Australia®

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15th February 2002

Attention: Mr Gavin Jones

Mr Tim Grimwade
A/g General Manager
Adjudication Branch
Australian Competition & Consumer Commission
PO Box 1199
DICKSON ACT 2602

Dear Mr Grimwade

Applications for Authorisation Nos. A90811 and A90812
Applicant: Health Purchasing Victoria (HPV)

We submit this document in opposition to the above authorisation request. This document expands upon the basic submission lodged on 4 January 2002 in relation to the application for interim authorisation sought by HPV in December 2001 and the further material later provided by our solicitors Middletons.

Our solicitors have indicated that they might be separately sending to the Commission by facsimile today some further points specifically directed at section 90(6) of the Trade Practices Act 1974.

Yours Sincerely

Russell Bateman
Chief Executive Officer

(Enclosures: Submission and Annexures)

Submission in Opposition to Application

Submitted to the Australian Competition & Consumer Commission

Submitted by the Nursing Australia Group of Companies

Application Nos. A90811 and A90812
Submitted by Health Purchasing Victoria

Restriction of Publication of Part Claimed

Pursuant to Section 89 (5)

Commercially sensitive information appears at pages 3,25,26,27,34,35,36

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Nursing Australia's Submission on HPV's Substantive Application

1. Introduction

1.1 Executive Summary of Nursing Australia's Submission

Health Purchasing Victoria (**HPV**) has made an application to the Australian Competition & Consumer Commission (**Commission**) for authorisation in relation to the calling and awarding of a tender by HPV, on behalf of various public health services, for the exclusive acquisition of temporary agency nursing staff from nursing agencies by the public health services (**Proposed Conduct**).

The stated objective behind the Proposed Conduct for the exclusive tender of temporary nursing staff is to reduce the overall nurse staffing costs of health services in public hospital facilities in Victoria. For the reasons set forth below, this objective will not be achieved by the proposed exclusive tender arrangement. In any event, even if the proposed benefits could be achieved (which is denied for the reasons set forth below), those benefits will not flow from or be in any way connected with the imposition by HPV of a fundamentally anti-competitive exclusive tender arrangement.

Nursing Australia contends that HPV's application for authorisation is fundamentally flawed in that there is no cogent evidence or recognised economic theory which points to the conclusion that the benefit which the Government seeks to obtain of reducing overall nurse staffing cost in public hospital facilities in Victoria will be achieved by the imposition of an anti competitive exclusive tender arrangement. The Government's objective can be achieved by other means which do not detrimentally affect the competitive forces in the relevant market.

HPV's submission is based on two false premises. First, that, by reducing the level of agency nurses' incomes, nurses will work longer hours to maintain their income and therefore reduce the overall nurse staffing cost in public health services. This proposition is unsustainable. Nurses will not be attracted to work greater hours in the public system by paying them less. The Proposed Conduct will exert further pressure on the public system by nurses exiting the public system to work in private hospitals where the rate of pay is substantially higher. That cannot be to the public's benefit. Second, that the perceived benefits can only be achieved by an exclusive tender arrangement. This proposition is also unsustainable. The exclusivity of the tender does not result in public benefit. The public benefit could be achieved by other means such as minimum terms and conditions which make nursing agencies compete on both price and non-price criteria such as quality of service, efficiency of service, ability to fill vacant positions, speed at which positions can be filled and the quality of nurses provided.

Each of these factors have a public benefit which can be achieved without the need of making the tenders exclusive. It is the exclusive nature of the tenders which makes them offensive. There is no public benefit which results from the exclusive nature of the tenders which would justify the grant of authorisation by the Commission.

The exclusivity of the Proposed Conduct will result in a substantial lessening of competition in the nursing agency market as:

(a) unsuccessful tenderers will be excluded from approximately 70% of the public sector market;

(b) unsuccessful tenderers will not be able to maintain:

(i) a viable pool of nurses;

(ii) the information technology infrastructure to provide the services;

(iii) the administrative infrastructure to provide the services;

such that they will be at a substantial disadvantage to compete against the successful tenders at the end of the first term of the exclusive contracts.

The following is an executive summary of why Nursing Australia contends that the public benefits contended by HPV of reducing overall nurse staffing cost and attracting nurses to work additional hours in the public health system will not be achieved:

- Victoria is experiencing a nursing shortage.[1] Nurses have become highly-skilled professionals and carers with university-educated Registered Nurses forming the core of the health workforce[2] (see section 2.2(c)).

- Each highly-skilled nurse lost to the public health system will take at the least 4 years investment in education to replace. The cost of high turnover is enormous (see generally section 2.1(b)).[3]

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[1] The National Review of Nursing Education Discussion Paper, December 2001, 1; The Nurses Recruitment and Retention Committee Final Report, May 2001, 2.

[2] The National Review of Nursing Education Discussion Paper, December 2001, 5.

[3] National Review of Nursing Education Discussion Paper, December 2001, 86.

- The public benefits that HPV purports may result from the Proposed Conduct are erroneous (see section 3.3).

- The HPV contention that a retrograde approach to nurses wages at the margin, that is in relation to agency nurse, 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.

- The public detriment resulting from a lessening of competition in the relevant markets, and particularly the nursing agencies/public health service market, will outweigh the public benefits that HPV purports would result from the Proposed Conduct (see section 3.2).

- HPV's contention that an exclusive tender arrangement for the provision of agency nurses is an appropriate strategy is fundamentally flawed. HPV's proposal to remove any form of real competition, limit nurses' choices in terms of work opportunities, reduce nursing wage rates and fix agency prices is regressive and will only exacerbate any shortages in the supply of nurses to the Victoria public sector.

- There have been numerous reports commissioned by the Victorian government regarding the nursing profession. These reports have invariably found, amongst other things, that a worldwide shortage of nurses exists due in no small part to a high attrition rate in the profession (see section 2.1(a)).

- The level of utilisation of agency nurses in Victoria represents only 3.1% of the nursing Equivalent Full Time (EFT) positions in 2001. There has been no material change in the usage of agency nurses by public health services in recent years (see section 2.1(d)).

- In their current form, nurse banks currently operated by individual health services are unable to provide the number of nurses required to fill unplanned vacancies. This inability is due to the high number of nurses that are required with a broad spectrum of qualifications in order to satisfy the diverse staffing requirements of any single health service (see section 2.1(f)).

- Nursing Australia has been successful in recruiting nurses to work additional hours to satisfy the demand for nurses in public health services (see section 2.1(h)).

- The differential cost of employing a permanent nurse and engaging an agency nurse is marginal when on-costs are factored into agency rates(see section 3.3(a)). If full cost absorption is adopted as required by the National Competition Council in considering the benefits or otherwise of evaluating an external supplier, it will become apparent that a typical agency nurse placement will cost [redacted] times the base award. A typical supplemental nurse provided by a nurse bank will cost **2.5** times the base award (see section 3.3(a)).

