ANALYSING THE NATURE AND CHARACTERISTICS OF THE NURSING AGENCY INDUSTRY IN SOUTH AFRICA

Omolola Iwayemi Olojede

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of

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DECLARATION

I, Omolola Iwayemi Olojede declare that this research report is my own work. It is being submitted for the degree of Master of Public Health in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signed on this 15th day of October, 2012

DEDICATION

To Sasha Adetutu

PRESENTATION ARISING FROM THE RESEARCH

Olojede, O. and Rispel, L. *Understanding the characteristics of nursing agencies in South Africa: Implications for health service delivery*. Poster session presented at: Closing the health equity gap: Public health leadership, education and practice. 7th Public Health Association of South Africa (PHASA) conference; 2011 November 28 – 30; Johannesburg, South Africa.

ABSTRACT

Background

The aim of this study was to describe the nature and characteristics of nursing agencies and their implications for the South African health care system.

Methods

A mixed method study was used that included in-depth interviews with six key informants and a telephone survey of 106 nursing agencies.

Results

The majority of agencies (76.9%) were established between 2000 and 2009; reported formal contracts with their clients (77%) and a code of conduct (97.9%). They mainly service private patients (45.1%) and old age homes (27.4%). Between 5.7% and 67.4% of agencies provide non-financial benefits to casual health workers. The main challenge is reported gaps in the regulation and monitoring of the industry.

Conclusion

There is need for tighter regulation and monitoring of nursing agencies in the health sector, in order to ensure that casual health workers are not exploited, while meeting the care needs of clients in old-age and private homes.

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ACRONYMS AND ABBREVIATIONS

AICU	Adult Intensive Care Unit
AIDS	Acquired Immune Deficiency Syndrome
ANASA	Association of Nursing Agencies in South Africa
BCEA	Basic Conditions of Employment Act
CHP	Centre for Health Policy
COID	Compensation for Occupational Injuries and Diseases
COSATU	Congress of South African Trade Unions
DENOSA	Democratic Nurses Organisation of South Africa
GHWA	Global Health Workforce Alliance
HRH	Human Resources for Health
ICU	Intensive Care Unit
ILO	International Labour Organisation
MDGs	Millennium Development Goals
NAO	National Audit Office
NDOH	National Department of Health
NDOL	National Department of Labour
NPSWU	National Public Service Workers Union
PICU	Paediatric Intensive Care Unit
PSC	Public Service Commission
RESON	Research on the State of Nursing
RWOPS	Remunerative Work outside the Public Service
SABC	South African Broadcasting Cooperation
SANC	South African Nursing Council
TES	Temporary Employment Services
UK	United Kingdom
USA	United States of America
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

1.1 BACKGROUND

There is global recognition of the importance of human resources for health (HRH) defined as "all people engaged in actions whose primary intent is to enhance health", and their contribution to health system performance and good health care outcomes [1]. The significance of HRH to population health and access to health services is illustrated by the establishment of the Global Health Workforce Alliance (GHWA). The Alliance has pointed out that when human resource issues of a country are not prioritised, service delivery and other health system components will be negatively affected [2-3]. In South Africa, the health workforce is a key priority for the National Department of Health (NDOH) [4] in order to achieve the country's Millennium Development Goals (MDGs) and to improve the performance of the health system.

Nurses in South Africa, as elsewhere, make up the largest single group of health care providers and their role in attaining quality health care services cannot be over-emphasised [5-8]. They play various roles in the health sector, including the provision of personal health services to populations, management and leadership, and they are often the link between communities or patients and health care facilities [9].

However, there are numerous challenges faced by this group of health workers. These include, inter alia: changes in disease patterns; growing demand for health care services; an ageing nursing workforce; decrease in the nurse-population ratio; shortage of nurses especially in specialised areas such as intensive care and theatres; and an increasing process of casualisation of nursing work, evidenced by practices such as moonlighting and increased use of agency nurses [10-13]. Many hospitals in both the public and private sectors rely on agency nurses in specialised areas. Although there is little evidence in South Africa to show the impact of the utilisation of nursing agencies on the health system, anecdotal evidence suggests that nursing agencies and the resultant process of casualisation of nursing work has impacted on service delivery, with many reported negative consequences, including high staff absenteeism rates caused by unauthorized moonlighting and abuse of sick leave by nurses; low productivity due to heavy workload, physical and mental fatigue; low morale and poor quality of care [12, 14].

Generally, casualisation – which refers to the employment of workers on a contract part-time basis without the benefits associated with permanent employment [15], has been one of the changing patterns of work in South Africa and elsewhere [16]. It is widespread, for example in the agriculture and the mining industries where workers are employed on short-term contracts [16]. The casual employment is typically done through a temporary employment agency (TES) or labour broker who employs the casual worker and then contracts the person to a company, organisation or individual that needs the service [17]. This method of employment has also found its way to the health sector, influenced by globalisation of the health workforce, individual preferences for flexibility and the additional income it offers [18-19]. Developments in the health sector are particularly evident in the employment of nurses who are employed through nursing agencies [20-22]. Hence nursing agencies are labour brokers in the health sector.

Several social scientists have conducted studies to describe and understand the process of casualisation of labour in South Africa [23-26]. Very few studies focus on the health sector, and these studies are limited to developed countries where the focus is on nurses who work for agencies, rather than the nursing agencies themselves [21-22, 27-31]. In the South African context, the anecdotal evidence suggests that there has been a growth of the nursing agency industry, particularly in the last decade [12, 14]. This growth in the number of nursing agencies has had both positive and negative consequences for the health system and for the individual nurses. Until 2005, commercial nursing agencies were required by law to register with the South African Nursing Council (SANC) [32], but the National Health Act classified nursing agencies as health establishments under the jurisdiction of the Department of Health [33]. Little is known about the nature and characteristics of these nursing agencies except that they play the role of labour intermediaries or labour brokers.

In light of limited empirical evidence on these important role players in the health sector, particularly how the nursing agency industry operates, their advantages and disadvantages to the health system, and the current issues facing the industry, the evidence generated by an empirical study is potentially useful to policy-makers and by the broader academic community. The remainder of this chapter sets the scene for

the study that was conducted by outlining the problem statement, presenting a review and critique of existing literature, and summarising the rationale for the study. The chapter concludes with the study aim and objectives.

1.2 PROBLEM STATEMENT

In South Africa, existing information obtained from workshop presentations and technical reports [12, 14] suggests that:

- There is high expenditure on nursing agencies in both the public and private health sectors.
- Nursing agencies are not always able to provide the categories and skills of nurses needed.
- Nursing agencies do not always comply with their contractual agreements.
- Nursing agencies provide a mechanism for nurses to do moonlighting, with many reported negative consequences for health care delivery.
- There is lack of adequate monitoring and supervision of agency nurses by the agencies.
- The legal framework is not clear on the accountability and governance of nursing agencies, with resultant confusion and difficulties of monitoring and evaluation.

As indicated above, there is little empirical information on the nursing agency industry in South Africa, their impact on the health system, and the policies and strategies needed to address some of the identified problems.

1.3 LITERATURE REVIEW

1.3.1 Definition of terms

Nursing agency

In terms of the 2003 National Health Act (section 1), nursing agencies are considered to be part of health establishments, which are defined as "*the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services"* [33: p.12].

A nursing agency according to the 1978 Nursing Act (section 1) *"means a business which supplies registered nurses or midwives or enrolled nurses or nursing auxiliaries to any person, organisation or institution, whether for gain or not and whether in conjunction with any other service rendered by such business or not"* [32: p.4].

Agency nurse

A nurse registered with the South African Nursing Council (SANC) who is employed by a commercial nursing agency, providing temporary cover in a health care facility. The nurse is paid by the agency, which, in turn, charges the health facility a fee. Agency nurses may be registered with several agencies as well as having a job in a public or private health care facility [34].

Labour brokering

Labour brokering in the South Africa Labour Relations Act is known as 'Temporary Employment Services' (TES). It is defined as *"any person who, for reward, procures for or provides to a client other persons (a) who render services to, or perform work for, the client; and (b) who are remunerated by the temporary employment service"* [35: section 198, para.1]. Therefore, the labour broker is a person or organisation that engages in the act of labour brokering [36].

1.3.2 Conceptual framework: Triangular form of employment

Casual labour started as early as the 19th century [29] and evolved into many fields including the health sector [37]. In general, casual work means that the employees work on a part-time or contract basis without the benefits associated with permanent employment [17]. Some have referred to this kind of labour as 'modern slavery' because of its lack of benefits and job security [38].

Social scientists have described different types of casualisation which includes *work time flexibility* i.e. changes to working time patterns through shift systems, part-time or temporary work and *numerical flexibility* i.e. adapting the size of the workforce in response to changing utilisation patterns. Numerical flexibility includes sub-contracting, outsourcing and use of casual employees [17]. Nonetheless, in the case of a temporary employment agency (TES) or labour broker, it involves a triangular form of employment that includes a third party who is an intermediary between the employee and the employer. In the case of the triangular employment, there is no formal relationship between the employee and employer. This form of employment has consequences because labour laws do not always protect the employees [17]. Figure 1 illustrates the relationship between the casual worker, the temporary employment agency (the labour broker) and the employer.

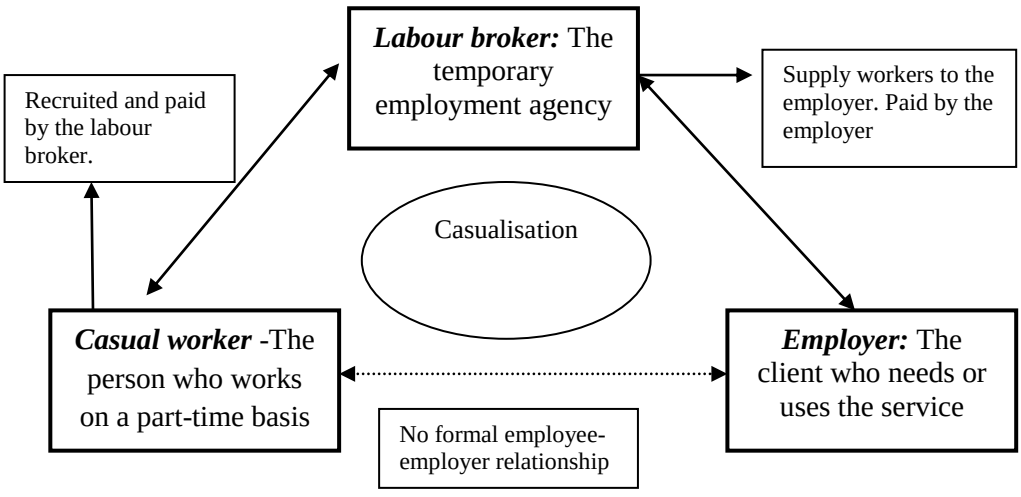

Figure 1: Triangular employment in labour brokering

The change in the pattern of work from permanent jobs to casual jobs has drawn global attention with growing concerns about the indiscriminate use of casual workers [16]. Consequently, the International Labour Organisation (ILO) is at the forefront of ensuring that all persons have "decent work" [16]. ILO wants all workers to have the four components of decent work namely: "employment, worker's right, social protection and social dialogue" [39: p.8]. Their focus however is mainly on eliminating casual labour in the construction, infrastructure, agriculture and domestic labour sectors [16, 39]. Interestingly, there has been little focus on professional health workers (in particular nurses) or on the health sector. One of the ILO strategies is to empower countries' trade unions to fight against limitations on workers' rights [40-41]. These global changes in work patterns and the consequences have stirred debates, encouraged studies and audits of casual work across different countries, and resulted in lobbying for international policy changes to protect the rights of workers or to eliminate all casual forms of employment [22, 24, 31, 38, 42-44].

1.3.3 The nursing agency industry in South Africa

In South Africa, the growth in the nursing agency industry appears to be related in part to nursing shortages [11]. Hospitals in both the public and private health sectors depend on casual nurses supplied by nursing agencies in specialised areas such as intensive care units (ICUs), when there are high volumes of patients, and/or when permanent staff members are absent, or on leave [45].

Some analysts have attributed the increase in the number of nursing agencies in South Africa to other labour-related changes such as the decrease in full time employment and an increase in casual labour in the agriculture, construction and gold mining industries [23-26].

Information on nursing agencies is also available through the Association of Nursing Agencies in South Africa (ANASA), a voluntary, umbrella body set up to represent the industry. ANASA has developed a code of ethics, constitution and standards for their members [45]. In 2011, the association had around 50 member nursing agencies in seven provinces with the highest concentration in the two urban provinces of

Gauteng and the Western Cape. However, this number only represents a small proportion of the overall 500 agencies as listed in the South African Nursing Council (SANC) database which was the only source of information on the number of registered agencies at the time of the study. There is almost no information available on the nursing agencies that are not part of ANASA, and the Department of Labour does not collect routine information on the providers of temporary services, of which nursing agencies would be a part.

1.3.4 Proposed ban of labour brokers and nursing agencies in South Africa

In the last few years, labour brokers have come under the spotlight of labour/trade unions and the media. The Congress of South African Trade Unions (COSATU), the largest labour federation in South Africa, is at the forefront of the fight against labour brokers. Through the media and various websites, COSATU has made calls for a total ban of the labour brokering industry because it undermines the collective bargaining power of unions, and exploits casual workers [46-49]. There has not been much focus on nursing agencies, which provide temporary employment services. The reasons for the proposed ban may not apply to nursing agencies as nurses have specialised skills and do not fall into the definition of casual semi-skilled workers described by the ILO.

Yet within the labour movement, there does not appear to be consensus on the banning of labour brokers. For example, the National Public Service Workers Union (NPSWU) suggests a "phased combination of regulation until an appropriate position exists for the ban of labour broking" [36: p.22]. This is due to the effect a ban may have on the health sector since it is believed that agency nurses make up high percentage of nurses in public hospitals. NPSWU also pointed out that the number of vacancies will be more than the number of nurses available to fill the positions [36]. Nonetheless, at the time of writing, COSATU had organised a national strike to call for the total ban of labour brokers [49].

