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management policies, which view individual agreements as preferable to regulation both through enterprise agreements and award-making.[103]

These changes in federal legislation, and employment practices, reflect a policy objective of encouraging parties to move away from a highly centralised system of labour regulation at the national or industry level (multi-employer awards and enterprise agreements) towards a more individual, oriented system (agreements between an individual employer and employee). These processes of individualisation and decentralisation are designed to give greater flexibility to both workers and employers, so that the particular circumstances and objectives of the worker and employer can be accommodated by agreement. Importantly, this policy of industrial relations deregulation is not limited to encouraging the parties to adopt individual agreements that are registered under the WR Act. Government policy has always been clear that bargaining is to be encouraged, whether or not that takes place under the WR Act, a state labour relations statute, or through the common law. This is apparent in the principal object of the Act (contained in s 3) as being "to provide a framework for cooperative workplace relations which promotes the economic prosperity and welfare of the people of Australia by ... (c) enabling employers and employees to choose the most appropriate form of agreement for their particular circumstances, *whether or not that form is provided for by this Act* (emphasis added)". The individual bargaining in question here is the common law contract negotiated between each nurse and the nursing agency.

The proposal of HPV goes directly against these well-developed principles of labour market policy in Australia. Put succinctly, Australian labour market policy recognizes that bargaining is a more efficient mechanism for setting wages and other conditions than award-making and secondly, that individual agreement-making is more efficient than multi-employer, collective, enterprise agreements. The HPV proposal will disable individual agency nurses from entering into individual agreements on wages. It will restrict agency nurses (and agencies and health providers) to either the award wage rate, or the enterprise agreement rate. Importantly, empirical information suggests that the existing nursing agency arrangements delivers to nurses (and

[103] S Deery and J Walsh, 'The Character of Individualised Employment Relations in Australia: A Model of "Hard" HRM' in Deery and Walsh, above n 19, especially p 117-118.

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agencies and health services) what is thought to be highly desirable from a policy perspective: flexibility and choice.[104]

(ii) The public benefit in facilitating family-friendly work practices and encouraging women's participation in the labour market

Something like 90% of nurses in Victoria are women and it appears that most of them have children.[106] For reasons no doubt due to flexibility and choice about whether to accept a placement, agency work appears to be particularly suited to nurses with family responsibilities.

Australian labour market policy, and broader social policy, contains clear objectives of encouraging family-friendly work practices and arrangements, in addition to encouraging the participation of women in the paid work force. This is reflected in a number of developments, including the establishment and public funding of specialist agencies for the purpose of addressing the issues of work and family, and women's employment.[107] Further, policy statements of both the Federal and State government articulate these public policy objectives. In its policy statement on women, the Commonwealth Government states that it:

> *"recognizes the importance of creating a workplace environment which helps parents to meet the challenges they face in juggling their work and family*

[104] Roy Morgan Research, *Code Blue Nurses Survey*, responses to question 1.
[105] Ibid. It is noted that a lack of ability to accommodate family responsibilities is a reason why nurses leave permanent nursing positions.
[106] *Nexus*, NBV December 2001; Roy Morgan Research, *Code Blue Nurses Survey*, responses to question 15.
[107] These agencies include, at the federal level, the Work and Family Unit within the federal Department of Employment and Workplace Relations (http://www.dewrsb.gov.au/workplacerelations/workandfamily/), the Office of the Status of Women (http://www.osw.dpmc.gov.au/index.html) and the federal Equal Opportunity for Women in the Workplace Agency (http://www.eeo.gov.au/). Victorian agencies include the Office of Women's Policy, located in the Victorian Department of Premier and Cabinet

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commitments. The Government is raising awareness among business and the community of the scope within the workplace relations system for achieving family-friendly working arrangements. It is providing practical assistance for women, and men, to combine their work and family responsibilities."[108]

The Victorian Government's policy statement on women includes the following:

"It makes good economic sense to support women in the paid and unpaid workforce. Women make up an increasing share of the paid workforce, often while also bearing an additional unpaid workload at home. The Bracks Government is committed to improving access to flexible work options and to family friendly work practices so that women, and men, can maintain their involvement in the workforce while also meeting their caring responsibilities."[109]

These public policy objectives are reflected in various pieces of legislation which regulate the labour market. Importantly s 3 of the WR Act states that the principal object of the Act is "to provide a framework for cooperative workplace relations which promotes the economic prosperity and welfare of the people of Australia by:

(i) assisting employees to balance their work and family responsibilities effectively through the development of mutually beneficial work practices with employers; and

(j) respecting and valuing the diversity of the work force by helping to prevent and eliminate discrimination on the basis of race, colour, sex, sexual preference, age, physical or mental disability, marital status, family responsibilities, pregnancy, religion, political opinion, national extraction or social origin; and

(k) assisting in giving effect to Australia's international obligations in relation to labour standards."

(http://www.women.vic.gov.au/owa/owasite.nsf). See also the federally funded Australian Institute of Family Studies (http://www.aifs.org.au/).

[108] Commonwealth Government, *Women 2001*, p 7-8. This document also states that one of the four key elements in the government's policy regarding women is to help parents to return to work (p 7).