- The HPV contention that nursing agencies are paying inflated salaries and extracting inappropriate profits is wrong.

- The demographic considerations of the nursing workforce have considerable influence on the potential response to the proposed action and cannot be discounted (see section2.2(c)).

- The introduction of nurse to patient ratios has increased the demand for nurses relative to the supply of nurses (see section 2.3(b)).

- Over half of the recent increase in nursing agency costs reflects the underlying increase in the wages of nurses and associated on costs. The remaining increase in

confidentiality granted for
areas outlined in red

nursing agency costs reflects to a significant extent, the necessity for nursing agencies to recover capital expenditure on existing technology and infrastructure in order to continue to be able to provide a competitive and viable service to both health services and nurses. (see section 2.3(d)).

- The demand for Nursing Australia's nursing agency services has reduced as a result of rises in agency costs, which indicates that the nursing agencies/health services market experiences own price elasticity of demand (see section 2.3(f)).

- There are five potential markets that will be negatively effected by the Proposed Conduct. The most significant impact of the Proposed Conduct will be in the nursing agencies/public health services market and the nursing agencies/nurses market as a result of the exit of unsuccessful tenderers from these markets (see section 3.1).

- 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.

- The proposed Provision for Temporary Nursing Services Agreement that successful tenderers will be required to execute will have a dramatic impact on the nursing agency industry. In effect it will change nursing agencies from suppliers of labour to suppliers of healthcare services and, in doing so, evidences an intention by HPV to abuse its market power (see section 3.4(a)).

- The terms of the Temporary Nursing Services Agreement will result in a significant distortion of the nursing agencies' market in that nurses willing to make themselves available for agency work will leave the nursing pool of the unsuccessful tenderers and join the successful tenderer's agency. This will deliver market dominance in the provision of agency nurses to the successful tenderers. This anti competitive result will become acute at the expiration of the first term of the Nursing Services Agreement as it is likely that unsuccessful tenderers will have left the market completely.

1.2 Application by Health Purchasing Victoria

HPV has sought authorisation under section 88(1) of the Trade Practices Act 1974 (Cth) (**TPA**) on the basis that:

- the Proposed Conduct may constitute a contract, arrangement or understanding which contains a provision that would, or might be, an "exclusionary provision" within the meaning of section 45 of the TPA; and

- the Proposed Conduct may constitute a contract, arrangement or understanding which would have the purpose, or is likely to have the effect, of substantially lessening competition within the meaning of section 45 of the TPA.

HPV's application contends that the Proposed Conduct would result, or would be likely to result, in a benefit to the public that may outweigh the detriment to the public constituted by any lessening of competition that will result directly from the Proposed Conduct. There is no evidence referred to in HPV's application which would justify such a conclusion. There is no recognised economic theory which would justify such a conclusion. At best, HPV's application is based on mere assertion of public benefit which does not withstand scrutiny for the reasons set out below.

1.3 Legal Grounds for Opposition

HPV's application was made under section 88(1) of the TPA. Section 88(i) allows the Commission to grant an authorisation to make and give effect to a contract, arrangement or

understanding containing a provision which constitutes an "exclusionary provision" or may have the purpose or effect of substantially lessening competition within the meaning of section 45.

The TPA provides that the Commission will only grant authorisation if the applicant satisfies the relevant test in section 90(6) of the TPA. Section 90(6) states that the Commission will grant authorisation only if it is satisfied in all the circumstances that:

- the provision of the proposed contract, arrangement or understanding would result, or be likely to result, in ***a benefit to the public***; and
- that ***benefit would outweigh the detriment to the public constituted by any lessening of competition*** that would be likely to result from the proposed contract, arrangement or understanding.

In assessing the relevant public benefit, a comparison must be made of the future position that would exist if the Proposed Conduct were not entered into, or given effect to, with the future position which would arise if the Proposed Conduct were entered into or given effect.

This necessarily involves two primary considerations:

- whether the Proposed Conduct is likely to operate in practice so as to give rise to the public benefit; and
- whether the Proposed Conduct is the most appropriate method of achieving the desired public benefits given the public detriment associated with the proposed conduct.

Nursing Australia submits that the proposed conduct will not give rise to the public benefits. Moreover, any public benefits that may arise from the granting of authorisation are far outweighed by the public detriment that will be occasioned by the imposition of an anti competitive exclusive tender arrangements for nursing services. Nursing Australia contends that there is no basis disclosed in HPV's application which would justify the imposition of an anti competitive exclusive tender arrangement. In any event, to the extent that any public benefit may be achieved, then that public benefit may be achieved by means other than the Proposed Conduct and the imposition of an exclusive tender arrangement.

1.4 Description of Nursing Australia

(a) Background

Nursing Australia commenced on 23 August 1986. It was founded as a management body to administer the affairs of a number of nursing agencies. During its 15 year history Nursing Australia has garnered many awards for excellence in enterprise, service and business. From 1992 to 1995 Nursing Australia has won a number of Telstra and Victorian Government awards for business excellence. In 1993, it became the first employment services company in the world to be awarded ISO-9001 quality accreditation. Subsequently, in 1995, Nursing Australia was invited to actively participate and promote Australian business through the "Drum on Business" campaign conducted by the Federal Government. Nursing Australia is the only business in Victoria to have twice won the Victorian Employer Chamber of Commerce and Industry award for enterprise. Nursing Australia regards its principal goal as being the provision of a level of service and support in order to:

- encourage nurses to remain in the nursing profession;
- encourage the return of nurses to the profession; and

- inspire students to enter the profession.

(b) Nursing Australia's participation in the nursing agency industry

Nursing Australia provides a significant number of casual nursing placements into a wide range of health services. Indeed, Nursing Australia has a client relationship with most health care service providers in Victoria. As these relationships have existed over many years, Nursing Australia has had the opportunity to gather a large amount of empirical data.

Nursing Australia acts as a management service to administer the affairs of a number of individual agencies (which have common ownership). The individual agencies reflect the wide range of specialities and services that are part of the diversity of the nursing workforce. In excess of 25,000 nurses across Australia form the basis of the Nursing Australia database.

2. Background

2.1 Nursing Agency Industry

(a) Reviews of the Nursing Industry

The nursing profession has been the subject of a number of major reviews in recent years. Copies of these reviews are attached in the annexures to this submission (see Annexures 5 and 1).

(i) The Nurse Recruitment and Retention Committee Final Report, May 2001 and the Victorian Government Response of June 2001

In order to address the current shortage of nurses in Victoria, in February 2000 the Victorian government appointed the Nurse Recruitment and Retention Committee (**Committee**) to provide advice on matters relating to the registered nurse workforce in Victoria.[4] The Committee focused on issues surrounding the attraction and recruitment of nurses, the exodus of nurses from the workforce and the retention of qualified, experienced nurses.

