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13 March, 2002

Our Ref: GW:CW:7800
Your Ref: Mr G Jones

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

FILE No.
ENTITY
D MAN D02/13723

Dear Sir

Code Blue Specialist Nursing Agency Pty Ltd - Application Lodged By Health Purchasing Victoria Nos. A90811 and A90812

We enclose herewith the following:

1. Submission of our client; and
2. Appendices A and B to the Submission.

Our client requests that the following parts of the Submission and Appendices A and B be excluded from the register by reason of the confidential nature of those parts.

1. Those parts of Submission highlighted in pink highlighter colour; and
2. All of Appendix A.

These matters relate to confidential financial details of our client's business and the confidential details of its clients.

Yours faithfully

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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.

SUBJECT MATTER OF SUBMISSION:

The Applicant's request for authorisation

1. Background to Code Blue

Code Blue Specialist Nurses Agency Pty Ltd (***"Code Blue"***) submits that the application by Health Purchasing Victoria (***"HPV"***) for the grant of authorisation pursuant to s. 88(1) of the ***Trade Practices Act*** **1974** (the "Act") should be refused. Code Blue provides a valuable service in placing specialist nurses in both public and private hospitals in Victoria. Specialist nurses include critical care nurses, emergency

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nurses, theatre nurses and midwives. All of the nurses places by Code Blue are registered under Division 1 of the Nurses Act 1993.

Code Blue is the largest of the specialist nurse placement agencies in Victoria. It has conducted its business in Victoria for about 6 years. Code Blue conducts its business from its administrative centre at 62 Robinson Street, Dandenong, Victoria.

Code Blue employs approximately 18 full time staff members in administering its operations.

The Code Blue business operation essentially involves matching the particular nursing needs of hospitals with the qualifications, skills and availability of the nurses registered with Code Blue. About 95% of the specialist nursing placements involve filling short term vacancies which arise from day to day in both private and public hospitals. Prior notice given by the hospitals to Code Blue to fill these vacancies typically ranges from between about 3 weeks to as short as 2 hours in some cases.

Code Blue provides the very nurses hospitals are most in need of – skilled, experienced, educated specialist nurses. Code Blue nurses are very well qualified:

Specialist nurses form the "elite" of nursing practice. They are hands-on, bedside nurses who, even when in-charge, are required to use their skills, knowledge and experience to provide direct care and also to supervise educate and mentor junior staff. They are expected to work closely with doctors and other health professionals, and care for the sickest people in the public health system. These patients cannot be discharged early, rather they require continuous 1:1 care.

It is also true that Code Blue nurses constitute the nurses who are most disenfranchised and disenchanted by the current career structure in nursing.

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Code Blue is owned and operated by a specialist, qualified critical care nurse who remains actively involved in the nursing profession through the Australia College of Critical Care Nurses. Code Blue actively and successfully recruits specialist nurses from interstate and overseas who may not otherwise come to work in the Victorian health system. Many of these nurses eventually take permanent positions in some form in the public health system.

Code Blue, as a significant provider of nursing agency facilities in the market claims for the purposes of s. 90A of the Act to have an interest in the application of HPV which is real and substantial. Accordingly, it seeks to make this submission as an "interested person" within the meaning of the Act.

2. HPV Request for Authorisation

Section 88 of the Act provides that the Australian Competition and Consumer Commission (ACCC) may grant an authorisation in relation to conduct that would otherwise constitute a contravention of the Act.

HPV has requested the ACCC to grant it authorisation pursuant to s. 88(1) of the Act for exemption from the operation of specific provisions of the Act, namely:

- **s. 45(2) (a) (i)** (the exclusionary provision);
- **s. 45(2) (a) (ii)** (anti-competitive agreements); and
- **s. 45(2) (a) (ii)** (price fixing through s. 45A).

[1] Roy Morgan Research *Code Blue Nurses Survey*. 2002 p 20

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It is a matter of note that the HPV has not sought authorisation for exemption from s. 47 of the Act (exclusive dealing) in respect of its proposed scheme.

It is submitted that these provisions of the Act provide the cornerstone of the protection of competition for the Australian economy provided by the Act. They comprise sections of Pt IV which prohibit conduct which results, or is likely to result, in a substantial lessening of competition in a market.

It is further submitted that, in the absence of authorisation granted by the ACCC pursuant to s. 88(1) of the Act, the conduct of the HPV would be plainly anti-competitive and in breach of these important provisions of the Act.

Further, the conduct proposed by the HPV would amount to a breach of the letter and intention of the Code Conduct Agreement between the Commonwealth of Australia and the State of Victoria, including the enabling legislation and the regulations made thereunder.

Section 90(6) of the Act provides that the ACCC shall not grant an authorisation unless it is satisfied "in all the circumstances" that the proposed conduct (by HPV) "would result, or be likely to result, in a benefit to the public and that that benefit would outweigh the detriment to the public constituted by any lessening of competition that would result, or be likely to result".

The arguments presented below are of relevance to a consideration of the grant of an authorisation under s 90(6) in three ways. First, they are relevant to the statutory requirement that the ACCC be satisfied about the effects of the proposed conduct "in all the circumstances". This wording appears to mean that an unlimited range of public benefit and detriment factors and arguments are potentially relevant in the ACCC's consideration of an application for an authorisation.[2]

Secondly, the arguments that appear below are relevant in the ACCC's consideration of whether a "benefit to the public" would result, or be likely to result, from the

[2] CCH, *Australian Trade Practices Reporter*, Volume 1, 12-310.

