Private Medical Practice Bulletin

For the benefit of our members

AMA

Issue No 10 July 2013

AUSTRALIAN NURSING FEDERATION CLAIM FOR "LOW PAID AUTHORISATION" REJECTED BY FAIR WORK COMMISSION

The AMA welcomed the decision by the Fair Work Commission (FWC) to reject the Australian Nursing Federation (ANF) claim for a low paid bargaining authorisation for practice nurses working in medical practices.

The Federal AMA, along with AMA Victoria and AMA Tasmania, opposed this claim before the FWC, arguing that practice nurses are not low paid and that they already bargain extensively with employers at the local level.

The AMA argued that the ANF claim had the potential to drive up costs for practices by centralising the negotiation of wages and conditions.

"The AMA presented extensive witness evidence and supporting submissions to the Commission in support of the case against the ANF application

"In rejecting the ANF application, the FWC concluded that most practice nurses were not low paid and that the case for the authorisation was not strong.

"It found several important factors indicated that multi-employer bargaining may be undesirable or less appropriate than genuine enterprise-based bargaining and, on that basis, it was not in the public interest to make the authorisation."

The ANF application covered 682 medical practices, most in Victoria, Tasmania, and New South Wales. However if the ANF was successful in its application they would have flowed that decision to other states including Western Australia.

Attached to this Private Practice Bulletin is the full decision of Vice President Watson of the Fair Work Commission.

Should any Practice have any queries regarding this bulletin please do not hesitate to contact Gary Bucknall email gary.bucknall@amawa.com.au or telephone 9273 3000.

FAIR WORK COMMISSION

DECISION

Fair Work Act 2009
s.242 - Application for a low-paid authorisation

Australian Nursing Federation
v
IPN Medical Centres Pty Limited and Others

(B2011/3940)

VICE PRESIDENT WATSON MELBOURNE, 17 JUNE 2013

Application for a low paid authorisation - practice nurses - whether employees are low-paid - access to collective bargaining or difficulty bargaining at an enterprise level - history of bargaining in the industry - relative bargaining strength - commonality in enterprises - whether improvements in productivity - whether authorisation in the public interest - Fair Work Act 2009 - ss. 171, 241, 242, 243, 284.

Introduction

[1] This decision relates to an application by the Australian Nursing Federation (ANF), lodged on 11 November 2011, for a low-paid authorisation under s.242 of the *Fair Work Act 2009* (the Act). The application is made in relation to nurses employed in general practice clinics and medical centres performing nursing work described in Schedule B of the *Nurses Award 2010* (the Award).[1] I will refer to the nurses covered by the application as 'practice nurses'. The ANF seeks an authorisation which, if granted, would permit it to bargain for a multi-enterprise agreement covering all of the employers named in the revised list of respondents dated 1 February 2013.[2]

[2] The consequences of granting a low paid authorisation include the availability of the assistance of the Fair Work Commission (the Commission) to facilitate bargaining,[3] the availability of bargaining orders in relation to the multi-employer bargaining arising from the Act's good faith bargaining requirements,[4] and the availability of a low paid workplace determination by way of arbitration by the Commission,[5] These rights are not otherwise available for a bargaining representative who seeks to bargain on a multi-employer basis.

[3] The matter was initially allocated to Commissioner Cribb and referred to me on 12 June 2012. On 19 June 2012, directions were made for the filing of outlines of submissions, witness statements and other material by any party opposing the application and by the ANF and any party supporting the application.

[4] In the week commencing 4 September 2012, I heard evidence from ANF witnesses. In the week commencing 19 November 2012, I heard evidence from witnesses of the respondents. The parties subsequently filed written submissions and the matter was listed for final closing submissions on 24 and 25 January 2013.

[5] In the proceedings Mr C Dowling, of counsel represented the ANF. Mr M Harmer appeared for Independent Medical Centres Pty Limited, Allied Medical Group Holdings Pty Ltd and Lonnex & Millenium Management Holdings Pty Ltd, collectively known as IPN. These entities operate medical practices which employ practice nurses. Mr T McDonald appeared for the Australian Medical Association (AMA) Limited, AMA Victoria Limited and AMA Tasmania Limited. AMA members are doctors who own and operate medical practices. Mr M Ritchie appeared on behalf of the Victorian Employers' Chamber of Commerce and Industry (VECCI), an employer association acting on behalf of 26 individual respondents named in the application. Mr M Follett, of counsel, appeared for the Primary Health Care Ltd, which is a group comprised of two separate employing entities; Idameneo (No 123) Pty Ltd and Sidameneo (No 456) Pty Ltd. Primary Health owns and operates 77 medical centres in Australia.

[6] Others to make submissions included Healthscope Limited and Health & Life. A number of other individual employers opposed the application. A large number of general practices on the list of employer respondents were unrepresented in the proceedings.

The Application

[7] The ANF's application seeks a low-paid authorisation with respect to nurses employed under the Award by employers listed in an amended schedule of approximately 682 respondents. The original application states that:

- The ANF is an employee organisation entitled to represent the industrial interests of the employees in relation to work to be performed under a multi enterprise agreement for the purposes of s.242 of the Act;
- The employees that are the subject of the application are low paid, have either not had access to collective bargaining or face substantial difficulty bargaining at the enterprise level;
- The history of bargaining in the industry and the relative bargaining strength of the employers and the employees supports the authorisation being made;
- The employees' current terms and conditions are inferior compared to relevant industry and community standards;
- All of the named respondents have substantial commonality in the services provided, staffing, funding and operations;
- It is in the public interest to make the authorisation.

[8] The application included a list of employers to which the authorisation would apply. The list of employers was subsequently amended and a revised list of employers was provided on 12 December 2012, with further revisions being provided on 1 February 2013. The revised list contains approximately 682 employers. The employers represented in the proceedings strongly oppose the application on both jurisdictional and merit grounds.

Statutory Provisions

[9] Section 242, under which the application is made, is in Division 9–Low-paid Bargaining, of Part 2–4 of the Act. Part 2–4 deals with Enterprise Agreements. The objects of Part 2–4 are found in s.171. Section 171 refers to the provision of a framework to provide collective bargaining for agreements that will deliver productivity benefits. It states:

> "**171 Objects of this Part**
>
> The objects of this Part are:
>
> (a) to provide a simple, flexible and fair framework that enables collective bargaining in good faith, particularly at the enterprise level, for enterprise agreements that deliver productivity benefits; and
>
> (b) to enable FWA to facilitate good faith bargaining and the making of enterprise agreements, including through:
>
> (i) making bargaining orders; and
>
> (ii) dealing with disputes where the bargaining representatives request assistance; and
>
> (iii) ensuring that applications to FWA for approval of enterprise agreements are dealt with without delay."

[10] Division 9 contains its own objects in s.241. That section reads:

> "**241 Objects of this Division**
>
> The objects of this Division are:
>
> (a) to assist and encourage low-paid employees and their employers, who have not historically had the benefits of collective bargaining, to make an enterprise agreement that meets their needs; and
>
> (b) to assist low-paid employees and their employers to identify improvements to productivity and service delivery through bargaining for an enterprise agreement that covers 2 or more employers, while taking into account the specific needs of individual enterprises; and
>
> (c) to address constraints on the ability of low-paid employees and their employers to bargain at the enterprise level, including constraints relating to a lack of skills, resources, bargaining strength or previous bargaining experience; and
>
> (d) to enable FWA to provide assistance to low-paid employees and their employers to facilitate bargaining for enterprise agreements.

> Note: A low-paid workplace determination may be made in specified circumstances under Division 2 of Part 2-5 if the bargaining representatives for a proposed enterprise agreement in relation to which a low-paid authorisation is in operation are unable to reach agreement."

[11] As a Full Bench of Fair Work Australia has observed[6]:

> "The terms of s.241 are to be read in the context of the enterprise agreement provisions in the rest of Part 2–4. When the provisions as a whole are considered, it is apparent that the legislative policy underlying the low-paid authorisation provisions is that while bargaining on a single enterprise basis is the preferred approach, multi-enterprise bargaining is permitted "to assist and encourage low-paid employees ... to make an enterprise agreement that meets their needs". The other provisions of Division 9 set out the means by which these objects are to be carried into effect."