The Committee's Report lists 86 recommendations aimed at attracting people into nursing, recruiting those who have left back into nursing and retaining nurses who are currently employed in the public health sector in Victoria.[5]

The Committee recognised that Victoria should be implementing strategies that result in the attraction of sufficient people of high calibre to nursing to ensure supply meets demand, that stems the exodus of experienced qualified nurses not only from the bedside but also from the profession and that retains nurses who not only provide best practice care, but are satisfied in their work.

Although all recommendations made by the Committee were unanimously endorsed, the Committee expressly recognised that the issues are many and complex and require *long term*, as well as immediate, solutions.

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[4] The Nurse Recruitment and Retention Committee Final Report, May 2001, Foreword.

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

In accepting the Committee's recommendations the Victorian Minister for Health expressly acknowledged that "nurses are critical to the delivery of quality healthcare in the State, in both the hospital and community settings".[6] Nursing Australia submits that the Proposed Conduct ignores the critical role undertaken by nurses in delivering Victorian healthcare services in a mis-directed, misguided and unsustainable attempt to reduce the costs of Victorian public healthcare.

(ii) National Review of Nursing Education, Discussion Paper, December 2001

On 30 April 2001 the then Commonwealth Minister for Education, Training and Youth Affairs and Minister for Health and Aged Care jointly announced the National Review of Nursing Education (**Review)**.

The Commonwealth acknowledged a reduced level of interest in school leavers in nursing as a career, the cost of nursing education, the changing demands of the labour market in terms of the types of knowledge and skills required and the timing and distribution of those needs all combine to create a highly complex relationship between the education of nurses and the labour market.[7] It was held that it was time to examine these issues through a review of nursing education to ensure that nursing education meets the needs of the changing labour market.

The Review recognised that the issue of the nexus between nursing education and the demands of the labour market had become a focus of concern.[8] They further acknowledged that there exists a general nursing workforce shortage as well as shortages in specialist areas.

(iii) Further Government Reports

In addition, the following state government reports have been released: Nursing Recruitment and Retention Taskforce Final Report, (NSW Health 1996); South Australian Nursing Recruitment and Retention Taskgroup Report (Department of Human 1998); Report into Nursing Recruitment and Retention (Queensland Health 19999); Attracting Nurses Back Into the Workforce (Health Department of Western Australia) and Rethinking Nursing 1999, a national forum sponsored by the Commonwealth Department of Health and Aged Care.

(b) Demand for Nurses and Supply of Nurses

There is widespread support for the view that there are insufficient nurses staffing the Victorian public health care system.[9] Yet, the problem is not exclusive to Victoria, for it is an unavoidable fact that a worldwide shortfall exists in relation to the

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[6] The Nurse Recruitment and Retention Committee Final Report, May 2001, Foreword by John Thwaites MP, Minister for Health.

[7] National Review of Nursing Education, Discussion Paper, December 2001, 2.

[8] National Review of Nursing Education, Discussion Paper, December 2001, 2.

[9] The Nurse Recruitment and Retention Committee Final Report, May 2001, 1; National Review of Nursing Education, Discussion Paper, December 2001; Department of Employment, Workplace Relations and Small Business 2000, Department of Human Services 1999.

demand for nursing services compared with the available supply.[10] Indeed, many jurisdictions assume that such shortage will remain for the foreseeable future[11]. Victoria is one such jurisdiction, for the Department of Human Services (**DHS**), in its *Nurse Labourforce Projections, Victoria 1998 – 2009* estimated that with current levels of demand for health services, Victoria would face a shortfall of 5500 registered nurses by 2008.[12] Thus, even without the potentially disastrous consequences of the Proposed Conduct, concern exists that the current rate of attrition "will continue to outstrip the number that enter".[13]

The attrition rate from the nursing profession is regarded as being one of the primary reasons for the shortage. More precisely, a greater number of persons are electing to abandon the profession than are graduating to replace them. Nationally, the overall number of graduates from the Bachelor of Nursing programs has been steadily declining.[14] According to the latest Victorian figures, in 1998 there were 69,811 nurses registered and 56,350 of these were in the workforce. Thus, 13,461 nurses were registered, but not employed in nursing.[15]

To add to the pre-existing shortage, the Committee's consultation process revealed that many nurses currently working are considering leaving the profession in the short term future.[16] Any further exodus will only serve to exacerbate projected shortages. Further, as many as 12% of nurses who have already left the public health care system have indicated that they are not prepared to return.[17]

The outcome of this shortage manifests itself in a requirement for currently-working nurses to make themselves available in excess of their normal work hours. This extra availability can occur with persons currently working part time accepting additional work, or it may be persons who have full time employment electing to offer more hours of labour.

It is crucial to appreciate that the costs incurred in providing sufficient labour hours must match not only the general shortfall, but the specific shortfall in areas of speciality will be greater than basic award rates. This point is expanded on in sections 2.1(f) and 2.2(a) in this submission.

(c) Victorian Government's Attempts to Attract Nurses

DHS has acknowledged the basis of the nurse labour force shortage and, in line with recommendation 16 of the Committee, has conducted an extensive campaign to

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[10] The Nurse Recruitment and Retention Committee Final Report, May 2001, 30; The National Review of Nursing Education Discussion Paper, December 2001, 12.

[11] The Nurse Recruitment and Retention Committee Final Report, May 2001, 30.

[12] The Nurse Recruitment and Retention Committee Final Report, May 2001, 1.

[13] The Nurse Recruitment and Retention Committee Final Report, May 2001, 3.

[14] Australian Institute of Health and Welfare 1999, as cited in The Nurse Recruitment and Retention Committee Final Report, May 2001, 31.

[15] The Nurse Recruitment and Retention Committee Final Report, May 2001, 34.

[16] The Nurse Recruitment and Retention Committee Final Report, May 2001, 39.

[17] Campbell Research & Consulting 2000, as cited in The Nurse Recruitment and Retention Committee Final Report, May 2001, 39.

encourage both registered non-practising and unregistered nurses to return to the workforce. This campaign has been reported as costing approximately $26.9 million over a twelve month period.[18] The campaign has reportedly attracted some 2,600 nurses to re-enter the workforce. No statistics have been published about the number of nurses who exited the profession during this period. The campaign focused on high-profile advertising and some subsidisation of re-entry programs.

The following selected quotations illustrate the Victorian Government's rhetoric regarding the issue of nurse staffing in public health services:

> *The Government remains committed to supporting and promoting the profession of nursing in Victoria.*[19]
>
> *In accepting the Nurse Recruitment and Retention Committee's Final Report I am confident that Victorian nurses will now feel that they can practice in an environment where they are valued and rewarded for their crucial contribution to the health of all Victorians.*[20]
>
> *The nursing workforce is a dynamic entity which is sensitive to changes in health care delivery patterns.*[21]
>
> *[Current structure] continues to flourish in what is a seller's market (ie nurses market).*[22]

Nursing Australia submits, however, that HPV's application for authorisation of the Proposed Conduct is inconsistent with the Victorian Government's rhetoric and will not result in the achievement of its stated objectives.