The Act furthers these objectives through a number of mechanisms. In making awards, and in approving both enterprise agreements and Australian Workplace Agreements, the WR Act requires the Australian Industrial Relations Commission to take into account a number of matters. These include furthering the objects of the Act, taking into account the public interest, taking into account the principles embodied in the *Sex Discrimination* Act 1984 (Cth) and the Family Responsibilities Convention (both discussed below), and the need to prevent and eliminate discrimination on a range of grounds including sex and family responsibilities.[110] These ideas are not new to federal industrial law, with prohibitions on discrimination on a range of grounds, including sex and family responsibilities, being first inserted into the federal industrial legislation in 1993.[111]

In addition to these provisions in industrial legislation, most equal opportunity statutes in Australia, including the *Sex Discrimination* Act 1984 (Cth) and the *Equal Opportunity* Act 1995 (Vic), prohibit discrimination on the ground of sex and on grounds that pertain to family responsibilities.[112] These principles apply to work relationships.

It is important to appreciate that Australia is bound, under international law, to ensure that the needs of workers with family responsibilities are accommodated, and that discrimination against women in the workplace is eliminated. Australia has ratified a number of important conventions, including the UN Convention on the Elimination of All Forms of Discrimination Against Women (1979) (ratified in 1983), the ILO Discrimination (Employment and Occupation) Convention (1958) (ratified in 1973) and the ILO Workers with Family Responsibilities Convention (1981) (ratified in 1990).

The ILO Workers with Family Responsibilities Convention (1981) contains a central provision (in article 3(1)) that:

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[109] Victorian Government, *Valuing Victoria's Women: Policy Statement 2000-2003*, p 6. See also Victorian Government, *Valuing Victoria's Women: Forward Plan 2000-2003*, especially p 12.
[110] WR Act s 88B, s 90, s 93, s 93A, s 170LU, s 170VG. See also s 170CK.
[111] These provisions were first included in the reforms introduced by the Industrial Relations Reform Act 1993 (Cth). This Act amended the *Industrial Relations* Act 1988 (Cth).
[112] See, eg, Sex Discrimination Act 1984 (Cth) s 5, s 7A; Equal Opportunity Act 1995 (Vic) s 6(ab), (ea), (k).

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"[w]ith a view to creating effective equality of opportunity and treatment for men and women workers, each Member shall make it an aim of national policy to enable persons with family responsibilities who are engaged or wish to engage in employment to exercise their right to do so without being subject to discrimination and, to the extent possible, without conflict between their employment and family responsibilities:"

In addition, article 4 provides that:

"[w]ith a view to creating effective equality of opportunity and treatment for men and women workers, all measures compatible with national conditions and possibilities shall be taken--

(a) to enable workers with family responsibilities to exercise their right to free choice of employment; and

(b) to take account of their needs in terms and conditions of employment and in social security.

Australia's obligations under international law, and our domestic legislation, evince a clear policy objective of encouraging work practices and arrangements that assist workers to accommodate their family responsibilities. Empirically it is women in Australian society that bear most of the burden of family responsibilities.[113] For this reason, the issue of workers with family responsibilities is an issue of gender. The current work arrangements of agency nurses in Victoria further this public interest to assist workers to accommodate their dual roles as worker and as carer.

(iii) The Public Benefit In Supporting The Supply Of Labour Through Agency Arrangements

It appears that the HPV proposal is likely to undermine the viability of nursing agencies. There is a public interest in ensuring the continuation of this form of labour supply arrangement as it enables a matching of the objective of a health service for a

[113] M Bittman, *Juggling Time: How Australian Families Use Time*, Office of the Status of Women, Department of Prime Minister and Cabinet, 1991; A VandenHeuvel, *When Roles Overlap: Workers With Family Responsibilities*, Australian Institute of Family Studies, Monograph No 14, 1993.

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numerically and functionally flexible labour supply with an employee's desire for choice and flexibility about whether and when to work.

Since the early 1990s there has been a marked increase in the use by Australian employers of labour supply agencies. This has occurred across both the private and public sector, and is one of a number of contemporary labour practices favoured by employers, and many employees. It is part of the broader embracing of labour market flexibility in Australia. In 1997 it was found that the percentage of Australian workplaces that had used labour hire agencies rose from 14% in 1990 to 21% in 1995.[114] There are several reasons why employers have embraced agency arrangements, including, in most cases, reduced labour costs and importantly, numerical and functional workforce flexibility. In some studies it is concluded that agency workers inject expertise into an employer's workplace.[115]

Agency arrangements for the supply of labour present the type of flexibility in employment relations that government policy is aimed at promoting. This is partly reflected in the objectives of the WR Act, especially s 3(c), discussed above. The policy of successive governments from the early 1990s has been to facilitate employers to use labour supply agencies. The result is that such agencies have flourished, with government support.

(b) Gender Concerns and Objections

The HPV proposal is contrary to the public benefit in that the assumptions that underpin it are classically ignorant of the realities women in the workforce face.