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proposed conduct by HPV. The onus is on the applicant to satisfy the ACCC of this public benefit aspect of s 90(6). This concept of public benefit has been interpreted as "anything of value to the community generally, any contribution to the aims pursued by the society including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress."[3] The ACCC Digest ("the Digest") refers to public benefits as being "community objectives" being met efficiently. The Digest notes that although the emphasis of public benefit is primarily on efficiency considerations, intangible benefits such as the environment and health may also be regarded as public benefits.[4] Importantly, the ACCC is required to not only assess potential public benefits, but to also take into account any "detriments [that] are intrinsic to, or represent the economic cost of a perceived [or claimed] benefit to the public".[5] These detriments must be taken into account in assessing the weight to be given to the public benefits claimed by the applicant.[6] It has been held that the appropriate approach for the ACCC to take is to compare the position that would exist in the future were HPV to go ahead with its proposed conduct with the position in the future were HPV not to go ahead with the proposed tender arrangement.[7] For these reasons, we argue that public detriments, such as those articulated in the arguments set out below, ought to be taken into account by the ACCC in its task of assessing the veracity of the applicant's claim that a "benefit to the public" would result, or be likely to result, from the proposed conduct by HPV.

Thirdly, the arguments contained below may be able to be raised in relation to the concept of "detriment to the public constituted by any lessening of competition that would result, or be likely to result". Although the detriment is stated to be restricted to a lessening of competition, it has been held that as with the assessment of public benefit, the concept of detriment to the public should be given a wide interpretation to mean "any impairment to the community generally, any harm or damage to the aims

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[3] *Re QCMA and Defiance Holdings Ltd* (1976) ATPR 40-012, quoted in CCH, *Australian Trade Practices Reporter*, Volume 1, 12-380. This formula was approved in *Re 7-Eleven Stores Pty Ltd* (1994) ATPR 41-357; *Victorian Newsagency* (1994) ATPR 41-357.
[4] ACCC, *ACCC Digest*, 3-1850.
[5] *Re Cadbury Schweppes Pty Ltd* (1981) ATPR 40-200; sub nom *Re Southern Cross Beverages Pty Ltd* (1981) 50 FLR 176, cited in R.V.Miller *Miller's Annotated Trade Practices Act 2001/22nd Edition* Law Book Company 2001, p 693.
[6] Ibid.
[7] *Re Media Council of Australia (No 2)* (19897) 88 FLR 1, discussed in ibid.

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pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency".[8]

3. The Market

The Trade Practices Tribunal commented on the meaning of 'market' in *Re Queensland Cooperative Milling Association and Defiance Holdings (1976) ATPR 40-012 (at 17,247)*:

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

The concept of a 'market', then, is informed by the idea that there exists close competition between firms and that there is substitution between one product and another, and one source of supply and another. In determining the boundaries of the market, attention needs to be paid both to the notion of a product market and a geographical market. Functional and time considerations are also relevant dimensions to be considered.

Hood observes, with respect to the Australian health care industry, that

> *Market definition principles that have evolved from other industries in Australian competition law may not translate easily to health care because of factors such as the complexities of the types of medical products available, the*

[8] *Victorian Newsagency* (1994) ATPR 41-357 at 42, 683, quoted in the ACCC, *ACCC Digest*, p 536.

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interaction of the public and private health systems, and the complex legislative background of the health care industry.[9]

Acknowledging these complex interactions, the product market in relation to HPV's request can be described as the demand for, and supply of, nurses. The relevant geographical dimension is the state of Victoria. Within this geographic boundary, the principal institutions that compete for nurses are the public health system, the private health system, and nursing agencies. The Victorian institutions also compete to some degree with similar institutions in other Australian states and abroad, but it is convenient and appropriate in this instance to set the geographical focus as being restricted to Victoria: levels of migration to nursing jobs outside of Victoria would seem to be negligible.

There is close competition between the public and private health systems, and between these and the nursing agencies, in obtaining nurses to work for them. The fact that this is so is in some ways ironic. Agencies are competing against the very organisations that they are supplying: the public and private health systems. Agencies such as Code Blue are both suppliers to hospitals and competitors to them. In relative terms, the competition provided by the agencies would appear negligible in that they provide only about 5 per cent of the total nurse labour requirements of the public health system. In some sectors of the market, however, reliance on agency staff is higher. HPV states in attachment B to its application for authorisation that "emergency wards are sometimes staffed by up to 50% of agency nurses".

To repeat: the public health system competes in this market against the agencies, even though the raison d'être of the latter is to enable these same institutions to meet their staffing requirements (and, as a result, compete more effectively in the market for the provision of health care).

Hospitals and agencies are competitors in the sense that both are rival employers. This has arisen not because of shortages of nurses but as a result of changes in government legislation in the 1990s which changed the responsibilities of agencies and shifted

[9] Antra Hood, "Anti-competitive Detriment and Public Benefit in the Australian Health Care Industry: A Progress Report", *Australian Business Law Review*, 28, August 2000, p. 295.

