to learn anything during the day.
>
> The nature of children has also changed over this period, and particularly in the last ten years. Our knowledge and understanding of the importance of early intervention for life-long outcomes for children has highlighted the need for quality education. Families are expecting that early learning will provide that early intervention, particularly for identified education delays, a lot more than they used to.

[546] This evidence further supports our conclusion that the work of CSEs under the CS Award is undervalued.

7.7 Should the Caring Skills benchmark rate apply to CSEs?

[547] It is next necessary to consider whether the findings we have made justify the wage rates for CSEs being set by reference to an alignment with the Caring Skills benchmark rate. As earlier noted, the ACA, while accepting that gender-based undervaluation had occurred, took the position that there were important differences in the work of PCWs, HCWs and AINs in aged care which militated against such an alignment. We do not accept this. While it is obvious that the work of aged care employees and CSEs is different in important respects, we consider on the basis of our findings that they exercise skills and discharge responsibilities which are of equal or comparable work value. One way of demonstrating this is to refer to the evidence of a witness in the aged care proceedings, Mr Sewell, which the Full Bench in the *Stage 1 Aged Care decision* relied upon in its consideration of the issue of 'invisible' skills. Mr Sewell, an employer witness of considerable experience in the aged care sector, agreed that the following skills were characteristic of the work of PCWs in aged care:[514]

- The ability to piece together resident information, past traumas, for example, to better understand present behaviour
- Developing a fine-tuned knowledge of a resident's idiosyncrasies and preferences to support smooth patterns of hygiene, meals, sleeping
- Being alert to co-workers' emotional pressures, strengths and needs
- Quickly picking up early warning signs of impending disturbances or an approach that isn't working
- Observing, responding to, reporting even very slight changes in residents
- Adapting one's voice, tone, body language to knowledge of how it is that residents would best respond

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[513] Exhibit CS7 (witness statement of Nicole (Nikki) Graham, 27 November 2024) [32]–[34].

[514] [2022] FWCFB 200, 319 IR 127 [844]–[845].

- Dealing increasingly with residents from different language groups and ensuring that residents either within the same language group or between language groups are able to interact
- Assessing the urgency and importance of simultaneous [draws] on the worker's attention, and
- Smoothly switching back and forth between work that is individualised to one particular resident and then work within a team.

[548] The Full Bench accepted that the above constituted 'invisible' skills of the type that are commonly mischaracterised as personal attributes or traits — a matter fundamental to the gender-based undervaluation of work.[515] On the basis of the findings we have earlier made, we consider that each of the above 'invisible' skills finds an analogue in the work of CSEs.

[549] It is also necessary to recall that the Caring Skills benchmark rate in the *Stage 3 Aged Care decision* was itself derived from the rate for a Certificate III-qualified SACS employee under the SCHADS Award as operated upon by the ERO. The findings we have made earlier about the 'invisible' skills of disability support workers covered by the SCHADS Award, including the need for constant engagement and verbal and non-verbal communication with clients, emotion management, the provision of emotional and psychological support, understanding of and empathy with clients who may be non-verbal or less than fully verbal, understanding of a client's needs and anticipation of problems and the integration of education into regular activities, again, all find close analogues in the work of CSEs.

[550] In respect of all three groups of employees, it is fundamental that the exercise of these 'invisible' or 'soft' skills is not an incidental or irregular feature of the work but is constant and wholly integrated with the exercise of all of the 'hard' or 'technical' skills of the work. In this respect, CSEs, PCWs, HCWs and AINs in aged care and disability support workers may be contrasted with the indirect care workers considered in the *Stage 3 Aged Care decision*, some of whom may be required to exercise 'invisible' skills but only in an incidental way that is not significant in the context of their overall duties.[516]

[551] For these reasons, we conclude that CSEs at the Certificate III-qualified level perform work that is of equal or comparable value to PCWs in aged care and disability support workers under the SCHADS Award with an equivalent qualification and that, accordingly, an alignment with the Caring Skills benchmark rate is justified.

7.8 Support Workers

[552] Notwithstanding that Support Workers in the ECEC sector were not identified as a subject of the Review, the ACTU and the UWU proposed that their wages be increased by 23 per cent, in line with the increase that would be produced by an alignment with the Caring Skills benchmark rate. In support of this position, Ms Rodger gave evidence concerning her duties as a longstanding cook in the ECEC sector and the extent to which her duties require her to have meaningful interaction with children and parents, and some of the evidence of other witnesses as well as the Balnave/Briar Report referenced the work of cooks.

