In its submission to the Commission in support of HPV's application for interim authorisation, the ANF misleadingly cited recommendation 53 in the Blair Decision as stating:

> *"that employers should endeavour to meet the ratio through the employment of permanent staff. Where this is not possible, bank staff may be used in the interim. Agency staff should only be used for unexpected absence, such as sick leave."*

Nursing Australia submits that the ANF have misleadingly quoted[51] Commissioner Blair. In fact, the sentence in a sentence immediately preceding the extract cited by the ANF, Commissioner Blair stated that:

> *"On the issue of agency employment being strictly limited to unexpected roster vacancies, the* ***Commission believes in granting that claim it would be restrictive and would not assist in dealing with the current crisis*** *within the public health system."*[52] [Emphasis added]

The ANF specifically requested that the AIRC make a recommendation on a claim that agency nurses be used only for unexpected roster vacancies. The AIRC refused.

In the Blair Decision, the AIRC observed that:

> *The Victorian public cannot expect that, where the health system is in crisis in terms of availability of nurses, nurses work beyond the rostered hours in order to ensure that the appropriate health care is provided to the public hospital and not get compensated for that additional time.*[53]

This observation fundamentally supports Nursing Australia's submission and underlines the fundamental flaw in the logic supporting HPV's application. It cannot be expected that nurses will be willing to work additional shifts without compensation. In the current environment, nurses are willing to work additional shifts in public health services as an agency nurse. There is no sound basis for the assertion that nurses would be prepared to increase the number of shifts that they were willing to work in the public system for the lesser compensation that would be available following HPV's proposed tender process.

(b) Introduction of Nurse to Patient Ratios

The Blair Decision which both supported and caused the implementation of nurse to patient ratios was a significant and fundamental change in the workplace of the public health sector. The implementation of the ratios was based upon nursing workloads. As many reviews of nursing conditions both domestically and internationally have reported, workloads are a major factor in the decision of nurses to either reduce or withdraw their working services.[54] The implementation of nurse to patient ratios has been responsible for the increase of approximately 1,650 EFT

---

[51] Submission of Australian Nursing Federation (Victorian branch) dated 24 December 2001, 4.

[52] Victorian Hospitals Industrial Association v Australian Nursing Federation, AIRC, 30 August 2001, 35..

[53] Victorian Hospitals Industrial Association v Australian Nursing Federation, AIRC, 30 August 2001, 43.

[54] The Nurse Recruitment and Retention Committee Final Report, May 2001, 41.

positions across the Victorian nursing workforce.[55] This, in turn, has resulted in an increase in demand for nurses supplied by nursing agencies.

In a context of pre-existing shortages of skilled staff, the decision to implement and increase nursing ratios pre-supposed that a quantum of nurses existed in the labour force who were not working solely due to inadequate financial compensation. Clearly, this supposition has proven to be more problematic than anticipated. The number of nurses required to meet the nurse to patient ratio requirements represents an increase beyond the shortfall already existing. An attempt to meet this demand has been made through a number of strategies. As previously discussed, the Victorian Government through the Nurse Policy Branch of the DHS undertook an extensive recruitment campaign. A number of re-entry programs were also established by the State Government (see section 2.1(c)). A significant component of the staffing requirements demanded by the ratios has been met through the use of casual staff.

Nurses who choose to work additional hours make their labour services available through both nursing agencies and nurse banks. As discussed in section 2.2(a), employees who consistently work hours in excess of the "ordinary hours" as defined within the Award[56] are entitled to be remunerated according to overtime provisions. Yet, according to both research[57] and evidence to the Committee, the true extent of overtime in the public health care sector is significantly under-reported.[58] Although entitled to claim overtime under the Award, many nurses are reluctant to do so. The Committee found that claiming overtime is actively and/or passively discouraged in some areas of the Victorian health services.[59] Considine & Buchannan suggest that between 300 – 450 EFT positions a week are being filled using unpaid labour through overtime.[60] Indeed, the Committee recommended that, where required, hospitals must be reminded of their Award obligations regarding overtime provisions.[61] Further, the Committee recommended that management encourage Nurse Unit Managers to claim legitimate overtime to ensure that a negative culture does not develop in relation to the payment of overtime.[62]

It is worthwhile to note that the effective arms-length relationship between nursing agencies and hospitals in terms of the employee/employer arrangement actually serves to reduce the overall expenditure on nursing wage costs when overtime and penalty payments are considered.

---

[55] VHIA, Bulletin, 573

[56] Nurses (Victorian Health Services) Award 1992.

[57] Considine & Buchannan 1999, *The Hidden Cost of Understaffing: An Analysis of Contemporary Nurses Working Conditions in Victoria*, Australian Centre for Industrial Relations, Research & Training, University of Sydney as cited in The Nurse Recruitment and Retention Committee Final Report, May 2001, 38.

[58] The Nurse Recruitment and Retention Committee Final Report, May 2001, 38

[59] The Nurse Recruitment and Retention Committee Final Report, May 2001, Recommendation 49, 44.

[60] The Nurse Recruitment and Retention Committee Final Report, May 2001, Recommendation 49, 38.

[61] The Nurse Recruitment and Retention Committee Final Report, May 2001, Recommendation 49, 8, 81.

[62] The Nurse Recruitment and Retention Committee Final Report, May 2001, Recommendation 50, 8.

(c) Increase in the Remuneration of Critical Care Nurses

The "critical care" speciality of nursing represents approximately 7% of the nursing workforce.[63] Approximately 7% of agency nurses work in areas designated as critical care. Critical care nurses therefore represent approximately 7% of the 5% of the nursing workforce that are working as agency nurses. A trend of rewarding the skills of critical care nurses began a number of years ago on an international scale. It is common knowledge that placements to the Middle East began offering significantly inflated wages more than 5 years ago. Similar trends have occurred in both the United Kingdom and the United States. It is an accepted reality that a number of Victorian public sector hospitals have paid wage rates in excess of the basic awards for many years. The drive to increase wage rates for critical care nurses working through nursing agencies has therefore occurred primarily in response to the emerging market awareness of these nurses themselves. Commercial considerations require that an agent remunerate nurses at a level which is at least competitive in the market place.

In order to attract nurses from other pursuits in order to increase their availability for additional work, nursing agencies have had to pay higher rates of remuneration to nurses which reflect the true opportunity cost of nurses providing additional working hours.

(d) Increases in Agency Rates

HPV's contention that reducing the wage rates of nurses will increase the amount of hours that they offer to work is implausible. The most basic classical economics theory may presume that an unsophisticated worker in a common market for labour services may accept a lesser price for a greater number of hours if the alternative is not palatable or does not exist. A health care system which consists of professional tertiary-educated practitioners working in an environment of an acknowledged worldwide shortage is unlikely to accept such a proposition. The elementary contentions of own price elasticity are further discussed in section 2.3(f).

The increases in fees charged by agents during recent years are understandable in the context of a maturation of the marketplace. The technological requirements necessary to successfully manage the vast number of placements required by health services with the lesser number of availabilities offered by nurses willing to work are enormous. Many have considered the returns to be commercially unsustainable. The exit of "Adecco" from the healthcare industry in 1997 and the reluctance of other larger general human resource specialist companies to enter this market is evidence of this.

Typical rates of return for agencies are significantly less than the double-digit returns regarded as normal in other industries. In order to remain competitive and to sustain the quality processes necessary to place large volumes of staff with minimal notice, the technological investment is enormous. Nursing Australia has invested significant sums of money during the past 12 months in extending its ability to meet the needs of nurses and health services in a timely and efficient manner. The costs of this cannot be absorbed into Nursing Australia's cost structure without causing a non-commercial outcome.

