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4 February 2002

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A/g General Manager
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Australian Competition &
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FILE No
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cc:

Mr Gavin Jones
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DICKSON ACT 2602

Dear Mr Grimwade

HPV Application for Authorisation Nos A90811 & A90812 - Further Submission

I refer to the Commission's meeting with Steve Sant, Chief Executive Officer of Health Purchasing Victoria, and Rachel Olliffe, of our office, on 20 December 2001, in which the Commission requested additional information on the public benefits associated with the proposed tender for the acquisition of nurse agency services.

I attach for your consideration our further submission regarding the public benefits of the proposed tender. In addition to a detailed consideration of the public benefits likely to result from the proposed tender, the attached submission also addresses:

- the role of the nurse agency issue in the current nurse supply shortage in Victoria;
- market definition; and
- market analysis.

In addition to the further submission, I also attach for your convenience of reference the following documents referred to in the attached further submission:

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Australian COMPETITION & CONSUMER COMMISSION CANBERRA - 5 FEB 2002

- 1 the Australian Industrial Relations Commission decision in *Victorian Hospitals' Industrial Association and Australian Nursing Federation*, dated 31 August 2000;
- 2 the Nurse Recruitment and Retention Committee's Final Report published in May 2001; and
- 3 the Government Response to the Nurse Recruitment and Retention Committee published in June 2001.

It should be noted that the proposed tender has not been amended subsequent to the changes advised in my letter to you of 16 January 2002. I will provide you with further information on the proposed written direction as soon as it becomes available, as requested in your letter of 24 January 2002.

If you have any further queries regarding my client's application for authorisation or should you wish to discuss the content of the attached further submission in greater detail, please contact me.

Yours sincerely



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Encl.

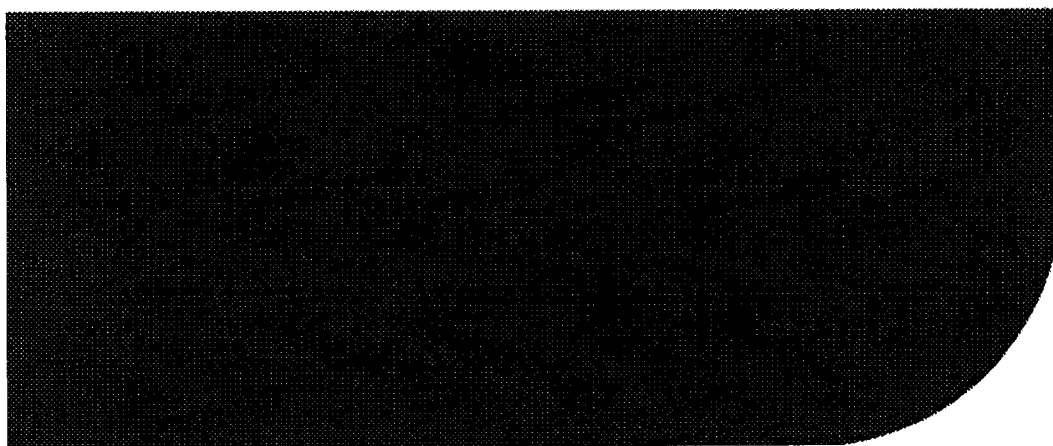


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HPV Applications for authorisation Further submission to ACCC

4 February 2002



This further submission is made on behalf of Health Purchasing Victoria ('HPV') to supplement the Application for Authorisation Nos. A90811 & A90812, lodged with the Commission by HPV on 30 November 2001.

This further submission has the following parts:

1. Summary
2. Background
3. Proposed conduct
4. Market definition
5. Market analysis
6. Why increased nurse agency fees and wages for agency nurses will not increase the supply of nurses
7. Why the recommendations made by the NRRC and accepted by the Victorian Government will not solve the nurse agency problem without any need for a tender
8. Public benefits of the proposed tender

1 Summary

We will demonstrate in this further submission that the escalating fees charged by nurse agencies and the escalating wages paid by these agencies to nurse agency staff plays a critical role in perpetuating and exacerbating both the exodus of nurses from the Victorian nursing workforce and the reduction in hours of availability by those that remain in the profession. In other words, the escalating fees charged by nurse agencies exacerbate the nurse supply shortage.

Therefore, the proposed exclusive tender by HPV on behalf of the Melbourne and Geelong health services named in the Attachment ('Health Services') for the provision of nurse agency staff is an essential measure designed to break the self-perpetuating cycle of attrition and reduction in working hours and, in so doing, foster the successful implementation of the recommendations of the Australian Industrial Relations Commission ('AIRC'), in its enterprise bargaining decision of 31 August 2000, and the Nurse Recruitment and Retention Committee ('NRRC'), in its Final Report on the Victorian nurse shortage published in May 2001, to address the nurse supply shortage. We submit that, in the absence of authorisation of the proposed exclusive tender for the provision of nurse agency staff, the successful implementation of those recommendations will be significantly hampered. In other words, we submit that the proposed exclusive tender by HPV will provide a significant benefit to the public by playing a vital role in remedying the nursing shortage in Victoria, with all the concomitant costs that that shortage involves.

In addition, the escalating nurse agency fees and the resultant increased reliance on nurse agency staff has negative implications for:

- the cost of health services to the public, whether funded privately or by the public purse;
- the range and quality of other goods and services provided by the Government at public expense to improve public welfare;

- the range of health services offered by the Health Services;
- the quantity of publicly funded health services made available by the Health Services for the community (ie, the number of publicly funded beds); and
- the quality of patient care.