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them from being merely agents to being employers of nurses. The legislative changes required agencies to pay the nurses directly, and to provide superannuation, WorkCover, and leave requirements.

It needs to be stressed that competitive forces operate not only between but also within each of the three sets of institutions referred to above. The nursing agencies compete against each other in obtaining nurses as well as in providing them to the public (as well as private) health system. The Victorian Government has sought to portray the escalation in the charges imposed on hospitals by agencies as a case of mounting avarice by agencies, with Minister Thwaites using emotive terms such as 'greedy' and 'profiteering' to describe the agencies.[10] A less sinister, and altogether more accurate, assessment is to see the rising charges as testimony to the extent of competition among the agencies in trying to entice nurses to work for them rather than a rival agency. There has been a bidding war among the agencies, one that indicates the operation of competitive forces. The HPV application, we argue below, seeks to constrain, possibly even remove, these competitive forces.

Substitution is a matter of perception and a matter of degree. Whether and to what degree a substitute exists must be related to the need that the individual or organisation wishes to be satisfied. It is a question of the extent to which a given product satisfies a particular need.

In considering a labour market, it is important to consider the notion of substitutes from the perspective of both those who demand the product and those who supply it.

For the Victorian public health system, operating in the nursing labour market, the need to be satisfied is the supply of nurses. There are three sources by which this need can be met, each of which is substitutable for the other: the system's own nurses (permanent staff), bank nurses, and agency nurses. That agency nurses are perceived by the public health system to be a substitute for the other two sources of supply is self-evident: indeed the very purpose of agencies is to provide substitute labour services as and when needed. Furthermore, managers of the public health system have

[10] See, for example, Richard Barker, 'Agencies attack "nursing bank" plan', *The Age*, 8 January 2002, p. 3

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noted, usually by way of complaint, that permanent staff and agency staff are often one and the same people.[11]

We are dealing in this submission with a labour market, and as noted above it is also critical to consider the nature of the market from the perspective of those supplying the product, the nurses themselves. For the latter, there are several substitute employers: the private sector health system, the public sector health system, and agencies. This is the hallmark of a healthy market: the existence of choice. We argue below that the HPV proposal threatens to curtail the choices presently available to nurses.

It should be noted further that there are also choices for nurses as to how their services will be provided. They can work as permanent staff, as bank staff, or as agency staff. There is choice too between offering services on a full-time, part-time or casual basis.

If the need to be satisfied is defined more broadly as employment, rather than employment specifically as a nurse, then perceptions of what constitutes substitutes is likewise broadened. The fact that some 24,500 registered nurses do not work as nurses indicates the extent to which many nurses have opted to use a substitute labour market to meet their employment needs.

We argue below that the HPV proposal will encourage nurses to broaden their perception of the substitutes available to them, and will encourage them to leave employment as nurses.

For the public system, as noted, permanent staff, bank staff, and agency staff are all substitute sources of supply in the nurse labour market. The nursing needs of the public health system, however, are diverse. In a very broad sense one can talk of nurses constituting a generic product, in that they all provide something called nursing services. It is also true, however, that 'nurses' are a heterogenous group: there are

[11] See, for example, Stan Capp, 'Bleeding hospitals dry', *The Age*, 11 January 2002, p. 11. Mr Capp is chief executive, Southern Health. He writes that his nurses 'are being actively encouraged at present to reduce their permanent shifts with us in order to take up the *same* shifts with an agency' (emphasis added). He further notes that nurses are frequently working similar shifts in the same work areas but under two different employment arrangements.

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many different types of nurses, each with different skills and different levels of training, and working in many different contexts (be it critical care, paediatrics, etc). A midwife cannot be substituted with a mental health nurse. A renal nurse cannot be substituted with a perioperative nurse. A general nurse cannot replace a cardiothoracic nurse with years of experience or postgraduate qualifications. Certainly, a general nurse can be substituted for a general nurse, but each nurse will have a body of knowledge in a specialty area of nursing *and* a preference for the type of work they do. If a permanent nurse calls in sick or unable to work, and there are no bank replacements who are willing to work that shift or at short notice, then the only alternative is an agency nurse, willing to work.

It follows that what the public health system seeks, and what the agencies offer, is not a single product but a variety of products. A specialist nurse, to repeat, could be a substitute for a generalist nurse but the reverse is not true. The market has responded to this heterogeneity. Code Blue specialises in the provision of specialist nurses to meet the specific needs of the public and private health system for nurses with such skills.

If we are to use the term 'imperfect substitutes' in relation to the nursing labour market, then the focus should not be on permanent staff versus agency staff, but on the fact that nurses are a collection of people with heterogenous skills and capabilities. This is true of permanent staff as it is of agency staff.

4. Influences on the Market

(a) The Nursing Workforce in Victoria and the Structure of the Victorian Health System

The nursing workforce in Victoria is made up of 91.8% women and 8.2% men.[12] Total nurses employed in the Melbourne metropolitan and Geelong (public) health networks at June 30, 2001 was 23,952. These nurses filled 15,691 EFT (Effective Full Time) positions.[13]

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[12] *Nexus*, NBV November 2001

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In 1998, of 69,811 Registered Nurses, 56, 350 were employed. Almost 20% of registered nurses were not working in the nursing profession.[14] The registered nurse figures for 2001 are 71,097, being 63,339 women and 5,758 men.[15] This was a net increase of 1,022 nurses registered in Victoria from 2000 to 2001[16]. By April 2001, the Health Minister was claiming 1,224 nurses had returned to the public hospital system[17]. These figures show a net loss of 222 nurses for the financial year 2000-2001. Information on the proportion of registered nurses *not* in the workforce is not readily available for 2001, however the Australian Nursing Federation (ANF) states there are now some 20,000 nurses who are registered but not working as nurses.