[12] Section 242(1) of the Act sets out who may apply for a low-paid authorisation. It states:

> "(1) The following persons may apply to the FWC for an authorisation (a ***low-paid authorisation***) under section 243 in relation to a proposed multi-enterprise agreement:
>
> (a) a bargaining representative for the agreement;
>
> (b) an employee organisation that is entitled to represent the industrial interests of an employee in relation to work to be performed under the agreement.
>
> Note: The effect of a low-paid authorisation is that the employers specified in it are subject to certain rules in relation to the agreement that would not otherwise apply (such as in relation to the availability of bargaining orders, see subsection 229(2)). "

[13] Section 243 sets out the matters that the Fair Work Commission is required to take into account in dealing with an application under s.242. It reads:

> "**243 When FWC must make a low-paid authorisation**
>
> *Low-paid authorisation*
>
> (1) FWC must make a low-paid authorisation in relation to a proposed multi-enterprise agreement if:
>
> (a) an application for the authorisation has been made; and
>
> (b) FWC is satisfied that it is in the public interest to make the authorisation, taking into account the matters specified in subsections (2) and (3).
>
> *FWC must take into account historical and current matters relating to collective bargaining*

(2) In deciding whether or not to make the authorisation, FWC must take into account the following:

(a) whether granting the authorisation would assist low-paid employees who have not had access to collective bargaining or who face substantial difficulty bargaining at the enterprise level;

(b) the history of bargaining in the industry in which the employees who will be covered by the agreement work;

(c) the relative bargaining strength of the employers and employees who will be covered by the agreement;

(d) the current terms and conditions of employment of the employees who will be covered by the agreement, as compared to relevant industry and community standards;

(e) the degree of commonality in the nature of the enterprises to which the agreement relates, and the terms and conditions of employment in those enterprises.

FWC must take into account matters relating to the likely success of collective bargaining

(3) In deciding whether or not to make the authorisation, FWC must also take into account the following:

(a) whether granting the authorisation would assist in identifying improvements to productivity and service delivery at the enterprises to which the agreement relates;

(b) the extent to which the likely number of bargaining representatives for the agreement would be consistent with a manageable collective bargaining process;

(c) the views of the employers and employees who will be covered by the agreement;

(d) the extent to which the terms and conditions of employment of the employees who will be covered by the agreement is controlled, directed or influenced by a person other than the employer, or employers, that will be covered by the agreement;

(e) the extent to which the applicant for the authorisation is prepared to consider and respond reasonably to claims, or responses to claims, that may be made by a particular employer named in the application, if that employer later proposes to bargain for an agreement that:

(i) would cover that employer; and

(ii) would not cover the other employers specified in the application.

What authorisation must specify etc.

(4) The authorisation must specify:

(a) the employers that will be covered by the agreement (which may be some or all of the employers specified in the application); and

(b) the employees who will be covered by the agreement (which may be some or all of the employees specified in the application); and

(c) any other matter prescribed by the procedural rules.

Operation of authorisation

(5) The authorisation comes into operation on the day on which it is made."

[14] By virtue of s.243(1), the Commission must make a low-paid authorisation if it is satisfied that it is in the public interest to do so, taking into account the matters in ss.243(2) and (3). Other aspects of the legislative scheme are also relevant to the application, including the provisions of the Act regarding majority support determinations, scope orders and protected industrial action.

Case Law

[15] In the only other application for a low-paid authorisation (the Aged Care Case) since these provisions were enacted, a Full Bench of Fair Work Australia said[7]:

"**[14]** Some initial observations should be made about the nature of the public interest test. The controlling criterion is satisfaction in the public interest. That criterion is a broad one and is confined only by the limits of the scope and purpose of the Act, as the following passage from the decision of the High Court of Australia in *O'Sullivan v Farrer* indicates:

"[T]he expression "in the public interest", when used in a statute, classically imports a discretionary value judgment to be made by reference to undefined factual matters, confined only "in so far as the subject matter and the scope and purpose of the statutory enactments may enable ... given reasons to be (pronounced) definitely extraneous to any objects the legislature could have had in view"" (references omitted).

[15] While the tribunal is required to take into account the matters specified in ss.243(2) and (3) in applying the public interest criterion, we do not think it was intended that those matters are the only ones capable of being relevant to the public interest. Other matters potentially affecting the public interest can also be taken into account. The public interest is distinguishable from the interests of the parties, although it is clear from the matters specified that there is a substantial overlap where these provisions are concerned."

[16] After reviewing the facts of that matter against the criteria in s.243(2) and (3) the Full Bench said:

> **"[36]** Leaving out of consideration employers and employees to whom an enterprise agreement applies, we are satisfied that the employees to whom the authorisation would apply are low-paid, that they either have not had access to enterprise bargaining or face substantial difficulty in bargaining at the enterprise level and that making an authorisation would assist them to bargain. Other matters identified in s.243(2) also point to an authorisation being in the public interest: the history of bargaining, the relative bargaining strength of the employers and employees and the high degree of commonality in the nature of residential aged care enterprises and, leaving aside employees to whom enterprise agreements apply, the conditions of the employees."

[17] It will be seen that the task of determining whether to make a low-paid authorisation is based on a broad discretionary test described as the Commission being satisfied that it is in the public interest to make the determination. The specific factors required to be taken into account and the objects and scheme of the legislation are the key considerations in applying this test.

The Evidence

[18] The application made by the ANF seeks to cover nurses employed to provide health and community services in what are generally referred to as general practice clinics or medical centres. General practice clinics and medical centres vary in size but are usually small facilities at which medical services are provided to the general public. Practices may be operated by a single doctor, a group of doctors in partnership or by a larger corporate entity that operates multiple clinics. In recent years there has been an increasing trend for medical clinics to be operated by a large corporate entity. For example IPN operates 160 medical centres Australia wide and employs more than 2400 healthcare professionals. Primary Healthcare operates 77 medical centres.

[19] Doctors are the most important professionals in general practice and medical centres and are often the owners of the business. Larger practices employ other doctors in the practice. The clinics employ a range of clerical and administrative staff performing duties such as reception duties, typing, accounts, bookkeeping, and practice management. Depending on the skills and experience of the employee and the needs of the practice an employee may perform a variety of different functions often on a multi-disciplinary basis. Nurses employed primarily to perform nursing duties are commonly referred to as practice nurses. The role of a practice nurse varies from clinic to clinic, and can range from providing general healthcare services such as vaccinations and wound care to a more educational role, such as diabetes education. Both registered nurses and enrolled nurses work as practice nurses. In some of the larger medical chains they carry titles such as Treatment Room Attendants.

[20] Practice nursing is a growing area of employment arising from changed business practices and various forms of funding assistance for the engagement of practice nurses. The number of practice nurses in Australian medical clinics has increased substantially over the last 20 years. Between 1995 and 2009, the number of registered nurses working as practice

nurses increased from 5304 to 8889. Over the same period, the number of enrolled nurses increased from 1442 to 2184.[8]

[21] The demography of practice nurses varies from that of nurses employed elsewhere. Compared to nurses employed across the health system, practice nurses tend to be older, are more likely to work part time and a lower proportion are male. The proportion of practice nurses who are degree-qualified (registered nurses) is equal to the proportion of degree-qualified nurses employed in other settings. In a 2011 survey conducted by the Australian Practice Nurses Association (APNA), 65% of respondents indicated that they held at least one postgraduate qualification, and 87% of registered nurse respondents reported a postgraduate qualification.

[22] Practice nurses are mostly employed on a part time or casual basis. Of the respondents to the 2011 APNA survey, only 23% reported that they are employed on a full time basis. 72% of respondents stated they were part time or casual employees. The responses indicated that the average hours of work per week were between 27 and 28 hours.

[23] The workplace arrangements governing the terms and conditions of practice nurses are varied. The APNA survey showed that the largest proportion of respondents (38%) are covered by individual employment contracts. A further 35% stated that they are covered by awards, and 6% by a collective agreement. This information needs to be treated with some caution as strictly speaking all employed nurses would be covered by awards and an individual contract of employment of one type or another. Approximately 17% of the practice nurse respondents were unsure or did not state the arrangements which govern their employment. Practice nurses also tended to be paid on an hourly basis (88%), and to be paid an all-up hourly rate which included loadings and allowances.

[24] The APNA survey showed that the average hourly rate of pay for enrolled nurses in 2011 was $25.17, and $31.11 for registered nurses.

[25] The employment of practice nurses is also affected by Commonwealth funding arrangements via Medicare, which provide subsidies to general practices for work done by doctors and practice nurses. When practice nurses perform work set out on the Medicare Benefits Schedule (MBS), the medical practice bills Medicare and obtains a rebate for a portion of the cost of providing the service.

[26] In the 2001/2002 financial year, the Commonwealth Government introduced a 4-year Nurses In General Practice (NIGP) scheme. This scheme included the payment of a Practice Incentive Payment (PIP) to eligible practices to encourage them to employ nurses, training and support to develop the practice nurse role and a scholarship and upskilling scheme for rural and remote nurse re-entry. The NIGP was extended for a further 4 years in 2005/2006.

[27] In addition to these arrangements, certain items were added to the MBS in 2004 relating to work performed by a practice nurse. Originally, this included immunisations and wound care. Later, pap smears, chronic disease management and antenatal care were added as MBS items.

[28] In January 2012, the Commonwealth Government introduced a Practice Nurse Incentive Program (PNIP) which forms part of the funding system for practice nurses. The PNIP provides incentive payments to medical practices which employ practice nurses,

however it also removes six billable items from the MBS in favour of these broader incentive payments. The current Medicare funding arrangements are expected to remain in place until 2015. This follows from a historical context of the government seeking to fund nurses in general practice.