By controlling nurse agency fees, in particular the wage component passed on to nurse agency staff, and so reducing or preventing an increase in the reliance on nurse agency staff in public hospitals, the tender will deliver considerable public benefits in respect of the above matters.

HPV does not consider that there is no role for nurse agencies in the supply of nurses by the Victorian public and private health sectors. Rather, HPV considers that the exclusive tender will return nurse agencies to their traditional role, as a supplier of nursing services to fill temporary vacancies. As will be discussed below, the nurse agencies currently have an expanding role in filling permanent nursing staff vacancies as a result of the escalating nurse agency fees and remuneration for agency nurses, against the background of the nurse supply shortage.

2 Background

The applications for authorisation made by HPV in relation to the proposed exclusive tender for the provision of nurse agency staff to the Health Services are lodged in the context of:

- a current shortage of nurses in Victoria; and
- a range of measures adopted by the Victorian Government and Victorian health services with respect to the recruitment and retention of nurses by those health services.

In February 2000, the Victorian Minister for Health established the NRRC to examine the existence of a Victorian nurse shortage and provide advice to the Minister on matters in relation to the registered nurse workforce in Victoria. The NRRC published its Final Report in May 2001 (copy attached). The NRRC concluded that there was a nurse shortage in Victoria (at page 1):

There is widespread support for the view that there are insufficient nurses staffing the Victorian public health care system. The Department of Human Services, in its *Nurse Labourforce Projections, Victoria 1998-2009* report of 1999, estimated that with current levels of demand for health services, Victoria would face a shortfall of 5,500 registered nurses by 2008. Department of Human Services data demonstrates that, of 69,000 nurses with current registration in Victoria, more than 13,000 are not currently employed in the nursing workforce.

Shortages were identified by the NRRC in general areas as well as the specialties of critical care, accident and emergency, mental health, aged care, neonatal intensive care and rural midwifery, and the major shortage identified was in experienced qualified nurses: Final Report at page 41.

The Final Report made over 80 high priority, 80 medium priority and 55 long term priority recommendations designed to address:

- the attraction and recruitment of nurses;
- the exodus of nurses from the workforce; and
- the retention of qualified, experienced nurses within the public hospital sector.

The Victorian Government published its response to the NRRC's Final Report in June 2001 (copy attached), in which it accepts the greater majority of the NRRC recommendations with respect to nurse retention and recruitment.

2000 Enterprise bargaining agreement

In addition, running parallel to the work of the NRRC was a round of negotiations by the Australian Nursing Federation ('ANF') and the Hospital Services Union of Australia ('HSUA') for a multi-employer enterprise bargaining agreement following the expiry of existing 1997 public sector certified agreements on 30 September 2000. The negotiations resulted in an industrial dispute between ANF and the Victorian Hospitals' Industrial Association ('VHIA'), representing public sector health services, which was forwarded to the AIRC. As the ANF's log of claims related to both:

- 1 traditional industrial issues; and
- 2 recruitment and retention issues,

Commissioner Blair's enterprise bargaining decision of 31 August 2000 (copy attached) considered issues of nurse retention and recruitment.

Commissioner Blair concluded that there was a Victorian nurse shortage, in the following terms (at paragraph 144):

The Commission, after having considered all the arguments of the parties would provide the following recommendations on the very clear understanding that what is now the outcome of these proceedings is a package, a package that is designed to deal with the acknowledged crisis within the public hospital sector. It is true that there is some argument by some parties that a crisis does not exist. However, the overwhelming evidence before this Commission is that there is a crisis in nurse recruitment and retention and workload to the extent that if it is not addressed now with measures to deal with the short term issues as well as providing some measures to deal with the long term issues, then the nursing crisis will get worse. Those who choose to say that there is not a nursing crisis, in the Commission's view, are in a state of denial.

The recommendations of Commissioner Blair in the decision, which were certified as a multi-employer certified agreement for employment of nurses in the public health sector, included recommendations with respect to issues of recruitment and retention. For example, Commissioner Blair recommended fixed nurse patient ratios and the temporary closure of beds where those ratios could not be met and the use of agency nursing staff only for unexpected absences, such as sick leave.

The main nurse agencies currently providing nursing services to the Victorian public and

private health sectors are (in no particular order):

- Code Blue
- Nurse agencies in Staffing Australia Group
- Twin Hills
- Critical Solutions
- AustraHealth
- Malvern Nursing Agency
- Prime
- Alpha
- Melbourne Nursing Agency
- Belmore
- Time Critical
- Macedon
- PRN
- PCC
- Peninsula
- Colbrow
- Australian Nursing Solutions
- Nurse Bank Australia

The companies in the Staffing Australia Group own the following nurse agencies (in no particular order):

- Care nursing agency
- Ace nursing agency
- Clover nurses agency
- Medihealth Mental health specialists
- Western nursing agency
- Teamwork
- Gordon
- Clinical Nurse Specialists

The 'nursing employment services network' comprised of these agencies is known as Nursing Australia. Further information on the nurse agencies in the Staffing Australia Group is available from Nursing Australia's website at www.nursingaustralia.com.au.