Discussions relating to relative returns cannot ignore relative costs. The principles of competitive neutrality require that a fully absorbed cost be calculated for government services when comparing those of the private sector. Nursing Australia strongly

---

[63] The Nurse Recruitment and Retention Committee Final Report, May 2001, 36.

contends that the true costs of employment to the public sector are at least as great as those experienced by nursing agencies. The recruitment of any nurse by any authority requires that stringent selection processes are the end point of a recruitment campaign that will include advertising, interviewing and administrative processes. Similarly, all statutory requirements must be factored into the true cost. In the case of nurses recruited by the Victorian public sector the costs of a major advertising campaign must be acknowledged. In terms of the actual costs of purchasing a nurse's services, the provisions of salary packaging must not be ignored. Through the Fringe Benefit Tax (FBT) exemption (which is available to employees of public health services) "salary packaging" provides effectively an increase in salary of $17,000. This benefit is offered to casual nurses through the existing nurse banks of the public sector. The effective value of this is equivalent to a 34% increase in wages. Whilst the burden is carried by the Commonwealth, it would be highly inaccurate and misleading not to reflect this calculation in any public benefit calculation. This practice is widespread in public health services and the implications of compensating staff from state government revenues should this tax advantage be denied are great.

In examination of the public benefit test the ramifications of the true cost to the Commonwealth resulting from the FBT exemption must be considered. As salary packaging is offered to casual nurse bank staff the additional cost to the Commonwealth of approximately 2,000 EFT claiming the full advantage could be extrapolated to be as much as $34,000,000. In its submission relating to the public benefit that will allegedly result from the Proposed Conduct, it is misleading for HPV not to disclose this consideration.

Rates charged by nursing agencies reflect a maturation of the market. The market demands that risk is minimised and that efficiency is maximised in the allocation of scarce nursing resources. The costs of allocation must be absorbed in any realistic analysis of industry costs. Whilst a small percentage of nurses (ie the "critical care" nurses) are able to command wage rates in excess of twice the basic award rate, this small percentage is in fact 7% of 5% (see section 2.3(c)) or in basic terms no more than 0.35% of the total labour force supplied by nursing agencies to the public health services. Nursing Australia contends that this figure may represent a small price in relation to the overall services offered by agency nurses. It must also be acknowledged that it is common practice for permanent staff members to be remunerated at one or more grades higher than their substantive classification as an incentive to "retain" their services.

As discussed under section 2.3(a), the introduction of mandatory nurse to patient ratios saw the demand for nursing staff, both permanent and casual, increase dramatically.

The nurse to patient ratios were phased in over the period between December 2000 and March 2001. Over this period Nursing Australia observed a [redacted] increase in orders with a corresponding decrease of [redacted] in the volume that could be supplied, in effect a [redacted] reduction in Nursing Australia's ability to meet the staffing requirements of its clients.

This clearly reflected a significant tightening of the nursing labour market and demonstrated the lack of additional nurses available to cover the new mandatory ratios.

To overcome this alarming trend and attract nurses back into nursing, Nursing Australia embarked on a substantial investment and resourcing program in June 2001.

Confidentiality granted for areas outlined in red.

This program involved five key elements:

- additional technology and infrastructure;
- increased nursing allocation resources;
- nurse support program;
- recruitment advertising; and
- nurses uniforms.

The key elements are discussed below.

(i) Technology and Infrastructure

Over the 7 months to January 2002, Nursing Australia increased capital expenditure on technology and infrastructure by over 300% compared with the total expenditure over 2000/01. By June 2002, capital expenditure will increase by over [redacted], compared with the previous year.

The investment supported improved computer systems, new recruitment offices and other infrastructure.

(ii) Nursing Allocation resources

With a tightening of the nurse labour market, significant additional effort was required to locate and allocate the same number of nurses and shifts. During the past 18 months the average time taken to locate and allocate staff members has increased by some 40%, reflecting the greater degree of specialisation required by both health services and nurses.

(iii) Nurses Support Program

As discussed in section 2.1(h), a Nurse Support Unit was established to assist nurses who no longer actively practise and those who are new to the profession. This initiative will cost over [redacted] in 2001/02. The Nurse Support Unit were also tasked with assisting overseas nurses into Australia.

(iv) Recruitment advertising

As discussed under section 2.1(h), Nursing Australia undertook extensive recruitment marketing to attract nurses back into nursing via the "Value" campaign.

The cost of this recruitment was significant at over [redacted] million. Over the same period, DHS are reported to have spent $26.9 million to recruit 2,600 nurses at $10,300 per nurse.[64] It should be noted that Nursing Australia achieved a recruitment rate of [redacted] per nurse.

(v) Nurses Uniforms

As identified by the Committee's findings, nurses wanted to be seen as professionals. A commonly overlooked strategy has been to ignore the ramifications of creating a perception of belonging and the "image" of professional status. To this end, Nursing Australia commissioned a leading corporate designer to produce a uniform which reaffirmed the professionalism of nurses. This cost exceeded [redacted]

---

[64] Winning Nurses Back To Nursing Australia", *The Age*, 8 December 2001, Nursing Classifieds.

Confidentiality granted for areas outlined in red.

(e) Changes in Agency Fees over the past 18 months

Between June 1999 to December 2001, agency charge rates for general nurses have increased [redacted] Of this increase, half (ie [redacted], represented nurse wage-related changes comprising of: 10% being underlying EBA increases, a further 8% over-award payments and approximately 9% being car-parking assistance which is also paid by public hospitals to subsidise permanent staff. This must also be considered in the context of the 34% over award effect resultant from FBT exemption in public health services.

The remaining half of the increase (ie [redacted]) increase was the unavoidable consequence of initiatives required to attract and retain nurses in nursing.

The key elements are as follows:

- Superannuation Guarantee 2.9%
- Workcover 1.9%
- Additional Nurse Allocations 1.5%
- Recruitment marketing 4.9%
- Capex – Technology & infrastructure 3.2%
- Recruitment 2.2%
- Nurses Support 1.0%
- Nurse Uniforms 2.0%
- [redacted] [redacted]

It should be noted that over this period as a direct result of the above initiatives, Nursing Australia has successfully increased by [redacted] its ability to meet the staffing requirements of its clients.

As indicated by the Chairman of the National Competition Council a true and accurate accounting of the health services' costs over the same period will demonstrate similar underlying costs.[65] These costs are effectively unavoidable in order to achieve a comparable result.

As indicated in section 3.3(a) below, the costs differential between casual nurses employed directly by a hospital nurses bank and agency nurses is not only immaterial, it is demonstrably more cost effective to utilise agency staff.

(f) Price Elasticity of Demand

Over this period of agency cost increases, the effect of the price increase has reduced demand for agency staff in the Nursing Australia group – clearly, the market is price sensitive and has reacted accordingly.

---

[65] "Reforming Health Care – Privatisation, Deregulation and Competition" paper presented 25 February 1999.

Confidentiality granted for areas outlined in red

Nursing Australia has commissioned Mr Robert Officer and Mr Joshua Gans of the Melbourne Business School to prepare an analysis of the price elasticity of demand in the nursing agencies/health services market. Given the time constraints involved in preparing this submission, this analysis is not available to be provided to the Commission at this time. However, Nursing Australia anticipates that if this matter proceeded to a hearing before the Australian Competition Tribunal (ACT), the analysis prepared by Mr Officer and Mr Gans would be submitted in support of Nursing Australia's submission before the ACT.

