

AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

*Workplace Relations Act 1996*

Section 503 referral to Full Bench to make a workplace determination

**Health Services Union**

and

**Austin Health and others**

(BP2007/4059 and others)

**WITNESS STATEMENT OF ANGELIA GAYE DIXON**

I, **ANGELIA GAYE DIXON**, of Peter MacCallum Cancer Centre, St Andrews Place, East Melbourne, in the State of Victoria, General Manager of Haematology and Medical Oncology, say as follows:

**Professional and Academic Background**

- 1 I am the General Manager of Haematology and Medical Oncology at Peter MacCallum Cancer Centre (**PMCC**).
- 2 I have been employed at PMCC for approximately 8.5 years. I have worked in my current role at PMCC for approximately 6.5 years, and, immediately prior to that I worked as the Business Manager of Haematology and Medical Oncology at PMCC for approximately 2 years.
- 3 In my current role at PMCC, I am responsible for the operations and strategic development of the Division of Haematology and Medical Oncology at PMCC. I perform this role in joint partnership with Professor John Zalberg, the Professor Director of the Division of Haematology and Medical Oncology at PMCC.

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- 4 Immediately prior to working at PMCC, I was employed as a Program Manager for Breast Screen at Maroondah Hospital.
- 5 I hold a Diploma of Applied Science in Medical Technology and a Master of Business Administration (MBA).
- 6 I am authorised to make this statement on behalf of the Division of Haematology and Medical Oncology at PMCC. I make this statement from my own knowledge except where otherwise indicated. Where I make statements based on information provided by others, I believe such information to be true.

### Structure of PMCC

- 7 PMCC is a hospital solely dedicated to cancer, which has its own integrated cancer research programs and laboratories.
- 8 The organisational structure of PMCC is divided into the following:
- clinical divisions - namely, Haematology and Medical Oncology, Surgical Oncology and Radiation Oncology;
  - a research division; and
  - operational departments, such as, finance, and strategic and redevelopment.

Now produced and shown to me and marked "**Exhibit AD-1**" is a true and correct copy of the PMCC Organisational Structure as at 25 August 2008.

- 9 Haematology and Medical Oncology is a clinical division within PMCC and it contains the following departments:
- Pharmacy;
  - Familiar Cancer Centre;
  - Pathology;
  - Infectious Diseases/Infection Control;
  - Medical Oncology;
  - Pain and Palliative Care;
  - Pastoral Care;
  - Haematology;
  - Occupational Therapy;

- Nutrition;
- Physiotherapy;
- Social Work;
- Speech Pathology;
- Central Cancer Library;
- Clinical Psychology;
- Centre for Blood Cell Therapies;
- Clinical Trials Research;
- Centre for Biostatistics, Clinical Trials and Ethics;
- Endocrinology;
- Cardiology;
- Neurology;
- Nephrology;
- Respiratory Medicine; and
- Human Ethics secretariat.

- 10 Within the departments listed in paragraph 9 above, the Pastoral Care, Occupational Therapy, Nutrition, Physiotherapy, Social Work, Speech Pathology, Central Cancer Library, Clinical Psychology and Human Ethics departments report directly to me. The remainder of the departments report directly to Professor John Zalcborg.
- 11 The Haematology and Medical Oncology division at PMCC primarily provides services to its patients at its East Melbourne site, however, on-site visits are also made by PMCC's staff to facilities at Box Hill and Moorabbin on a weekly or fortnightly basis.

### **Funding**

- 12 The Haematology and Medical Oncology division at PMCC receives the majority of its funding from the State Government through the Division of Human Services (**DHS**) (apart from the Centre for Biostatistics, Clinical Trials and Ethics).
- 13 The Haematology and Medical Oncology division at PMCC also receives funds from granting bodies through submissions and from commercial companies for clinical research undertaken on their behalf.

- 14 The funds from granting bodies are fixed for the completion of a particular project - it is not ongoing funding. For example, funding was provided to PMCC from the Western and Central Integrated Cancer Service for a 12 month project into the scope of key allied health indicators across hospitals.

