THE McKell Institute

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The Importance of Penalty Rates for Our Health Workforce

The economic & health impacts of cutting penalty rates

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Foreword

Following on from the McKell Institute's report on the economic impact of penalty rate cuts in Australia's retail and hospitality industries, this report looks at the economic and health impacts of cutting penalty rates for nurses, midwives and aged care workers.

This report highlights the importance of penalty rates to the health of patients, the incomes of nurses, midwives and aged care workers and local economies around Australia.

Any reduction in penalty rates risks worsening forecast shortages in the nursing profession.

On average twenty per cent of gross nurse, midwife and aged care worker income is from penalty rates, reflecting the high demands on the profession to work unsociable and irregular hours.

Any cut to penalty rates threatens to significantly reduce the take home pay of nurses, midwives and aged care workers and negatively impact on the local economies where they work and live.

Meeting the challenge of an ageing population as well as advancing health technology requires a growing and highly skilled health workforce. The risk of reduced penalty rates will only exacerbate these challenges by reducing workforce participation.

The draft recommendations of the Productivity Commission report on the Workplace Relations Framework currently excludes nurses from recommended penalty rate cuts proposed for the retail and hospitality sectors. This report provides further evidence to support the argument to maintain penalty rates for the health workforce. Further, it notes the proposed exception of health workers from penalty rate cuts is unreliable, particularly given the experience of countries like the United Kingdom where penalty rate cuts are now being pursued in the National Health Service.

The campaign to cut penalty rates, hitting the lowest income workers in Australia, also places the future of our health workforce at risk.

The Hon John Watkins
CHAIR,
MCKELL INSTITUTE

Sam Crosby
EXECUTIVE DIRECTOR,
MCKELL INSTITUTE

Executive Summary

Penalty rates have been a key feature of Australia's wage system for over 100 years, but are under threat following a campaign by employer groups and a productivity commission inquiry into the workplace relations framework.

The Prime Minister has declared that changes to the current system are "inevitable"[1].

The changes proposed include eroding the current regulation of penalty rates and reducing the premium for working unsociable and long hours. This campaign represents a threat to the incomes of low and middle income earners in Australia, including nurses, midwives and aged care workers.

The Productivity Commission draft report highlighted that it was Australia's lowest paid workers in the Retail, Hospitality and the Health and Social Care sectors that report amongst the highest rates of night and rotating shift work that attracts penalty rates. Any cuts will disproportionally impact on these workers.[2]

Analysis undertaken for this report by *Union & Community Data and Analytics* estimates that the permanent nursing workforce in acute and psychiatric hospitals and nursing staff and direct care workers, (assistants in nursing/personal care workers), employed in residential aged care facilities derive around 20 per cent of income from penalty rates.

The scope of this study covers the most important workplaces where regular shift and weekend work is undertaken by nursing staff, and assistants in nursing (AINs)/ personal care workers (PCWs). However, nurses work in a range of other work situations where penalty loadings and allowances exist for shift and weekend work. This study covers just over half of the registered nurses.

It is estimated that nurses earn at least $3.6 billion a year in penalty payments. Importantly for regional economies around $1 billion of this penalty rate income flows to regional and remote areas each year.

Applying the current proposal being considered for retail and hospitality workers, namely reducing Sunday penalty rates to Saturday levels, permanent nursing and midwifery employees within acute and psychiatric hospitals and direct care nursing staff including AINs/PCWs employed in residential aged care would be $359 million a year worse off.

On an individual level nurses and AINs/PCWs in residential aged care would be thousands of dollars worse off each year if penalty rates are cut.

Registered Nurses working in public hospitals can expect to receive an average pay cut of 2% or $1,921 a year if Sunday penalty rates were reduced to the level of Saturday penalty rates.

While the health sector is not the current focus of efforts to reduce or remove penalty rates, there is a real prospect that changes in one industry will have a ripple effect to other industries, as is the experience internationally. This is a particular threat to the health sector which is under constant scrutiny due to rising costs and the need to find long term savings.

The discussion paper provides a brief overview of the arguments for and against penalty rates, including the importance of penalty rates in providing an economic incentive to employees to work long and outside standard hours. Most employees would choose not to work long or unsociable hours if they were not adequately compensated.

Australia's future health care needs will quite literally require all hands on deck, as the population ages and the ratio of working aged to non-working aged drops by almost a half. Policies that erode the compensation paid to our nurses and midwives for working the unsociable hours required to provide 24 hour/7 day a week health care undermine our ability to meet these challenges.

The discussion paper highlights the flow on impacts of any cuts to the penalty rates of nurses, midwives and aged care workers penalty rates, including worsening attrition, shortages of nurses and a reduction in the care available to patients.

Over 80 per cent of nurses and midwives in a recent survey indicated they would consider leaving the profession if penalty rates were cut.

Penalty rates are relied upon by workers across all industries in Australia. The proposed changes risk undermining the incomes of these workers and removing the much need compensation for working unsociable and long hours.

Productivity Commission Inquiry

On August 4 2015 the Productivity Commission (PC) released its draft report into the Workplace Relations Framework, with the final report submitted to Government on November 30 2015.

"Penalty rates have a legitimate role in compensating employees for working long hours or at unsociable times. They should be maintained. However, Sunday penalty rates for cafes, hospitality, entertainment, restaurants and retailing should be aligned with Saturday rates."

PC, Workplace Relations Framework, Draft Report, Page 4.

The PC appears to have accepted arguments from industry and the Government that in the context of the new 24/7 economy the role of penalty rates has changed.

While recommendations do not currently extend beyond the hospitality and retail sector, it is of concern that these same arguments are being used by the Government in England to cut overtime and shift work pay loading in the National Health Service. Furthermore, industry bodies such as the Australian Chamber of Commerce and Industry are continuing to call for cuts to penalty rates in to other industries and on public holidays[3].

The PC rationale for not considering penalty rates in essential services at this time is that the payment of penalties arrangements have remained in lock-step with community expectations.

However, one of the strongest arguments put forward by the PC is that because retail and hospitality services are now expected to be provided 24 hours a day, 7 days a week the need for penalty rates has reduced. Paradoxically, this is one of the strongest rationales why penalty rates are needed in essential services, to ensure the provision of services 24 hours a day, 7 days a week. If the argument holds for the retail and hospitality sectors, it is clearly only a matter of time before it is extended to essential services by Governments keen to reduce costs in the health sector.

Being available and prepared to work 24/7 is not a new requirement for our nurses, midwives and aged care workers. Penalty rates are a long established community expectation for the valuable work performed in industries that require this level of commitment from its workforce.

Notwithstanding this, there is a real concern that any erosion of the principals underpinning the application of penalty rates across the economy will in time reach the health sector with significant impacts on the take home pay of nurses, midwives and aged care workers, local economies where nurses reside and reduced access to patients and residents to high quality health care.

Rationale for Penalty Rates

Penalty rates have been an integral part of Australia's industrial relations system for over 100 years. In Barrier Branch of Amalgamated Miners Association v Broken Hill Pty Company Ltd (1909), Justice Higgins first awarded penalty payments to compensate employees being made to work at inconvenient times, and to act as a deterrent against 'long or abnormal hours being used by employers'.

Under The Fair Work Act 2009 modern awards must provide additional remuneration for overtime, weekends, public holidays and shift work. Penalty rates compensate employees for working long hours, working at night and working on the weekends. The premium rate of pay reflects the extra cost of working long and unsociable hours to employees.

Penalty rates vary across industries and occupations, with rates of pay linked to when work is undertaken and the total hours worked. The Fair Work Ombudsman categorises three broad time related wage rates as 'penalty' rates:

- Shift loadings, weekend and evening pay premiums. These premiums are based on when work occurs and are not dependent on how many hours a person has worked during the week;
- Overtime rates are higher wage rates for hours worked greater than the ordinary hours listed under the relevant workplace agreement;
- Holiday pay applies to additional pay where employees must work on Public holidays.
- Many Australians work long hours and during nights.

Productivity Commission estimates based on the latest HILDA survey of Australia Households indicate that almost 1.2 million Australians work schedules that are likely to involve night work[4].

According to the most recent ABS data, 2.4 million Australians report working on a Saturday or Sunday[5].

Over one quarter of Australians with multiple jobs report working on a Sunday, which is more than three times the rate of Australians with a single job who report working on a Sunday[6].

Penalty rates provide compensation to employees and offer an economic incentive for people to work unsociable hours. Many employees would choose not to work long or unsociable hours if they were not adequately compensated.

Moreover, millions of Australians would face a real drop in income if penalty rates were cut or abolished. As an integral part to the wages system many Australians rely heavily on penalty rates to get by and provide for their families.

Nurses, midwives and aged care workers rely heavily on penalty rates, which independent modelling by *Union & Community Data and Analytics* indicates represent 20 per cent of average gross income.

Benefits to Employers

Penalty rates provide a mechanism for employers to extend the hours of existing employees, thereby allowing employers to avoid the fixed costs of hiring additional workers. In the case of highly skilled workers, such as nurses, these fixed costs can be high and consequently represent a significant cost avoided by employers.

Penalty rates also provide a mechanism for employers to provide a service or continue operation outside normal business hours where it is either profitable to do so or required due to a public service obligation.

Health Impacts

There is strong evidence that persistently working long hours and irregular hours increases the risk of a range of illnesses.

Long hours of work have been linked to coronary, sleep and psychological health conditions. Nash et al. (2010) for example found higher rates of psychiatric morbidity among Australian doctors working long hours[7].

Shift work in particular has been linked to poorer health outcomes. A systematic review of the evidence has shown that working regular night shift can lead to excessive sleepiness and insomnia, and has been linked to higher rates of smoking, increased stress, higher rates of obesity, elevated blood pressure and higher levels of cholesterol[8]. Research even indicates a possible link between night work and cancer due to melatonin suppression[9].

Reduced Wellbeing

The Australian Work and Life Index (AWALI) survey measures how work intersects with other life activities. It is based on a survey of randomly selected 2,690 working Australians.

The AWALI index contains five measures which assess respondents' perceptions of work-life interference[10].

The 2014 AWALI indicates that most Australian workers continue to work on weekdays between eight and six (62 per cent)[11]. Working unsocial hours remains a minority experience. 5.8 per cent work evenings and 19.1 per cent on weekends[12]. 13.1 per cent of Australian workers regularly work both evenings and weekends[13].

Those who work unsocial hours have worse work-life interference than those who do not. Working on weekends is worse for work life interference than working weekdays. The AWALI scores (note higher scores reflect higher work-life interference) were[14]:

- 52.5 for people working regularly on Saturdays and Sundays;
- 51.4 for regular Sundays (but not Saturdays);
- 43.8 for regular Saturdays (but not Sundays) and
- 38.9 for work on weekdays only.

Based on the findings from the 2014 AWALI there is a case for paying workers a premium for Sunday work and for weekend and evening work more generally, given the poorer work-life interference associated with Sunday work.

Arguments Used Against Penalty Rates

A number of arguments have been advanced to abolish or cut penalty rates.

Efficiency

Penalty rates increase the cost to businesses and government services operating on weekends, at night or on public holidays. This reduces business profits and increases costs to Government, reducing the demand for labour and productivity across the economy.

These efficiency arguments ignore the fact that penalty rates increase incomes across the economy, increasing consumer demand and adding to economic growth. This is particularly important in regional and rural communities where average household income is around $600 lower per week than in metropolitan areas[15]. There are also important equity and anti-poverty benefits from penalty rates in lifting the take home pay of some of the lowest paid workers in our economy. Any cuts to penalty rates would disproportionally impact on these workers.

The table below illustrates that workers in the accommodation and food services sector are significantly more likely to work night shift and have a rotating shift which would attract penalty rates. These workers are almost amongst the lowest paid in our economy with total weekly earnings half the national average[18]. The proposed cuts to the penalty rates will disproportionally affect these already low paid workers.

TABLE 1: WORK SCHEDULES AND AVERAGE TOTAL EARNINGS BY INDUSTRY

	PER CENT OF WORKERS WITH A REGULAR NIGHT SHIFT[16]	PER CENT OF WORKERS WITH A ROTATING SHIFT[17]	TOTAL EARNINGS
All Industries	2.3	7.9	1136
SELECTED INDUSTRIES			
Accommodation and Food Services	7.6	17.9	556.3
Retail	2.8	8.9	671.4
Health Care and Social Assistance	4	16.7	998.5
Transport, Postal and Warehousing	5.5	13.7	1368.1
Manufacturing	3.3	6.4	1259.0

Source: Productivity Commission estimates based on HILDA Release 13.0 and ABS Cat No 6302.0 May 2015

Out of Date

It is often argued that penalty rates no longer serve the function they once did in attracting labour to work during unattractive, unsocial hours, since, as a result of changes in the composition of the workforce, reductions in the length of the standard working week and working year, and growth in unemployment, the hours preferences of employees have changed.

