5 Proposed Public Benefits Test

We have endeavoured to respond to the arguments presented by the HPV in each of the following sections. Public benefits need to be viewed in terms of both cost and the level of service and care provided to the public.

5.1 Reduction in the overall nurse staff costs to health services.

The tender proposes that agencies would pay nurses at or close to the relevant Award/EBA and charge HPV a flat fee (or close thereto) on top of this. The HPV believes that this would reduce the overall nursing costs with the hospitals. The HPV have presented a number of incorrect or extreme rates rather than accurately comparing the true cost of agency nurses to either employed nurses or nurse bank staff.

The two cost contributors to the rate the nursing agencies charge to hospitals are:

a) nurse labour rates; and
b) nursing agency payroll services fee.

Labour rates

In terms of labour rates, the nurse pay rates that have been quoted by the HPV represent the base level hourly award rate of pay for a full time nurse. This rate does not take in to account additional on costs associated with personal leave, annual leave, public holidays, long service leave etc. To account for this, under the award/EBA, all casual nurses receive a 25% loading to allow for these factors. This casual rate of pay would also apply to any nurses working within a nurse bank.

The RCSA acknowledges that to attract nurses to undertake additional shifts or to re-enter the workforce and thus increase the overall supply, nursing agencies may decide to pay the nurse at a higher grade or rate of pay. Failure to do so would reduce the number of available nurses within the system and thus reduce the nursing services available.

To illustrate this point, the following is a summary of the current award rates for registered nurses, showing the ordinary base rate, the casual rate and a projected average agency rate, if agencies graded non-specialist nurses up by 2 grades:

Classification	Award Ordinary Rate	Award Casual Rate	Ave. Agency Rate	$ and % increase on award casual rate
RN G2Y1	$17.2632	$21.5789	$23.8618	$1.10, 5%
RN G2Y2	$18.1737	$22.7171	$25.0658	$1.10, 5%
RN G2Y3	$19.0895	$23.8618	$26.2796	$1.10, 5%
RN G2Y4	$20.0526	$25.0658	$27.4836	$1.10, 4%
RN G2Y5	$21.0237	$26.2796	$28.1612	$1.07, 4%
RN G2Y6	$21.9868	$27.4836	$28.8388	$1.05, 4%
RN G2Y7	$22.5289	$28.1612	$30.0197	$1.06, 4%
RN G2Y8	$22.5289	$28.8388	$30.3750	$1.05, 4%

Due to the extreme shortage of specialist nurses and the difficulty in attracting nurses to work additional shifts, specialist nurse rates *have* increased far more significantly than any other type of nurses. The RCSA would estimate that specialist nurses may be paid approximately 50% above the casual award by some nursing agencies. While this may seem to be excessive, the consistent theme highlighted by specialist nurses in survey comments was that:

a) they would reduce their hours (28%) or leave the profession (47%) if they were not paid at this rate; and
b) they considered that this was the first time they had been valued according to their skills and the intensity, responsibility and importance of the work they undertake.

The majority of shifts which agencies provided are for non-specialist nurses, so while these increased rates do have a net increase on the cost of agency nurses, these costs are insignificant when compared to the impact of the reduction in the nursing workforce to either patient care.

Nursing Agency Payroll Service Fee

In terms of the nursing agency commission, the following table provides a comparison between the direct and indirect overheads of a nurse bank, when compared with an agency[16].

Estimate Of The Comparative Costs To A hospital In Using Bank Staff Or Agency Staff.			
	Bank Staff	**Agency Staff**	**Difference**
Direct Costs			
Superannuation	8%	Paid by agency	+8%
Workcover	3%	Paid by agency	+3%
Professional Indemnity Insurance	2%	Paid by agency	+2%
Indirect Costs		Paid by agency	
Recruitment	8%	Paid by agency	+8%
Payroll Function	5%	Paid by agency	+5%
Human Resource Functions	5%	Paid by agency	+5%
Ongoing Education	5%	Paid by agency	+5%
Bank Management	12%	Paid by agency	+12%
Payroll of Agency Mgmt Fees	Nil	Ave 44%	-44%
TOTAL	**48%**	**Ave 44%**	**4%**

Based on both the labour rate and the operating costs of running a nurse bank, the RCSA does not believe that there will be any significant cost savings achieved from this tender.