The workforce reflects the structure of the health system. It is characterised as follows: nurses work in the public and private sectors, in not-for profit institutions, in acute care, aged care, rehabilitation, industry, schools, and in the community.

The public hospital system in Victoria is but one part of the health system – and by no means the only important part of the system.

Since 1989 nurses have been solely educated in universities at undergraduate level. Prior to this time, most nurses were educated in hospital-based hands-on training programs. Specialist nurses are educated to graduate certificate, graduate diploma level, and fewer to masters and PhD.

While workforce planning occurs at a pace, there are limits to the accuracy of such work. In particular, the needs of the private sector and aged care are often overlooked in the Victorian workforce planning processes, masking the reality of figure on shortages across the entire health care sector.[18] While 1240 students completed nursing degrees in 2001, not all of these graduates have registered. There were 1,105 overseas nurses and 580 interstate nurses registered in Victoria 2000-2001.[19] Despite

[13] *Hospital Highlights Report for Year ended June 2001*, DHS. P11.
[14] *Nurse Recruitment and Retention Committee Final Report May 2001*, DHS p34
[15] *Nexus*, NBV November 2001
[16] NBV Annual Report 2000-2001, p7
[17] Julie-Anne Davies, "Numbers up as strategy cuts in" *The Age*, Saturday April 7, 2001.
[18] *National review of nursing education discussion paper* (2001) DESTp 13
[19] NBV Annual Report 2000-2001 p 9.

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these new registrations, the NBV reports a net increase of 1004 registrations in 2001[20], yet the publicly touted figures are that some 2650 nurses have been recruited to public hospitals[21]. Clearly, these nurses have been poached from the private, not-for-profit and aged care sectors.

Workforce projections are inaccurate in addressing the current and future requirements for all nurse requirements in each sector of the entire health system in Victoria. Workforce figures take little account of the needs of the health system as a whole, as these figures are driven by the needs of the public hospital system by DHS bureaucrats.

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

1. 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. [22] The average age of nurses in 1994 was 39.1 years, while in 1997, it was 40.4 years. More starkly, in 1986, 23.3% of nurses were under 25 years and 17.5% were over 45. Ten years later, only 7.7% were under 25, while 30.3% were over 45.[23]

2. Nurses are increasingly difficult to recruit particularly experienced, skilled nurses into permanent positions. Of those nurses currently in the workforce, public hospitals are struggling to retain the skilled, experienced and well-educated nurses.

[20] Nexus, Nov 2001, p3
[21] Tom Noble "Thwaites slashes nursing numbers", *The Age*, Saturday, March 2, 2002
[22] *Nursing Labourforce 1999* (2001) AIHW p37.

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(b) The Nature and Reasons for the Shortage of Nurses

(i) The Nature of the Shortage

Specialties in nursing include perioperative (theatre), emergency, cardiothoracic, neurosciences, neonatal intensive care, paediatrics, intensive care and coronary care, renal, aged care, oncology, midwifery and mental health. The Australian Institute of Health and Welfare (AIHW) reported shortages of nurses in Victoria in each specialty area with the exception of oncology and paediatrics in 2001[24]

There has been plethora of research over the past 5-10 years relating to the shortage of nurses. While the Nurse Labourforce Projections for Victoria 1998-2009 determines there are adequate nurses "available"[25] to meet the health needs of the community until 2009, many of those nurses are NOT making themselves available to work.

The Victorian Government through the Department of Human Services with the support of peak nursing organisations, including the Australian Nursing Federation (ANF), set out to identify recruitment and retention problems, define the demographic of those leaving nursing and develop strategies to keep nurses nursing while attracting those outside the public hospital system back into the system.

The Victorian Government appointed the Nurses Recruitment and Retention Committee (NRRC) in February, 2000. The Committee was to determine why some 20% of nurses registered in Victoria are not working in the profession, and to make recommendations on how to prevent further exodus from the system, how to retain those currently in the system, and what was required to lure nurses back into the public health system. Some 86 recommendations were made, 44 requiring revision of state government policy and/or funding for implementation. Notably, 39 of the 86 recommendations revolve around education. This may reflect the dominance of nurse academics on the Committee.

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[23] *Ibid.*
[24] Ibid. p25
[25] *Nurse Labourforce Projections Victoria* 1998-2009, DHS 1999, p25

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The NRRC's research methods included review of literature, submissions from public and private hospitals and peak bodies, a series of surveys, focus groups and a number of community consultations in regional and metropolitan centres.