However, as the 2014 AWALI survey noted above demonstrates workers still have a strong preference for working standard hours and would be less inclined to work unsociable hours if penalty rates were cut or abolished.

International Competitiveness

International competitiveness is also often flagged, with Australia retaining one of the strongest regulations of penalty rates in the developed world.

The Treasurer for example, recently pointed to the UK as an innovative example of where tax credits are used to compensate for the relatively lax regulation of penalty rates[19]. However, the UK Government is currently arguing for both cuts in remaining penalty pay for nurses, and cuts in existing income tax credits.

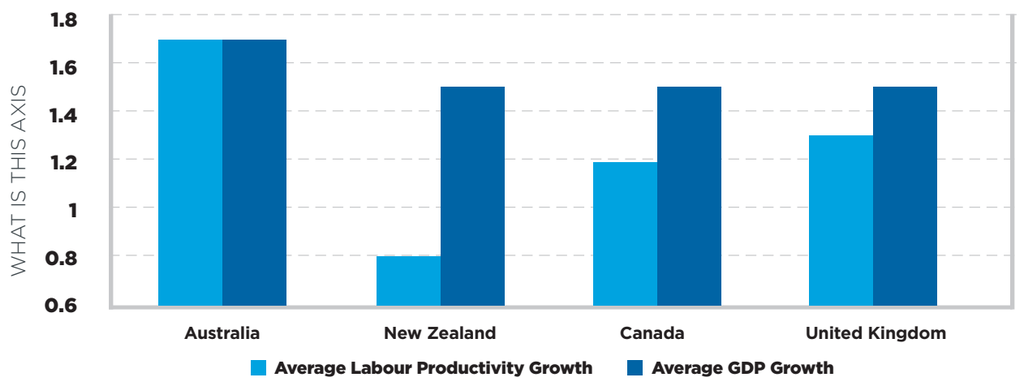
TABLE 2: INTERNATIONAL APPROACHES TO PENALTY PAY

New Zealand	Unlimited number of hours may be agreed between employer and employee as long as health of employee is not endangered. Any compensation for work in excess of agreed weekly hours must be agreed between employer and employee.
Canada	For industries under federal government jurisdiction overtime is provided where employees work over 40 hours per week
United Kingdom	Maximum working week of 48 hours with no overtime premium provided.

Source: PC Draft Report (amended)

It is of note that despite arguments that penalty rates inhibit Australia's competitiveness Australia's average gross domestic product (GDP) and labour productivity growth outstripped each of the comparator countries during the period 1995-2014.

FIGURE 1: AUSTRALIA'S GROWTH AND PRODUCTIVITY OUTSTRIPS COMPARATOR COUNTRIES



Source: OECD Statistics - Growth in GDP per capita and labour productivity

Nature of Health Workforce

Health expenditure accounts for an increasing proportion of Australia's gross domestic product (GDP), and is forecast to increase from 9.8 per cent in 2012-13[20] to 12.4 per cent by 2032-33[21]. The health workforce is the single largest component of the health budget, and the nursing and midwifery profession is the largest health profession in Australia.

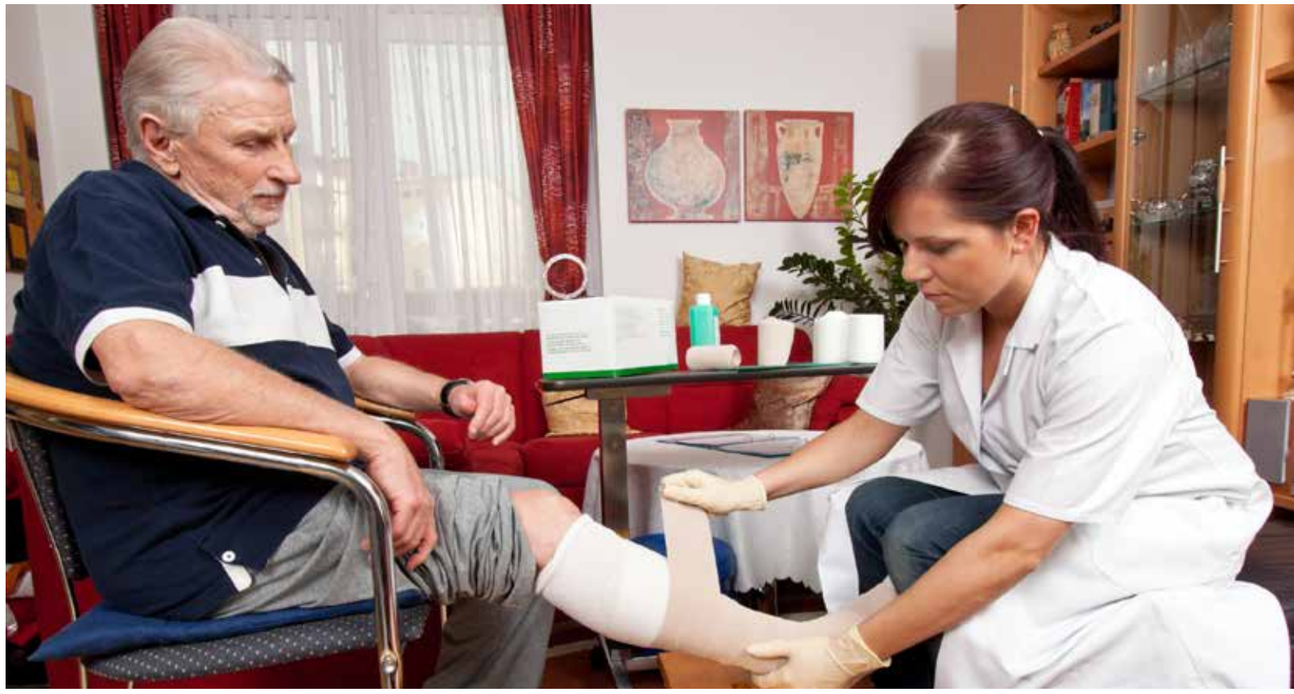
TABLE 3: REGISTERED HEALTH PRACTITIONERS, 2013

PROFESSION	NUMBER REGISTERED
Nurses and midwives	344,190
Medical practitioners	95,013
Psychologists	30,456
Pharmacists	27,972
Physiotherapists	25,545
Dentists	15,479
Dental hygienists	1,759
Dental prosthetists	1,195
Dental therapists	1,093
Oral health therapists	943
Occupational therapists	15,769
Medical radiation practitioners	14,002
Chiropractors	4,736
Optometrists	4,730
Chinese medicine practitioners	4,122
Podiatrists	4,037
Osteopaths	1,837
Aboriginal and Torres Strait Islander health practitioners	310

Note: Numbers do not add to total due to people registered in more than one profession.
Source: National Health Workforce Data Set 2013

Australia faces the future challenge of sustaining and building its health workforce to meet the rising demand for health and aged care. Demand is being driven by an ageing population living longer with more complex health issues, the increasing availability of new technology and treatments and higher consumer demands.

The ratio of working to non-working age people is predicted to nearly halve from 4.5 today to 2.7 by 2054-55[22]. This will impact on the supply of workers to the labour market and have widespread economic impacts. In addition, it is unlikely that there will be enough working aged people to meet the future demand for nurses, midwives and aged care workers.



The nature of health care is also changing with the burden of disease shifting due to significant increases in chronic disease and multi-morbidities. The role of nurses is expanding particularly in the primary care setting and meeting this demand, without impacting other areas of the health system such as hospitals, will be critical to the ongoing functioning of the health system.

Structure of the nursing and aged care workforce

Latest figures indicate that there were 300,979 registered nurses in Australia in 2014, working across a multitude of settings[23]. Registered Nurses have completed as a minimum a three-year bachelor degree and are registered with the Nursing and Midwifery Board of Australia (NMBA).

Enrolled Nurses usually work alongside Registered Nurses to provide patients with basic nursing care, doing less complex procedures. Enrolled Nurses must have completed a Certificate IV or a Diploma of Nursing from a vocational education training provider, and are also registered with the NMBA. In 2014, there were 59,160 Enrolled Nurses registered in Australia[24].

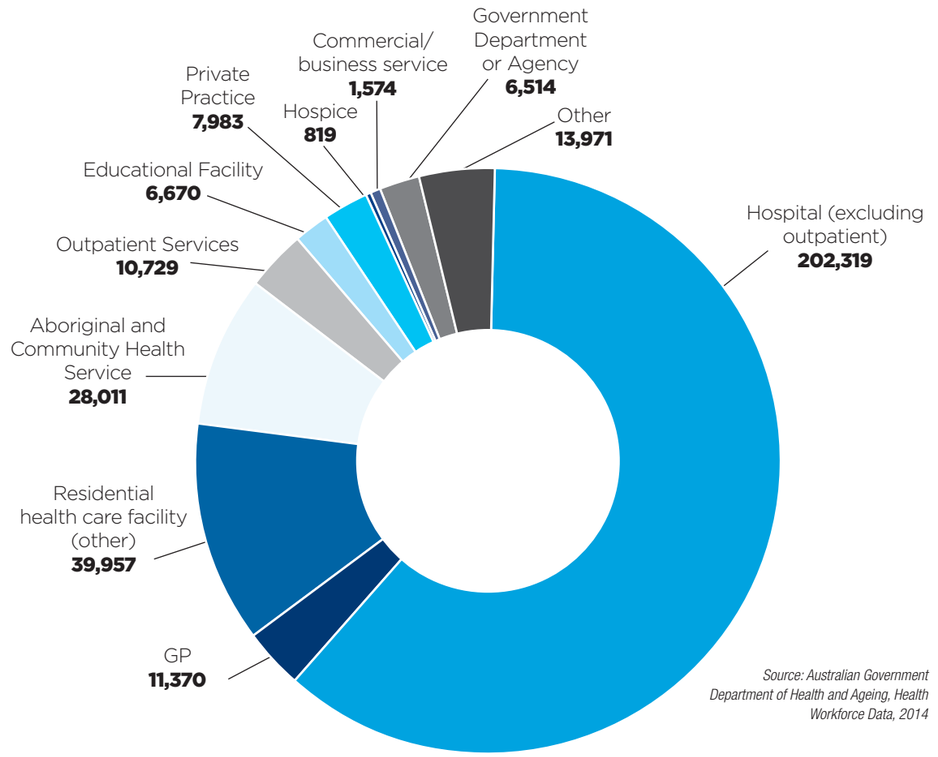
Personal Care Assistants work in aged care settings and account for the 68.2 per cent of the aged care workforce. In 2012 there were 100,312 personal care assistants working in aged care[25].

Varied Settings

While Personal Care Assistants are largely employed in our aged care facilities, Nurses and Midwives work across a variety of settings in our community. They provide care to Australians when and where they need that care. In addition to the high profile settings of hospitals and aged care facilities, nurses work in private practices including GP surgeries, aboriginal and community health centres, schools and universities, and in prisons.

Crucially just over 60 per cent of nurses and midwives registered work in a hospital setting, and a further 10 per cent work in aged care facilities both of which operate 24 hours a day, 7 days a week (Health Workforce Data, Department of Health and Ageing, 2014). The provision of high quality services within these settings requires highly skilled and experienced quality qualified nurses and midwives to work 24 hours a day, 7 days a week.

FIGURE 2: VARIED SETTINGS OF NURSE WORKFORCE, AUSTRALIA 2014



Source: Australian Government Department of Health and Ageing, Health Workforce Data, 2014

Ageing Workforce

The nursing, midwifery and personal care assistant workers are ageing and the imminent retirement of older nurses and carers will have dramatic impact on the workforce.

The percentage of nurses aged 55 years and over increased from 19.8 per cent in 2009 to 24.3 per cent in 2014[26]. This ageing of the nursing workforce is expected to continue into the future.

Future Shortages

A combination of an ageing workforce reducing the supply of nurses and an ageing population increasing demand for nurses and personal care assistants is creating forecast shortages that threaten the delivery of health services.