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[515] Ibid [846]–[848].

[516] [2024] FWCFB 150, 331 IR 137 [252]–[255].

[553] Without diminishing the importance of their work, or the evidence of Ms Rodger, we are not satisfied that cooks in the ECEC sector generally exercise, to the same degree or at all, the skills and responsibilities of CSEs providing direct care to children, including the 'invisible' skills identified in the Balnave/Briar Report. Nor are we satisfied that their skills and responsibilities exceed those of cooks in the general hospitality industry. The evidence, and the description of cooks' work in the ASF, does not demonstrate that cooks are required as a matter of course to have formal engagement with families, to report on matters such as the eating habits or patterns of children, or to routinely sit with children to provide support and encouragement while they eat. These duties and responsibilities are undertaken by CSEs. The mandatory role of Food Safety Supervisor is required in all food service establishments in NSW and there are likely similar requirements in other States and territories. While cooks in ECEC centres contribute to menu planning and setting, they are not required to hold a formal qualification. The evidence is that ultimate menu or nutrition responsibility, including in centres where there is more than one cook, resides with Directors or Assistant Directors. Nor are the guidelines (identified in the Balnave/Briar Report) requiring healthy, attractive and culturally-appropriate meals prepared to nutritional standards, delivery of meals to rooms on time, and meals supplied within budget different to the requirements placed on cooks in general hospitality. Further, the skills of independent decision-making, judgment, technical knowledge, time management, and contextual awareness of general food safety standards identified in the Balnave/Briar Report are not distinguishable from the skills required of cooks in the hospitality industry generally. For these reasons, we have concluded that the evidence does not demonstrate an undervaluation of the work of cooks in the ECEC sector requiring remedy. In respect of Support Workers performing other functions, there was no evidence before us.

[554] We note that the evidence did indicate that some cooks in the ECEC sector are required to hold an ECEC Certificate III qualification, and to go onto the floor at various times, to maintain the required ratio of educators to children. Under the existing provisions of the CS Award, these circumstances would have to be addressed either through using the 'principal purpose' test to determine whether such an employee should be classified under the CS Award as a Support Worker or a CSE, or by the application of the higher duties provisions in clause 18 of the award. We do not consider that either of these mechanisms constitutes an appropriate way to deal with the situation described. Our *provisional* view is that the CS Award should be varied so that cooks who are required to hold an ECEC Certificate III qualification, or to be actively working towards that qualification, and who may be required to work 'on the floor' at any time to maintain the ratio of educators to children, should be paid the rate for CSEs holding that qualification for all hours worked.

7.9 Rectification of gender-based undervaluation of CSEs — *provisional* views

[555] As earlier stated, we have formed the view that the work of CSEs is, once their exercise of 'invisible' skills is properly taken into account, of equal or comparable value to that of PCWs in aged care under the Aged Care Award and the SCHADS Award, and SACS employees under the SCHADS Award. On that basis, we consider that the minimum rate of pay for a Certificate III-qualified CSE under the CS Award (currently Level 3.1) should align with the Caring Skills benchmark rate.

[556] However, we do not consider that this should result in a proportionate increase to all rates of pay in the existing classification structure for CSEs, as proposed by the ACTU and the

UWU other than for Directors. We accept the ACA's submission that the existing classification structure is unlikely to reflect work value, since each CSE classification above Level 1 contains varying numbers of annual incremental pay points not based on any identified distinctions on work value. As earlier discussed, progression between increments is based partly on time served and partly on an employee's competency at their existing level and demonstration of the skills necessary to advance to the next pay point. However, the CS Award does not specify any criteria for assessing this beyond the classification criteria for the classification as a whole, rendering (as some of the evidence before us indicates) the pay points at least in part a mechanism for rewarding perceived individual performance rather than properly-assessed minimum remuneration reflective of differentials in work value. Further, the classification structure is not reflective of the regulatory regime now applicable to children's services whereby:

- educators who work 'on the floor' in CBDCs must either:
  - hold a Certificate III in ECEC or be working towards one; or
  - hold a Diploma in ECEC; and
- there is a mandatory minimum proportion of diploma qualified staff.