(d) Role of the Nursing Agency Industry

The nursing agency industry has existed internationally since the beginning of the modern era of nursing in the early part of the 20th century. One nursing agency which is part of the Nursing Australia Group has traded for over 60 years.

The role of a nurse's agent can be compared to the role of any employment agent. The agent is engaged by a party wishing to sell their labour services. The economic principle of imperfect information ensures that an agent who makes it their business to be aware of multiple work opportunities in a market is in a position to match the work-availability of a nurse with the work requirements of a health service.

Table 1 sourced from the Review illustrates the relative numbers of Registered Nurses in each major speciality group for each state.[23]

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

[19] The Nurse Recruitment and Retention Committee Final Report, May 2001, Foreword by John Thwaites MP, Minister for Health.

[20] The Nurse Recruitment and Retention Committee Final Report, May 2001, Foreword by John Thwaites MP, Minister for Health.

[21] Department of Human Services 1999 and Buerhaus, Staiger & Auerbach 2000 as cited in The Nurse Recruitment and Retention Committee Final Report, May 2001, 30.

[22] The Nurse Recruitment and Retention Committee Final Report, May 2001, 83.

[23] National Review of Nursing Education, Discussion Paper, December 2001, 36.

Table 1 – Number of Nurses Employed Throughout Australia

Area of clinical nursing	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Mixed medical and surgical	3,809	9,849	5,874	4,561	3,973	727	301	199	29,293
Medical	8,901	2,421	2,426	1,542	1,041	492	162	76	17,059
Surgical	5,947	3,004	2,926	1,560	1,195	393	274	109	15,408
Coronary care or surgery	1,623	993	–	–	–	–	72	–	2,688
Geriatric/gerontology	9,750	13,147	5,087	2,417	3,417	1,061	281	134	35,294
Oncology	996	984	600	–	–	67	38	–	2,684
Perioperative /operating Theatre/recovery	4,472	3,588	2,503	1,358	1,309	404	238	102	13,974
Rehabilitation	1,592	1,686	–	–	–	64	33	–	3,375
Renal	477	400	–	–	–	–	49	–	926
Respiratory medicine/asthma	379	90	–	–	–	14	3	–	486
Critical care/intensive care	3,317	2,211	1,741	903	835	197	196	72	9,472
Casualty accident/emergency	2,134	1,499	1,067	589	455	159	119	117	6,139
Midwifery	4,263	4,060	2,360	1,192	1,354	426	325	212	14,192
Mental health/psychiatric	4,254	3,060	2,222	1,123	1,134	299	127	75	12,294
Community nursing	1,737	2,179	1,625	991	983	394	153	233	8,295
Developmental disability	1,502	371	186	180	190	92	12	2	2,535
Occupational health	168	305	221	108	149	8	5	16	981
Paediatric	886	1,057	1,089	632	486	119	110	144	4,522
Aboriginal health	50	17	–	–	–	–	–	–	67
Child and family health	707	865	446	209	255	131	88	28	2,729
School children's health	129	171	119	186	30	–	12	24	672
No one principal area	584	937	934	424	44	121	23	166	3,233
Other	1,623	2,771	3,105	1,409	1,065	339	331	252	10,894
Total	**59,297**	**55,665**	**34,528**	**19,385**	**17,916**	**5,507**	**2,952**	**1,961**	**197,211**

DHS figures indicate 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.[24] Table 2 further estimates the numbers of Registered Nurse positions (Division 1, 2 and 3) provided by nursing agencies in total in Victoria. This data is drawn from the known recruitment capacity of all agencies in conjunction with data supplied by hospitals across Metropolitan Melbourne. It should be noted that both Table 1 and Table 2 represent total nursing numbers including both public sector and private sector health services.

[24] The Nurse Recruitment and Retention Committee Final Report, May 2001, 83.

Table 2 – Number of Nurses Employed in Victoria

Speciality of Nursing	Nurses	Agency	Agency Percentage
Mixed Medical and Surgical	9,849	1,100	7%
Medical	2,421	-	
Surgical	3,004	-	
Coronary Care	993	-	
Geriatric	13,147	867	7%
Oncology	984	-	
Operating Theatre	3,588	63	2%
Rehab	1,686	-	
Renal	400	-	
Respiratory	90	-	
ICU	2,211	203	9%
Emergency Dept	1,499	265	18%
Midwifery	4,060	260	6%
Mental Health	3,060	203	7%
Community Nursing	2,179	3	0%
Developmental Disability	371	-	
OHS	305	-	
Paediatric	1,057	66	6%
Aboriginal Health	17	-	
Child and Family Health	865	-	
School Health	171	-	
No Specific Area	937	-	
Other	2,771	-	
	55,665	**3,030**	**5%**

When expressed as EFT positions the data is transformed to that reported in Table 3.

Table 3 – Number of Equivalent Full Time Nurses Employed in Victoria.

1999/2000 EFT Statistics	Data
Nursing EFT	40,000
Agency EFT	1,200
Agency nursing as % of total	3%
Agency Growth Reported in 2001	4%
Total Agency EFT increased by 4%	1,248
Revised Agency Percentage	3.1%

The 2000 edition of the *Hospital and Health Services Yearbook* lists some 147 public hospitals in Victoria with 12,337 public beds available.[25] Private hospitals total 123 with 6,322 beds available.[26] All data reflects the combined public and private health sector markets. In order to extract data relating solely to the public health sector, the available data should be discounted by between 30% to 40% in each speciality.

As can be demonstrated, the actual level of nursing agency utilisation as a percentage of total EFT staff is approximately 3.1% of total establishments. There is

[25] Hospital and Health Services Year Book 2000 (edition 24), 16.

[26] Hospital and Health Services Year Book 2000 (edition 24), 16.

no data to support the contention that a significant migration has occurred from the public health sector to agency nursing. This analysis does not preclude a shift of employed staff from the public health sector to the private health sector.

An essential consideration in any discussion regarding the cost of nurses or the ability to recruit nurses is the vast range of skills and qualifications which characterises the profession. Annexure 7 lists in excess of 280 basic qualifications or skill sets that are then applied across the relative experience gradings which apply to each nurse. The permutations are significant and indicate why chronic shortages of skills may exist in specific areas of nursing for prolonged periods.

(e) Nature of Placements

Unlike general employment agents who typically receive days or weeks of notice to supply a placement (which placement may extend for weeks or months), nursing agencies offer a service under which they receive notice of, on average, between 3 to 4 hours for a placement that usually lasts for 8 hours. This matching process is intensive and expensive in terms of both the technology and human resources required to administer such a system. Without the investment in technology and human resources, the staffing shortfalls that occur each day in health services worldwide would be greatly exacerbated.