Use of agency nursing staff

With respect to the reliance by Victorian health services on agency nursing staff, the NRRC in its Final Report comments on the 'paucity of data on workforce variation between studies' at page 36:

Currently the Department of Human Services has no consistent data on the number of nurses working in the public hospital system. It cannot establish the number of part-time workers, the split between divisions, the number of casual nursing staff or the number of agency staff employed by public hospitals with any confidence.

Some indication of the level of reliance on agency nurses by Victorian health services can be gained by considering the percentage of the Victorian nursing workforce that work as agency nurses. The NRRC states at page 83:

Department of Human Services figures indicated that agency nurses (nurses working for an agency as their principal form of employment) comprised 3.5% of the Division 1 nursing workforce, while a further 14% worked for agencies as a second

or third means of employment. In total 7,133 working Division 1 nurses were estimated to engage in some form of agency work (Department of Human Services 1999²). The workforce percentages are similar for nurses in Divisions 2 and 3.

Despite the lack of data on the reliance by hospitals on agency nurses, the NRRC conclude that reliance on agency nursing staff is increasing at page 82:

Agency nurses have traditionally been employed in hospitals to cover ad hoc or unplanned periods of absence of permanent staff, for example due to sick leave, family leave or unpaid leave.

Over recent years the use of agency nurses appears to have increased significantly, although this was unable to be quantified due to the lack of historical workforce data.

The NRRC concludes that the increasing reliance on agency nurses results from the difficulty encountered by hospitals in filling vacancies (at page 83):

It was also reported through both the hospital submissions and the nurse forums that the increase in use of agency nurses has been largely due to an inability of hospitals to recruit nurses to permanent positions.

This interdependence between the ability of hospitals to fill permanent positions and the level of reliance by hospitals of agency nurses is supported by a comparison of estimates of the level of reliance on agency nurses in our submission dated 30 November 2001 and the data with respect to the inability of hospitals to fill permanent positions. You will recall, that in our submission we provided HPV's best estimate of the level of reliance by Victorian health services on agency nurses. We estimated that Victorian metropolitan health services generally satisfy approximately 5% of their nursing staff requirements by engaging agency nurses. The nurse agencies provide a much greater proportion of the health services requirements for nursing services for wards such as the emergency ward and the critical care ward, however, with the level of reliance on agency nurses increasing to as much as 50%. This can be compared to conclusions drawn by the NRRC (at page 38) from data produced by a state-wide vacancy survey undertaken in 1999 across both the public and private sectors²:

The data suggested that the majority of metropolitan hospitals were having difficulty filling vacancies, particularly in specialist areas such as critical care and inpatient mental health services, and suggested a shortage of experienced, qualified nurses.

Thus, it is safe to assume that if the difficulty of filling permanent nursing positions increases, the level of reliance on agency nurses will increase.

Nurse pay differentials

Our submission of 30 November 2001 discussed the wage differential for agency nurses as compared to other nurses. By way of reminder, currently health services pay nurse agencies between 1.5 and 3 times the Award / Enterprise Bargaining Agreement rate for the provision of nursing services. The percentage of nurse agency fees that are passed through to agency nurses as remuneration varies from nurse agency to nurse agency. By

¹ *Nurse Labourforce Projections Victoria 1998-2009*, Public Health & Development Division, Department of Human Services, Melbourne.

² *Nursing Workforce Survey 1999*, Australian College of Nurse Management Inc, Melbourne

way of example, Southern Health's best estimate of the percentage of agency fees of a significant supplier of its nurse agency service requirements that is paid to agency nurses as remuneration is 53% (ie the agency's commission fee is 47%).

The following table sets out some examples of the Award / EBA rate paid by Southern Health for a Division 1, Grade 2, Year 5 nurse with graduate certificate allowance, as compared to the nurse agency fees and Southern Health's 'best estimate' of nurse remuneration where Southern Health obtains a Division 1, Grade 2, Year 5 nurse with graduate certificate allowance from a significant supplier of its nurse agency service requirements.

Shift	Award / EBA rate	Nurse agency fees	Agency nurse wages
Afternoon shift Monday to Friday for Division 1 (Grade 2, Year 5 with graduate certificate allowance) nurse	\$24.69 per hour	Up to \$88.39 per hour	Up to \$44.85
Night shift Monday to Friday for Division 1 (Grade 2, Year 5 with graduate certificate allowance) nurse	\$38 per hour for non-permanent night shift worker \$48 per hour for permanent night shift worker	Up to \$120 per hour	Up to \$63.60
5 shifts in average rotating roster cycle for Division 1 (Grade 2, Year 5 with graduate certificate allowance) nurse	Total cost of \$1,265.55	Total cost of \$4,429.46	Total remuneration of \$2,347.61

It should be noted that nurse agency fees and the commission fees deducted from these fees to determine agency nurse remuneration vary from nurse agency to nurse agency. The figures set out in the table above are provided for one nurse agency only, a significant supplier of nurse agency services to Southern Health. If additional information of this type is required in relation to other nurse agencies, this can potentially be provided on request.

3 Proposed conduct

The proposed conduct will be briefly revisited here, incorporating the revisions we advised the Commission of in our letter of 16 January 2002.