[29] The ANF is a craft union covering the vocation of nursing. It is one of the unions with coverage of employees in the health sector. In 2004 it sought to engage in formal bargaining for practice nurses in Victoria by issuing a written notice of its intention to make an agreement and by serving a formal log of claims on a large number of employers. In 2010 it held a forum for practice nurse members. In 2011 it served a further log of claims on employers. No new agreements were reached as a result of the service of this log of claims.

[30] A substantial amount of evidence was led by the parties to the application. In total, 51 witnesses gave evidence during the hearing. A list of witnesses is annexed to this decision.[9] Further witness statements were provided by the parties, but were either no longer relied upon by the parties at the time of the hearing or the witnesses were not required for cross examination. Despite the extent of this evidence it only represents a small proportion of the employers and employees covered by the application.

[31] The ANF relied on the evidence of eight practice nurses, four union officials from the ANF, one union official from the NSW Nurses Association, researcher Dr Larissa Bamberry and Ms Belinda Caldwell, Chief Executive Officer from the Australian Practice Nurses Association. The ANF also relied on several collective enterprise agreements, annual reports from companies operating medical centres and pay slips issued to practice nurses.

[32] Ms Yvonne Chaperon, Assistant Federal Secretary of the ANF stated that the ANF made the application because of calls by ANF members, but also because of the ANF's broader goal of improving employment conditions for nurses. It was also her evidence that it was her belief that ANF practice nurse members generally supported the application.

[33] She gave evidence of forwarding correspondence to a large number of general practices and medical centres seeking bargaining for an enterprise agreement and the general lack of responsiveness of the employers to that request. Mr Chaperon was not, however, able to give detailed evidence about the views of individual respondents named in the application. Ms Chaperon's reason for this was that she is not a member of the Industrial Division which deals with bargaining. Mr Chaperon's evidence was that she was more involved in attempts to bargain during 2004-2005, where in her opinion the employers refused to engage in bargaining because at that time they did not have a legal obligation to bargain.

[34] Ms Chaperon conceded that many practice nurses might be paid above Award rates of pay despite the absence of an enterprise agreement made under the provisions of the Act. She said that enterprise agreements that more commonly apply to nurses in other areas of employment usually cover a broader range of matters than the terms and conditions provided by employers to practice nurses on an individual basis, and there are usually additional benefits to nurses covered by these enterprise agreements.

[35] Ms Chaperon rejected the suggestion that practice nurses might not be paid as highly as hospital nurses because their work is less demanding. Ms Chaperon said that in her professional experience, practice nurses often care for a wider range of patient needs than

those required to be addressed in hospitals, and that the same level of skill and training is required for practice nurses and hospital nurses.

[36] Ms Leonie Kelly, industrial officer at the ANF Victorian branch gave evidence relating to her professional experience as a union official. Ms Kelly's evidence was that there were approximately 1,586 practice nurse members of the ANF in Victoria, and an additional 409 ANF members who identify medical practices as their secondary place of work. Ms Kelly gave evidence that approximately 62% of all practice nurses in Victoria are also ANF members, and that each of the named respondents to the matter employed at least one practice nurse who was also an ANF member.

[37] Under cross examination, Ms Kelly stated that after the ANF log of claims had been served on the respondents, a large portion of them contacted the ANF indicating that they did not wish to bargain for an enterprise agreement. Ms Kelly's evidence was that unless ANF members employed at these clinics contacted the ANF, the ANF did not follow up on the contact from the employers.

[38] Ms Belinda Caldwell, CEO of the APNA, gave evidence that although the APNA is not an industrial organisation, she often received contact from practice nurses seeking advice about their employment conditions. APNA has a membership of approximately 3000 nurses who are predominately employed in general practices. She said that each year APNA, in accordance with testing methods created in conjunction Monash University, conducts a survey of all of its members to gather data about their employment.

[39] Ms Caldwell gave evidence that, in her experience, there are several aspects of the practice nursing environment which "inhibit negotiation of fair wages and conditions."[10] These factors include:

- The isolation of nurses from their colleagues because they often work alternate part-time hours in smaller clinics making it difficult to form a collective opinion;
- The demographics of practice nurses and associated societal and cultural norms which contribute to practice nurses finding industrial negotiations distressing;
- The less-than-optimal human resource arrangements of medical clinics which are often run by busy general practitioners; and,
- External pressure caused by Commonwealth Government funding arrangements

[40] The following practice nurses gave evidence for the ANF:

- Ms Lynda Burrell;
- Ms Monica Knobloch;
- Ms Jane Goldsmith;
- Ms Lisa Taliana;
- Ms Jennie Carr;
- Ms Julianne Badenoch;
- Ms Amy Bowler;
- Ms Deidre Morgan.

[41] But for Ms Bowler, each of the practice nurses who gave evidence for the ANF is a registered nurse. Ms Bowler is an enrolled nurse.

[42] Ms Burrell gave evidence that she has been a nurse for over 30 years. Ms Burrell is employed on a part time basis by IPN at IPN's Mermaid Beach clinic in Queensland. Ms

Burrell's evidence was that she has been paid a base rate of $25 per hour since her employment commenced in 2008, and that during that time she has had one performance appraisal. Ms Burrell's evidence also included her employment at a second medical centre, an imaging and x-ray business, where her rate of pay is $36.65 per hour. It was Ms Burrell's evidence that in her view, both of her roles require a similar level of skill and experience, and she is not sure why she is paid more for one role than the other.

[43] Ms Knobloch gave evidence that she was employed as a practice nurse at the Exeter Medical Clinic for a period of 9 months, first as a casual employee and later on a part time basis. Ms Knobloch resigned from the medical clinic to take up a permanent position at the Launceston General Hospital. Ms Knobloch's evidence was that she worked two days per week at the medical clinic, usually Mondays and Fridays, and that she was employed on a rotating 24 hour, 7 day per week roster at the hospital. Ms Knobloch stated that she was not required to work weekends at the clinic because it was not open.

[44] Ms Goldsmith is a registered nurse and midwife employed at the Gisborne Medical Centre (GMC). Ms Goldsmith gave evidence that she was first employed by GMC as a casual practice nurse in October 2009 and was paid $26 per hour. In February 2010 she was made a permanent part time employee, and was paid $23 per hour. In May 2010 Ms Goldsmith was made team leader and her salary increased to $24 per hour. Since then, her salary has increased further to $28 per hour. In addition to her work at GMC, Ms Goldsmith gave evidence that she works 8 hours per week as a midwife at the Mercy Hospital for Women, earning $32.64 per hour plus allowances under the *Nurses (Victorian Public Sector) Agreement*. In addition, Ms Goldsmith gave evidence that she is employed for a further 8 hours per week at the Kilmore and District Memorial hospital, where she works as either an Associate Nurse Unit Manager or as a Night Supervisor. As Associate Nurse Unit Manager, Ms Goldsmith earns $35.54 per hour, and as the Night Supervisor $40.43 per hour.

[45] Ms Goldsmith's evidence was that although the role she has at GMC is more varied and different from her roles in the hospitals, she does not regard it as being less complex. Under cross examination, Ms Goldsmith stated that one of the reasons she chose to work as a practice nurse at GMC was that the hours were more reasonable, and made for a better balance with her life.

[46] Ms Taliana gave evidence that at the time the application was made, she was employed as a practice nurse at Gamon Street Medical Centre, which has since closed. She was paid $28 per hour. At the time of Ms Taliana giving evidence, she was employed at Watervale Medical Centre and was paid $32 per hour. Ms Taliana also gave evidence of her experience seeking pay increases, stating that she had requested increases and been refused on three separate occasions. Ms Taliana rejected the suggestion that nurses working individually in medical practices had greater bargaining power, stating that approaching a general practitioner to seek a pay rise was intimidating and disheartening. Ms Taliana also gave evidence that she was undertaking further postgraduate study in diabetes education in order to increase her skill level.

[47] Ms Carr gave evidence that she was employed as a practice nurse at Deepdene Medical Clinic, and had been since July 2009. She gave evidence that she is employed on a part time basis, and is paid $31.20 per hour. She stated that she was not required to work nights or weekends, although at one time the clinic had considered employing her on Saturdays to run a vaccination clinic. In Ms Carr's view, the clinic decided not to because it

meant they would have to pay her more. Ms Carr's evidence included that she had previously had the assistance of the ANF in relation to dispute with her employer over an individual employment contract. Ms Carr gave evidence that it was beneficial to her to have the help of the ANF.

[48] Ms Bowler gave evidence that at the time of the application she was employed as an enrolled nurse at the Thompson Road Clinic, and was paid $25 per hour. At the time of the hearing, Ms Bowler was employed by Peninsula Health, a hospital, and paid $27 per hour. Ms Bowler stated that she had previously contacted the ANF for assistance in dealing with her employer over her terms and conditions of employment.

[49] The Australian Medical Association (AMA) relied on the evidence of eight doctors and eight practices managers, as well as a letter from a current practice nurse and one from a former practice nurse of medical centres it represents. It also relied upon a report and evidence provided by Roger Kilham, Director of Kilham Consulting.

