SUBMISSION TO

FAIR WORK COMMISSION

Matter No:

AM 2015/2 – FAMILY FRIENDLY WORK ARRANGEMENTS
Common Issue

SUBMISSION IN REPLY

27 OCTOBER 2017

SUBMISSION BY
PRIVATE HOSPITAL INDUSTRY EMPLOYER ASSOCIATIONS

Australian Private Hospitals Association
Australian Private Hospitals Association – South Australia
Australian Private Hospitals Association – Victoria
Australian Private Hospitals Association – Tasmania
Catholic Health Australia
Day Hospitals Australia
Private Hospitals Association of Queensland
Private Hospitals Association of New South Wales
Private Hospitals Association of Western Australia

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[1] This submission is being lodged on behalf of the Private Hospital Industry Employers' Associations (PHIEA) which includes: Australian Private Hospitals Association (APHA), the Private Hospitals Association of Queensland (PHAQ), APHA – South Australia; APHA – Victoria; APHA – Tasmania, Private Hospitals Association of New South Wales, Private Hospitals Association of Western Australia, Catholic Health Australia and Day Hospitals Australia. These organisations collectively represent approximately 95% of licensed private hospital beds in Australia and in addition, represent approximately 90% of all Free Standing Day Hospitals.

The Modern Awards that cover the industry are:

- Health Professionals and Support Services Award 2010
- Medical Practitioners Award 2010
- Nurses Award 2010

Introduction

[2] PHIEA notes the following relevant points contained in the Full Bench *Preliminary Jurisdiction Issues Decision [2014] FWCFB 178*8 as under:

[60]

3. The Review is broader in scope than the Transitional Review of modern awards completed in 2013. The Commission is obliged to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net taking into account, among other things, the need to ensure a 'stable' modern award system (s.134(1)(g)). The need for a 'stable' modern award system suggests that a party seeking to vary a modern award in the context of the Review must advance a merit argument in support of the proposed variation. The extent of such an argument will depend on the circumstances. Some proposed changes may be self-evident and can be determined with little formality. However, where a significant change is proposed it must be supported by a submission which addresses the relevant legislative provisions and be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation. In conducting the Review, the Commission will also have regard to the historical context applicable to each modern award and will take into account previous decisions relevant to any contested issue. The particular context in which those decisions were made will also need to be considered. Previous Full Bench decisions should generally be followed, in the absence of cogent reasons for not doing so. The Commission will proceed on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time that it was made.

4. The modern awards objective applies to the Review. The objective is very broadly expressed and is directed at ensuring that modern awards, together with the NES, provide a 'fair and relevant minimum safety net of terms and conditions'.

5. In the Review the proponent of a variation to a modern award must demonstrate that if the modern award is varied in the manner proposed then it would only include terms to the extent necessary to achieve the modern awards objective (see s.138). What is 'necessary' in a particular case is a value judgment based on an assessment of the considerations in s.134(1)(a) to (h), having regard to the submissions and evidence directed to those considerations.

6. *There may be no one set of provisions in a particular modern award which can be said to provide a fair and relevant minimum safety net of terms and conditions. There may be a number of permutations of a particular modern award, each of which may be said to achieve the modern awards objective.*

7. *The characteristics of the employees and employers covered by modern awards varies between modern awards. To some extent the determination of a fair and relevant minimum safety net will be influenced by these contextual considerations. It follows that the application of the modern awards objective may result in different outcomes between different modern awards.*

[3] PHIEA strongly opposes the ACTU application and considers that in the context of the Health Professionals & Support Services, Medical Practitioners and Nurses Awards, the ACTU has failed to advance a merit argument demonstrating that inclusion of its proposed *Family Friendly Working Hours* clause is <u>necessary</u> to meet the Modern Awards Objective.