Table 7 in section 3.3(a) illustrates the build up costs which must be incurred by any employer. A significant point is that the single cost attributed to an agency placement includes all costs.

2.4 International and Interstate Comparisons – A Worldwide Shortage

The shortage of nurses in both the public and private sector is an acknowledged worldwide phenomenon.[66] This international shortage of nurses has resulted in countries introducing a variety of initiatives to address this shortage. These initiatives are aimed at both recruiting new members to the profession and encouraging nurses who might otherwise leave the profession to remain in it. For example, the United Kingdom has recently amended legislation to greatly relax immigration laws to allow easier entry for professionals including, specifically, nurses. For example, the United Kingdom has recently amended legislation to greatly relax immigration laws to allow easier entry for professionals including, specifically, nurses.

In consideration of the relative merits of a collective tender process for any tender process the effects of national experience should also be considered. In terms of the competitive effects of bulk tendering in New South Wales, note the following example.

By way of example, the exclusive tendering provisions for the supply of medical devices to New South Wales Health (NSWH), administered by the NSWH Peak Purchasing Council, has resulted in the market exit of a number of suppliers in that state. This has demonstrably reduced the level of competition in the market for such items as pulmonary chest drains, prosthetic devices, cardiac pacemakers and many other highly specialised items. The reduced level of competition has seen costs escalate, that is the cost benefits supposed to have accrued from the tender process have been eradicated. This is common knowledge amongst the medical supply industry within New South Wales.

3. Submission in Opposition to Application

3.1 Relevant Markets

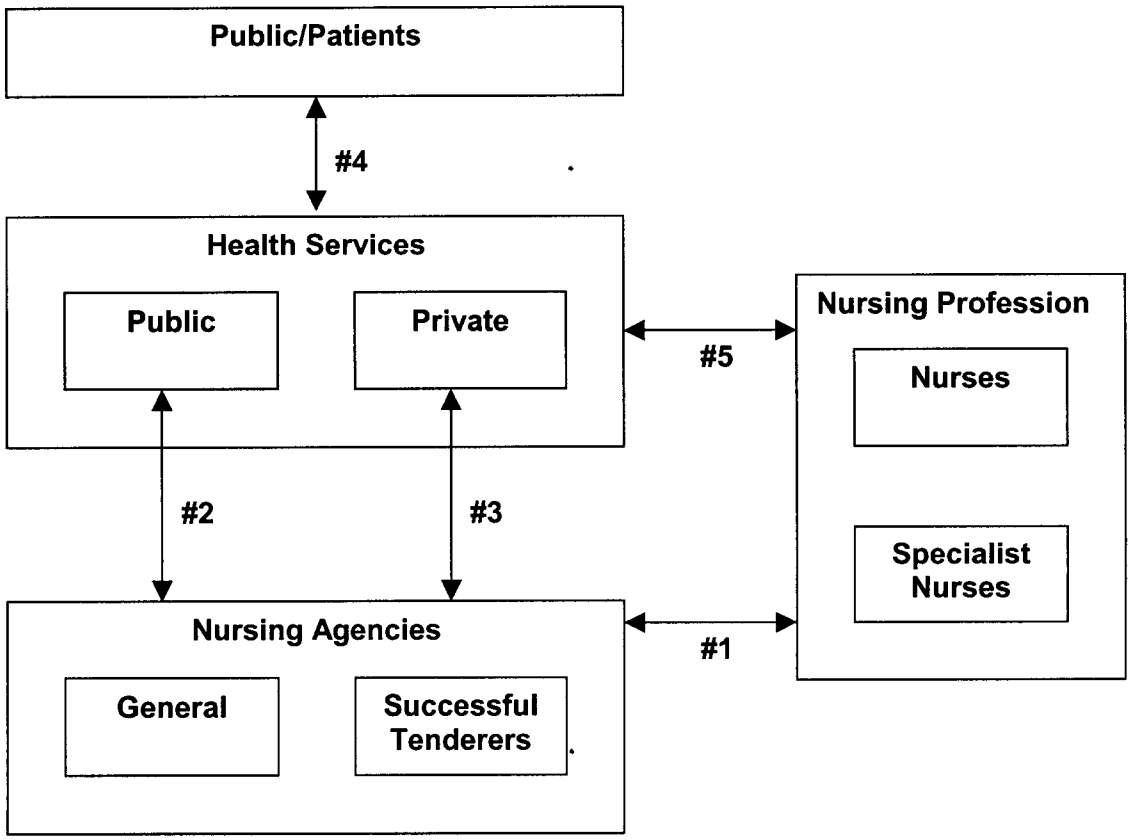
Nursing Australia submits that there are five relevant markets in which there will be no public benefit which flow from the Proposed Conduct. In any event, Nursing Australia contends that any perceived benefit may be achieved more effectively and efficiently by means other than the imposition of an anti competitive tender arrangement.

The relevant markets are diagrammatically represented in Table 6 below.

---

[66] The Nurse Recruitment and Retention Committee Final Report, May 2001, Letter to the Minister from Professor Margaret Bennet (Chair of the Nurse Recruitment and Retention Committee.)

Table 6 – Diagram of Relevant Markets



Market #1

The market for the provision of nursing agency services to nurses (including specialist nurses).

Market #2

The market for the provision of nursing agency services to public health services.

Market #3

The market for the provision of nursing agency services to private health services.

Market #4

The market for the provision of health services to the patients.

Market #5

The market for the provision of nursing services (including specialist nurses) to health services.

An explanation of the relevant markets is set out below.

(a) Market #1 – The market for the provision of nursing agency services to nurses (including specialist nurses)

Nursing Australia submits that nursing agencies provide nursing agency services to the nursing profession, including the placement of an agency nurse in a health services according to the agency nurse's desired availability, the rate of remuneration and working conditions. Agency nurses are able to engage the services of any of a number of nursing agencies and have a high level of transferability between agencies.

There is also a sub-market for provision of nursing agency services to specialist nurses, such as critical care nurses. Specialist nursing agencies operate which cater exclusively, or substantially, for a specialist area of the nursing profession.

The market for the provision of nursing agency services to nurses (including specialist nurses) does not appear to have been specifically addressed by HPV in its application or supporting submissions.

(b) Market #2 – The market for the provision of nursing agency services to public health services

Nursing Australia submits that there is a market for the provision of nursing agency services to public health services. All nursing agencies are currently able to compete with each other to meet the staffing requirements of both public health services and private health services. However, the market for the provision of nursing agency services to public health services should be regarded as separate from the market for the provision of nursing agency services to private health services, as the Proposed Conduct will only directly impact upon the public system. The Proposed Conduct may, however, have indirect consequences for the private system as outlined in section 3.2(c).

HPV's application for authorisation is principally concerned with the interplay between the nursing agencies that participate in this market.

(c) Market #3 – The market for the provision of nursing agency services to private health services

Nursing Australia submits that there is a separate market for the provision of nursing agency services to private health services, as the Proposed Conduct will not limit the ability of private health services to acquire the services of nursing agencies. The Proposed Conduct may, however, have indirect consequences for the private system as outlined in section 3.2(c).

(d) Market #4 – The market for the provision of public health services to the public

Nursing Australia submits that the market for the provision of public health services to the public is relevant for the purpose of assessing the Proposed Conduct. HPV's application is predicated on the notion that the Proposed Conduct is necessary to increase nursing staff availability, and will reduce the likelihood of bed closures. Bed closures by public health services will impact upon the ability of health services in general (both public and private) to provide health services to the public.