The HPV application incorporates a number of implicit and unquestioned assumptions about the nature of the Australian nurse as a member of not only the health labour force, but of society in general. The obvious equal opportunity issues are not discussed in the HPV application, even though the hoped-for outcomes are based on

[114] A Moorehead, M Steele, M Alexander, S Kerry and L Duffin, *Changes at Work: The Second Australian Workplace Industrial Survey*, 1997.
[115] S Young, 'Outsourcing: Lessons From the Literature' (2000) 10 *Labour & Industry* 97. All Code Blue nurses are specialists, with 88% holding postgraduate qualifications (in the form of a graduate

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economically outmoded, sexist understandings of the nature and future of nursing practice. As noted in this submission the larger proportion of nurses are women. Nursing is a highly gendered occupation. Occupational gender segregation has been at the heart of debates about gender inequality in terms of pay rates and working conditions. Many of the problems confronting nurses arise from the continuing devaluation of nursing as 'women's work'. with a focus on care and nurturing as their 'natural talent' rather than as technical skill. It is clear that the HPV application operates with the view that agencies which represent nurses' interests (in terms of higher pay, flexibility of choice in terms of work place and work time, the capacity to balance work life with other aspects of valued living such as family roles or qualification upgrading and the capacity to retain autonomy and independence as a skilled worker) should not retain the capacity to operate in a situation of competition where they can continue to serve nurses interests. It is clear that autonomy, independence and choice are not seen as vital to nurses satisfaction with work even though all research which has examined reasons for nurses leaving the occupation include lack of adequate remuneration and dissatisfaction with the lack of choice, independence and autonomy in the workplace are consisted cited as reasons for departure. They are held responsible for what they have found wanting in the organisation of the health system. It seems that they are held responsible for taking positive action to assert their rights in the market place by taking control of their choices regarding the selling of their labour for market value. They have not been classified as 'good girls'. In fact they have been classified as 'bad' precisely because they have chosen to value their work skills and capacities (and by extension themselves) via the exigencies of the competitive market. They have challenged the gender contract[116] in Australian society.

A consideration of gendered work requires an examination of how women are viewed because this influences the perception of women's work, in this case nursing work. Rather than running through the mass of human rights, social justice and feminist literature regarding such matters, for the purposes of this submission, it is important to note the views about women and nurses within society at large (not only the medical

certificate or a graduate diploma, masters or PhD) and the other 12% having extensive experience in their area of specialty: Roy Morgan Research, *Code Blue Nurses Survey*, p20.

[116] See Appendix for definition and explanation of the terms 'gender contract'.

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and health profession context). It is important to do so because these views are influential in how such work is, or is not, given adequate recognition and recompense. It is also important in enabling an understanding of why the HPV proposal is in effect a negation of the rights of nurses to a competitive environment to sell their labour (with or without the use of agencies). The Appendix which is attached briefly summarises some of the theoretical positions which have informed the following discussion.

Nursing has been, and in many ways still is, viewed as an extension of the female role, valuing nurturing, caring support, care and concern. Reverby suggests that nursing's economic dilemma grows out of nursing's "order to care in a society that refuses to value caring"[117]. Healing has been regarded the natural responsibility of mothers and wives. Caring as part of healing was (and in many cases, still is) considered to be a woman's duty and therefore economic reward was not considered necessary. Numerous scholars[118] have pointed out that caring as a concept has been inappropriately 'gendered' given that notions of professional caring have been derived from the concept of caring as a feminine obligation. The assumption about the female role here is that women should always provide care as a 'natural' part of their being, and that this is not only 'natural' but 'proper' in terms of their relationship to men and children. The concomitant understanding is that women should carry out caring even if it is detrimental to their own needs and wants, otherwise they are going against their own nature. These characteristics have been described as a 'tyranny of niceness'[119] in the sense that in conforming to such idealised assumptions about the nature of being a 'good' woman and hence being a 'good nurse' implies forswearing one's own needs as a professional engaged in career work. That is, it implies negating one's professional and economic identity as a nurse who is an autonomous, independent individual in the market place.

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[117] Reverby, SM (1987) *Ordered to Care:The Dilemma of American Nursing, 1850-1945* New York: Cambridge

[118] Bent,K.N. (1993) Perspectives on critical and feminist theory in developing nursing praxis. *Journal of Professional Nursing*, 9 (5):296-303; Evans, M.(1997) *Introducing contemporary feminist thought.* Oxford:Blackwell Publishers.

[119] Street, A. (1995) *Nursing Replay:Researching nursing culture together.* Melbourne:Churchill Livingstone.

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Further complicating the pay issue is nursing's roots in the religious orders. It has been asserted that: "The correlation between nursing and a religious calling and the resultant belief that willing self sacrifice was essential to nursing practice provide the justification needed to support low pay and long hours of labour that historically characterised the nurses employment"[120]. Traditional expectations which surround caring as a feminine and hence nursing activity involve subjugation of the self and following on from this, selfless devotion to duty[121]. This, in turn, is translated to mean that nursing should be a vocation in which women are expected not to be concerned about career paths or the need for higher pay. This fits with a sexist, discriminatory attitude to women in general, where they are viewed as being in the world to provide for the needs of others alone, and not themselves. Hence, caring has been constructed as an inherently feminine pastime (unintellectual, unskilled and emotional) with traditionally little social or economic recognition. Nurses are expected to care in a society that does not place a high monetary value on caring.