[4] The ACTU seeks to introduce an automatic right for eligible employees to tell their employers the days and hours they will work. Unlike applications received under s.65– *Right to Request Flexible Work Arrangements,* the ACTU Family Friendly Working Hours proposal provides no ability for the employer to refuse a request on reasonable business grounds.

Management who have a global view of the competing and pressing needs of the business are in the best position to determine whether or not a request to work certain hours on specified days is manageable and sustainable. To remove the certainty that the appropriate workforce will be in place to meet the needs of the business on a particular day, would be to remove the certainty that the business can remain viable. In the case of hospital employers, there is an additional and overriding imperative and that is the need to ensure that an appropriately skilled and experienced workforce is engaged on each and every shift, in every clinical unit, to facilitate the delivery of safe patient care.

[5] This submission will outline some of the specific characteristics of the private hospital industry and its workforce and the complexities associated with rostering in a clinical environment. It will articulate how the ACTU proposal would not only be contrary to the efficient and productive performance of work; adversely impact on employment costs and administrative complexity but most importantly, remove the ability for the hospital to ensure the delivery of safe patient care on each and every shift. Introducing an industrial provision which has the potential to enable employees' wishes to take precedence over patient safety, would be contrary to the public interest and therefore must be rejected.

Overview of the Private Hospital Sector

[6] The figures below, taken from the Australian Institute of Health and Welfare (AIHW) report *Australian Hospital Statistics 2015 -16* provide an indication of the size and scope of the private hospital industry.

- 630 private hospitals of which 289 provide overnight care and 341 are free standing day hospitals
- 33,074 private hospital beds & 1,617 operating theatres
- 4.3 million episodes of admitted patient care (separations) or 41% of the total separations from all Australian hospitals
-
- 9.7 million patient days of care
- 66,801 FTE staff - 93% of whom work in overnight hospitals.
- 37,471 FTE staff are nurses or 56% of total staff.
- Hospital staffing data published by the Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS) is expressed in FTEs rather than headcount, but the 66,801 FTEs employed in the private hospital sector is conservatively estimated to equate to a headcount in excess of 125,000 personnel

HOSPITAL EMPLOYEES

Please note: All staffing data published by AIHW for both public and private hospitals is expressed as FTE – not headcount

	PUBLIC	**PRIVATE**	**TOTAL**
Demographic Profile			
Number of Hospitals	701	630 (289 overnight and 341 day hospitals)	1,331
Number of Beds	60,957	33,074	94,031
No. of Patient Separations	6.2 million	4.3 million	10.5 million
No of Patient Days	20.2 million	9.7 million	29.9 million
Occupation – all staffing number expressed as FTE			
Salaried Medical Officers (FTE) Note: In the private hospital sector relatively few doctors are employed but are Visiting Medical Officers billing patients for services provided and not employees of the hospital.	40,445 13.1% of total workforce	1,293 1.9% of total workforce	41,738
Diagnostic and Allied Health Professionals (FTE) NB: In the private hospital sector, the majority of diagnostic and allied health service provision is provided by 3rd party contractors not salaried personnel employed by the hospital	42,902 14.0% of total workforce	4,133 6.2% of total workforce	47,035

Total Nurses (includes RNs; ENs; Midwives (FTE)	139,572 45.5% of total workforce	37,471 56.1% of total workforce	177,043
Clinical Support Staff	*Not stated*	4,717 7.1% of total workforce	4,717
Administrative and Clerical staff (FTE)	49,066 16% of total workforce	9,937 14.8% of total workforce	59,003
Personal Care, domestic and Other Staff (FTE)	35,092 11.4% of total workforce	9,250 13.9% of total workforce	44,342
TOTAL FTE STAFF	307,077	66,801	373,878

Source: AIHW Hospital Statistics 2015-16 & ABS Private Hospitals 2015-16:

Profile of the Nursing Workforce in Australia

[7] Registrant Data for the reporting period January - March 2017, published by the Nursing and Midwifery Board of Australia details the following statistics: http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

- 382,477 practising Enrolled & Registered Nurses and Midwives in Australia.
- 341,133 or 89.2% of these practising nurses are female.
- 172,506 or 45% of female practising nurses are 44 years of age and under and fall within the Australian Bureau of Statistics recognised child bearing age range of 16-44 years. It is reasonable to assume that the majority of employees in this age group would have some parenting responsibilities.
- In 2016, the average age of the total nursing and midwifery workforce was 44.3 years.
- 143,754 or 37.5% of registered practising nurses are 50 years of age or over.