(f) Nurse Banks

A nurse bank is a collection of nurses who are employed by the relevant health service (eg a hospital) and work for a flexible number of hours per week depending on shortfalls in the health service's staffing requirements.[27] Each health service will generally operate a nurse bank to cover unplanned absences. The nurses notify the health service when they are available and as roster vacancies exist, they are engaged for those shifts. Indeed, the Committee's recommendation 56 was to encourage health facilities to (re-)establish nurse banks to meet their ad hoc staffing needs.[28] However, nurse banks have not alleviated the need for health services to engage the services of agency nurses for the reasons outlined below.

Table 4 below illustrates a model of a typical major hospital. The hospital has a number of departments, wards and services. Each of these areas will have a base establishment of staff. Industry average absenteeism is generally accepted as being in the order of 5%.[29] Table 4 therefore indicates 5% absenteeism in each area of the theoretical hospital. The potential permutations and combinations of absenteeism are then indicated across a four week block.

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[27] The Nurse Recruitment and Retention Committee Final Report, May 2001, Recommendation 56, 84.

[28] The Nurse Recruitment and Retention Committee Final Report, May 2001, Recommendation 56, 8.

[29] The Nurse Recruitment and Retention Committee Final Report, May 2001; Victorian Hospitals Industrial Association v Australian Nursing Federation, AIRC, 30 August 2001, 30.

Table 4 – Example of Hypothetical Metropolitan Health Service

		Beds	EFT Establishment	Shifts Per week	5% Sick Leave	Replacement Shifts Per Day
Ward 1	Gen Surg	30	26	181	9	1.3
Ward 2	Medical 1	30	26	181	9	1.3
Ward 3	Oncology	26	22	157	8	1.1
Ward 4	Renal	20	17	121	6	0.9
Ward 5	Orthopedic	26	22	157	8	1.1
Ward 6	Plastics / Vascular	26	22	157	8	1.1
Ward 7	Maternity	24	21	145	7	1.0
Ward 8	Gynae	24	21	145	7	1.0
Ward 9	Neuro	24	21	145	7	1.0
Ward 10	Cardiac	26	22	157	8	1.1
ICU		6	25	176	9	1.3
CCU		10	27	189	9	1.4
Emergency		20	40	280	14	2.0
Radiology			15	105	5	0.8
Outpatients			10	70	4	0.5
Operating Theatre	6 Theatres		66	462	23	3.3
		292	404	2829	141	20

Matrix Week One

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Replacement Shifts Per week	AM	PM	ND
1.3		1.0	2.0	2.0	1.0		7.3	2	2	3
1.3	2.6		2.0	2.0	1.0	1.0	9.9	3	1	4
1.1				2.0		1.0	4.1	2	1	2
0.9	2.0	1.0	1.0	3.0	2.0		9.9	4	2	4
2.2	1.1	2.0			1.0	2.0	8.3	3	2	3
1.1	1.1				1.0	1.0	4.2	2	1	2
1.0	1.0	2.0	2.5		1.0	1.0	8.5	3	3	3
2.0					2.0	1.0	5.0	2	1	2
2.0	3.0	1.0	2.0		1.0	1.0	10.0	4	2	4
1.1	1.1	2.0		3.0	1.0	1.0	9.2	4	2	4
1.3	1.3	3.0	3.0		2.0	1.0	11.6	5	2	5
1.4		1.6	1.0	1.0		1.0	6.0	2	1	2
2.0	3.4	2.0	3.0	2.0	1.0	1.0	14.4	6	3	6
0.8	1.0		1.0	1.0	0.5	2.0	6.3	3	1	3
0.6	0.3	2.0		3.0	2.0	1.0	8.8	4	2	4
3.3	3.3	4.0	2.0	3.0	1.0	1.0	17.6	11	2	5
23	21	22	20	22	18	16	141.0			

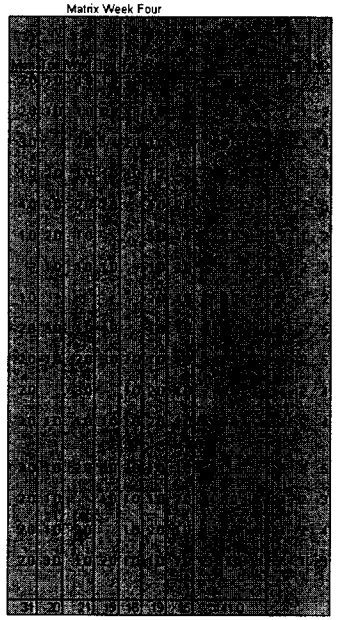
Matrix Week Two

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Replacement Shifts Per week	AM	PM	ND
			3.0	2.0	1.0		6.0	2	2	2
2.0	1.0	1.0			1.0		5.0	2	1	2
3.0		2.0		2.0	1.0	1.0	9.0	4	2	4
1.0	2.0	1.0	1.0	3.0	1.2		9.2	4	2	4
4.0	2.0	2.0	1.0		1.0	2.0	12.0	5	2	5
2.0	2.0	1.0			1.0	1.0	7.0	3	1	3
1.0	1.0	1.0	1.0		1.0	1.0	6.0	2	2	2
3.0					2.0	1.0	6.0	2	1	2
2.0	3.0	1.0	4.0		1.0	1.0	12.0	5	2	5
1.1	3.0	2.0		2.0	1.0	1.0	10.1	4	2	4
1.3		3.0	2.0		2.0	1.0	9.3	4	2	4
1.4		3.0	1.0	2.0		1.0	8.4	3	2	3
3.0	1.0	2.0	3.0	2.0	1.0	1.0	13.0	5	3	5
2.0	1.0		1.0	1.0	1.0	2.0	8.0	3	2	3
1.0	2.0	2.0		1.0	2.0	1.0	9.0	4	2	4
2.0	3.0	1.0	2.0	1.0	1.0	1.0	11.0	7	1	3
30	21	22	19	16	18	15	141.0			

Matrix Week Three

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Replacement Shifts Per week	AM	PM	ND
			1.0	2.0	1.0		4.0	2	1	2
1.0			3.0		1.0		5.0	2	1	2
		2.0			1.0	1.0	4.0	2	1	2
3.0	2.0	1.0	3.0	3.0	1.2	1.0	14.2	6	3	6
	3.0	2.0	1.0		1.0	2.0	9.0	4	2	4
	2.0	1.0	2.0		1.0	1.0	7.0	3	1	3
1.0	1.0	1.0	1.0		1.0	1.0	6.0	2	1	2
		2.0		2.0	1.0		5.0	2	1	2
2.0	3.0	1.0	4.0		1.0	1.0	12.0	5	2	5
0.8	3.0	2.0		2.0	1.0	1.0	9.8	4	2	4
2.0	1.0	3.0	2.0		2.0	1.0	11.0	4	2	4
2.0		3.0	1.0	2.0		1.0	9.0	4	2	4
4.0	1.0	2.0	3.0	2.0	1.0	1.0	14.0	6	3	6
2.0	1.0	1.0	2.0	2.0	1.0	2.0	11.0	4	2	4
1.0	2.0	2.0		2.0	2.0	1.0	10.0	4	2	4
2.0	3.0	1.0	2.0		2.0		10.0	4	2	4
21	22	24	25	15	17	17	141.0			

Matrix Week Four



It must be appreciated that this model (which demonstrates a single institution) is then repeated across <u>all</u> institutions each day. The 5% absenteeism factor represents an <u>entirely</u> different skill matrix each day.