The more recent concept of 'care' in nursing is one which is used in opposition to the term 'cure' so that nursing has tried to incorporate a fuller model of healing which does not negate the healing nature of care and revalues it. However, whether theorising about care or practising it, nurses are expected to act out of an obligation to care, taking caring on, more as an identity than as work, and expressing altruism without thought of autonomy either at the bedside or in their profession. Thus they have had to contend with what appears as a dichotomy between the duty to care for others and the right to control their own activities in the name of caring.

Nursing, in Australia as elsewhere, is still searching for a government which will recognise what philosopher Joel Feinberg argues comes prior rights; that is being "recognized as having a claim on rights".[122] The way in which this government has operated by putting forward the HPV proposal is to ignore nurses' claim on rights for autonomy, control and choice through entry into a competitive market. This is done through applying, wittingly or otherwise a sexist model of women's work and women's role in society.

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[120] Hughes, L. (1980) The public image of the nurse. *Advances in Nursing Science* Vol 2 (3):55-72
[121] Caffrey R. and Caffrey, P. (1994) Nursing:Caring or co-dependent? *Nursing Forum*, 29 (1):13-17.
[122] Feinberg, J. (1980) *Rights, Justice and the Bounds of Liberty*. Princeton:Princeton University Press

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First, to engender nurse caring as feminine, and position it as innately instinctive to women, is to deny the advanced knowledge and skills that lie within the therapeutic caring acts of nurses (Here we are not referring only to the additional technologically based skills that are regularly acquired by specialist nurses but to the full complement of skills attached to quality nursing). Such views have in no small measure led to a significant devaluation of nursing alongside the unequal power relations which characterise the position of nursing vis a vis medicine. Even with the shift of nursing education into the tertiary education sector, such views have remained implicit in popular images of nursing and as such operate as a filter in negotiations regarding the nature of work done by nurses and the level of remuneration considered appropriate for the tasks they carry out. It also operates as a filter in comprehension and response to the contentious issues regarding the structuring of working conditions that nurses face.

In the Australian health system, much of the thinking implicit in the arguments put forward by HPV continues this discriminatory mode by assuming that agencies and agency nurses are 'greedy' (read here 'morally improper' and 'unnatural women') for wanting to be paid what they believe they are worth (or translating that into economic conceptualisation - what the market is willing to bear). Recently, they have been both implicitly and explicitly blamed for the ills of the health system for doing so. This is the case even though it is quite clear from any historical reading of the problems of the Australian health care system that the existence of agency nursing was in a number of ways a response to the problems and not a cause. Federal and state initiatives targeted at regulating the supply of health care in response to continuing increases in demand have resulted in the rationing of services through waiting lists and the emergence of standard benefit packages. Rather, the implications of cost containment on the Australian health care system have been an increase in staffing needs and worsening conditions in the workplace which have included lack of mobility due to cutbacks and insecurity, high levels of stress and little room for career development due to the mandatory nature of shift work attached to upward moves[123].

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What seems to be argued in HPV's application is that if we want the health system to work and governments are not to have financial 'blow outs' we simply need to reign in salary costs and 'get nurses back into line'. A monopolised and closed system of hiring is presented as the solution because it is socially acceptable to consider female workers as not needing to consider themselves as economically worthy. The assumption made by the government is that by closing off the competitive option they will 'fix' the ailing health system. There are practical consequences of such sexist thinking. Instead what might be the outcome of following this model is that when nurses are unable to find a way to 'care with autonomy' many nurses will abandon the effort to care or abandon nursing altogether.

It is not surprising then that all nurses acknowledge that their rates of pay are inadequate given the tasks they are expected to carry out and the skill and knowledge required to do so. What is of concern is that the rates of pay which are part of the HPV proposal simply retain the pay relationship to this already devalued labour. This is also part of the implicit thinking when it comes to the enterprise bargaining of nurses' wages which are still low given the current structuring of the health system and their position in it historically. (It is well known that wage costs in services are regarded as critically important in determining elasticity of demand for services.[125] However, advocates of low wage costs to maximise employment are implicitly, but rarely explicitly, promoting the continuation or widening of the gender pay gap. We know that pay tends to be relatively low in services, a tendency reinforced by the concentration of women in these sectors. Low hourly pay is accompanied by high levels of part-time working on the one hand and by long hours of work on the other to translate the low hourly wage into a reasonable living wage. It is clear that this is the case with nursing). It is unclear why agency nurses, or for that matter all nurses should accept a situation which prevents attempts to gain better remuneration. Perhaps the expectation is for nurses to return to a situation of submissive self-sacrifice rather than to assert that they will take their chances in the marketplace.

[124] Roy Morgan Research, Code Blue Nurses Survey.

