INTRODUCTION

The purpose of this submission is to comment on the statements made and conclusions drawn by the ACCC within its' draft determination of the Health Purchasing Victoria tender authorisation. In addition, the RCSA will be highlighting those tender conditions that we believe the Commission should consider when making its' final evaluation.

The RCSA recently participated in the pre-determination conference, held on August 15th, 2002. During this conference, the RCSA made representation that it believed that the ACCC had misdirected itself in its authorisation function under section 90 of the Trade Practices Act 1974 and further, that the comparison of the effects of the HPV tender process and the DHS direction was flawed.

The RCSA has requested that the ACCC should determine the public benefit issue in light of the merits of the HPV tender authorisation application, without reference to the existence of the Directive.

The Commission itself makes the statement in section 5.39 of the determination that *'Having proceeded on the basis that the written direction will remain in place, as indicated to the Commission by the DHS, if the direction is subsequently revoked, this may constitute a material change of circumstance'*. Should the tender be authorised and subsequently proceed, contracts will be established between HPV and the successful tenderer(s). If such a material change of circumstance was to occur, does the Commission believe that these contracts would be cancelled, that the tender would be re-called and then be re-presented to the ACCC for subsequent authorisation? We do not believe this would be the case; the tender should therefore be considered on its own merits.

COMMENTS RELATING TO THE DRAFT DETERMINATION

Section 2: Background to the Industry.

Nursing in Australia

In section 2.1 and 2.2, it should be noted that the Commission has cited out of date figures regarding the number of nurses registered within Australia and specifically within Victoria.

Nursing Shortage

In section 2.7, the Commission notes that a DHS study has projected that 'if current levels of demand for health services are maintained, Victoria will face a shortfall of 5500 registered nurses by 2008. ' We would draw attention to the fact that this figure is viewed as significant. While the Commission fallaciously dismisses Agency nurses as representing only a small section of the market, it is apparent that any reduction in the number of available nurses will have an effect on care provided.

In addition, it should also be noted that the demand for health services has increased since the time at which the cited report was written. For example, in the past year, demand for Emergency services has increased by 12%, up from 8% the year before. The Royal Melbourne hospital has reported that demand for patient services had increased by 15% over the previous year. Increasing demand for services and a decrease in the number of available nurses will ensure that the shortfall occurs long before 2008.

Nursing Agency Services in Victoria

In section 2.14, the Commission has stated that Agency nurses represent just 3.3% of the nurses working in the Victorian public health system and 2.4% in the private system, based on figures from the *Nurse Labourforce Projections Victoria 1998 –2009.* This report derives nursing employment figures on data from 1996, now 7 years old.

During the past 7 years, the nursing market has drastically altered. A significant number of nurses joined agencies to improve their working conditions and hospitals increased their use of agency services, both as a means of reducing the number of permanent staff they required and as a reflection of the difficulties in recruiting full time staff members.

As such, both the agency market and the number of nurses who participate within this market have markedly increased over the last few years. Agency nurses cannot be dismissed as an insignificant portion of the workforce. We believe that between 10-15% of the total nursing workforce have undertaken Agency work, either working full time with an agency or supplementing their shifts with agency work. Many nurses have returned to nursing as a result of improved agency pay rates.

Amended Application in Light of Section 42 Written Directive

In section 2.35, the Commission states that the HPV amended the tender documents so as to ensure consistency with the conditions of engagement as set out in the DHS directive. This statement is incorrect. The Directive states that the capped price is 80% above the base award rate for nurses. This figure excludes GST. When this condition was incorporated within the tender, it became subject to clause 11.2 of the proposed Service Agreement, which states that *'The fees referred to in clause 10 and Schedule 3 includes any amount of GST that the Health Service is required to pay in relation to the supply made by the Contractor.'.*

Section 3. The Application

We submit that the points raised against section 2.35 should stand against section 3.2.

In light of the price capping requirements, the conditions outlined in section 3.3 would seem to be irrelevant, especially given that the stated assessment criteria does not stipulate that this is a factor on which agencies are assessed.