Whilst we are not able to quantify in absolute terms, it is the experience of PHIEA's members, that increasingly, employees over the age of 50 years, have some degree of weekly caring responsibilities – either grandchildren or elderly or incapacitated family members.

Currently, these predominantly female employees manage parenting and/or caring responsibilities through part time or casual employment.

The data overleaf is extracted from the Australian Government Department of Health, Nurses and Midwives National Health Workforce Data Set (NHWDS) 2016 Fact Sheet http://data.hwa.gov.au/publications.html#nrmw

- Hospitals are the principal work setting for 61.5% of all employed nurses and midwives in Australia.

[8] **Nurses and Midwives – Average Hours Worked – Clinical/Non-Clinical 2013 - 2016**

Average Hours Worked Per Week	2013	2016
Clinical	30	29.5
Non-Clinical	4.4	4
Total	34.4	33.4

Nurses and Midwives – Females Average Hours Worked by Age Group 2013 - 2016

Age Group	Females Average Hours 2013	Females Average Hours 2016
<19 years	31.6	31.6
20-34	35	34.4
35-44	31.9	31.7
45-54	34.8	33.3
55-64	34.7	32.8
65-74	29.9	28.4
75+	29.2	24.3

Extracts from the Workplace Gender Equality Agency *Australia's Gender Equality Scorecard – Key Findings from the Workplace Gender Equality Agency's 2015-16 Reporting Data* (November 2016).

[9] Whilst acknowledging that it does not represent the entire workforce, nonetheless data from the Workplace Gender Equality Agency is illuminating in that it shows a direct correlation between gender composition and participation in the workforce on either a full time, part time or casual basis.

It is an indisputable fact that many industries are dominated by employees of one gender. Mining and Construction are male dominated (84.2%) whilst females are the dominant gender in the Health Care and Social Assistance industry (80.2%).
Of significance, is that in the 2015-16 reporting year, in the male dominated Mining industry, 95.6% of employees were full time, whereas in the predominantly female Health Care and Social Assistance Industry, the percentage of full time employees was just 26.7%.

This report noted that in the dataset for the 2015-16 year, in the *Health Care and Social Assistance* (HCSA) industry there were 593,819 employees within 652 organisations of whom 80.2% were female. The employee breakdown for the health care and social assistance industry for the 2014-15 years compared to mining and all industries combined is noted below:

2015-16 (HCSA)

593,819 employees within
652 organisations – 80.2% female

Full Time 26.7%
Part Time 50.3%
Casual 23.0%

2015-16 (Mining)

148,724 employees within
154 organisations – 15.8% female

Full Time 95.6%
Part Time 2.0 %
Casual 2.3%

2015-16 (All Industries)

4,025,304 employees within
4,697 organisations – 49.7% female

Full Time 55.0%
Part Time 21.3%
Casual 23.7%

[10] In August 2017, the Australian Government Department of Employment released its industry employment projections for the five years to May 2022, noting that Health Care and Social Assistance is projected to make the largest contribution to employment growth, increasing by 16.1% or 250,500 employees.

Many of these employees have caring responsibilities which may limit their workforce participation. In addition, the rapidly ageing workforce is likely to see an increase in the number of older employees choosing to reduce their hours of work over time. Therefore, it is anticipated that there will be further reductions in the percentage of full time workers in this industry and a corresponding increase in the number of employees seeking to work on a part time or casual basis.

