

Bargaining in an Iron Lung: A Case Study of Enterprise Bargaining in the Private Hospital and Aged Care Industry

Nils Timo

Introduction

Government policy in the 1980s and 1990s has substantially changed the way in which health care is delivered and organised. As a labour intensive sector, there are particular repercussions for the management of work. This is illustrated in the way in which pending arrangements have been used as a vehicle to implement widespread structural and workplace reform.

One legacy of the Federal ALP government initiatives under enterprise bargaining was to compel private sector health workers to seek wage increases through actual dollar savings at the enterprise level. In aged care, a cap of 1.8 per cent was imposed by the government on the funding of award wage increases. Funding grants set per bed discouraged additional revenue being raised directly from aged care consumers. For private hospitals, the funding of enterprise bargaining was to be achieved through the introduction of key performance indicators and efficiency measures at the workplace. Private hospital funding is derived wholly from negotiations with private health insurers.

This paper is based on a detailed case study of enterprise bargaining in the private hospital and aged care sector in Queensland during 1995-1996 in the non-nursing sector. The paper examines employer and trade union bargaining strategies. Two approaches to wage negotiations are identified: productivity/performance linked and a cost minimisation/reductionist approach. Private hospitals have relied on linking wage increases to productivity measures and key performance indicators at the enterprise level. Aged care and nursing homes have relied on minimisation measures and economic incapacity and enterprise bargaining claims have been the subject of arbitration. The AWU and QNU are the major unions in health care in Queensland. The role of the Commission, the success and failure of productivity linked wages and cost minimisation strategies are examined.

The paper concludes by assessing the outcomes of enterprise bargaining in human services and the importance of the bottom line. Constraints on funding have provided employers with the opportunity to concession bargain. For trade unions, the pitfalls of bottom line bargaining have necessitated a much closer relationship with members, more effective workplace consultative structures and the acceptance of limited forms of agency bargaining. The case study illustrates the limited choices faced by health workers in achieving equity in wage outcomes, and illustrates the precarious position of such workers in a deregulated industrial relations system.

Industrial relations

The Queensland private health and aged care industry is characterised by a 'for profit' sector dominated by private hospitals and a 'non-profit' sector representing church groups, nursing homes, community based groups, hostels and respite care centres. While these groups share common award coverage, they have opposing philosophical and commercial interests.

The industry is dominated by the unions: the Australian Workers Union of Employees, Queensland (AWU) covering allied health and operational classifications and the Queensland Nurses Union of Employees (QNU) which covers nurses. The major award coverage of the AWU is under the Private Hospital and Nursing Home Employees Award - State and the Award for Employees providing accommodation services for Aged Persons, etc. - excluding South East Queensland. Coverage of hostels and respite care centres in the South East Queensland is held by Australian Liquor, Hospitality and Miscellaneous Workers Union (ALHMWU).

The industry is dominated by two funding arrangements. First, private hospital are funded by contracts with major private health insurance funds. Second, the aged care sector is predominantly funded by government through either SAM (Services Aggregate Module) covering the supply of nursing services, or CAM (Care Aggregate Module) covering supply of nursing services. Aged care facilities such as nursing homes are also able to charge fees, but these have traditionally been minor sources of revenue due to Government restrictions. CAM funding is subject to dollar for dollar funding (e.g. any surpluses must be returned to the Commonwealth), whereas SAM funding can generate surplus or profit to be used for other purposes. For some time, employers have been funding nursing claims under enterprise bargaining by pillaging their SAM surpluses. This has

impacted on trade union bargaining strategy by limiting the scope of non-nursing unions to gain enterprise bargaining increases.

Workplace reform and productivity measures in health

Productivity measurement and performance standards have historically been associated with the organisation of health work. Budgetary pressure and community expectations have had contradictory influences on the outcomes of health; the first imposing financial constraints, the latter necessitating quality outcomes. Since the 1970s and 1980s, health care has undergone substantial changes associated with hospital closures, redesignation of functions, transfer of public health services to the private sector, and a greater rationalisation of services and closure of smaller less economic health services.