It is proposed that HPV will call and award an exclusive tender for the provision of agency nursing services to the Health Services listed in the Attachment by the successful tenderer(s). It is proposed that HPV will give a written direction under s132(2)(c) of the *Health Services Act* 1988, requiring each Health Service (other than the Sisters of Charity Health Service) to acquire all their agency nursing staff requirements exclusively from the successful tenderer(s) and appointing HPV as their agent to contract on their behalf with the successful tenderer(s). The Sisters of Charity Health Service will enter into a standard form agency contract agreement with HPV appointing HPV as its agent for the purposes of the tender process and agreeing to acquire agency nursing services exclusively from the successful tenderer(s).

The Tender Conditions (as set out in the revised Request for Tender provided to the Commission as an attachment to our letter of 16 January 2002) require that a conforming tender include an agreement to remunerate agency nurses at the Award / EBA rate. Under the Tender Conditions, a tender that does not conform with this requirement will be a non-conforming tender, which HPV, in its discretion, may disregard. Tenderers will, therefore, now be requested to tender with respect to:

- the agency commission fee for the provision of nursing services; and
- any discount for volume or early payment, which is offered.

The Tender Conditions with respect to the commission fee have not been amended since our application for authorisation dated 30 November 2001. Similarly, the criteria for assessing the tenders have not been amended since the application date.

HPV will enter into standing offer contracts, on behalf of the Health Services, with the successful tenderer(s) for the provision of agency nursing services on the terms and conditions set out in the tender. A copy of the revised Services Agreement was attached to our letter of 16 January 2002.

4 Market definition

In order for the Commission to assess whether the proposed conduct would be likely to result in a public benefit that would outweigh the detriment to the public from any lessening of competition it will be necessary for the Commission to consider the issue of market definition.

Defining the market

The market concept was explained by the Tribunal in *Re QMCA and Defiance Holdings* (1976) ATPR 40-012 (at 17,247) ('QMCA'), as follows:

A market is the area of close competition between firms or, putting it a little differently, the field of rivalry between them. (If there is no close competition there is of course a monopolistic market). Within the bounds of a market there is substitution - substitution between one product and another, and between one source of supply and another, in response to changing prices. So a market is a field of actual and potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive.

The area of close competition between firms or the field of rivalry between them is defined by reference to the 4 dimensions of a market: product, geographic, functional and time.

The market must be defined by reference to the conduct to be assessed:

...the process of identification of the relevant market must be carried out keeping in mind the object of doing so. (The Full Federal Court in *Australian Meat Holdings Pty Ltd v Trade Practices Commission* (1989) ATPR 40-932)

Put differently, a purposive approach is taken to market definition by Australian trade practices law. A market definition may be different depending on the conduct to be assessed. To assess the public benefits and potential anti-competitive detriments of the proposed conduct it is necessary to define the product and geographic dimensions of the market.

Product market

Delineation of the relevant product market requires identification of the goods and / or services supplied or acquired by the corporation engaging in the conduct to be assessed and the substitute products, both on the demand-side and on the supply-side.

The conduct under consideration here is an exclusive tender for the acquisition by public hospitals of nursing staff from nurse agencies, pursuant to a direction from HPV under the *Health Services Act 1988* requiring each of the relevant health services to acquire all their agency nursing staff requirements from the successful tenderer(s).

Both public and private hospitals acquire nursing staff services through a combination of:

- direct acquisition of individual nurses (permanent full-time and part-time and casual);
- acquisition from their own nurse banks for temporary nursing staff requirements; and
- acquisition from nurse agencies for temporary nursing staff requirements.

Where a hospital acquires nurses directly, the product acquired is nursing services. By contrast, where a hospital acquires nursing services from nurse agencies or its own nurse banks, the product consists of a package of services, that is, nursing services *and* a co-ordinatory service and (in the case of nurse agencies) may also include administrative services that reduce the transaction costs associated with the use of nursing services in the production of health services. A nurse agency or nurse bank provides nursing services but it also provides the service of co-ordinating demand and supply, matching the availability of individual nursing staff with the hospital's individual requirements. In addition, a nurse agency may also provide administrative services, by being responsible for PAYE contributions, superannuation guarantee and workcover obligations, for example.

Substitution

The three types of nursing services set out above are substitutable. For example, as discussed in the material under the heading Background, where a hospital is not able to fill permanent vacancies this may result in increased reliance on agency nurses.

However, nursing services from these 3 sources are not perfect substitutes. Nurses acquired directly, or from a hospital's nurse bank, generally know the physical site, the procedures and the type of patients in the ward / unit in which they are to work, and nurse bank nurses' qualifications and experience are generally known. By contrast, agency nurses in most cases do not know the physical site, the procedures and the type of patients

in the ward / unit in which they are to work and often agencies are unable to provide nurses with appropriate qualifications and / or experiences for the shift³. This has implications for the quality of patient care, with the result that hospitals prefer nurses acquired directly or through their own nurse banks to agency nurses.

Specialisation, experience and qualifications

In addition, it is necessary to consider the significance of nursing staff with different levels of expertise and specialisations. Nursing staff with different experience and qualifications provide complementary nursing services. For example, the nursing services provided by a Division 2 nurse may be used in combination with the nursing services provided by a Division 1 nurse in a ward or unit, to meet the requirements of the ward or unit in relation to a combination of different nursing tasks efficiently. Further, a particular public health service may require both the nursing services of a nurse with experience in coronary care and the nursing services of a nurse with experience in critical care to provide health services to the public. We note that the issues raised by a consideration of the benefits and detriments of the proposed conduct are relevant to nurses generally, regardless of specialisation, qualifications and experience.