(e) Market #5 – The market for the provision of nursing services (including specialist nurses) to health services

Nursing Australia submits that there is also a market for the provision of nursing services (including specialist nurses) to health services directly. This provision of nursing services directly to health services may take the form of full-time employment, part-time employment or participation in the nurse bank operated by a particular health service. These services may be characterised as healthcare services, as opposed to the nursing agency services provided by nursing agencies to health services.

3.2 Effect of Proposed Conduct on Competition – Anti-Competitive Detriment

Nursing Australia submits that the granting of authorisation by the Commission in relation to the proposed conduct will have a significant negative impact on the levels of competition in the relevant markets identified in item 3.1 above.

(a) Provision of nursing agency services to nurses (including specialist nurses)

The Proposed Conduct will have a dramatic impact on the nursing agencies/nurses market. Given that the public health services which HPV represents account for approximately 70% of the casual nurse EFT positions in Victoria.[67] The failure of an existing nursing agency in the tender process would immediately reduce the number of participants in the nursing agencies/nurses market and would concentrate market share in the successful tenderers.

A reduction in the number of nursing agencies would result in a decease in the level of competition amongst nursing agencies to provide agency services to nurses. The nursing agencies/nurses market is currently a highly competitive market in which nursing agencies are differentiated based on the quality of their service and the rates they are able to offer agency nurses and the rates charges to clients. The implementation of HPV's tender process would effectively create a situation where nurses desiring to work in the public system would not have the ability to acquire the services of a nursing agency other than the successful tenders.

Given that few (if any) nursing agencies will be able to viably tender due to the terms of the proposed tender documentation (see section 3.4(a)), the proposed conduct will effectively remove competition in the nursing agencies/nurses market as it relates to public health services.

(b) Provision of nursing agency services to public health services

The Proposed Conduct will reduce the level of competition in the nursing agencies/public health services market. The proposed Provision of Temporary Nursing Services Agreement provides that the successful tenderers will have the exclusive right to provide temporary nursing services to the public health services that are party to the Agreement.[68] The tender process will, therefore, eradicate competition between participants in the nursing agencies/public health services market other than successful tenderers.

---

[67] Australian Institute of Health and Welfare, "Australia's Health 2000".

[68] Application by HPV, Attachment A: Tender Documentation, Provision for Temporary Nursing Services, clause 2.5.

If few existing nursing agencies submit a tender or are successful in the tender process, the few agencies that are successful tenders will control approximately 70% of the casual nurse EFT positions in Victoria. The proposed Provision of Temporary Nursing Services Agreement is intended to operate for an initial period of five years, followed by a further term of two years at the option of the health services. This will result in the exit of a substantial number of existing nursing agencies from the nursing agencies/public health services market. Aside from this initial exit of nursing agencies from the market, the proposed conduct would also create a total barrier to entry for parties seeking to enter the market.

(c) Provision of nursing agency services to private health services

The Proposed Conduct would result in a significant number of nursing agencies exiting the nursing agency industry generally or attempting to strengthen their market share in the nursing agencies/private health services market. However, the nursing agency services/private health services market is dominated by Mayne Health, which is generally considered as accounting for approximately 60% of the nurse EFT positions in the private system. In these circumstances, it is unlikely that unsuccessful tenderers will be able to adequately transfer all of their activities to the private sector.

As stated above, the tender process will result in a significant barrier to entry in the nursing agencies/public health services market. It may, however, also create a barrier to entry in the nursing agencies/private health services market. Potential new entrants to the nursing agencies/private health services market will not be able to exploit the economies of scale that successful tenderers operating in the nursing agencies/public health services market will be able to exploit.

(d) Provision of health services to the public

Nursing Australia submits that the Proposed Conduct would result in a reduction in the ability of public health services to meet staffing requirements and satisfy mandatory nurse to patient ratios, which will ultimately result in bed closures. However, the proposed conduct would not specifically affect competition amongst participants in the health services/public market, except for the distorting effect it may have on staffing costs for private health services compared with staffing costs for public health services.

Private hospitals are not governed by a central body, such as the DHS, and would have a lesser ability to enter into collective purchasing arrangements in relation to staffing.

(e) Provisions of nursing services (including specialist nurses) to health services

The Proposed Conduct would negatively affect competition in the nurses/health services market. The proposed Provision of Temporary Nursing Services Agreement attempts to create parity between working as an employee nurse and working as an agency nurse (through a successful tenderer) in terms of both income and working conditions. Nurses would be restricted in their ability to work in a public health service through a placement made by a nursing agency. A nurse will only be able to work in a public health service through an agency that is tied to the proposed Provision of Temporary Nursing Services Agreement as a result of submitting a successful tender.

This will create an inequality in bargaining power for nurses, who will no longer be able to negotiate higher rates for their services. Many nurses undertake placements through nursing agencies as additional shifts to their ordinary shifts as permanent employees. In return for these additional shifts, nurses are currently able to demand

higher rates for shifts performed as an agency nurse. These rates reflect an interaction between the supply of nurses and the demand for their nursing services. The Proposed Conduct would reduce the ability of nurses to negotiate these higher rates of pay for additional shifts undertaken in a public health service.

In summary, the effect of the Proposed Conduct will be to reduce the level of competition in each of the relevant markets with no demonstrated public benefit which would justify the imposition of anti competitive exclusive tender arrangements. HPV's submission simply does not demonstrate a link between the Proposed Conduct and the contended public benefits. Furthermore, HPV's submission does not consider whether the perceived public benefits may be achieved by some means other than the imposition of an anti competitive exclusive tender arrangement.

3.3 Public Benefits

Nursing Australia re-iterates its opposition to the purported public benefits that HPV asserts will result from the Proposed Conduct. Nursing Australia's position has previously been provided, in more general terms, in its previous submission (opposing HPV's application for interim authorisation) lodged with the Commission on 4 January 2002 and Middletons' letter to the Commission dated 22 January 2002.

Nursing Australia's submission in response to the public benefits that HPV asserts will result from the Proposed Conduct are set out below.

(a) Decrease in staffing costs

Constraint of public expenditure is cited as the principal purpose of the tender. An unsupported claim is made that health services can pay 150–300% of the award or EBA rate for the services of an agency nurse.[69] Nursing Australia cannot support this contention and submits that it should therefore be disregarded by the Commission.

The example quoted by HPV appears to compare the basic **weekday** earnings of a Registered Nurse **exclusive of on-costs** with the **weekend** charge rates of a specialist intensive care nurse **including on-costs**. The comparison is misleading as it compares two different positions. Table 7 demonstrates the actual full cost absorption comparison between the two modalities of supplying supplemental staff. The conclusion that nurses supplied via an agency are less expensive is readily demonstrated.

[69] Application by HPV, Attachment B: Outline of Proposed Conduct, Trade Practices Issues and Public Benefits, 5.