[11] In support of its claim that the family friendly work arrangements clause is necessary, paragraph 47 (c) of the ACTU's submission of 9 May 2017, states:

> *The high levels of part time work in Australia disguise the fact that many part time positions are precarious and do not offer secure employment that properly supports working parents and carers or allow them to re-enter the full-time workforce when they are able to do so.*

With regard to the private hospital industry, PHIEA would refute this claim. In preparing a submission to the Part Time and Casual Full Bench in February 2016, PHIEA sought nursing staffing data from a representative sample of acute overnight hospitals and the table overleaf represents the consolidated information for organisations representing approximately 42.3% of the industry. A review into the make up of types of employment undertaken in 2007 in the lead up to the introduction of the modern awards amongst a similar sample group, showed almost identical percentages when compared to the same data collected for the 2014/15 financial year.

In the private hospital industry when looking at the types of employment, two counters are used – one is the headcount and the second, which is the most relevant to the hospital, is the actual hours worked by each employee type.

Chart 1 shows the percentage of people employed as either full-time, part-time or casual at financial year end (FYE) 2008 and then again at FYE 2015.

Chart 2 shows the percentage of hours worked by each work group for the FYE 2008 and then again for FYE 2015.

Chart 1

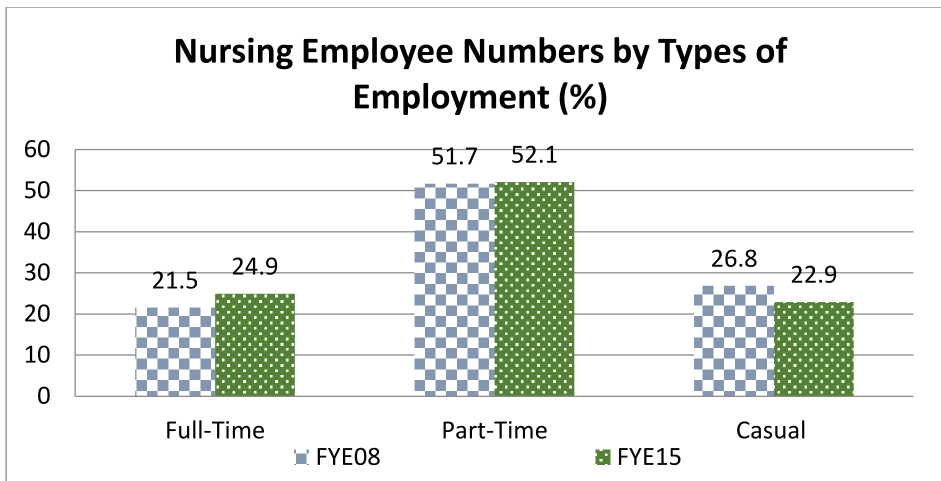
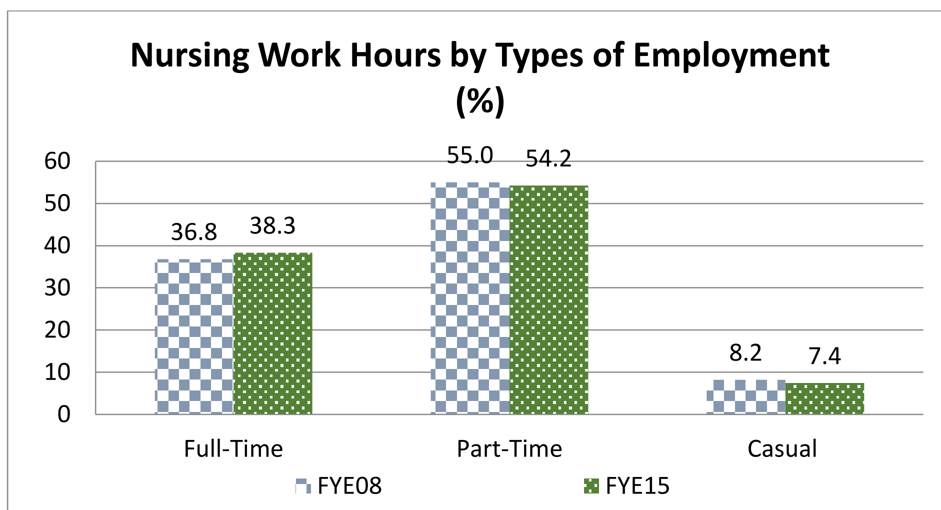