[557] Our *provisional* view is that there should be a new, simplified classification structure which is substantially based on the qualifications framework for the ECEC sector, with the rates of pay structured by reference to the Caring Skills benchmark rate. This classification structure, when fully implemented (not taking into account future AWR outcomes) would be as follows:

Classification	Criteria	Relativity to Level 3	$ per week
CSE Level 1 Introductory Educator	An employee whose primary role is to work directly with children and who has less than 12 months' experience as a CSE.	90%	1,142.80
CSE Level 2 Educator	An employee whose primary role is to work directly with children and who has at least 12 months' experience as a CSE.	95%	1,206.30
CSE Level 3 Qualified Educator	An employee whose primary role is to work directly with children and has obtained an approved Certificate III-level early childhood education and care qualification.	100%	1,269.80
CSE Level 4 Experienced Educator	An employee whose primary role is to work directly with children, who has obtained an approved Certificate III-level early childhood education and care qualification and has obtained four years' post-qualification industry experience at CSE Level 3.	104%	1,320.60

Classification	Criteria	Relativity to Level 3	$ per week
CSE Level 5 Advanced Educator	An employee whose primary role is to work directly with children and who has completed a diploma-level early childhood education and care qualification or an equivalent approved qualification for out of school hours care.	108%	1,371.40
CSE Level 6 Lead Educator/ Room Leader	An employee who has been appointed as a Lead Educator or Room Leader in accordance with relevant legislation or regulation.	112%	1,422.20
CSE Level 7 Assistant Director	An employee who is appointed as: • the Assistant Director of a service; • Children's Services Co-ordinator; • Family Day Care Co-ordinator; • Family Day Care Trainee Supervisor; or • School Age Care Co-ordinator and who has completed an AQF Level 5 or Level 6 Diploma in Children's Services or equivalent or is deemed by the employer or relevant legislation to hold such qualification or possess such experience as appropriate or required for the position.	122%	1,546.70
CSE Level 8 Director	An employee who is appointed as the Director of a Service and has completed a relevant degree or other qualification or is deemed by the employer or relevant legislation to hold such qualification or possess such experience as appropriate or required for the position.	142%	1,803.20

[558] The above structure includes the roles of Family Day Care Co-ordinator and Family Day Care Trainee Supervisor, which align with that of Assistant Director of a Service at Level 7, as is the case with the current Level 5. This would partially facilitate the implementation of our *provisional* view stated in respect of the SCHADS Award that coverage of family day care work should fall entirely under the CS Award. However, the current range of classifications for Family day care employees in Schedule D of the SCHADS Award is broader than this, and we invite further submissions in due course regarding whether it is

necessary to add further family day care roles at other levels in the CS Award structure in order to fully implement this *provisional* view.

[559] In establishing the rates for Directors and Assistant Directors, we have had regard to the fact that they are responsible for managing and implementing educational programs developed by teachers who hold degree-level qualifications, and for managing Educators, who may be appointed to roles where they are in charge of a group of children. The rates for teachers are set by the EST Award and it is necessary that the rates for Directors exceed the rate for teachers given their respective roles. The proposed wage rates for Directors and Assistant Directors (Levels 8 and 7 respectively) have been set by reference to the current percentage relativities that the rates for these classifications in the existing structure bear to the new key classification of CSE Level 3, applicable to an Educator holding an AQF Level 3 qualification, undertaking caring work. Because there is no qualification requirement to hold the roles covered by these classifications, they operate on the basis that it is the work of the role itself, and not any qualification that a person in the role may hold, for which the minimum wage rate has been set. Consistent with this, it is our *provisional* view that the qualification allowance in clause 15.6 of the CS Award for Directors or Assistant Directors holding a Graduate Certificate in Childcare Management or equivalent should be abolished.

[560] The translation of existing employees under the CS Award to the new structure, with the total increase to the award minimum wage rates identified, would operate as follows:

Current Classification	New Classification	Increase (%)
Level 1.1	CSE Level 1	24.8
Level 2.1	CSE Level 2	27.8
Level 2.2	CSE Level 2	23.7
Level 3.1	CSE Level 3	23.0
Level 3.2	CSE Level 3	18.9
Level 3.3	CSE Level 3	15.3
Level 3.3 (with 4+ years' post-qualification experience at Level 3)	CSE Level 4	19.9
Level 3.4	CSE Level 5	18.0
Level 4.1	CSE Level 6	17.0
Level 4.2	CSE Level 6	15.2
Level 4.3	CSE Level 6	13.5
Level 5A.1	CSE Level 7	21.6
Level 5A.2	CSE Level 7	19.9
Level 5A.3	CSE Level 7	18.2
Level 5.1	CSE Level 7	21.6
Level 5.2	CSE Level 7	19.9
Level 5.3	CSE Level 7	18.2
Level 5.4	CSE Level 7	17.8
Level 6A.1	CSE Level 8	23.0
Level 6A.2	CSE Level 8	21.5
Level 6A.3	CSE Level 8	20.0
Level 6.1	CSE Level 8	23.0
Level 6.2	CSE Level 8	21.5
Level 6.3	CSE Level 8	20.0
Level 6.4	CSE Level 8	15.7