Table 7 – Hospital / Agency Comparison

	Grade	Rate per hour	Casual Loading (1) 25.0%	Overtime loading (2) 23.8%	Agency Premium (3) 10.0%	FBT Concession 34.0%	Super 8.0%	Workcover 3.0%	Professional Indemnity 1.0%	Provision for Long Service Leave 1.5%	Recruitment (5)	Payroll processing	General Administration (6) 22.0%	Per Hour	Per Week	Ratio to Award Base
Hospital wage	RN 2:8	$ 28.54	$ 7.14	$ 6.79	$ 2.85	$ 9.70	$ 2.28	$ 0.86	$ 0.29	$ 0.43	$ 6.00	$ 0.30	$ 6.28	$ 71.45	$ 2,715	2.50
Agency charge	RN 2:8															

Notes:

(1) Casual Loading as per Nurses (Victorian Health Services) Award 2000

(2) Overtime Loading is expected to apply to all shifts worked by casual nurse bank staff on the basis that 66% of casual nurses are already work full time. Overtime loading will equal 66% x 1.875 penalty rate - effectively 23.8%

(3) FBT Concession represents the non-taxable component of gross wages taken in the form of other benefits by Public sector employee nurses. This concession is equivalent to a 34% increase over the equivalent Agency nurse's remuneration for the same shift. Salary packaging is made available to most nurses in the Public sector with a participation rate of approximately 80%.

(4) Recruitment. This reflects the fully costed Nursing recruitment campaign undertaken by the Public sector over 2000/01 expressed over the number of nurses actually recruited. The recruitment campaign is reported to have cost $ 26.9 million and recruited 2,600 EFT nurses.

(5) General administration costs reflect co-ordination, communication, HR and associated infrastructure costs

Confidentiality granted for areas outlined in red

Table 7 addresses this disparity by building up the hospital wage to incorporate the same elements as the agency charge so that a meaningful comparison can be made. The agency rate is the actual cost charged to the client for a basic shift and is inclusive of all on-costs.

Table 7 represents the actual scenario which will prevail in Victoria with an adoption of wide scale use of nurse banks. That is the calculation allowed for overtime payments must be acknowledged. Similarly the true cost of the FBT exemption must be acknowledged. When these considerations are included in a cost comparison the results are evident. The full cost of utilising supplemental staff provided by an agency is [redacted] times the base award. The full cost of using supplemental staff provided by a nurse bank is 2.5 times the base award.

When on-costs are transparently incorporated into the quoted hospital wage it becomes substantially greater. Similarly, when the 'average' agency rate as opposed to the special critical care nurses on a public holiday rate is quoted for weekdays, it becomes substantially lower. The obvious conclusion is that, when public hospitals consider a fully inclusive employment cost basis, the (often misleading) cost disparity between direct employment and agency supply vanishes. In fact, a strong case is presented to indicate that the use of agency staff is in fact less expensive. Agency nurse costs are approximately [redacted] times the basic award whilst the true costs of providing supplemental staff via an internal process will exceed 2.5 times the basic award.

Significantly, as discussed in section 2.3(c) "over-award" payments have been commonplace in general, and in specialist nursing areas particularly, for many years. Such specialist areas include critical care nurses where the skill base, concomitant responsibility and accountability are great. The making of 'over award' payments exists in both public and private sectors and is commonplace across the major hospitals of Victoria and throughout Australia. It would be not only misleading but also erroneous to suggest that payments greater than the base Award/EBA are the sole province of nursing agencies. In fact, public hospitals have always paid higher rates to nurses than nursing agencies when a true cost analysis is performed.

HPV expects, in line with its statement that the main criteria for awarding the tender is that tenderers will provide temporary nursing staff on the basis of the Award, that the tender process will result in nursing agencies paying nurses less than is currently the norm. HPV also anticipates a reduction in the "commission". These erroneous assumptions assume that the cost of providing agency nurses is itself highly elastic. Experience suggests that this is not the case.

Nurses' agents must undertake detailed recruitment processes, quality checking procedures, education, advertising and support in a manner consistent with any recruitment or labour hire industry sector. The management of large numbers of personnel with vastly differing skill bases and with preferences and the matching of those skills with the plethora of demands for staff from purchasers is a complex and sophisticated process. The smallest of nursing agencies will incur substantial costs in matching a few staff to a few "purchase orders". Naturally, larger nursing agencies expect proportionately greater infrastructure costs – such costs being absorbed over a greater number of work placements.

The public benefit accruing from a decrease in costs paid by the health services for their temporary staff is expected to be funded by an acceptance of a lower hourly rate by nurses. Commonsense dictates that this is not a process designed to increase the effectiveness of care delivery by professionals. In its application for

confidentiality granted to figures outlined in red.

authorisation, HPV contend that nurses placed through agencies are paid 1.5 – 3 times Award / EBA rates[70]. HPV provides no evidence to support this statement. In fact 90% of agency nurses working with the Nursing Australia group are paid around 10% above the award rates. Nursing Australia's average net profits after tax are less than [redacted]

The HPV submission does not make mention of the availability of salary packaging to public sector nurses. It is a mathematical fact that the Fringe Benefit Tax (**FBT**) exemptions offered via salary packaging equate to an over award payment This benefit - which can exempt from FBT up to $17,000 per annum - effectively provides a net pay increase of $8,500 to permanently employed nurses. This is not available to agency nurses but represents a redistribution of Commonwealth tax revenues to the State Government Health Sector. In consideration of any argument which involves income relativities cognisance should be given to this factor. In other words, the nurse agencies have to offer an additional 34% in wage rates to match the Victorian Government's benefits alone. In fact, in a fully cost absorbed analysis of the costs of employment, it is appropriate to describe the full cost of employing a typical Registered Nurse through a nursing agency as a supplemental staff member. The true cost of such an employee will be approximately [redacted] times the basic Award rate. The true cost of providing the same supplemental staff through a hospital based nurse bank will be approximately **2.5** times the basic Award rate. The HPV contention that nursing agencies are paying inflated salaries and extracting inappropriate profits is wrong.

(b) Employment equality and workplace harmonisation

HPV makes the assertion that differences in the rates of pay between employee and agency nurses results in industrial unrest and disharmony, which is supported by purely anecdotal evidence. It is difficult to conclude that a Victorian Government initiative which places downward pressure on the incomes of nurses will create industrial harmony.

In the present environment, any nurse who was willing to work additional hours would be able to choose to supplement their income by working as an agency nurse. Given the ability of all nurses to work as agency nurses, the assertion made by HPV appears to be relatively unsustainable.

(c) Price certainty

Price certainty is a desirable factor. It also notes that the actual quantum that is under discussion is marginal. Nursing agencies provide only a few percentage points of a health service's staffing requirements. The actual cost of using the agency nurse is the small margin between the cost of the nurse's wages including on-costs and the charge rate and Nursing Australia contends that this is less costly to the public than the Victorian Government's true costs.

Price certainty can, however, be obtained without the need to impose an anti competitive exclusive tender arrangement. HPV's submission does not demonstrate any link between the public benefit of price certainty and the Proposed Conduct.

Price certainty has previously been achievable via individual tender/contract arrangements between hospital purchasers and providers. Nursing Australia would

---

[70] Application by HPV, Attachment B: Outline of Proposed Conduct, Trade Practices Issues and Public Benefits, 5.

confidentiality granted to figures outlined in red.

suggest that revisiting this strategy is a simple, cost effective and competitive mechanism that individual health services can administer

(d) Reducing bargaining imbalance and promoting equitable dealings

HPV asserts that the demand for agency nurses has increased by 4% that is 51.92 nurses or 0.0012% of the total nursing workforce of approximately 40,000 EFT.[71] Subsequently it is asserted that "many health services are unable to meet their nurse staffing needs because there are insufficient numbers of qualified nurses in Australia".[72] It is also asserted that "employee nurses have been reducing their employment shifts with health services and increasing shifts as an agency nurse".[73]

Table 8 – National Nursing Shortages

Specific shortages and difficulties

DEWRSB data provide a grim picture of particular shortages across Australia by State and Territory (see Table 6.3).