According to Davies (1995), health care is now much more managerialised with a greater emphasis on explicit standards and measures of performance in qualitative terms that set specific targets for health personnel. There is a greater emphasis on output controls, with rewards and resources being allocated to successful performance and away from decline and failure (1995: 125).

Productivity bargaining in health care therefore assumes greater importance as health services move away from institutional protections and monopolies and exposed to greater market variation. Enterprise bargaining in health has moved away from an award focus to reducing the constraints on employers and employees to agreeing on greater workplace flexibility and hence greater efficiency. Productivity bargaining is therefore contextual having both opportunities and constraints.

As complex organisations, hospitals have been increasingly subject to the principles of rational management in a process which Reverby describes as the 'search for the hospital yardstick' (1979: 206). These techniques, based on scientific management have their origins in the Efficiency Movement in the United States during the 1900s which sought to systematise and organise industry according to a set of problem solving techniques based on examining work flow coordination, introduction of cost-control and control of labour. This is not to argue that the hospital efficiency movement has a direct historical nexus with Taylorism. Rather 'hospital Taylorisation' is an idealised conception of the process of restructuring and rationalisation of health work which borrowed from organisational and rationalisation principles applied to industry. The application of these principles in the reorganisation of health work took two forms. First, the rationalisation of medical care through specialisation, standardisation and codification of procedures whereby the technical base of medicine is being continually narrowed from general job roles and skills to specific and specialised functions (McKinlay and Arches, 1985: 176-178). Second, it has also initiated a growth in functional specialisation of technical and specialist occupations which have made health work increasingly collective and complex (Bellaby and Oribador, 1980: 300-304; Rademaker, 1980).

The application of large-scale economic and well established management techniques developed in industry has also had a major impact on hospital organisation, whereby time-saving and cost-saving could be achieved through rationalisation and efficiency (Sax, 1974; Haywood, 1974: 11). Time and motion studies, used to establish standards of performance in factories, were found applicable to nursing. The organisation of the hospital along the lines of greater efficiency and productivity enabled patient ratios to be increased.

The aim of making the health service more efficient relies upon reducing unit labour costs. In a labour intensive sector, with technological innovations limited to particular areas of direct patient care and the problems associated with cutting pay under a centralised award system, this inevitably means a greater emphasis on the use and the productivity of labour. In hospitals this has concentrated on control over the labour process, with attempts to cut costs through intensification of work, restricting staff levels and reducing labour costs through casualisation and skill mix changes (Timo, 1989).

The impact of the above developments on hospital services has been profound. In the 1980s, health services (like public sector changes elsewhere) have been dominated by the growth in managerialism in health care where a greater emphasis is placed on output controls using private sector practices. A greater focus on output controls is illustrated in the growth of new patient management and cost system such as Case Mix and Diagnostically Related Groups (DRGs) as more efficient means of allocating and costing resources (Davies, 1995: 125). The effect has been to place greater stress on labour allocation and labour cost. The perceived excesses of managerialism in terms of staff reductions, trading off award conditions (i.e. attempting to achieve cost savings) cut

backs in services and ward closures highlighted the growing need for more sophisticated approaches to organisational performance and measurement in the context of enterprise bargaining.

The union approach to productivity performance and workplace reform

The AWU campaign for enterprise bargaining commenced in 1993 for the making of a new Private Hospital and Nursing Home Employees Award - State. The main purpose was to seek parity in wages and related ties between the private and public sectors. A key feature of public sector industrial relations during the Goss Labor government was the restructuring of public health employment. The introduction in 1990 of the classification and remuneration system sought to rationalise public sector wages and employment conditions according to four skill streams: professional, administrative, technical and operational. Each stream was set up with a series of wages and skill bands and were employees would be translated across to. Upon application by the Crown, this remuneration standard was approved by the Queensland Industrial Relations Commission (QIRC) on the 3rd July, 1991, taking effect as from the 1st July, 1991. These rates of pay were seen by the AWU as appropriate for the private sector.