Much of the material handed down in the NRRC Interim Report in March 2000 and *The Hidden Costs of Understaffing An analysis of contemporary nurses' working conditions in Victoria*[26] formed ANF evidence to the AIRC in an industrial dispute over the Award in front of Commissioner Blair[27]. This evidence was used in particular in support of the ANF claim for reparation of nurse-patient ratios as a method for nurses to control their workloads. Indeed, the AIRC supported nurse-patient ratios.[28] In order to maintain those ratios, particularly in specialist areas, agency nurses must be used on an increasingly regular basis. The alternative to employing agency nurses is not being able to maintain ratios, and for each hospital to run the "risk" of nurses closing beds. Bed closures have previously been used as an industrial tool with success since 1985. Bed-closures as a method of controlling workloads are no longer viewed only as an industrial tool. The NRRC considers closing beds is a useful way to control nursing workloads, as set out in Recommendation 44.[29] Indeed, Commissioner Blair set up a process to enable bed closures as a legitimate means of controlling workloads.[30]

The ANF commissioned a study *The Hidden Costs of Understaffing An analysis of contemporary nurses' working conditions in Victoria*[31] in 1999 to examine how cost control measures impact on the nature of nurse's work, and how nurses on the job have responded to funding shortfalls. The NRRC "has learnt that some hospitals maintain unfilled vacancies as part of their staffing profile, with no intention of filling them"[32]. We have a situation where the hospitals are not filling vacancies and risking bed closures when ratios are not met, increasing the need for agency staff that the

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[26] Considine, G. & Buchanan, J. *The Hidden Costs of Understaffing An analysis of contemporary nurses' working conditions in Victoria* Australian Centre for Industrial Relations Research and Training, 1999 ANF (Vic Branch) Melbourne.
[27] Ibid
[28] Public Sector Heads of Agreement – Monitoring Committee, Dec 2001.
[29] *Nurse Recruitment and Retention Committee Final Report May 2001*, DHS p8
[30] AIRC C No. 35605 of 2000, para [174]1.
[31] Considine, G. & Buchanan, J. *The Hidden Costs of Understaffing An analysis of contemporary nurses' working conditions in Victoria* Australian Centre for Industrial Relations Research and Training, 1999 ANF (Vic Branch) Melbourne.
[32] *Nurse Recruitment and Retention Committee Final Report May 2001*, DHS p37

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hospitals are reluctant to use because of increased payrolls. In fact, the costs associated with use of, and a stronger market for, agency nurses are currently not budgeted for. Rather than amend budgets, the hospitals are setting up a no-win staffing system where ratios cannot be met, adequate permanent staff are not being recruited and agency nurses are not to be used other than for unplanned absences.

(ii) The Reasons for the Shortage: Why Nurses leave Permanent Work

Again, a raft of information exists on why nurses leave nursing or, more precisely, leave permanent employment in nursing. The ANF-commissioned *Hidden Costs of Understaffing* provides further useful information on just how difficult it is to be a nurse – any nurse - in the Victorian public hospital system.

In very broad terms, the problems cited by nurses and causing them to leave nursing are workload; working conditions; remuneration; lack of a suitable career structure; lack of reward or recognition for further education; extensive unpaid overtime; poor understanding of nurses' work and conditions in which nurses work by managements; limited flexibility in shift times; rostering; compulsory night-shift, particularly for Assistant Unit Managers. There are further issues which relate to nurses being women, prominently an inability for nurses with children to take holidays at school holiday time; shift times that do not coincide with school drop-off and pick-up times; inadequate child-care or child-care with unsuitable hours; working with agency or inexperienced new-graduate staff.

Compulsory nightshift needs to be explained. In general in Victorian public hospitals, each unit (or ward) has a Nurse Unit Manager (NUM) and up to five Assistant Unit Managers (AUMs). The AUMs manage the unit in the absence of the NUM. The NUM works a straight dayshift, usually 8:30am – 4:30pm. In most cases, there are difficulties recruiting permanent night duty AUMs, so the five AUMs are rostered on a rotating basis through the night duty. Most AUMs hate working nightshift. A glance at vacancies in any Saturday Age will show a majority of advertised public hospital nursing vacancies are for AUMs. AUMs are paid at Grade 3B.

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If Grade 2 nurses are to proceed through the career structure from Grade 2, they must take an AUM or NUM position for promotion. There is no other mechanism in the career structure to reward clinical excellence than to take an AUM (Grade 3) or NUM (Grade 4) position. Grade 3 positions involve many administrative tasks and these nurses are supernumerary on the evening shift and, on occasions, at night. The Grade 4 NUM is supernumerary and the role is almost entirely administrative. The NRRC describes "the inability of the current career structure to retain nurses in clinical positions" as a recurring theme among nurses[33].

Apart from these problems for nurses, nursing is sheer hard work. It is physically and mentally demanding, and places the ultimate emotional strain on nurses who are required to deal with death and personal tragedy for patients and their families, while not being able to meet the demands of their own families. Further, there is great concern within the profession that nurses' roles and the demands of their roles are not clearly understood by their own nursing and hospital administrators, let alone the Government or the general public[34]. The work nurses do is at once technically demanding and extremely intimate, based on the development of individual relationships with patients and their families. Only those within the relationship can know it, and quantify the resources a nurse provides them.