[50] The following doctors provided evidence for the AMA:

- Dr Mark Kennedy;
- Dr Cameron Martin;
- Dr Jane Sklovsky;
- Dr Elroy Schroeder;
- Dr Annette Douglas;
- Dr Jack Lipp;
- Dr John Menzies;
- Dr Christine Longman.

[51] Dr Kennedy gave evidence of negotiations with the nurses he employs at the You Yangs Medical Clinic. His evidence was that previously, practice nurses had been paid according to the length of time they had been employed. After the three part time nurses approached him, it was agreed they would all be paid the same rate of $30 per hour. Dr Kennedy further gave evidence that the nurses at You Yangs Medical Centre work out their own roster arrangements.

[52] Dr Kennedy also operates the Corio Medical Clinic. His evidence was that nurses at the Corio clinic are paid different rates, and work nights, weekends and public holidays. In Dr Kennedy's opinion, an agreement of the type proposed by the ANF would be problematic because it would reduce the flexibility available to nurses and his clinics.

[53] Dr Martin gave evidence that in his opinion, practice nurses are in a position of power when negotiating with their employers because of a shortage of nurses. He stated that in 2010, the last time his practice advertised for a practice nurse, they received two applications and both applicants expected to be paid well above Award rates.

[54] Dr Schroeder gave evidence that at the time of the hearing, the practice nurses employed by him at the Yarra Valley Clinic were paid $33 per hour, and were entitled to five weeks' annual leave per year. He also provided a letter from a nurse at the Yarra Valley Clinic written in response to the ANF application. The nurse's letter states that the nurse is happy with the current terms and conditions of employment offered by the clinic.

[55] Dr Douglas gave evidence that she owns and runs four practices in Tasmania, and that she manages a further two. Her evidence was that the minimum rate of pay across the practices is $30 per hour, but that the roles of the various practice nurses vary significantly.

[56] Dr Lipp gave evidence that he is a general practitioner at the Bridge Street Clinic, and that the clinic employs five nurses, one on a part time basis. The pay rates of the nurses range from $23 per hour to $40 per hour. Two of the nurses perform administrative work in addition to their nursing duties.

[57] Dr Menzies gave evidence that the nurses he employs are all paid according to the Award. His evidence was that the rates of pay of his three nurses ranged from $30.15 per hour to $33.07 per hour. In addition, the nurses receive 5% of the income they generate associated with MBS items.

[58] The evidence of the practice managers largely reflected the evidence of the doctors who gave evidence for the AMA. The following practice managers gave evidence for the AMA:

- Ms Meryl Jerome;
- Ms Elaine Cotter;
- Ms Sharon Powell;
- Ms Jane Tudor;
- Ms Gail Pascoe;
- Mr Andrew Wright;
- Ms Julie Cartwright;
- Ms Jenny Ktenidis

[59] The practice managers identified the standard hours of work for the practice nurses employed at their clinics and general practices, noting that practice nurses are generally not required to undertake shift work, and that the general practices were able to accommodate flexible working hours.

[60] The evidence of the practice managers also indicated a variety of different approaches to discussions about wage rates. Ms Sharon Powell, practice administrator at LMC Lilydale said: "we do not negotiate pay, however discussions occur from time to time....Wage reviews occur annually."[11] Ms Meryl Jerome, practice manager of Benalla Church Street Surgery, said that the nurses' "pay rate is usually increased by CPI annually, which is specified in the contract."[12]

[61] The practice managers indicated strong support for conducting workplace relations within their individual enterprises and strong opposition to conducting bargaining as part of a larger group of employers.

[62] Mr Kilham has an honours degree in economics and has specialised in health economics since 1989. He provided a report analysing the wage levels of practice nurses. In Mr Kilham's assessment, practice nurses are not low-paid when compared to the Australian workforce in general.[13] Further, he states that practice nurses generally are not low-paid when compared to nurses working in other sectors, such as aged care.[14]

[63] As to the market position Mr Kilham also stated:

> *"*GP practices generally have to match or better the wage rates offered by the other sectors. Practice nurses and would-be practice nurses are well aware of the rates paid by those sectors, and, given their options for employment in them, are well placed to ensure that their earnings do not fall behind. They are empowered also because Australia has a general shortage of nurses.*"*[15]

[64] As to bargaining practices, Mr Kilham expressed the view that there is not an imbalance in the power relationship between practice nurses and their employers and that practice nurses can access enterprise-level bargaining. He said:

> *"*Practice nurses have been able to bargain effectively with doctors because they have market power. They are able to deal as a professional with a professional. Since most medical practices are small enterprises, there is no marked imbalance in power such as what might be expected, for example, where a multi-national company is operating residential aged care facilities.*"*[16]

[65] Mr Kilham also stated that there is not a great degree of commonality in the nature of the various general practices and medical clinics named as respondents. He stated that the practices operate under different structures and provide varied services to their clients. Mr Kilham also said that there are inherent differences in the work requirements for practice nurses employed in rural, regional and urban practices.

[66] VECCI relied on evidence from one doctor, three nurses and eight practice managers of the medical centres it represents. It also relied on evidence from Ms Lisa Burrell, who manages the services for workplace relations at VECCI and Mr Sean Curtain, General Manager of Human Resources of UoM Commercial Ltd, a medical centre which provides medical services to patients as well as learning opportunities for students of the University of Melbourne.

[67] Dr Peter Roessler gave evidence that he has a positive working relationship with his employed practice nurses. He stated that he pays above award rates, and that the practice nurses he employs have flexible working arrangements. Ms Leonie Dyball, a nurse employed by Dr Roessler also gave evidence for VECCI. She stated that she is currently paid above the Award, has adequate study leave and receives allowances. She also gave evidence that her employment is flexible, and that she is happy to negotiate directly with her employer.

[68] The nurses employed by VECCI members all gave evidence that they were satisfied with their terms and conditions of employment, that they are paid penalties and overtime where applicable, and that they do not support the ANF's application. The nurses also gave evidence that they feel comfortable approaching their employers to discuss their terms and conditions of employment, and that they do not require the assistance of a third party such as the ANF to do so.

[69] The practice managers called by VECCI all say that their practices pay their employed practice nurses above the relevant Award rates. Further, the practice managers all state that the practice nurses have greater flexibility and work more sociable hours than nurses employed elsewhere.

[70] Ms Burrell outlined the steps she took to identify respondents named in the initial application who were either incorrectly named or did not employ a practice nurse. Further, Ms

Burrell's statement includes the results and her analysis of surveys sent to named respondents in the ANF's application. It was Ms Burrell's evidence that she believed many of the respondents named by the ANF in its application have not been correctly identified, or do not employ a practice nurse who would be subject to any multi-enterprise agreement arising out of a low-paid authorisation, were such an authorisation to be made.

[71] Ms Mandy Harrington, acting practice manager at The Elms Family Medical Centre, gave evidence that the ANF's correspondence seeking to bargain for an enterprise agreement incorrectly named the medical centre itself as an employer of practice nurses, where a different corporate entity employs practice nurses.

[72] Mr Curtain's evidence was that the nurses employed by UoM Commercial Ltd are paid over Award rates, above $35 per hour, and that they are not required to work weekends. The salaries of the nurses are review annually, and it was Mr Curtain's evidence that interim pay reviews and increases are possible.

[73] IPN relied on evidence from Nikkie Salagiannis, State Manager of New South Wales of IPN, Mark Beckett, Chief Financial Officer and Company Secretary of IPN, Scott Beattie, Chief Business Development Officer of IPN and Claresta Hartley, IPN's solicitor.

[74] Mr Beattie gave evidence that IPN employs approximately 713 practice nurses who are covered by the Award.[17] Mr Beattie said that should the cost of employing nurses increase beyond current levels, IPN would not be able to afford to employ as many nurses in its general practices.[18]

[75] Mr Beckett's evidence covered the Award coverage and pay rates for IPN nurses. Attached to his witness statement were tables detailing the number of nurses employed by IPN in each state, and their individual rates of pay.[19] It was Mr Beckett's evidence that IPN employs 136 nurses in Queensland, 18 in Victoria, 56 in Tasmania, 44 in South Australia, 175 in New South Wales and 114 in Western Australia. The data in Mr Beckett's evidence also sets out the percentages of nurses paid above Award rates on a state-by-state basis. It shows that on average, IPN nurses working full time in Victoria earn 14.3% above their relevant Award rates, where those working in Western Australia earn 28% above their relevant Award rates.

[76] Mr Beckett gave evidence that no IPN nurses are paid below the Award rate, and that on average, across Australia IPN nurses are paid 14.6% above the applicable Award rate.[20] Mr Beckett's evidence also showed that Australia-wide, full time IPN nurses earned on average 18.6% above the Award rate, while part time nurses earned 14.3% above the Award. Nurses employed on a casual basis earned on average 9.9% above the Award rate.