[16] Prepared by the RCSA membership for submission to the IRC in 2001.

In addition, while most, if not all agencies send their current rates to hospitals, hospital allocation staff are often unaware of agency costs and as such, often contact agencies purely based on personal preference. Where hospitals are paying premium prices for nursing services, efficiencies could be gained by more appropriate agency selection.

We believe that there may be some in-efficiencies within the public health system. Potentially, with trimming and re-budgeting, better efficiencies could be obtained within the public hospital system, without putting nursing services at risk and therefore improve overall public benefit.

The HPV tender will not affect the **existence** of market forces which govern the allocation of nursing resources, but those forces are likely to dramatically affect the allocation of nursing resources within the hospital system. Competition for scarce nursing services will remain intense and those resources will move toward the higher returns, which will exist in the private hospital sector, or to agencies other than the successful tenderer. Why would nurses want to work for the lower returns offered by the successful tenderer, when they can do agency work in the private hospital sector for higher returns and greater flexibility? For these reasons, the tender is likely to significantly increase the shortage of nurses in the public hospitals, not help to eliminate it. This increased shortage will result in more bed closures and significantly reduce public benefits.

5.2 Employment Equality and Workplace Harmonisation

The difference between agency and employed nurse pay rates or skill levels has been cited as a cause of disharmony in the workplace.

Despite the quoted base salary being at the award rate, within the public hospital system there are many circumstances whereby the actual wage received by a permanent staff member is effectively increased due to the provision of additional benefits such as car parking. In addition, salary packaging can result in benefits to the employed nurse of up to an additional 30% above the award. These benefits are unavailable to agency nurses.

We further refute the comment that 'agency nurses receive between 1.5 to 3 times the award/EBA rate'. This ratio was previously used in the HPV submission with respect to the rate paid to the agency (not the nurse) which we have already cited as based on extreme examples.

With regard to skill levels, it should be remembered that many nurses employed at one hospital are often agency nurses at another hospital. An individual agency nurse's level of competence is ascertained at the time of interview. The qualification of CCRN and other specialties should provide the nurse with a standard of expertise that has been assessed by a recognised tertiary institution, which does include clinical performance objectives and examinations that are mandatory to gain the qualification. The agency nurse's skills may not always match those of permanent staff. Permanent staff may not always match the skills of the agency nurse. Often, the permanent staff

member is also the agency nurse, whether it is at the same place of employment or elsewhere.

A large number of agency nurses are highly experienced nurses with between 8 and 20 years of experience, often with post graduate qualifications in one or more areas of nursing and many of whom have acted in or currently act in, senior roles within the hospital environment. These nurses include Associate Change Nurses (ACNs), Nurse Unit Managers (NUMs), hospital supervisors, educators and ex-Director of Nursing (DONs).

The nurse in charge may in fact allocate the agency nurse less acute patients until the performance of the agency nurse is examined accordingly. This should not be viewed as a negative – any 'new' staff member would initially be allocated less acute cases. For this reason, nursing agencies will always endeavour to send a nurse who has previously worked in a unit to ensure that they are a 'known' entity. In many cases, hospitals will request specific nurses based on their experience and familiarity with the unit and as such, the nurse would be working with more acute patients.

The issue of continuity of care with agency staff in the intensive care setting has also been raised. Realistically, it is not achieved with permanent staff as in the major public Level 1 ICU's, there are more than 100 permanent staff, working on a shift basis. Continuity of care in essence is the passing on of information about a patient from one health care worker to the next, in order to continue the quality of care over a 24hr period. If the reliance on continuity of care were placed on the same health care worker looking after the patient, it would fail, as an individual health care worker cannot offer a round-the-clock service. This applies equally to nurses as well as to doctors; it is standard practice for medical registrars to rotate shifts and wards throughout a hospital.

Any disharmony which may exist is insignificant in comparison with the myriad other problems within the permanent nursing profession.

5.3 Price Certainty

The tender proposes to fix prices for a 3 year period with the only variations as a result of changes to the award or EBA. While this would in theory provide price certainty to hospitals, it ignores the global nature of the market place and assumes that nurses will stay within the system when working at the award.