Recent data from Health Workforce Australia, the Government body responsible for health workforce planning, indicates that the shortage of nurses may reach over 140,000 by 2030[27]. In 2010 the Department of Health and Ageing estimated that the aged care workforce would need to increase by two to three times before 2050 to provide care to the growing number of aged care residents[28].

A number of strategies are being implemented to address the shortage in nurses including the Nursing Retention and Productivity Project, and The Clinical Fund Training Program. The Government is due to release an Aged Care Workforce Strategy by the end of 2015.

Nursing retention is of ongoing concern, with a 2012 national survey of the attitudes of nurses and midwives, conducted for the ANMF by the Monash University Department of Management, finding that 23 per cent of nurses and midwives were likely to leave the profession in the next year and 33 per cent frequently thought about leaving.

Role of Penalty Rates in the Health Sector

"There is no continuity/regularity to the roster you work, so it is much more difficult planning family time, even simple things like being home every night to cook dinner, or help with homework, or put the kids to bed become tricky. "

"Planning for social functions is also difficult. Things that are spontaneous are virtually impossible because of shift work, it is impossible to commit to a sporting team because you cannot get a regular day off or night off each week. Working public holidays becomes a chore, when everyone else is planning weekends away or their family Christmas lunch, we have to work."

Penalty rates play a crucial role in the health sector, compensating health professionals for the provision of their labour 24 hours a day, 7 days a week.

Whether patients get sick at 9 am on a Monday morning or 9 pm on a Saturday night, they expect and need the best possible care from the health system. This requires health professionals to be able and willing to work 24 hours a day, 7 days a week.

Quality of Care

I think the public need to know that in health care, weekends and night times are often the busiest, least predictable times, with the hardest work and the least resources available.

In recent years an increasing number of studies have reported the association between weekend admission to hospital and increased mortality, or the so called 'weekend effect'[29]. It has been hypothesised that this weekend effect maybe partly attributable to less and lower quality staff working on weekends[30].

In fact a recent study looked specifically at the ability of seven-day stroke specialist ward rounds and nurse staffing levels to mitigate the weekend effect in stroke patients in England[31]. While seven-day specialist ward rounds had no significant impact on outcomes, the weekend effect was highly sensitive to weekend nurse staffing levels. Stroke units with weekend nurse/patient ratios of around 1:4 had no significant weekend effect.

Another study by the Global Comparators project in 2014 found that the extent of the weekend effect is much less in Australia than in comparable countries such as the UK and the USA[32]. There was no significant increase in the adjusted odds of 30-day death on the weekend compared with a Monday emergency admission in the Australian sample.

Emergency patients in English, US and Dutch hospitals showed significant higher adjusted odds of deaths on Saturdays and Sundays compared with a Monday admission. Emergency patients admitted to the six Dutch hospitals had the highest adjusted odds of 30-day death at 1.20 and 1.17 for Saturday and Sunday.

While there are many potential causes for Australia's better performance, it is worth noting that Australia has the strongest and most universal application of penalty rates to attract an adequate number and high quality staff across weekend shifts amongst the countries studied.

Retaining Workforce

Penalty rates compensate nurses, midwives and aged care workers for the unsociable hours intrinsic to the profession.

Nurses and midwives have no choice but to work shift work due to the roster, taking them away from their family and community responsibilities. 56.4 per cent of nurses surveyed by the ANMF said they had no choice but to work shift work due to the roster[33].

Independent analysis undertaken for this report by Union & Community Data and Analytics using the *ANMF Facilities and Agreements Database* indicates that 20.1 per cent of nurses and aged care income is derived from penalty rates[34]. This is indicative of the heavy reliance on shift and weekend work in the health sector to ensure that hospitals and aged care facilities are appropriately staffed 24 hours, 7 days a week.

TABLE 4: REGISTERED NURSES, MIDWIVES, ENROLLED NURSES AND AINS/PCWS (RESIDENTIAL AGED CARE) - AGGREGATE GROSS ANNUAL AND PENALTY DERIVED WAGES. ALL ACUTE AND PSYCHIATRIC HOSPITALS, PRIVATE REHABILITATION HOSPITALS, AND RESIDENTIAL AGED CARE FACILITIES

	GROSS ($M)	AGGREGATE PENALTY PAY ($M)	PENALTY PAY SHARE (%) OF GROSS WAGES
NSW	5,950	1,197	20.2%
VIC	4,243	839	19.8%
QLD	3,673	708	19.5%
SA	1,530	316	20.7%
WA	1,773	364	20.5%
TAS	431	91	21.2%
NT	173	40	23.1%
ACT	307	65	21.1%
AUSTRALIA	**18,081**	**3,623**	**20.1%**

Source: Productivity Commission estimates based on HILDA Release 13.0 and ABS Cat No 6302.0 May 2015

The income generated by penalty rates is relied upon by nurses, midwives and aged care workers to meet their day to day living costs, but also provides much needed income in the local communities they serve.

ANMF Facilities and Agreements Database

The *ANMF Facilities and Agreements Database*[35] contains data on around 4000 health care facilities nationwide. The database holds comprehensive information on pay scales, penalty rates, allowances and conditions pertaining at each facility. The database links facilities to over 1,150 current enterprise agreements and awards.

The database allows the modelling of gross and penalty rate components included in this report and breakdowns at a facility, local, state and national level.

The full methodology is included at Appendix C.

International Comparisons

Penalty pay for nurses, midwives and aged care workers are a normal feature of pay and conditions in comparable countries to Australia. But there are differences in the rates of pay across jurisdictions. Below is a snapshot of different arrangements in operation across selected jurisdictions in Australia, New Zealand, Canada and the United Kingdom.

TABLE 5: PENALTY RATES OF PAY IN SELECTED INTERNATIONAL JURISDICTIONS

	NIGHT SHIFT	SATURDAY SHIFT	SUNDAY SHIFT	PUBLIC HOLIDAY
NSW[36]	15 per cent loading	50 per cent loading	75 per cent loading	150 per cent loading
NZ Health Boards	25 per cent loading	50 per cent loading	50 per cent loading	Up to 100 per cent loading
British Columbia - Canada[37][38]	$3.50 per hour	$2 per hour	$2 per hour	50 per cent loading
UK NHS[39]	30 per cent-50 per cent loading	30 per cent-50 per cent loading	60 per cent-100 per cent loading	60 per cent-100 per cent loading

Impact of Removal

While not the current focus of the campaign to reduce or remove penalty rates, the likely impact of any change on the health sector is an important part of the debate. The concern for nurses, midwives and aged care workers is that the current focus on the hospitality and retail sector is merely the start of a long campaign to reduce or remove penalty rates across the economy.

In addition, it seems incomplete to merely focus on the likely impacts of removing or reducing penalty rates in one industry when, if implemented, these changes may end up being applied more broadly.

There are two main impacts of removing or reducing penalty rates in the health sector. The first is on the income of nurses, midwives and aged care workers. The second is on the number of nurses, midwives and aged care workers willing to continue to supply their labour at reduced rate of pay.

The independent analysis undertaken for this report by Union & Community Data and Analytics finds that total lost income of nurses, midwives and personal care workers from removing penalty rates in acute and psychiatric hospitals, and residential aged care facilities would be over $3.6 billion per annum, while the impact of reducing Sunday penalty rates to Saturday penalty rates would be $359 million per annum.

The analysis also finds that reducing or removing penalty rates will have a disproportionate impact in regional and rural areas.

A recent survey of the nursing and midwifery profession by the ANMF provides a snapshot of the likely impact of removing penalty rates on labour supply. 85 per cent of nurses report that they would no longer be willing to undertake shift or weekend work if penalty rates were removed. This would have significant reduction in the care available to patients and aged care residents.

Impact on Incomes of Removal

Removing or reducing penalty rates for shift or weekend work would significantly reduce the take home pay of nurses.

The analysis in this section assesses what the impact of current proposals to reduce Sunday to Saturday penalty rates would be on nurses and aged care workers. We note that the scale of losses may be greater depending on the scope of future proposals to cut penalty rates.

Sunday penalty rates are the largest component of penalty derived wages for nurses, and aged care workers across Australia and represent over 35 per cent of total penalty rate income[40].

TABLE 6: PENALTY DERIVED WAGES (ALL FACILITIES) OF NURSES, MIDWIVES AND AINS/PCWS- SHARE (%) OF TOTAL GROSS WAGES BY PENALTY TYPE

	LATE SHIFT	NIGHT SHIFT	SATURDAY	SUNDAY	PUB HOLIDAY	ALL PENALTIES
NSW	2.1%	2.0%	5.1%	7.6%	3.4%	20.2%
VIC	1.7%	2.9%	6.1%	6.2%	2.9%	19.8%
QLD	2.4%	2.3%	5.1%	7.7%	1.9%	19.5%
SA	2.1%	2.5%	5.1%	7.6%	3.4%	20.7%
WA	2.5%	4.1%	5.1%	7.5%	1.3%	20.5%
TAS	2.5%	3.0%	5.0%	8.2%	2.5%	21.2%
NT	2.4%	3.0%	4.9%	9.6%	3.3%	23.1%
ACT	2.1%	3.1%	5.0%	7.6%	3.3%	21.1%
AUSTRALIA	**2.1%**	**2.6%**	**5.3%**	**7.3%**	**2.7%**	**20.1%**

The losses from a reduction in Sunday penalty rates across the board to match Saturday penalty rates would reduce the take home pay of nurses ,midwives and aged care workers by $359 million per year.

TABLE 7: ACT OF REDUCING SUNDAY PENALTY RATES TO SATURDAY RATES[41]

	AINS/PCWs (Residential Aged Care) Aggregate Lost Wages ($m)	Registered Nurses, Enrolled Nurses & Midwives (Residential Aged Care, Acute & Psychiatric Hospitals) Aggregate Lost Wages ($m)	Total Lost Wages (Nursing Staff in Residential Aged Care, Acute and Psychiatric Hospitals; AINs/PCWs in Residential Aged Care ($m)
NSW	-35.74	-115.12	-150.87
VIC	-2.00	-1.35	-3.35
QLD	-17.74	-70.24	-92.25
SA	-9.46	-29.08	-38.54
WA	-8.30	-35.86	-44.17
TAS	-4.61	-9.18	-13.79
NT	-0.48	-7.72	-8.20
ACT	-1.24	-6.68	-7.92
AUSTRALIA	**-79.58**	**-279.52**	**-359.10**

Note: Awards and Agreements covering Victorian hospitals and aged care facilities generally provide the same penalty rates and shift allowances for Saturday and Sunday work. The lost wages for Victorian nurses and personal care workers relate to those few private sector health facilities that are not subject to an enterprise agreement and are therefore covered by the Nurses Award 2010.

Impact on the Regions

The impact of penalty rates and other payments with respect to labour market conditions is complex, particularly in relation to regional and remote areas.

The income earned by nurses, midwives and carers flows into the local communities they serve, and the importance of this income in regional and rural Australia is higher due to the nature of the nurse workforce and lower average incomes and employment in regional areas.

The latest Survey of Household Income and Wealth from the ABS illustrates the disparity between capital cities and other regions.

TABLE 8: HOUSEHOLD MEAN GROSS INCOME (2013-14)[42]

	REGIONS	CAPITAL CITY
NSW	1,663	2,435
VIC	1,482	2,118
QLD	1,839	2,122
SA	1,433	1,750
WA	2,047	2,686
TAS	1,385	1,729
AUSTRALIA	**1,685**	**2,261**

Analysis undertaken for this report using detailed information on existing workplace agreements and the location of hospitals alongside aggregate health and workforce data indicates that of the $3.6 billion nurses and aged care workers earn annually in penalty rates, close to $1 billion is in regional and remote Australia.

AIHW data shows that the nursing ratio (employed nurses per head of population) is higher in remote areas than major cities, resulting in a slightly higher share of wages in remote areas being derived from penalty rates.

TABLE 9: RATIO OF FULL TIME EQUIVALENT REGISTERED AND ENROLLED NURSES PER 100,000 POPULATION ACROSS REGIONS

	MAJOR CITIES	INNER REGIONAL	OUTER REGIONAL	REMOTE	VERY REMOTE	AUSTRALIA
Registered nurses	985	864	832	1,030	1,092	952
Enrolled nurses	160	232	245	208	142	182
All nurses	**1,145**	**1,096**	**1,077**	**1,239**	**1,233**	**1,134**

Source: AIHW National Health workforce dataset: Nurses and Midwives 2014 Supplementary Tables - Overview Tables. Table 13: Employed nurses and midwives: number, average total weekly hours worked and FTE rate, division, remoteness area of main job.