### Allied Health Professionals

- 15 There are a total of 50.308 EFT employed at the Haematology and Medical Oncology division at PMCC that are covered by the *Health Services Union of Australia – Health Professionals – Victorian Public Sector – Multiple Business Agreement 2004-2007*. The composition of these Allied Health professionals is outlined in the table below.

	EFT	Grade 1	Grade 2	Grade 3	Chief Grade 1	Chief Grade 2
Social Work	10.87	0	7.87	2.0		1
Physiotherapy	5.0	1	2.0	1.0		1.0
Music Therapy	0.445		0.42	0.025		
Occupational Therapy	4.21	1	1.368	1.0	0.84	
Library	1.9	1.0	0.6		0.7	
Pastoral Care	6.658*	*Pastoral care staff are classified as Community Development Workers c1, c2 and c3. They are supervised by an Administrator (who performs as a Chief and is paid at that level or above).				
Centre for Biostatistics, Clinical Trials and Ethics	19.225 (Data Managers)		18.225	1		
Pathology Laboratory	2.0	2.0				

### Specific response to Health Services Union's claims

- 16 I am aware that the Health Services Union of Australia (HSU) has filed a draft workplace determination in these proceedings. I have reviewed that draft workplace determination and make the following comments.

#### *Organisational Change in Consultation*

- 17 At clause 8 of the HSU draft Workplace Determination, the HSU seeks a structured organisational change process requiring consultation when employees are affected by change which is likely to have a significant impact on them, including work practices or location; job security; remuneration; training; new technology or equipment; or the way work is or would be carried out by an employee.

- 18 If the organisational change process proposed by the HSU is mandated even for changes that effect a single employee, or a small number of employees, it will become difficult for me to manage my division effectively in a patient centred way. This proposal would hinder the ability for changes to be adopted in a reasonable period of time, even when the proposed change has wide support and is not controversial. Change that could be subject to this lengthy process include, for example, a change in the documentation requirements of patient records or a request that a staff member attends (statutory or other) training.

### *Staffing Profile*

- 19 At clause 18 and Schedule 2 of the HSU draft workplace determination, the HSU seeks that there be a skill mix of Allied Health professionals in each "department" of no less than 1/3 grade 1, 1/3 grade 2 and 1/3 senior clinician or higher classification (**Staffing Profile**).
- 20 In my view, the proposed Staffing Profile is not practical or achievable within my division at PMCC. On the most basic level, the Staffing Profile will not be achievable in all departments, especially in the smaller departments with fewer than three people (where a single staff member cannot be classified across the levels) or in departments where there are a number of part-time staff that elect to work more or less hours. For example, to achieve the proposed Staffing Profile in Music Therapy, I would be required to hire a part time employee at Grade 1 level that would work 0.42 EFT and then I would need an additional Grade 3 or above employee to work 0.395 EFT.
- 21 The composition of specific levels of staff in my division at PMCC are determined by considering the services provided by the division and matching qualified staff to undertake the required service. This staffing profile is determined by the complexity of the individual services provided within each department. For example, Grade 3 senior clinicians can only be employed where that type of work is available. Without this work being available, employees would be paid for a level of work that they were not providing, which would not be cost effective and may cause employees to be dissatisfied.
- 22 The "one size fits all" proposed Staffing Profile does not improve the quality of patient care because it does not consider the different needs of patients using different services within different divisions. For example, there are currently no Grade 1 social workers within my division at PMCC. The reason that the staffing profile for social workers is Grade 2 and above is because the significant physiological issues of cancer patients (especially for palliative care patients) requires a high level of competency and resilience from the treating social workers. The social work skills required for a case load of patients who have all been diagnosed with cancer, is not typically held by entry level employees with less experience.
- 23 If PMCC was required to implement the proposed Staffing Profile it would have enormous funding implications. PMCC would find it extremely difficult to fund the proposed Staffing

Profile because in many cases it would require the hiring of additional staff and the promotion of staff to higher wage levels, irrespective of whether they are required to work at that level. For example, the Centre for Biostatistics and Research Trials currently has 18.225 EFT at Grade 2 level and 1 Grade 3. To implement the proposed Staffing Profile, PMCC would have to either appoint the same number of Grade 1 employees and 17.225 senior level employees, or it would have to promote 8.1125 EFT from Grade 2 to Grade 3 and hire 9.6125 EFT at Grade 1.