Chart 2



On average in the 2015 FY;

- 24.9% of nursing employees were full-time and they worked 38.3% of available work hours
- 52.1% were part-time and worked 54.2% of available work hours
- 22.9% were casual and worked 7.4% of available work hours

[12] From this sample group, only 7.4% of available work hours in the 2015 FY were worked by casuals – all other hours were worked by *permanent* employees. In respect of the private hospital industry therefore, PHIEA rejects the ACTU assertion that part time positions are *'precarious and do not offer secure employment that properly supports working parents and carers or allow them to re-enter the full time workforce when they are able to do so.'*

[13] To assist the Commission in understanding why flexibility in the employment of part time and casual employees is so critical to the private hospital industry, it is necessary to outline the medical model of care in private hospitals which is markedly different to that of the public sector and gives rise to significant fluctuations in patient occupancy that cannot be rostered for with absolute certainty.

Patients can only be admitted to a private hospital under the care of their treating doctor – unlike the public hospital sector, there are no direct patient admissions – with the exception of admissions via a private hospital emergency department.

As evidenced in the table on page 4, the private hospital sector employs relatively few salaried doctors, instead medical and surgical services are predominantly provided by credentialed Visiting Medical Officers (VMOs) who are independent contractors, each managing their own business. There is no traditional employer/employee relationship and most VMOs would have admitting/treatment rights at more than one hospital. As non-employees, establishing working hours, holiday leave and study leave in conjunction with hospital management is not mandatory. Management is usually advised when the medical practitioner will be away rather than consulted in advance. Late notice of an absence and potentially late cancellation of booked operating theatre time may result in beds being closed and wards and theatres being overstaffed.

[14] The effect of this medical model is that private hospitals have very little control over the number of patient admissions or the rostering of VMO leave periods to smooth out any 'peaks or troughs' as activity is largely determined by the VMOs' admission practices and in consequence occupancy can be highly variable. Occupancy levels may vary from less than 50% at holiday periods (Christmas and New Year) to full capacity at other times in the year. In contrast, public hospitals experience reasonably consistent occupancy levels.

For example, in the private hospital sector, a major orthopaedic conference can see the closure of orthopaedic wards. Individual surgeons taking leave can see patient numbers decline – surgeon illness can have the same effect. Conversely, an outbreak of flu can lead to medical wards overflowing. Prior to a period of leave, it is quite common for surgeons to increase their operating theatre time to provide care to patients who may be on their waiting list, and of course during this period, additional staff and beds would be required.

[15] Hospitals that have maternity units and emergency departments tend to experience greater fluctuation than some of the others as their patient numbers are even more difficult to predict. For example, a hospital will roster staff to its emergency department based on average activity but any change to this average will result in extra nurses being required at short notice, or not enough work for those that are currently at work. Throughout the year, school holidays tend to see periods of low occupancy as medical specialists often take leave to coincide with school vacations. During these periods of reduced activity, hospitals roster accordingly by not offering shifts to casual employees or extra shifts to part-time employees for example.

[16] Fluctuating occupancy, unexpected absenteeism and the challenges associated with managing employee turnover are not the only factors influencing staffing and rostering decisions. Patient acuity is absolutely critical to safe staffing. Whilst a unit may be an acute surgical unit, the patients in the beds will have a range of nursing care needs either because of age, other existing health conditions or the complexity of their medical or post-operative surgical care. As patient numbers change and as patients' care needs change, management must have the ability to react quickly to ensure that patient safety is not compromised.

[17] These changing business needs also impact on the support teams who work with the nursing staff such as allied health, food services, cleaning, maintenance and administration – that is, employees covered by the Health Professionals and Support Services Award.

[18] As detailed on page 5 of this submission, nurses comprise approximately 56% of the private hospital workforce. In an environment of increasing demand for hospital services, a rapidly ageing workforce and shortages in specialty areas of nursing, it is imperative that private hospital employers are afforded maximum flexibility in rostering the right staff to the right clinical units at the right time.

[19] Filling a nursing roster for a clinical unit over 24 hours, 7 days a week is a complex process which requires the consideration of many factors including:

- The number of expected patients
- The complexity and acuity of each patient's condition
- The specialty area and type of work on the unit/ward and how much of it must be undertaken by a Registered or Enrolled Nurse and how much an Assistant in Nursing or Patient Care Assistant may be able to do.
- The experience levels of the staff and the number of temporary staff and staff in orientation or training on the unit at any particular time and
- Minimum guaranteed working hours in place for each individual employee

[20] If the ACTU proposal were to be included in the health care awards such that eligible employees with parenting or caring responsibilities had a right to determine the hours and days they were to work, the complex process of rostering would become almost impossible.

The ACTU Revised Family Friendly Working Hours Clause

[21] Under the ACTU's proposed *Revised Family Friendly Working Hours Clause,* if an employee has completed at least 6 months of continuous service with the employer, they are eligible to apply for family friendly working hours if they have: (a) parenting responsibilities or (b) caring responsibilities and (c) can provide evidence of these responsibilities if requested by the employer.

This applies to both permanent and casual employees.

The employee determines what form 'family friendly working hours' arrangements take and is required to give the employer 'reasonable notice' in writing of their intention to commence working these new family friendly working hours.

[22] 'Reasonable notice' is not defined which clearly would create the potential for dispute as in the absence of a specified period, perceptions of what may be considered 'reasonable' are likely to differ. The notice must contain;

a) the period of time that the employee requires family friendly working hours

b) the specific days and hours of work that the employee wishes to work

c) The date on which the employee wishes to revert to their former working hours.

Only the hours change under this request, the job the employee is in with the existing hourly rate of pay remains.

[23] If the employee is to commence family friendly working hours due to parenting responsibilities, they may revert to their former working hours at any time up to the child reaching 'school age'.

School age is not defined which would create potential for dispute, given that there are different State regulations regarding the age at which children can (a) commence their first year of non-compulsory schooling and (b) are compulsorily required to attend school. It is not specified whether 'school age' under this clause means the first year of compulsory schooling – i.e. 6 years of age in most, but not all States, or if 'school age' would be interpreted to mean the age at which the child of the particular employee commenced school, which could be less than 6 years of age.

Potentially, the employer may be required to hold the previous working hours open for up to 6 years, however if an employee with parenting responsibilities then has another young child to care for, it is assumed that under this clause the employee would be permitted to refresh the advice to their employer, provide the birth certificate of the new child, with the effect that the initial period of up to 6 years could potentially extend by up to 6 years for each subsequent child.

[24] Once the child reaches school age, the employee no longer has an entitlement to family friendly working hours and it is assumed, is required to revert to their former working hours.

In reality, it is probable that this would give rise to a dispute as it is highly likely that the employee would not want to return to a rotating roster over seven days of the week when, for example, for the past 6 years under their family friendly working hours arrangement they had been working from 9-3 Monday to Friday.

[25] The family friendly working hours clause proposed by the ACTU applies to any employee who has responsibility (whether solely or jointly) for the care of a child of school age or younger.

The way the clause is worded means this entitlement is not just for parents but could be for grandparents who care for their grandchildren a few days a week or even for someone who cares for their neighbour's children.

The word 'responsibility' in isolation is not defined. An employee does not have to have any family ties to the child or the person being cared for. Therefore, this

responsibility could be voluntarily assumed by the employee on behalf of an acquaintance. In this scenario, the employee would still have the responsibility for the care of a child of school age or younger or caring responsibilities and therefore, would meet the criteria.

[26] If the employee is taking the family friendly working hours for caring responsibilities, the proposed variation does not stipulate this has to be for a family member or a member of the household but simply for another individual who needs care on an ongoing or indefinite basis because they:

a) have a disability
b) have a medical condition
c) has a mental illness; or
d) are frail and aged.

[27] In paragraph 178, the ACTU states that:

'*paid caring roles are not intended to be included in the definition of caring responsibilities in the ACTU's clause and the mere fact that an employee resides with someone who needs care would not be, of itself, sufficient to enliven the clause."*

Whilst this may be the ACTU's intent, PHIEA does not believe this is reflected in the actual wording of the clause.

[28] Employees on family friendly working hours with caring responsibilities can stay on these hours indefinitely, although after 2 years the employer would not need to hold the previous hours open. However, maintaining systems to make sure the replacement employee is converted to permanent in 2 years' time to ensure they have greater security, would be an additional administrative burden.

Employees engaged to replace an employee on family friendly working hours under this proposal must be informed of the temporary nature of their engagement.

If after 6 months, this temporary employee who has been told that the position they are in is temporary in nature for up to 6 years, requests family friendly working hours for 2 years because of their caring responsibilities, how would an employer be expected to manage this scenario?

[29] The ACTU family friendly working hours proposal allows for employees with either parenting or caring responsibilities to tell their employer on what days they will work, and during what hours and when this new arrangement is to start. Providing the hours worked are less than what is currently being worked, the employer must accept this new arrangement.

This automatic right for eligible employees to nominate days and times of work, completely ignores the fact that an employer may not need someone to work on the day or at the time, the employee has nominated. For example, 6 employees may have already told the employer they are only available to work on a particular day and at specified times, and the employer may not require that many staff to satisfy the needs of that particular shift.

[30] Under the ACTU's proposed variation, and in the absence of a 'right to refuse', technically, it would be possible for a significant number of highly experienced nurses with more than 6 months service with the employer, to all request family friendly working hours on week days only and between the hours of 9.00 am and 3.00 pm. Were this to eventuate, self-evidently it would be impossible for a hospital or units within a hospital to provide safe patient care on a 24/7 basis and there would be no alternative but to close some wards/units or perhaps even the entire hospital.

In an environment of a rapidly ageing population and increasing demand for hospital services, any diminution in current availability of beds or clinical services would be contrary to the public interest.

[31] At paragraph 188, the ACTU states that:

> *The term 'working hours' is used in the clause rather than 'position' or 'role' because the intention of the clause is that employees will work on a reduced hours basis in their* ***existing position,*** *including the same location, status and remuneration level as defined in clause X4.6 of the ACTU's proposed clause"*

However, in a hospital environment, there are a number of positions which require continuity in order to meet deadlines, for example positions involving clinical research, clinical investigations, safety and quality auditing for accreditation or licensing requirements, or customer complaints to name a few. These types of positions generally cannot be job-shared without considerable duplication between all people undertaking that task as everyone must understand everything that has gone before in order to build on this information, therefore in order to be efficient, the employer requires one person to follow the process to ensure that nothing is overlooked or forgotten.

[32] Parental leave provided for in the Fair Work Act allows the employee with 12 continuous months of service to take up to 12 months of unpaid leave with the ability to request a further 12 months of leave. The employee is then able to request flexible working arrangements (s.65).

At paragraph 115, the ACTU argues that the 'right to request' flexible working arrangements under the Act is not assisting employees balance their work and family responsibilities.