Note: FTE is based on total weekly hours worked and is based on a 38-hour working week.

AIHW data also shows nurses are on average working longer hours in remote areas, potentially contributing to slightly higher share of incomes in regional and remote areas being derived from penalty rates.

TABLE 10: AVERAGE WEEKLY HOURS WORKED BY EMPLOYED NURSES AND MIDWIVES: SELECTED CHARACTERISTICS, REMOTENESS AREA 2014

	REMOTENESS AREA						
CHARACTERISTIC	MAJOR CITIES	INNER REGIONAL	OUTER REGIONAL	REMOTE	VERY REMOTE	NOT STATED	AUSTRALIA
Average weekly hours worked	33.7	32.6	33.9	37.0	40.3	35.7	33.6

Source: AIHW National Health workforce dataset: Nurses and Midwives 2014 Supplementary Tables - Overview Tables. Table 13: Employed nurses and midwives: number, average total weekly hours worked and FTE rate, division, remoteness area of main job, 2014

These regional differences may be due to lower nurse numbers in regional areas, but may also reflect rostering practices in the smaller regional facilities. It may be more efficient to have staff working longer shifts than employing additional part-time nurses in these smaller facilities. As a result, a slightly higher share of gross wages is due to penalty rates in regional and remote areas with potentially larger impacts faced by regional areas should penalty rate be cut. Analysis of agreement data shows that the higher average ratio of penalty pay to ordinary hours pay pertains to agreements covering private hospitals and aged care facilities in regional and remote locations.

TABLE 11: REGISTERED NURSES, MIDWIVES, ENROLLED NURSES (EMPLOYED IN ACUTE AND PSYCHIATRIC HOSPITALS AND RESIDENTIAL AGED CARE) AND AINS/PCWS (EMPLOYED IN RESIDENTIAL AGED CARE) – AGGREGATE GROSS ANNUAL WAGE - AUSTRALIA[43]

	AGGREGATE GROSS ANNUAL WAGES ($M)	AGGREGATE PENALTY PAY ($M)	PENALTY PAY AS A SHARE OF GROSS WAGES (%)
Major Cities	$13,231	$2,648	20.0%
Regional	$4,586	$921	20.1%
Remote	$263	$54	20.6%

Analysis using detailed information on agreements operating at individual hospitals and aged care facilities has found that under the proposal to cut Sunday penalty rates to Saturday penalty rate levels nurses working in regional and rural Australia would lose a higher percentage of their gross pay.

FIGURE 3: LOSSES FROM REDUCING SUNDAY PENALTY RATES TO SATURDAY LEVELS

Impact on Individual Nurses

In many ways the aggregate impacts hide the scale of the losses for individual nurses and aged care workers that rely on income from penalty rates to help support their families. Depending on the nature of shifts individual nurses and aged care workers may lose a significant portion of their total wages.

SCENARIO A

Registered Nurse in a Public Hospital working standard 152 hour shift per four weeks , which includes two early Sunday, one late Sunday and one early Saturday shift per month.

The modelled "representative' 152 hour 4 week rotating roster includes: 5 Afternoon/late Shifts; 5 night shifts; 2 Saturday Shifts; 2 Sunday Shifts and 1 public Holiday. Effectively this models two weeks of rostered day shifts; 1 week of rostered night shift; and 1 week of rostered afternoon/late shift; 2 rostered weekends and 1 public holiday.

On average across the nation, a registered nurse working this representative 152 hour shift per month stands to lose $1,548 per year if Sunday penalty rates were cut to match Saturday penalty rates, or $29.70 per week. Outside Victoria, where Sunday and Saturday penalty rates are already equivalent in public hospitals due to different shift allowance arrangements in that state, the average annual impact is a loss of $1,900 per year or $36.44 a week.

This average cut equates to around 1.6% of the average wage for a registered nurse working this representative 152 hours per month. Outside of Victoria, the cut is equivalent to a 2.0% in annual gross wages.

TABLE 12: IMPACT ON REGISTERED NURSE WORKING A REPRESENTATIVE152 HOURS PER FOUR WEEKS

	LOSS PER WEEK ($)	LOSS PER YEAR ($)	% GROSS PAY
NSW	-33.90	-1767.47	1.90%
VIC	0.00	0.00	0.00%
QLD	-37.70	-1965.57	1.97%
SA	-35.33	-1841.95	1.95%
WA	-37.45	-1952.92	1.95%
TAS	-35.77	-1865.08	1.95%
NT	-85.72	-4469.63	3.76%
ACT	-37.80	-1970.86	1.94%
AUST	**-29.70**	**-1548.46**	**1.63%**
AUST (EXCL. VIC)	**-36.44**	**-1900.33**	**1.97%**

The foregoing analysis provides a snapshot of the impact on a single representative 152 hour shift applied across public workplaces in Australia. For context, it is useful to compare this with the modelled impacts based on the nursing capacity utilisation rates at different times of the day and week. This provides a more accurate assessment of the overall impact on registered nurses of cuts.

This analysis shows that on average full time Registered Nurses working in Public Hospitals would receive a pay cut of 2.0% or $1,921 a year if Sunday penalty rates were reduced to the level of Saturday rates. Excluding Victoria from the analysis, an average cut of 2.55% is estimated equivalent to $2,461.70.

TABLE 13: IMPACT ON REGISTERED NURSE WORKING IN PUBLIC HOSPITALS

	IMPACT (WEEKLY)	IMPACT (ANNUAL)	% AVERAGE FTE GROSS ANNUAL WAGES
NSW	-44.87	-$2,339	-2.51%
VIC	0.00	$0	0.00%
QLD	-48.10	-$2,508	-2.51%
SA	-45.08	-$2,350	-2.49%
WA	-47.79	-$2,492	-2.49%
TAS	-45.64	-$2,380	-2.49%
NT	-109.38	-$5,703	-4.80%
ACT	-48.23	-$2,515	-2.47%
AUST	**-36.83**	**-$1,921**	**-2.03%**
AUST (EXCL. VIC)	**-$48.40**	**-2461.70**	**-2.55%**

SCENARIO B

Enrolled Nurse in a Public Hospital working average hours[44]

This scenario deals with an Enrolled Nurse working average hours and performing the same proportion of work attracting penalty loadings as is available across the hospital. However, the losses would clearly be even more for any Enrolled Nurses working a disproportionate share of their rostered hours on Sundays.

The average hours worked by an enrolled nurse in a hospital varies from state to state. In this scenario B we review the impacts on a state-by-state basis using the average working hours for each state. Within this study, the average hours worked nationally is 32.6 hours, based on state averages derived from AIHW data.

On average across the nation, an enrolled nurse working 32.6 hours per week would be $1,281.02 worse off each year if Sunday penalty rates were cut to Saturday levels, or $25.47 per week.

This average cut equates to around 1.8% of the average wage for an enrolled nurse in a Public Hospital working average hours of 32.6 hours per week. Excluding Victoria, an enrolled nurse would be $1,606.42 worse off, or $31.59 a week equivalent to 2.63% of total wages.

TABLE 14: IMPACT ON THE AVERAGE WAGE OF A FULL TIME ENROLLED NURSE WORKING IN A PUBLIC HOSPITAL

	IMPACT (WEEKLY)	IMPACT (ANNUAL)	AVERAGE HOURS	% AVERAGE FTE GROSS ANNUAL WAGES
NSW	-30.17	-1573.00	33.3	-2.59%
VIC	0.00	0.00	30.4	0.00%
QLD	-30.64	-1597.91	32.9	-2.58%
SA	-28.11	-1465.77	30.2	-2.57%
WA	-31.01	-1617.01	32.4	-2.57%
TAS	-30.16	-1572.83	32.0	-2.56%
NT	-65.55	-3417.92	33.1	-4.95%
ACT	-34.89	-1819.46	36.3	-2.55%
AUST	**-25.47**	**-1281.02**	**32.2**	**-2.14%**
AUST (EXCL. VIC)	**-31.59**	**-1606.42**	**32.6**	**-2.63%**

SCENARIO C

A personal care worker in an Aged Care facility working a full time equivalent of 38 hours per week[45]

On average across the nation, personal care workers in aged care facilities face a cut of $1,088 per year, if Sunday penalty rates are cut to match Saturday rates of pay, or $27.49 per week. Outside Victoria, personal care workers face an average cut of $1,433.50 per year or $27.49 per week.

This average cut equates to around 2.0% of the average wage for a personal care worker in an aged care facility working a full time equivalent of 38 hours per week. Outside Victoria, the cut is higher – on average 2.65% of average full time earnings.

TABLE 15: IMPACT ON AN AIN/PCW WORKING FULL TIME EQUIVALENT HOURS (38 HOURS PER WEEK)

	LOSS PER WEEK ($)	LOSS PER YEAR ($)	% AVERAGE FTE GROSS WAGES
NSW	-$26.83	-$1,398.77	-2.59%
VIC	-$2.02	-$105.32	-0.18%
QLD	-$26.31	-$1,371.97	-2.51%
SA	-$26.57	-$1,385.40	-2.59%
WA	-$26.82	-$1,398.27	-2.51%
TAS	-$46.62	-$2,431.04	-4.48%
NT	-$43.85	-$2,286.61	-4.05%
ACT	-$31.24	-$1,629.09	-3.00%
AUST	**-$20.87**	**-$1,088.01**	**-1.98%**
AUST (EXCL. VIC)	**-$27.49**	**-$1,433.50**	**-2.65%**

Impact on Labour Supply of Removal

"I think that reducing or stopping penalty rates will have a devastating effect on the nursing profession."

"We already have difficulties in finding enough staff let alone enough skilled staff to cover the outside hours/weekends now, imagine what will happen when they remove the compensation/incentive. This will have a ripple-on effect, affecting the quality of care."

"There is very much less support from medical staff and management which can be very tough when something out of the ordinary happens."

Penalty rates compensate nurses, midwives and aged care workers for the disruption to their lives of working night shifts and over weekends and holiday periods. The reduction or removal of penalty rates will reduce the number and quality of staff willing to work during these periods, and potentially exacerbate the predicted shortage in nurses and midwives into the future.

Labour Supply and Shortages

Labour markets work on the basis of supply and demand. One of the main arguments for reducing penalty rates across the economy is that it will increase labour demand and thereby create jobs. This ignores the income effects of reducing penalty rates on aggregate demand and therefore employment. In addition, reducing penalty rates is likely to reduce the supply of labour as workers are less willing to work unsociable hours.

Health Workforce Australia's currently predicts a shortage of nurses and midwives of almost 140,000 by 2050[46]. In this context, any further attrition of the current nurse workforce would undermine the existing strategies and polices to alleviate the shortfall. Such shortages threaten the sustainability of the health system and the quality of care received by patients. Any reduction in penalty rates would only exacerbate this projected shortage and make attracting more nurses, particularly into hospital and aged care settings, more difficult.

A recent ANMF survey of 13,000 nurses and midwives found that 85 per cent would not be willing to continue to undertake shift work if penalty rates were cut or abolished. This represents a significant threat to the functioning of our health system which relies on nurses and midwives being willing to work overnight and over weekends. Access to the care currently available to patients admitted or requiring care overnight and on weekends is likely to suffer as a result.

Any reduction in penalty rates would also reduce the attractiveness of the nursing and midwifery profession and is likely to result in more nurses and midwives leaving the profession. A 2013 national survey of the attitudes of nurses and midwives by Monash University found that up to 23 per cent planned to leave the profession in the next year and a further 33 per cent frequently thought about leaving[47].

56 per cent of nurses and midwives surveyed by the ANMF reported that they only work weekend and shift work because of the roster requirements[48]. These nurses and midwives are not choosing to work these shifts due to convenience.

If penalty rates were reduced or removed more nurses and midwives could be expected to leave the profession rather than continue to work unsociable hours without commensurate compensation.

Worsening Weekend Effect

Mitigating the so-called weekend effect relies heavily on attracting adequate numbers of high quality nursing staff on weekends. The ANMF survey has illustrated that by cutting penalty rates the number of nurses willing to work these shifts will fall.

As a result any move to remove or reduce penalty rates may lead to a worsening of the weekend effect in Australia and has the potential to increase mortality rates for patients admitted on or near weekends.

Conclusions

The campaign to cut penalty rates is a threat to the wages and conditions of all Australian workers, but particularly those that work in industries which rely heavily on penalty rates to operate 24 hours a day, 7 days a week.