- 24 In addition to the wage costs, the proposed Staffing Profile would have enormous restructuring and administrative costs associated with implementing and monitoring the change in the composition of staff. These administration costs would include the time spent on consulting with employees, arranging the allocation of different staff to different pay levels, the costs of payroll in managing the different pay increases and drafting new employment contracts for some employees.
- 25 Even if PMCC could fund the Staffing Profile, it may not be possible to recruit people with the appropriate skill set and clinical speciality in order to undertake the role. In the past PMCC has had difficulty recruiting physiotherapists because the public sector has to compete against private practice to attract these candidates. As a result of these shortages it can take a lengthy period of time to fill vacancies. For example, recently it took several months to recruit a physiotherapist to fill a vacancy at PMCC.
- 26 In my view, the proposed Staffing Profile is not practical from a patient service perspective. For example, if my division at PMCC needed an additional 1 EFT of Grade 1 in direct care services to meet patient demand, then we would also have to increase the EFT of Grade 2 and Grade 3 staff by 1 EFT each to maintain the staffing profile. This would be very costly. Alternately, in this situation we could increase each of the grades EFT by 0.33 to total 1 EFT. However, given that Grade 3's do less clinical work than Grade 1 staff, we would not achieve the same gain of EFT in terms of direct patient care. Further, if the second option was adopted, we would also be increasing the number of part time staff which increases the staff management requirements and also the associated hospital infrastructure costs.
- 27 If the proposed Staffing Profile was introduced and PMCC could not fill the vacancies, it would be in breach of the agreement or it could be forced to appoint someone to the role that was not appropriately qualified.
- 28 In my view, decisions about the right balance of staffing levels should remain at the discretion of PMCC. This will allow flexibility for the staffing profile to match the services that are being offered.

*Chief Structure*

- 29 At clause 21.10.7 of the HSU draft workplace determination, the HSU seeks that a hospital department, howsoever called, that operates on one campus appoint a Chief and a Deputy Chief of the department, who will be remunerated according to the total numbers of staff in the department and the numbers of health professionals that the Chief is operationally and/or professional responsible for.
- 30 In my view, it is unnecessary to appoint a Deputy Chief where the size of a department does not create the need for this level of management. For example, in Occupational Therapy with just over 4 EFT including the existing Chief, we would need to appoint a Deputy Chief. This does not provide additional patient care. In fact, adding additional levels of management could reduce efficiency because of the increased "red tape".
- 31 For example, PMCC does not currently have a Chief for Music Therapy because the small number of staff in that division (0.445 EFT) would make appointing a Chief (manager) unnecessary. In such a case, the Chief would be managing only one or two other staff members with a total EFT of less than 0.5. We currently manage music therapy under our social work department and under the proposed classification we would need to appoint a team leader in music therapy as an additional appointment which will increase costs without a productivity or patient care benefit.
- 32 Further, the appointment of Deputy Chiefs would not improve the efficiency of PMCC because individual department may not have the management workload for that level. As a general rule, Chiefs are expected to undertake management and administrative duties and little clinical work. However, this type of management work will not exist in all smaller departments within PMCC.
- 33 At PMCC the appointment of Deputy Chiefs would reduce the level of experience offered to a wide range of employees in a department. Currently at PMCC when a Chief is on annual leave, a staff member from within that department can be appointed to act in the role of that Chief in order to provide them with management experience. As a general rule, the staff members that are given the opportunity to act up in a higher position are varied so that a range of senior staff members have this opportunity. However, if a Deputy Chief was appointed to each department, the acting up role would be undertaken by the Deputy Chief which would reduce the overall opportunities for a number of team members.