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The second issue that bears some thought is the way in which it is assumed that the only issue regarding the structuring of labour costs is that of adequate pay for the skill and amount of work. However, the issue of discrimination that is implicit in this context is related to the role of men and women in the family and how this is extended to wage negotiations and concepts of comparative need (See Appendix for full discussion of this set of concepts). Often the assumption underlying discussions of women's relationship to the labour market is the concept of the 'family wage' which has not been discussed lately as it has been assumed that this idea had been laid to rest by the impact of the feminist movement on the recognition of women's rights as independent, individuals in Australia. However, in Australia this notion has resurfaced implicitly in the proposed restructuring of the health labourforce currently brought to the ACCC for approval. It is the idea that an adult male ought to earn enough to enable him to support a wife and children. It has often been identified with the concept of the living wage: a wage which is one that a man can keep himself, his wife and children at a decent level. Hence, if women are in a relationship with a male and have children then the male's salary should be enough for all of them. The corollary of this thinking is that if most nurses are women, then most of them in the relevant age groups are in such relationships and therefore the remuneration they receive is not about the provision of the living wage, but really the provision of 'pin money' because after all it is not they who are the breadwinners. This flawed discriminatory logic suggests that if nurses are behaving as society expects them to in their roles as women then there is no need for them to have an equal opportunity to compete in the market place. Of course this is in contravention of the Sex Discrimination Act except that it refers to an entire group rather than a single individual.

Notwithstanding this critique, there are many women in agency nursing who are also mothers and who do experience difficulty in balancing the needs of the workplace and their children's needs. Access to reliable and affordable child care and car parking would make a return to nursing much easier. Currently, there are very few resources in the health system available to pay for such supports. Given that the current

[125] (Esping-Anderson, 1995 *Europe's Welfare States at the end of the Century:Frozen Fordism or Post-Industrial Adaptation?* Paper presented at the 17th conference of the international Working Party on Labour Market Segmentation).

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payments to permanent or bank staff are insufficient to make it possible for nurses to manage to pay these costs, agency work enables the flexibility financially and time wise to make working in nursing a feasible option for the many women concerned with these issues.

There are two negative trends in nursing that severely impact on the ongoing provision of high quality health care in the public sector-

The nursing workforce is aging. Older nurses retiring or cutting back on the number of shifts they work are not being replaced at an adequate rate by younger nurses. Of nurses registered in Victoria in 1997 18.1% were aged between 40-44 years, 17.67% were aged between 35-39, 30.49% were under 35 years of age while 32.92% were aged 45 and older. The average age of all employed nurses was 40.3 years [126] In 1997 there were 222,211 nurses employed in nursing in Australia. Of these, 175,937 were registered nurses and 46,274 were enrolled nurses. In 1997, there were 69,960 employed registered and enrolled nurses in NSW, 61,641 in Victoria, 36,813 in Queensland, 21,711 in Western Australia, 20,465 in South Australia, 6,014 in Tasmania, 3,384 in the ACT and 2,223 in the NT. Of all employed nurses, 17,003 or 7.7% were male. There is a continuing decline in full-time equivalent (FTE) nurse employment per 100,000 population throughout Australia. This means that, on average, patient numbers per FTE nurse have been increasing. For example, in public hospitals between 1995-96 and 1998-99, patient separations per FTE nurse increased by 10.5%, from 44.6 to 49.3.

The corollary of this is that the larger number of women in the nursing workforce are in the baby boom demographic. If we look at the implications of this for the future needs of nursing labour we can use the research conducted in Canada as a useful forecasting process:

> *"The largest number of Canadian registered nurses are in the 40-45 age range and by 2011 many will have retired. They in turn will join the largest proportion of the Canadian population, people aged 45 and over, who have the highest usage rate of health services. The shortages are expected to be*

[126] *Nursing Labourforce 1999* (2001) AIHW p37.

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most severe in Canada's rural areas, as well as in intensive care, theatres and accident and emergency nursing."[127]

This has specific economic and social implications in the Australian context which is not dissimilar. It is well known that occupational stress where the work is of high intensity but there is little autonomy (nursing) leads to a higher number of health complaints.[128] It is clear that there will be a need for *even more* nursing care in the aforementioned areas as well as in the areas of mental health and aged care. The structure suggested by HPV, while focussing on cost reduction to the system as a whole does not take into account that nurses know these parameters of future stress in the system and will not see a constrained working environment as an adequate solution to either the health system strain or to their personal career needs, or in fact their future health needs[129].

Agency workers explicitly identify with the idea of a 'trade-off' between the stability and security of employee status, on the one hand and the greater autonomy of self-employment. It is also providing compensation for the unequal distribution of family responsibilities .The traditional gender division of labour market roles has cost older women dearly and resulted in the pauperisation and increasing marginalisation of older women. They are bearing the brunt of the current feminization of poverty. The looming crisis in pension system funding in industrialised countries raises fears about the future pensioners. Social security systems based on the principle of uninterrupted paid employment are structurally disadvantageous to women, a weakness accentuated by the current trend towards reducing budget deficits by cuts in welfare spending. Why would agency nurses wish to ignore the evidence and not provide for their retirement years.

Raising the status of feminised occupations is recognised to be extremely difficult and the use of the comparable worth strategy to win pay rises was rejected by the

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[127] Hyde-Price, C (1998) Disappearing nurses *Nursing Standard* Vol 13 (5) p29.