While the health sector is currently being treated as a 'special case' due to community expectations, the reality is that if penalty rates are abolished or reduced in one industry, it is likely that in time these changes will flow through to other industries.

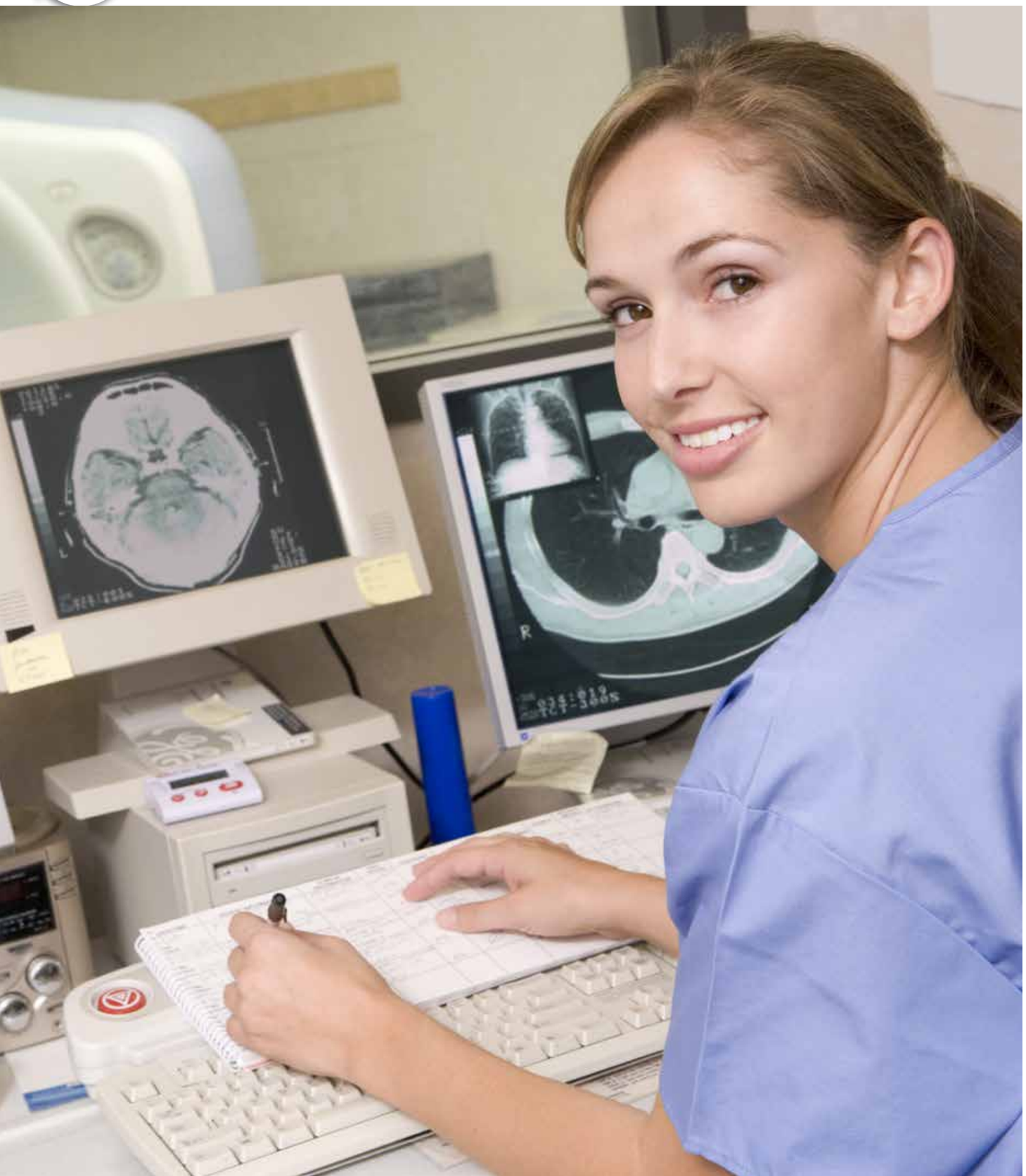
This paper has illustrated the flow on impacts to nurses, midwives and age care workers from the proposed erosion in penalty rates across the Australia economy.

Nurses and aged care workers stand to lose over $359 million per year in wages with the move to reduce Sunday penalty to Saturday levels, and a further $3 billion per year could be under threat if the reforms go any further.

At an individual level, Registered Nurses working in public hospitals can expect to receive an average pay cut of 2% or $1,921 a year if Sunday penalty rates were reduced to the level of Saturday rates. In NT the cut may be over $5,000 per year. Excluding Victoria from the analysis, an average cut of 2.55% is estimated, equivalent to $2,462 a year.

The impact this would have on individual nurses is high, but the impact will be felt more broadly with it likely to exacerbate projected shortages in nurses and midwives and lower the quality of care received by patients.

Health is the ultimate 24/7 industry and it illustrates in a 24/7 economy the need to continue to compensate employees asked to provide their labour at unsociable and inconvenient times.



Appendix A – Acute, Psychiatric and Rehabilitation Hospitals

TABLE 16: AGGREGATE COMPONENTS OF TOTAL WAGE FOR REGISTERED NURSES, MIDWIVES AND ENROLLED NURSES EMPLOYED IN ACUTE, PSYCHIATRIC AND REHABILITATION HOSPITALS – BY STATE

	AGGREGATE GROSS WAGES ($M)	AGGREGATE GROSS PENALTY PAY ($M)	AGGREGATE NET WAGES ($M)	AGGREGATE NET PENALTY PAY ($M)	AGGREGATE PENALTY PAY AS SHARE OF GROSS WAGE (%)
NSW	3859.6	782.6	3106.0	639.5	20.3%
VIC	2654.8	527.4	2137.2	431.4	19.9%
QLD	2637.0	503.8	2122.6	415.6	19.1%
SA	977.6	204.2	789.0	166.9	20.9%
WA	$1,281.5	$268.7	$1,031.0	$222.3	21.0%
TAS	$275.5	$57.9	$221.6	$47.3	21.0%
NT	$156.1	$36.1	$125.5	$29.5	23.2%
ACT	$244.5	$52.3	$196.6	$42.6	21.4%
AUST	**$12,085.4**	**$2,432.9**	**$9,728.3**	**$1,994.8**	**20.1%**

TABLE 17: AGGREGATE COMPONENTS OF TOTAL WAGE FOR REGISTERED NURSES, MIDWIVES AND ENROLLED NURSES EMPLOYED IN ACUTE, PSYCHIATRIC AND REHABILITATION HOSPITALS – BY REMOTENESS AREA

	AGGREGATE GROSS WAGES ($M)	AGGREGATE GROSS PENALTY PAY ($M)	AGGREGATE NET WAGES ($M)	AGGREGATE NET PENALTY PAY ($M)	AGGREGATE PENALTY PAY AS SHARE OF GROSS WAGE (%)
Major Cities	$9,036.0	$1,820.0	$7,273.2	$1,476.1	20.1%
Inner Regional Australia	$1,852.5	$371.5	$1,491.3	$308.8	20.1%
Outer Regional Australia	$977.6	$196.4	$787.3	$169.2	20.1%
Remote Australia	$151.1	$31.7	$121.5	$28.1	21.0%
Very Remote Australia	$68.3	$13.3	$55.0	$12.6	19.4%
AUSTRALIA	$12,085.4	$2,432.9	$9,728.3	$1,994.8	20.1%

TABLE 18: AGGREGATE IMPACT OF SATURDAY FOR SUNDAY PENALTY RATE, FOR REGISTERED NURSES, MIDWIVES AND ENROLLED NURSES EMPLOYED IN ACUTE, PSYCHIATRIC AND REHABILITATION HOSPITALS – BY STATE

	LOSS IN WAGES ($M)	PER CENT OF GROSS PAY
NSW	-$88.97	-2.31%
VIC	-$0.39	-0.01%
QLD	-$60.95	-2.31%
SA	-$21.41	-2.19%
WA	-$29.52	-2.30%
TAS	-$6.37	-2.31%
NT	-$6.87	-4.40%
ACT	-$5.62	-2.30%
AUSTRALIA	**-$220.15**	**-1.82%**

TABLE 19: AGGREGATE IMPACT OF SATURDAY FOR SUNDAY PENALTY RATE, FOR REGISTERED NURSES, MIDWIVES AND ENROLLED NURSES EMPLOYED IN ACUTE, PSYCHIATRIC AND REHABILITATION HOSPITALS – BY REMOTENESS AREA

	LOSS IN WAGES ($M)	PER CENT OF GROSS PAY
Major Cities	-$160.10	-1.77%
Inner Regional Australia	-$32.03	-1.73%
Outer Regional Australia	-$21.99	-2.25%
Remote Australia	-$4.40	-2.91%
Very Remote Australia	-$1.64	-2.40%
AUSTRALIA	**-$220.15**	**-1.82%**

TABLE 20: IMPACT OF SATURDAY FOR SUNDAY PENALTY RATES ON AVERAGE EARNINGS OF REGISTERED NURSES, MIDWIVES AND ENROLLED NURSES EMPLOYED IN ACUTE, PSYCHIATRIC AND REHABILITATION HOSPITALS – BY STATE

REGISTERED NURSES AND MIDWIVES

	FTE (38 HOURS PER WEEK)					AVERAGE					
	AVERAGE FTE GROSS WAGES (ANNUAL)	AVERAGE FTE GROSS PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	AVERAGE FTE PENALTY PAY (WEEK)	IMPACT (WEEK)	AVERAGE WEEKLY HOURS	AVERAGE GROSS WAGES (ANNUAL)	AVERAGE PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	AVERAGE PENALTY PAY (WEEK)	IMPACT (WEEK)
		$	$	$	$	Hrs		$	$	$	$
NSW	$92,599	$18,728	**-$2,325**	$359	**-$45**	35	$85,215	$17,235	**-$2,140**	$331	**-$41**
VIC	$88,239	$17,476	**-$14**	$335	**$0**	32.8	$76,181	$15,088	**-$12**	$289	**-$0**
QLD	$98,725	$18,798	**-$2,481**	$361	**-$48**	34.4	$89,476	$17,037	**-$2,248**	$327	**-$43**
SA	$92,795	$19,314	**-$2,309**	$370	**-$44**	33.9	$82,752	$17,223	**-$2,062**	$330	**-$40**
WA	$99,348	$20,771	**-$2,471**	$399	**-$47**	32.6	$86,005	$17,992	**-$2,139**	$345	**-$41**
TAS	$94,938	$19,922	**-$2,360**	$382	**-$45**	33	$81,813	$17,168	**-$2,033**	$329	**-$39**
NT	$118,471	$27,355	**-$5,691**	$525	**-$109**	35.6	$111,114	$25,656	**-$5,338**	$492	**-$102**
ACT	$101,258	$21,602	**-$2,505**	$414	**-$48**	38.7	$103,203	$22,017	**-$2,553**	$422	**-$49**
AUSTRALIA	$94,031	$18,872	**-$1,867**	$362	**-$36**	34	$84,255	$16,911	**-$1,673**	$324	**-$32**

ENROLLED NURSES

	FTE (38 HOURS PER WEEK)					AVERAGE					
	AVERAGE FTE GROSS WAGES (ANNUAL)	AVERAGE FTE GROSS PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	AVERAGE FTE PENALTY PAY (WEEK)	IMPACT (WEEK)	AVERAGE WEEKLY HOURS	AVERAGE GROSS WAGES (ANNUAL)	AVERAGE PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	AVERAGE PENALTY PAY (WEEK)	IMPACT (WEEK)
		$	$	$	$	Hrs		$	$	$	$
NSW	$68,777	$14,342	**-$1,782**	$275	**-$34**	33.3	$60,325	$12,579	**-$1,563**	$241	**-$30**
VIC	$69,284	$14,254	**-$18**	$273	**-$0**	30.4	$55,445	$11,407	**-$15**	$219	**$0**
QLD	$71,940	$14,279	**-$1,857**	$274	**-$36**	32.9	$62,209	$12,348	**-$1,606**	$237	**-$31**
SA	$70,747	$15,179	**-$1,818**	$291	**-$35**	30.2	$56,188	$12,055	**-$1,444**	$231	**-$28**
WA	$73,257	$15,794	**-$1,880**	$303	**-$36**	32.4	$60,706	$13,088	**-$1,558**	$251	**-$30**
TAS	$73,436	$15,895	**-$1,883**	$305	**-$36**	32.0	$62,594	$13,549	**-$1,605**	$260	**-$31**
NT	$79,045	$18,840	**-$3,918**	$361	**-$75**	33.1	$69,236	$16,502	**-$3,432**	$316	**-$66**
ACT	$74,150	$16,324	**-$1,892**	$313	**-$36**	36.3	$71,971	$15,844	**-$1,836**	$304	**-$35**
AUSTRALIA	$70,467	$14,652	**-$1,456**	$281	**-$28**	31.8	$59,420	$12,355	**-$1,228**	$237	**-$24**