The crucial aspect to understand is that a health service's skill requirements existing on any single day are entirely different to the skill requirements demanded on any other day. Consequently, a large pool of staff must be available upon which to draw in order to satisfy basic staffing needs on any given day. Considered in isolation, an immediate issue becomes apparent: how does an individual health service maintain sufficient availability of relief staff to meet all requirements at any specific time. By way of example, the following empirical observations have been made at one particular health service.

In order to provide an average of 150 EFT positions over a 12 month period, more than 5,000 individual nurses were required to fill the skill requirements demanded by that specific health service.

The logistics and technology necessary to manage a casual pool of more than 5,000 persons are significant. Recruitment, assessment, placement, remuneration, service entitlements and statutory obligations must be met for each placement.

A further consideration, however, is of even greater consequence. A person offering his or her skills to work actually desires to work. If work is not available, a rational person will seek work elsewhere.[30] An individual health service's nursing bank will therefore find its pool of staff is in a constant state of flux as individuals move to other health services in order to match the parameters of their availability with the parameters of work opportunities.

The principle of imperfect information is clearly a factor in the success or otherwise of individual hospital nurse banks. Table 4 indicates a model of a single city health service with multiple departments. The many permutations that exist in one health services are cumulative across the health system. The relative number of staff required at one facility is the same at another. In a model where information is imperfectly available, "wastage" and inefficiency occurs. Many nurses are left without work opportunities on any one day: similarly, many unplanned vacancies (usually attributable to illness) are left unfilled due to the inability to match availabilities and needs.

An agent such as Nursing Australia brokers information across a significant number of health care facilities utilising a large database of personnel. The short notice/short duration nature of placements requires the ability to process many requests for staff in a short period of time. Sophisticated technology is necessary to match the skills of nurses to the needs of hospitals in placing short-term requests at short notice.

In their current, under-resourced form, Victorian health services' nurse banks are inefficient. During a shortage of skilled nursing resources, a reliance on in-house inefficient nurse bank models will have a deleterious affect on nursing availability simply through the mechanism of imperfect information. The corollary is, however, that the costs of processing large volumes of transactions to minimise that inefficiency are significant and cannot be ameliorated. That is, the technology required to manage large numbers of placements in an efficient and effective manner is unavoidably costly.

It must be appreciated that this model which demonstrates a single institution is then repeated across all institutions each day. The 5% absenteeism factor represents an entirely different skill matrix each day.

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[30] The Nurse Recruitment and Retention Committee Final Report, May 2001, 84.

(g) No material change in rate of agency nurse usage by health services

Recent trends illustrate that there has been no material change in the rate of nurse agency usage by health services in recent years.[31]

The Australian Institute of Health and Welfare (**AIHW**) reports that during 1997 total nursing EFT numbers employed in Victoria was 48,813 with 69.2% or 33,778 EFT employed in the public sector[32]. Extrapolation at an average employment cost of $50,000 per annum indicates that the aggregate Victorian public sector nurse salary expenditure was $1,689 million per annum.

It must be appreciated that the costs incurred in recruitment, employment, placement, and administration will be at least as great for any health service as they will for any nursing agency. This point is crucial in any examination of the public benefit accruing from a consolidated tender process. All nurses who are employed must be subject to an interview process to determine the appropriateness of their qualifications for placement. All employees regardless of employment status must be administered through a payroll process. All casual staff must be managed through a mechanism that matches their availabilities with the required placements. Nursing Australia reiterates that these costs cannot be escaped regardless of the status of the employer. These costs must therefore be considered in any model which accurately estimates the public benefit accruing from the action proposed by HPV.

None of the costs referred to above will be avoided by the imposition of an anti competitive exclusive tender arrangement. Furthermore, there is no basis to suggest that an exclusive tender arrangement will result in the imposition of any competitive pressure on these "add on costs" of providing temporary nursing services. These "add on costs" are structural costs which will not be removed by the Proposed Conduct. Furthermore, these "add on costs" have not been taken into account in HPV's application when considering whether the Proposed Conduct is likely to have any effect on decreasing nurse staffing costs.

(h) Nursing Australia's Attempts to Attract Nurses

Nursing Australia has undertaken its own extensive program based upon the findings of the Recruitment and Retention Committee. Nursing Australia's program places an emphasis on flexibility, value and remuneration. Further, these key aspects have been supported by a program of continuous education and support. Nursing Australia established a "nurse support" resource whose goal is to address the concerns of nurses re-entering the workforce. Highly skilled nurses support new graduates, returnees and those expanding their range of skills from sub-acute to acute areas.

Nursing Australia's approach is based on recognising the inherent value of nurses to the community and supporting their clinical practice with a comprehensive education program. This approach has resulted in Nursing Australia achieving a high degree of success in returning nurses to the practising workforce.

Monitoring of recruitment statistics indicates that Nursing Australia has produced results equivalent to approximately 40% of the Government campaign. The cost, however, has been substantially less in terms of marketing. The transaction costs

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[31] Based on Nursing Australia's empirical data.

[32] Based on Nursing Australia's empirical data.

associated with recruitment, interviewing, reference-checking, employment on-costs and statutory costs are however understandably similar.

These costs must be acknowledged in any reconciliation of the relative effectiveness of any recruitment campaign. Effectively, it may be argued that in excess of $10,300 of marketing expenses are involved for each of the 2,600 nurses that DHS claims to have attracted back to the nursing profession (see section 2.1(c)).

(i) Conclusion

The Committee recognised that the issues surrounding recruitment and retention of nurses are complex and are influenced by a multitude of factors, of which pay rates is but one factor and not all of which are within the scope of Government to control.[33] The ageing of the nursing workforce, the proliferation of career opportunities available to women, the increasing demands placed on the healthcare system by society, rapid changes in healthcare technology together with associated requirements for educational preparation, and the trend towards community care for all but the sickest patient, have a direct effect on the demands made on the nursing workforce.[34]

Nursing Australia has been successful in attracting nurses back into the workforce and to work additional hours by being more innovative and flexible in its approach to employing nurses which has a real public benefit of attracting more nurses back into the workforce.