Sub-markets

We submit that there is one market for the supply of nurses to the public and private health sectors which encompasses nurses acquired directly by the health services from the nursing workforce, nurse bank nurses and agency nurses. However, there is a discontinuity in substitution of the type described by the Australian Competition Tribunal in *Re QMCA and Defiance Holdings* (1976) ATPR 40-012:

Sub-markets are more narrowly defined, typically registering some discontinuity in substitution possibilities. Where the defining feature of a market is the existence of close substitutes (whether in demand or supply), the defining feature of a sub-market is the existence of still closer and more immediate substitutes. Sub-markets may be especially useful in registering the short-run effects of change; but they may be misleading if used uncritically to assess long-run competitive effects.

We submit that the nursing services supplied by hospital employed nurses and the nursing services supplied by nurse banks are in one sub-market of the market for the supply of nurses, and the nursing services supplied by nurse agencies is in another sub-market. We consider this is an appropriate market definition for considering the proposed conduct due to:

- the marked discontinuity in substitution between the nursing services provided by hospital employed nurses and nurse banks and the nursing services provided by nurse agencies, due to the comparative quality implications of obtaining nurses from each of these 3 sources;
- the inter-relationship between total demand for nursing services and demand for nursing services supplied by nurse agencies; and

³ Supporting material for each of these assertions is provided in discussion below.

- the inter-relationship between the level of supply of nurses in permanent employed positions and through hospital nurse banks, and the level of supply of nurse agency nurses, which arises as a result of the nurse supply shortage.

Derived-demand for agency nursing services

The demand for nursing services supplied by nurse agencies is a derived-demand equal to total demand for nursing staff services less the nursing staff services provided by nurses in permanent employed positions and temporary nursing staff services acquired from individual hospital nurse banks. Therefore, the demand for nursing services supplied by nurse agencies is dependent on:

- total demand for nursing services; and
- the level of supply of nursing services provided by nurses in permanent positions and through hospital nurse banks (that is, the demand for agency nurses is the residual demand).

Further, as will be established below, the existence of a nurse supply shortage means that there is a significant inter-relationship between the number of nurses listed with nurse agencies, and the number of nurses employed in permanent positions and listed with nurse banks ($S_{\text{nurses}} = f_n$ (Stock of trained nurses employed + net flow of new nurses entering / exiting workforce) x hours worked). An increase in the number of nurses listing with nurse agencies or in the hours of availability of nurses for shifts through nurse agencies will be accompanied by a reduction in the number of nurses in permanent positions with hospitals and listed with nurse banks or in the number of hours of availability of permanently employed nurses or nurses listed with nurse banks. The hospitals (through both permanent positions and their individual nurse banks) and the nurse agencies are competitors in the acquisition of nurses as a result of the nurse supply shortage. Further, the competition between hospitals and nurse agencies in the acquisition of nurses from the Victorian nurse workforce has the potential to influence the level of demand for agency nurses because the demand for agency nurses is a derived-demand.

Defining a market for the supply of nurses with 2 sub-markets determined by reference to directly acquired nursing staff services for permanent positions and co-ordinated temporary nursing staff services would not facilitate consideration of these significant demand and supply inter-relationships that are integral to an assessment of the public benefits and potential anti-competitive detriments of the proposed conduct.

Geographic market

The market for the supply of nurses is a Victorian market. The area of close substitution between the 3 sources of nursing services is Victoria. Defining the geographic market as a Victorian market facilitates an assessment of the Victorian supply shortage, the role of the nurse agencies operating in Victoria in the supply shortage and the proposed conduct.

The relevant market for the purposes of assessing the public benefits and potential anti-competitive detriments of the proposed conduct is a market for the supply of nursing services in Victoria.

5 Market analysis

It has been suggested in the public forum that nurse agencies are "just like other medical businesses" such as medical clinics and that, in the context of a nurse shortage "the market sorts out what is a reasonable price". Indeed that "[t]his is how all free markets work": Dr Sarah Russell "Nurses are simply setting a market price" *The Age* Thursday 10 January 2002.

We submit that, as a result of demand inelasticity (particularly in those specialist areas in which the nurse supply shortage is most acute, such as critical care, and accident and emergency) and the prevailing conditions in the market for the supply of nurses, the market for the supply of nursing staff can be distinguished from the markets in which "other medical businesses" operate. We submit that, contrary to what can generally be expected in a free market absent market failure, the operation of market forces and pricing signals will not drive the market for the supply of nurses back towards equilibrium with supply of nurses equal to demand. Rather than resulting in an expansion in supply of nurses and a reduction in demand by the public health sector, the escalating fees charged by nurse agencies for the provision of nursing staff can be expected to result in further curtailment of supply (ie there is a backward sloping supply curve in the market for the supply of nursing services). Combined with relatively invariant demand for nursing staff, the increasing fees charged by nurse agencies can be expected to drive the market for the supply of nursing services further and further away from equilibrium via a reduction in working hours and retirement. Hence, whilst an adequate level of wages is important, they are not the means by which the nurse shortage can be overcome.

Why increased nurse agency fees and wages for agency nurses will not increase the supply of nurses

The 3 sources of supply of nurses in Victoria are:

- 1 the tertiary education sector;
- 2 net migration; and
- 3 nurses currently registered in Victoria.