Nurses will either elect to work in areas where they will earn a better rate of pay, for example on standard agency rates within other private hospitals or they may elect to work interstate or overseas. As demonstrated by the survey, 68% of nurses will leave the nursing profession or choose not to work any additional shifts as they do not perceive there are any 'benefits' in so doing, thus worsening the shortages.

This will have a detrimental effect on the general public, as the Public Hospital system will be forced to close beds, due to lack of nursing resources. This will impact on service provision and cause funding penalties.

In response to the worsening shortage, hospitals would be forced to go outside their preferred contracted suppliers or the award, to attract nurses back to the profession or entice new graduates. Therefore, price certainty could not be achieved.

It is naive to assume that price certainty could be practiced within a free market. It is difficult to achieve price certainty when there is ample supply, let alone where demand far exceeds supply.

5.4 Reduction in the Bargaining Imbalance and Promotion of Equitable Dealings

The HPV has stated that there has been an increase of 4% in the demand for agency nursing services, with a commensurate increase in costs of 44%. The tender submission also states that the health services have little or no bargaining power in the acquisition of nurses.

Based on the RCSAs understanding of agency payment structures and the relative movements with nursing salaries and client rates over the last 12 months, we would agree that there has been a substantial increase in specialist nurse pay rates, with a much lesser increase paid to non-specialist registered nurses.

However the following points should be noted:

- The number of bookings made for general nursing services (registered and enrolled) far exceeds the number of bookings made for specialist nurses, therefore any salary increases for specialist nursing services would be 'diluted' within the overall number; and
- We would argue that a 44% increase in costs across all disciplines is extreme. *If* there has been an increase in costs, we believe that there has been a far more significant *increase in the use* of agency services, than the stated 4%. All agencies surveyed by the RCSA reported a far more significant increase in volume of bookings over the past 12 months. We would also dispute that *only* 5% of public hospital nursing services are provided by agency staff.

The tender submission states that the health services have little or no bargaining power in the acquisition of nurses. There are a large number of nursing agencies within the Victorian marketplace and currently hospitals deal with each nursing agency equitably and each agency independently structures its' pricing and operations. Hospitals represented by the HPV are in no way disadvantaged in their bargaining power when compared to any other Victorian hospital. The market is extremely competitive and supply and demand factors are influential in the resultant outcomes.

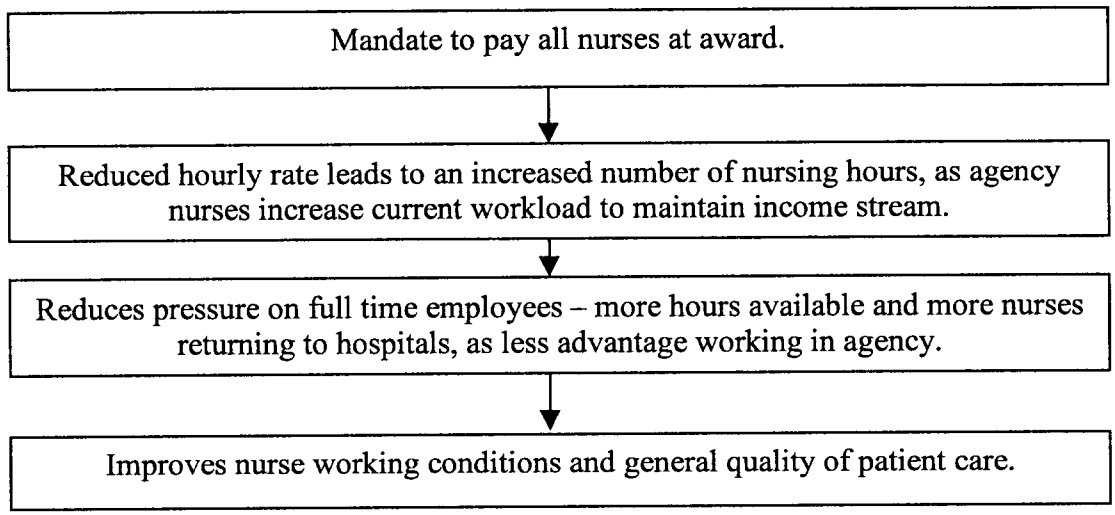
5.5 Increase in Nursing Staff Availability

As the HPV states itself, there are insufficient numbers of qualified nurses available in Australia. The HPV believes that increased rates of payment to agency nurses attracts nurses from hospital employment (full time, part time or bank) and subsequently allows nurses to reduce the number of hours that they are required to work, the latter impacting the total amount of available nursing services in Victoria.