(c) The Nature and Role of Health Care Funding

The 2001-2002 Victorian health budget has been increased by $459 million to increase emergency and elective surgery[35]. The greatest growth in the demand for services has been in emergency admissions, over 7% growth last year. This growth has been consistent over the past several years.[36]

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[33] *Nurse Recruitment and Retention Committee Final Report May 2001*, DHS, p45
[34] *National Review of Nursing Education Discussion Paper.* (2001) Department of Education, Science and Training p.7
[35] *Victorian – Public Hospitals Funding Guidelines 2001-2002* Acute Hospitals Division, DHS, June 2001. p1
[36] ibid p6

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The funding provided under the Winter Emergency Demand Strategy 2001 – 2002 has proven to be effective in better managing patients. Additional funding will be provided for care coordinating in some metropolitan hospitals.[37]

Emergency Department Enhancement funds are available to provide enhancement to emergency department functioning, eg establishing short stay units and rapid assessment teams.[38] Some $469 million will be committed over 4 years (from 2000) to recruit an extra 1,300 nurses to improve nurse-patient ratio and nurses' working conditions. [39]

A major objective of the Funding and Policy Guidelines is to increase inpatients by 2.8% or by 27,400 admissions[40]. The recurrent budget has increased from $13 million to $15.5 million in 2001-2002, to provide emergency services (in hospital emergency units) that better manage emergency attendance and can prevent patients from being admitted to wards.[41]

Each Health Service is funded on a model that includes reaching through-put targets. This is clearly evidenced in the original HPV application to the ACCC [42]. These targets generally provide funding incentives to ensure the highest through-put of patients in a manner which is politically palatable – the HPV application mentions ambulance by-pass penalties.

Conditions of funding

Through-put above targets will in general not be paid, however, through-put in excess of target up to 2% will be paid 50% of target B rate.[43]

Funding for quality improvement programs is provided to metropolitan health services under a new consolidated Quality Fund totalling $58.9 million.[44]

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[37] ibid p33
[38] ibid p33
[39] ibid p1
[40] ibid p5
[41] ibid p8
[42] Application for Authorisation Nos A90811&A90812 lodged by Health Purchasing Victoria, 14-12-01, Attachment B para 3.
[43] *Victorian – Public Hospitals Funding Guidelines 2001-2002* Acute Hospitals Division, DHS, June 2001. Section B –Conditions of Funding p5

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One must ask where is quality when there is a severe nursing staff shortage - a shortage that will be worsened by cutting agency nurses' payment rates and agency nurse usage. This is exacerbated by the appalling deployment of agency nurses within each hospital for each shift by nursing administrators. Agency nurses are frequently and repeatedly placed in areas not suitable to their skills and experience, and then blamed for not having the necessary skills and experience to provide quality patient care.

Bonus funding has been identified in the DHS 'Policy and funding Guidelines 2001-2002' for metropolitan health service. This bonus funding is paid retrospectively on the basis of performance against targets. For example, 6.25% will be available every month subject to performance against monthly indicators, and a further 6.25% will be available each quarter subject to quarterly and 6 monthly indicators.[45]

Bonus funding depends on performance against indicators specified at each campus. Health services (eg. Southern Health has 3 major hospitals) must achieve satisfactory performances at all campuses. If not, bonus will be reduced by an amount equal to campus allocation.[46]

Monthly indicators include

Ambulance bypass

- % of Emergency patients who are admitted to beds within 12 hours
- emergency triage category 1 patients attended to and being seen by
- medical and nursing staff immediately
- elective category1 patients admitted within 30 days
- Hospitals must meet targets for all four of these monthly indicators to achieve bonus.[47]

Quarterly indicators include

- Number of patients on elective surgery waiting list

[44] *Quality Framework Business Rules 2001/2002 Acute Health Division*, DHS, July 2001 p1
[45] ibid p1
[46] ibid p 1

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- Proportion of elective category 2 patients overdue on waiting list
- Day of planned surgery admissions
- Same day surgery rate[48]

Critical Care service indicators that affect bonus funding

The percentage of Intensive Care Unit (ICU) patients transferred from public hospitals when an ICU bed not being available, as a percentage of the total number of ICU separations (admissions and discharges).

The percentage of Coronary Care Unit (CCU) patients transferred from public hospitals when a CCU bed is not available, as a percentage of the total number of CCU separations (admissions and discharges).[49]

Emergency service indicators

Emergency services (accident and emergency units) performance indicators were introduced in 1995 to encourage improved access to emergency services[50] these include

- Occasions of ambulance bypass
- percentage of emergency patients admitted to inpatient beds within 12 hours of arrival in accident and emergency unit
- Time taken to treat triage category 1 to category 5 patients [51]

Bonus payments are made to individual hospitals on the basis of performance against monthly targets for ambulance bypass and other aspects of the indicators mentioned above. [52]

Hospitals in the Home (HITH) Services

Commenced in 1994, HITH has proven to be a cost effective way of managing particular groups of acute inpatients. 43 hospitals in Victoria have HITH program and

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[47] ibid p 2
[48] ibid p 2
[49] ibid p 54
[50] ibid p 90
[51] ibid p 90
[52] ibid p 90

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share in an annual incentive funding.[53] HITH allows for early return to their homes for chosen patients, who have care provided through home visits by medical, and particularly nursing staff. These patients remain "admitted" patients, and are not formally discharged until the HITH staff visiting them determine discharge is appropriate.

Those hospitals that equal or exceed the average substitute rate (of HITH for patients who would normally be required to stay in the hospital) will receive bonus allocations in addition to their base grant.[54]

Metropolitan hospitals are expected to reach a target substitute rate that has been negotiated with each health service [55].