[128] Paoli, P (1999) *Psychosocial stressors in the workplace and their consequences for health:the European dimension* APA-NIOSH Work Stress and Health 99 Organization of Work in a Global Economy-Abstracts http://www.apa.org/pi/wpo/niosh/abstracts1.html.

[129] Clinton M and Scheiwe D.1998 Management in the Australian Health care Industry (2nd ed) South Melbourne: Addison Wesley Longman

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Arbitration Commission due to its implications for changes across the system. The more interesting issue in this case is that of considering the HPV application as a means of again clearly opting for a devaluation of nursing skill and disallowing women to operate in the same way as men in the marketplace. Given the sheer numbers of women working as nurses it is clear that the proposal put forward by HPV is not one which benefits the career aspirations of a large segment (51%) of the public.

(c) Fostering Business Efficiency

To the extent that the proposal will severely weaken the operations of agencies, it will have a negative impact on allocative efficiency. As argued above, nursing agencies improve allocative efficiency by helping to match supply (nurses of varying skill levels) and demand (the requirements of hospitals for nurses as and when needed). Hospital banks will not be able to do this: they operate principally at a hospital level. And even proposals such as the Royal Hospital Bank, which include more than one hospital, remain limited in scope. Unlike agencies, they do not operate on a system-wide basis. Accordingly, they will do a less than optimal job in matching available nurses with the specific job requirements of the public system overall.

We also note that the tender proposal will almost certainly reduce allocative efficiency because it will place excessive strains on a single organisation (the successful tenderer) to meet all the demands of the hospitals to which it is supposed to be the sole provider of agency staff.

(d) Industry Rationalisation That Reduces Costs And Increases Efficiency

We have already acknowledged that rationalisation will certainly happen under HPV's proposal because those agencies not selected under the tender arrangements will find it difficult to survive. We also acknowledge that, there may be lower or contained unit production costs, in that the tender arrangements are designed to force agencies to pay award rates. Accordingly, public hospitals will have lower wage costs.

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The key point, however, is that the ACCC and the Tribunal in recognising the above as a public benefit, have in mind a situation in which it is the process of rationalisation that reduces costs. Under the HPV tender arrangement there will be rationalisation of agencies but that will not itself lead to a reduction in costs. The latter will occur simply because of the requirement that award rates be paid.

This criterion also needs to be examined from the perspective not only of the public hospitals but also that of the agencies. It is by no means clear that the costs of the agencies will fall.

(e) Expansion of Employment

The Victorian government believes that expansion of employment will occur because the budgeted funds will employ more nurses. As we have argued, there are important reasons to doubt this. We have shown that the proposed arrangements, particularly the lowering of pay, will act as a disincentive for nurses to stay as nurses. There is no evidence that the government will budget increased funds to nursing other than for recruitment.

(f) Promotion Of Industry Cost Savings Leading To Contained Or Lower Prices

For the public hospitals, as noted above, there will undoubtedly be cost savings. This is a central purpose of HPV's proposal. Whether this will lead to prices being either contained or lowered, however, is open to doubt. Indeed, it is not clear what prices we are talking about here. As an aside, we are not aware of any evidence that, as a result of the increase in agency charges over the last 12 months, the prices charged for health care have increased.

(g) Promotion Of Equitable Dealings In The Market

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The Victorian government takes the view that the tender arrangements will bring about pay equity by removing the wage differential between agency and hospital nurses. We argue, however, that equality is not the same thing as equity. The latter is about fairness. There is nothing fair about paying nurses less than what they think is justified given their training and contribution to society. There is nothing fair about paying agency nurses the same rates as permanent staff, when agency nurses give up the security and entitlements associated with permanent employment conditions. There is nothing fair about trying to force nurses to work longer hours to compensate for lower pay per hour. And there is nothing fair about destroying individual autonomy.

(h) Assistance to efficient small business

We deem this largely irrelevant, but we would nevertheless observe that Code Blue, like many other agencies, is both a small business and an efficient one. HPV's proposal will serve only to threaten the existence of Code Blue and other similar organisations.

(i) Industrial harmony

The Victorian government will undoubtedly suggest that the HPV proposal will result in an increase in industrial harmony because there will no longer be the preoccupation among nurses with wage relativities. We argue, however, that the result of the proposal on industrial harmony is at best ambiguous.

There are at least three reasons for this. First, our argument that the tender arrangements will only worsen nurse shortages has as its logical corollary heightened disharmony within the industry because shortages can only mean a worsening of the workload facing the remaining nursing population. Second, as argued at length above, there will heightened concerns about 'appropriate' pay rates not being paid. Third, again as argued extensively above, there will be concerns about being forced to work longer hours and having less flexibility.

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We make the following observations on the ANF and its stance in relation to agency nurses. We do so in the context of the government failing to consult the community or stakeholders. The ANF has *not* asked its agency nurse members about agency nursing and has not conducted any form of consultation with its agency nurse members. The ANF is actively involved in a campaign to reduce the pay rates and usage of agency nurses in public hospitals. The ANF campaigned to minimise the use of agency nurses as part of the case in the AIRC before Commissioner Blair in 2000, firmly stating agency nurses should only be used to "top-up" a permanent workforce and only for unexpected absences [130].