2.2 Participants in the Nursing Agency Industry

(a) Nursing Agencies

A description of the role of nursing agencies in the healthcare industry is provided in section 2.1 of this submission.

To illustrate the role that nursing agencies play in providing supplemental staff to health services, it is useful to consider one of the documents lodged in support of HPV's application for authorisation: Southern Health's submission dated 4 January 2002, refers to its staffing requirements consisting of 2,280 EFT positions.[35] Of these 2,280 EFT positions, 150 EFT positions or 6.5% are described as being supplied by nursing agencies.[36] Southern Health acknowledges that it requires 2,280 EFT and presumably agrees to the cost of employment of 2,280 EFT positions. This is significant in the context of a global shortage of skilled nurses and a resultant need to rely on additional hours being worked by nurses regardless of their means of employment.

One must appreciate that although agency nurses are as qualified and experienced as permanent nurses, the nature of their employment differs in that in any given period of time they are requested to work over a range of shifts (morning, daytime and night time) over as many as 20 wards and multiple departments in a number of different facilities across an entire health care system.

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[33] The Nurse Recruitment and Retention Committee Final Report, May 2001, 2.

[34] The Nurse Recruitment and Retention Committee Final Report, May 2001, 2.

[35] Submission of Southern Health dated 4 January 2002, 1.

[36] Submission of Southern Health dated 4 January 2002, 1.

As illustrated in the Schedule, there are quantifiably over 280 different types of qualifications for nurses. The 150 EFT positions that HPV and Southern Health refer to is not simply a matter 150 nurses working 150 EFT positions. The matrix model detailed in Table 4 (section 2.1(f)) illustrates that the 150 vacancies that exist on any one day will be of a different skill profile to any other day. When considered in the context of a 12 month period the permutations form a very large number. Empirically in fact, it requires over 5,000 individual nurses to appropriately staff the specific requirements of 150 EFT positions over a 12 month period.

The transaction costs involved in recruiting, allocating, managing, and administering 5,000 persons are considerable. These costs are not acknowledged in Southern Health's submission or any other document submitted by HPV in its application for authorisation. Furthermore, HPV's application does not identify how these costs will be reduced or removed by the imposition of an anti competitive exclusive tender arrangement.

Further, no recognition is made of the fact that a significant majority of the 150 EFT positions supplied through a nursing agency are persons working hours in addition to their normal employment. Statistically, Nursing Australia calculates that at least 66% of nurses working through a nursing agency have employment in another health service as either full-time or part-time workers. The vast majority of agency nurses are working additional hours at their personal convenience and attracted by the flexibility and higher hourly pay rates paid by the nursing agencies. Agency nurses effectively offer their services at a time convenient to themselves in addition to the hours that they normally work. Southern Health's submission also expressly recognises that a number of nurses are working within the same health service as both an employee and agency nurse.[37] The flexibility required to balance the needs of their personal lives in conjunction with the limited range of work opportunities available through a single employer creates the need to work through agencies which are spread over a number of geographically located health centres and which can provide the flexibility that is sought by nurses seeking to work additional shifts.[38] In essence, a significant proportion of the 150 EFT nurses provided via an agency will in any one week be working in addition to their normal "ordinary hours". There is no evidence which suggests that the imposition of the Proposed Conduct will result in nurses continuing to make available their time to work additional hours in the public hospital system. The evidence is to the contrary. The significant public detriment which will result from the Proposed Conduct will be that nurses will withdraw their labour from the public hospital system rather than work additional hours for the award rate.

The Nurses (Victorian Health Services) Award 2000 (**Award**) indicates quite clearly that a nurse working in excess of their ordinary hours will be paid at the rate of time and half for the first two hours and double time there after.[39]

As such, the Award expressly recognises that nurses working in excess of their normal hours are entitled to be paid at the higher rate. HPV's submission is misconceived and based on a false premise in that it does not recognise the existence in the public hospital system of overtime rates of pay. The Proposed Conduct will not achieve one of its stated objectives of attracting nurses back into the public hospital system as nurses will not make their labour available to a nursing

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[37] Submission of Southern Health dated 4 January 2002, 1.

[38] The Nurse Recruitment and Retention Committee Final Report, May 2001, 84.

[39] Submission of Southern Health dated 4 January 2002, 2.

agency which is limited to paying the award rate for normal hours worked when the public hospital system presently recognises the payment of higher rates for overtime.

Southern Health submission is flawed in that it fails to take account of the "add on costs" of providing nurses through a nursing bank which includes superannuation, workers compensation, long service leave and annual leave. The omission of these significant "add on costs" results in Southern Health's submission presenting a misleading picture as to the purported costs benefits of a nursing bank.

Table 5 indicates the breakdown of cost items associated with employment of a casual staff member. Table 5 indicates items which are statutory requirements and those which are potentially not applicable to the public sector. It is of note that the cost for the Victorian government to recruit 2,600 EFT positions is reported as being as great as $26.9 million.[40] The costs associated with recruitment by nursing agencies, which have a structure that evolved over 80 years and is designed to support mass recruitment, are markedly less. The costs of recruiting outlayed by the Victorian Government through its campaign, and the savings offered by agencies in fulfilling the same function, cannot be ignored in the examination of the public benefit accruing from this submission.

Table 5 – Breakdown of Casual Staff Costs

Casual Loading	- Award / EBA Requirement
Penalty Rates	- Award / EBA Requirement
Overtime Payment	- Award / EBA Requirement
Superannuation	- Statutory Requirement
Workcover Insurance	- Statutory Requirement
Personal Indemnity	- Requirement
Advertising	- Effective Requirement
Infrastructure	- Effective Requirement
Education	- Effective Requirement
Recruitment	- Unavoidable Requirement
General Overhead	- According to Accounting Principles at each service
Profit	- Not applicable to a public entity

(b) Health Services (public and private)

The health care market as an employer represents a similar division between the public sector and private sector as would be expected in the division between those holding private insurance and those not. Approximately 70% of the acute health care market is provided by the public sector. Subsequently, approximately 70% of nurses work in the public sector.

The private health care sector has been the subject of much research. Typically, the ratio of full time to casual staff will be greater in the private sector as there tends to be a greater element of elective admissions to the private sector by virtue of the historical nature of private health. As such, the requirement for casual nurses in the private sector is subject to substantial variance in accordance to fluctuating demand. The private sector may expect to engage up to 20% of its staff on a casual basis allowing for capacity to flex both upward and downward according to demand.

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

Despite the flexible nature of demand in the private sector, that sector's typical "busy" period not surprisingly corresponds with that of the public sector. Few elective admissions are unnecessary: however, it is reasonable to conclude that the winter months see a substantial increase in demand for both public and private sectors. The implications of this are that attempts to constrain the individual choices of nurses may well be associated with a substantial movement of nurses away from the public sector to the private sector at least in the short to medium term.