Consistent with this, the NRRC's Final Report identifies the following 3 sources of new or additional supply from which nurses can be recruited (at page 21):

- 1 the tertiary education sector;
- 2 net migration; and
- 3 re-entry to the workforce (a significant proportion of nurses currently registered in Victoria are not currently participating in the Victorian nursing workforce: see Final Report at page 31 and extract above from Final Report under 'Background').

Addressing the Victorian nurse shortage therefore involves *recruitment* from these 3 sources of supply and *retention* of those nurses currently registered in Victoria and participating in the Victorian nursing workforce.

Net migration plays a negligible role as a source of supply. The Final Report states (at page 33) that the cost of sponsorship and migration agents means hospitals use migration as a last resort. Further, migration is not a sustainable source of supply as the nurse shortage is a global phenomenon (see page 33 of the Final Report). As a result, migration can be ignored for present purposes in examining the effect of escalating nurse agency fees and increasing wages for agency nurses on supply.

Therefore, to assess the effect of escalating nurse agency fees and increasing wages for agency nurses on the level of supply of nurses in Victoria, it is necessary to examine the effect of those increasing fees and wages on:

- graduate recruitment; and
- the level of workforce participation by nurses currently registered in Victoria (ie, the extent of re-entry by registered nurses (if any) and the effect on retention).

We will examine the effect of increasing agency fees and wages for agency nurses on the level of workforce participation by registered nurses first and return to examine the effect on graduate recruitment.

Increasing agency fees and wages for agency nurses reduces the level of workforce participation by nurses currently registered in Victoria.

The Final Report by the NRRC refers (at page 35) to a 1999 nursing report that found that in the period 1996 to 1998 there was no change in the number of registered nurses in Australia from a decade earlier, however, there was a steady decline in the number of available hours worked by nurses. The Report also refers to research undertaken by Research International on the current and future workforce participation intentions of nurses and states (at page 31):

...the NRRC notes the findings of the focus group research undertaken by Research International which found that, 'when asked their future intentions, most (nurses) intend to either scale back their participation, or plan to leave within the next 5-10 years' (Research International 2000, Appendix 6).

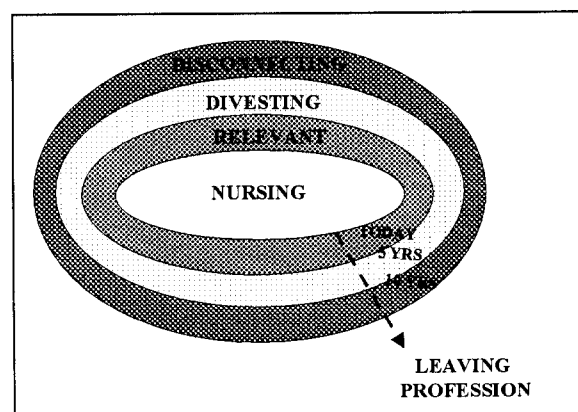


Diagram from the Research International 'Report of the Focus Group Consultation' in Appendix 6 of the Final Report (see page 179): "While nursing has been, or is, relevant to their context today for a majority of nurses, the trend is to be divesting responsibility within the next five years and to be somewhere else (that is, disconnected) within the next ten years."

The Final Report (at page 31) refers to the trend towards casualisation of the nurse workforce through casual work and self-employment (ie, through nurse agencies) and states that this is in part due to societal changes which have led to 'greater expectations in balancing a career with life outside of work'. For reasons of family, education, age and health, there are an increasing number of men and women who wish to reduce hours below the full-time 'career' nurse requirements that are currently 'the norm' in the public health sector.

So, nurses generally and those listing with agencies, in particular, are likely to be seeking to reduce their hours with a view to placing greater emphasis on life outside work. As discussed in our submission dated 30 November 2001, the escalating wages paid by nurse agencies for nursing staff facilitates a reduction in hours by nurses that otherwise may not be financially able to reduce their availability, thereby reducing the overall supply of nurses. The increased wages for agency nurses provides an incentive for nurses to list with agencies and reduce their available hours for permanent shifts in hospital employment.

The supply curve can, therefore, be represented diagrammatically as follows:

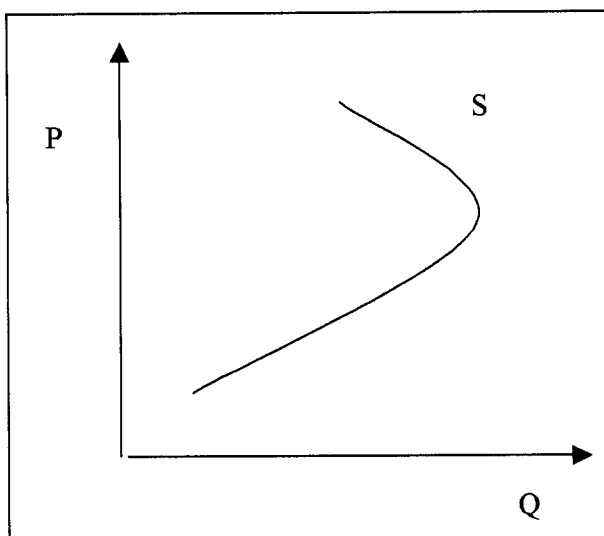


Diagram 1 - Supply curve in market for supply of nurses

As the level of supply in the market for the supply of nurses reduces in response to an increase in nurse wages, it can be assumed that the market for the supply of nurses is functioning on the backward sloping portion of the supply curve depicted in Diagram 1.