In response to this call on the ban of labour brokers, ANASA has pointed to the negative consequences of a ban for the health system. As an organisation, they have been lobbying the National Department of

Health (NDOH), the SANC, the National Department of Labour (NDOL) and other stakeholders to ensure that the ban does not occur [52-54]. It is important to note, however, that nursing agencies in South Africa are business entities [32] whose main priority is profit-making [66]. This may be their motivation or interest to avoid a ban.

In contrast to COSATU's position, the Minister of Labour aims to tighten the control over labour brokers through additions to the labour legislation that will curb employee abuses and protect workers' rights. The draft regulations provide for amendments to regulate casual employment, part-time or temporary work [50: Labour brokers]. This is a different approach from the total ban of labour brokers. Similarly, the presidential state of the nation address indicated that all abusive forms of employment will be eliminated but the address was silent on the issue of a total ban on the industry [51].

1.3.5 Studies on the nursing agency industry in developed countries

The majority of studies have been conducted in the United States of America [55-56], United Kingdom [18, 27, 29, 57-62], New Zealand [28, 63] and Australia [30, 64-67, 96], but these studies focus on agency nurses rather than on the nursing agency industry.

In general, the studies compare the characteristics of agency nurses to permanent hospital nurses, their relationship with permanent staff nurses, agency nurses motivation for working for agencies, management of agency nurses by the hospital administration, the quality of health delivery by the nurses, and permanent nurses' relationship with agency nurses [27-28, 63-66]

In terms of the actual nursing agencies, very few empirical studies have been done. An Australian study that aimed to obtain in-depth knowledge on nursing agencies explored a number of issues including why hospitals used specific agencies, benefits provided to nurses, formal relationships with hospitals, nurse allocation methods of nurses, communication process with hospitals and 'professionalism' [65, 67]. A telephone survey and some interviews were conducted with agencies. The study found that agencies were of the view that they assist hospitals in alleviating nurse shortages and that their role was important in the

health system. Although it is one of the few published studies, this study had a very low response rate of 23% with only six agencies included [67] and only three participating agencies were interviewed in another component of the overall study [65]. In addition, the study was conducted in the year 2000, so the information is dated and the health system in Australia is very different from the one in South Africa.

Information on the nursing agency industry tends to be published in government documents, non-peer review journals, magazines or the media. Some documents tend to focus on the provision of advice for hospitals and nurses. For example, such advice includes the ability to select an agency with good methods of communication; the offer of protection for nurses when the need arises, an agency with good marketing skills; one that is true to its word; an agency that is well equipped and provides information; responds quickly to the needs of clients; and perform good background checks on nurses [68-74].

In some popular articles, nursing agencies have been portrayed as contributors to community development such as supporting children's education [75-76]. However, in the main, the reports tend to highlight the negative aspects of agencies such as the costs associated with their services, the sub-optimal quality of care provided by agency nurses and the lack of nurse-patient relationships. The complaints are usually from hospitals, clients and the media [57, 59-60, 77-78].

This has led to discussions regarding tighter regulation of the industry and for strategies to reduce the cost associated with their use in hospitals [34, 79-82].

1.3.6 Studies on the nursing agency industry in South Africa

There is a dearth of studies on nursing agencies in South Africa, with existing information limited to conference or workshop presentations or technical reports [12, 14]. Reported problems range from high expenditure, poor compliance with contractual agreements, through to lack of monitoring and evaluation [12, 14]. An investigation by the Public Service Commission in 2004 found that some "private" agencies contribute to unauthorised moonlighting by nurses, and other related misconduct such as abuse of sick

leave, absenteeism, and corruption. These in turn add to heavy workload in the public sector, as well as physical and mental fatigue of nursing staff that contribute to poor health system performance [14].

1.4 STUDY JUSTIFICATION

There are several reasons for undertaking a study on the nursing agency industry in South Africa:

1. There is a *dearth of empirical studies* on nursing agencies in South Africa and in sub-Saharan Africa.
2. There is *limited* information on:
    a. The *nature and characteristics* of nursing agencies that operate in the country
    b. The relationship between the industry and their clients in the health sector, and existence of monitoring structures and mechanisms
    c. The relationship between the agencies and nurses, and whether there are similar issues of the infringements on the rights of workers as highlighted in other forms of casual employment
    d. The influence (positive or negative) of nursing agencies on health care delivery in South Africa.

The value of an objective study that aims to develop new knowledge on the nature and *characteristics of nursing agencies* in South Africa is borne out by recent health policy developments in South Africa. In 2011, the Minister of Health referred to moonlighting and agency nursing as the "twin devils" at the national nursing summit, and the Nursing Compact called for better regulation of nursing agencies [4, 83]. In addition, the management of the industry is one of the top priorities of the national HRH strategy for the period 2012 to 2017 [117].

1.4.1 Aim

To describe the nature and characteristics of nursing agencies and their implications for the South Africa's health care system.

1.4.2 Objectives

i. Describe the characteristics of nursing agencies in terms of:
    a. Distribution across provinces
    b. Distribution of clients across private and public hospitals
    c. Ownership of agencies
    d. Contractual relationship between nursing agencies and hospitals
ii. Explore the nature of employment relationship between agencies and nurses in terms of:
    a. Cadres of nurses being employed by the agencies
    b. Demand for categories, skills and number of nurses by hospitals
    c. Opportunities provided for nurses such as career development, remuneration packages and incentives
iii. Describe the challenges experienced by nursing agencies in their business
iv. Analyse the legislation, policies and management of nursing agencies by relevant stakeholders.

In summary, nursing agencies are both health establishments (in terms of the Health Act) and labour brokers (in terms of the Labour Relations Act) in South Africa because they employ agency nurses through a triangular form of employment. Labour brokers have been under public scrutiny with calls that range from tighter regulation of the sector to a total ban. There is limited information in South Africa on the nursing agency industry, which provides the backdrop to this study. The next chapter will therefore describe the methods used to achieve the aims and objectives of the study.

CHAPTER TWO: MATERIALS AND METHODS

2.1 INTRODUCTION

This chapter describes the overall study approach and methods (sampling, data collection and analysis) which were in line with the study aim and objectives.

2.1.1 Study Population

The overall population for this study was nursing agencies in South Africa registered with SANC in 2010, who are not members of ANASA. This is because a separate study focused on ANASA members. In addition, ANASA members only represent about one tenth of the more than 500 agencies registered by the SANC.

2.1.2 Study Design

This was a cross-sectional study utilising both quantitative methods of data collection obtained through a telephone survey of nursing agencies that are not members of ANASA, and qualitative information obtained through in-depth interviews with key informants.

2.1.3 Study Components

The study consisted of a qualitative, formative component and a quantitative, survey component, summarised in the table below and described in further detail thereafter.

Table 1: Nursing agency research study components

Objectives	Methods	Instruments
Analyse the legislation, policies and management of nursing agencies	Qualitative component that involved interviews with six key informants from government, trade unions and the private health sector	Semi-structured interview schedule
• Describe the characteristics of nursing agencies • Explore the nature of employment relationship between agencies and nurses • Describe the challenges experienced by nursing agencies	Quantitative component that involved a telephone survey with nursing agencies	A structured questionnaire with some open-ended questions

2.1.4 Ethical Issues

Ethical clearance for the study was obtained from University of the Witwatersrand's Human Research Ethics Committee (medical) with reference number M10971 (Appendix 1). Standard ethical procedures were adhered to, and included detailed information sheets (Appendices 2 & 3); informed consent and voluntary participation (Appendices 4 & 5).

The survey questionnaire, audio recordings and interview transcripts were coded with the identity of each respondent kept anonymous. All identity links to codes is kept private and can only be accessed by the researcher. In addition, the names of informants and agencies are not reflected in this report. The audio recordings and questionnaires will be destroyed two years after the results are published.

2.2 KEY INFORMANT INTERVIEWS

2.2.1 *Sampling*

A total of six key informants were purposively selected based on past and present relationships with the nursing agency industry or labour brokering. The informants were from government (3), trade unions (2) and the private health sector (1).

2.2.2 *Data collection*

An interview guide (appendix 6) that consisted of eight main questions with additional probing questions was designed according to the study objectives. Participants were contacted through telephone calls and interviews were scheduled according to the convenience of each participant. All participants except one were interviewed in their enclosed offices at different locations within Gauteng province. There was one exception of a recorded telephone interview for which consent was obtained.

The study information sheet was sent through email correspondence to the six informants. At the beginning of the each interview, consent forms for participation and permission to record the interview were signed voluntarily. All interviews were conducted by the researcher who was accompanied by a staff member of the CHP.

Each interview lasted between 25 – 45 minutes and was digitally recorded after informed consent had been obtained. The interview focused on participants' experience and knowledge of nursing agencies, perceived advantages and disadvantages, debates regarding the ban of labour brokers and the control and management of nursing agencies.

2.2.3 *Data management and analysis*

In order for the researcher to analyse the interviews, short course training on qualitative research was done and relevant text books consulted [84]. All interviews were transcribed verbatim within one week of each interview and it was checked against the recordings several times to ensure accurate representation of the interview. The researcher ensured good familiarisation with the corpus data. After the initial reading, common themes emerged. Each transcript was manually colour coded under main themes and sub-themes such as "knowledge and perception", "advantages of nursing agencies", "disadvantages of nursing agencies" and others. To ensure reliability, there was inter-code agreement with a CHP staff member. The staff member independently coded all the transcribed interviews and the themes were

compared to what the researcher had. In the majority of interviews, similar codes were assigned, but in cases where different codes were assigned, there was discussion until agreement was reached.

The analysis was inductive i.e. drawing themes from the data and not using a pre-determined framework. The first step in the analysis was to look at the words and phrases used by key informants, without preconceived notions or classification [84]. At the second step, the researcher examined the language used by each key informant in light of the interview questions. Inductive codes were developed based on the issues that were brought forward repeatedly or discussed at length by the participants. Similar codes were then grouped into themes using a 'cut and paste' method [85]. These themes are presented in the results section.

2.3 NURSING AGENCY SURVEY

2.3.1 *The sampling frame*

The SANC was contacted to obtain a list of nursing agencies registered in its database. A list of 500 individual nursing agency names was obtained including the physical address, business numbers and email address of each agency. The database was cleaned using the criteria listed below.

First, agencies that are members of ANASA, obtained from the organisation's website [86], were excluded. This was because another study had focused on ANASA members. This list was cross checked with a telephone call made to ANASA office to ensure its accuracy. Second, some agencies indicated on the list as 'closed' were excluded. Third, where agencies had multiple branches, only one branch was selected to represent the agency. Thereafter, the remaining agencies were checked to ensure that all had at least contact numbers, physical and email addresses. Based on the exclusion criteria, the total number of agencies so derived was 402 and this constituted the final sample frame.

2.3.2 *Calculation of sample size*

Using this sampling frame of 402, the overall sample size was calculated, selecting the variable of interest as the proportion of agencies with a "code of conduct". This was set at 80%, with the lowest value at 70%

and the highest at 90%. The confidence interval was set at 95%. Epi-Info statistical package was used to calculate a total sample size of 53 agencies. This figure was doubled to 106 in anticipation of a 50% non-response rate. The sampling approach is shown in figure 2.

2.3.3 *Sampling*

Each agency was allocated to a province based on the physical address and phone numbers. Previous information indicated that the majority of nursing agencies are located in Gauteng and Western Cape provinces. The researcher used Google engine to search for which province an agency's address location and telephone codes belonged to, while two CHP staff that are South African citizens, independently allocated each agency to a province. The results were then cross checked for accuracy. The agencies were grouped into three strata namely "Gauteng", "Western Cape", and "Others". The stratification according to size was carried out and the sample size within each stratum is shown on table 2. The random sampling was done using STATA version 10 statistical package [87].

Table 2: Stratified random sample of province by size

	Gauteng	**Western Cape**	**Others**	**Total**
Total number of agencies per province before sampling	192	81	129	402
% of sampling frame for each province	48%	20%	32%	100%
Sample size in each strata	51	21	34	106

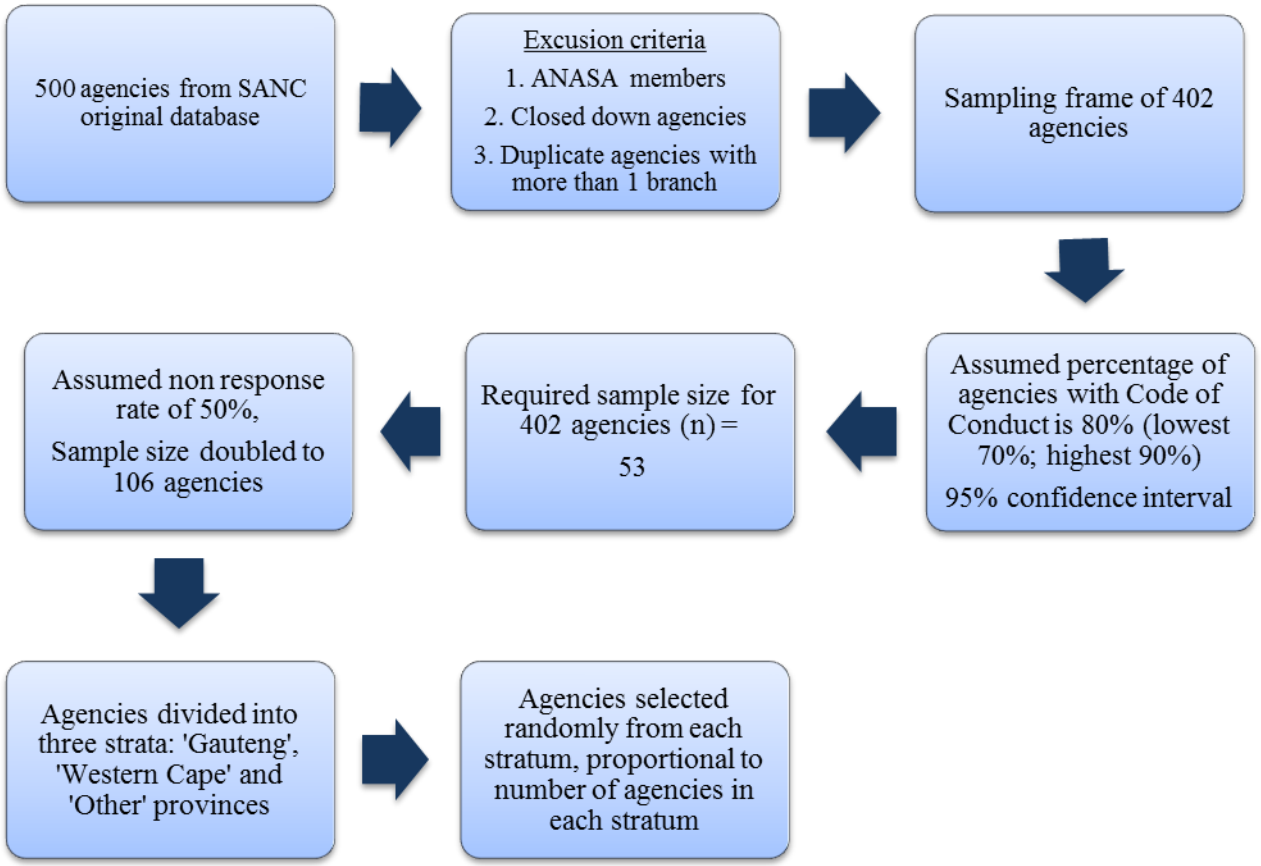

Figure 2: Sampling approach and calculation of sample size

2.3.4 *Data collection tool*

The data collection tool was developed as follows:

- A Centre for Health Policy (CHP) questionnaire on nursing agencies was examined.
- The principal investigator of an Australian nursing agency study was contacted [65] in order to obtain a copy of their survey questions. After reviewing the questionnaire, many of the questions were either not relevant or already covered, so it was not used.
- The researcher used the CHP tool and adapted the final data collection instrument for this study by reducing the number of open-ended questions. The structure of the questionnaire consisted of

close ended questions, 7-point Likert scale statements that ranged from “strongly disagree” to “strongly agree” [88], with seven open ended questions.