Appendix B – Residential Aged Care Facilities

TABLE 21: AGGREGATE WAGE COMPONENTS OF REGISTERED NURSES AND MIDWIVES, ENROLLED NURSES AND AINS/PCWS EMPLOYED IN RESIDENTIAL AGED CARE FACILITIES – BY STATE

	AGGREGATE GROSS WAGES ($M)	AGGREGATE GROSS PENALTY PAY ($M)	AGGREGATE NET WAGES ($M)	AGGREGATE NET PENALTY PAY ($M)	AGGREGATE PENALTY PAY AS SHARE OF GROSS WAGE (%)
NSW	2090.45	417.17	1818.69	362.94	19.96%
VIC	1588.01	311.79	1381.57	271.26	19.63%
QLD	1037.04	204.52	902.22	177.94	19.72%
SA	552.60	111.70	480.76	97.18	20.21%
WA	492.44	94.95	428.42	82.61	19.28%
TAS	155.20	33.46	135.02	29.11	21.56%
NT	17.18	3.82	14.95	3.32	22.23%
ACT	62.36	12.46	54.25	10.84	19.99%
AUST	**5995.27**	**1189.87**	**5215.89**	**1035.19**	**19.85%**

TABLE 22: AGGREGATE WAGE COMPONENTS OF REGISTERED NURSES AND MIDWIVES, ENROLLED NURSES AND AINS/PCWS EMPLOYED IN RESIDENTIAL AGED CARE FACILITIES – BY REMOTENESS AREA

	GROSS WAGES ($M)	GROSS PENALTY PAY ($M)	NET WAGES ($M)	NET PENALTY PAY ($M)	PENALTY PAY AS SHARE OF GROSS WAGE (%)
Major Cities	4195.48	827.81	3650.07	720.20	19.73%
Inner Regional Australia	1284.10	258.19	1117.17	224.62	20.11%
Outer Regional Australia	471.92	94.79	410.57	82.46	20.09%
Remote Australia	33.28	6.93	28.96	6.03	20.82%
Very Remote Australia	10.48	2.16	9.12	1.88	20.58%
AUSTRALIA	**5995.27**	**1189.87**	**5215.89**	**1035.19**	**19.85%**

TABLE 23: IMPACT OF SATURDAY FOR SUNDAY PENALTY RATES ON AGGREGATE GROSS WAGES OF REGISTERED NURSES AND MIDWIVES, ENROLLED NURSES AND AINS/PCWS EMPLOYED IN RESIDENTIAL AGED CARE FACILITIES – BY STATE

	AGGREGATE LOSS IN WAGES ($M)	PER CENT OF GROSS PAY
NSW	-$46.93	-2.24%
VIC	-$2.55	-0.16%
QLD	-$22.64	-2.18%
SA	-$12.37	-2.24%
WA	-$10.76	-2.19%
TAS	-$6.03	-3.88%
NT	-$0.60	-3.48%
ACT	-$1.63	-2.61%
AUSTRALIA	**-$103.51**	**-1.73%**

TABLE 24: AGGREGATE IMPACT OF SATURDAY FOR SUNDAY PENALTY RATE, FOR REGISTERED NURSES, MIDWIVES AND ENROLLED NURSES EMPLOYED IN ACUTE, PSYCHIATRIC AND REHABILITATION HOSPITALS – BY REMOTENESS AREA

	AGGREGATE LOSS IN WAGES ($M)	PER CENT OF GROSS PAY
Major Cities	-$70.24	-1.67%
Inner Regional Australia	-$22.92	-1.78%
Outer Regional Australia	-$9.27	-1.96%
Remote Australia	-$0.83	-2.50%
Very Remote Australia	-$0.26	-2.45%
AUSTRALIA	**-$103.51**	**-1.73%**

TABLE 25: IMPACT OF SATURDAY FOR SUNDAY PENALTY RATES ON AVERAGE EARNINGS OF REGISTERED NURSES AND MIDWIVES, ENROLLED NURSES AND ASSISTANTS IN NURSING/PERSONAL CARE WORKERS EMPLOYED IN RESIDENTIAL AGED CARE FACILITIES – BY STATE

REGISTERED NURSES

	FTE (38 HOURS PER WEEK)					AVERAGE				
	AVERAGE FTE GROSS WAGES (ANNUAL)	PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	PENALTY PAY (WEEKLY)	IMPACT (WEEKLY)	AVERAGE GROSS WAGES (ANNUAL)	PENALTY PAY (ANNUAL)	IMPACT	PENALTY PAY (WEEKLY)	IMPACT
		$	$	$	$		$	$	$	$
NSW	$86,204	$16,909	**-$2,184**	$324	**-$42**	$57,185	$11,217	**-$1,449**	$215	**-$28**
VIC	$78,521	$14,169	**-$144**	$272	**-$3**	$52,088	$9,399	**-$96**	$180	**-$2**
QLD	$76,774	$14,815	**-$1,890**	$284	**-$36**	$50,930	$9,828	**-$1,254**	$188	**-$24**
SA	$83,863	$16,740	**-$2,130**	$321	**-$41**	$55,632	$11,105	**-$1,413**	$213	**-$27**
WA	$84,857	$16,275	**-$2,066**	$312	**-$40**	$56,292	$10,797	**-$1,370**	$207	**-$26**
TAS	$83,418	$17,812	**-$3,719**	$342	**-$71**	$55,337	$11,816	**-$2,467**	$227	**-$47**
NT	$72,977	$15,871	**-$2,795**	$304	**-$54**	$48,411	$10,528	**-$1,854**	$202	**-$36**
ACT	$86,880	$17,054	**-$2,567**	$327	**-$49**	$57,634	$11,313	**-$1,703**	$217	**-$33**
AUSTRALIA	$82,107	$15,781	**-$1,632**	$303	**-$31**	$54,467	$10,468	**-$1,083**	$201	**-$21**

ENROLLED NURSE

	FTE (38 HOURS PER WEEK)					AVERAGE				
	AVERAGE FTE GROSS WAGES (ANNUAL)	PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	PENALTY PAY (WEEKLY)	IMPACT (WEEKLY)	AVERAGE GROSS WAGES (ANNUAL)	PENALTY PAY (ANNUAL)	IMPACT	PENALTY PAY (WEEKLY)	IMPACT
		$	$	$	$		$	$	$	$
NSW	$65,637	$12,920	**-$1,662**	$248	**-$32**	$44,363	$8,733	**-$1,123**	$167	**-$22**
VIC	$65,857	$12,748	**-$114**	$244	**-$2**	$44,511	$8,616	**-$77**	$165	**-$1**
QLD	$63,447	$12,358	**-$1,559**	$237	**-$30**	$42,882	$8,352	**-$1,054**	$160	**-$20**
SA	$66,803	$13,241	**-$1,581**	$254	**-$30**	$45,151	$8,950	**-$1,069**	$172	**-$20**
WA	$63,243	$12,085	**-$1,544**	$232	**-$30**	$42,745	$8,168	**-$1,043**	$157	**-$20**
TAS	$67,477	$14,335	**-$2,969**	$275	**-$57**	$45,607	$9,689	**-$2,007**	$186	**-$38**
NT	$66,291	$14,476	**-$2,578**	$278	**-$49**	$44,805	$9,784	**-$1,743**	$188	**-$33**
ACT	$65,192	$12,860	**-$1,920**	$247	**-$37**	$44,062	$8,692	**-$1,298**	$167	**-$25**
AUSTRALIA	$65,266	$12,779	**-$1,263**	$245	**-$24**	$44,112	$8,637	**-$854**	$166	**-$16**

ASSISTANT IN NURSING/PERSONAL CARE WORKER

	FTE (38 HOURS PER WEEK)					AVERAGE				
	AVERAGE FTE GROSS WAGES (ANNUAL)	PENALTY PAY (ANNUAL)	IMPACT (ANNUAL)	PENALTY PAY (WEEKLY)	IMPACT (WEEKLY)	AVERAGE GROSS WAGES (ANNUAL)	PENALTY PAY (ANNUAL)	IMPACT	PENALTY PAY (WEEKLY)	IMPACT
		$	$	$	$		$	$	$	$
NSW	$54,046	$10,873	**-$1,399**	$209	**-$27**	$36,052	$7,253	**-$933**	$139	**-$18**
VIC	$57,207	$11,511	**-$105**	$221	**-$2**	$38,161	$7,679	**-$70**	$147	**-$1**
QLD	$54,677	$10,873	**-$1,372**	$209	**-$26**	$36,473	$7,253	**-$915**	$139	**-$18**
SA	$53,448	$10,888	**-$1,385**	$209	**-$27**	$35,654	$7,263	**-$924**	$139	**-$18**
WA	$55,816	$10,797	**-$1,398**	$207	**-$27**	$37,233	$7,202	**-$933**	$138	**-$18**
TAS	$54,300	$11,773	**-$2,431**	$226	**-$47**	$36,222	$7,853	**-$1,622**	$151	**-$31**
NT	$56,493	$12,667	**-$2,287**	$243	**-$44**	$37,685	$8,450	**-$1,525**	$162	**-$29**
ACT	$54,262	$10,935	**-$1,629**	$210	**-$31**	$36,197	$7,294	**-$1,087**	$140	**-$21**
AUSTRALIA	$55,084	$11,063	**-$1,088**	$212	**-$21**	$36,745	$7,380	**-$726**	$142	**-$14**

Appendix C – Scope and Methodology

1. SCOPE

Work places

This analysis covers three broad categories of facility:

- Public acute and psychiatric hospitals;
- Private acute, psychiatric and rehabilitation hospitals; and
- Private and public sector residential aged care facilities.

Public acute and psychiatric hospitals

By focusing analysis exclusively on peer reviewed acute, psychiatric and rehabilitation hospitals[49], a range of public hospitals are removed from the scope of analysis including:

- mixed sub-acute and non-acute hospitals;
- out-patient hospitals and centres;
- early parenting centres;
- drug and alcohol hospitals/centres;
- unpeered hospitals; and
- hospitals of unknown classification.

The study includes principal referral hospitals, maternity and children's hospitals and very small hospitals in regional and remote localities.

The analysis relies on baseline AIHW workforce and hospital data for a range of variables including public hospital capacity (available beds), nurse to bed ratios, hospital peer group classifications and ratios of registered nurses to enrolled nurses.

The AIHW hospital survey is based on information from 750 hospitals. Limiting the scope of analysis to peer reviewed acute, and psychiatric hospitals reduces the scope of the analysis to 643 public hospitals.

Almost three quarters of all nurses employed in Australian public hospitals are covered by the analysis, although this proportion varies significantly between states and territories due to differences between states in the mix of hospital types. This issue is further compounded by network establishment data provided by Victoria that is not attributed to specific hospitals. The restriction on public hospitals used for the analysis, and the variation in degree of coverage between states, accounts for discrepancies between AIHW hospital data aggregates and estimates generated by this study. Table A1 below details the distribution of facilities covered by this analysis by facility type, capacity and state.

Following AIHW practice, the data on public hospitals includes 15 privately owned hospitals that effectively function as part of the public health system. These hospitals are then excluded from private hospital datasets.

Care should be taken when interpreting this data which presents the average impact of penalty rate changes and the share of gross wages attributed to penalty payments. An average measure does not necessarily reflect any particular roster, and for nurses and other health workers there is no standard distribution of shifts. Nurses working rosters in which weekend work and afternoon/ night shifts are relatively over- represented or predominate will rely more heavily on penalty payments, and consequently they will be more greatly affected by Penalty Rate changes than the average impacts presented in tables within the report.