The Proposed Conduct will not result in the public benefits contended by HPV in its submission. The effect will be that nurses choosing to work additional shifts will not make their labour available to the public hospital system but will migrate to the private sector where the provision of their labour will attract higher remuneration. The evidence and basic economic theory all suggest that nurses will allocate additional labour to that sector where they will receive the greatest remuneration. This is particularly the case where their skills are portable and there are no barriers to moving between the public and private sectors.

(c) Nursing Profession

In line with the international move of preparatory nursing courses into universities, the transfer of nursing education from "apprenticeship–like" hospital-based programs to university study commenced in Australia following the Commonwealth Government's 1984 announcement that the transfer of nurse education from hospitals to tertiary facilities was in principle supported. This transfer was unevenly completed between the various States and Territories, but was completed by the end of 1993. There has been overwhelming support for the initial preparation of Registered Nurses to remain in universities.[41]

The shift from hospital-based nursing training for Registered Nurses was a response to the need for a more broadly educated nurse with stronger theoretical and scientific underpinnings of practice. It was also an attempt to raise the professional status of nursing.[42] Not surprisingly, the transfer of nurse education to tertiary facilities has resulted in a body of professionals with a higher level of formal qualification and greater opportunities to transfer their skills. Yet, despite this, many nurses feel that they are not respected and valued as professionals. The Committee heard numerous examples of a perceived lack of respect for nurses by colleagues, other health professionals (particularly the medical profession) and non-nursing management. [43] Nurses want to have their skills and knowledge recognised, to be supported in professional development and to have some control over their work and better remuneration reflecting their skill base.[44] HPV's application appears to regard nurses as a mere commodity, which will work longer hours in order to maintain income.

Adequate remuneration is a pre-existing issue for many nurses. Indeed, the Review specifically stated that "nurses require pay and conditions commensurate with their education and expertise".[45] Nurses report that the salary structure does not remunerate them sufficiently for their practice and knowledge, and that the lack of

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[41] National Review of Nursing Education, Discussion Paper, December 2001, 109.

[42] National Review of Nursing Education, Discussion Paper, December 2001, 10.

[43] The Nurse Recruitment and Retention Committee Final Report, May 2001, 44.

[44] National Review of Nursing Education, Discussion Paper, December 2001, 10

[45] National Review of Nursing Education, Discussion Paper, December 2001.

recognition for postgraduate study and for excellence in practice is a significant disincentive.

The 18 years since 1984 have witnessed a change in the demographic of those undertaking nurse education. Much of the variation is common across all industry, however the significance in the case of nursing is that; students have choices and students also have obligations. Where the option is not considered favourable, there is a probability that students will elect to pursue other career choices. The Review clearly recognises that nursing students are aware of the remuneration opportunities of both nursing and other careers. The natural corollary is that nursing is not regarded as a particularly desirable profession by many prospective students.

The Review recognises that whilst nurses are generally more rigorously schooled they are also more readily able to choose alternative employment that does not have the negative factors associated with the nursing profession. Indeed, a university education provides not only technical skills, but also aims to provide all students with an opportunity to develop "higher order thinking and communication skills".[46] A lack of flexibility and unsociable working conditions are frequently cited in the Review as factors that both students and current nurses are continually assessing.

Both the Committee's report and the Review identify the increasing specialisation of the medical industry. Technology continues to demand a higher level of skill in operation and monitoring. Both the Committee's report and the Review describe the rate of change as being great and that many nurses find this challenging in a negative sense. A polarisation toward specialist skills is occurring that results in few individuals being able to provide the level of skill required in specialist areas. The specialist areas are also considered to have high stress levels.

Accompanying the advancement of technology is a concomitant requirement for nurses to maintain their skill levels. Post-graduate education is effectively mandatory in order to maintain the appropriate level of knowledge. Perversely, there is little remuneration advantage for those who pursue further education[47] - a fact which effectively acts as a further disincentive, both to post-graduate study and remaining in the nursing profession.

Indicatively, the Graduate Careers Council of Australia provides the following data relating to graduate salaries during 2001.[48] Nursing, even after the EBA increases of August 2000, is a distant last.

Information Technology -	$35 - $40,000
Dentistry -	$50,000
Medicine -	$47,500
Physiotherapy -	$32,000
Podiatry -	$34,000
ACT Public Service -	$31,147
Nursing -	$29,000

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[46] National Review of Nursing Education, Discussion Paper, December 2001, 112.

[47] The Nurse Recruitment and Retention Committee Final Report, May 2001, 46, 65.

[48] See URL <www.gradlink.edu.au>.

2.3 Recent Changes in Public Health Sector

(a) Australian Industrial Relations Commission

The Australian Industrial Relations Commission (**AIRC**) issued a decision on 31 August 2001 regarding notification of an industrial dispute by the Victorian Hospitals Industrial Association (**VHIA**) against the Australian Nursing Federation (**ANF**) relating to the Nurses (Victorian Health Services) Award 1992 (**Award**). The decision was handed down by Commissioner Blair (**Blair Decision**).

A copy of the Blair Decision is attached to this submission as Annexure 6.

A significant recommendation in the Blair Decision was the introduction of nurse to patient ratios. At the time, the ANF argued that the nurse to patient ratios were necessary to:

(i) resolve the workload issues which are causing nurses to leave nursing;

(ii) attract nurses back into nursing;

(iii) ensure for safe proper standards of nursing care;

(iv) establish minimum nursing staffing levels; and

(v) reduce stress, frustration and fatigue which then relates to the use of sick leave.[49]

In its submission before the AIRC, the VHIA and the DHS strongly opposed the introduction of the proposed nurses to patient ratio on the grounds that:

(i) a 1:4 nurse to patient ratio would necessitate an injection of 800 to 1,200 EFT nurses which was viewed as impossible by the employer groups represented by the Victorian Hospitals Industrial Association;

(ii) not being able to obtain an additional 800 to 1,200 nurses would result in bed closures in the environment of 800 to 1,200 beds overall;

(iii) consequently, greater pressure would be placed upon the already strained workload of nurses; and

(iv) the nurse to patient ratio mix is a prerogative of government.[50]

The introduction of the nurse to patient ratios has created a situation where health services are required to source additional shifts from employee nurses (including nurses through a health service's own nurse bank) or engage agency nurses in order to meet the nurse to patient ratios. Despite the need to maintain and even elevate staffing levels to meet the nurse to patient ratios, the rate of usage of agency nurses has remained relatively constant since the phasing in of ratios over December 2000 to March 2001 as supported by HPV in its initial application for authorisation.

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[49] Victorian Hospitals Industrial Association v Australian Nursing Federation, AIRC, 30 August 2001, 30, 31.

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