2.3.5 *Procedure for data collection*

The data collection was done by the researcher through telephone interviews. As the telephone calls were made using the telephone numbers retrieved from the agency list, some inconsistencies were observed. Some of the telephone numbers were incorrect or unreachable, a few agencies were no longer in operation, and some were not nursing agencies. To alleviate the observed inconsistencies, the researcher checked the nursing agency names against Google search and the South African yellow pages.

The procedure for the telephone interviews was as follows:

- An introductory call was made to explain the purpose of the study and give an invitation for participation.
- The information sheets and consent forms were sent through email and fax to agencies that had technical facilities.
- Depending on their willingness, participants were given some time to read through the information. They gave their responses through the telephone or sometimes responses were received by email. The consent forms were also sent in this manner.
- The completion of the questionnaire depended on each participant. A few wanted to go ahead with the questions, some preferred to see the questions by email and then book an appointment to call, others wanted permission from an authority prior to participation. Each questionnaire (appendix 7) was completed by the researcher based on the oral response from the participant.
- This was done without putting any pressure on the participants. Every other agency that could only be reached by cell phone was asked to give an oral consent voluntarily. While some agreed, some of them declined.

- An average of three follow up calls were made to each participant, but in some instances up to nine calls were made to an agency.

2.3.6 *Addressing the sources of bias in the survey*

For this type of study, the researcher recognised that bias may be present at any stage of the research. The activities described below attempted to reduce bias in the quantitative component of the study.

- To avoid sampling bias, a stratified random sample was selected to ensure that agencies had an equal chance of being selected from the three strata, and to ensure that agencies in Gauteng and Western Cape do not constitute the only ones selected.
- A low-response rate was accounted for by doubling the sample size. In addition, a minimum of three calls was made to ensure a high response rate.
- Only one person (the researcher) collected the survey data. The data was entered by the same researcher who had good knowledge on the research topic, and all data was checked repeatedly.
- Telephone interviews are much more likely to be biased because of the lack of physical contact between the interviewer and respondent and low response rates. To address the problem of low response rate, at least three calls were made to each agency and detailed call log documents were kept that included the number of times each agency was called, the appointment dates and time and the state of completeness of each telephone interview.

2.3.7 *Data management and analysis*

A coding sheet was developed and each variable allocated a unique code. The data was entered into an excel spread-sheet, checked for mistakes and cleaned in preparation for its importation into STATA. At the analysis stage, an exploratory analysis was done for all variables. Categorical variables were described by numbers and frequencies on tables while the three continuous variables (nurses registered, nurses supplied and rates paid to nurses) were summarised in means, standard deviation, median and interquartile range. The variables were grouped into tables according to generated topics such as

characteristics, clients/nurses relationship with agencies, and challenges. The Likert scale options of strongly agree, agree and slightly agree were pooled into one group called "agree" while strongly disagree, disagree and slightly disagree were grouped as "disagree".

Following descriptive analysis, a test for statistical significance was done to compare the characteristics of nursing agencies (e.g. type of client, year established, number of branches, etc.) across provinces and between public and private sector clients (study objective 1). The analysis also sought to determine whether the nature of the employment relationship (study objective 2) differs according to province or between public and private sector clients of agencies. The Fisher's exact test was conducted when expected cell sizes were less than '5' under each province. The Chi square test was used to test the number of observations of '5' and above. The t-test was used for categorical variables of two groups with a continuous variable. All tests were done at a 95% confidence interval.

The overall study's data collection and analysis were done over a period of ten months (appendix 8). Data collection and analysis of the two components were done simultaneously during this time period. The results of the study are described in the next chapter.

CHAPTER THREE: RESULTS

3.1 INTRODUCTION

In this chapter, the study results are presented. First, the results of key informant interviews are presented to give a broad background and context of the nursing agency industry in South Africa. The main purpose of this component was to answer the questions on the context, regulations, legislation and policies on nursing agencies in South Africa. The component also explored key informants' perceptions on the proposed ban of labour brokers and how the change will affect the health care system.

Second, the quantitative aspect of the nursing agency survey is presented by describing the main characteristics of survey participants (the agencies), contractual agreements, policies and relationships with their clients. Furthermore, the formal relationships between the agencies and their agency staff i.e. nurses or caregivers are also described. This chapter concludes with the reported industry challenges.

3.2 RESULTS OF KEY INFORMANT INTERVIEWS

The key issues to emerge from the key informant interviews are summarised in the box and then elaborated on below.

Box 1: Main themes from Key Informant Interviews

1. Key informants' knowledge and perceptions of the nursing agency industry was patchy, with varied impressions on the industry itself, and the main reasons for their existence and growth in the last decade.
2. There appears to be gaps in the existing legislation that governs nursing agencies, in part due to changes in the National Health Act, with resultant lack of clarity on the reporting and monitoring authority.
3. The perceived advantages of nursing agencies are both at an individual and health system level: For the individual nurses, benefits include the flexibility of work it provides, opportunity to earn extra salary and the availability of some non-monetary benefits. For the health system as a whole, nursing agencies are perceived to: provide readily available human resources, encourage the sharing of nursing expertise; and there are reported cost savings.
4. The perceived disadvantages of nursing agencies at the individual level are overworked nurses, lack of benefits associated with permanent employment and poor working environment. From the health system point of view, the use of nursing agencies is costly to government and there are allegations of poor service delivery.
5. The perceptions on the proposed ban on labour brokers varied, depending on the position of key informants, with some respondents strongly in support of the proposed ban while others wanted stricter regulations or transitional arrangements to buffer the health system against the impact of a total ban on labour brokers.

3.2.1 Knowledge and perceptions of the South African nursing agency industry

Informants were asked about their views on when and why nursing agencies came onto the labour market including the reasons for the industry's growth. None of the respondents could comment authoritatively on the time of the establishment of nursing agencies, and were speculating as can be seen from the quotes below:

> *"It* [the evolution of nursing agencies] *must have been in the mid-90s."* (KI5, Government official)

Another respondent noted the following:

> *"Since I started working in the trade union movement, I mean, being active in the trade union movement as early as around 1988, I have known the industry to actually be there. It has been there throughout."* (KI2, Trade union official).

Perceived reasons for the existence of nursing agencies

The overwhelming reason advanced for the growth in the nursing agency industry is as a result of the nursing shortage:

> *"The nursing agencies in South Africa has been in operation for quite a long time and they are used for variety of reasons because we are all aware of the current shortage of nurses in particular the professional nurses and those nurses with specialised qualifications. Most of the* [health] *facilities resolve to use them whenever they have got a challenge in terms of their human resources. And now of late, one could see that there's an emerging trend that the nursing agencies are also growing and there are quite a number of new ones that are coming on board because it also appears to be a lucrative market for this type of business."* (KI6, Government official)

The same key informant indicated that because of shortages of nurses, agencies have also been established in rural areas due to the increased need for them in these areas:

> *"At first they were more concentrated in metropolitan area but now you will find they are also in remote rural areas because as much as the new facilities are being open and there's shortage of staff, the only way to get staff then is to use the agencies to place nurses into these particular areas. That has led to the growth of this industry."* (KI6, Government official)

Another respondent commented on the geographical distribution of nursing agencies across the country from big cities to smaller cities:

"What I know is that most of them are in big cities. I know that they are in Joburg, Durban and small towns we don't have those things [nursing agencies] *particularly as far as I know. And they have 'mushroomed'. There were few in the past. I'm not sure of their numbers."* (KI3, Trade union official)

Nursing agencies as labour brokers

Key informants were also asked to describe their understanding of the kind of employment nursing agencies offer. All six respondents stated that nursing agencies are labour brokers that provide part-time jobs, illustrated by the following quotes:

"Nursing agencies according to my understanding are groups out there which have organised themselves to organise the nurses to work on a part-time basis. So they are labour brokering groups." (KI5, government official)

The other respondent explains agencies as follows:

"They are labour brokers because, remember, they are the middle person. You are on the database. They supply, they employ, the institution pays the labour broker or nursing agencies, and the nursing agency in turn, pays you. So, if I'm the institution, I have nothing to do with you. We have no contractual agreement with you. I've got contractual agreement with the agency." **(**KI6, government official)

And a third respondent emphasised the triangular type of employment common to all labour brokers:

"But the bottom line is that it is the same thing, it's a triangular type of employment which in most cases is detrimental to the employees because it doesn't allow the rights for the employee."

"It is not only the employee and the employer relationship. Somebody always is this middle person, and in most instances, it is this labour broker…. for me, that constitutes an unfair labour practice and therefore, it is unconstitutional." (KI4, Government official)

However, two informants pointed out that there may be a difference between casual nurses or care-workers supplied by nursing agencies and casual workers in other sectors, such as mining or agriculture. These views are shown in the following quotes:

"With nursing agencies, I might say it [casual labour] *is better than in other industries in the sense that you don't fire a nurse like you will fire anybody anyhow. I know I've handled some relative's case who was fired from work. That's when I could see that these industries are quite horrible. I've never seen it in health in the way they happen…They are not pushed around, but maybe the main reason is that they've got specialised skills with nurses."* (KI3, Trade union official)

"I am not sure with the nursing industry, I am talking about this in generic terms because labour brokers are everywhere in each and every sector. But I'm referring to labour brokers in general….I experience this labour brokering stuff so for me to talk about in its entirety because the way they are working in the health sector may differ in the way they operate in other sectors." (KI4, Government official)

Some key informants were of the opinion that institutions or establishments that create nursing agencies have the financial capability and power to do so:

"This industry [nursing agency], *just like the security industry has got serious backers, they've got the businesses, they've got the financial muscle to manipulate them* [clients or hospitals] *and get into serious contract with these institutions* [clients or hospitals]." (KI2, Trade union official)

Perceptions about the nurses who work through agencies

Three respondents (KI 1,2,5) indicated that agency nurses are not usually unemployed but have jobs in the public health sector while engaging in moonlighting. To these respondents, some nurses who work in public hospitals as permanent workers could also be involved with nursing agencies:

> *"I remember also when one of the very senior staff members* [government] *asked them* [nursing agencies] *'give us the IDs [identity numbers] of these people* [agency nurses]*....and then they couldn't give the IDs because why? Most of these people* [nurses] *who are doing moonlighting for us or even in the private sector, these are the people mostly …who are in the system of the government."(*KI5, Government official)

Another respondent commented as follows:

> *"I think throughout my actual experience especially within health is that you have several nursing agencies in South Africa which take nurses who are actually in the public sector in particular as and when they actually need them to perform certain functions."* (KI2, Trade union official)

However, a respondent pointed out that moonlighting practice is not only limited to public sector nurses. Some permanent staff nurses in private hospitals may sometimes work through nursing agencies:

> *"It's mostly public sector nurses who then work in the private sector, but you would find private sector nurses working at one hospital and then on the week off, they go work in another private hospital. So, it's not only the public sector nurses."* (KI1, Private health official)

3.2.2 Regulation of Nursing Agencies

In response to the question on the regulatory framework governing nursing agencies, there were uncertainties on this and whether nursing agencies were regulated adequately. Some of the participants were aware of the changes in the legislation governing nursing agencies.

"In terms of the old Nursing Act, the nursing agencies were regulated by the Nursing Act, but in terms of the new Nursing Act, they are no longer regulated, they are to be regulated by the Health Act. But then, I don't think that's enough, some measures need to be put in place in terms of that." (KI6 Government official)

On the other hand, the new Health Act has not been fully implemented and some respondents indicated that this is an issue (KI 1, 5, 6) because the authority for controlling nursing agencies seems to be afloat without any organisation taking responsibility for it:

"The [Health] *Act was passed but it wasn't implemented because of outstanding regulations."* (KI1, Private health official)

Notwithstanding, most key informants' uncertainty regarding the legislation, they were in agreement that there is a gap in the regulatory framework, with some respondents indicating that the regulation of nursing agencies seems non-existent (KI 1, 2, 3, 4).

"In actual fact, I am not aware of any legislation or regulations that say if you run an agency you have to do this….there is an organisation for nursing agencies called ANASA." (KI1, Private health official)

"I am not aware of any legislation that actually governs nursing agencies, I am not aware." (KI2, Trade union official)

"In South Africa, there is no specific law that deals with labour brokers and as I said …to that section 82 of the Basic Conditions of Employment Act which deals with temporary employment services." (KI4, Government official)

3.2.3 Perceived advantages of Nursing Agencies

While some respondents thought nursing agencies had advantages, others could not see any advantages of agencies nor their positive contribution to the health system (KI 2, 4). The perceived advantages to the

individual nurse (three respondents) were flexibility, ability to earn additional income and other non-monetary benefits such as training. The perceived advantages to the health system (three respondents), namely were: availability of human resources, sharing of expertise, and cost savings.