Following 12 months of negotiations, the AWU reached agreement with private hospitals through the Private Hospitals Association of Queensland (PHAQ) and the Aged Care Industry. The new Award provided for rates of pay based on the public sector and skill levels comparable with public hospital employees.

Bolted to the new award was an industrial agreement providing a framework for delivering an enterprise bargaining increase of 9.5 per cent over 18 months. The use of an industrial agreement (as opposed to a certified agreement) was considered preferable, as under the Queensland *Industrial Relations Act*, such an agreement can be made directly between a trade union and an employer without the formalities involved in the making of a certified agreement. This was considered essential in order to enable the new award and the enterprise bargaining process to commence simultaneously.

The agreement provided a framework for the development of key performance indicators, and provided for a consultative workplace structure which was oversighted by a State level union and employer consultative committee. An element of the bargaining process was the agreement to develop appropriate workplace performance indicators linked to wages outcomes under the enterprise agreement. The parameters of negotiation covering hospital-based performance indicators were directed to the following:

- flexibility of work patterns
- work practice reviews
- workplace/workforce structure
- multi-skilling
- organisational change
- best practice and continuous improvement processes
- measures to ensure certainty in employment
- accommodating the needs of workers with family responsibilities.

The Industrial agreement was important to the overall success of the bargaining by providing a framework:

- which set the agenda for matters to the bargaining at individual workplace level
- set the quantum and timing of EB increases
- stipulated an employee consultative framework
- locked in place agreed operative dates for EB increases.

The relationship between the new Award and framework agreement is set and is Figure 1 below.

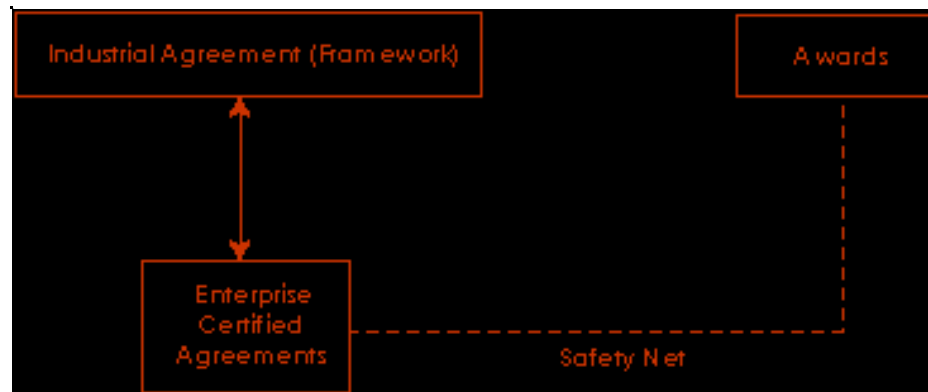


Figure 1: Agreement making process

The bargaining process was based on the agreement providing the vehicle for local enterprise level discussions. The relationship between the parties and the structure of negotiations is set and in Figure 2 below.