Current Classification	New Classification	Increase (%)
Level 6.5	CSE Level 8	14.6
Level 6.6	CSE Level 8	13.3
Level 6.7	CSE Level 8	11.9
Level 6.8	CSE Level 8	10.7
Level 6.9	CSE Level 8	9.4

[561] We have not included the current Level 4A classifications in the above translation table because it is unlikely that employers could appoint persons without qualifications to the roles of Lead Educator or Room Leader consistent with applicable regulatory requirements in the ECEC sector, including the requirement for minimum ratios of qualified educators to children. We have also not included the current Level 3A classifications because they appear to be obsolete.

7.10 Operative date and phasing-in

[562] Our *provisional* view as to a new classification structure and minimum wage rates for CSEs will, if implemented, obviously have significant cost implications for employers in the ECEC sector. As set out in the translation table above, the total increase to the minimum wage rate for a Certificate III-qualified CSE under the *provisional* view will be 23 per cent. It is not in dispute that the sector is heavily reliant on Commonwealth government funding and that the capacity for employers in the sector to bear the cost of the new wages structure will depend to a large degree upon an adjustment to that funding. In respect of the outcome of these proceedings specifically, the Commonwealth has made no commitment to or decision about increased funding and has indicated that it seeks the opportunity to make further submissions about cost and implementation once we have stated our conclusions about the existence of gender-based undervaluation and the steps necessary to rectify it. The likely outcome of a lack of a funding commitment on the part of the Commonwealth beyond the scope of the Retention Payment scheme is that providers will be forced to increase their fees, which will have consequences for the capacity of at least some parents with young children to participate in the workforce.

[563] There are two matters which are ameliorative of the cost impact. The first is the Retention Payment associated with the entry of employers into the ECEC Agreement (or another 'compliant workplace instrument'), which will fund a total wage increase of 15 per cent above the current award wage rates by 1 December 2025. Because, as explained in the Commonwealth's submission, this amount will effectively absorb any award wage increases of a lesser amount, this means that, for those employers who render themselves eligible for the Retention Payment, a substantial proportion of the award wage increases proposed would be funded at least for the duration of the Retention Payment scheme. The second is that it is clear that, independent of the Retention Payment scheme, a significant minority of employers covered by the CS Award already pay above-award wages, whether through enterprise agreements or individualised arrangements, and there is therefore some capacity in the ECEC sector to absorb increases in award wage rates.

[564] Having regard to these matters, our *provisional* view as to the implementation of the classification structure and wage rates is that:

(1) the wage rates should be phased in over a period of five years in annual increments; and

(2) there should be an initial increase to the award wage rates for CSEs of 5 per cent operative from 1 August 2025.

[565] We will invite further submissions about the above *provisional* views before finally determining what variations to the CS Award are necessary to meet the modern awards objective and the minimum wages objective.

8. NEXT STEPS

[566] A determination to vary the Pharmacy Award to implement the first phase of the outcome we have determined is published together with this decision.

[567] In respect of the *provisional* views we have expressed concerning the HPSS Award at paragraphs [177]–[179], [235]–[236] and [289]–[290], the SCHADS Award at paragraphs [392]–[396], the ATSIHW Award at paragraphs [447]–[451] and the CS Award at paragraphs [557]–[561], we will as a first step program each award for conference in order to ascertain in the first instance the nature and scope of any issues which interested parties may wish to raise in response to those *provisional* views. These conferences will be conducted after the parties have had a reasonable opportunity to properly consider the *provisional* views. They will not occur until after 3 May 2025. Based on parties' responses at the conferences, we will then, to the extent necessary, program the Review for further hearing to finalise the variations to the awards necessary to rectify the gender-based undervaluation we have found to have occurred.