Advantages to individual nurses

One key informant was of the opinion that agencies provide nurses with the flexibility of choosing when and where to work according to their personal preferences:

> *"There are people who would prefer to work only in agencies because of the flexibility. You know you choose where and when to work. There's no strings attached. They really contribute a great deal because there are people that we know who just choose to work for nursing agencies rather than opting for a permanent employment in either public or private institutions."* (KI6, Government official)

This view was supported by another respondent who was of the opinion that flexibility helps some nurses to plan their time and to solve domestic issues that may be important to them:

> *"My sister-in-law is a theatre sister and she decided she didn't want to work so many on-call hours because she works from 7am-4pm and then be on call during the night. So she went to work for a nursing agency because she could say this is where I want to work….. It's more flexible. So she could end up with five shifts for the week. She does work weekends when she's not on call, and she makes the same amount of money. So, for her, it was a solution to her problem."* (KI1, Private health official)

The second advantage for the individual is the additional income that nurses get when working through agencies:

> *"It creates opportunities for them for a second salary. Because most people working for the nursing agencies are also employed, let me say 70% are employed by either private or public*

institutions. So it creates an opportunity for them for a second salary, a second pay cheque which is good for them." (KI6, Government official).

The third advantage furnished is the availability of training opportunities or continuing professional development for agency nurses:

> *"At least if you work in a controlled environment where they hopefully do things like in-service training , that there would be some kind of continuous professional education, from the agency side, which you wouldn't have if you were to be an independent practitioner."* (KI1 Private health official)

Advantages to the health system

Some respondents (KI 1, 3, 6) were of the opinion that nursing agencies assist with providing skilled nurses in specialised areas to clients when needed.

> *"The advantage is that you are able to get the resources as and when you need them because when you need a nurse in point A, you pick a phone and call, they provide. That's an advantage and the turnaround time is quite quicker, and of course you shorten the lengthy process of recruitment."* (KI6 Government official)

> *"They definitely assist with the provision of healthcare. Because without them, people would not be able to provide adequate care in special units like ICU and in theatre. I mean you would find sometimes over a weekend that a unit is staffed entirely through agency nurses. And in specialised areas like neonatal ICU and ICU theatre, you can't just take a nurse out of a ward and move them around. So, in that instance, you absolutely have to have specialised nurses. And the most likely place to find them is at the nursing agencies."* (KI1 Private health official)

Another said:

> *"In terms of saying whether they have any benefits in terms of health care delivery, I will say to some extent because they do provide staff that we ordinarily do not have . So if you don't have, you can always tap from them."* (KI3, Trade union official)

Another key informant pointed out that agencies were able to supply nurses even in times of industrial action:

> *"During the strike, it was interesting that they were willing to offer us nurses who could help in those hospitals where we didn't have nurses helping."* **(**KI5, Government official)

A second advantage to the health system is that nursing agencies enable the sharing of skilled nursing expertise in hospitals across the public and private health sectors:

> *"You are able to share the expertise of the health professionals. You share expertise because this nurse works in ICU in a private hospital, she can then work in a public health facility and use her expertise."* (KI6, Government official)

One respondent was of the opinion that there are cost savings as agencies provide staff to the health sector, which does not have to pay benefits to permanent staff:

> *"It's like casual labourers, you pay, and they go. I'm talking in terms of strings attached like your pension or other benefits, fringe benefits, because if you an employee from the agency, the agency's role is just to pay this person. No other strings attached."* (KI6, Government official).

3.2.4 Perceived disadvantages of nursing agencies

Key informants' perceived disadvantages are to the individual nurses and to the health system. To the individual, the disadvantages mentioned included: overworked nurses (KI 1, 2, 3, 5, 6), lack of benefits associated with permanent employment (KI 1, 2, 3, 5, 6), and poor working environments (KI 1, 2, 3, 4,

6). The perceived disadvantages to the health system included costs incurred (KI 1) from the use of agency nurses and poor service delivery.

Disadvantages to nurses

Participants were of the opinion that nurses who have multiple jobs with agencies may be overworked and fatigued from working different shifts such that it becomes a threat to them and their patients.

> *"Nurses are given time off to rest in most cases and instead of resting, they are working and they work more hours than they should and by the time they come back from their rest, they need another rest."* (KI5 Government official)

> *"The people* [nurses] *may overwork and that can affect the productivity because a person may work a full 24 hour cycle. You work 12 hours, you are in private institution, another 12 hours, you are working night shift in the public institution so it becomes very difficult to regulate. So, that's where the medico legal issues come in."* (KI6, Government official)

Another disadvantage was the lack of benefits that are normally associated with permanent employment. Respondents were of the opinion that though it may seem that agency nurses get extra income from working with agencies, this is off-set by the risks involved in temporary employment. Furthermore as a part-time employee, the individual nurses are not entitled to the benefits of permanent staff:

> *"I know of people also who have resigned their jobs to take up work with the agencies fulltime. They don't have benefits, they don't have anything. It's a very risky thing. I don't, I wouldn't advocate for that at all. I'm not sure but I know that in private health, they survive by personnel from agencies. They don't have their own staff. For whatever reason that they're having but for me, it's a risky practice and therefore I will not condone it at all."* (KI3, Trade union official)

Nurses are also not paid other benefits that protect their health:

> *"Because I think it is exploitation that the nurses work for agencies, and that the agency is not paying UIF* [unemployment insurance fund] *and they are not paying for COID* [compensation for occupational injuries and diseases]." (KI1, Private health official)

A respondent pointed out the lack of job security associated with this type of agency employment:

> *"Because you know there are some certain people who have resigned from their jobs and they say I'm making better money when I can just work here and there. There's no job security."* (KI5, Government official)

Respondents were of the opinion that nurses may experience poor working environments which may not be conducive for their functionality. Their unfamiliarity with a hospital environment may create a negative perception from other colleagues who may regard them as incompetent. Two respondents (KI 1, 3) commented as follows:

> *"Unfortunately, the general belief is that agency nurses don't offer better service because they* [agency nurses] *are not part of the team* [permanent staff]. *And that might just be a perception because they're not part of the team. But you know often I deal with complaints from the industry. And often I'll get a complaint about a nurse. And when I go back to the hospital and they'll say "oh, it was an agency nurse." It's like they abdicate the responsibility."* (KI1 Private health official)

Agency nursing also leads to lack of continuity of care, thereby affecting the nurse-patient relationship.

> *"I'm working here; tomorrow I'm working there* [talking about a nurse]. *So there isn't a caring relationship. It is I'm here to perform a function. I do the temperature and I do the dressings and I do the medicine and I go home. I don't particularly care what happens to this guy on the bed, I will never see him again. Whereas, if you see the man when he came in, and he's been for his*

surgery and you've watched him recover, you've got a certain kind of feeling towards him because you see him every day. So I think that's negative." (KI1, Private health official)

Disadvantages to the health system

Respondents were of the opinion that the costs incurred by government to use nursing agencies are high.

"The public sector doesn't have money. So, they will say that they will prohibit the [public] *hospitals from using nursing agencies because they don't have money...they go over salary budgets because they pay so much money to* [using] *agency staff. But it* [nursing agencies] *costs so much so that is a huge issue."* (KI1, Private health official)

As indicated above, the nurses employed by the agencies may be tired, so that the agencies indirectly compromise the quality of care provided and the performance of nurses especially in the public sector:

"These people [nurses] *who are working in the state, most of them, who are going to do part-time work in private, and then by the time they come back to our public hospitals, you find these people are tired because they've been working on the private side."* (KI5, Government official).

3.2.5 Proposed ban of labour brokers and nursing agencies

The perceptions on the proposed ban on labour brokers varied, depending on the position of key informants (whether a trade unionist or private health official), with some respondents strongly in support of the proposed ban while others wanted stricter regulations or transitional arrangements to buffer the health system against the consequences of a ban. Those key informants supporting the ban were of the opinion that it will yield positive results:

"The ban doesn't actually have an impact on the [health] *system itself. The nursing agencies by themselves are a contributory factor to the problem of shortage. For me, the implication* [of the ban] *will be positive, in the sense that then, there will be mass production of that skill that is being 'dangled' by agencies, that 'we have got this gift so we can give it to you'…. That will*

translate in job opportunities for those who are unemployed. Therefore, unemployment will go down and poverty will go down because more people will be employed, more people will be afforded the opportunity to be able to positively contribute to the economy of the country." (KI2, Trade union official)

The second group of respondents was of the opinion that the industry needs to be properly regulated:

"I wouldn't opt for a ban; I would opt for them being regulated. Because there are advantages… But on the other hand, if they are not properly regulated, it will lead to unintended effects, like poor quality because some of the people that are supplied are not of good quality because they just supply because you need a person. But if they are properly regulated, I think that can be, those advantages can outweigh the disadvantages of labour brokers." (KI6, Government official)

At the same time, this respondent said that a ban of nursing agencies will not necessarily have negative consequences if other structures are created to cushion the ban:

"It does not mean that in the absence of nursing agencies, there will be crises provided you put other mechanisms like, internal nurse bank. Nurses are registered there; you procure them as at when you need them. And they also indicate when they want to work." (KI6, Government official)

One view from two informants was that nurses who depend on agencies will feel the effect of the ban, and this may discourage some nurses from continuing in the profession.

"Well, they [agency nurses] *will be uncomfortable simply because a nursing agency provides you with an opportunity to work when and as you need it. That's why I'm not for a complete ban because it gives latitude to nurses to determine when to work. Like there are nurses who only work in the agencies because they can manipulate their own working times."* (KI6, Government official)

"Those nurses would then lose income, because if you are working seven nights in one place, full time employment…and then you're working seven nights at the agency, you've got double your income. So you'll lose half your income immediately if the agency closes. And in actual fact, it will be so bad for nursing, and the nurses who work there to take it away because you'll end up removing very competent nurses, who provide care to patients who wouldn't get it otherwise because some union guy decided that labour brokers should be banned." (KI1, Private health official)

3.3 RESULTS OF NURSING AGENCY SURVEY

3.3.1 Introduction

There were 52 nursing agencies that participated in the survey, representing a 49.1% response rate. Details of response rates by province are shown in table 3 below.

Table 3: Outcome of telephone interviews with nursing agencies

Description	**Gauteng**	**Western Cape**	**Others**	**Number**	**Percentage**
Refused agencies	10	2	4	16	15.1%
Non-operational agencies (ascertained during survey)	7	6	6	19	17.9%
Completed questionnaires	27	9	16	52	49.1%
Phone calls with no response (ringing on three occasions without answer)	6	3	8	17	16%
Not eligible - ANASA members not initially excluded	1	1	0	2	1.9%
Total	51	21	34	106	100%
Survey response rate	**49.1%**				

The key results of the telephone survey are summarised in Box 2 below.

Box 2: Key survey results

1. Main characteristics of surveyed nursing agencies
    - Gauteng province accounted for the highest proportion of responding agencies (25.5%).
    - About three-quarters of surveyed agencies provide casual staff to the private health sector 38/52 (73%) compared to agencies that provide casual staff to the public health sector 10 (19.2%). Private sector clients include old age homes, private hospitals and private industry/ company clinics.
    - The majority of agencies surveyed (76.9%) were established between 2000 and 2009
    - A small percentage of agencies (10%) are owned by larger organisations as opposed to 90% without a parent body. The majority of agencies have one branch (82.6%).
2. Relationship between nursing agencies and clients
    - The mean number of nurses allocated to clients on a daily basis is 22.
    - More than three quarter of agencies (77%) have formal contracts with clients.
    - 92.1% of agencies allocate nurses based on client demand.
    - In terms of clinical services, nursing agencies provide nurses for geriatric care (36.5%) followed by adult intensive care unit (AICU) (35.4%).
    - 97.9% of agencies indicated that they have a code of conduct.
3. Relationship between nursing agencies and nurses
    - 86.3% of agencies employ professional nurses while two thirds (66.7%) employ caregivers
    - 59.6% of nursing agencies pay nurses and caregivers hourly salary rates at the end of every month while 25.6% agencies pay on a weekly basis.
    - The benefits provided by agencies include: training (66%), injury on duty (66%), unemployment insurance (56%), and indemnity cover (48%). Other benefits include participation at conferences, souvenirs and accommodation.
    - 70% of agencies pay professional nurses between R50 and R99 per hour. All other categories of nurses or caregivers are paid less than R50 per hour.
4. Challenges of nursing agencies
    - The top four challenges of nursing agencies include: shortage of specialised nurses (93.7%), recruitment of nurses (83.3%), commission rate paid by agencies (80%), and lack of government support (66.6%).

3.3.2 Distribution and main characteristics of survey nursing agencies

Figure 3 shows the provincial distribution of respondents. Gauteng agencies accounted for 25.5% of the 49.1% of agencies that responded to the survey.