If some requests for flexible working arrangements have not being agreed to by the employer then perhaps it is because such a request would have introduced reduced flexibility, increased costs or generated some other specified adverse impact on the business. As previously stated, it is management who have a global view of the competing and pressing needs of the business and who therefore, are in the best position to determine whether or not a request to work certain hours is manageable, not the employee.

[33] At paragraph 181 it states:

> *The ACTU's clause provides access to a temporary reduction in working hours only, not any other form of flexible working arrangements. This is narrower in scope than s. 65, which does not place any limits on the types of changes to work arrangements*

that can be requested. 'Changes in working arrangements' are not defined in s.65 but include changes in hours, patterns and locations of work.

In discussing the necessity of the clause at paragraph 41 the ACTU states that:

"*Modern work is still organised around an old idea: the default employee is unencumbered by parenting or caring responsibilities and is available to work full-time throughout his or her life, and primary carers of children and others are required to 'work around' this model."*

Whilst the above statement may well be true for some industries or occupations – for example – mining where as detailed on page 6, 84.2% of the workforce are male and 95.6% are employed on a full time basis, this is not the case in the health care and social assistance industry where 80.2% of the workforce are female but only 26.7% work full time.

[34] As noted on page 5 of this submission, 45% of female practising nurses are of child bearing age, the majority of whom are likely to have parenting responsibilities. 37.5% of practising nurses are over the age of 50, and anecdotal feedback indicates that it is this age cohort that is most likely to have some level of carer responsibility, either for elderly family members or to care for grandchildren, and in consequence choose to work part time.

[35] The ACTU submission concedes at paragraph 138 that: *"Employees in supportive working environments who feel comfortable asking for changes still ask, (mostly women, in larger businesses, the public sector and sales and community and personal service occupations) and most are granted their request."*

Feedback from PHIEA members indicates that in the female dominated private hospital industry, employee requests for flexible working arrangements are usually accommodated.

[36] In preparing this submission, PHIEA sought data from member organisations regarding the total number of nursing staff (headcount) on parental leave both paid and unpaid as a percentage of the total permanent nursing headcount.

Responses were received from hospitals with a total of 13,220 beds or 40% of the industry which is a representative sample. These organisations had a total of 25,322 permanent female employees of whom, as at June 2017 – 265 employees or 1.05% were on paid parental leave and a further 553 employees or 2.19% were on unpaid parental leave. Therefore, at any one time, in this sample group 3.23% of female permanent staff are off on parental leave, many of whom will seek to work reduced hours on their return from parental leave.

[37] Private hospitals endeavour to work with their staff to accommodate flexible working arrangements, not only for those employees who have child caring responsibilities but also those who have other pressing private commitments. However, accommodating these requests is not without cost to the employer.

Where additional staff need to be recruited to fill the balance of hours, additional costs may include:

- Uniforms
- Orientation
- Annual Competency Training
- Ongoing education and
- Training for any new procedures and associated equipment, or possibly
- Agency fees

[38] Hospitals exist to provide treatment to those vulnerable members of the community who are sick, injured or require mental health care. They are governed by a complex regulatory regime designed to maximise system safety and minimise the potential for patient harm. One of the most important elements in facilitating patient safety is the availability of a highly skilled and experienced clinical work force.

[39] PHIEA considers that the NES adequately provides for family friendly work arrangements and therefore, the ACTU proposal is not 'necessary' to meet the modern awards objective.

[40] Subsection 156 (5) provides that in a Review, each modern award is reviewed in its own right. PHIEA submits that the ACTU evidence is generalised, and that it has failed to provide a merit based argument in relation to the inclusion of its proposal in either the Nurses Award, Medical Practitioners Award, or Health Professionals and Support Services Award.

[41] In the context of the awards covering the health industry, for reasons already stated, PHIEA considers that the ACTU's proposal is untenable and cannot be supported.

[END OF SUBMISSION]