*Fixed Term Employees*

- 34 In clause 15 of the draft workplace determination, the HSU seeks to restrict fixed term employment so that fixed term positions longer than 12 months automatically convert to permanent positions.
- 35 In general, PMCC provides fixed term positions when specific funding or grants are given to undertake a project and staff need to be hired for that project. Also, fixed term employees may be engaged to backfill other employees roles when they are on maternity leave or are undertaking a temporary change in role. For example, a permanent employee may have a change in role by undertaking a PhD, and while that employee is undertaking that changed role, PMCC would want the flexibility to hire a fixed term employee to replace that employee during their absence.
- 36 When PMCC receives additional funding for specific projects, this funding is usually provided for a fixed period or until a particular project is complete. During the term of the project, PMCC may hire fixed term employees with specialised skills to complete this work. However, these employees may not be able to be redeployed on a full time basis after the project is complete because there may not be the case load or services to support any additional employee/s. For example, PMCC recently received specific funding for a project into the scope of key Allied Health indicators across hospitals. This research is being undertaken by a dietician on a fixed term contract. At the end of this project, there may not be a vacancy at PMCC for this dietician to become a permanent staff member.
- 37 Further, in general, if funding was extended for a period beyond its initial term, PMCC would want the flexibility to re-engage employees for a further fixed term, even if it was beyond the 12 month period. This flexibility would not exist for PMCC under the HSU's proposal, even though this arrangement may be suitable for the individual circumstances of the employee and PMCC.
- 38 If fixed term Allied Health professionals were automatically converted to permanent employees after 12 months, then PMCC would either hire another employee to complete a project at the end of an employees 12 month fixed term contract (which would be inefficient for running projects), or PMCC would, where possible, hire qualified individuals other than Allied Health professionals to undertake longer projects.

*Backfilling of certain absences*

- 39 In the draft workplace determination, the HSU seeks leave cover for any employee who is absent on annual leave for a period of five days or more.

- 40 In my view, backfilling can only be implemented if there is additional funding to meet the cost. These costs include the administration cost to allocate these backfill employees to additional roles, arranging backfill employees' pay, advertising, coordinating backfill employees with agencies and training backfill employees in statutory training, for example, fire training, emergency procedures, back care, and training in respect of PMCC's IT systems, policies and procedures.
- 41 Without such funding, backfilling could either not be implemented or it would be adopted at the expense of other services. Alternatively, backfilling would be adopted by reducing the numbers engaged to undertake a service and reassigning staff members to undertake backfill work.
- 42 If specific increased funding is not provided for backfilling, then the discretion as to how and when to backfill should remain with PMCC. This process, is essential in order to ensure that resources are always allocated to the areas where the services are in greatest demand.
- 43 Even if funding was available for backfill employees, this funding would only operate in disciplines where there were a large number of people trained in the discipline. In my view, it would not always be possible to recruit individuals on a short term basis where the permanent employee was in a highly specialised field or where there was a shortage of particular professionals, for example, physiotherapists.

#### *Appointment of Senior Clinician – Grade 4*

- 44 At clause 21.11 of the HSU draft Workplace Determination, the HSU proposes that at least one full-time Senior Clinician at the Grade 4 level be appointed for each health professional discipline on each site and in each section of the relevant department.
- 45 Within my division of PMCC, we do not currently have any Grade 4 Allied Health professionals. Accordingly, if we were required to appoint Grade 4 employees it would be a significant costing issue. The appointment of additional Grade 4 clinicians to each discipline is one of the most significant new costs in the draft workplace determination.
- 46 If these additional salary increases were not specifically funded, then PMCC would have to review services with a view to service reduction.
- 47 If this proposal was implemented, PMCC would, where possible, promote Grade 3 employees and then recruit for staff members at a lower position. Adopting this proposal would change the nature of services provided by PMCC because Grade 4 employees undertake less clinical work, so the extra clinical workload would either be allocated to employees at a lower level or the Grade 4 employees would perform work at the lower level (even though they were being paid for more complex work).

*Automatic progression*

- 48 At clause 21.1.3.1 of the HSU workplace determination, the HSU seeks that an employee who is qualified as a UG1 health professional post tertiary study shall be classified as, or deemed to be classified as a UG1, Grade 1, 4<sup>th</sup> year of experience after qualification.
- 49 The consequences of this will be that an employee may be paid at the higher rate even though they may not be able to perform at that level. Therefore PMCC would have additional costs to pay without any additional productivity or service gains to patients.