The HPV has not demonstrated a sufficient degree of public benefit to justify authorisation of the proposed tender and proposed service agreement. This is best illustrated with a comparison of the situation as it currently exists, as outlined in section 2 of this document, and the position that would apply in the future if authorisation was granted.

To redress the increasing use of agency nurses , the tender requires all agencies that wish to deal with HPV to pay nurses at the award or EBA rate and the HPV proposes the following model as the likely outcome:

Figure1: Proposed HPV Model for Increasing Nursing Staff Availability



Unfortunately, there are a number of fallacies within this model. **This model totally disregards the fact that those nurses undertaking agency shifts will reduce the number of additional shifts that they work or altogether leave the system.** This model has been defined as a closed-system and naively ignores any 'leakage' that will occur.

As outlined our survey revealed the following outcomes should agencies be forced to pay nurses at award/EBA:

OUTCOME	SPECIALIST	DIV1	DIV2
Nurses who will **REDUCE** their shifts	28%	17%	15%
Nurses who will **LEAVE** the profession	47%	45%	33%

Given the total number of nurses working either part time or full time within agencies, **these figures cannot be ignored**.

The award level remuneration, together with the inflexibility of hospital shiftwork and rotation has repeatedly been cited as one of the most significant causes of dissatisfaction within the profession. Turning back the clock will not only affect those nurses working through agencies, but will send a message to all nurses regarding how the public hospital system values their services.

Rather than viewing agencies as attracting nurses away from hospitals, a more appropriate view is that agencies have stemmed the flow of nurses leaving the profession by offering them a viable lifestyle alternative. **Removing this employment option will lead to a net reduction in available nursing resources, both in the short and long term, an undoubted major public benefit risk.**

Nurses will 'vote with their feet' as they have other employment options; within allied health, the pharmaceutical industry, the ambulance service, health promotion agencies or totally outside of the health industry.