What about demand?

Demand for nurses in the public health sector is relatively price inelastic, particularly in specialist areas, such as critical care and accident and emergency, in relation to which the nurse shortage is most acute. Demand does not respond to the fees charged for the provision of temporary nursing staff by nurse agencies.

There are a number of reasons for this, including:

- 1 **Critical care inter-hospital transfers.** There is strong evidence that the inter-hospital transfer of a critical care patient, which occurs where a hospital does not

have a critical care bed, has *severe adverse effects* on patient outcomes. Public hospitals are reluctant to transfer critical care patients and, accordingly, are reluctant to close critical care beds.

- 2 **Funding arrangements for public hospitals.** Complex arrangements with respect to the funding of hospitals, including case mix funding and budget allocation, is a recognised reason for hospital reluctance to close beds. The NRRC refers to funding arrangements as a reason that bed closures are rare (at page 42 of the Final Report):

Where the workload was considered too high, and additional staff could not be provided, an obvious strategy to ensure reasonable workloads was to close beds. Even where a ward / unit was successfully using a workload measurement tool such as Trendcare, and therefore had evidence that the ratio was too high, beds were rarely closed. This situation was imputed to the use of the casemix funding formula and budget allocation.

Operating as public hospitals' primary funding allocation tool, casemix is an episodic based remuneration system. In effect, a public hospital is remunerated under casemix for each weighted episode of care up to a certain maximum amount.

Under casemix, each public hospital may have several Weighted Inlier Equivalent Separation ('WIES') targets depending on the funding stream (ie public, veterans affairs etc). A hospital may have a total WIES target allocated to them of, say, 10,000 WIES. To determine the hospital's actual WIES, every patient's episode of care is assigned a Diagnosis Related Grouping ('DRG') based on the diagnosis and treatment(s) involved. Every DRG has a standard associated weighting that is based on relative average costs, usually obtained through a cost weight study. In addition, every DRG and episode of care combination is assessed for excessively long or short (outlier) lengths of stay to determine 'inlier equivalence'. For example, a particular type of treatment may have an associated DRG weighting of 0.6 for a standard 'inlier' case. In the event that an episode of care has an unusually low or high length of stay, a determination is made as to the case's 'inlier equivalence'. An episode of care that involves a 2 day stay where the usual expectation is for a 10 day stay is clearly outside the 'normal' range. Conversely, an episode that involves a 10 day stay where the usual expectation is for a 1 day stay is also outside the 'normal' range. The weighting for these episodes is therefore adjusted according to the rules for this DRG to reflect the relatively high or low length of stay. The DRG weight and the 'inlier equivalence' is multiplied to determine the actual WIES for each episode of care. The hospital's total number of WIES is determined by summing the WIES for each episode of care. The price for each care stream is subsequently multiplied by the hospital's WIES for the relevant care stream to determine the funding for the hospital assuming that the hospital does not exceed its capped funding.

Victorian metropolitan public hospitals generally operate substantially below their WIES target. Therefore, the closure of beds by one of these public hospitals will result in fewer episodes of care, a reduction in the hospital's WIES and, therefore, a reduction in the hospital's casemix funding. However, a substantial proportion

of public hospitals' costs are fixed costs and do not vary with episodes of care. A hospital must operate at or above a certain level of occupancy to achieve the economies of scale necessary to recover its fixed costs. Thus, a public hospital will be reticent to close beds as a result of casemix funding.

In addition to case mix funding, public hospitals are also paid bonus funding under the 'Quality Framework' and 'Quality and Funding Guidelines' for quality performance against targets set individually for each hospital. Hospitals have a series of monthly, quarterly and bi-annual targets, with bonus payments made in arrears for each month. Significant funding is at stake each month. The monthly funding bonus by hospital is as follows: the Alfred, \$220,535; Austin and Repatriation Medical Centre, \$160,734; Monash Medical Centre, \$165,400; Frankston, \$115,883; the Royal Melbourne, \$189,385; St Vincent's Hospital, \$144,488. Each public hospital must meet all targets for the month to receive the funding bonus at stake for the relevant hospital. As achieving the targets requires a commitment to resources, public hospitals budget on receiving 60-70% of their potential funding bonus for the year. Bed closure makes it very difficult for a public hospital to meet all targets for the month, as required to receive its funding bonus. Consider, for example, the following bonus funding targets:

- 2.1 **Ambulance bypass** Our submission dated 30 November 2001 referred to the reduction in government funding that occurs where a health service exceeds its allocated number of ambulance bypasses in a month, occurring where there is not an available bed in the emergency ward. There is strong evidence that, in order to ensure that a hospital meets this target, the hospital needs to run at 80-90% occupancy. Bed closure makes it very hard to meet this target. This target explains the disproportionately large reliance on agency nurses (up to 50%) in emergency wards.
- 2.2 **Admission block** Each public hospital has a monthly target for the percentage of emergency patients who are admitted to an inpatient bed within 12 hours of a decision to admit. Bed closure makes it difficult for a public hospital to meet this bonus funding target. This target explains the disproportionately large reliance on agency nurses (up to 50%) in emergency wards.
- 2.3 **Admission of elective category 1 patients** Each public hospital has a monthly target for the percentage of elective category 1 patients admitted within 30 days of being added to the hospital's waiting list by a consultant. Elective category 1 patients cannot be admitted without a bed. Accordingly, bed closure makes it difficult for a hospital to meet this target.
- 2.4 **Critical care inter-hospital transfers** Each public hospital has a bi-annual target for the percentage of critical care patients transferred to another hospital as there is not a critical care bed available. Accordingly, closure of critical care beds makes it very hard for a public hospital to meet this 6-monthly target. Combined with the implications

for patient care of critical care inter-hospital transfers (discussed above), this target explains the disproportionately great reliance on agency nursing staff (up to 50%) by critical care wards.