TABLE A1:
AVAILABLE BEDS BY PUBLIC HOSPITAL TYPE AND STATE (HOSPITALS WITHIN SCOPE OF STUDY)

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
PRINCIPAL REFERRAL	6,921	3,475	3,968	1487	1,314	483	367	762	**18,777**
LARGE & MEDIUM ACUTE	7,387	5,412	4,885	1422	2,103	539	183	258	**22,189**
SMALLER ACUTE	2,865	1,811	1,584	1239	1,108	119	114	0	**8,840**
VERY SMALL	334	178	80	107	195	36	0	0	**930**
OTHER ACUTE SPECIALISED	25	182	0	0	0	0	0	0	**207**
PSYCHIATRIC	1,171	348	399	149	226	0	0	0	**2,293**
WOMEN'S & CHILDRENS	549	679	488	316	491	0	0	0	**2,523**
TOTAL	**19,252**	**12,085**	**11,404**	**4,720**	**5,436**	**1,177**	**664**	**1,020**	**55,758**

TABLE A2:
SHARE (%) OF AVAILABLE BEDS WITHIN EACH STATE BY HOSPITAL PEER GROUP

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
PRINCIPAL REFERRAL	35.9%	28.8%	34.8%	31.5%	24.2%	41.0%	55.3%	74.7%	**33.7%**
LARGE & MEDIUM ACUTE	38.4%	44.8%	42.8%	30.1%	38.7%	45.8%	27.6%	25.3%	**39.8%**
SMALLER ACUTE	14.9%	15.0%	13.9%	26.3%	20.4%	10.1%	17.2%	0.0%	**15.9%**
VERY SMALL	1.7%	1.5%	0.7%	2.3%	3.6%	3.1%	0.0%	0.0%	**1.7%**
OTHER ACUTE SPECIALISED	0.1%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.4%**
PSYCHIATRIC	6.1%	2.9%	3.5%	3.2%	4.2%	0.0%	0.0%	0.0%	**4.1%**
WOMEN'S & CHILDRENS	2.9%	5.6%	4.3%	6.7%	9.0%	0.0%	0.0%	0.0%	**4.5%**
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%

Private acute, psychiatric and rehabilitation hospitals

This study is limited to private acute, psychiatric and rehabilitation hospitals. The scope of the study does not include:

- Private day hospitals;
- Specialist clinics and procedural centres; and
- Sub acute specialty hospitals.

The 254 private hospitals used in this analysis are drawn from the ANMF Agreements and Facilities Database. By comparison, the ABS survey of private acute and psychiatric hospitals draws on information from 286 hospitals. The degree of overlap between the ABS survey and the database used for this analysis varies from state to state. Australia-wide, the available beds covered by this analysis account for just over 90% of the available beds in the private hospitals covered by the ABS Survey. Table A3.1 summarises the number of hospitals by type, capacity and state within the scope of this analysis. Table A3.2 summarises the available beds by hospital type, and state where available beds are taken to be equivalent to 85% of reported total beds.

TABLE A3.1:
NUMBERS OF PRIVATE HOSPITALS WITHIN SCOPE OF STUDY (ANMF FACILITIES DATABASE) – BY STATE AND TYPE OF FACILITY

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
LARGE & MEDIUM ACUTE	46	37	28	11	11	5	1	2	141
SMALL ACUTE	19	16	9	12	4	2			61
PSYCHIATRIC	11	10	6	2	2	1		1	33
REHABILITATION	5	9	2	2					18
GRAND TOTAL	**81**	**72**	**45**	**27**	**17**	**8**	**1**	**3**	**254**

TABLE A3.2:
NUMBERS OF PRIVATE HOSPITALS WITHIN SCOPE OF STUDY (ANMF FACILITIES DATABASE) – BY STATE AND TYPE OF FACILITY

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
LARGE & MEDIUM ACUTE	4476	4376	4030	1233	2145	466	85	203	17014
SMALL ACUTE	572	451	252	311	137	72	0	0	1794
PSYCHIATRIC	609	782	485	111	112	23	0	81	2204
REHABILITATION	308	558	56	110	0	0	0	0	1032
GRAND TOTAL	**5965**	**6167**	**4823**	**1765**	**2394**	**561**	**85**	**284**	**22044**

Private and public sector residential aged care facilities.

The study covers 2686 residential private and public sector aged care facilities. Table A.4 below provides counts and capacities of aged care facilities by state and sector.

TABLE A3.3: NUMBERS OF PRIVATE HOSPITALS WITHIN SCOPE OF STUDY (ANMF FACILITIES DATABASE) – BY STATE AND TYPE OF FACILITY

	PRIVATE FACILITIES (N)	PLACES	PUBLIC FACILITIES (N)	PLACES	TOTAL FACILITIES (N)	PLACES
NSW	736	55744	73	2665	809	58409
VIC	613	44597	97	3111	710	47708
QLD	473	35568	14	457	487	36025
SA	187	14422	38	1567	225	15989
WA	336	24187	37	1592	373	25779
TAS	28	1766	9	416	37	2182
NT	20	1119	0	0	20	1119
ACT	21	1859	4	136	25	1995
AUST	**2414**	**179262**	**272**	**9944**	**2686**	**189206**

Occupational Classifications: Nurses and Personal Care Workers

The study presents estimates of gross wages, net wages and penalty pay for:

- Registered Nurses & Midwives
- Enrolled Nurses; and
- Assistants-in-Nursing & Personal Care Workers.

The estimates provided by this analysis are of permanent staff only – employment of agency staff is not modelled. The analysis concludes that the study facilities employ around 153,000 nursing employees (excluding agency nurses in public hospitals) and 110,000 personal care workers in residential aged care.

The matrix below sets out the scope of analysis by occupational group and type of workplace.

	PUBLIC HOSPITALS	PRIVATE HOSPITALS	RESIDENTIAL AGED CARE
Registered Nurses & Midwives	✔	✔	✔
Enrolled Nurses	✔	✔	✔
Personal Care Workers/ AINs	✘	✘	✘

Table A5 sets out estimates of FTE employed nurses and numbers of nurses employed (headcounts) within facilities included in the scope of the survey as at August 2015.

Midwives

The report considers registered nurses and midwives as a single category of nurse. Midwives' wages and penalty payments are not excluded from the study. There are many reasons why disentangling midwives earnings from registered nurses in a meaningful and statistically valid way is difficult. Firstly, midwives represent a small component of the hospital nursing workforce. Secondly, a significant proportion of midwives are also qualified as registered nurses. Thirdly, there is insufficient reliable data available to inform good modelling decisions about the distribution of midwives across hospital workplaces. It is however worth noting that, on average, midwives work patterns do differ in important ways from registered nurses. Midwives are more likely to work longer hours and perform more overtime than registered nurses.

Personal Care Workers and Assistants-in-Nursing

The wages and penalty pay of personal care workers and assistants-in-nursing are only estimated for residential aged care facilities. Personal Care Workers are the mainstay of the direct care workforce in these facilities, with more than twice as many personal care workers and assistants-in-nursing being employed as the combined number of enrolled and registered nurses.

Within private and public hospitals, the proportion of personal care workers and assistants in nursing is very low. Furthermore, the differing ways in which various state health departments report employment numbers makes any reliable modelling of gross wages difficult.

TABLE A5: ESTIMATED NUMBERS ('000) OF EMPLOYED NURSES (AUGUST 2015) WITHIN SCOPE OF ANALYSIS – BY STATE AND FACILITY TYPE

	FTE				HEAD COUNT			
	RNS & MS	ENS	PCWS	TOTAL	RNS & MS	ENS	PCWS	TOTAL
02 New South Wales	43.38	8.68	25.55	77.62	49.30	11.28	38.31	98.89
Res. Aged Care	5.12	4.08	25.55	7.72	7.72	6.04	38.31	38.31
Hospitals - Private	6.54	1.21	-	7.75	7.10	1.38	-	8.49
Hospitals - Public	31.73	3.39	-	35.11	34.48	3.86	-	38.34
03 Victoria	31.48	6.12	19.03	56.63	37.79	8.35	28.52	74.66
Res. Aged Care	3.81	3.04	19.03	5.75	5.75	4.50	28.52	28.52
Hospitals - Private	7.24	1.27	-	8.51	8.38	1.59	-	9.97
Hospitals - Public	20.43	1.81	-	22.24	23.66	2.27	-	25.93
04 Queensland	27.16	4.99	12.93	45.09	31.02	6.44	19.38	56.84
Res. Aged Care	2.59	2.07	12.93	3.91	3.91	3.06	19.38	19.38
Hospitals - Private	5.26	1.12	-	6.38	5.80	1.30	-	7.10
Hospitals - Public	19.31	1.81	-	21.12	21.31	2.09	-	23.40
05 South Australia	10.63	2.76	6.83	20.22	12.44	3.57	10.24	26.25
Res. Aged Care	1.37	1.09	6.83	2.06	2.06	1.61	10.24	10.24
Hospitals - Private	1.91	0.48	-	2.39	2.14	0.56	-	2.70
Hospitals - Public	7.35	1.19	-	8.54	8.23	1.40	-	9.63
06 Western Australia	13.16	2.21	5.94	21.31	15.62	2.95	8.90	27.48
Res. Aged Care	1.19	0.95	5.94	1.79	1.79	1.40	8.90	8.90
Hospitals - Private	2.86	0.47	-	3.33	3.21	0.55	-	3.76
Hospitals - Public	9.11	0.79	-	9.90	10.62	1.00	-	11.62
07 Tasmania	3.08	0.56	1.90	5.54	3.71	0.75	2.84	7.30
Res. Aged Care	0.38	0.30	1.90	0.57	0.57	0.45	2.84	2.84
Hospitals - Private	0.68	0.10	-	0.78	0.81	0.12	-	0.93
Hospitals - Public	2.02	0.16	-	2.18	2.32	0.19	-	2.51
08 Northern Territory	1.25	0.20	0.21	1.66	1.35	0.24	0.32	1.90
Res. Aged Care	0.04	0.03	0.21	0.06	0.06	0.05	0.32	0.32
Hospitals - Private	0.10	0.01	-	0.11	0.11	0.01	-	0.12
Hospitals - Public	1.11	0.15	-	1.26	1.18	0.17	-	1.35
09 Australian Capital Territory	2.40	0.35	0.76	3.51	2.43	0.42	1.14	3.99
Res. Aged Care	0.15	0.12	0.76	0.23	0.23	0.18	1.14	1.14
Hospitals - Private	0.34	0.06	-	0.40	0.34	0.06	-	0.40
Hospitals - Public	1.90	0.17	-	2.07	1.87	0.18	-	2.04
Australia	**132.54**	**25.89**	**73.15**	**231.57**	**153.65**	**34.01**	**109.65**	**297.32**
Res. Aged Care	**14.66**	**11.68**	**73.15**	**99.49**	**22.10**	**17.29**	**109.65**	**121.49**
Hospitals - Private	**24.93**	**4.73**	**-**	**29.66**	**27.89**	**5.58**	**-**	**33.46**
Hospitals - Public	**92.96**	**9.47**	**-**	**102.42**	**103.67**	**11.15**	**-**	**114.82**

2. METHODOLOGY

The *ANMF Facilities and Agreements Database*[50] contains data on around 4000 health care facilities nationwide. The facility data has been developed by combining and updating information from ANMF internal records, AIHW Public Hospital Listings, State and Commonwealth Health Department listings of public and private hospital and other health facilities, DSS listings of residential aged care services and capacities, commercial listings of private hospitals and the internet. Within the database, facility data is mapped to over 1,150 current enterprise agreements and awards. The database holds comprehensive information on pay scales, penalty rates, allowances and conditions pertaining at each facility.

The core analytical tasks were to:

- Quantify that component of gross pay attributable to penalty loadings applied to hours worked in afternoon and night shifts, weekend work and public holidays (penalty pay); and
- Generate estimates of gross wages.

These tasks were required to be undertaken at a facility level, so that regional, electorate, state and estimates could be generated through aggregation.

The first stage in quantifying penalty pay was to estimate, for each facility, the ratio of total annual penalty pay to ordinary-hours-based annual wages for registered nurses & midwives, and enrolled nurses. These ratios were generated by extracting wage rates, shift penalties (and shift allowances in the case of Victoria), weekend and public holiday penalty loadings from the database for each facility as at August 2015 and applying them to a shift-based nursing capacity schedule (see Tables 1 and 2 below). In residential aged care, this analysis was extended to personal care workers and assistants-in-nursing.