HITH unplanned return to hospital report targets

No planned return by HITH patients is the target set for this financial year. Performance is assessed six monthly.[56]

Having briefly outlined the funding system, the political aspect of health care delivery must be considered. A primary political imperative exists to reduce waiting lists for elective surgery, as the waiting lists are easily quantifiable and simply understood by the general public and used as a crude yardstick for how our public health system is functioning. Increases in waiting lists equals poor management by the government. Nurses closing beds due to lack of available nursing staff equals cancelled elective surgery. The hospital fills up (there are less beds to fill), goes on ambulance by-pass, misses out on funding incentives, and the whole episode is usually reliably, if sensationally, reported in the press. This is a politically unpalatable scenario.

[53] ibid p106
[54] ibid p 106
[55] ibid p 106

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5. A Comparative Perspective

Nurses are leaving the profession throughout the western world. We can usefully compare the Victorian debate on approaches the nursing shortage, and the role of agencies, with what has happened in Britain and Canada, as their health systems are most similar to Australia.

Canada

There are a number of problems caused by nursing shortages in Canada, most significantly an aging workforce,[57] nurses having to work extended days in a row, prolonged periods of overtime and a high rate of absenteeism[58]. Canadian nurses are in many cases required to work as many as 60 days in a row to ensure adequate shift cover.

"In B.C., Premier Gordon Campbell's new Liberal government has moved to force nurses and other hospital workers to continue on the job for 60 days. Nurses will no longer have the right to refuse to work overtime, which they have been doing to protest stalled contract talks for the past two months"[59].

British Columbian nurses were involved in a series of strikes and walkouts through 2001 to ensure the government understood their issues.

"These confrontations are symptomatic of a new assertiveness among nurses, fuelled by exhaustion, frustration and pent-up anger over being undervalued by governments and medical administrators. "[60]

2001 saw numerous strikes and walkouts, and a new pay structure has been handed down in 2002.

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[56] ibid p 107
[57] "Nursing shortage chronic", *Halifax Chronicle-Herald*, June 11, 2001
[58] "Why Canadian nurses are so angry" Andre Picard, *The Globe and Mail*, 20-6-01
[59] "Florence Nightingale Flexes her Muscles" *The Star*, Canada, June 21, 2001.
[60] Ibid.

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There is also a serious drain of experienced nurses and new graduates to the United States. At least 10% of new nursing graduates in Canada head to the U.S. every year, while one in every eight nurses in Hawaii is Canadian[61]

Canada does not have agency nurses.

The United Kingdom

The following table provides a summary of the key points of comparison between the way the British authorities have negotiated with nursing agencies and responded to the shortage of nurses and what has happened in Victoria.

Table 1. Comparison between UK and Victorian approaches to nursing agencies and nursing shortages.

United Kingdom	Victoria
PASA Purchasing and Supply Agency already exists	HPV Health Purchasing Victoria developed in 2001 with amendment to the *Health* Act 1958 Strategic plan released October 2001[62]
Nursing Agencies in UK are regulated by the *Care Standards* Act 2000 and the *Nurses Agency* Act of 1957	Nursing agencies in Victoria are not regulated. They were until 1992, but with the review of the *Nurses* Act 1993, sections relating to regulation of nursing agencies were repealed. However, the DHS in conjunction with the Nurses Board of Victoria released a discussion paper in mid-2001 to discuss the notion that nursing agencies be re-regulated
Long process of investigation and public consultation specifically about the use and cost of agency nursing staff and locum doctors. *Brief Encounters – Getting the best from temporary nursing staff* released 2000 by Audit Commission. Significant findings were that agency nurses have difficulty providing the same level of care as	There has been no consultation with nurses or with the community. There was a meeting between DHS and ANF on 24-12-01; the agenda and outcomes of which have not been made public. ANF did not consult with agency nurse members There has been no formal, comprehensive investigation or inquiry into nursing agencies or agency nurses in relation to

[61] Transcript – "Taking the pulse of Canada's nurses". CBC News Online, June 2001http://cbc/news/indepth/background/nurses.html

[62] Health Purchasing Victoria *Strategic Directions Statement 2001/2002*

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permanent nurses, particularly because of the way they are deployed in hospitals[63] The NHS could not survive without agency nurses There are similarities in the extent of the nurses' shortage in UK to Australia. *Draft Care Standards* Act 2000 released for public comment 2000.	the nursing shortage There are no plans to review the nature, extent, problems, benefits, etc. of nursing agencies and agency nurses
Recruiting and retaining nurses, midwives and health visitors in the NHS released early 2001 London Agency Project trialing changes to use of agency staff, followed by announcement of 29 London-based nursing agencies as preferred providers November 2001 Agreements between preferred agencies and NHS include a 25%reduction in agency nurse payments and agency commissions	Formation of Recruitment and Retention Committee to determine reasons why nurses are leaving permanent work and what needs to happen to retain nurses in the system. AIRC determine industrial dispute in favour of public hospital nurses by introducing nurse:patient ratios ANF release *Hidden Costs of Understaffing* survey results 2000. Survey conducted with 10% of ANF members, or about 2.7% of nursing population in 1999. Recruitment and Retention Committee release final report and recommendations, which State Government responds to in formal document NRRC comments on nursing agencies based on open consultation attended by nine (9) people.
September 2001 Development of NHS Professionals and release of document *NHS Professionals – a coordinated approach to temporary staffing* which addresses locum doctors as well as agency nurses. Implemented initially in London and two regional NHS areas, for implementation across UK by end of 2003 NHS Professionals includes an "image", uniformity of processes and an extensive, centrally coordinated advertising campaign	Major Melbourne metropolitan public hospitals set up new nurse banks with a particular focus on enticing agency nurses into the public hospitals. Each hospital runs its own bank. Integrated website set outlining nursing vacancies around Victoria. Now extensively advertising in major Saturday press in employment pages. Nurse-banks are not centrally co-ordinated or "branded".
	The week before Christmas, 2001 Victorian Government through HPV makes application to ACCC for interim authorisation to enable HPV to tender for