- 2.5 **Coronary care inter-hospital transfers** Each public hospital has a bi-annual target for the percentage of coronary care patients transferred to another hospital as a coronary care bed is not available. Closure of coronary care beds makes it very difficult for a public hospital to meet this funding target.

The targets discussed above are by way of example only. There are many other funding targets, the achievement of which is made difficult by bed closures. It is worth recalling that to receive the funding bonus at stake for a particular month, a public hospital must achieve *each and every* funding target applicable to that month. The 6-monthly funding bonus is the most difficult to obtain, as the hospital has to satisfy the greatest number of targets for this monthly funding bonus (all of the monthly, quarterly and 6-monthly targets apply).

- 3 **Public expectations** Due to the dependence on Government for public funding, public hospitals must take into account public expectations and perceptions in decision-making. Community expectations with respect to the availability of publicly funded hospital beds, and the associated political and public welfare implications of bed closures, make public hospitals reluctant to close beds.
- 4 **Fixed nurse patient ratios** Fixed nurse patient ratios were established by the nurse enterprise bargaining agreement as a result of the recommendations made with respect to nurse patient ratios in the AIRC's enterprise bargaining decision of 31 August 2000. Commissioner Blair's decision recommended that where the relevant nurse patient ratio set out in his decision could not be met, a public hospital must temporarily close beds until the nurse patient ratio was satisfied. For the reasons discussed above, Victorian public hospitals are reluctant to close beds. The fixed nurse patient ratios, in combination with the funding implications of bed closure, mean that, theoretically, the only limit on rates for agency nurses is that the cost of the agency nurses required to meet each and every bonus funding target does not exceed the total bonus funding at stake for the relevant month. In practice, Victorian public hospitals are likely to acquire agency nurses to meet any shortfall in their nursing staff requirements regardless of price.

Therefore, the contraction in supply of nurses as a result of increasing agency fees and wages for agency nursing staff is accompanied by the absence of a demand response. The lack of a demand response to the increasing cost of nursing staff can be explained in part by the funding arrangements established by Government for the public health sector and in part because there is no reduction in demand for the health services produced using nursing staff as an input as the ultimate consumers of these health services, as the increased cost of production is not directly passed on to these consumers. Generally, the public health sector will employ agency nursing staff, whatever the cost, in preference to bed closure. (Planned bed closure may occur at the commencement of a new financial year, however, as part of budgetary planning for the new financial year by health services.)

The demand curve in the market for the supply of nurses can be represented diagrammatically as follows:

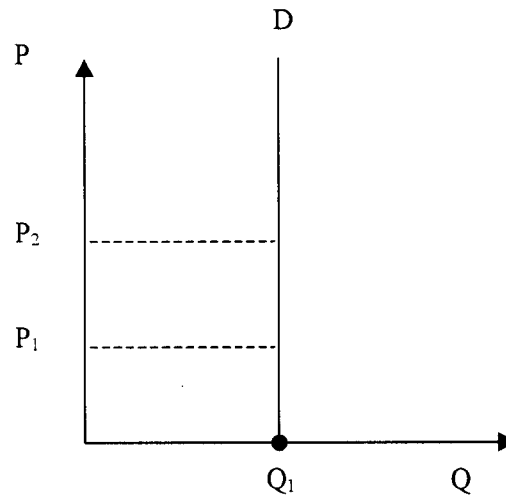


Diagram 2 - Demand curve in market for supply of nurses

(NB: For convenience of illustration, the demand curve has been drawn as perfectly inelastic. In reality, the demand curve would not be perfectly inelastic and would slope slightly left to right.)

The vertical demand curve in Diagram 2 illustrates that demand does not vary significantly, if at all, as agency nurse wages increase. In Diagram 2 demand is Q_1 for both a wage level of P_1 and a wage level of P_2 .

Interaction between demand and supply further reduces supply

As already discussed, the increased wages for agency nurses provides an incentive for nurses to list with agencies and often, after a lag, to reduce their available hours for permanent shifts in hospital employment. Given the nurse shortage and the inelastic demand for nursing staff, the result is increased reliance by hospitals on nurse agency staff as they face difficulties filling their permanent positions. The NRRC states (at page 82 of the Final Report) that '[o]ver recent years the use of agency nurses appears to have increased significantly'. The NRRC refers to suggestions that agency nurses, traditionally engaged to covered unplanned leave, being used to fill employed full-time vacancies, as hospitals are pressured to keep beds open due to funding arrangements: Final Report, page 83.

This, in turn, increases the workload of permanent nursing staff. Permanent nursing staff face an increased work load, as a result of increased reliance on agency nursing staff, in the form of:

- shouldering a disproportionate share of the burden of providing quality care and continuity of care; and
- orientating and supervising agency staff.