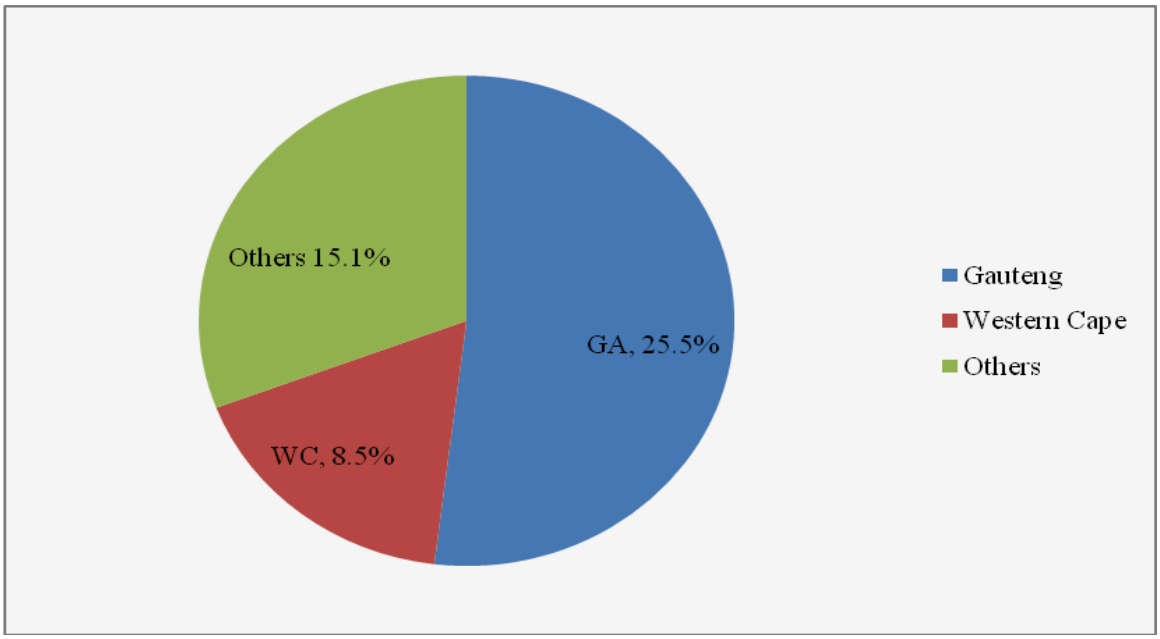

Figure 3: Provincial distribution of responding nursing agencies

Thirty eight (73%) nursing agencies have clients in the private sector: the latter consists of private hospitals, old age homes, private home patients and private industry/ company clinics. On the other hand, ten agencies (19.2 %) service the public health sector which is mainly made up of provincial departments of health. It should be noted that nursing agencies can have both private and public clients at the same time. Table 4 which is extrapolated from table 5 (Type of nursing agency client) explicitly shows that 32 nursing agencies (61.5%) serve private clients only, six (11.5%) agencies serve both public and private clients while ten (19.3%) nursing agencies neither serve the public sector nor private sector clients and had no clients at the time of survey.

Table 4: The proportion of agencies that serve public and private sector hospitals/clients

*Private sector clients (%)	*Public sector clients (%)		Total
	Number of agencies without public sector clients	Number of agencies with public sector clients	
Number of agencies without private sector clients	10 (19.3)	4 (7.6)	14 (26.9)
Number of agencies with private sector clients	32 (61.5)	6 (11.6)	38 (73.1)
Total	42 (80.8)	10 (19.2)	52 (100)

*Public sector clients are combined provincial departments of health
*Private sector clients are combined: private hospitals, old age homes, private home patients and private industry/ company clinics
*P-value = 0.254 (Fisher's exact)

The overall characteristics of responding agencies are shown in table 5. Specifically, 27.4% of nursing agencies have old age homes as clients followed by provincial departments of health (19.2%). A total of 23 (45.1%) nursing agencies serve other clients in their homes which are mainly private patients. At least ten agencies supply nurses or caregivers to at least one provincial department of health. The majority of agencies (n=40; 76.9%) were established between 2000 and 2009. The majority of agencies surveyed are not owned by larger organisations (90%); only five agencies have a parent organisation (10%); and 82.7% of agencies have one branch. Only one agency from the Gauteng province has up to 5 branches, but this constitutes only 1.9% of the surveyed agencies. As can be seen from table 5, there are no statistical significant differences between the characteristic of nursing agencies and their location in the country.

Table 5: Characteristics of nursing agencies by province

Characteristics of nursing agencies	**Gauteng**		**Western Cape**		**Others**		**Total**		**P-value**
Sample size (n)/%	**n = 27**	**%**	**n = 9**	**%**	**n = 16**	**%**	**n = 52**	**%**	
Mean number of years in business (SD)	8.2 years (SD = 7.5)								
Type of nursing agency client [No. (%)]									
Public clients	4	40.0	3	30.0	3	30.0	10	19.2	0.50*
Private clients	18	47.3	7	18.4	13	34.2	38	73.0	0.64*
Specific clients of nursing agencies [No. (%)]									
Old age homes	8	30.7	4	44.4	2	12.5	14	27.4	0.19*
Departments of Health	4	14.8	3	33.3	3	18.7	10	19.2	0.50*
Medi-clinic	4	15.3	2	22.2	1	6.25	7	13.7	0.56*
Life health care	5	19.2	0	0.0	4	25.0	9	17.6	0.30*
Netcare	4	15.3	1	11.1	4	25.0	9	17.6	0.61*
Other private hospitals	3	11.5	0	0.0	4	25.0	7	13.7	0.25*
Other – private patients	11	4.23	6	66.7	6	37.5	23	45.1	0.39*
Year Established No. (%)]									
≤ 1964	1	3.7	0	0.0	0	0.0	1	1.9	0.40*
1986 – 1994	1	3.7	1	11.1	1	6.3	3	5.8	
1995 – 1999	4	14.8	3	33.3	1	6.3	8	15.3	
2000 - 2009	21	77.7	5	55.5	14	87.5	40	76.9	
Branches of agencies [No. (%)]									
1 branch	24	88.9	7	77.8	12	75.0	43	82.7	0.44*
2 branches	2	7.4	1	11.1	3	18.8	6	11.5	
3 branches	0	0.0	1	11.1	1	6.2	2	3.8	
5 branches	1	3.7	0	0.0	0	0.0	1	1.9	
Ownership of agencies [No. (%)]									
Owned by larger organisations	1	4.0	2	22.2	2	12.5	5	10	0.19*

- Public sector clients are combined provincial departments of health
- Private sector clients are combined: private hospitals, old age homes, private home patients and private industry/ company clinics

*Fisher's exact

3.3.3 Relationship between nursing agencies and clients

The mean (average number) of nurses registered with the agency was 644, with a very wide range of one to 20,293, and a standard deviation of 3,054.5. Hence it is more appropriate to look at the median number of nurses registered with agencies, which was 50 nurses/caregivers (IQR = 15-120). Further analysis indicates that the mean number of nursing staff and caregivers allocated daily to clients was 22 (SD=22.1) and a median of 15 (IQR = 5-31.5). Three quarters of agencies (77%) indicated that they have formal contracts or agreements with their clients. The proportion of agencies that reported that they have a code of conduct was 97.9%.

Table 6: Nursing agencies relationships with all types of clients

Variable	Number	Frequency (%)	Agencies with private sector clients (%)	Agencies without private sector clients (%)	P-value
Formal contracts with clients	37	77	31 (83.8)	6 (16.2)	0.04[c]
Agencies with policy/framework	41	82	30 (73.2)	11 (26.8)	0.57*
Agencies with code of conduct	48	97.9	35 (72.9)	13 (27.0)	0.70*
Agencies with reporting mechanism for client complaints	47	95.9	34 (72.3)	13 (27.7)	0.53*
Allocation method of nurses					
By client demand	47	92.1	37 (78.7)	10 (21.3)	0.05*
By nurse preference	18	35.2	15 (83.3)	3 (16.7)	0.23*
By nurse specialty	34	66.6	26 (76.5)	8 (23.5)	0.44*
Average number of nurses registered with nursing agencies					
Median (IQR)	50 (15 – 120)				
Mean (SD)	644 (3,054.5)				
Average number of nurses supplied to clients daily					
Mean (SD)	22 (22.1)				
Median (IQR)	15 (5 - 31.5)				

- Public sector clients are combined provincial departments of health*
- Private sector clients are combined: private hospitals, old age homes, private home patients and private industry/ company clinics

*Fishers exact, Chi square = [c], SD = Standard Deviation, IQR = Interquartile range

Survey participants report that the supply of nurses to clients is mostly based on a client's demand (92%) for the type of nurse needed. This proportion is twice as much as the proportion of agencies who report that nurses are allocated to clients based on their personal preference. All agencies in the sample have at least one form of communication with their clients especially for reporting issues relating to nurses or staff. Eighty two percent of agencies say communication is done through letters; verbally (76%) while 4% of agencies share information with clients through newsletters. Table 6 shows that nursing agencies that have private sector clients were more likely to report formal contracts with clients (83.8%), compared to those who had formal contracts with the non-private sector clients (16.2%), and this difference was statistically significant (chi 2 = 4.10; p-value = 0.04).

In terms of clinical services, 36.5% of agencies provide nurses for geriatric care followed by adult intensive care units (35.4%) and other services (9.6%). Other services include HIV/AIDS testing in some private organisations and occupational health services in staff clinics.

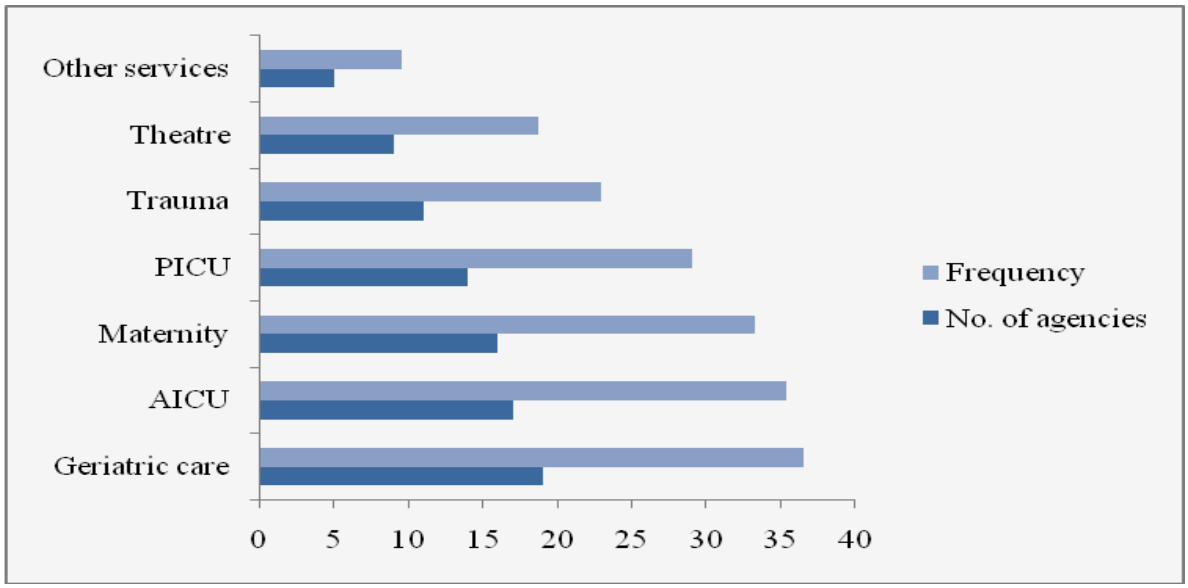

Figure 4: Clinical services provided by nursing agencies

*****These are not mutually exclusive. An agency can provide nurses for more than one type of clinical service
* Frequency are percentages while No. of agencies are actual numbers

In terms of quality monitoring, 80.8% of agencies agreed with a statement that they check the SANC registration of nurses and a high proportion (81.6%) agreed with a statement that they request certified copies of a nurse's qualifications. About one fifth of agencies (21.1%) indicated that they conduct reference checks with past employers.

3.3.4 Relationship between nursing agencies and nurses

86.3% of agencies employ professional nurses, enrolled staff nurses (64.7%) while 60.8% and 66.7% of agencies employ nursing assistants and caregivers respectively.

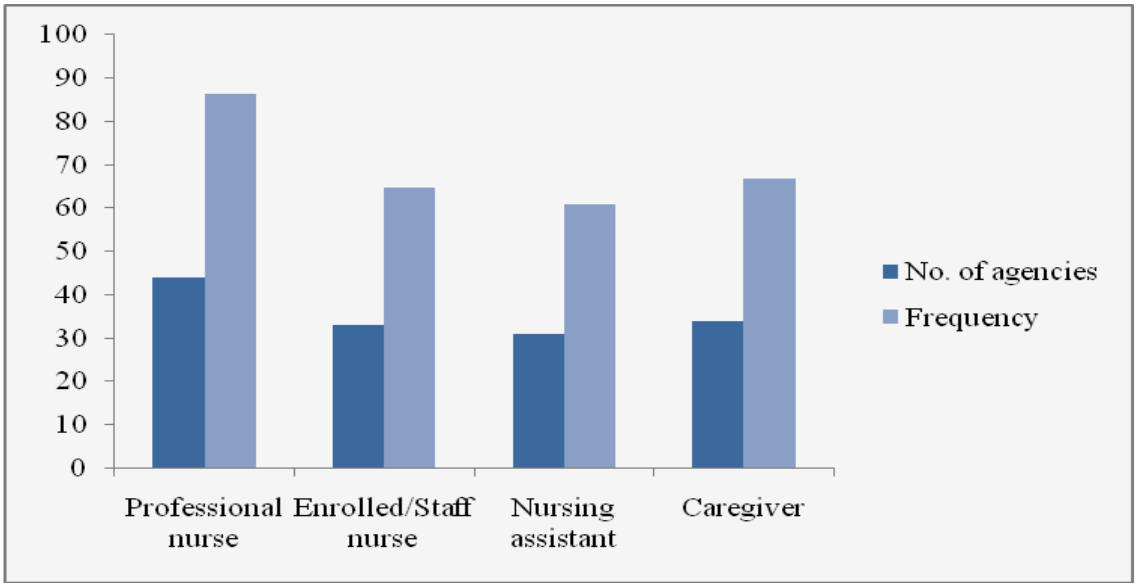

Figure 5: Type or category of nurse working for agencies

* These are not mutually exclusive as an agency can employ all categories of nurses and/or caregivers
* Frequency are percentages while No. of agencies are actual numbers

In terms of reported pay rates professional nurses are the highest paid by the hour and almost a three and quarter of them are paid between R50-99 (South Africa rands), while about half of agencies (54.2%) pay enrolled/staff nurse less than R50 per hour. Although professional nurses and enrolled/staff nurses could be paid up to R150 per hour by agencies, neither nursing assistants nor caregivers are paid up that much (table 7). However, while professional nurses and enrolled/staff nurses could be paid up to R150 per hour by agencies, neither nursing assistants nor caregivers are paid up that much (table 7).