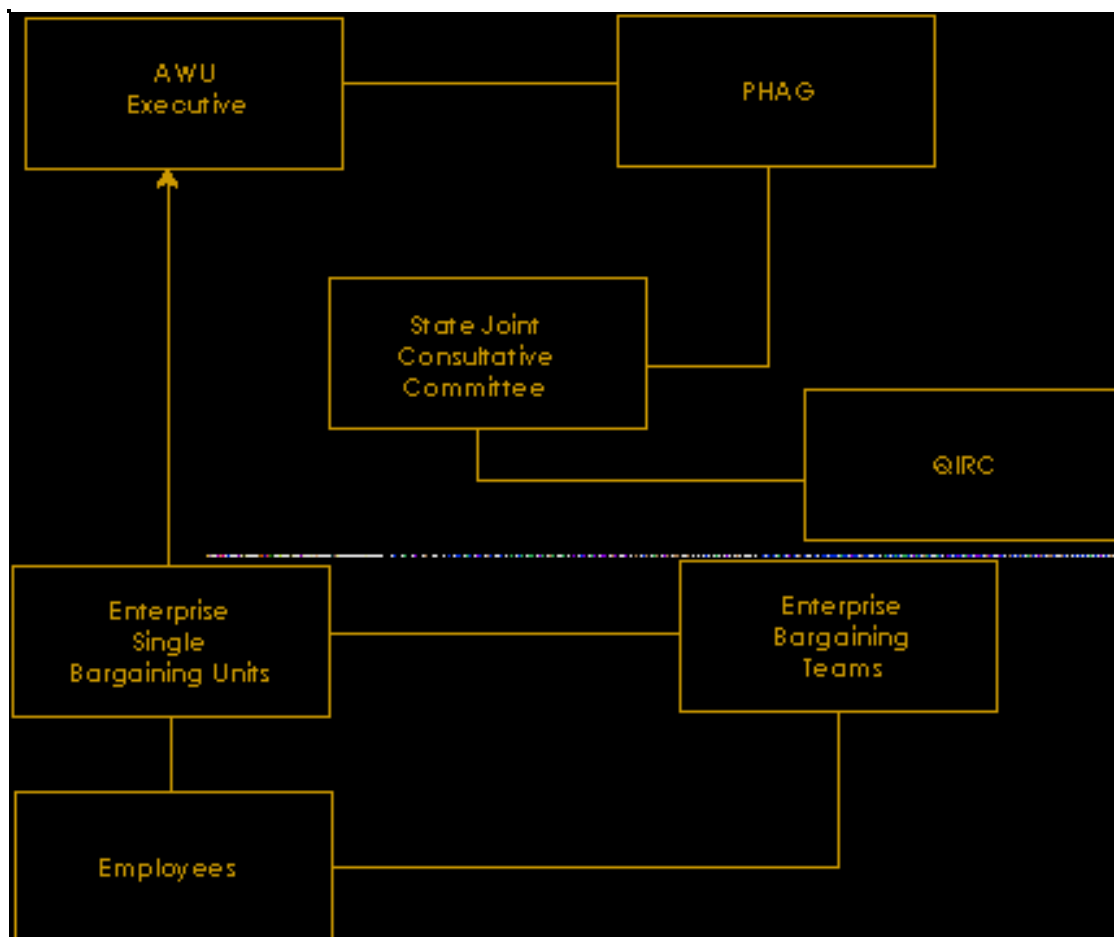


Figure 2: Structure of bargaining

The above framework for negotiations guided the enterprise bargaining and workplace change process for private hospitals during 1995-1996. At the time of approving the agreement, aged care employers withdrew from the process on the basis that they could no longer agree to a collective outcome. This position reflected growing tensions within the aged care industry between those seeking a collective outcome and those (predominantly church organisations) seeking single

enterprise based outcomes.

The following section examines the productivity outcomes of enterprise bargaining in private hospitals.

Productivity and cost reduction/productivity outcomes

The debate in Australia since the late 1980's has focused on attempting to locate trends in workplace change. Hall and Harley (1995) have identified two broad approaches, involving a cost reduction and productivity enhancement strategies:

Cost reduction / profitability oriented strategies are seen as including:

- concentration on the maintenance of high levels of profitability in the short-term
- achieving increases in profitability through cost reductions in areas such as R&D, investment, training and maintenance
- concern with cost reduction through cuts in wages and conditions
- use of new technologies to replace labour and to reduce labour costs by substitution of skilled workers with lower skilled machine functions
- the facilitation of flexibility in employment through deregulation of labour market practices and the employment of casual and temporary or seasonal employees who can be shed when demand falls
- replacement of higher-wage full time workers by lower-wage part-time and casual workers
- low levels of investment in training and a reliance on 'poaching' skills
- hierarchical organisational structures and enforcement of managerial control
- relatively high rewards for managers compared to the workforce associated with high expectations placed on management performance.