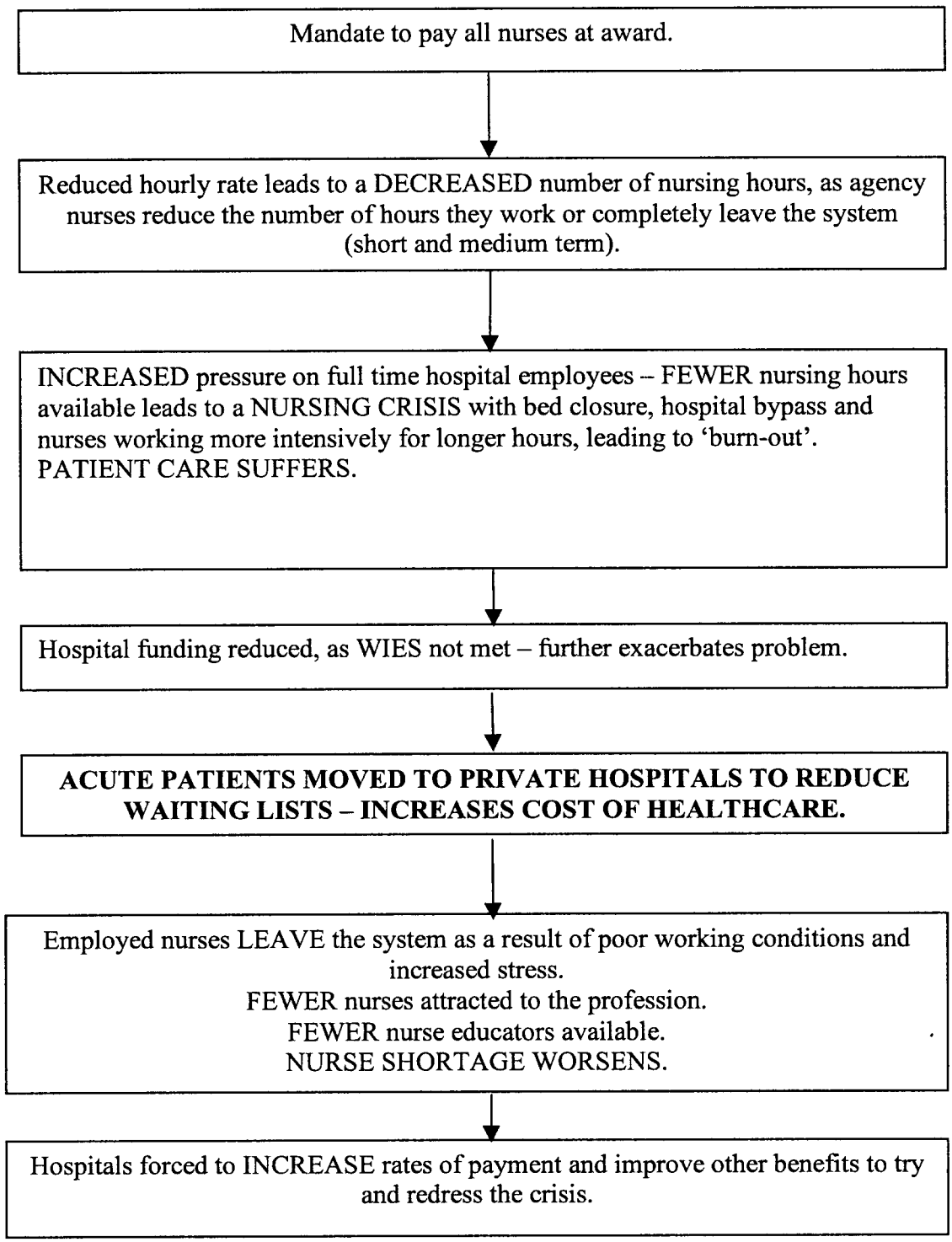
The position that will apply in the future if the proposed tender and service agreement receive authorisation is detailed in Figure 2 - Realistic Outcome of HPV Tender, on the following page.

While this scenario may seem to be extreme, this scenario is already occurring in Victoria as a result of the requirement by some hospitals to reduce the number of agency nurses. For example, The Royal Melbourne Hospital operates a 24 bed ICU. It is our understanding that since instituting a freeze on the use of agency nurses within this unit in January, this hospital has required its' own staff to work a significant number of double shifts, leading to burn-out. In addition, non-ICU staff have been brought in to meet the shortage from other areas within the hospital.

It has been reported to us that this situation has resulted in 7 senior staff resigning in the last few weeks; this shortfall will not be made up by newly trained staff, as of the 31 students who completed Critical Care training last year, only 11 remain. In addition, rather than meet this crisis with agency nurses, *the hospital is transferring patients to the Melbourne Private Hospital ICU.* Melbourne Private then contacts nursing agencies to secure the required staff and undertakes treatment.

In the United Kingdom, the NHS (National Health Service) regularly contracts all available beds and theatre time from private hospitals for a year on end as part of its' NHS Direct service, in an attempt to process patients and reduce waiting times. The NHS also regularly sends patients to Germany to try and reduce patient queues, as a result of their own crisis.

Figure 2: Realistic Outcome of HPV Tender



5.6 Fostering Business Efficacy

Very few, if any hospitals currently tender for the provision of nursing services.

In the past, when hospitals have attempted to operate tenders, they did not meet their expected outcomes.

Although the HPV would have us believe the contrary, nurses are not commodities. Nurses are individuals, with individual needs and lifestyle requirements.

5.7 Conclusion in Respect to the Public Benefit Argument

As shown by the ACCC in their assessment of the interim submission, the issue is far more complex than outlined by the HPV.

The primary public benefit argument of the HPV submission is dollar driven. In authorising this submission, there is a far greater public benefit resulting in reduced services and as such, the outcome could be hospitals continually on bypass, helicopter transfers or bed closures **as a result of the fundamental issues of nurses leaving the system.**

The Victorian hospital system has set a level of services they provide, which even with its current difficulties, is seen globally as a model system for the provision of health services. To maintain that level of service, the current proposal by the HPV will not deliver the expected outcomes to either the government or the health system.