In section 3.4, the Commission states that the successful tenderer(s) will be appointed on various criteria including 'tenderer's willingness to pay nurses the relevant Industrial Award or Enterprise

Bargaining Agreement. This statement is incorrect. In section 4.2 of the Request For Tender Document (dated 9 April 2002), there is no such criterion listed.

Section 5. Commission Evaluation

Future with and without test

In section 5.2 of the draft determination, the Commission stated that the counterfactual which it has applied is one where, in the absence of the tender process, the public health services party to the proposed arrangements would negotiate individually with agencies for the supply of temporary nursing staff.

Section 42 written direction

In section 5.7, the Commission initially states that it is not assessing whether the public benefit generated by the written direction outweighs any associated public detriment. However, in section 5.8 and 5.10, the Commission then states that it has evaluated the tender arrangements in the context where the DHS exists and will continue to remain in place. Subsequently, the Commission has now determined to assess the public benefit and detriment over and above that generated by the written direction.

As stated in our original submission to the pre-conference, we believe that the Commission has misdirected itself on this point and should assess the tender without reference to the directive.

Reduction in long term supply of nurses

The Commission has incorrectly stated the Directive in section 5.17. The Directive has capped the total amount that hospitals will *pay* for the provision of nursing services, as the relevant award plus 80%. There is no direction as to the *remuneration* that a nurse will be paid. At minimum, the nurse is required to be paid at the casual award rate, which is calculated at 25% above the base award rate. Therefore, within the Directive structure, agencies could in theory pay nurses at any price point between base award plus 25% and base award plus 80%, although allowances for oncosts such as superannuation, Workcover and other operating costs would need to be applied.

In contrast, the tender not only stipulates the capped amount that will be paid to agencies for the provision of services (including GST), but also requires agencies to nominate any over the award payments which they may elect to make to nurses. (According to the assessment criteria, this information is not part of the tender evaluation). In addition, the tender also requests details on any volume discounts that may apply.

While both the RCSA and individual agencies have indicated that given their average cost structures, it would be difficult for agencies to submit pricing below the 80%, it is apparent that any agency who does tender for this business will be required to do so.

Therefore, it would seem that the conclusion drawn by the Commission that it would be unlikely that the tender would reduce casual nursing remuneration below the written direction cap is incorrect.

Currently within the directive capped pricing structure, most agencies have had to continue to pay their nurses above the casual award rate, as nurses are unwilling to work at the standard award rate within the public system. If agencies are expected to provide hospitals with a discount in addition to offering pricing that cannot exceed 80% of the base rate including GST, then the most likely area to be affected is nurse remuneration. Agencies may do this directly by reducing remuneration, or indirectly by adhering more strictly to superannuation legislation, which requires that they only pay nurses who have earned over $450 per month at any one client site rather than $450 in total.

In this instance, nurses who could not be found work within the private system would be forced to work at reduced remuneration within the public system. While some nurses may stay within the public system, the RCSA believes that the majority of nurses, especially those within specialist ranks, would leave the nursing profession to pursue higher paying, less physically and emotionally demanding jobs. This will not only reduce the total pool of available nurses and thus further exacerbate the overall shortage, but will, most importantly, reduce the number of highly experienced and qualified nurses within the system who both now and in the future would provide leadership and mentoring to younger nurses.

Possible reduction in number of nursing agencies

According to Commission figures, the health services covered under the HPV tender constitute 50% (46.9%) of the total demand for nursing services. The Commission then states that consequently, a large portion of the market would remain open to nursing agencies. The remaining market would therefore be composed of non-metropolitan public health services (20.1%) and private health services (33%).

While the Commission believes that this proportion of the market is sufficient to maintain those agencies who were unsuccessful in the tender, it ignores two fundamental issues. Firstly, the non-metropolitan public health market does not have a high demand for agency services and does not and will not represent any significant business opportunity. Secondly, the private market is dominated by a small number of operators and is therefore effectively a closed market.

- Most of the remaining private hospitals are operated/controlled by Mayne Health, Benchmark, Ramsay, Healthscope or Catholic care groups.

- These groups are seeking the lowest possible price (often at the capped rate) or are also arranging preferred or exclusive provider arrangements.

- This will effectively reduce the number of agencies that can trade within the market place and subsequently put agencies out of business.