Table 6. 3 Shortages of Registered Nurses by specialisation/Enrolled Nurses – March 2001

Nursing occupation	AUST	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Registered Nurse (general)	N	S	S	S	S	S	S	S	S
Accident/Emergency	N	S	S	S	S	S	S		
Aged Care	N	S	S	S	S	S	S		S
Cardiothoracic	N	S	S	S	S	S	S		
Community	N	S		S		S	S	S	
Critical/Intensive Care	N	S	S	S	S	S	S		S
Indigenous Health				R	S	S		S	
Neo-Natal Intensive Care	N	S	S	S		S	S		
Neurology	N	S	S	S	S	S			
Oncology	N	S	S	S	S	S	S		S
Operating Theatre	N	S	S	S	S	S	S	S	S
Orthopaedics	N	S				S	S		
Paediatric	N	S	S	S	S	S	S		
Palliative Care	N	D	S		S	S			
Perioperative	N	S	S	D	S	S			
Rehabilitation	N	S		D			S		
Renal/Dialysis	N	D	S	S	S	S	S	S	
Respiratory	N	S							
Registered Midwife	N	S	S	S	S	S	S		
Registered Mental Health	N	S	S	S	R	S	S		S
Enrolled Nurse	N	S	S	S	S	S	S		

N = National shortage S = State or Territory wide shortage

D = Recruitment difficulties R = Regional shortage (outside capital city only)

[71] Application by HPV, Attachment B: Outline of Proposed Conduct, Trade Practices Issues and Public Benefits, 6.

[72] Application by HPV, Attachment B: Outline of Proposed Conduct, Trade Practices Issues and Public Benefits, 6.

[73] Application by HPV, Attachment B: Outline of Proposed Conduct, Trade Practices Issues and Public Benefits, 6.

These assertions do not appear to withstand any degree of scrutiny. As indicated under Table 3 section 2.1(d), there are approximately 40,000 EFT Registered Nurses in Victoria. The number at any one time acting as agency nurses is less than 5% (see Table 3). It is of note however that the actual number of individual nurses making up that small percentage is as many as 25% of the workforce or 10,000 people.[74] This reflects the highly casual nature of agency nursing where in many instances an individual nurse may choose to work no more than one additional shift as an agency nurse per year.

Shortages in various skill specialities are reported in the Review as indicated in Table 8 above. Specialist areas are particularly represented as requiring increased participation. The issue raised by HPV relating to the price premium payable to some categories of nurses is factual in relation to critical care nurses. As described elsewhere, it has been common practice in both the public and private sector to remunerate these highly skilled individuals at a premium "above award" rate for many years.

Nursing agencies are to some extent in actual competition with private and public sector employers for the services of skilled nurses wishing to work casually. As private and public sector facilities remunerate staff at specific levels, it becomes necessary for nursing agencies to respond and match these rates as a matter of competition. In an attempt to compress the remuneration of a small number of nurses, specifically critical care nurses, the HPV proposal is likely to result in a significant decrease in availability of these persons as they elect not to sell additional hours of their labour at the proposed rates. Critical care nurses, by way of example, have opportunities to supplement their income through acting as casual lecturers where market rates are between $70 and $100 per hour. As indicated in Table 1 (section 2.1(d)) Intensive Care or Critical Care nurses effectively constitute approximately 7% of the calculated nursing agency workforce. There would seem little public benefit in implementing a strategy designed to reduce the earning capacity of 7% of the 5% of the total nursing workforce working as agency nurses. This is specifically germane to this discussion as critical care areas are regarded as having difficulty in attracting appropriately qualified staff worldwide.

The marginal economics necessary to attract highly skilled nurses to offer more of their labour is regarded by Nursing Australia as a short term solution. Longer-term solutions must reflect the need to attract more persons into the nursing profession and specifically the critical care areas. Market forces will then bring about a resolution of this apparent earning disparity. It must be emphasised however that the short-term requirement to attract nurses to these areas addresses a vital aspect of the health care delivery system of acute services.

It is apparent that, if HPV has absolute discretion in an exclusive tender process, control of 70% of the market will provide it with a disproportionate degree of market power. As a discrete non-substitutable market those companies failing to be appointed to the panel of suppliers will be forced from the market. Similarly, all competitive forces within the nursing labour supply market will be removed – thus, the HPV proposal involves introducing regulation at a time when the general economy is moving to deregulation.

---

[74] Nursing Australia's recruitment statistics indicate that in any one year 25% of working nurses will work with a nursing agency.

(e) Increases in nursing staff availability

HPV's application is based upon the erroneous assumption that nurses will draw a fixed level of income and adjust their working hours to maintain this income. This is contrary to past experience as amply documented in the various reports on nursing retention. Furthermore, there is no economic theory which would support the assumption. HPV's contention that the Proposed Conduct would produce the public benefit is wholly undermined by the false assumption that if a nurse is paid less money per hour then that nurse will work longer hours to maintain the same income level. This is contradictory to past experience as documented in the various reports cited earlier. The fact is, nurses are exiting the profession because of inadequate remuneration, inflexible working hours, substandard working conditions, heavy workloads and discontent generally with conditions which exist within the public sector.

It is Nursing Australia's contention, based upon the experience of recruiting in excess of 5,000 individual nurses per year, that a significant number of nurses who have been drawn back to the profession (as a result of opportunities for flexibility and recognition of their specific skills) will in fact return to employment opportunities outside of nursing. Many nurses have elected to pursue a career in industries such as sales, customer service, and other avenues where their training in human resource management allows them to have portability. Failing to recognise the right and ability of nurses to choose their working environment is a significant failing of the HPV approach to the nursing shortage.

A strategy actively designed to exacerbate the issues regarded as deleterious by nurses does not seem to serve the public interest in the short or long term. It is of note that the Chief Nursing Officer of Victoria reported in a paper presented to the International Council of Nurses in June 2001 entitled "*Managing the Contemporary Workforce*" that;

> *One could argue that the "old" leadership model or way of doing things in nursing was about command and control – this was in keeping with history and health care organisations that had a formal hierarchy, layers of management and employees who stayed with the organisation for life. Unfortunately, this model still exists, yet the workplace today is vastly different – there are flatter structures, some nurses want to challenge the status quo which can be very unsettling for older, experienced nurses, nurses are not necessarily loyal to one organisation and there is a greater need for flexibility both in terms of approach and response given the casualisation of the workforce and greater career choice for women. There are benefits in being less controlling, more consultative and more empathetic. This is how people will be attracted to nursing. There is a real imperative to treat nurses differently and invest in them if the nursing workforce is to be managed more effectively. It would seem that very few health care organisations have a planned approach to identifying leaders and developing their people. This is a contributing factor in nursing's inability to attract and retain younger nurses.*[75]

Nursing Australia concurs with these sentiments in terms of the cultural aspects associated with the shortage of nurses in health care systems worldwide. It is however inconsistent with the approach promoted by HPV, which suggests lowering

---

[75] Chief Nursing Officer of Victoria in a paper entitled "Managing the Contemporary Workforce" presented to the International Council of Nurses, June 2001.

remuneration levels in order to force nurses to increase their base hours of availability.