*Meal Breaks*

- 50 At clause 28.3 of the HSU draft workplace determination, where an employee is unable to take meal breaks on more than three occasions in any fortnight, the HSU seeks that the employee is paid for all time after the first five hours of the shift when he/she was unable to take a meal break at time and a half.
- 51 In my view this proposal is unworkable as it would take away the autonomy of Allied Health professionals. If this proposal was adopted, Managers within PMCC would be forced to monitor that employees were taking their meal breaks. The supervision of meal breaks would not be an effective use of a managers time. Further, such supervision may create conflicts between staff, as the Allied Health professionals may feel micromanaged.
- 52 If this proposal was adopted, managers would be required to monitor an employees' meal breaks in order to ensure that an employee, who took a meal break, did not later make a claim for additional money that they were not entitled to receive.
- 53 If this proposal was adopted, it would reward employees for missing meal breaks. In my view these break are important and employees should not be encouraged to work though a break.

**General comments regarding claims made by the HSU**

- 54 The increasing age of Australia's population has meant that there has generally been an increase in the number of patients using the health services in Australia. The increase in the number of patients using the health services in Australia has affected all staff within the health industry, not just Allied Health professionals.
- 55 In my view, one of the effects of an increased number of patients using Australia's health service is that patient waiting periods have increased, as there is a limit to the number of patients that any health care professional can treat.
- 56 Within the health industry over the last decade or so there has been a change in the way that health services are provided to patients. Generally, the length of a patient's stay as an in-

patient in a hospital has been reduced. One reason for the reduced periods of time that patients spend as an in-patient in a hospital is because medical advancements have meant that some illnesses can be treated in a shorter period of time, for example, as a general observation, developments in less invasive surgical techniques have reduced patient recovery times.

57 Further, and perhaps more relevantly, the amount of time that patients spend in hospitals as in-patients has been reduced because of a redistribution of services. Specifically, patients that do not need the constant monitoring or level of care given to in-patients at a hospital, are frequently treated by accessing the out-patient facilities (whether it be at a community on-site facility, hospital or home based care). The impact of this re-distribution is two-fold. Firstly, patients being treated as in-patients in a hospital often have more serious conditions (otherwise they may have been referred to out-patient facilities), and, secondly, the length of time a patient spends using in-patient services in a hospital is frequently shorter as they receive follow up care as an out-patient. For example, the majority of patient services provided at PMCC are provided to out-patients.

58 The effect of the re-distribution identified in paragraph 57 above, does not necessarily mean that all patient illnesses have become more complex in the last seven years. Rather, in my view, the distribution of where patients receive health care has changed, so that patients being treated as in-patients in hospitals often have more serious illnesses that require monitoring, such as multiple illnesses.

59 In any event, in my view, the nature of illnesses treated by Allied Health professionals is not dissimilar to other health care workers and the types of illnesses they treat would be of the same complexity as the illnesses treated by other health care workers. This is demonstrated by the fact that in most cases, patients receive services from multiple disciplines within a hospital.

60 Allied Health professionals, like all health care professionals, are required to participate in professional development. In my view, the types of professional development that Allied Health professionals are currently electing to undertake is less generalised and more specific. Whereas, Allied Health professionals in the last decade would have had a level of expertise in many areas, nowadays many Allied Health professionals elect to focus their professional development into specialised areas. The effect of this change is not that professional development has increased for Allied Health professionals but rather the way in which professional development has been undertaken is less generalised. In my view, this change in professional development is reflective of the changes being undertaken by all health workers and it reflects a choice that is made at an individual level.

DATED: 9 September 2008

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**ANGELIA GAYE DIXON**

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**EXHIBIT AD-1**

This is the Exhibit referred to in the witness statement of Angelia Gaye Dixon dated 9 September 2008 and marked **AD-1**.

# Peter MacCallum Cancer Centre ORGANISATIONAL STRUCTURE