Productivity oriented and value adding strategies are seen as containing the following features:

- a long-term focus on productive capacity and favourable market share
- achieving increases in profitability through productivity development – maintaining or increasing R&D, investment and training
- concentration on a high wage, high skilled workforce engaged in high value added production
- the integration of new technologies into a production process built on a highly skilled workforce
- active management intervention to reduce employee turnover so as to maximise the return from training and experience
- employment security
- concentration on training and skills development at all levels of the workforce
- organisational arrangements which facilitate participative practices involving the workforce in decisions about production processes – building employees' skill and experience into production
- collective approaches to enterprise decision-making rewarding the work group rather than individual managers (drawn from Hall and Harley, 1995: 79-80).

These two approaches are seen as encompassing different styles of managerial behaviour and employment relations and differing levels of employee involvement in decision making. A cost reduction or profitability strategy would be associated with a strong managerial prerogative, intrusive HRM practices, strong employee disciplinary procedures, and concession bargaining (e.g. clawing back conditions and benefits) with trade unions. Productivity and value adding strategies would be associated with weaker managerial prerogative in favour of closer employee involvement, employment security, acceptance of new technology, a joint approach to performance measurement and trade unions playing a positive role in organisational improvement.

How do the above approaches apply to enterprise bargaining in private hospitals and aged care in Queensland? The framework agreement required each hospital to finalise a local certified agreement by October 1996. Forty hospitals responded by establishing a range of key performance indicators under the framework agreement. The size of the hospitals is set out below in Table 1.

Table 1: Size of hospitals

No. of beds	Hospital size	Percentage
<200	5	12.5
101 – 199	13	32.5
51 – 100	12	30.0
21 – 505	12.5	
1 – 20	5	12.5

Private hospitals also provide a full range of services. They are described in Table 2 below as follows

Table 2: Sample of hospitals

Surgical / Medical / Maternity	11
General Medical / Surgical	8
Surgical / Medical / Obstetrics / Psychiatric	17
Surgical / Medical / Obstetrics / Intensive and Coronary Care	4

N = 40

By the end of September, 40 performance agreements have been reached. Each contained a range of performance increases negotiated locally. These are set out in Table 3 below as follows.

Table 3: Ranking of performance measures

KPI	Percentage
Operational costs / energy savings (meet budget target)	39.4
Waste	29.5
OHS / work related injuries	21.3
Accreditation / quality standards	19.7
Absenteeism / turnover	19.7
Patient satisfaction / customer focus	19.7
Best practice / organisational effectiveness / TQM	18.0
Staff development / training	16.4
Labour flexibility / new work practices	14.8
Extra services / access	9.8
Mission and values / organisational culture	8.2
Human error / re-work	8.2
Meal costs (patient)	8.2
Communication	8.2
Patient turnover	6.6
Employee involvement	6.6
Labour costs / hours per patient	6.6
New technology	4.9
Improve supervision	1.6
Grievance procedure	1.6
Patient processing	1.6

Notes:

1. Average duration of KPI process was six months.
2. Operational costs include telephone, chemical costs, service delivery, stock control, energy use.
3. Waste include general and medical waste.
4. OHS issues include OHS training, knowledge of OHS procedures, compliance with OHS guidelines, workers compensation premiums.
5. Labour flexibility include new work practices, rostering, multi-skilling, greater work effort.
6. Sample of KPIs: 164.