In a Newsflash to all members in January this year, the ANF misrepresented the core issue in the HPV application to its members. HPV clearly and precisely states that tenders for agency nurses will be to supply nurses at the award or enterprise bargaining rate of pay. The ANF said in its Newsflash

> *"whilst placing a cap on hourly rates which hospitals will be required to pay agencies, [the tendering process] will still mean nurses who choose to work agency will be able to work at any or all of Melbourne's metropolitan public hospitals as well as Barwon Health. The ANF met with Department of Human Services (DHS) Representatives regarding the proposal on the 24/12/01."*[131]

The ANF in its January Newsflash to all members

a) failed to mention the wages paid to the agencies would be significantly cut, not capped at the current rate as implied
b) failed to mention that agency nurses could only work in the Melbourne metropolitan and Barwon Health public hospitals *if* they were members of the agency/ies that won tenders
c) failed to describe the issues discussed at the December 24, 2001 meeting with the representative of the DHS or any agreements or concessions made to the DHS in regard to agency tenders and/or agency nurses' current entitlements.
d) failed to consult its agency nurse members prior to or following its meeting with DHS on 24/12/01

[130] AIRC C No. 35605 of 2000
[131] ANF Newsflash to members, 10-1-02

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Clearly, the ANF does not represent its agency nurse members. Any submission provided by the ANF to the Government for use in the HPV submission, or presented in an ANF submission to the ACCC must be viewed with caution. Moreover, the failure of key stakeholders to consult each other in an industrial setting is a recipe for industrial disharmony.

14. Why the HPV Scheme Constitutes Public Detriment

(a) A reduction in the number of effective competitors – buyers and sellers

This will certainly occur, for reasons explained above. The reduction in the number buyers will occur as a result of the reduction in the number of agencies that will inevitably follow the introduction of three-year exclusive tenders. There will also be a reduction in the number of sellers, that is, nurses. Not only will the proposal encourage a further reduction in the number of nurses, it will also lead to a reduction in the total number of hours (or shifts) worked by those who remain as nurses.

(b) Increased restrictions on entry

It will be very difficult, for anyone wanting to set up a new agency, to do so once the tender arrangements are in place. The tender requirements favour big players.

(c) Constraints on competition by market participants affecting ability to innovate effectively and conduct their affairs efficiently and independently

The tender arrangements will place a stranglehold on how the agencies can compete. Presently, as we have explained, agencies have been innovative in providing a variety of non-pecuniary benefits to encourage nurses to sign up with them. The stranglehold imposed by the tender arrangements can be expected to bring such innovations to a swift end.

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15. Conclusion

HPV's application is predicated upon the false premise that, if agency nurses are paid a reduced hourly rate (the award rate), then those nurses will increase the number of hours which they work in the public hospital system to maintain their level of weekly income. This premise is misconceived. It is contrary to logic and defies the most basic economic theory, namely that persons who are supplying labour which is in high demand will allocate that labour resource where they are best remunerated. This is particularly the case where nurses' labour is portable as between the public and private sectors, there being no barriers to entry in working in either or both sectors.

HPV's submission does not identify any evidentiary basis for the benefits which HPV contends will flow from the exclusive tender arrangements. Code Blue contends that the stated public benefit of attracting nurses back to the public hospital system will not be achieved by the imposition of anti-competitive exclusive tender arrangements. Such arrangements will result in nurses withdrawing additional hours of labour from the public sector and allocating that labour to the private sector to obtain higher remuneration or withdrawing the additional labour altogether from the hospital system.

In any event, even if the perceived public benefits can be derived by the proposed conduct, those benefits can be achieved by other means rather than the imposition of anti-competitive exclusive tender arrangements. There is simply no public benefit which is identified in HPV's application which would justify the blatantly anti-competitive tender arrangement for which HPV seeks authorisation from the Commission. Furthermore, it is wrong for HPV to suggest that the perceived public benefits can only be achieved by an exclusive tender arrangement. There is no causal nexus between the exclusivity of the tender arrangements and the perceived public benefit. Furthermore, HPV has failed to identify why the public benefits cannot be achieved by other less anti-competitive means such as specifying minimum terms and conditions upon which nursing agencies may compete.

The ultimate concern under the Act must always be the benefit of the public. Accordingly, any possible detriment or benefit to the public must be given full weight.

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As we have submitted, based upon the available evidence, it is not open for the ACCC to be satisfied, in all the circumstances, that the scheme proposed by the HPV would result, or be likely to result, in a benefit to the public and that the benefit would outweigh the detriment to the public constituted by the lessening of competition that would result, or be likely to result.

DATED: 13 March 2002

Signed on behalf of

CODE BLUE SPECIALIST NURSING AGENCY PTY LTD

.....

