Inquiry into the Fair Work Commission Annual Report 2019-20

Health Services Union

Submission to the House of Representatives Standing Committee on Employment, Education and Training

9 November 2021

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About Us

The Health Services Union (**HSU**) is a growing member-based union with nearly 90,000 members working across the health and community services sectors in every state and territory.

The HSU advocates for meaningful, secure employment with strong wages, good conditions and access to representation of an individual's choice. We work to secure the livelihood of not just our members, but all Australians. Our work and advocacy are in recognition of the inextricable link between accessible, quality and safe health care with meaningful social and economic participation. Valued health and social care workforces are central to delivery of these outcomes.

Our members work in aged care, disability services, community health, mental health, first response, alcohol and other drugs, public hospitals, and private practices.

HSU members include, but are not limited to, health professionals, social workers, paramedics, disability support workers, aged care workers, personal and community care workers, physiotherapists, occupational therapists, diagnosticians, nurses, scientists, technicians, clerical and administrative staff, doctors, medical librarians, and support staff.

We are committed to advancing and protecting the wages and conditions, rights and entitlements of our members through campaigning, education and workplace activism. The HSU also provides a range of services and support to assist members with many aspects of working and family life.

We are a driving force to make Australia a better place. We work to ensure the rights of not just our members, but all working Australians, are protected. Our work and advocacy are in recognition of the inextricable link between accessible, quality and safe healthcare and meaningful social and economic participation. A valued health workforce is central to delivery of outcomes.

HSU National is the trading name for the Health Services Union, a trade union registered under the Fair Work (Registered Organisations) Act 2009. While this submission has been prepared by HSU National, it is made on behalf of our branches and members Australia-wide.[1]

[1] HSU National is the trading name for the Health Services Union, a trade union registered under the Fair Work (Registered Organisations) Act 2009.The HSU has registered branches for New South Wales/Queensland/Australian Capital Territory; Victoria (4); Tasmania; South Australia/Northern Territory; and Western Australia.

Executive Summary

HSU members have and continue to work at the frontline of public health care and management in response to the COVID-19[2] pandemic in diverse roles across every affected level of our country's health and community services infrastructure. Via the lived experiences and insights of our members, we are expertly placed to make a submission to the House of Representatives Standing Committee on Employment, Education and Training's (**Committee**) Inquiry into the Fair Work Commission Annual Report 2019-20 (**Report**).

The Committee is particularly interested in the President, Justice Iain Ross AO's, observation at page 6 of the Report that 'while responding to the consequences of the pandemic, the Commission has also seen an increase in its caseload with substantial increases in the number of unfair dismissal matters and workplace disputes'. While it is apparent from the Fair Work Commission's (**FWC**) Annual Report 2020-21 the specific trend with respect to unfair dismissals and disputes observed by Ross J in the 2019-20 Report does not appear to have continued through 2020-21, there is no doubt that COVID-19 is and will continue to have industrial reverberations for some time to come. That there may continue to be increased demands generally on the FWC as Australia continues to chart its path out of the pandemic seems uncontroversial.

COVID-19 and the various policy and regulatory responses which continue to evolve at both state and federal levels have exposed and amplified existing industrial issues and labour market inequalities – often with devastating consequences. Whilst not an exhaustive list by any means, most notably for HSU members the industrial issues and inequalities which have come to the fore during the pandemic include the scourge of low wages and insecure work and the ineffectiveness of the current industrial relations framework to deal with the same, access to leave entitlements (in particular, in relation to testing, isolation, quarantine and vaccination requirements), workload exacerbations, access to PPE, and vaccination mandates.

While solutions to these issues should have already been developed, there remains an opportunity for reform and improvement. Governments, industry, employers, the workforce and its representatives must work together to develop forward-thinking and thorough responses to the industrial issues which have been amplified during the COVID-19 crisis.

[2] For consistency, the term used herein will be COVID-19 however, the HSU understands and draws attention to the differentiation between the virus being known as SARS-CoV-2 and COVID-19 as the disease that can develop from the virus.

COVID-19 – Industrial Issues

Low wages

The COVID-19 pandemic has highlighted major shortcomings in Australia's industrial relations framework, including the inadequacy of award wage rates and conditions, and an enterprise bargaining system which fails to achieve significant above-award outcomes for employees in funded sectors.

Many of the workers who have played, and continue to play, critical roles through the pandemic keeping our communities strong, our loved ones safe, and supporting our most vulnerable, are award reliant. This is particularly the case in the aged care and disability sectors. Award wages in such sectors are low, reflecting an historical undervaluation of care work. Award reliant workers receive only the national minimum wage increases year to year. Bargaining is, at best, marginally successful in sectors that are primarily only government funded and then usually in relation to non-monetary conditions.

The only viable option (given the demonstrated ineffectiveness of the equal remuneration provisions of the Fair Work Act 2009 and the FWC's low paid bargaining stream) to increase award wages is to pursue award variations on work value grounds. Such proceedings are costly, resource intensive (including for the FWC), and slow. They are often resisted on economic grounds by employers who cry poor or those who are reliant on funding to operate.

The HSU currently has two work value applications on foot before the FWC seeking to increase wages by 25% for residential and in-home aged care workers covered by the Aged Care Award 2010 and the Social, Community, Home Care and Disability Services Industry Award 2010, respectively.

Despite recommendation 76 of the Royal Commission into Aged Care Quality and Safety, the Government has not been prepared to meet with the Aged Care Workforce Industry Council, employer peak bodies, providers, advocates and unions to discuss the abovementioned applications. Even their participation would be a step forward.

Work value applications are lengthy and drawn-out processes, as evidenced by the application by the Independent Teachers Union to vary Educational Services (Teachers) Award 2020 (first made as an application under the Equal Remuneration[3] provisions in 2013, later amended to an application on the grounds of work value[4] in 2018). The matter is not yet finalised.

The fact that the funder of services refuses to even come to the table to discuss the HSU's applications will inevitably make the journey for fair and properly valued wages for care workers harder and longer.

Even where employees in funded sectors are employed under enterprise agreements, bargaining is hamstrung for a number of reasons.

First, in the context of COVID-19, HSU organisers report an increase in employers (particularly for-profit aged care providers) taking latitudes by using the excuse of COVID-19 to resist or delay bargaining in the sector despite the significant increase in demands being placed on their staff as a

3 C2013/6333

4 AM2018/9

direct result of the pandemic. As a result, workers languish on agreements that had either passed or were close to passing their nominal expiry dates at the beginning of the pandemic and are now years out of date.

Where support for a majority support determinations (**MSD**) is unlikely to be achieved, and the employer refuses to bargain, the only available alternative is to apply to terminate an agreement and hope this may prompt employers into bargaining (if transitioning to the award may be more of an impost for an employer than bargaining), or otherwise have workers revert to the award. This is far from an ideal scenario.

HSU Branches report they are considering both MSDs and applications to terminate agreements with several employers. Given the intransigence exhibited by some, an increase in termination or MSD applications to the Commission, and therefore the Commission's workload, is more than possible.

To address this particular issue, the HSU calls for changes to the Fair Work Act to:

- Require employers to respond to a bargaining request where the NED has passed;
- Good faith bargaining provisions to apply to a request to bargain; and
- The FWC be given the power to conciliate and/or determine the outcome of a bargaining request dispute.

The second, and more significant, issue with respect to enterprise bargaining is that the current enterprise bargaining system does not provide for the economic employer – the funder – to be at the bargaining table. This creates significant barriers for workers hoping to achieve wage outcomes.

For example, in the aged care and disability sectors, the funder is the Federal Government. Government resourcing largely dictates the wages and conditions for these workers. Individual providers in the care sectors are not the decision makers when it comes to pay and conditions. Unlike other sectors where negotiations take place directly with the people controlling the purse strings, the Government is not compelled to be involved in discussions on wages in the sectors it funds under the current enterprise bargaining framework.

As a result, many workers – particularly those in feminised workforces – are at, best, on wages that are only fractionally above the award minimums even where they are covered by an enterprise agreement.

While increasing award wages through work value applications (if successful) will provide a boost to enterprise agreements in the same sectors in the short term, any gains will simply be eroded again over time unless there is meaningful reform to the enterprise bargaining system with a particular focus on the unique challenges faced by low paid workers in funded sectors.

To address this issue, the HSU calls for changes to the Fair Work Act to provide for funded sector bargaining, with the following key principles:

- The establishment of a dedicated care sector panel in the FWC with experts in various sectors which would facilitate the bargaining and agreement making process, including through dispute resolution (arbitration);
- The empowerment of the care sector panel through statute to compel the attendance and involvement of the funder in bargaining;

- Sector wide (industry bargaining) in funded sectors, enabling discussions to include not only the funder but provide nuanced variations for the portion of the sector involved, for example, aged care or disability;
- The care sector panel should deal with future care sector award matters (including work value applications).

Access to leave entitlements

COVID-19 has also highlighted the prevalence of insecure work and under-employment and the eroding effect this has on workers' rights including access to appropriate or adequate leave entitlements.

By the very nature of their work and workplaces, health and social care workers are at increased risk of exposure to COVID-19 and other illnesses and present an increased risk of transmitting the virus and other illnesses to those in their care. This is increased during cold and flu season, and in the context of COVID-19, requires additional vigilance and precautionary measures, such as higher infection control measures. As such, these workers were (and are still) required to use personal or other leave at higher-than-normal rates to test, isolate or quarantine.[5]

In addition, the prevalence of precarious employment in these sectors means workers are often not entitled to accrual of paid leave or do not have large accruals, especially not enough to cover test and isolate orders or a 14-day isolation, which is likely to occur regularly given workers are required to test if they present with even minor cold or flu symptoms. HSU organisers report that even where employees are required to isolate due to an exposure in their workplace, they are not being paid by their employer for the leave period, despite this being a work incident (particularly in private medical practices).

As the following two case studies reflect, the issue of leave entitlements is one of the most frequently raised concerns of HSU members in the context of COVID-19.

Case Study 1 - Isolation Leave

"John" is a radiographer at a large hospital in inner Melbourne. His workplace has one of the city's biggest COVID-19 wards. John's role requires him to work with COVID-19 and non-COVID-19 patients while he carries out diagnostic testing and imaging. Due to workforce capacity pressures, allied health professionals like John must work with COVID-19 and other patients. There are not enough of them, or the equipment needed for their work, to completely separate them. This has meant that John often has to "test and isolate" due to potential exposure to the virus. He has not himself ever contracted SARS-COV-2.

As John is employed on a full-time contract, he has accrued personal leave entitlements. Early in the pandemic and at intermittent times during, there have been small leave payments offered to him, in addition to his personal leave, by his employer for isolation periods. However, as the pandemic has continued and this funding has not been adequate or steady, he has most often had to isolate using

[5] Gilbert, L & Lilly, A, 'Independent Review of COVID-19 outbreaks at: St Basil's & Epping Gardens', 30 November 2020, pp. 18-19.

his sick leave or without any paid leave. This has become an increasing issue over Melbourne's recent lengthy lockdown.

John's employer has offered him 2 days paid pandemic leave but in exchange for a reduction in his personal leave of up to 7 days per annum. This means that the benefit of the paid leave for test and isolate requirements is offset by a 30% reduction in his paid personal leave entitlement under the NES. As John is fit for work during these periods, it also means he is giving up paid sick leave when he is not unwell. Given the frequency of having to test and isolate, and the reality that this is only going to increase as lockdowns ease and transmission and cases spike, John will not be any better off with this scheme. John is worried that he will contract COVID-19 or as the next influenza season arrives, he will develop a cold, flu or like symptoms and require his sick leave when he is actually unwell but won't have enough left in his leave balance.

John and his colleagues recently outlined these concerns to his employer. Shortly after, they removed the offer of any paid pandemic leave for test and isolate and instead introduced a 'Vax2TheMax' program. This provides 1 day of extra Annual Leave upon evidence that the employee has had two doses of COVID-19 vaccination. Employees were instructed to then use personal leave or unpaid leave for any ongoing test and isolate requirements.

John was advised by his employer that there is simply not enough money available for them to continue furloughing staff with pay during test and isolate periods. John accepts this reasoning as over the past 20 months, he has watched the hospital work at stretched staffing and resource capacity. He understands it is only going to get worse and there are only so many staff, PPE, equipment etc to go around. John and many of his colleagues understand they will have to accept testing and isolating without paid leave, only because they know that if they don't, there will be no staff left to help their patients and keep the hospital running.

Case Study 2 – Isolation Leave

"Samantha" worked at a hospital that had a cluster outbreak. She had to self-isolate for a number of days, in line with policy, until she returned a negative test. She missed shifts and incurred financial loss as a result. There was confusion as to whether Samantha was entitled to special COVID-19 paid leave under the Commissioner of Public Sector Determinations. The confusion arose because at the declared commencement time of the outbreak, Samantha had finished her rostered shift but was held back on premises to complete patient case notes - a task that her paid hours work did not allow enough time for. Technically, Samantha had 'clocked off' and therefore was denied test and isolate entitlements.

While the FWC, on application by the HSU and other unions, awarded paid pandemic leave to aged care workers under a limited number of awards, this was a delayed and temporary measure. Paid pandemic leave was not granted by the FWC until August 2020 (after the FWC initially rejected the application) and it excluded causal workers with irregular hours from accessing the leave. This exclusion undermined the very intent of the claim and overlooked the exact workers who were at highest likelihood of working multiple jobs to subsidise low hours and low wages.

The FWC's decision to award paid pandemic leave appeared to be reactive to extensive outbreaks in residential aged care facilities in Victoria at the time, rather than a proactive measure which could provide comfort for any worker required to test, isolate or quarantine that they would not be penalised financially for doing so. The entitlement was removed in March 2021, notwithstanding the continuation of the pandemic.

The HSU calls for a change to the NES entitlements of all workers in care sectors to encapsulate the following:

- Paid pandemic leave for all workers, including casual workers, if they contract COVID-19 (or other relevant diseases);
- Paid test, isolate and/or quarantine leave for all workers, including casual workers if they are required to test, isolate and/or quarantine by their employer, or health or emergency government orders/powers;
- Paid vaccination leave, to receive and recover from any side effects of an available vaccination.

Workload

Low or inadequate staffing levels in many health and social care settings has resulted in an incredible level of burnout among HSU members. In many sectors, for example aged care, inadequate staffing levels connected to issues with attraction and retention of staff are well documented and pre-date the COVID-19 pandemic.[6]

Members report being required to work increased amounts of overtime and being expected to work through meal breaks and forego taking leave.

Case Study 3 - Extended Shifts

"Lucy" is an allied health professional as a large hospital in South Australia. Since mid- 2020, she has regularly been required to carry out extended shifts or additional shifts to meet surge workforce demands arising from the continuing COVID-19 pandemic. Lucy should receive an 8-hour break between shifts, to ensure her own and patients' safety and wellbeing. Extended and additional shift requirements due to lack of staff means that Lucy and her colleagues are being called back with as little as 5 hours between shifts. The number of full-time staff over the past 2 years has been significantly reduced. It is unclear why at the time of increased pressures that full-time staff have been cut down.

Adequate staffing levels must be provided for to ensure workers can complete their work within their ordinary hours. In order to address problems associated with attraction and retention, given the risks to workers associated with providing frontline care during the pandemic, it is essential that providers negotiate with unions and government to ensure wages are increased to reflect this effort. This will require policy and regulatory measures to match from Government as the main funder of aged care,

[6] Ibid 6, pp. 221-222 and Australian Government, Department of Health, 'A Matter of Care: Australia's Aged Care Workforce Strategy', Aged Care Workforce Strategy Taskforce, June 2018, p. 54.

including more funding, funded leave, funding transparency measures and accountability. Stable, properly funded care jobs can play a significant role in the social and economic recovery post-COVID and investment in the sector now will be essential to delivering this outcome.

Access to PPE

While HSU members and organisers report issues with access to personal protective equipment (**PPE**) are less common now than at the beginning of the pandemic, it has been widely reported that access to PPE and training in donning and doffing of PPE have been woefully inadequate throughout the pandemic.

Case Study 4 – Access to PPE

"Ben" is an allied health professional working in a large public hospital in South Australia. When the COVID-19 pandemic began to take hold in 2020, Ben was never fitted for, or even provided, full Personal Protective Equipment. When Ben raised this safety concern, he was told the hospital did not have enough PPE and they had to make decisions about what cohorts of workers would be given full access and fit-testing. Ben was advised that as he was an allied health worker in the hospital, he was "low-risk" for transmission and infection of SARS-COV-2. Health professionals like Ben not only spend hours providing direct care to multiple patients, but they also move around the entire hospital, rather than being able or restricted to only work within certain departments and locations. Ben has been very worried about his family and the potential of contracting the virus and taking it home to loved ones and his community. To protect against this, and to manage his stress in lieu of his employer providing and fitting full PPE, Ben made the decisions to separate himself from his family, until the hospital could provide adequate PPE. It was many months into the pandemic when Ben and his allied health colleagues received full PPE and underwent fit-testing.

Clear, consistent Government advice on the PPE has been an issue for employers and employees since the beginning of the pandemic. Confusion and anxiety around PPE emerged early as the number one report of concern from HSU members across all occupations, sectors and states/territories in 2020. It persists as one of the key issues raised by our members, as highlighted in the case study above from October 2021. At various times throughout the pandemic, the Government – or in their absence other health sector stakeholders – have issued various PPE guidelines, if any at all, depending on the health and social care setting a person works in or visits.

To highlight the confusion, the aged care sector provides a good example. In April 2020, the Department of Health provided five official sets of PPE guidance, applicable to aged care settings and extending to the treatment of older patients in other health settings, including in-patient, non-inpatient, and transfers. In May 2020, the aged care industry in consultation with Government introduced a visitation code also dealing with PPE requirements for staff and visitors, including contractors, to residential facilities.

In contrast to the above plethora of advice for aged care facilities, the disability sector and many allied health professions, including physiotherapists, social workers and radiographers, have received minimal advice on PPE. The only official source of information on PPE use is from the NDIS Quality and

Safeguards Commission. It is not clearly connected to the Department of Health/Government guidelines. The HSU is deeply concerned by this dearth of advice and support, particularly in the disability sector as it faces unique challenges in education, infection control and advocacy. The disability sector also presents with similar risks to the aged care sector, such as the event of an outbreak in residential settings, and yet PPE availability and training is still simply not being considered in the same depth for the sector.

As the highly contagious Delta variant drives high rates of community transmission, occurring at a time when restrictions are easing across the country, HSU members are facing immense pressures, including anxiety that PPE supplies will not be able to meet sustained demand. Additionally, health care workers are primarily required to use fit tested N95 masks. While acknowledging that N95 masks are effective, our members also report that they often result in pressure marks and cuts to their faces. There are more comfortable and therefore potentially safer alternatives, but these are often not considered due to cost imperatives.

As communities commence 'COVID normal' living and the pressures on our health system increase, essential workers should be afforded adequate, comfortable and readily available PPE. The HSU anticipates increased member queries and requests for support as they manage ongoing (and increasing) PPE and other IPC controls in this stage of the pandemic. Government and employers have a duty to protect the safety of health workers. Without PPE, this duty cannot be met, and health care workers will get sick. Lack of PPE will lead to serious illness, and in some cases deaths, of Australians.

As a result, there is the potential for increased health and safety and other disputes in the FWC and other relevant jurisdictional tribunals.

Vaccination mandates

The HSU supports the mandating of COVID-19 vaccinations for workers in front line health care and vulnerable social care settings. It is the HSU's experience that the vast majority of our membership share the same view and have readily taken up the vaccination when available despite the lack of any universal access to vaccination leave to either receive the vaccine or recover from any side effects.

Ongoing issues flowing from vaccination mandates which may impact the FWC's caseload include disputes around employer vaccination policies and workforce attrition.

The HSU encourages employers who determine to introduce COVID-19 vaccination policies to ensure such policies are consistent with, and do not go beyond, the relevant public health orders that apply in their jurisdiction. However, individual employers do and will likely continue to implement vaccination policies that are out of line with public health orders. Members' concerns around such employer-specific policies often go to a tendency for policies to overreach on medical evidence, for example, requiring details of a worker's medical exemption to then be reviewed by management or human resources (as opposed to simply accepting a medical exemption from a worker's doctor made in line with relevant guidelines). Employer policies are ambiguous as to the purpose of additional reviews of sensitive information by management. The HSU is concerned by the potential privacy and industrial ramifications of diverting from official advice and guidance on medical exemptions

In addition, to date, public health orders and vaccination policies have inconsistent approaches to redeployment for medically exempt workers. Some allow for these workers to continue in full PEE

although this can compound worker discomfort and burnout (see above under 'Access to PPE'), while others provide no employment recourse for exempt workers. In addition, vaccine mandates have and will inevitably mean those workers who choose not to be vaccinated will be required through one means or another to leave their jobs. This workforce attrition in settings which, as described above, already suffer from inadequate staffing levels in many cases, will likely compound the overwork and workload issues being experienced by HSU members.

It is plausible that employer-specific vaccination policies and approaches to managing medically exempt workers may give rise to an increase in disputes or, potentially, unfair dismissal or other like applications before the FWC in the future.

Concluding remark

The issues outlined above can be complex, interrelated, and do not represent an exhaustive list of the issues encountered to date or those which may continue to arise in the future course of the pandemic. Governments, industry, employers, the workforce and its representatives must work together to develop forward-thinking and thorough responses to the COVID-19 crisis. Solutions can be (and should have already been) developed by examining the case studies contained herein.