Table 7: Nursing agency reported hourly pay rates to nurses or caregivers

Hourly rate in South Africa rands Number (Percentage)	Professional nurse	Enrolled/Staff nurse	Nursing assistant	Caregiver
< 50	1 (3.3)	13 (54.2)	15 (68.2)	20 (86.9)
50-99	21 (70.0)	10 (41.7)	5 (22.7)	2 (8.7)
100-149	7 (23.3)	0 (0.0)	2 (9.0)	1 (4.3)
> 150	1 (3.3)	1 (4.2)	0 (0.0)	0 (0.0)
Average (mean) hourly salary (SD)	89.6 (34.1)	52.5 (30.5)	47.3 (29.9)	29.7 (21.5)
Median hourly salary (IQR)	85.8 (65 – 109.5)	43.7 (37.8 – 60)	35.9 (30 – 52.5)	20 (16 –40)

Figure 6 shows that 59.6% of agencies make hourly payments on a monthly basis to their nurses. Apart from financial payments, some nursing agencies indicated they provide non-financial benefits to nurses such as training and injury on duty benefits (66%) (table 8).

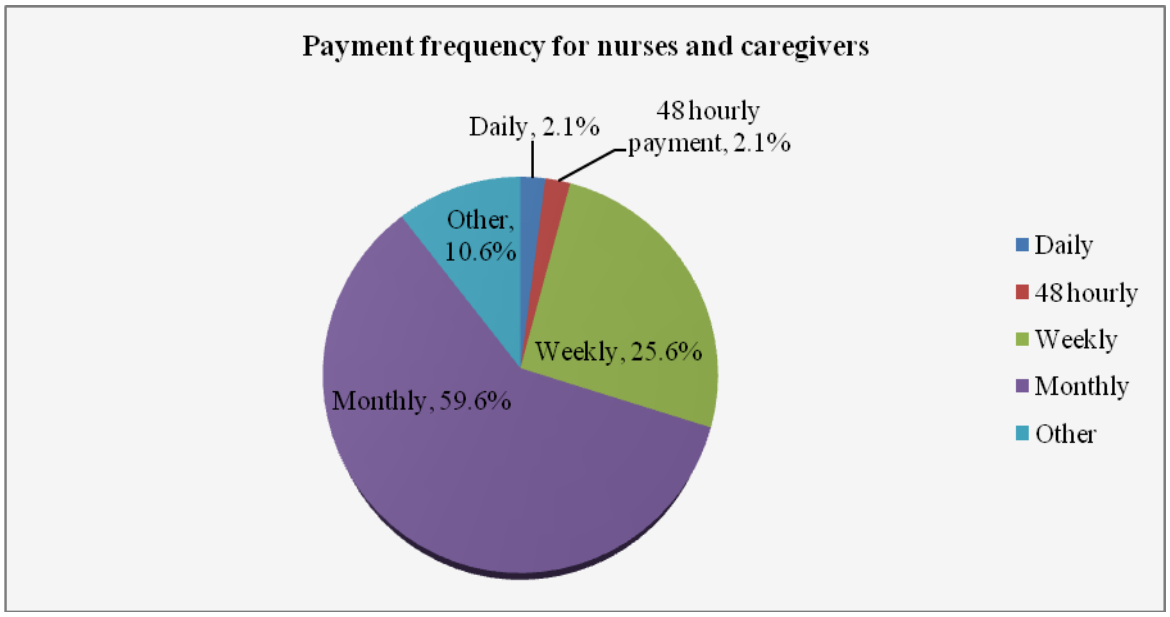

Figure 6: Frequency of payment for agency nurse or caregiver

Table 8: Types of non-financial benefits to agency nurses and caregivers

Non-Financial	No. (%)
Clinical facilitation	33 (67.4)
Training	33 (66)
Injury on Duty	33 (66)
Unemployment insurance	28 (56)
Indemnity cover	24 (48)
Conferences	10 (20)
Other benefits e.g. souvenirs, accommodation	10 (19)
Sick leave	3 (5.7)

*These are not mutually exclusive. An agency can provide more than one benefit

3.3.5 Reported challenges of nursing agencies

In response to a series of statements related to the challenges in operating their business and the overall health system problems, figure 7 shows that the highest reported challenges were issues related to nurses followed by issues with government and the rate of commission and then client-related challenges. Items that scored 80% or more were: shortage of specialised nurse (93.7%); recruitment of nurses (83.3%); and prescribed commission rate (80%). Government lack of support to nursing agencies scored 66.6% agreement. In addition, client partnership (43.9%), client's timely payment of fees (43.5%), clear client's expectations (28.6%), nurses commitment (28.6%), unsatisfactory performance of retired nurses (28.2%) and communication with clients (18.3%) all obtained agreement scores below 50%. Other perceived challenges were unsupportive regulatory body (n=8), high competition for clients between agencies (n=5), unreliable nurses (n=4), and the lack of support for caregivers (n=2).

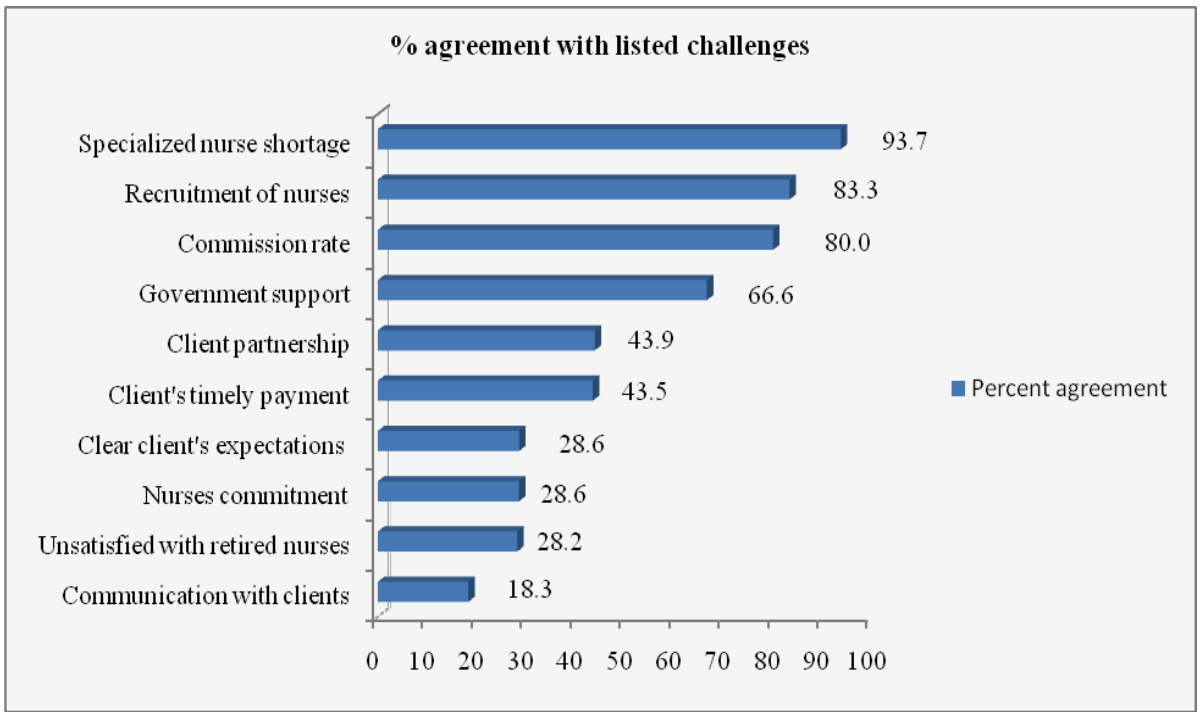

Figure 7: Nursing agencies reported challenges

Table 9: Other perceived challenges obtained in open ended question

Governing organisation and health system (no. of agencies)	**On clients** (no. of agencies)	**On nurses** (no. of agencies)	**Others** (no. of agencies)
• Regulating body is unsupportive e.g. when complaints are made or information is asked (8) • Lack of recognition of nursing agencies (2) • Unsure of the establishment governing nursing agencies (1) • ANASA registration is expensive (1) • Proposed Labour broker ban (1)	• High competition for clients between agencies (5) • Lack of nurse orientation in some private hospitals (1) • Inability to meet clients' demand (1) • Hospital owned agencies take most work (1) • Smaller agencies not patronised • Racial discrimination or bias in selecting an agency by clients	• Some nurses are unreliable (4) • Nurses' misconduct (2) • Low quality nurses (1)	• No support for caregivers e.g. registration with SANC (2) • Unqualified nursing agency owners (1)

The next two chapters will discuss the study findings in light of the literature, explore the policy implications of the findings, make policy recommendations and highlight issues requiring further investigation.

CHAPTER FOUR: DISCUSSION

4.1 INTRODUCTION

This is one of the first empirical studies that focus on the nursing agency industry, its characteristics and relationships with clients and the nurses they employ on a casual basis. In this chapter, the findings of the study are discussed based on the study objectives and in light of the available literature. In line with recommendations on integrating the findings from mixed methods studies [90], this chapter will also contrast the findings obtained from the qualitative and quantitative components of the study and explore the policy and health system implications of these findings.

4.2 The context and characteristics of nursing agencies

This study was done at a time of heated debates in South Africa on the future of labour brokers and on the negative impact of nursing agencies on the public health sector [83]. The qualitative component of the study found gaps in key informants' knowledge on the nature and characteristics of nursing agencies. However, there was a general perception that there has been a growth in the industry in the last decade. The survey verified the perceptions, which found that the majority of agencies surveyed (76.9%) were established between 2000 and 2009. This implies a fourfold increase in the number of agencies established during this period, when compared to the number established in the 1990s.

The increase in the number of nursing agencies could be linked to the growing casualisation of the labour force in the country [94-95], in the Southern Africa region [24, 92] and in industrialised countries [21, 31, 93]. At the same time the growth could also be linked to the HRH challenges experienced in the South African health system. For example, in 1994, there were 251 nurses per 100 000 population, compared to 110 per 100 000 in 2007: hence fewer nurses were available relative to population size [13]. As with all cross-sectional surveys, the temporal sequence between the establishment of a nursing agency and nursing shortages or growing labour force casualisation could not be determined. In light of limited empirical

studies on the industry characteristics, it is not possible to compare the findings of the study with those in other countries.

Key informants were of the opinion that the majority of nursing agencies are part of a bigger company. However, the survey found that only 10% of agencies are owned by larger companies. Unfortunately, the study did not determine whether the owners of the agencies are nurses, as Leroy argued that nursing agencies are usually not owned by nurses themselves [11]. It would be interesting in future studies to determine what proportion of agencies are owned by nurses.

4.3 The clients of nursing agencies

Although it was anticipated that hospitals were the main clients of nursing agencies, this study found that 73% of surveyed agencies provide an average of 22 nurses or caregivers to the private health sector which includes old age homes, private hospitals and private industry/company clinics. In fact, 61.5% of agencies serve private clients only, and do not have any public sector clients. Just over one quarter (27.4%) of nursing agencies have old age homes as clients, and geriatric care comprises an important component of the clinical services that nursing agencies provide (36.5%). These findings suggest that old age homes and geriatric care are the niche areas of these smaller nursing agencies. It might be that ANASA members are the main providers of nursing services to large hospitals and that the smaller agencies cannot or would not compete with the larger agencies for the patronage of hospitals. As the findings of the ANASA study are being analysed, it is not possible to compare the findings in this study with that of the ANASA study. However, any legislative or policy initiative on nursing agencies would need to take account of the nursing care needs of old age or private homes.

It is beyond the scope of this study to determine whether all nurses or caregivers in these nursing agency databases are ‘active’ employees, as it depends on the frequency of their use or availability to work for clients, as was found in the nursing agency study in Australia [67]. This is an area for future research in South Africa.

In this study, the bulk of nursing agencies (97.9%) indicated that they have a code of conduct, and 77% of agencies indicated that they have formal contracts with clients. Although this is a requirement of the Basic Conditions of Employment Act (BCEA) that states that labour brokers are to be jointly responsible for an employee [101:p.32], it is encouraging that so many have a code of conduct. However, nursing agencies with private sector clients were more likely to report formal contracts with clients (83.8%), compared to those who had formal contracts with non-private sector clients (16.2%). This is of concern as one would expect similar or greater accountability by non-private sector clients for public monies spent on nursing agencies. As was the case with the nursing agency study in Australia [67, 96], this study found that the predominant method that clients used to report complaints to nursing agencies was through informal, verbal methods.

The study found that nurses or caregivers are allocated based on clients' demand, rather than on nurse or caregiver's preference or skills. In the qualitative component, some key informants indicated that agencies are unable to meet the demands of clients and may place nurses in areas where they are not suited and therefore cannot perform optimally. This in turn affects the quality of care. Other studies have found that when nurses are not allocated to clients as requested, the quality of care is compromised [27, 66-67].

Key informant interviews suggest that an overall quality assurance mechanism in the nursing agency industry is lacking and that nurses supplied to clients tend to be exhausted and prone to medico-legal incidents. This perception was corroborated in the survey which found that 80.8% of agencies agreed with a statement that they check the SANC registration of nurses and 81.6% agreed with a statement that they request certified copies of a nurse's qualifications. Of concern, however, is that almost one fifth of agencies DO NOT seem to comply with these basic quality checks of checking registration or requesting copies of qualifications. Only one fifth of agencies (21.1%) indicated that they conduct reference checks with past employers. Hence these is an area that needs improvement, as the failure of a nursing agency to

conduct these basic quality checks could lead to serious negative incidents both for individual clients and for the health system as a whole [118].

4.4 The relationship between nursing agencies and the casual employees

The study found that although these nursing agencies employ various categories of nurses, two thirds of agencies make use of the services of caregivers. Studies in South Africa have shown that caregivers came into existence as part of the response to the HIV & AIDS epidemic [97-99]. These caregivers can be vulnerable to exploitation, and there have been calls for them to be regulated and be salaried employees [100]. Although their exact role in nursing agencies is not known, it is an important area for further research so as to understand caregivers' roles in the nursing agency industry and the type of services they provide for clients.

The study found that professional nurses were paid the highest hourly rates, while the majority of care-givers (86.9%) and nursing assistants (68.2%) were paid less than R50 per hour. This suggests the potential to exploit caregivers, who are neither regulated by the SANC nor through the normal employment contracts of full-time employment. Caregivers are also least likely to be members of trade unions, so could be vulnerable when casually employed by nursing agencies.