Geoffrey Wilson,

Principal

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IN THE MATTER of:

Applicant, Health Purchasing Victoria; and

Application for authorisation Nos. A90811 and A90812 lodged by Health Purchasing Victoria as Applicant under Sub-section 88(1) of the *Trade Practices Act* 1974

TO: **AUSTRALIAN COMPETITION AND CONSUMER COMMISSION**

SUBMISSION BY: **Code Blue Specialist Nursing Agency Pty. Ltd.**

APPENDIX B TO CODE BLUE SUBMISSION

Explanation Of Concepts in Women's Issues

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It is generally taken that **sex** refers to anatomical and physiological differences between men and women, while **gender** is taken to mean the socially constructed differences, as seen in behaviour, beliefs, values, etc. In colloquial discourse, and, at certain historical moments, in scientific discourse too, a causal relationship is established between these two terms, with the idea that the characteristics of masculine gender, also known as masculinity and female gender, or femininity, are automatically determined by the anatomical differences between males and females. According to this perspective, which is known as biological determinism, biological differences determine to a large degree the social and cultural differences observed between men and women. The authors who defend this type of analysis firmly believe that there exist two sexes which can be clearly differentiated from a genetic, anatomical and physiological point of view and that the behaviour of each social group, i.e. men and women, is largely determined by such biological differences.

Thomas Laqueur[1] shows that such a dichotomous vision of the sexes is a relatively recent phenomenon in the history of Western thought. This is how he approaches the question in the preface of his book :

> *"The West, like any civilisation, has always inquired into the differences between the sexes. But when one speaks of man and woman does this refer to gender, a cultural definition of moral, emotional and social qualities, or to sex, defined by anatomical specifics?*
>
> *These two notions never overlap. From Antiquity, Aristotle, in his definition of the order of beings, and Galien, in his anatomical definition of the body, provide the basis of the single sex model which was dominant until the 18th century, and in which gender defines sex: men and women are ranked according to their degree of metaphysical perfection, along an axis in which the peak is occupied by man. Anatomically there is no difference between men and women except than women's*

[1] Laqueur, Thomas. (1992) La fabrique du sexe: Essai sur le corps et le genre en Occident, Gallimard, Paris

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sexual organs are inside the body and not the outside. Gender was thus considered a fact of nature determined by the perfect hierarchy of the cosmos. Sex was an effect of convention, allowing one to usefully make distinctions within the anatomical unity.

In the 18th century a different model of sexual difference emerged: the model of two sexes, in which, unlike the previous model, sex defines gender. On the anatomical and physiological level men and women are incommensurably different and therefore sex determines qualities, virtues and roles according to biological base. Sex is an immutable fact of nature, gender an effect of the biological determinism in a universe of cultural, political, artistic and social conventions.

The two models do not follow a linear history: from the 16th century authors spoke of irreducible anatomical differences, others in the 20th century such as Freud in his essays on sexual theory think of sex in terms of the single sex model. The two models coexist in time, and their influence on minds cannot be simply explained by general economic, cultural or social developments, nor by progress in anatomical knowledge, which was most often moulded in representations dictated by one of these models" [2]

It is the second model of sexual difference, according to which sex determines gender, which has dominated Western thought for more than three centuries. The transfer from one of these models to the other does not seem to be related to changes over time in the objective scientific knowledge about the human body. The emergence of the sexual difference model was probably more influenced by the Enlightenment and scientific rationalism. In the political and philosophical context of 18th Century Europe, the idea of male supremacy could no longer be legitimately attributed to the "will of the gods"; it needed to be founded and explained in a rational way. What could be more convenient than the **obvious** physiological differences between men and women? The gradual imposition of this dichotomous view of sex categories took place at a specific moment in European history, marked by the first stages of the industrial revolution and the turmoil of the French revolution. The ideology of *women's natural inferiority* was instrumental,

[2] ibid.

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amongst other events, in their exclusion from the so called *universal* suffrage introduced in France after the 1789 Revolution.

This model is founded on a belief in a fundamental *natural* binary polarisation between the sexes in all human society. Like any hypothetical model, it has undergone various attempts at scientific demonstration. Throughout the 18th, 19th, and even 20th centuries, there has been a plethora of *scientific* research which has sought to measure the *natural* differences between the sexes and to use its findings to explain, and simultaneously justify, the specific position of men and women in Western societies. Considerable scientific time and energy has been paid to the precise measurement of differences in the physical strength of men and women, to the influence of hormones on their physiological and psychological characteristics. Particular attention has been paid to the size of the brain - this organ being generally smaller or lighter in women than in men. Research has been used to assert the "natural incapacity" of women to occupy certain social functions and conversely has been used to promote the idea of women's *natural aptitudes* in other spheres.

The recent belief that, on an anatomical and physiological level, men and women are *incommensurably different* helps to understand the importance of the differentiation process, i.e. the gradual emergence of what some authors have called *the similarity taboo* between the sexes[3].Rather than presenting gender categories as a continuum, the dichotomous sex model considers each sex as a sub-type of the human race. It further states that such biological differences determine a binary divide in all areas of social life, from the norms associated with physical and aesthetic appearance, to intellectual ability and behaviour. Differentiation is largely achieved through the process of "gender socialisation."

This dichotomous vision of the sexes has been used since the end of the 19th century, i.e. at a time when the different welfare systems were being created in Europe, as a basis for

[3] Mathieu, Nicole-Claude. (1992) *L'anatomie politique: Catègorisations et idèologie du sexe,* Editions Cùtè-Femmes, Paris.

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