However, the Commission believes that this should not be an issue as there are low barriers to entry so agencies can freely join and leave the market place. This is also untrue.

To offer a viable service to nurses/hospitals and move beyond a single owner/operator operation, at minimum an Agency needs to:

1. Recruit nurses through advertising, such as newspapers or Yellow Pages entries;
2. Develop and implement rigorous recruitment practices, including thorough reference checking, police checks and overall competency assessment etc;
3. Establish company operations so that the Agency can operate on a 7day*18hour or 7day*24hour basis to meet both hospital and nurse service requirements;
4. Provide training to nurses, as appropriate to client requirements;
5. Undertake and fund payroll management services. Nurses are paid weekly but invoices for services provided may remain unpaid for up to 3 months;
6. Provide Workcover and Professional indemnity insurance;
7. Establish clients and understand client requirements, through marketing visits; and
8. Invest in or develop automated allocation software.

These activities are both time consuming and costly; an Agency requires significant investment if it is to grow. The Commission seems to believe that those agencies that would leave the market as a result of the tender and the smaller available market share can quickly re-enter the business. This is not the case. Likewise, new participants cannot quickly enter the market, meeting demand at a lower price.

In section 5.29, the Commission is also incorrect in its' assessment that many nursing agencies are divisions of larger recruitment agencies which provide staff across a number of industries. This is untrue. Of the agencies represented by the RCSA, we are aware of only two agencies to which this statement applies. We are unaware of any non-member nursing agencies to which this statement applies.

ISSUES WITH THE TENDER AND SUBSEQUENT SERVICE AGREEMENT CONDITIONS

a) The inclusion of GST within the 80% price capped structure.

As outlined in section 3.4 and 3.5 of the tender, the maximum price payable to the tenderer must not exceed 80% above the base award rate and must include GST.

Under the directive, the maximum price payable to an agency is 80% above the base award for a particular grade of nurse. This figure excludes GST. Therefore, the maximum effective markup on the base rate could be 80%, or 44% above the casual rate.

As the tender pricing is to include the provision for GST, the maximum effective markup on the base rate would be 63.6%, or 30.8% above the casual rate.

As previously indicated, realistically this is an unsupportable price structure for most if not all agencies. In addition, we do not believe that Nurse banks could operate within this structure.

b) Agency to assume liability for payroll tax

In accordance with the Employment Agency Provisions of the Victorian Payroll Tax Act, the host employer assumes responsibility for the payment of payroll tax. It is our understanding that Public Hospitals are currently exempt from this payment and as such, they are liable for no further payments. If agencies were unable to gain similar exemption, then additional costs may be incurred as a result.

c) Imposition of financial reductions as a result of non-performance

As defined in clause 3.6 of the proposed Service Agreement, successful tenderers will be required to conform with performance indicators, as yet unspecified. Failure to comply shall entitle Health Services to impose financial reductions, also currently unspecified. In addition, failure to provide any part of the nominated services may also be viewed as a default, as defined by clause 13. In this instance, the agency would be forced to pay the difference between the agency rate and the rate that the nurse was supplied at, plus a 10% administration fee.

Agencies have a standard business imperative to maximise the number of nurses who are filling shifts. Just as nursing agencies have no control over when orders are received or cancelled by a hospital, likewise, they have limited or no control over how many nurses will be available to meet specified demand, as nurses dictate their own availability.

Therefore RCSA cannot support financial impositions as a result of non-performance.

In addition, we also believe that Nurse Banks will not be subject to either performance indicators or penalties.

d) Assumption of additional liability

Clause 8 of the Service Agreement requires that the Contractor indemnify each Health Service against any liability, loss, claim or proceeding as a result of the provision of Services. Every insurance company contacted by the RCSA or its' member agencies has stated that agencies who sign up to such an Agreement will automatically be in default of their existing policies in assuming additional liability.

e) Automatic imposition of additional liability insurances

Clause 9 of the Service Agreement defines the required level of liability insurance. However, the clause also states that *'In the event that the Contractor cannot or does not comply with all of the provisions of this clause, the Health Services may (but are not obliged to) effect insurance which so complies at the expense of the Contractor which expense shall be promptly paid by the Contractor to the Health Services.'*

As this clause stands, it does not provide the Contractor with the opportunity to 'make good', instead, they could be automatically insured and then billed. Given the escalating costs of insurance, if a tender could not adequately meet their insurance requirements they may elect to withdraw supply rather than pay additional premiums.

f) No allowance for increasing operating costs

Capped pricing makes no allowance for increased costs which may occur over time, such as Workcover or professional indemnity/liability insurance, which HSV requires Contractors to maintain. Given the current upwardly spiralling costs of insurance, these costs will represent a more significant proportion of the oncosts, with each policy renewal.