As shown in Table 3, the main emphasis by private hospitals have been as reducing operational costs and waste. Best practice, staff training and labour flexibility ranked 7th, 8th and 9th in importance. Follow-up discussions with managers suggested that private hospitals emphasise the importance of cost cutting through reductions in operating costs and waste. Significantly, hospital managers found that reducing absenteeism was more important than implementing greater labour flexibility. One argument was the desire of hospitals to keep trained staff rather than rely on casual and irregular labour. Private hospitals have restructured their workforce by gradually shifting work effort from permanent to increasing numbers of casual and part time employees. While this reflects a growing casualisation of the health workplace, maintaining employee commitment to the job remains a concern for managers. Nothing in the various enterprise agreements (other than an EB pay increase) suggested an attempt to deal with this problem

Role of the industrial relations commissions

Since the 1993 amendment to the Queensland *Industrial Relations Act 1990*, the Queensland Industrial Relations Commission (similar to the Australian Industrial Relations Commission) have had responsibility for maintaining two streams for workplace change: as award stream and an enterprise bargaining stream. The Commission was also required in carrying out its functions to have regard to agreements between employees and unions at the workplace.

The AWU application for the new Private Hospital and Nursing Home Employees – Award State was heard before the QIRC in December, 1995. Despite the consent nature of the award application, the QIRC refused to grant the new wages relativities which would have brought rates of pay in the private sector health up to those of public sector health workers granting instead the less favourable relativities from the Metal Industry Award. The QIRC, sitting as a single commission, referred the application to a Full Bench of the QIRC as a special case.

The Full Bench heard the special case in August, 1996. By that stage, aged care employers had withdrawn their agreement to the new rates of pay due to concerns about the new Federal Coalition government policy changes and funding arrangements in aged care. The decision of the Full Bench was to refuse the AWU application for the introduction of the new wages relativities, arguing that those employers who wish to pay the new rates should do so by way of individually negotiated certified agreements. While the Full Bench rejected the consent claim by way of award variation, surprisingly, the Full Bench decision endorsed union pattern bargaining.

As a consequence of the Full Bench failure to ratify the consent arrangement, a number of private hospitals withdrew from their involvement in enterprise bargaining. Of the 40 private hospitals, only six had agreed to honour the earlier arrangements. The union in turn, initiated a number of local disputes in an attempt to have the employers bargain in good faith and implement the earlier agreement.

Discussion

One of the primary objectives of private hospital and aged care employers has been to control expenditure. The results of the introduction of key performance indicators under enterprise bargaining have highlighted reducing operational costs and wastage as key areas. While labour flexibility is important, private hospitals have experienced a shortage of skilled labour which combined with a huge level of absenteeism, has constrained managerial freedom to 'hire and fire'. Emphasis has been placed on waste reduction, improving quality outcomes and reducing costs wherever possible. The targeting of costs reflects the nature of funding and the types of contracts entered into with the major private health insurers whereby labour and operating costs are part of broader activities targets aimed at increasing the level of hospital functions while reducing operational overheads. Despite the focus on cost reduction, the negotiation over key performance measures was successful in compelling private hospitals to examine organisational performance issues.

Aged care employers derive nearly all income and revenues from the Commonwealth government. Their decision to withdraw from the enterprise bargaining process reflects uncertainty and confusion over the future of funding. This position has been supported by the centralised arbitration system where the QIRC has rejected attempts by the union to regulate the enterprise bargaining process through a coordinated approach based on the creation of a modern Private Hospital and Nursing Homes Award to underpin this process and provide a secure safety net.

The impact on employees is profound. The failure to set appropriate wages at an award level means that each workplace will need to conclude their own certified agreement. To date, only six private hospitals have chosen to do so, and only one large religious organisation in aged care. The result for employees of the process is an extended wages pause. The only role with the QIRC is to have here will be to process (upon application) the three \$8.00 safety net adjustments and to take a 'hands off' approach to bargaining.

Conclusion

This case study has sought to give a glimpse of enterprise bargaining in the private hospital and nursing home industry. The study highlights the role of bargaining strategies and the importance of bottom line bargaining for employers. The role of the centralised tribunal system has also been detailed. For employees, the process of enterprise bargaining is likely to be long, frustrating and unrewarding.

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