Contrary to the views of some of the key informants, agencies do provide non-financial benefits and this is positive. However, the non-financial benefits provided by nursing agencies to casual employees ranged from a very low sick leave benefit (5.7%), to training (66%), injury on duty (66%) or clinical facilitation (67.4%). Only 48% of agencies pay indemnity cover for staff. In terms of the South Africa Health Act 61 of 2003, health establishments (which include nursing agencies) are required to have insurance cover [33]. This means that an indemnity cover or a form of insurance is a requirement for the establishment of an agency.

The findings point to the need for improved regulation or enforcement of existing legislation, as well as better monitoring and evaluation of nursing agencies.

4.5 Reported challenges of the nursing agency industry

The highest reported challenges by agencies, were nurse-related, notably shortages of specialised nurses (93.7%), recruitment of nurses (83.3%) and certain behavioural aspects. This implies that the country's overall shortage of nurses especially in specialised areas [13, 106-107, 110] also affects nursing agencies. It could therefore lead to competition between agencies and health care facilities for the employment of the limited number of specialised nurses, thus exacerbating the overall HRH problems in South Africa. On behaviourial aspects, some nurses were considered to be unreliable and less committed to work especially when they are fatigued which lead to poor service delivery. Fatigue and sleeping on duty with negative consequences for patient care have also been reported in studies in other countries [108-109].

This study has found that a monitoring system of agency nurses is lacking (see above). In theory, a nurse can register and work with more than one agency within a short time period or the registration or qualifications of a nurse might not be checked, thus impacting on quality of care, a finding supported by an Australian study [21]. The study findings again point to the need for tighter regulation of agencies, and improved monitoring and evaluation.

4.6 Regulatory gaps and governance of nursing agencies

There are gaps in the existing legislation that govern nursing agencies, in part due to changes in the National Health and [33] Nursing Acts [32,102], with resultant lack of clarity on the licensing, reporting and monitoring authority. Although ANASA has developed standards for nursing agencies in the country [45], these are a voluntary set of guidelines for their members and are not enforceable. Moreover, ANASA is not a regulatory body, but one that represents the industry.

In the qualitative component, the key informants identified the lack of clarity on monitoring of nursing agencies as a problem, while agencies highlighted the lack of support from government as one of their top five challenges. It is beyond the scope of this study to analyse in detail the policy gaps in regulating

nursing agencies. Nonetheless, the findings point to the need to address these gaps in policy and legislation.

At the time of the study, the suggested ban of all labour brokers was very topical. Although not a specific study objective, the study has revealed that the triangular form of employment in nursing agencies is different to that found in other sectors e.g. agriculture [16, 38] and that the situation is more complex. This study points to the need to enforce key provisions of the BCEA and to ensure that care-workers are treated in a humane way, that there are some forms of legal or policy control, and that they have decent work as envisioned by the ILO [39].

A ban of the nursing agency industry is likely to have minimal negative effect on the health system if proper transitional arrangements are made such as the creation of nurse banks which are temporary employment services similar to nursing agencies but established and controlled by the government [105]. This has been the case in the United Kingdom. At the same time, a ban may discourage some nurses from practising nursing due to the lack of flexibility when there is no agency work [111]. De Ruyter's (2007) study showed that there were some nurses who prefer to work for agencies as a means of exiting the nursing profession [61]. Moreover, the sharing of special nurse skills and expertise could be lost [112]. Hence, any policy option selected by government would need to address the behaviours of individual nurses and examine mechanisms for flexible work, such that it benefits both nurses and the health system.

There are no doubts that the existence and operation of nursing agencies is controversial depending on different sectors' point of view. A hospital for example may support the use of agencies to deal with absenteeism or poor staff retention or the flexibility provided by agencies, in response to changing patient or workloads. On the other hand, nursing agencies, albeit a specialised form of labour brokers, are disadvantageous to labour unions as they undermine their collective bargaining power and infringe on the rights of workers. This is one of the unions' major reasons for the proposed call for the ban of labour brokers [46-47].

This study has revealed that this group of agencies that are not members of ANASA provide services to old age homes, and private homes, similar to the findings of a study done in a UK health district [113]. The policy implication is that these agencies provide services to institutions that have remained *outside* of the mainstream debates on labour brokers. Hence, the views of old age homes and private individuals who make use of agency nurses would also need to be elicited.

4.7 Study strengths and limitations

The key informants were carefully selected, based on their perceived knowledge and expertise. The researcher conducted all the interviews to ensure consistency in the phrasing of questions and to provide any clarity needed. Notwithstanding the selection process and the seniority of the positions occupied by the key informants, the study found gaps in their knowledge, which could not have been anticipated. Although the key informants provided rich insights into the complexity of nursing agencies and the health system, the small number of people interviewed means that the views expressed are not generalisable.

Despite careful planning and specific steps to minimise bias, which included a doubling of the sample size from 53 agencies to 106 agencies, a major weakness of the study was the low response rate of 49.1% in the telephone survey. However, this response rate of 49.1% was much higher than an Australian study which had a response rate of 23% [67]. Non-operational agencies and no response to numerous phone calls accounted for 34% of non-respondents, indicating the problems with the SANC data-base. These database problems arose because of the legislative vacuum as SANC is no longer responsible for nursing agencies. Nonetheless, it was the best available database from which the sample could be drawn.

The study did not ask for the reasons why these agencies were not operational, but this could be due to the lack of sustainability of smaller agencies. Only 15% of agencies refused, so one could speculate that with an accurate and updated database, the actual response rate would have been much higher. In addition, ANASA members were excluded which limits the generalisability of the study findings to all agencies.

All ethical guidelines were followed for the telephone survey. However, telephone surveys do not allow anonymity of responses, as is the case with surveys using self-administered questionnaires. Hence there could be social desirability bias, particularly in the responses on the provision of benefits and on the code of conduct. Some of the questions might have been unclear or misunderstood by respondents and the person being interviewed may have had limited knowledge on the agency they work with. The study was limited by the small sample size and this may explain some of the findings that were not statistically significant. In the analysis, some responses were not mutually exclusive, which limited the type of analysis conducted. Future studies regarding nursing agencies can build on the questionnaire used in this study and refine the questions to ensure that they are mutually exclusive.

Nevertheless, the study strengths are numerous. The study focus is novel, and it is one of the first studies that focus on the nursing agency industry in South Africa. The findings provide a basis for future research on the nursing agency industry, and the whole process of casualisation in the health sector. Selecting a stratified random sample, rather than a convenient sample of agencies is a strength, and the study provides unique information on agencies that are not part of ANASA. The use of a pretested questionnaire and key informant interviews allowed for interesting perspectives on issues in the nursing agency industry. Another major advantage of the study is that it is timely as it was done within the context of a vibrant policy debate on the future of labour brokers and nursing agencies in the country. As this is the first research to study the nursing agency industry itself rather than agency nurses, the study sheds light on the nature and characteristics of the industry. The mixed method approach of data collection allowed for diverse responses from key informants across important sectors (trade unions, government; and private health sector) and allowed for a comparison with the survey responses from agencies.

The last chapter concludes with key recommendations, and suggestions for further areas of research.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The South Africa health system faces numerous problems of recruitment, management and retention of health workers especially nurses. Moonlighting and casualisation of the workforce compound these challenges, especially in the public health sector [118]. Anecdotal evidence suggests that the nursing agency industry, as an intermediary, contribute to these challenges. On the other hand, the industry is faced with many challenges, including the proposed ban of labour brokers.

Using a mixed method approach, this study sought to describe the nature and characteristics of the nursing agencies and their implications for the South Africa's health care system. The key results of the study were presented and discussed in the previous chapters. The study findings underscore the need for improved regulation of nursing agencies, and enforcement of existing legislation, in the short-term, and an open policy debate on the future of nursing agencies in the long-term, such that it meets the needs of different health establishments, while protecting the rights of casual employees.

5.2 RECOMMENDATIONS

Based on the study findings, the study recommendations are listed below:

Box 3: Summary of recommendations

1. Short-term recommendations
    - A comprehensive list of licensed nursing agencies should be compiled
    - The list should be updated annually to avoid duplications and non-existing agencies
    - A revised set of regulations should be drawn up that should govern the operation of nursing agencies
    - A set of quality standards that are part of the national core standards should be developed and should apply to all nursing agencies, and be enforced by the Department of Health
    - Caregivers could be recognised as relevant human resource for health (HRH)
    - Caregivers should be given some form of licensure to perform their duties and their conditions of services should be regulated
3. Broad recommendations for the overall nursing agency industry
    - Regulate and monitor labour intermediaries in the health sector
    - Investigate the establishment of internal nurse banks in the public sector
    - Ensure good monitoring system to manage moonlighting
    - Develop guidelines to manage agency nurses
    - All agencies should be mandated to provide information to government on a set of core indicators, that covers both their clients and the casual employees
4. Areas for further research should include:
    - The proportion of nursing agencies owned by nurses
    - The role of caregivers in the nursing agency industry
    - Quality of care provided by agency nurses and by the agencies
    - Periodic audits and detailed costing of nursing agencies in the public sector
    - Investigate policy options for the management, regulation and future role of nursing agencies in the country.

5.2.1 Short term recommendations

As was found in this study, the registration of a nursing agency with the SANC does not imply that the agency is in operation. Since the control of nursing agencies now rests with the NDOH, a first step in strengthening the management of nursing agencies should be the development of a comprehensive database of all registered agencies in the country. This database should be updated on a yearly basis.

The NDOH's immediate focus should be on existing nursing agencies rather than registering new ones. In terms of the Health Act, a comprehensive set of regulations should be developed, covering both the clients and employees of the agencies. The guidelines should draw on best practice in other countries such as the UK [114, 116] and the results of this study. The regulations should include a set of quality standards that are part of the national core standards. These regulations should be published for public comments as a matter of urgency.

Within the context of the broader debate on community health workers, caregivers could also be recognised as relevant HRH and given some form of licensure to perform their duties. Should this be the case, the recognition should go together with appropriate training and recognition of their employment rights.

5.2.2 Broader recommendations for the industry

There is a need for structures to be put in place within the NDOH to ensure that there is a management system for nursing agencies. In this system, a mechanism whereby the maximum number of hours a nurse has worked should be available to health care services or nursing agencies to address moonlighting and reduce low quality of care. This may lessen the problem of nurses overworking and undermining the quality of care especially in the public sector. Since nursing agencies are health establishments but also labour brokers, they are at a dilemma of being under the NDOH, SANC and NDOL. There is a need for consensus on developing a regulating document that will outline the roles and responsibilities of the three organisations in regulating the industry.

The NDOH could create a special unit to monitor the activities of nursing agencies annually. This special unit could be within the Office of Standards Compliance that could work together with a responsible unit at the NDOL to enforce labour practices of nursing agencies.

Since a quarter of nursing agencies provide care to services that cater to the older population (geriatric care) in the health system, smaller agencies appear to meet this need for geriatric care. Therefore, it is recommended that, as transitional arrangements and decisions on the industry are being made, it would be advisable to consult these stakeholders before a final decision on a ban is made.

An important area to consider in strengthening the TES in the health sector will be to investigate the development of nurse banks. Nurse banks are internal pools of nurses and temporary staffing bodies controlled by the government and within the hospital or health establishment. Different from nursing agencies, the use of these banks reduces costs and allows for a greater control. In the UK, the government through the National Audit Office (NAO), Department of Health and the Audit Commission encourage the use of nurse banks rather than of nursing agencies. The good practice guide [115-116] encourages trusts to employ bank nurses rather than nursing agencies. There are also guidelines on making the nurse banks attractive to nurses and reduce the over reliance on nursing agencies [103, 104].

As part of tighter regulation, all agencies should be mandated to provide information to the responsible government institution on a set of core indicators that covers both their clients and the casual employees. This will ensure that casual health workers are not exploited, while meeting the care needs of clients in old-age and private homes.

5.2.3 Areas for further research

One of possible areas for future research is to determine the reasons for the establishment of nursing agencies and whether these are owned by nurses, whether practising or retired.

The quality of care provided by agency nurses and nursing agencies is not known, hence a comparative study between permanent nurses and agency nurses can be done to provide reliable information on the issue. Caregivers' role in the industry can also be determined through further studies.

For monitoring and evaluation purposes, periodic audits and detailed costing of agencies, similar to the UK National Audit Office reports [34] could be adapted for the purpose of determining the cost of agencies in the public sector.

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APPENDIX 1: Ethical Clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Miss Omolola Olojede

CLEARANCE CERTIFICATE	**M10971**
PROJECT	Analysing the Nature and Characteristics of the Nursing Agency Industry in South Africa
INVESTIGATORS	Miss Omolola Olojede.
DEPARTMENT	School of Public Health
DATE CONSIDERED	01/10/2010
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 03/11/2010 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Prof L Rsipel

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX 2: Information Sheet for Key Informants

Introduction

Hello,

My name is Lola Olojede, a postgraduate student studying Masters in Public Health at the University of Witwatersrand. As part of the degree requirement, I am expected to submit a thesis to my school on a research area particularly related to my field which is in Health systems and policy.

I would like to invite you to participate in a study on nursing agencies in South Africa to have your opinion as an organization/establishment on issues relating to the agencies by asking your some questions.

Introduction and background

The Centre for Health Policy (CHP) in the School of Public Health at the University of the Witwatersrand, Johannesburg has obtained funding from Atlantic Philanthropies for a multi-year project with the overall goal of developing and strengthening the evidence for improved nursing policy development and practice in South Africa.

The aim of this research study is to examine the characteristics, patterns and health system consequences of nursing agencies and moon-lighting in South Africa. The information obtained could be used to inform or advocate for policy or health system improvements in line with the objectives of the National Nursing Strategy. We are requesting your participation as a representative of your organisation.

The interview will take about 60 minutes to complete. It focuses mainly on nursing agencies, their challenges, policies governing their operation and any recommendations you might have regarding nursing agencies in South Africa. The questions are not a test, so there is no right or wrong answer. It is your opinions and experiences that are important. You may refuse to answer any questions that you don't feel comfortable answering.

Confidentiality

The information that you give will be kept confidential. None of the researchers who work in this research project are staff members of any government department, health authority or nursing agency. All responses to the interview will be assigned a code. We undertake that all information provided by you will be used only for the purpose of the study and all responses will be treated as private and confidential. Your name or that of the agency will not be revealed in any written data or report resulting from the study.