[63] *Brief Encounters – Getting the best from temporary nursing staff* 2000 The Audit Commission, UK p10.

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	agency nurses from agencies at or near award rates. Interim authorisation denied by ACCC
Office of Fair Trading currently investigating London Agency Project to determine whether Framework Agreements breach trade practices legislation. Decision/determination expected late February, early March 2002.	HPV application to ACCC amended to tendering for agency nurses supplied to public hospitals at the award or EBA rate. ACCC to consider substantive issues. All submissions to be in by March 13, 2002
British NHS system still struggling to find adequate nurses. Agency usage for many agencies as high as ever – "Winter beds" currently open, where extra beds and wards are made available for winter increase in admission. Press reports of NHS sending surgical patients to France and Germany[64] as there are not enough nurses in Britain to care for these people Blair says if he can't get the NHS running properly, he will leave[65]	Thwaites directs Networks and hospitals to severely cut the use of agency nurses. Announces this direction to the public and warns that the public hospitals can no longer afford current levels of agency use. This means elective surgery will be cancelled and beds will be closed, in breach of Government's own Funding and Policy Guidelines. ANF "welcome" the Government's actions, despite never having asked agency nurse members. Monash Medical Centre closes 14 cubicles in Accident and Emergency Department, and cancels some elective surgery. Sends permanent theatre nurses to work in Accident and Emergency.
British officials have monitored and reported exact numbers of registrations for nurses returning to the nursing workforce. [66] Since February, 2001 there have been 1,347 nurses returning to the NHS in London who were previously out of the nursing workforce.	Victorian NBV has not reported exact figures of nurses returning to nursing. Cannot differentiate between new graduates registering for the first time, nurses returning to the workforce, nurses from interstate and nurses who delayed in getting annual registration in by 31 March cut-off date and re-registered late.
London, with a population in excess of Australia's, has had 1347 returning nurses since February 1999	On Friday, March 2, 2002, the Health Minister is quoted in "The Age" newspaper that the public hospitals have recruited 2650 new nurses [67]. But few of theses are in fact returning to the nursing workforce. Most have been enticed from other areas of our health system, notably aged care. March 3, 2002 Articles in both The Age and Herald-Sun reporting the Victorian

[64] Assorted press summaries
[65] ibid
[66] Pan London Newsletter – 13 December 2001, Department of Health, UK.
[67] Tom Noble, "Thwaites slashes nursing numbers", *The Age*, Friday march 2, 2002, p1.

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	Government's statement that it would recruit 3000 additional full-time nurses into the public hospital system[68] – from where?

There are some notable differences between agencies in Britain and Australia and some striking similarities. The biggest difference is that British nursing agencies are highly regulated through the *Nurses Agency* Act of 1957 and the *Care Standards* Act 2000 (Commencement No.. (England) and Transitional and Savings Provisions) Order 2001. Victorian agencies are not regulated, save that their nurses are regulated by the *Nurses* Act 1993. Anyone can set up an agency. The Victorian nursing agency industry is regulated by the market – with which the Victorian Government through HPV is seeking to interfere. British nurses were just as keen to leave the health system[69] and just as keen to work for an agency as Victorian nurses, and for identical reasons. Indeed, nursing and its hierarchical, intransigent, routinised development in Australia resembles nursing in Britain more than any other country. This is probably due to similar public health and pharmaceutical benefits systems.

In Britain, the Health Department has developed "NHS Professionals"[70] as a nationally co-ordinated, locally managed nurse bank to recruit nurses from agencies and out of retirement as a way of dealing with a shortage of nurses, specialist nurses in particular. The Victorian model of enhanced , co-ordinated nurse banks combined with the HPV proposal to tender for agency services at fixed (Award) rates appear to be based on the British model. The British model is almost two years ahead of the Victorian model.

There is a fundamental difference between the models – the NHS worked harder at gaining public support and consultation, and worked at consultation with agencies. (There was even public consultation on amendments to The *Care Standards* Act

[68] AAP "State to hire 3000 nurses" *Sunday Age*, 3-3-02, p5 and
David Wilson, "Push for 3000 full-time nurses" *Sunday Herald-Sun*, p30
[69] *Recruiting and retaining nurses, midwives and health visitors in the NHS – a progress report.* (2001) NHS Executive (UK)
[70] *NHS Professionals A co-ordinated, NHS-led approach to temporary staffing.* (2001) Department of Health (UK)

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