If this proposal succeeds, there will be a drastic reduction in an already depleted supply. This will have both immediate and long term effects.

Public hospitals provide an essential public service. Nurses already feel devalued by the current health systems and there is no public interest in further alienating the essential service being provided. Can a value be put on such an essential public service?

There is no public benefit in forcing nurses to leave the profession.

6 General Implications from a Competition Perspective

The need to identify specific issues within the tender document is in our view not the purpose of this submission.

While public benefits have been previously explored and refuted, we aim to highlight the overall market implications that this tender would have, should it be authorised.

The RCSA believes this tender:

- Would discriminate against smaller players as a result of cash flow implications, accreditation, reporting, and additional commercial management issues;
- Would ensure that larger agencies will get the majority of business because only they can support the commercial conditions, which could leave the market in a much less competitive environment progressively throughout the first tender period;
- Will prevent nurses from doing extra shifts in hospitals where they are employed, which will prevent agencies from providing the most experienced staff to hospitals. In so far as the successful tenderer is concerned, this restriction will substantially affect its ability to compete with other agencies. For example, if:

    a) a particular hospital required the services of a nurses; and
    b) the only nurse the agency had on its books who was available and had the requisite skill set was also a permanent employee of that hospital.

  The successful tenderer would be prevented from filling the order. This will clearly result in a substantial lessening of the ability of the successful tenderer to compete.

In addition, as nurse banks have not previously been well managed, any increase in the size of nurse banks will result in a requirement for the management of the nurse banks to be contracted or privatised. This has already occurred in the U.K., where a previous government attempt to run a nurse bank resulted in the creation of the (private) British Nursing Agency.

Today, within Melbourne Health, the Royal Melbourne, Royal Children's and Royal Women's Hospitals are already seeking to combine their nurse banks (the Royal Bank). It is only a matter of time before hospital governance elects that nurse bank management is not a core business and as such, should be contracted externally.

APPENDIX 1 – SAMPLE OF RCSA SURVEY

SURVEY

1. I work in the following area: *(please tick)*

   Specialist ❑
   General DIV1 ❑
   EnrolledDIV2 ❑

2. Agency work is: *(please tick <u>one</u> of the following)*

   a) My only source of income. ❑
   b) Supplements my full time nursing wage. ❑
   c) Supplements my part time nursing wage. ❑
   d) Supplements my income while I work in another profession. ❑

3. I work with an Agency because:

	Very Important	Important	Not At All Important
a) The Agency pays me well.	❑	❑	❑
b) I can choose when I wish to work.	❑	❑	❑
c) I can choose where I wish to work.	❑	❑	❑
d) I enjoy working in a variety of hospital settings.	❑	❑	❑
e) I avoid any bureaucracy within the hospital system.	❑	❑	❑
f) The Agency staff treat me with respect and values my services.	❑	❑	❑

4. I believe that the rates I am paid with the Agency: *(please tick <u>one</u> of the following)*

   a) Reflect the true value of my skills and intensity of the work. ❑
   b) Are too low as they do not reflect my true value. ❑
   c) Are too high. ❑

5. If the Agency was forced by the Victorian State Government to pay my salary at or close to the Award rate of pay and therefore reduce my income, I would: *(please tick <u>one</u> of the following)*

   a) Continue to work the same number of shifts that I currently work. ❑
   b) Increase the number of shifts I work to maintain my income. ❑
   c) Reduce the shifts I work because it is no longer worth doing extra. ❑
   d) Move to a hospital nurse bank and increase the shifts I work. ❑
   e) Consider other career options and leave nursing. ❑

6. I also work in a Hospital Bank

   a) No ❑
   b) Yes ❑

7. I work in a Hospital Bank because:

a) the agency cannot provide me shifts at this hospital. ❑
b) I enjoy working Bank. ❑
c) I am happy with my rate of pay. ❑
d) The Bank gets me extra shifts when the agency can't. ❑
e) Other reasons (please specify) ❑

Thank you very much for your time and participation in this survey.

If you wish to provide any additional comments or submissions, please feel free to do so in the space below or as an attachment.

The survey results will remain anonymous, however, if you are happy for us to contact you in the future for any further comment, could you please provide your name and contact details:

Name: Contact No: