The result? Further permanent staff exchange permanent employment for employment through a nursing agency at increased rates with the associated benefit of being able to reduce hours or, alternatively, for leaving the nursing workforce and joining the growing ranks of registered but non-participating Victorian nurses. The work load of the remaining permanent staff grows greater still and so the vicious cycle continues ever-exacerbating the nurse supply shortage.

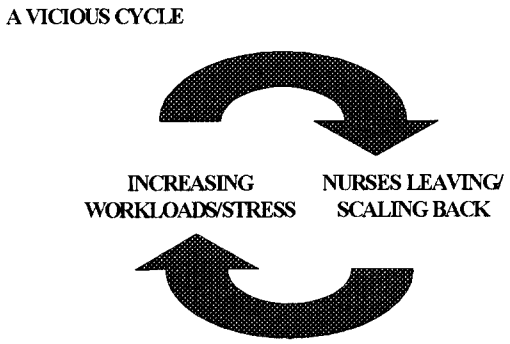

Diagram from the Research International 'Report of the Focus Group Consultation' in Appendix 6 of the Final Report (see page 174)

By attracting nurses out of permanent positions and into joining nurse agencies, and by enabling nurses to scale back their availability, the escalating wages paid by nurse agencies for agency nursing staff plays a critical role in fuelling the vicious cycle represented diagrammatically above. It exacerbates, rather than solves it. While the trade off between the job security offered by a permanent position and the increased rates of pay, reduced work load and stress and job flexibility offered by self-employment through an agency would usually result in a stable level of nurses employed through nurse agencies, in the current climate of nurse shortage the benefits of job security are significantly eroded (if not eliminated). Indeed, the NRRC refers to 'certainty of work', and the ability of agencies to offer regular preferred shifts to their staff[4], as a reason for selecting agency nursing as a primary career choice: Final Report, pages 82 & 83.

The Final Report comments on the vicious cycle triggered by over award pay rates for agency nursing staff and the resultant increasing reliance by hospitals on agency nursing staff at page 42:

> Where the number of staff is not sufficient for the patient load, agency nurses tend to be used. In some instances, hospitals have contracts with only one agency and the nurses become familiar with the units in that hospital. [The contracts referred to here by the NRRC have expired since the time of the NRRC review.] However, this

[4] The Final Report discloses that the times of the shifts they are required to work is a significant issue for the majority of nurses: Final Report at pages 42 & 43. New graduate and inexperienced nurses complain that they do a disproportionate number of the undesirable shifts, such as night shifts and Saturday night and Sunday morning shifts: Research International 'Report of Focus Group Consultations', Appendix 6 of Final Report, at page 190.

> is not always the case. Hospitals may find themselves with nurses who do not know the unit and in some instances do not have the qualifications or experience necessary to provide quality care for the patients in the unit. This increases the load on the full-time experienced nurses. Many nurses saw the orientation and supervision of agency staff as an additional burden in an already overstretched work environment, and there was a widespread perception that many agency nurses were often being used in circumstances other than of last resort by management. The over award pay rates offered by agencies to certificated specialist nurses was considered a destabilising factor by many nurses, compounding the difficulties facing health care facilities in attracting permanent staff.
>
> With the losses of experienced nurses from wards / units, the concomitant increase in new graduates and relatively inexperienced nurses results in inordinately heavy workloads being carried by both the experienced and less experienced nurses. The former tend to suffer 'burn out' and the latter may find themselves unable to cope with the heavy demands. Therefore, both groups may choose to either leave the workforce, reduce to part-time or join an agency. This situation has been described by the focus group report as a 'vicious cycle' (Appendix 6, p22). [Square bracketed commentary added.]

The Final Report further explores the impact on the workload of permanently employed experienced nurses of reliance on agency nurses at page 43:

> For the experienced nurses who remain at the bedside, there has been an increase in the time spent on supervision of inexperienced nurses (new graduates and agency nurses). In general, experienced nurses accept that supervision and monitoring are part of the role associated with clinical experience. However, with high numbers of new graduates, and with agency nurses often unfamiliar with unit requirements and sometimes lacking the experience necessary for the type of patient in the unit, the amount of time spent on this activity is perceived as excessive and detracts from the ability to apply continuous quality care to patients. In addition, as new graduates do not receive the support and mentoring required to help build their confidence, this contributes to their attrition from the workplace.

Finally, while registered non-working nurses are identified by the NRRC as a potential source of increased supply, 27% of registered non-working nurses surveyed in June 2000 by Campbell Research & Consulting[5] reported that the area of work they were most likely to work in if they returned to work is agency / casual: Final Report at page 137. When considered in the context of the 'vicious cycle' created by heavy reliance on agency nurses, this highlights the difficulty of attempting to alleviate the nurse shortage without also addressing the disproportionate incentives to list with agencies given the differential in remuneration without an accompanying reduction in job security.

The demand and supply curves in the market for the supply of nurses, established above, can be used to illustrate the vicious cycle described above. The demand curve can be

[5] Campbell Research & Consulting, *Nursing Return to Work Survey Final Report*, June 2000 published as Appendix 3 to the Final Report

mapped on the supply curve as follows:

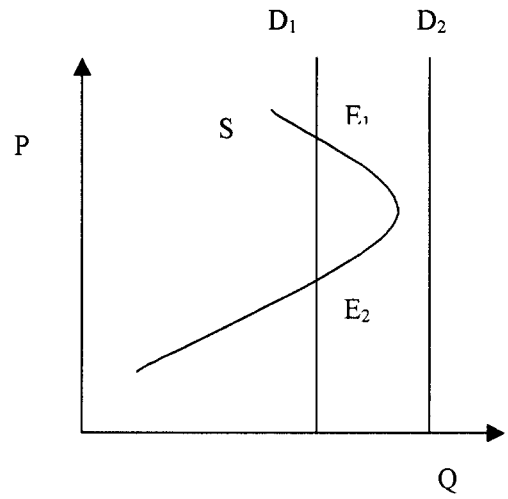

Diagram 3 - Market for the supply of nurses

As the supply curve is backward sloping, it is possible that the demand curve does not intersect with the supply curve at any point. In other words, demand may be represented by either the demand curve D_1 or the demand curve D_2 in Diagram 3. If demand can be represented by D_1, there are 2 possible points of equilibrium in the market for the supply of nurses, E_1 on the backward sloping portion of the supply curve and E_2 on the forward sloping portion of the demand curve. If demand can be represented by D_2, there are no points of equilibrium (given the current position of the demand and supply curves). It is more likely, given that (as will be discussed below) escalating wages for agency nurses also results in progressive leftward shifts in the supply curve, that the demand curve in the market for supply of nursing services can currently be represented by D_2.

As discussed above, there is currently a supply shortage (ie demand exceeds supply). The discussion above also established that supply contracts in response to an increase in wages and the market is functioning on the backward sloping portion of the supply curve. Therefore, the current level of nurse wages in the market for the supply of nurses must exceed P_1 in Diagram 4 below. (Demand equals supply at P_E and demand exceeds supply at all prices above P_E.)

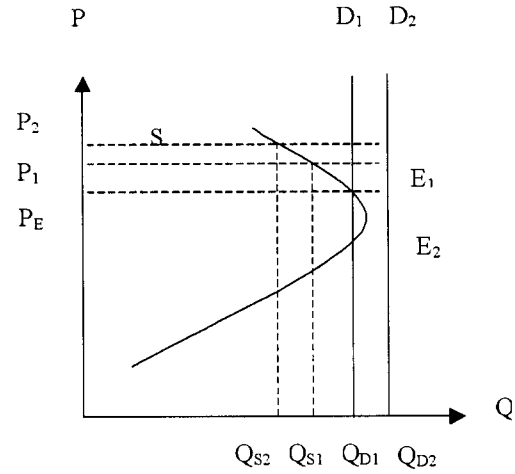

Diagram 4 - Price signalling of supply shortage results in movement along supply curve away from possible equilibrium

Assume that the current wage level in the market for the supply of nurses is P_1 in Diagram 4. Therefore, supply equals Q_{S1} and demand equals either Q_{D1} or Q_{D2}. The vicious cycle in which escalating nurse agency fees feed into a self-perpetuating series of reductions in supply can be represented by both:

1 upward pressure on wages as demand exceeds supply resulting in wages increasing to P_2. Supply contracts to Q_{S2} while demand remains equal to Q_{D1} or Q_{D2}. Therefore, the supply shortage has worsened. The market for the supply of nurses is 'unstable'. All other market conditions remaining constant, price signalling of the supply shortage will result in a movement *along* the supply curve *away* from the possible equilibrium of E_1; and

2 a leftward shift in the supply curve. As working conditions for nurses in permanent positions worsen, through for example increased workloads following listing by more permanent nurses with agencies in response to the increase in remuneration for agency nurses, the following things occur:

2.1 A portion of nurses in permanent positions will reduce the hours they are available to work or exit the nursing workforce in response to the deterioration in working conditions. The result is a contraction in the level of supply of nursing services for any given wage level;

2.2 A portion of nurses in permanent positions will list with agencies in response to the deterioration in working conditions. The result, after a lag, will be a contraction in supply for a given level of wages in the market generally as some of these nurses reduce their available hours in response to the increased remuneration of agency nurses; and

2.3 Agency nurses generally will also consider the nursing workforce to be less attractive as a result of the increased stress and dissatisfaction of permanently employed nurses and some may reduce the hours they are

available to work for a given level of remuneration, thereby resulting in a reduction in the supply of nursing services for each wage level.

The effect of deteriorating working conditions is, therefore, to reduce the level of supply of nursing services for each given level of wages. This can be represented by a leftward shift in the supply curve. The new supply curve can be represented as S^1 in Diagram 5. The level of supply (ie the total number of hours the nursing workforce is prepared to work) has reduced for each given wage level. In addition, the series of supply effects triggered by the amelioration of working conditions in the nursing workforce means the further the market is from the turning point in the supply curve, the greater the contraction in supply for each given wage level (ie the backward bending portion of the new supply curve is flatter than the old supply curve).

Consider wages equal to P_1. Supply has decreased from Q_{S1} to Q_{S2} as a result of the leftward shift in the supply curve.

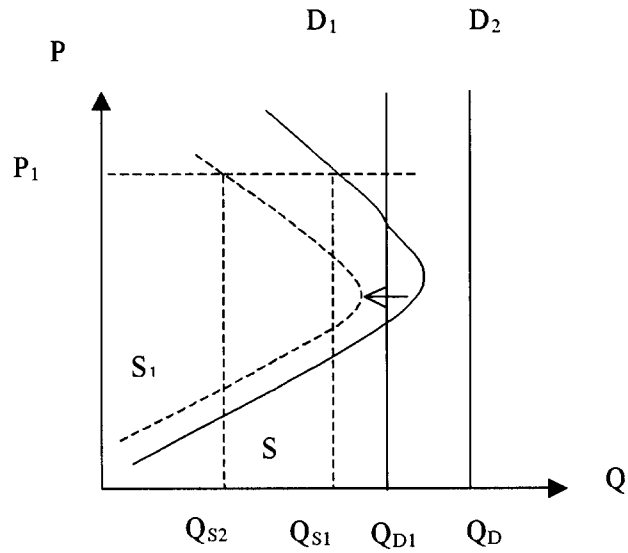

Diagram 5 - Price signalling of supply shortage results in leftward shift of supply curve

We submit that Diagram 5 is an accurate representation of the supply curve following a leftward shift as a result of deteriorating working conditions. However, even where the new supply curve, S_1, cuts the old supply curve, S, at some point on the backward bending portion of the old supply curve, the resultant expansion in supply will not remedy the supply shortage. If S_1 cuts S and sits above S to the left of the intersection, the leftward shift of the supply curve may result in a *temporary* increase in supply for the price P_1. However, as the supply shortage will continue to exist, the upward pressure on prices will result in a movement along S_1 to the left, eliminating the temporary expansion in supply. (The only exception to this will occur where the new supply curve, S_1, intersects D_1 at the prevailing price level, P_1. This is highly unlikely, particularly given that, as previously discussed, the demand curve is more likely to be at D_2.) The only permanent solution to the nurse supply

shortage is a change in the underlying conditions in the nursing workforce, such that the market is moved to the forward sloping section of the supply curve.

Role of Graduate Nurses

The Final Report discloses (at pages 31 & 32) that, while nationally the number of graduates from the Bachelor of Nursing programs has been steadily declining, Victoria has not had any difficulties in filling undergraduate nursing places and the attrition rate for the Bachelor of Nursing programs remains comparable with the average undergraduate attrition rate. However, at page 41 the Final Report notes that in 1998 only 68% of graduate nurses entered the Victorian nursing workforce. This suggests that, while there is little scope for an increase in the number of graduates from the Bachelor of Nursing programs as a result of higher wages for nurse agency staff, it is *possible* that a greater number of graduates may be attracted to enter the Victorian nursing workforce. (We observe, however, that the Final Report does not refer to more comprehensive data on the percentage of graduate nurses entering the Victorian nursing workforce and, accordingly, this is only drawing a tentative conclusion.)

However, as can be seen from the extract set out directly above, the Final Report expressly states that the increasing wages offered to agency nurses by nurse agencies results in inordinate workloads for experienced and inexperienced nurses alike. Further, as a result of the shortage of permanently employed experienced nurses and the heavy workload of the remaining experienced nurses, new graduate and inexperienced nurses are often left without adequate supervision or mentoring and are exposed to an excessive level of responsibility. Being given menial tasks where there is insufficient time available for training, older staff that do not take the time to determine a graduate nurse's skill level and 'cranky' and 'unsupportive' nurses worn down by heavy workloads and on-going stress are all cited as problems by new graduate nurses: Research International 'Report of the Focus Group Consultation' in Appendix 6 at page 189 of Final Report.

Increasing agency fees and wages for agency nurses results in high attrition of newly recruited graduate and inexperienced nurses.

The result is that new graduate and inexperienced nurses also consider leaving the nursing workforce, reducing their number of hours in an attempt to control their workload or listing with an agency. The Research International 'Report of the Focus Group Consultation' (Appendix 6 at page 189 of the Final Report) states:

> ...after a relatively short exposure to clinical practice, their reported intent is in line with other nursing segments researched in terms of expectations for the future: for the majority, their career beyond the next five years is out of bedside nursing!

Does a nurse agency or any group of nurse agencies have a degree of market power?

The nurse agencies that currently provide nursing services to the Victorian public and private health sector are set out in the Background material. Further, in the Background material we also identified that 8 of the nurse agencies are within the Staffing Australia group of nurse agencies. Reliable data on the market shares of each of the nurse agencies is not available. However, it is HPV's understanding that the nurse agencies in the Staffing Australia group currently provide approximately 30% of Victorian metropolitan

public hospitals' requirements for agency nursing services (by staffing hours) and that this figure can rise to up to 78% for particular hospitals. *Refer to the confidential side letter for additional information.*

As discussed in defining the relevant market for the purposes of assessing the proposed conduct, the Victorian nurse supply shortage, together with the fact that the demand for agency nursing services is a residual demand results in:

- a significant inter-relationship between the supply of nursing services provided by permanent nurses and / or listed with nurse banks, and the supply of nursing services provided by nurse agencies; and
- a significant inter-relationship between the demand for agency nurses and the supply of nursing services provided by permanent nurses and / or nurses listed with nurse banks.

The existence of a shortage of nursing services means that the hospitals (through both permanent positions and their nurse banks) and the nurse agencies are competitors in the acquisition of nurses. In addition, as the total demand for nursing services is relatively price inelastic the Victorian public hospitals have little countervailing bargaining power in their dealings with nurse agencies. As a result, if the nurse agencies are able to signal an intention to increase nurse agency fees they can:

- increase remuneration for agency nurses;
- reduce the supply of nursing services provided by permanent positions and through nurse banks; and
- thereby, increase the derived demand for agency nursing services.

In other words, if nurse agencies are able to co-ordinate with respect to price, the supply shortage, relatively inelastic total demand for nursing services and the derived demand for agency nursing services means that the nurse agencies would be able to influence the level of demand for agency nursing services.

HPV submit that, as the Staffing Australia Group of nurse agencies supply approximately 30% of Victorian metropolitan public hospitals' total agency nursing service requirements, it is reasonable to assume that the nurse agencies in the Staffing Australia Group are able to act as a market leader with respect to price. An increase in agency fees by the nurse agencies in the Staffing Australia Group signals future nurse agency fees to the rest of the nurse agencies operating in Victoria. *Refer to the confidential side letter for additional information.*

6 Public benefits

We submit that the substantive public benefits arising from this proposal are as follows:

6.1 Alleviating supply shortage

As established above, the prevailing conditions in market for the supply of nurses mean that the market is 'unstable'. The operation of price signaling of the supply shortage (through increased nurse agency fees and wages for agency nurses) are driving the market further and further away from equilibrium, that is where the supply of nurses equals the demand for nurses. In addition, the price signaling also has a negative effect on working conditions (as permanent nurses list with agencies increasing the workload of those remaining permanent experienced nurses), reducing the number of hours nurses are prepared to work for a given wage level.

The only permanent solution to the nurse supply shortage is for the market for nursing services to move to the forward sloping portion of the supply curve. Therefore, addressing the nurse supply shortages requires:

- the successful implementation of measures to shift the supply curve to the right by improving the working conditions of nurses and expanding the level of supply for a given level of wages. An improvement in the underlying working conditions in the nursing workforce will also change the slope of the supply curve (compare Diagram 5 above); and
- the successful implementation of measures to move the market for the supply of nurses along the supply curve in the direction of equilibrium. As the market may be functioning on the backward bending portion of the supply curve, this requires a reduction in the level of wages for agency nurses.

We submit that in order to address the conditions underlying the nurse supply shortage and return the market to the forward sloping portion of the supply curve it will first be necessary to contain the escalating wages for agency nurses. We will demonstrate this by considering the likelihood of success of the following measures, in the absence of the proposed tender:

- a series of NRRC recommendations for addressing the nurse agency issue; and
- a series of Government accepted NRRC recommendations for addressing the nurse supply shortage generally.

NRRC recommendations for addressing the nurse agency issue

The NRRC considers the particular issues raised by agency nurses at pages 82 to 84 of the Final Report. After discussing the increased reliance on agency

nurses by the public health care sector over recent years and the problems encountered as a result (discussed above), the NRRC makes Recommendations 53, 54 and 55 aimed at addressing the nurse agency issue, which focus on the recruitment of permanent nurses and the procedures and strategies for recruitment of nurses to fill permanent vacancies. The stated rationale for these recommendations is as follows (at page 83):

> By recruiting permanent nurses, the health care industry will reduce its reliance on agency nurses, so that they will be used to cover ad hoc or unplanned absence only. It is hypothesised that, as a result, permanent staff satisfaction will be increased and a reduction in the attrition rate of permanent staff may be achieved. Further, as permanent positions are filled, the need for agency nurses reduces and the attractiveness of agency work as the principle source of employment diminishes.
>
> ...
>
> This strategy for recruitment and retention of permanent staff will be effective only if adequate funding is provided for permanent staff, full-time employment is encouraged as appropriate (particularly in some rural areas), and the procedures for filling vacancies are streamlined within health care facilities.

Recommendation 53: That health care facilities ensure that:

- *Strategies are being implemented to employ nurses on a permanent basis to fill permanent vacancies.*
- *Recruitment procedures for replacement of permanent positions are developed to ensure that such vacancies are filled within eight weeks of notice of resignation.*
- *Use of agency nurses is restricted to unplanned absences only.*

Recommendation 54: That the Department of Human Services monitors statewide trends in agency usage in the public health care industry on a quarterly basis.

Recommendation 55: That casemix funding be adjusted so that hospital funding is sufficient to ensure that ward / unit budgets and permanent staffing profiles include provision for leave relief such as annual leave and ADOs.

The NRRC also recommends that ad hoc staffing needs be met by hospital nurse banks as the experience and qualifications of nurses listed with the hospital nurse bank are known, and the nurses have undertaken any relevant orientation program operated by the hospital and are generally familiar with the ward / unit in which they are employed to work and are familiar with the type of nursing required.

Recommendation 56: That health facilities are encouraged to (re)establish Nurse Banks to meet the ad hoc staffing needs of the facility and that these nurses have access to the ongoing education program of the facility.

There is no doubt that the recruitment of permanent nurses and / or the temporary nursing staff requirements of the hospitals are met through nurse banks operated by the hospitals will deliver the benefits discussed by the NRRC. However, we submit that programs such as those contemplated by the NRRC for addressing the nurse agency issue will not be successful without some measure designed to contain escalating nurse agency wages. The public health sector will not be able

to successfully recruit permanent nursing staff while the remuneration for agency nursing staff continues to increase. An adequate level of wages for nurses is important in addressing the nurse shortage but increasing wages is not the answer to the supply shortage.

Put another way, Victorian public hospitals will not be able to recruit additional permanent nurses while the discrepancy between remuneration for permanent nurses and remuneration for nurse agency nurses continues to widen. Similarly, while the Health Services *currently* operate nurse banks for the purposes of satisfying their temporary nursing staff requirements, listing with a hospital nurse bank is not as attractive as joining an agency. Nurse bank nursing staff are paid the casual rates provided for in the relevant Award or enterprise bargaining agreement (as required by enterprise bargaining agreements and to avoid industrial disharmony). Thus, there is a differential in remuneration between casual nurses that list with agencies and those that list with hospital nurse banks that is currently widening. The Health Services will not be able to meet their ad hoc staffing needs for the facility from internal nurse banks unless and until this wage differential is addressed. Addressing the wage differential is a necessary pre-condition to the successful implementation of measures contemplated by the NRRC.

We submit that the successful implementation of NRRC Recommendations 53 to 56 to address the nurse agency issue is unlikely if unaccompanied by some measure, such as the proposed exclusive tender, to contain escalating agency nurse wages.

The NRRC does not consider any measures for containing wages for agency nurses, as previous attempts to contain agency nurse wages have not been successful. The NRRC states at page 83 of the Final Report:

> Although attempts have been made to contain differential pay rates through preferred provider contract arrangements, and despite widespread concern over the sustainability of these remuneration levels, it appears that the current structure continues to flourish in what has become a sellers' market.

However, the tender proposed by HPV can be distinguished from the preferred provider contract arrangements referred to by the NRRC as:

- it is an *exclusive* tender for the provision of temporary agency nursing staff; and
- the tender is to be conducted on behalf of all of the Health Services, not by individual health services.

The tender process will prevent a further wage driven leftward shift of the supply curve and so facilitate the success of measures adopted by the Government to address the nurse supply shortage generally, that is by improving workforce conditions and shifting the supply curve to the right. In addition, the tender process will also result in a movement along the supply curve in the market for

the supply of nurses towards a potential equilibrium (as discussed above) and so also partially reduce the extent of the supply shortage.

Government accepted NRRC recommendations for addressing nurse supply shortage

The Government has accepted a range of measures, proposed by the NRRC, to address the issues in nurse recruitment and retention that are perpetuating the nurse supply shortage. These measures are primarily designed to shift the supply curve to the right, that is increase the availability of nurses for a given wage level, and accordingly these measures focus on (for example) introducing greater work hour flexibility, improving education opportunities and career structures, and improving working conditions.

For example, the following NRRC recommendations designed to introduce greater flexibility for nurses to meet their personal needs, such as family needs, have been accepted by the Government in its Nurse Recruitment and Retention Committee Government Response of June 2001:

- NRRC Recommendation 48 provides that a greater emphasis should be placed on flexibility, fairness and equity of rostering. The Government supports the principle of flexibility, fairness and equity in rostering and proposes that this issue be addressed at the local management level. In addition, Commissioner Blair's enterprise bargaining decision provided for an alternative roster to the 8:8:10 roster to be put in place by agreement between the ANF and the hospital, where such a roster is generally preferred by ANF members in any ward or unit;

- NRRC Recommendation 52 provides for full-time nursing staff to have access to an Accrued Day Off (ADO) to be taken in a flexible manner suitable to the nurse and the local facility. The AIRC enterprise bargaining decision, which pre-dated the NRRC's Final Report, has reintroduced the ADO across the Victorian health care system; and

- NRRC Recommendation 63 provides for DHS to undertake a review of nurses' childcare needs across all sections of the nursing workforce, with a view to formulating a strategy to best meet assessed needs. The Government accepted this recommendation and preliminary work for implementation has already commenced.

It is our view that, while nurse agency wages continue to escalate, improved procedures and strategies for the recruitment of nurses to fill permanent positions, greater Government monitoring of agency nurse usage and budgetary provision for leave relief, such as annual leave and ADOs, will not be successful. Government measures, such as these, for shifting the supply curve to the right will not be successful if unaccompanied by a measure to contain the escalating wages for agency nurses because, as demonstrated above, these escalating wages result in a series of dynamic changes that result in a leftward shift in the supply curve.

The Government measures set out above for addressing the nurse supply shortage can be implemented but these measures alone will not break the vicious cycle in the attrition and scaling back of participation by nurses in the Victorian nursing workforce. As discussed above, the proposed tender is essential for containing nurse agency wages and, so, breaking the vicious cycle and facilitating the recruitment of the additional permanent nursing staff necessary for the successful implementation of the recommendations of the NRRC, both in relation to the nurse agency problem and generally.

The proposed exclusive tender will play an essential role in reducing the incentive for permanent staff to exit hospital employment, list with agencies and reduce their total availability in the nursing workforce. In other words, the exclusive tender will prevent further leftward shifts in the supply curve and movements along the supply curve away from a potential equilibrium. By containing escalating agency nurse wages, the proposed tender will establish conditions conducive to the successful implementation of the NRRC recommendations accepted by the Government for promoting nurses' willingness to work for a given wage level. In other words, the proposed tender is a necessary, but not sufficient, condition for breaking the vicious cycle of attrition and scaling back of participation by nurses in the Victorian nurse workforce. The tender, therefore, provides the public benefit of making a significant and vital contribution to alleviating the nurse shortage in Victoria.

6.2 Quality of patient care

The increased reliance on agency nursing staff has implications for the quality of patient care. Agency nurses do not know the site / physical location, the procedures of the ward / unit or the types of patients in the ward / unit. They do not have the same sense of organisational loyalty or the sense of responsibility for, commitment to and involvement in the provision of quality services by the hospital. The NRRC observes at page 83 of the Final Report:

> An individual agency nurse's level of competence is not necessarily known when attending a shift and the nurse in charge is likely to allocate the less acute or complex patients to the agency nurse. As Snell (1997) notes, 'such staff are, in most cases, competent but their skills may not always match those of permanent staff, particularly if they are working in an area they are not totally familiar with'.

Further, agencies are often unable to supply a nurse who is adequately experienced and qualified to fill a vacancy. The NRRC refer (at page 83) to research that 'identifies the problem that, on most occasions, agencies are unable to supply a nurse who is adequately experienced and appropriately qualified to fill the vacancy (ACNMI et al, 1999)'[6].

These issues with over-reliance on agency nursing staff have potentially serious implications for patient care. To provide a hypothetical example, a *competent*

[6] *Nursing Workforce Survey 1999*, Australian College of Nurse Management Inc, Melbourne

agency nurse struggling with disorientation in a unit with which he or she is unfamiliar and filling a vacancy for which he or she is not appropriately qualified, may miss early signs of complications or may misdiagnose a patient in circumstances where a permanent nurse providing continuity of care would not. The implications for the quality of care provided to that patient are very serious.

In addition, as discussed above, the increased workload of experienced permanent nursing staff that results from the increased reliance on agency nurses also has implications for the quality of patient care. The NRRC refers to a reduction in patient care as *the first and most worrying* effect of high workloads for experienced nurses: Final Report at page 43. The reliance on agency nurses increases the workload of experienced permanent staff both through the need to supervise and monitor those agency nurses and the increased burden with respect to continuity of care. The NRRC state (at page 83):

> ...permanent staff will be required to nurse patients on an ongoing basis, again causing increased pressure and stress on those staff. This is further supported by research that identifies the problem that, on most occasions, agencies are unable to supply a nurse who is adequately experienced and appropriately qualified to fill the vacancy (ACNMI et al. 1999), which has resulted in further stress for permanent staff. In addition, agency nurses are often only present for one shift and the permanent staff report that they shoulder more responsibility for ensuring that there is continuity of care from one shift to another, as well as responsibility for orientation and supervision of agency nurses.

As already noted above, the NRRC describe the resultant reduction in the ability of experienced nurses to provide continuous quality care in the following terms (at page 43):

> For the experienced nurses who remain at the bedside, there has been an increase in the time spent on supervision of inexperienced nurses (new graduates and agency nurses). In general, experienced nurses accept that supervision and monitoring are part of the role associated with clinical experience. However, with high numbers of new graduates, and with agency nurses often unfamiliar with unit requirements and sometimes lacking the experience necessary for the type of patient in the unit, the amount of time spent on this activity is perceived as excessive *and detracts from the ability to apply continuous quality care to patients*. [Emphasis added]

The increased workloads of experienced nursing staff, exacerbated by over-reliance on agency nursing staff, has resulted in task-orientated care that is unresponsive to individual patient needs, according to one nurse at a Research International forum: Final Report at page 43.

Finally, the increasing reliance on agency nursing staff that results from escalating wages for agency nurses, results in industrial disharmony in the nursing staff at the Health Services. The Research International 'Report of the Focus Group Consultation' discusses Division 1 and 3 nurses' responses to the increased reliance on agency nurses (Appendix 6, pages 173 & 174 of the Final Report):

> A concern from Division 1 and 3 nurses is the increasing use and reliance upon agency and nurse bank to top up low staff numbers. Specific issues include:

-a resentment that management regularly pays the higher rates required for bank and agency nurses, when they are so cost-focused in all other aspects

-a belief that agency nurses are less productive than hospital staff since they are not familiar with the ward

-a perception that agency nurses have a 'pick and choose' mentality[7], positioning themselves as elitist

-Hence, some permanent nurses feel that agency nurses have an adverse impact on the morale of permanent staff on the ward and would prefer that bank nurses are used instead.

Again, this has implications for the quality of patient care.

We submit that by reducing the discrepancy between remuneration for nurse agency staff and for other nursing staff, the proposed exclusive tender will reduce the incentive for nurses to exit, or reduce shifts in, their permanent positions with the Health Services. The proposed tender will thereby:

- ***reduce the level of reliance on agency nursing staff or, at a minimum, prevent an increase in reliance by the Health Services on agency nursing staff; and***
- ***improve the quality of patient care or, at a minimum, will prevent any further deterioration in the quality of patient care.***

We submit that this represents a significant public benefit.

6.3 Range of services offered by Health Services

The financial implications for Health Services of escalating agency fees are discussed in our submission dated 30 November 2001. In that submission, we stated that the Government has not increased the current level of funding as a result of the increased staffing costs faced by the Health Services due to escalating agency fees and the increased reliance on nurse agency staff. We also stated that, as a result, any additional costs incurred by the Health Services in the acquisition of nursing staff at rates in excess of the relevant Award or Enterprise Bargaining Agreement rate must be funded from reductions in funding to other areas within the Health Services.

In our submission of 30 November 2001, we referred to bed closure, in other words a reduction in the quantity of publicly funded health services provided by the Health Services, as a potential effect of the budgetary strain on the Health Services as a result of escalating agency fees and increased reliance on agency

[7] Agency nursing staff state that their reasons for joining an agency include the ability to 'pick and choose' which hospitals and wards / units they will work in and the ability to secure regular preferred shifts (ie 'pick and choose' between shifts offered): Research International 'Report of the Focus Group Consultation' in Appendix 6 to Final Report, at page 196.

nursing staff. While bed closures are an option of last resort for the Health Services as a result of the budgetary strain, the effects of budgetary strain may be far more subtle and insidious. In particular, the range of health services offered by the Health Services may be reduced in preference to closing beds. For example, a clinic operated by a public health service may reduce its hours of operation in response to escalating agency fees, rather than closing beds.

The NRRC endorses the view that hospitals could expect considerable financial benefits to flow from containing the escalating agency fees and reducing reliance on nurse agency staff in the following terms (at page 83):

> It can be anticipated that minimising agency use will offer significant financial benefits for hospitals. It is difficult to calculate the cost to hospitals of employing agency nurses in place of permanent workers. A complicating factor is that changes to hospitals by agencies do not only reflect staff replacement, but also on costs and the cost of differential payment rates for certificated staff. For example, one major metropolitan hospital reported that it has to budget 60% on costs for agency staff. Nonetheless, significant savings could be anticipated as more permanent staff are employed.

These cost savings will be passed through by the Health Services to the consumer in the form of an increased range of health services or an investment in maintenance, replacement or upgrading in the infrastructure used to deliver patient care. As the Health Services that are to participate in the proposed tender are all public (or non-profit) health services, these Health Services will pass through cost savings for the benefit of consumers.

By containing total agency fees for the provision of temporary agency nursing staff, the exclusive tender proposed by HPV can be expected to reduce the Health Services' budgetary strain and so increase, or prevent a reduction in, the range of publicly funded health services provided by the Health Services and improve, or ameliorate any negative implications for, patient care. We submit that this represents a significant public benefit.

6.4 Countervailing market power

As a result of the price inelasticity of demand for nursing services) and the supply shortage (which reduces the public hospitals' ability to acquire nursing services from sources other than nurse agencies), individual Victorian metropolitan public hospitals have no countervailing market power in their acquisition of agency nursing services. The proposed exclusive tender for the provision of agency nursing services to all the Health Services (that is, the Victorian metropolitan public hospitals) will redress, to some extent, the inequity of bargaining power between the Health Services and the nurse agencies, in particular those nurse agencies within the Staffing Australia Group. As already discussed, as the Health Services are all public (or non-profit) health services, these Health Services will pass through the cost savings associated with the countervailing market power

provided by the proposed tender for the benefit of consumers.

The tender process offers public benefits by delivering countervailing market power to the Health Services.

Simon Uthmeyer
Partner
Phillips Fox
4 February 2002

Attachment

Details of parties to the proposed arrangements and on whose behalf this application is made

	Name of Health Service	Type of Health Service	Address of Health Service	Hospitals that are part of this Health Service	Type of Hospital[8]
1	Melbourne Health	Metropolitan Health Service	Level 10, Connibere Building Royal Melbourne Hospital Flemington Road Parkville, Vic 3052	Royal Melbourne Hospital Melbourne Extended Care & Rehabilitation Service	Both public
2	Western Health	Metropolitan Health Service	C/- Western Hospital Gordon Street Footscray, Vic 3011	Sunshine Hospital Western Hospital Williamstown Hospital	All public
3	Northern Health	Metropolitan Health Service	201 Bell Street Preston, Vic 3072	Broadmeadows Health Service Bundoora Extended Care Centre Northern Hospital	All public

[8] The public hospitals listed here may provide some private services.

	Name of Health Service	Type of Health Service	Address of Health Service	Hospitals that are part of this Health Service	Type of Hospital[8]
4	Austin & Repatriation Medical Centre	Metropolitan Health Service	Studley Road Heidelberg, Vic 3084	Austin Campus Repatriation Campus Royal Talbot Rehabilitation Centre	All public
5	Royal Victorian Eye & Ear Hospital	Metropolitan Health Service	32 Gisborne Street East Melbourne, Vic 3002	Royal Victorian Eye & Ear Hospital	Public
6	Peter MacCallum Cancer Institute	Metropolitan Health Service	St Andrews Place East Melbourne, Vic 3002	Peter MacCallum Cancer Institute	Public
7	Bayside Health	Metropolitan Health Service	C/- The Alfred Commercial Road Prahran, Vic 3181	Alfred Hospital Caulfield General Medical Centre Sandringham & District Memorial Hospital	All public
8	Eastern Health	Metropolitan Health Service	C/- Box Hill Hospital Nelson Road Box Hill, Vic 3128	Angliss Health Service Box Hill Hospital Maroondah Hospital Peter James Centre Yarra Ranges Health Service	All public

	Name of Health Service	Type of Health Service	Address of Health Service	Hospitals that are part of this Health Service	Type of Hospital[8]
9	Southern Health	Metropolitan Health Service	Monash Medical Centre Clayton Road Clayton, Vic 3168	Dandenong Hospital Hampton Rehabilitation Hospital Kingston Centre Monash Medical Centre - Clayton Monash Medical Centre - Moorabbin Cranbourne Integrated Care Centre	All public
10	Peninsula Health	Metropolitan Health Service	PO Box 52 Frankston, Vic 3199	Frankston Hospital Mt Eliza Aged Care & Rehabilitation Service Rosebud Hospital	All public
11	Dental Health	Metropolitan Health Service	407 Royal Parade Parkville, Vic 3052	Dental Health Services Victoria	Public
12	Women's & Children's Health	Metropolitan Health Service	Level 1, 132 Grattan Street Carlton, Vic 3053	Royal Children's Hospital Royal Women's Hospital	Both public

	Name of Health Service	Type of Health Service	Address of Health Service	Hospitals that are part of this Health Service	Type of Hospital[8]
13	Sisters of Charity Health Service	Denominational hospital	104 Studley Road Kew, Vic 3101	St Vincent's Hospital Caritas Christi Hospice Prague House St George's Health Service	All non-profit private, providing some public services
14	Barwon Health	Public Hospital	272-322 Ryrie Street Geelong, Vic 3220	The Geelong Hospital The Grace McKellar Centre North Geelong Community Rehabilitation Centre John Robb Aged Care Facility Grovedale Aged Care Facility Belmont Community Rehabilitation Centre and Belmont Day Activity Centre St Phillips Day Activity Centre Dorothy Thompson Day Activity Centre	All public