[77] Ms Salagiannis gave evidence that, in her view, the practice nurses employed by IPN were employed on more favourable conditions than those who work in other environments, such as hospitals. Ms Salagiannis cited the flexible hours, lack of shift work and performing less physically demanding work as being some of the comparative advantages of working as a practice nurse rather than a hospital nurse.[21] Ms Salagiannis further stated that although to her knowledge IPN had never been involved in collective bargaining, IPN nurses had previously approached IPN management to discuss improving their terms and conditions of employment.[22]

[78] Ms Hartley gave evidence of the rates of pay of the practice nurses employed by IPN who gave evidence for the ANF. The range of salaries in Ms Hartley's evidence of the ANF nurses was between $25 and $32 per hour for full time or part time nurses, and between $26 and $32 for casual nurses. She also provided extracts of various reports and statistical analyses about average Australian salaries and salaries of employees covered by the Award.

[79] Primary Health relied on the evidence of June Wong, head of Human Resources for the medical centres division of Primary Health. Ms Wong gave evidence that Primary Health employs approximately 487 practice nurses through two separate entities. Ms Wong stated that the majority of Primary Health's nursing staff work in large scale medical centres, where instead of employing doctors, Primary Health allows doctors to pay a fee for the use of Primary Health facilities and nursing services. Approximately 60% of the medical centres employ seven or more nurses. Ms Wong's evidence was that a majority of the nursing staff are employed as Treatment Room Attendants (TRAs) with a small number being employed in supervisory roles. In Ms Wong's opinion, working as a TRA does not require the same level of skill, complexity and experience that may be required in a hospital or a small local practice.

[80] Ms Wong also gave evidence of the pay rates of Primary Health nurses. Originally, Ms Wong stated that Primary Health paid 75% of its nurses above the minimum Award rate of $18.58. During cross examination, Ms Wong conceded that she did not know if all nursing staff are paid above the Award rate.

Jurisdiction

[81] IPN submits that the Commission's power to make a low-paid authorisation is limited to employees who are 'low-paid' and that no practice nurse correctly classified under the Nurses Award would fall within the range of hourly rates considered by the Commission in other cases to be low-paid. Reliance is placed on the objects of the relevant provisions and their apparent purpose. IPN's submissions are generally supported by other employer representatives.

[82] The ANF submits that the jurisdictional objection involves a misconstruction of the statutory provisions. It submits that the task of the Commission is to consider a range of matters in determining whether it is in the public interest to make the authorisation and that there is no basis for a separate preliminary determination of whether the employees concerned fall within the description of low-paid. It submits that in any event practice nurses are low-paid by reference to nursing industry standards in the public sector.

[83] The meaning of the term 'low-paid' is subject to strongly competing submissions in this case. However s.243 of the Act requires a low-paid authorisation to be made if the Commission is satisfied that it is in the public interest to do so, having regard to matters specified in subsequent sub-sections. Only one of the subsections makes any reference to low-paid employees.

[84] There is no doubt that the extent to which the employees subject to the application can be described as 'low-paid' is an important consideration in determining whether it is in the public interest to make the authorisation. However, I do not consider that satisfaction as to the low-paid status of the employees concerned is a jurisdictional hurdle to a consideration of the statutory test or the making of an order under s.243. In my view, the argument of the employers that there is no jurisdiction to hear and determine the application is unsound. The

Commission has jurisdiction to consider the application and make an authorisation if satisfied the statutory test has been met.

[85] I turn to consider the discretionary public interest test by reference to the factors required to be considered by s.243 of the Act.

Assistance to Low-Paid Employees

[86] This consideration is expressed in s.243 as "whether granting the authorisation would assist low-paid employees who have not had access to collective bargaining or who face substantial difficulty bargaining at the enterprise level".

[87] The first aspect of the consideration involves an assessment of whether practice nurses, or any other employees in general practice medical clinics are 'low-paid'. The term is not defined in the Act. However, it is a concept that has been commonly referred to in a variety of contexts in economic and workplace relations circles, including other provisions of the Act and in decisions of this Commission and its predecessors.

[88] IPN submits that principles of statutory interpretation support the adoption of a uniform meaning to terms used in legislation. It refers to the explanatory memorandum dealing with the mention of 'low-paid' in Division 9 of Part 2-4 and sections 134 and 284 of the Act.

[89] In the Aged Care case the Full Bench said[23]:

> **"[17]** There were a number of submissions relating to the concept of low-paid employees. We have no doubt that in the context of the provisions of Division 9 the phrase is intended to be a reference to employees who are paid at or around the award rate of pay and who are paid at the lower award classification levels.
>
> ...
>
> **[19]** We do not think it can be disputed that a very significant proportion of the employees in the aged care sector are low-paid in that they are paid at or around the award rate of pay and at the lower award classification levels. The applicants also relied on a report by Dr I Watson which compared levels of pay in the aged care sector with levels of pay for workers in comparable occupations working in other industries. Although various employer parties sought to criticise the report and submitted that we should reject it, we found the report useful. The following extract from the executive summary of the report indicates that aged care employees are low-paid in a relative sense:
>
> > "3 The Census data showed that the aged-care workforce is considerably over-represented in the lower bands of the income distribution and under-represented in the higher bands. Nearly half of the aged-care workforce earns between $400 and $599 per week. The comparable figure in other industries is closer to a third.
> >
> > 4 Some 56 per cent of the aged-care workforce could be regarded as minimum wage workers, compared with just 41 per cent among other industries.

> Particular occupations stand out. Nearly 80 per cent of cleaners and laundry workers working in aged care fell into the minimum wage category. The comparable figure in other industries was less than 60 per cent. Food preparation assistants were similar: in aged care 73 per cent were in the minimum wage category; in other industries the comparable figure was 61 per cent. Among carers and aides–who make up the majority of the aged-care workforce–the percentage in the minimum wage category was 57 per cent. In other industries it was 50 per cent."

[20] We accept that in general terms employees in the aged care sector are low-paid. On the other hand there are many employers who are included in the schedule of respondents to whom an enterprise agreement under the Act, or its predecessor, applies. For that reason it is not possible to conclude that employees of those employers have not had access to collective bargaining. We consider that the existence of enterprise agreements is a matter to be taken into account in deciding the scope of any authorisation we decide to make. (references omitted)

[90] A Full Bench in the 2010 Annual Wage Review considered the term in the context of s.284 of the Act. It said[24]:

> **"[237]** There is no consensus among the parties and other commentators with respect to a definition of the low paid. Because there is a continuous distribution of wages, there is no wage threshold just below which people are clearly low paid and just above which people are clearly not low paid. Rather, the lower the wage, the more "low paid" is the employee. People earning above or near median earnings are clearly not low paid in an absolute sense. In considering relative living standards and the needs of the low paid, we have focussed mainly on those receiving less than two-thirds of median adult ordinary-time earnings (currently about $700 per week) and its equivalent hourly rate (about $18.50). We have also had regard in particular to those paid at the C10 rate, in recognition of past practice, on the C14 rate, which is equivalent to the minimum wage, and on those whose full-time equivalent wages put them in the bottom quintile of the wage distribution. Employees on award wages that are above these rates can be considered to be low paid in a different sense. The comparison here is between the award rate and the bargained rate for similar work."

[91] This approach has been applied in annual wage reviews since that time. In the June 2013 case the Full bench said[25]:

> **"[362]** There is a level of support for the proposition that the low paid are those employees who earn less than two-thirds of median full-time wages. This group was the focus of many of the submissions. The Panel has addressed this issue previously in considering the needs of the low paid, and has paid particular regard to those receiving less than two-thirds of median adult ordinary-time earnings and to those paid at or below the C10 rate in the Manufacturing Award. Nothing put in these proceedings has persuaded us to depart from this approach."

[92] Counsel for IPN submits that the case before me provides an opportunity to provide clarity on the meaning of the term by aligning the approaches adopted in the Aged Care case and Annual Wage Review decisions. IPN submits that this would result in considering low-

paid employees as those on rates between the C14 and C10 classifications in the Manufacturing Award.

[93] The ANF submits that the term is one that should be applied in the relevant industry under consideration, that industry is the vocation of nursing and that as practice nurses are paid less than public sector hospital nurses, practice nurses are low-paid. It submits in the alternative that practice nurses are low paid because they are often paid at or around the award rate of pay.

[94] There are a number of problems with the ANF approach, not least of which is the comparison made with different industries in the health sector. I consider that the term low-paid used in the legislation is intended to have a consistent meaning, albeit one that cannot be defined by reference to a strict cut off point. The Aged Care decision and the approach in Annual Wage reviews involve a consistent approach. In my view that is the correct approach to adopt in this case. However the notion that the concept is a matter of degree involves an element of imprecision which in my view must be borne in mind. I propose to adopt a broad view to the term in the context of the evidence of pay of the employees concerned.

[95] The relevant reference points in line with this approach are as follows:

Low-paid Reference Points	Hourly Rates $
C14	15.96
Lowest Quintile	16.18
C10	18.58
Two-thirds median AWOTE	19.30
Range	15.96-19.30

[96] The rates of pay in the Nurses Award are as follows:

"14.2 Enrolled nurses

(a) Student enrolled nurse

	Per week $
Less than 21 years of age	612.90
21 years of age and over	644.80

(b) Enrolled nurse

	Per week $
Pay point 1	719.30
Pay point 2	728.80

Pay point 3	738.40
Pay point 4	749.00
Pay point 5	756.50

14.3 Registered nurses

Minimum entry rate for a:

(a) four year degree is $803.30 per week;

(b) masters degree is $831.00 per week.

Progression from these entry rates will be to level 1—Registered nurse pay point 4 and 5 respectively.

	Per week $
Registered nurse—level 1	
Pay point 1	769.30
Pay point 2	785.20
Pay point 3	804.40
Pay point 4	825.70
Pay point 5	851.20
Pay point 6	875.70
Pay point 7	901.20
Pay point 8 and thereafter	924.60
Registered nurse—level 2	
Pay point 1	949.00
Pay point 2	964.00
Pay point 3	980.90
Pay point 4 and thereafter	997.00
Registered nurse—level	

3	
Pay point 1	1028.90
Pay point 2	1048.00
Pay point 3	1066.10
Pay point 4 and thereafter	1085.30
Registered nurse—level 4	
Grade 1	1174.60
Grade 2	1258.70
Grade 3	1332.10
Registered nurse—level 5	
Grade 1	1185.30
Grade 2	1248.10
Grade 3	1332.10
Grade 4	1415.10
Grade 5	1560.90
Grade 6	1707.70

14.4 Nurse practitioner

	Per week $
1st year	1184.20
2nd year	1219.40

14.5 Occupational health nurses

	Per week $
Occupational health nurse—level 1	
Pay point 1	825.70
Pay point 2	851.20

Pay point 3	875.70
Pay point 4	901.20
Pay point 5	924.60
Occupational health nurse—level 2	
Pay point 1	949.00
Pay point 2	964.00
Pay point 3	980.90
Pay point 4	997.00
Senior occupational health clinical nurse	997.00
Occupational health nurse—level 3	
Pay point 1	1028.90
Pay point 2	1048.00
Pay point 3	1066.10
Pay point 4 and thereafter	1085.30

[97] The hourly rates for enrolled nurses derived from these weekly amounts range from $18.92 to $19.91. For student enrolled nurses, the hourly rates range from $16.13 to $16.97. The hourly rates for registered nurses range from $20.24 to $44.94.

[98] This comparison shows that only student enrolled nurses and enrolled nurses on the lower pay points who are paid at the award rates of pay could fall within the description of low-paid applied in other cases. The evidence indicates however that a very high proportion of practice nurses are registered nurses, they are classified above the lowest pay point for registered nurses, and they are commonly paid above award rates of pay. The evidence shows that enrolled nurses require considerable experience before they can be employed within a general practice and would therefore be entitled to a rate under the award greater than the lowest pay points.

[99] IPN submits that the registered nurses employed as practice nurses do not fall within the description of low paid and the enrolled nurses specified by the ANF also fall outside of that description.

[100] The ANF submits that even ignoring other terms and conditions, the relevant employees should be described as employees paid at or around the award rate of pay and at the lower award classification levels and this is more so if the employees are presently incorrectly classified.

[101] There was a considerable amount of evidence about the appropriate classification for certain employees. The evidence on those matters did not enable a finding as to under classification. However I do not consider that the question whether employees are correctly classified necessarily determines the question of whether the employees are low-paid.

[102] In my view the evidence reveals that very few of the employees subject to the application are paid below $19.30. The evidence of the rates of pay paid by witnesses called by the AMA ranged from $23 per hour to about $45 per hour. Most were paid around the $30 per hour level. A survey conducted by VECCI indicated that the average rate paid to 60 enrolled nurses is $25.91. The average pay rate for 202 Registered nurses in the survey is $32.05. IPN's evidence suggests a range of $18.59 - 35.63 for enrolled nurses and $19.67 - $50.00 for registered nurses. Healthscope's evidence indicates an average of $23.45 for enrolled nurses and $29.37 for registered nurses.

[103] On the basis of the evidence led in the proceedings I find that very few of the employees subject to the application fall within the definition of low-paid applied by the Aged Care and Annual Wage Review Full Benches.

[104] The second element of this criterion is whether the low paid employees have had access to collective bargaining or face substantial difficulty bargaining at the enterprise level. The first point that must be made about this element is that the provisions of the Fair Work Act regarding enterprise agreements apply to all employees and employers covered by the national system. The rights and obligations in the Act include appointing a bargaining representative, rights for default bargaining representatives, the right to take protected industrial action, and good faith bargaining obligations. Some of these rights are conditional on an employer agreeing to bargain or a bargaining representative obtaining a Majority Support Determination or Scope Order from the Commission. While these legal rights show that the employees have had legal access to bargaining, I am of the view that the criterion is referable to practical access and practical difficulties. Nevertheless the extent to which the legal options have sought to be utilised is a relevant consideration.

[105] The evidence led in this matter has been extensive. However given the very large scope of the application affecting approximately 682 employers and a much larger number of employees, that evidence can only be a snapshot of the position across the group as a whole. It is also clear on the evidence that circumstances vary considerably between different medical practices and the snapshot provided by the evidence does not demonstrate a uniform picture. The evidence gives an indication of the range of different circumstances but not a reliable indication of the overall situation or the extent to which the circumstances described in the evidence are common.

[106] It appears that the approach of the ANF to bargaining has been to seek to negotiate on a vocational basis by reference to the terms and conditions of nurses in the public hospital system. Nurses are not the largest group of employees in general practice clinics. Their roles vary considerably. Their duties often overlap with those performed by doctors, clerical and administrative staff. There is no evidence of any attempts at bargaining at the enterprise level across the range of employees employed in the general practice. There is no evidence of any attempts to access enhanced bargaining rights by way of a majority support determination or to engage in protected industrial action.

[107] There is evidence of many employers of practice nurses refusing to bargain with the ANF for an enterprise agreement for practice nurses arising from the approaches made by the ANF over recent years. There is also some evidence of practice nurses facing difficulties in raising issues with their employers over revised terms and conditions of employment and their formalisation in an enterprise agreement. There is evidence of a variety of reasons for the employers' refusal to bargain. There is also evidence of examples of successful dialogue between employers and their employees and expressions of satisfaction with the terms and conditions of employment and the existing arrangements by both employers and employees. There is some evidence of lack of employee support for the ANF efforts to bargain and any disturbance of the current situation. The evidence of difficulties in bargaining at the enterprise level extended to practical difficulties the ANF has encountered in participating in such processes compared to the convenience of participating in multi-employer bargaining.

[108] In my view the notion of assisting employees must involve an element of speculation as to the likely scenarios if an authorisation is given. Nevertheless it is important that an assessment be made of such matters because potential assistance to low paid employees is integral to this factor. If an authorisation is made and the ANF seeks to initiate multi-employer bargaining with all of the respondents, it will clearly not be a simple process. The employers will be drawn to the bargaining table against their will. The process of arranging participation, even with extensive rationalisation of employer representatives will be cumbersome.

[109] If the evidence of the positions of parties towards the content of an agreement in the matter before me is any indication, there will be substantial differences between the parties. The ANF will generally advance the position that the terms and conditions of practice nurses should more closely reflect those in the public hospital sector because of the similarities in the work of the nurses. The concept of terms and conditions that suit the needs and capacities of the general practices concerned appears to be absent from the ANF's approach.

[110] The employers will advance the position that the economics of their practices and the employee preferences for work in practice clinics should be primary considerations - as they have been to date. In my view these likely positions strongly suggest that the process will be very difficult and somewhat fractious. I propose to consider this matter further in the context of broader public interest considerations.

[111] Taking all of these matters into account I am of the view that granting an authorisation may provide some assistance to some low-paid employees. However it will affect many others and will not necessarily lead to a simple, amicable bargaining process. The difficulties with the process may detract from any genuine attention to employees who clearly fall within the category of low-paid, as they are a minority of those represented in the proposed multi-employer bargaining. On balance I consider that any assistance will be marginal and this consideration is not a strong factor in support of a finding that it is in the public interest to make the authorisation.

History of Bargaining

[112] This consideration is expressed in s.243(2)(b) as "the history of bargaining in the industry in which the employees who will be covered by the agreement work"

[113] A consideration of the history may indicate the desirability of providing an alternative avenue of multi-employer bargaining compared to the current availability of enterprise bargaining. I have referred to the history of bargaining above. The ANF has made attempts to bargain with employers primarily by forwarding correspondence and logs of claims seeking terms and conditions in line with the public sector hospital sector. Those attempts have not led to agreements with the respondents. No agreements were reached as a result of the service of a log of claims in 2011. There have not been any attempts at obtaining majority support determinations.

[114] Support by employees for bargaining by the ANF is variable. Support by employers has been minimal.

[115] The common existing practice is one-on-one discussions between the practice nurse and the owner of the practice. From time to time this leads to changes in terms and conditions. The employers submit that they have not sought to modify Award obligations through formalised bargaining under the Act and that existing arrangements are therefore at or above the award level.

[116] The ANF submits that the history supports the making of the authorisation. The AMA submits that superimposing a multi-employer enterprise agreement on top of existing above Award arrangements with terms akin to Victorian public hospital nurses has the potential to unnecessarily interfere with, or upset, single enterprise bargaining that has occurred.

[117] I will have regard to this history in considering the overall public interest. In my view it is descriptive of the current situation but given the widely divergent views about the current arrangements, the history is not a strong factor either in support or against the application.

Relative Bargaining Strength

[118] This consideration is expressed in s.243(2)(c) as "the relative bargaining strength of the employers and employees who will be covered by the agreement".

[119] The ANF submits that its members rely on the assistance of the ANF in bargaining, and this is acknowledged by the AMA, yet the AMA and other employers have refused to approach the ANF to collectively bargain on behalf of its members.

[120] The AMA and other employer representatives dispute the assertion that practice nurses have a weak bargaining position. They point to the professional-to-professional discussions that can be engaged in - with or without assistance. They point to the significant over-Award arrangements as an indicator of bargaining strength and the availability of mutual benefits that arise from the current arrangements. The acute shortage of nurses is also raised as a factor that enhances the bargaining strength of practice nurses.

[121] There is no doubt that a multi employer bargaining process will be more convenient to the ANF than the current enterprise based bargaining that is available. However this criterion requires a consideration of the respective bargaining strength of the employers and employees concerned. I do not consider that convenience to a bargaining representative is the same thing, although the availability of representation is part of the legislative consideration.

[122] The difficulties that have been experienced by the ANF to date are not supported by the fact that significant overaward payments are made. In my view the approach of the ANF to terms and conditions of employment is a reason for this discrepancy.

[123] The assertions about relative bargaining strengths are strongly contested. I conclude on the evidence that the employers are in a slightly better bargaining position, but that the ANF has not demonstrated that this is a significant factor giving rise to a finding that it is in the public interest to make an authorisation.

Current terms and conditions

[124] This consideration is expressed in s.243(2)(d) as "the current terms and conditions of employment of the employees who will be covered by the agreement, as compared to relevant industry and community standards".

[125] There is a significant amount of evidence about the terms and conditions of employment of practice nurses. The ANF submits that general practice nurses are paid at or around the Nurses Award at the lower classification level. The employers point to the average pay being well above the award. I do not consider on the evidence that the rates of pay can be described as at or around the Award level.

[126] The parties are also divided on the identification of the relevant industry and community standards for general practice medical clinics. The ANF points to public hospital nurses' conditions and other areas of nursing. The employers submit that these are not relevant industry or community standards.

[127] Predecessor legislation to the Act defined the concept of 'industry' as either an industry of an employer or the vocation of employees.[26] The current Act does not do so. I am therefore of the view that a relevant industry or relevant industry standard is one derived from a comparison of the industry of the employers, not vocations of employees.

[128] The ANF does not contend that the wages and conditions of practice nurses subject to the application are out of step with practice nurses generally. Rather, it relies significantly on a comparison with public hospital nursing rates. In my view its approach does not deal with the type of comparisons intended by the legislation, except in a very marginal way. It is of course not unusual for employees who perform similar work to be paid different wages and conditions depending on the industry in which they are employed. That is inherent in the enterprise bargaining system established by the Act and the different economic conditions of different industries. The ANF has not established that this factor lends strong support for an authorisation.

Commonality in Enterprises

[129] This factor is expressed in s.243(2)(e) as "the degree of commonality in the nature of the enterprises to which the agreement relates, and the terms and conditions of employment in those enterprises".

[130] The ANF submits that the evidence establishes that a significant majority of general practices provide a commonality of service and a commonality in the manner in which they provide that service.

[131] The employers submit that doctors set their own fees and patients are subsidised to defray the costs of those fees, but it would be wrong to equate general practices with publically funded industries such as the aged care sector. The employers point to the differences in practice delivery and capacity arising from the differences in scale, labour markets and variable amounts of multi-disciplinary responsibilities. The evidence also establishes the development of new practice models arising from new technology and the entry of large medical clinics and large corporate providers while more traditional approaches in many smaller clinics continue to exist. Specialisation in areas such as occupational health and chronic disease management also give rise to differences.

[132] I am satisfied on the evidence that the various employers covered by the application are substantially similar and a significant proportion of them do not have relevant differences between them. I consider therefore that the nature of their operations does not present a barrier to effective multi employer bargaining.

Identifying Improvements in Productivity

[133] The consideration is defined in s.243(3)(a) of the Act as "whether granting the authorisation would assist in identifying improvements to productivity and service delivery at the enterprises to which the agreement relates". This factor is clearly intended to ensure that consideration is given to the inherent notion of bargaining that improved terms and conditions may be available in return for improved business efficiencies.

[134] The ANF submits that the career structure it intends to negotiate for practice nurses will provide improvements in service delivery. The employers generally dispute the value of such a claim. They point to the specific local flexibilities relevant to each practice as the major source of productivity improvement.

[135] In my view the ANF has failed to establish that multi employer bargaining will assist in identifying improvements in productivity. Indeed, from the positions advanced by the parties in the proceedings, there is likely to be more disagreement over flexibilities and efficiencies through large scale multi-employer bargaining than there would be if bargaining is confined to the individual enterprises. In my view this factor does not support the granting of an authorisation.

Manageable Collective Bargaining Process

[136] This consideration is expressed in s.243(3)(b) as "the extent to which the likely number of bargaining representatives for the agreement would be consistent with a manageable collective bargaining process".

[137] In the proceedings before the Commission eight employer representatives represented about 40% of the employer respondents. The other respondents were unrepresented. Healthscope submits that an authorisation would make the negotiations manageable. The other employer representatives submit that it cannot be assumed that representation in the proceedings and in relation to award matters would be the same for bargaining. They submit that there could be a wide range of representatives who will attempt to represent the diversity of practices and the individuality of employment arrangements in those practices. The

employers also point to the evidence that some nurses have written to the ANF or otherwise indicated that they do not wish to be represented by the ANF.

[138] On the evidence led in this matter I find that the process of multi-employer bargaining envisaged by the ANF will be very cumbersome. With a large amount of good-will and effort by all parties it may be manageable, but from the positions advanced by the parties I doubt that this will be achieved. I also consider that even if the process were to become manageable, it is likely to be inefficient. There will be a need to consult with many individual employers and represent a position on their behalf. Any significant disagreements on either the employer or employee side will be likely to lead to further dispersion of representation. In my view it cannot be safely concluded that the multi-employer bargaining process will be manageable.

Views of Employers and Employees

[139] This consideration is expressed in s.243(3)(c) of the Act as "the views of the employers and employees who will be covered by the agreement".

[140] The ANF refers to the consultation it has had with its practice nurse members and submits that its application has the support of its members. There is some direct evidence of employee support. The employers rely on some evidence that the application was not authorised by the practice nurses employed by some respondents and led direct evidence that some practice nurses oppose the application.

[141] The employers represented in the proceedings advanced strong grounds for opposing the application. I conclude that the overwhelming employer view is against the concept of multi-employer bargaining.

External Control, Direction or Influence

[142] This consideration is expressed in s.243(3)(d) as "the extent to which the terms and conditions of employment of the employees who will be covered by the agreement is controlled, directed or influenced by a person other than the employer, or employers, that will be covered by the agreement".

[143] The employers point to the uneven funding arrangements applying to general practices and specialist practices and the capping of the Practice Nurse Incentive Program. No party suggests that the terms and conditions are controlled or directed by persons other than the employers. I do not consider that this consideration has any significance in this case.

ANF's Preparedness to Consider Claim and Single Enterprise Agreements

[144] This consideration is expressed in s.243(3)(e) as "the extent to which the applicant for the authorisation is prepared to consider and respond reasonably to claims, or responses to claims, that may be made by a particular employer named in the application, if that employer later proposes to bargain for an agreement that (i) would cover that employer and (ii) would not cover the other employers specified in the application."

[145] The ANF led direct evidence that it is prepared to consider and respond reasonably to claims, or responses to claims, that may be made by a particular employer if that employer chooses to bargain for a single enterprise agreement.

[146] The employers submit that there is no reasonable basis to accept that the ANF will adopt a reasonable approach to such matters given the circumstances of making this application and the objective of obtaining terms and conditions based on public sector hospital terms and conditions. The employers submit that the approach of the NSW Nurses Association to small workplaces was far more reasonable than the approach being advanced by the ANF in the proceedings.

[147] I acknowledge the bargaining difficulties envisaged by the employers. However I consider that the direct evidence of the ANF in this matter suggests a preparedness to consider alternative forms of agreement. To conclude that its bargaining position is unreasonable involves the adoption of a value judgment that I do consider is appropriate in the circumstances of this matter.

[148] This consideration appears to encourage the applicant to be flexible in its approach and not rule out the legislatively preferred approach of enterprise bargaining. I am of the view that its position adds support to its application.

Other factors

[149] The ANF and the employers have raised other matters relating to the context of general practices and other circumstances that they submit is relevant to an overall assessment of the public interest. IPN submits that any concession to the ANF's objectives will be contrary to the public interest because of its potential to significantly escalate costs, create pressure in other sectors and exacerbate nursing shortages in other sectors. It is also critical of what it terms "me-tooism" inherent in the ANF's approach. IPN submits that other objectives of a sector wide classification structure and reclassification of nurses are best pursued through other avenues rather than by this application.