PRESIDENT

Appearances:

Matter AM2024/19 (*Pharmacy Industry Award 2020*)

K Burke SC with *P Lettau*, counsel, *T Clarke* and *S Peldova-McClelland* for the Australian Council of Trade Unions.

M Buchanan for The Association of Professional Engineers, Scientists and Managers, Australia.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

S Wellard, solicitor, and *S Harris* for The Pharmacy Guild of Australia.

C O'Grady KC with *F Leoncio*, counsel, instructed by MinterEllison, for the Private Hospitals Group (Australian Private Hospitals Association, Catholic Health Australia, Day Hospitals Australia, Healthscope Operations Pty Limited and Adelaide Community Health Care Alliance Incorporated).

Matter AM2024/20 (*Health Professionals and Support Services Award 2020*)

K Burke SC with *P Lettau*, counsel, *T Clarke* and *S Peldova-McClelland* for the Australian Council of Trade Unions.

L de Plater for the Health Services Union.

S Schreier-Joffe and *T Wu*, solicitors, for Dental Assistants Professional Association Incorporated.

T Spence, counsel, instructed by *J Peñafiel*, solicitor, for the Phlebotomists Council of Australia.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

C O'Grady KC with *F Leoncio*, counsel, instructed by MinterEllison, for the Private Hospitals Group.

J Tracey KC with *B Holding*, counsel, instructed by DLA Piper, for Australian Pathology.

J Arndt for Australian Business Industrial, NSW Business Chamber Ltd and the Aged & Community Care Providers Association.

Matter AM2024/21 (*Social, Community, Home Care and Disability Services Industry Award 2010*)

M Robson and *B Kruse* for the Australian Municipal, Administrative, Clerical and Services Union.

C Gourlay for the Health Services Union.

A van Gent for the United Workers' Union.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

R Bhatt and *C Beasley* for The Australian Industry Group.

K Scott for Australian Business Industrial, NSW Business Chamber Ltd, the Aged & Community Care Providers Association and National Disability Services.

Matter AM2024/22 (*Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020*)

K Burke SC with *P Lettau*, counsel, *T Clarke* and *S Peldova-McClelland* for the Australian Council of Trade Unions.

N Blair for the National Aboriginal Community Controlled Health Organisation.

S Kilpatrick, *A Ropitini*, *K Martyres* and *J O'Shea* for the Victorian Aboriginal Community Controlled Health Organisation.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

Matter AM2024/23 (*Children's Services Award 2010*)

K Burke SC with *P Lettau*, counsel, *T Clarke* and *S Peldova-McClelland* for the Australian Council of Trade Unions.

C Gray-Starcevic for the United Workers' Union.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

R Bhatt, C Beasley and *L Cruden* for The Australian Industry Group, the National Outside Schools Hours Services Alliance and the Outside School Hours Council of Australia.

N Ward and *A Rafter* for Australian Business Industrial, NSW Business Chamber Ltd and the Australian Childcare Alliance.

Matter AM2024/25 (*Social, Community, Home Care and Disability Services Industry Award 2010* — application for variation by Australian Municipal, Administrative, Clerical and Services Union, The Australian Workers' Union, Health Services Union and United Workers' Union)

K Burke SC instructed by *M Robson* for the Australian Municipal, Administrative, Clerical and Services Union, The Australian Workers' Union, Health Services Union and United Workers' Union.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

R Bhatt and *C Beasley* for The Australian Industry Group.

K Scott for Australian Business Industrial, NSW Business Chamber Ltd, the Aged & Community Care Providers Association and National Disability Services.

Matter AM2024/27 (*Social, Community, Home Care and Disability Services Industry Award 2010* — application for variation by Australian Municipal, Administrative, Clerical and Services Union)

L Saunders, counsel, instructed by *M Robson* and *B Kruse* for the Australian Municipal, Administrative, Clerical and Services Union.

C Gourlay for the Health Services Union.

K Eastman SC with *C Dowsett*, counsel and *V Bulut*, counsel for the Commonwealth of Australia.

R Bhatt and *C Beasley* for The Australian Industry Group.

K Scott for Australian Business Industrial, NSW Business Chamber Ltd, the Aged & Community Care Providers Association and National Disability Services.

Hearing details:

2024.

Sydney:
2–6, 9 December.

Melbourne:
10–13, 16–20 December.

Final written submissions:

Australian Council of Trade Unions: 23 December 2024, 13 January 2025.
Private Hospitals Group: 23 December 2024, 17 January 2025, 28 January 2025.

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