The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in the form of a report.

Consent

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committees. We will ask you to sign or initial on the front page of the interview schedule to indicate your willingness to give your consent and take part. The CHP will appreciate your participation and the information that you are willing to provide.

Audio tape recording

We would also like to record the interview on an audio tape to enable us have your main thoughts and contribution to this study. Please be aware that the recordings will be kept under lock and key in a safe and destroyed after it has been transcribed and analysed. The recordings will not be transferred to anyone besides the researchers conducting this interview. A separate consent for this is attached.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the survey. Similarly there will be no negative consequences for individuals who do not want to participate. You will not be compensated for taking part in the study. You have the right not to answer any questions that makes you feel uncomfortable. However, we would really appreciate it if you do share your thoughts and insights about nursing agencies.

Contact details

We will be happy to answer any question you have about this study. This research has been approved by the University of the Witwatersrand Research Ethics Committee. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the ethics office on **(011) 717 1234.** If you have questions about the research, you may also contact one of the principal investigators:

Omolola Olojede

Student

University of the Witwatersrand, Johannesburg

Phone: +27 78 607 9933

Email: lola_olojede@yahoo.com

You can also contact my supervisor: Professor Laetitia Rispel

Phone: +271 171 3436

Email: Laetitia.Rispel@wits.ac.za

APPENDIX 3: Information Sheet for Nursing Agencies

Introduction

Hello,

My name is Lola Olojede, a postgraduate student studying Masters in Public Health at the University of Witwatersrand. As part of the degree requirement, I am expected to submit a thesis to my school on a research area particularly related to my field which is in Health systems and policy.

Using an appropriate random selection of nursing agencies to be interviewed from a list obtained by the South African Nursing Council with contact details, your organisation and particularly your branch have been selected to take part in the study. Therefore, I would like to invite you to participate in the study.

Aim or purpose of the study

The Centre for Health Policy (CHP) in the School of Public Health at the University of the Witwatersrand, Johannesburg has obtained funding from Atlantic Philanthropies for a multi-year project with the overall goal of developing and strengthening the evidence for improved nursing policy development and practice in South Africa.

The aim of this research study is to examine the characteristics, patterns and health system consequences of nursing agencies and moon-lighting in South Africa. The information obtained could be used to inform or advocate for policy or health system improvements in line with the objectives of the National Nursing Strategy. We are requesting your participation as a representative or owner of a Nursing Agency.

The questionnaire will take about 30 minutes to complete. It focuses on some aspects of your nursing agency, your main clients, which services you provide, your challenges and any recommendations you might have regarding nursing agencies in South Africa. The questions are not a test, so there is no right or wrong answer. It is your opinions and experiences that are important. You may refuse to answer any questions that you don't feel comfortable answering.

Confidentiality

The information that you give will be kept confidential. None of the researchers who work in this research project are staff members of any government department, health authority or nursing agency. The members of the research team will not know who has completed the questionnaire. All questionnaires will be assigned a code. We undertake that all information provided by you will be used only for the purpose of the study and all responses will be treated as private and confidential. Your name or that of the agency will not be revealed in any written data or report resulting from the study.

The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in the form of a report.

Consent

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committees. Since this is a telephone interview, we would require that you give an oral consent to participate to indicate your willingness to participate. We will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the survey. Similarly there will be no negative consequences for individuals who do not want to participate. You will not be compensated for taking part in the study. You have the right not to answer any questions that makes you feel uncomfortable. However, we would really appreciate it if you do share your thoughts and insights about nursing agencies.

Contact details

We will be happy to answer any question you have about this study. This research has been approved by the University of the Witwatersrand Research Ethics Committee. If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the ethics office on **(011) 717 1234.** If you have questions about the research, you may also contact me on:

Omolola Olojede

Student

University of the Witwatersrand, Johannesburg

Phone: +27 78 607 9933

Email: lola_olojede@yahoo.com

You can also contact my supervisor: Professor Laetitia Rispel

Phone: +271 171 3436

Email: Laetitia.Rispel@wits.ac.za

APPENDIX 4a: Key Informant Interview - Informed Consent

INFORMED CONSENT

I have been given an information sheet and I understand the purpose and objectives of the study. I further understand that my responses will be kept confidential and that it is up to me whether or not to complete this interview. It has been explained to me that even if I choose not to complete this interview, I should inform the researchers and indicate so in the space below. My refusal to participate will in no way prejudice me**.**

I agree voluntarily to participate in the interview **(please tick).**

Yes [ ] No [ ]

Initial/ Signature:.....

Date:.....

APPENDIX 4b: Key Informant Interview – Consent for Audio Recording

INFORMED CONSENT FOR AUDIO RECORDING

I have been given the information sheet on the project entitled: Analysing the nature and characteristics of the nursing agency industry in South Africa. I have read and understood the Information Sheet and all my questions (if any) have been answered satisfactorily.

I understand that I can decide whether or not the interview should be recorded and that there will be no consequences for me if I do not want the interview to be recorded. I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is recorded, the tape will be destroyed two years after publication of the findings. I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I agree voluntarily for the audio recording of this interview **(please tick).**

Yes [ ] **No [ ]**

Initial/ Signature:.....

Date:.....

APPENDIX 5: Nursing Agency Survey – Informed consent

INFORMED CONSENT FOR TELEPHONE INTERVIEW

I _____, declare that I have explained the
(Researcher name)

information given in this information document to the agency.....(Insert respondent code.

He/She was encouraged and given ample time to ask me questions. He/she was informed that the responses will be kept confidential and that it is up to him/her whether or not to participate in this telephone interview. I have explained to the person even if he/she chooses not to complete this interview, she/he should inform the researcher and can stop the interview at any time. The refusal to participate will in no way be prejudicial**.** The interview was conducted in English

Signed at _____ on _____
(Place) (Date)

Signature of Research Staff Witness

_____ _____

(Date)

APPENDIX 6: Key Informant Interview Schedule

Name of Organization: _____

Interviewer's name: _____

Date of interview: _____

Result codes

01 = Completed , 02 = Respondent not available, 03 = Respondent refused;

04 = Partially completed

05 = Other .....

NB:

- ***Circle all that apply***
- ***Tape record conversation if consent is given***

a. How has it evolved over time;

b. What is the size of the industry

c. Trends in industry growth (if increase, what accounts for the increase?)

d. What legislation governs it?

e. Features of the industry (e.g. uniqueness, peculiarities, etc)?

f. Contribution to employment in South Africa?

2. What would you say are the strengths/ advantages of the nursing agency industry?
   a. Probe for health care delivery or for the health system?
   b. What accounts for these strengths?
3. What are the challenges facing the nursing agency industry
   a. in general?
   b. In relation to the public sector
   c. In relation to private health sector
4. Please tell us about the current debate/ issues about labour brokers
   a. Are nursing agencies considered as labour brokers?
5. What regulatory framework or policies govern nursing agencies/labour brokers in South Africa?

a. Are there any gaps in policies/ legislation

b. Who is the custodian of the legislation?

c. Who monitors nursing agencies to ensure legislative compliance?

d. How are nursing agencies monitored to make sure they follow the set rules and regulations?

6. As you know, there is a debate on restriction or banning of labour brokers in South Africa which was raised in 2009. What is your opinion on this?

    a. What are the reasons for the call on restriction or banning?

7. Nursing agencies are also part of labour brokers. What are your views on the proposed ban of nursing agencies?

Prompt:

a. Implications for the South African health system?

b. Implications for nurses?

c. Other implications

8. What recommendations do you have in relation to the future of nursing agencies?

Probes:

a. Policies/ legislation

b. Uniform standards

c. Monitoring and evaluation

d. Other

THANK YOU VERY MUCH FOR AGREEING TO PARTICIPATE AND FOR ASSISTING US

APPENDIX 7: Nursing Agency Survey Questionnaire

For official use only

1. **Agency ID**		☐☐☐
2. **Province ID**		☐☐
3. **Date of completion:**	DD/MM/YY	☐☐☐☐☐☐
4. **Was consent obtained?**	**O** No 0 **O** Yes 1	☐
5. **Was the questionnaire completed?**	**O** No 0 **O** Yes 1	☐
6. **Date checked:**	DD/MM/YY	☐☐☐☐☐☐

7. Which year was the agency established?

   .....

8. Do you have a head office?
   No [ ]

   Yes [ ]

   8 (a) If yes, in which province is your head office located?

   .....

9. How many branches does your agency have?

   ……

10. Is your agency owned or created by a larger organisation?
    No [ ]

    Yes [ ]

11. Who are your current clients **(mark all applicable)?**

Num	Client	Yes=1	No=0
a.	Netcare	1	0
b.	Life Health Care	1	0
c.	Mediclinic	1	0
d.	Old age home	1	0
e.	Gauteng DOH	1	0
f.	North West DOH	1	0
g.	Limpopo DOH	1	0
h.	Mpumalanga DOH	1	0
i.	Free State	1	0
j.	KwaZulu Natal DOH	1	0
k.	Northern Cape	1	0
l.	Western Cape DOH	1	0
m.	Eastern Cape DOH	1	0
n.	Other, list		

12. Do you have formal contracts with your clients?

No [ ]

Yes [ ]

13. How many nurses are registered with your agency?

.....

14. How many nurses do you supply to your clients every day (on average)?

.....

15. In what ways are nurses assigned or allocated to your clients?

Num	Allocation method	Yes=1	No=0
a.	Based on clients' demand	1	0
b.	Based on nurse preference	1	0

Num	Allocation method	Yes=1	No=0
c.	Based on nurse speciality/training	1	0
d.	Other (please list)		

16. Which categories of nurses do you supply to your clients (tick all applicable)?

Num	Category of Nurse	Yes=1	No=0
a.	Professional registered nurses	1	0
b.	Enrolled nurses/ staff nurses	1	0
c.	Nursing assistants	1	0
d.	Care givers	1	0
e.	Other, Please list		

17. Which of the following clinical services are the major users of nurses working with your agency (tick all applicable)?

Num	Clinical services	Yes=1	No=0
a.	Adult Intensive care unit	1	0
b.	Paediatric intensive care unit	1	0
c.	Theatre	1	0
d.	Maternity units	1	0
e.	Trauma/ emergency care	1	0
f.	Other, Please list		

18. Do you offer training and refresher courses for nurses?

No [ ]

Yes [ ]

19. Do you offer clinical facilitation/ accompaniment for the nurses?

No [ ]

Yes [ ]

20. Does your agency have a specific policy or framework that guides the supply of nursing agencies?

No [ ]

Yes [ ]

21. Does your agency have a Code of Conduct or a Charter of Service Provision?

No [ ]

Yes [ ]

22. Do you have a mechanism for your clients to report any incidents (e.g. sleeping on duty, medico-legal, failing to report on duty, etc)?

No [ ] Skip to 23 (c)

Yes [ ]

23(a) **If yes,** in what ways do they report these incidents?

Probe:

Num	**Methods of reporting**	**Yes=1**	**No=0**
a.	Verbally	1	0
b.	Letters of complaints	1	0
c.	Newsletters	1	0
d.	Other, Please list		

23. Which of the following benefits do you provide for nurses?

Num	**Benefits**	**Yes=1**	**No=0**
e.	Indemnity cover	1	0

Num	Benefits	Yes=1	No=0
f.	Unemployment insurance	1	0
g.	Injury on duty	1	0
h.	Paid leave	1	0
i.	Airfares	1	0
j.	Attendance at conferences	1	0
k.	Holiday packages	1	0
l.	Other, Please list		

24. What is the frequency of payment to your nurses **(Tick one category only)?**

Num	Frequency	Tick
a.	Within 24 hours only	
b.	Within 48 hours only	
c. -	Within one week only	
d. -	Within one month only	
e.	Other, Please list	

25. Listed below are possible checks that could be done when supplying temporary nursing staff. Please indicate how strongly you would agree or disagree with each statement.

Statement	Strongly Disagree	Disagree	Disagree slightly	Neither disagree nor agree	Agree slightly	Agree	Strongly agree
Check South African Nursing Council registration	1	2	3	4	5	6	7

Request certified copies of qualifications as a nurse	1	2	3	4	5	6	7
Other, please specify							

26. Challenges experienced as a nursing agency

I would ask you some questions relating to challenges experienced while operating as a nursing agency in South Africa. Please answer as honestly as you can on a scale of 1 to 7. 1 for strongly disagree and 7 for strongly agree.

Statement	**Strongly Disagree**	**Disagree**	**Disagree slightly**	**Neither disagree nor agree**	**Agree slightly**	**Agree**	**Strongly agree**
A commission rate fixed by the Nursing Act presents a challenge to agencies	1	2	3	4	5	6	7
The government is supportive of nursing agencies	1	2	3	4	5	6	7
It is easy to communicate with the hospitals/clients	1	2	3	4	5	6	7
Clients/hospitals pay their fees on time	1	2	3	4	5	6	7
Client/hospital expectations of nursing agencies are clear	1	2	3	4	5	6	7
Clients/hospitals are willing to partner with agency on nursing training	1	2	3	4	5	6	7
Nurses are committed and loyal professionals	1	2	3	4	5	6	7

We have a challenge of recruiting nurses	1	2	3	4	5	6	7
There is shortage of specialised nurses	1	2	3	4	5	6	7
The performance of retired nurses is unsatisfactory	1	2	3	4	5	6	7
Other, Please specify							

27. What are the current rates paid to different nursing categories per hour?

Category	**Rate (in Rands)**
Professional/registered nurses	
Enrolled nurses/Staff nurses	
Nursing assistant	
Care givers	
Others (please specify)	

Any suggestions/ recommendations you would like to make regarding nursing agencies?

THANK YOU VERY MUCH FOR YOUR ASSISTANCE AND FOR COMPLETING THE QUESTIONNAIRE

APPENDIX 8: Timeline of Research Study

From Approval to Submission

	Year																			
Activity	**2010**							**2011**												**2012**
	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Feb/ Mar
Protocol approval by health sciences faculty																				
Ethics approval by Wits ethics committee																				
Interviews with key informants																				
Telephone interview with nursing agencies																				
Data analysis																				
Report writing																				
Submission																				