An emotive argument is placed regarding the desirability of permanently employed nurses enhancing patient care. This argument is raised periodically in discussions regarding nursing labour force issues. The argument pre-supposes that the agency nurse is a discrete individual, who only appears once and disappears, never to be seen again at the same institution. The reality is very different and illustrates the potentially misleading nature of poorly researched opinion. With reference to a database of "tens of thousands" of nurses and millions of individual shift placements, Nursing Australia can report that the "average" agency nurse actually already works either part time or full time and merely supplements their income with a flexible approach to work. That is, the nurse decides where and when they wish to undertake their additional duties, but typically and in the greater majority of cases these people are concurrently employed within the public or private health systems. Similarly, most agency nurses prefer to return to the same workplace on a relatively frequent basis. The contention that patient care quality suffers as a result of agency nurses being present is not substantiated and is indeed incompatible with the standard profile of an agency nurse.

The HPV contention that - a retrograde approach to nurses wages at the margin, that is in relation to agency nurse – that this will somehow produce an increase in the number of available permanent working hours is fundamentally flawed. The argument completely ignores the realities of the nursing profession. Demographically 93% of nurses are female. The average age of a nurse is currently over 43 years. Nurses are well educated and do have great portability of skills. Two decades ago it may have been possible to argue that female career choices were limited and that nursing benefited from an effective captive market. That situation no longer exists anywhere in the world. The current competitive environment for graduates exists in a completely separate social time scale to the 1950's and 1960's which saw nurses required to resign their positions if they chose to marry. Nurses are now capable of transferring their skills to other industries quite readily.

Importantly the HPV submission ignores the fact that the shortage of nursing personnel is a direct result of low entry numbers and low graduation numbers from the current education programs. As tertiary entrants student nurses have choices. They may elect to pursue other health-related programs such as physiotherapy or medicine or other disciplines all together. In proposing an environment which is regressive in terms of professional development, flexibility and recognition, HPV are proposing a strategy which will result in students electing to make other choices.

(f) Fostering business efficiency

Nursing Australia has some difficulty with this aspect of the document as reference is made to health funds as the purchasers of agency nurse services. It is assumed that any involvement of private health funds in a government tender for the provision of services would be subject to a separate process.

With regard to the efficiency principles described by HPV, the transaction costs involved in tendering are clearly significant. It is not clearly explained how administration costs will be reduced by forcing nursing agencies to set a standard price.

The utilisation of the terms "encourage prospective tenderers" and "offer competitive wages" are somewhat juxtaposed compared with their normal usage. Nursing Australia submits that a supplier not chosen to participate on the "panel" will effectively be required to exit the industry sector.

HPV is perversely suggesting that the misuse of market power that would result from an aggregation of purchasers would somehow improve business efficiency. On the contrary, Nursing Australia submits that the Proposed Conduct would have profound consequences on the nursing agencies/health services market that would reduce efficiency in this market (see section 3.4(a)). The market is actually regulated by the availability of skilled nurses rather than by any tender process. At this time, no tender system operates within the public sector. To suggest that the costs of administering a single tender is less than the costs of multiple tenders is therefore misleading. Currently, agencies are chosen by health services on the basis of their capacity to supply appropriate staff. There is no apparent business efficiency to be gained in this process.

3.4 Other Public Detriment

Nursing Australia submits that the Proposed Conduct will cause significant other public detriment resulting from a lessening of competition in the relevant markets identified and discussed in sections 3.1 and 3.2 of this submission.

The Proposed Conduct, particularly the tender process, will also have a negative impact on the nursing agency industry by dramatically and unfairly changing the role of nursing agencies in the healthcare sector.

(a) Tender Documentation

Nursing Australia submits that, if the proposed tender process were allowed to proceed, it would substantially lessen competition, particularly in the nursing agencies/nurses market, which would result in public detriment.

(i) Abuse of Market Power

Nursing Australia submits that if the Commission grants authorisation and the Proposed Conduct (ie the issuing of the tender) was allowed, few (if any) nursing agencies would be able to realistically and/or viably tender due to the terms of the proposed tender documentation (which is annexed as Attachment A to HPV's applications Nos. A90811 and A90812).

Nursing Australia submits that the extremely unbalanced and unreasonable nature of the tender documentation evidences an intention by HPV to abuse the market power for which it is seeking authorisation. If authorisation is granted by the Commission and the tender is issued, the terms of the tender would have a dramatic effect on the nursing agency industry such that it would completely change the nature of that industry. This is discussed below.

(ii) Existing Commercial Environment

The current nursing agency market in Victoria is characterised by multiple purchasers of nursing labour supplied by over 60 nursing agencies. Nursing agencies currently act as "brokers" by bringing together nurses available to work with health services that require supplementary nursing labour. As requested by the purchasers, nursing agencies supply and place available staff with those purchasers, typically health services.

It is well-established that the common law does not recognise the supplier of supplementary staff as the employer of those supplementary staff in circumstances where the work performed by the supplementary staff is not actually supervised or controlled by the supplier. Consequently, a health service (as purchaser) is the employer of any and all supplementary staff placed with the health service through a nursing agency.

The *Pay-roll Tax Act 1971 (Vic)* recognises the status of agency nurses as being employed by the health service, for it states that the end user of supplementary staff is liable for the payment of payroll tax, not the supplier of those supplementary staff.

A nursing agency does not clinically supervise or control the nurses whom it supplies to a health service. All nurses (including agency nurses) must follow doctors' orders and are also directed and supervised by nursing management and/or medical staff.

Nursing Australia attaches a copy of its standard agreement for the supply of supplementary staff as Annexure D. Clause 5 of this agreement clearly sets out the obligations of the health service as the employer of the supplementary staff.

Nursing agencies are currently suppliers of labour services in the form of independent contractors. More specifically, they are not the employers of those contractors.

(iii) Effect of Tender Process on the Pre-Existing Nursing Agency Industry

The terms of HPV's tender documentation effectively changes the role played by nursing agencies from being suppliers of labour services to being suppliers of healthcare services. The ramifications of this change are enormous.

The Request for Tender documentation states that "neither HPV nor the Health Services regard itself (sic) in any way as the employer/principal contractor of the staff provided by the Contractor".[76] A tender submission must include an acknowledgment by the tenderer that it accepts this statement.

The proposed change in the role of nursing agencies to suppliers of healthcare services is further emphasised in the insurance obligations contained in the proposed tender documentation (Provision for Temporary Nursing Services, clause 9). Under the terms of the proposed tender documentation, nursing agencies would be required to insure against loss or damage caused by or arising from the use of diagnostic equipment or procedures involving the omission of ionising radiations. Given that such equipment is owned by the relevant health service and the procedures for its use are under the control of the relevant health service, this provision implies that nursing agencies are providing a healthcare service which would give rise to insurable risk.

In extending the role of nursing agencies to becoming suppliers of healthcare services, HPV's tender documentation also requires that nursing agencies be liable for the payment of payroll tax in relation to their agency nurses.[77]

The increased insurance obligations and the imposition of payroll tax at the rate of 5.45% could only have the effect of significantly increasing the costs of any successful tenderer providing its services to HPV and the Health Services under the tender arrangement. As the costs of any tenderer can only be

---

[76] Application by HPV, Attachment A: Tender Documentation, Request for Tender, clause 3.17.

[77] Application by HPV, Attachment A: Tender Documentation, Provision for Temporary Nursing Services, clause 3.17.

increased under the terms of HPV's tender documentation, it is difficult to see how any tenderer can realistically and on a long term basis viably comply with clause 3.3 of the tender documentation which states that it is expected that temporary nursing staff will be provided by tenderers on the basis of the Award.