Nurse Banks will be covered under the Victorian Management Insurance Agency and as such, will not be subject to the same level of increase.

g) Monthly invoicing, to be paid after 30 days

All agencies pay nurses on a weekly basis and therefore also invoice clients on a weekly basis, with an average settlement time of 14 days.

Clause 10.8 of the Service Agreement stipulates that the Contractor shall only invoice clients at the end of each calendar month, with 30 day payment terms. This effectively means that hospitals will have up to 60 days to pay invoices, assuming that they pay on time.

Cash flow is always an issue for any business, however, the ridiculously low margins proposed within the tender will preclude the use of debt factoring, should the need arise. Agencies will not be able to fund operations under these conditions.

CONCLUSION

If the Commission continues to include the Directive within it's review, then we believe that the contention that the additional anti-competitive detriment resulting from the HPV tender is minimal, given that the Directive exists, is incorrect.

1. The HPV tender is more restrictive, as non-successful tenderers are excluded from providing service.

    - The Directive stipulates the terms under which agencies wishing to provide nursing staff to public hospitals must abide.
    - Not withstanding the arguments which we have previously presented regarding the proposed public benefits, all Agencies have the choice of providing nursing staff under these conditions and can freely enter and exit this market, irrespective of their ability to provide staff who are willing to work at these rates.

2. The HPV tender is more restrictive, as there are additional tender conditions that will exclude smaller agencies from responding to and working within the tender, who could otherwise work within the Directive.

    - The price that agencies can charge has been effectively reduced by 10% of the current capped rate, as the 'directive' price capping within the HPV tender *includes* GST, whereas the Directive prices *excludes* GST;
    - The service compliance requirements are more onerous and rigorous; and

    - There are financial penalties for non-performance or non-supply. Agencies have limited or no control over when nurses make themselves available or cancel out of shifts.

    Thus, smaller agencies who may not enjoy economies of scale, may be unable to fund the investment required in additional management systems required by the HPV or who may not be able to fund non-compliance penalties, will be essentially excluded from the tender. This tender will ensure that larger agencies will get the majority of business because only they can support the commercial conditions, which could leave the market in a much less competitive environment progressively throughout the first tender period.

However, we believe that the Commission has misdirected itself and should only consider the tender without reference to the directive.

This tender represents a serious threat to the supply of nursing services within Victoria. As attested by nursing action within both New South Wales and Queensland, pay rates are of prime concern within the nursing profession. Agency nursing provides nurses with a well paid, flexible option for employment and allows hospitals to maintain flexible staffing levels, ensuring that their patients receive the best care.

A recently commissioned federal government report on reviving nursing within Australia[1], warns that 22,000 nurses will leave the workforce during the next five years. This will be in addition to the 31,000 vacancies which already exist. Minister for Health, Senator Kay Patterson has stated that:

> "Nurses are pivotal in primary care, they're pivotal in nursing care, they're pivotal in tertiary care, in aged care. Everywhere you see health delivered you will find nurses and other people working in nursing-type activities."[2]

Nurse play a vital role in providing healthcare for all Victorians. For many nurses, agency nursing represents the only viable working alternative, allowing them to remain within the profession, either full time within the agency or supplementing their income from other full time nursing employment.

By authorising the HPV tender, the ACCC is supporting in instrument that will further erode nursing conditions, will ensure that even more nurses leave the public system and remove the motivation for many students to enter the nursing profession.

[1] Our Duty Our Care by Patricia Heath
[2] Nurse shortage 'frightening', Darren Gray, The Age 17 September 2002