[150] The most relevant object of the Act is contained in s.3(f) which provides:

> "**3** The object of this Act is to provide a balanced framework for cooperative and productive workplace relations that promotes national economic prosperity and social inclusion for all Australians by:
>
> ...
>
> (f) achieving productivity and fairness through an emphasis on enterprise-level collective bargaining underpinned by simple good faith bargaining obligations and clear rules governing industrial action;"

Public Interest

[151] The task of the Commission is to determine whether it is in the public interest to make the low paid authorisation taking into account all of the matters dealt with above. Having regard to the history of negotiations and the circumstances involved I have concluded that granting the application may provide some assistance to some low paid employees. However I have also noted that the authorisation will affect many others who do not fall within established notions of being 'low-paid' and the assistance that may be provided is likely to be minimal.

[152] Clearly the making of formal agreements under the Act is a key object of the Act and this is a factor that I should take into account. However "emphasis" is given to enterprise level collective bargaining. This has been described as a legislative preference for enterprise level collective bargaining.[27] It is clear on the evidence in this matter that the ANF has not sought to utilise other forms of assistance provided in the Act for enterprise level collective bargaining. Further, its approach has a clear vocational element. It seeks to make an agreement or agreements relating only to practice nurses, notwithstanding the overlap in duties with other employees engaged in general practices.

[153] The method the ANF has adopted to try to reach an agreement has been to serve a uniform log of claims on a large number of employers seeking terms and conditions based on those applicable to public sector hospital nurses. The ANF's approach is not consistent with a willingness to negotiate a package of benefits relating to the particular needs of each enterprise covering a wide range of award covered employees within the enterprise.

[154] In my view there is limited support for the application arising from a consideration of the possible assistance to some low paid employees, the objects of the Act, the bargaining strengths of the parties, the com0monality of the enterprises and the views of some employees. Factors that detract from the application are the prospect of less attention to improvements in enterprise service delivery and productivity, the highly adversarial and cumbersome nature of the process that is likely to be involved and the strong opposition from employers and some employees. Factors which are essentially neutral are the history of bargaining, the current terms and conditions, the influence of third parties and the willingness to consider enterprise agreements.

[155] The consistent employer opposition to the notion of multi-enterprise bargaining combined with the diverse negotiation positions of the parties does not auger well for a possible multi-employer bargaining process. Indeed it is inevitable that such a process will face significant logistical difficulties. In my view there is a greater prospect of agreements being reached if negotiations are conducted at the enterprise level with appropriate utilisation of the facilitative provisions of the Act. Further, there is a greater prospect of meaningful enterprise improvements being negotiated if the negotiations are conducted at the enterprise level. The factors in support of making a low-paid authorisation are not strong. On balance I am not satisfied that it is in the public interest to make a low-paid authorisation.

Summary and Conclusion

[156] Practice nurses are a rapidly growing class of employees who expand the capability and efficiency of medical services provided by general practice medical clinics. It is estimated that over 11,000 nurses are currently employed as practice nurses. General practices range from small traditional partnerships to large corporate chains. Most practice nurses are employed on a part time or casual basis on day work. They are generally paid higher than the relevant Award rate as a result of individual negotiations between the employer and the practice nurses and the operation of the labour market.

[157] For several years the ANF has attempted to negotiate an improved package of terms and conditions based on the benefits provided to nurses in the public hospital sector. Its attempts have been met with strong opposition by general practice employers.

[158] In these proceedings the ANF seeks a 'low-paid' authorisation to bargain with employers on a multi-employer basis. Such authorisations are intended to assist low paid employees who may be disadvantaged by enterprise bargaining. The ANF's revised application covers 682 employers in Victoria and Tasmania. The effect of an authorisation is to extend rights under the Act to the multi-employer negotiations in which the ANF now proposes to engage, in lieu of the preferred mode of bargaining under the Act - enterprise bargaining.

[159] The Commission must grant a low-paid authorisation if it is satisfied that it is in the public interest to do so. In applying that test the Commission must have regard to a non-exhaustive set of considerations specified in the Act.

[160] Approximately 80 witnesses were initially proposed to be called to give evidence in the proceedings. Ultimately, 51 witnesses gave evidence. I have concluded on the evidence presented by the parties in this matter that a low-paid authorisation may provide some assistance to some low paid employees. However most practice nurses do not fall within established definitions of 'low-paid' employees. In my view the assistance to low paid employees is likely to be marginal. Because of the dispersion of the practice nurses in small general practices, the ANF has faced difficulty bargaining on behalf of its members. It has not however accessed all rights available under the Act to advance the interests of its members by way of enterprise-based negotiations. The ANF has sought to negotiate on behalf of nurses alone rather than participate in processes covering a wider group of award covered employees within general practices. Its claims are based on the benefits provided to nurses in the public hospital sector rather than the needs and capabilities of the relevant employers. The current terms and conditions provided by the Victorian and Tasmanian respondents are not out of step with general practices elsewhere. They are probably less than the public hospital sector, although the different requirements of employees and lifestyle factors would need to be factored into such an analysis.

[161] Multi-employer bargaining is less likely to identify improvements in productivity and service delivery than enterprise bargaining. Multi-employer bargaining covering several hundred general practice employers is likely to be cumbersome. There are considerable doubts that the process will be manageable, even though there is substantial commonality in the general practices involved. Multi-employer bargaining is supported by a large proportion of employees. It is strongly opposed by most employers and some employees.

[162] In all of the circumstances I conclude that the case for the authorisation is not strong and several important factors indicate that multi-employer bargaining may be undesirable or less appropriate than genuine enterprise-based bargaining. For the above reasons, which are explained in more detail in the body of this decision, I am not satisfied that it is in the public interest to make the authorisation. The application is therefore dismissed.

VICE PRESIDENT WATSON

Appearances:

Mr C Dowling, of counsel, for the Australian Nursing Federation.

Mr M Follett, of counsel, for Primary Health Care Ltd.

Mr M Harmer for Independent medical Centres Pty Limited, Allied Medical Group Holdings Pty Ltd and Lonnex & Millenium Management Holdings Pty Ltd.

Mr T McDonald for the Australian Medical Association (AMA) Limited, AMA Victoria Limited and AMA Tasmania Limited.

Mr M Ritchie for the Victorian Employers' Chamber of Commerce and Industry

Hearing details:

2012.
Melbourne.
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August 21
September 3, 4, 5, 6, 7
November 19, 20, 21, 22, 23
December 13, 14.

2013.
Melbourne.
January 24, 25.

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[1] [MA000034]

[2] Exhibit D70

[3] Section 246.

[4] Section 230(2)(d)

[5] Section 260.

[6] [2011] FWAFB 2633 at [11]

[7] [2011] FWAFB 2633

[8] Bamberry L & Bridgen C, Australian Nursing Federation, *Practice Nurses, Salaries, Wages and Conditions*

[9] Annexure 1

[10] Exhibit D12, para 16.

[11] Exhibit M7, para 7.

[12] Exhibit M8, para 5.

[13] Exhibit M3, page 3

[14] Exhibit M3

[15] Exhibit M3, page 2

[16] Exhibit M3, page 4.

[17] Exhibit H13

[18] Exhibit H13, para 16.

[19] Exhibit H12, schedules B1-B7.

[20] Exhibit H12, para 23.

[21] Exhibit H10, para 19.

[22] Exhibit H10, para 44.

[23] [2011] FWAFB 2633

[24] *Annual Wage Review 2009-10* [2010] FWAFB 4000.

[25] *Annual Wage Review 2012-13* [2013] FWCFB 4000.

[26] See, for example *Industrial Relations Act 1988* s.4.

[27] [2011] FWAFB 2633 at [11]

ANNEXURE 1 - WITNESS LIST

ANF
Yvonne Chaperon
Lynda Burrell
Monica Knobloch
Belinda Caldwell
Jane Goldsmith
Leonie Kelly
Lisa Taliana
Jennie Carr
Julianne Badenoch
Agnes Stanislaus-Large
Patricia O'Hara
Amy Bowler
Larissa Bamberry
Deirdre Morgan
Elizabeth Robinson
Primary Health
June Wong
AMA
Roger Kilham
Mark Kennedy
Cameron Martin
Meryl Jerome
Sharon Powell
Jane Sklovsky
Elroy Schroeder
Jane Tudor
Elaine Cotter
Gail Pascoe
Annette Douglas
Andrew Wright
Jack Lipp
Julie Cartwright
John Menzies

Christine Longman
Jenny Ktenidis
VECCI
Danielle Harrison
Bernadette Szwaja
Mandy Harrington
Kath Streete
Emma Thompson
Christine Ziegler
Lisa Burrell
Peter Roessler
Leonie Dyball
Sean Curtain
Patricia McLeod
Stephen Ross
Jenny Yeo
Sharon Street
IPN
Nikki Saligianis
Mark Beckett
Scott Beattie
Jun Lei Hartley