(iv) Summary

Nursing Australia submits that the tender documentation is unbalanced, unreasonable and, due to the terms it seeks to impose on tenderers, will have a dramatic effect on the nature of the nursing agency industry. If authorisation is granted by the Commission and the Proposed Conduct (ie the issuing of the tender) was allowed, it would result in the unsustainable position of nursing agencies becoming suppliers of healthcare services, rather than suppliers of labour. It is clear that HPV is not prepared to pay more for that transfer of responsibility and risk, a situation that (if allowed to occur) is unfair and unreasonable.

Nursing Australia submits that the tender documentation therefore evidences an intention by HPV to abuse the market power for which it seeks authorisation; namely, the market power it holds as the controller of 70% of the nursing equivalent full-time employees in Victoria.

Nursing Australia's more detailed comments in relation to the proposed tender documentation are set out in the Schedule.

4. Other Submissions

4.1 Key Submissions in Support of Application

In the supplementary submission lodged by Southern Health on 4th January 2002 in support of the interim authorisation request it is indicated that the utilisation of agency nursing staff has remained consistent over the preceding two years. Data collected by Nursing Australia would indicate that the patterns of utilisation have been consistent for in excess of 5 years. It should be noted that the rate of utilisation of agency nurses by Southern Health is somewhat aberrant in comparison to other health services and has been so for many years. The original transfer of metropolitan hospitals to the suburb of Clayton in 1988 resulted in staff shortages related to geographic considerations. These shortages have not been specifically addressed during the ensuing years. Assertions relating to recent "changes" in the rate of utilisation should be interpreted in the context of a change in the skill mix of nursing agency staff rather than any real change in overall volume. The causative factors related to this may be related to internal factors within Southern Health.

5. Conclusion

Nursing Australia submits that the public benefits contended by HPV in its application will not result from the Proposed Conduct. That is so because there is nothing to suggest in HPV's application that the Proposed Conduct will in fact produce the perceived public benefits. Even if contrary to this submission the benefits can be derived, those benefits can be obtained without the need to impose an anti competitive exclusive tender arrangement. In these circumstances, there can be no justification which would warrant the Commission granting the authorisation sought by HPV.

Finally, HPV has in correspondence to the Commission foreshadowed that DHS may issue directives to public health services under section 132 of the *Health Services Act 1988 (Vic)* in relation to use of agency nurses by public health services. This demonstrates that there is no need to introduce anti competitive exclusive tenders to achieve the Government's

stated objectives of reducing the burden of agency staffing costs on the public hospital system.

The application by HPV for authorisation should be refused.

If the Commission would like to discuss any aspect of this submission with Nursing Australia or requires any additional information from Nursing Australia, please do not hesitate to contact:

Russell Bateman
Chief Executive Officer
Nursing Australia
Level 1
580 Church Street
RICHMOND VIC 3124
Tel: (03) 9254 2000

or Nursing Australia's solicitors:

Middletons
Attention: Sebastian Greene
Level 29
200 Queen Street
MELBOURNE VIC 3000
Tel: (03) 9640 4224

;hedule: Comments on Tender Documentation

The comments in this Schedule are intended to highlight the change in role that the tender documentation seeks to impose on nursing agencies from suppliers of labour to suppliers of healthcare services.

If Nursing Australia intended to submit a tender, it would have further requested amendments in relation to the terms and conditions of supply for its services.

Comments on the proposed Request for Tender

The Request for Tender (**RFT**) sets out the terms on which a prospective tender may submit a tender.

Part A: Clause 1 – General scope of purpose of the tender

The term of the exclusive provision of "nursing services" is intended to be for an initial term of five years with an option to renew for a further two years exercisable by each relevant health service. As a result of the exclusive nature of the proposed tender arrangement, unsuccessful tenderers will be precluded from servicing the public sector for a period of at least five years and up to seven years.

Part B: Clause 3.17 – Engagement/Employment of agency staff

In clause 3.17, the RFT specifically states that neither HPV nor the relevant health service is the employer or principal contractor of the staff provided by a successful tenderer. A tenderer is required to acknowledge that it accepts this statement in its tender submission.

Part B: Clause 4.7.5 – HPV has absolute discretion

HPV has an absolute discretion to accept a tender that has variations requested by HPV only of that tenderer and subsequent to the submission of the original tender. This provision would allow the preferential awarding of the tender after its close on terms that are different to the original terms proposed in the tender documentation and are not offered to all tenderers.

Part B: Clause 5.3 – No right of recourse

All rights a tenderer may have to challenge any unlawful or unethical conduct in awarding the tender are expressly waived.

Comments on the Provision for Temporary Nursing Services

The Provision for Temporary Nursing Services (**PTNS**) forms the basis of the proposed agreement under which services will be provided by successful tenderers to HPV on behalf of the health services.

Clause 3.6.2 – Performance Indicators

Clause 3.6.2 requires a success tenderer to conform to "Performance Indicators" that are to be set out in Schedule 4. There are no performance indicators currently set out in Schedule 4. Schedule 4 is also supposed to set out "financial reductions" that are to apply – presumably for a failure to comply with Performance Indicators. Whilst details of the Performance Indicators and the financial reductions are not provided in the tender documentation, the concept of penalties for failure to fulfil specific performance criteria appears to be particularly onerous and substantially exceeds current industry practice.

ıuse 6.4.4 – Staff Standard

Clause 6.4.4 requires that a successful tenderer must be satisfied that its agency nurses have demonstrated basic competency in the clinical area. Nursing agencies exercise a high level of skill and care in checking each agency nurse's qualifications and experience. However since nursing agencies cannot clinically supervise agency nurses, it is not possible to directly test demonstrated basic competency.

This provision also raises the issue of whether a successful tenderer would be granted sufficient access to a health service to be able to fulfil its obligation to test an agency nurses' basic competency in the clinical area.

Clause 6.7 – Compliance with polices, rules, procedures and standards

Clause 6.7 requires a successful tenderer to ensure that its agency nurses comply with polices, rules, procedures and standards. Given that nursing agencies do not exercise any clinical supervision over their agency nurses during their placement in a health service, this obligation is inappropriate.

Clause 6.10 – Training and instruction

Clause 6.10 requires a successful tenderer to ensure that its agency nurses are properly and sufficiently instructed. Given that nursing agencies do not exercise any clinical supervision over their agency nurses during their placement in a health service, this obligation is inappropriate.

Clause 6.11-16 – Responsibility of engagement/employment and conditions of service

The tender documentation proposes to extend the role of nursing agencies to suppliers of healthcare services, rather than their traditional role as suppliers of labour. This extension of the role of nursing agencies will result in the imposition of payroll tax at the rate of 5.45% in Victoria on nursing agencies in respect of its agency nurses for the first time.

It could be expected that nursing agencies would seek to recover this liability for payroll tax by increasing the service fees associated with providing their nursing agency services to health services. This additional cost is likely to off-set any potential cost savings achieved under the tender.

Clause 9.2.6 – Insurance: Specific obligations

Clause 9.2.6 requires that a successful tenderer accept liability and provide indemnity for injury or loss arising form the use of diagnostic equipment involving ionising radiations. Given that such equipment is owned by the relevant health service and the procedures for its use are under the control of the relevant health service, this provision implies that the nursing agencies are providing a healthcare service that would give rise to insurable risk.

Extension of "Services" to include healthcare services

Clause 18.1 defines "Services" as a combination of "Agency Services" and "Nursing Services". Agency Services appears to refer to the coordination and provision of the nursing agency services that is consistent with current practice. Nursing Services refers to the nursing services provided by the successful tenderer's agency staff pursuant to the tender. As stated in the body of Nursing Australia's submission, this distinction implies the provision of healthcare and associated clinical responsibilities, which are inconsistent with current practice.