TABLE A6:
NURSING CAPACITY UTILISATION BY SHIFT - HOSPITALS

DAY	SHIFT	NURSING CAPACITY
MONDAY TO FRIDAY	Day	100%
	Afternoon	80%
	Night	65%
WEEKEND	Day	80%
	Afternoon	80%
	Night	65%
PUBLIC HOLIDAYS	Day	80%
	Afternoon	80%
	Night	65%

TABLE A7:
NURSING CAPACITY UTILISATION BY SHIFT – RESIDENTIAL AGED CARE

DAY	SHIFT	NURSING CAPACITY
MONDAY TO FRIDAY	Day	100%
	Afternoon	60%
	Night	40%
WEEKEND	Day	80%
	Afternoon	60%
	Night	40%
PUBLIC HOLIDAYS	Day	80%
	Afternoon	60%
	Night	40%

For each facility, the ratio of penalty pay to ordinary hours pay was then applied to estimates of total wage (in the case of hospitals), or total ordinary hours wages (in the case of residential aged care) to generate estimates of penalty pay.

Estimates of total wages take into account three distinct components:

- Ordinary Hours wages – that portion of pay equivalent to the product of hours worked and the ordinary hours rate of pay.
- Penalty Pay – that portion of pay calculated as the sum of shift allowances (in the case of Victoria) and the product of the relevant penalty loading (on top of the ordinary hours rate) and total hours worked on Afternoon or Night shifts, Saturdays, Sundays and Public holidays; and
- Overtime and non-wage income such as allowances.

These components were then aggregated at regional, electorate, state and national levels to yield estimates of gross wages and penalty pay.

Estimates of FTE equivalent nurses wages in hospitals were converted to average wages using AIHW workforce data on the average weekly hours worked by each category. In residential aged care, nursing headcounts derived from the 2012 NILS survey were extrapolated to 2015 levels and used to calculate average nursing wages. Commonwealth income tax rates applicable to the average wage were then applied to the estimates of gross wage to calculate net wages and penalty pay at the facility level.

Different methods were used to model Gross Wages at the facility level in Residential Aged Care, Public and Private Hospitals. These methods are summarised briefly below.

Estimating Gross Wages in Hospitals

The following AIHW hospital and workforce data was used to model gross wages at the Facility level for Public Hospitals:

- Full Time Equivalent (FTE) nursing numbers and available beds by hospital type (peer group membership) and state.
- Average Nursing Wages in Psychiatric and Acute Public Hospitals by state; and
- Numbers of Employed Enrolled Nurses and Registered Nurses and Midwives by State and Remoteness Area.

This AIHW data, combined with wages data from within the ANMF Database, was used to generate:

- Average ratios of FTE nurses to available beds and average nurses wages per bed for each of 8 public hospital types (see Table Below) in each state; and
- Average ratios of RN to EN gross wages by state and remoteness area.

Hospital Pay Scale Relativities and Average Earnings

This study uses AIHW data on nurses average annual earnings by jurisdiction as baseline data. Inter jurisdictional relativities between average earnings and payscale rates differ. This means that a state with higher ordinary hours rate for top of level 1 Registered Nurses (or any other payscale level) will not necessarily report higher average earnings for Registered Nurses. There are many contributing causal factors including:

- The relative distribution of wages payments across the payscale may differ between jurisdictions ie. in some jurisdictions the distribution of nurses may be skewed towards the lower end of the payscale and in others the distribution may be skewed more towards the top level of the payscale.
- The differing state profiles of hospitals will contribute to these differences in distribution across the payscale. Jurisdictions with relatively larger hospitals and higher proportions of hospitals dealing with high level accuity (eg principal referral hospitals and large acute hospitals with larger ICU, ER and broad range of surgical specialisms) will report distributions of nurses skewed more towards the top end of payscales than other jurisdiction; and
- Differing wage reporting practices (one jurisdiction may report average wages over the year, another may report wages at end of period).

These ratios were then applied to hospital capacity (measured in available beds) to estimate gross wages by broad nursing classification at each facility.

TABLE A8: NURSES (TOTAL ENROLLED AND REGISTERED NURSES) AND WAGES PER BED BY PUBLIC HOSPITAL PEER GROUP DERIVED FROM AIHW HOSPITAL DATA (JUNE 2014)

HOSPITAL PEER GROUP	AVAILABLE BEDS	FTE NURSES PER BED	TOTAL WAGES	ANNUAL WAGES PER BED
Principal referral	18777	2.1	$3,597,277,760	$191,579
Specialist women's and children's	2523	2.9	$659,333,664	$261,381
Public acute group A	16228	1.8	$2,705,393,728	$166,717
Public acute group B	5829	1.6	$840,794,112	$144,236
Public acute group C	5735	1.3	$703,489,952	$122,664
Public acute group D	3003	1.2	$334,821,440	$111,510
Very small	915	1.4	$113,218,912	$123,801
Psychiatric	2113	1.6	$302,342,848	$143,114

In order to estimate Gross Wages at Private Hospitals, each of the 250 private facilities was benchmarked against Public Hospitals on the basis of size and function.

Gross wages at private hospital facilities were further calibrated by:

- Indexing nursing wage rates at each facility to public hospital rates;
- Adjusting Enrolled Nurses and Registered Nurses & Midwives pay relativities using facility based wage rates from the ANMF Agreements and Awards Database; and
- Adjusting the average ratios of Enrolled Nurse to Registered Nurses & Midwives according to using AIHW 2012 Private Hospitals Nursing Workforce data.

Modelled outputs were constrained and recalibrated so that:

- Average ordinary hours rates for all nursing classifications at each facility were within minimum and maximum bounds set by the relevant agreement or award payscales.
- Employment estimates and nurse to bed ratios were consistent with the 2014 ABS survey of private hospitals; and
- Aggregate gross wages were validated by reference to ABS survey of Private Hospitals.

Pay Scale Relativities

Pay relativities between nursing categories within the same workplace and between the nursing categories across workplaces were established by reference to hourly wage rates for:

- Top of level 1 for registered nurses,
- Top level enrolled nurses (excluding advanced skills and supervisory levels); and
- Entry level assistant-in-nursing and personal care workers holding Aged Care certificate 3 level qualifications.

Estimating Gross Wages in Residential Age Care

The hourly rates of pay at each facility, as at August 2015, were extracted from the ANMF Awards and Agreements Database for:

- Top of level 1 for Registered Nurses,
- Top level Enrolled Nurses (excluding advanced skills and supervisory levels); and
- Entry Level Assistant in Nursing and Personal Care workers holding Certificate 3 level qualifications.

The average of these rates across all facilities were applied to FTE nursing numbers extrapolated from the 2012 NILS report to generate, as a first iteration, an estimate of total gross ordinary hours wages for each category of nurse and care worker. Total ordinary hour's wages were then distributed across facilities in proportion to numbers of places at each facility, weighted on the basis of care intensity, and relative differences in the rate of pay between facilities. In line with findings of the Stewart Brown Survey, the estimate of Aggregate Gross Wages generated by this method is consistent with total care costs (wages plus on costs) equivalent to 60% of Government Care Subsidies and Resident Fees in 2014.

Footnotes

1. Massola J, Penalty rates: Liberal MPs push for cuts as Malcolm Turnbull suggests change is inevitable, Sydney Morning Herald, 7 October 2015 see: http://www.smh.com.au/federal-politics/political-news/penalty-rates-liberal-mps-push-for-cuts-as-malcolm-turnbull-suggests-change-is-inevitable-20151006 gk243h.html#ixzz3nw9kqOvD
2. Productivity Commission 2015, Workplace Relations Framework, Draft Report, Canberra
3. ACCI 2015, *Submission in Reply: Productivity Commission Inquiry into Workplace Relations*, https://www.acci.asn.au/resources/submission-reply-productivity-commission-inquiry-workplace-relations-framework
4. Productivity Commission 2015, Workplace Relations Framework, Draft Report, Canberra
5. ABS (2012), Working Time Arrangements, Cat. No. 6342.0, table 9
6. ABS (2012), Working Time Arrangements, Cat. No. 6342.0, table 9
7. Nash, Daly, Kelly, Van Ekert, Walter, Walton, Willcock and Tennant 2010, 'Factors associated with psychiatric morbidity and hazardous alcohol use in Australian doctors', Medical Journal of Australia, vol. 193, no. 4
8. Bannai, A. and Tamakoshi, A. 2014, 'The association between long working hours and health: a systematic review of epidemiological evidence', Scandinavian Journal of Work and Environmental Health, vol. 40.
9. Productivity Commission 2015, Workplace Relations Framework, Draft Report, Canberra
10. Barbara Pocock, Natalie Skinner and Philippa Williams Work–life in Australia: Outcomes from the Australian Work and Life Index (AWALI) 2007
11. Skinner, N. and Pocock, B. 2014, The Australian Work and Life Index 2014: The Persistent Challenge: Living, Working and Caring in Australia in 2014, Centre for Work + Life, University of South Australia, Adelaide, South Australia.
12. Ibid
13. Ibid
14. Ibid
15. ABS (2015), Survey of Household Income and Wealth 2013-14, Cat No. 6523.0
16. Estimates are averages from the last 5 waves of the HILDA Survey.
17. Estimates are averages from the last 5 waves of the HILDA Survey.
18. ABS (2015) , Average Weekly Earning May 2015, Cat No 6302.0
19. Massola J, Scott Morrison praises 'innovative' idea to trade tax credit for any future penalty rate cuts, , Sydney Morning Herald, 8 October 2015 see: http://www.smh.com.au/federal-politics/political-news/scott-morrison-praises-innovative-idea-to-trade-tax-credit-for-any-future-penalty-rate-cuts-20151006-gk2vg0.html
20. Australian Institute of Health and Welfare 2015. Health expenditure Australia 2013–14. Health and Welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.
21. Health Workforce Australia 2012. Health Workforce 2025, Volume One.
22. The Commonwealth of Australia (2015), 2015 Intergenerational Report
23. National Health Workforce Data Set 2014
24. National Health Workforce Data Set 2014
25. Department of Health and Ageing, 2012 National Aged Care Workforce Census and Survey Report, Commonwealth of Australia 2013
26. Health Workforce Australia, *Australia's Future Health Workforce – Nurses – Detailed Report*, August 2014
27. Health Workforce Australia, *Australia's Future Health Workforce – Nurses – Detailed Report*, August 2014
28. Parliamentary Library (2013). Briefing Book – Key Issues for the 44th Parliament. Commonwealth of Australia.
29. Ruiz M,et al (2015). *The Global Comparators project: international comparison of 30-dayin-hospital mortality by day of the week* BMJ Qual Safety , 24.
30. Ibid
31. Bray BD, Ayis S, Campbell J, Cloud GC, James M, Hoffman A, Tyrrell PJ, Wolfe CD, Rudd AG. Associations between stroke mortality and weekend working by stroke specialist physicians and registered nurses: prospective multicentre cohort study. PLoS Med. 2014 Aug 19;11(8)
32. Ibid
33. Australian Nurses and Midwifery Federation (2015), *What Do Your Penalty Rates Mean To You – Survey Of Nurses And Midwives Final Report*
34. Please see Appendix C for full methodology.
35. The ANMF Facilities and Agreements Database is provided exclusively to the ANMF by Union & Community Data and Analytics as a subscription service.
36. public health system nurses' and midwives' (state) award 2015: schedule b
37. district health boards / nzno nursing and midwifery multi-employer collective agreement 24 august 2015 – 31 july 2017
38. Canadian Federation of Nurses and Unions (2012), Overview of Key Nursing Contract Provisions, Canadian Federation of Nurses and Unions
39. Royal College of Nursing, Unsociable Hours, http://www.rcn.org.uk/support/pay_and_conditions/Supplements unsocial_hours__and__oncall/unsocial_hours
40. Please see Appendix C for methodology
41. Please see Appendix A and Appendix B for full set of tables.
42. ABS (2015), Survey of Household Income and Wealth 2013-14, Cat No. 6523.0
43. See Appendix A and Appendix B for full set of tables
44. See Appendix A for full set of tables
45. See Appendix B for full set of tables
46. Health Workforce Australia, *Australia's Future Health Workforce – Nurses – Detailed Report*, August 2014
47. Monash University Department of Management(2013), *National Survey of the Attitudes of Nurses and Midwives*
48. Australian Nurses and Midwifery Federation (2015), *What Do Your Penalty Rates Mean To You – Survey Of Nurses And Midwives Final Report*
49. Peer review refers to a grading system used by the Australian Institute of Health and Welfare (AIHW) for the classification of public hospitals for purposes of benchmarking and presenting data for publication, for example, Australian Hospital Statistics.
50. The ANMF Facilities and Agreements Database is maintained and provided exclusively to the ANMF by **Union & Community Data and Analytics** as a subscription service.

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