

## Howard's way: seeking conflict or building commitment?

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WHILE MANY COMMENTATORS are describing the Federal Government's industrial relations reform package as radical or even revolutionary there is very little in it that is a complete surprise. Further reduction in the power of the Australian Industrial Relations Commission (AIRC), greater simplification in the making of awards and agreements, an increase in anti-trade union legislation, and weakening of unfair dismissal provisions have been on the government's wish list for some time. The move to a national industrial relations system has also been on the government's agenda. The impact of these developments on the health industry is difficult to predict beyond saying that it appears to be a recipe for conflict and division. However, our main focus is not to discuss the detail and merits of the proposed changes but instead to ask whether these policies in any way address the major workforce issues facing the Australian health care sector in the twenty first century.

The Australian health sector is largely publicly funded and very labour intensive. Health sector employees are mainly tertiary educated and have strong, well organised trade unions and professional groups.<sup>1</sup> There are a number of key workforce problems facing the industry. These include rapid increases in technological innovation leading to constant demands for increased skills; an ageing workforce with fewer students attracted to areas such as nursing; recruitment and retention problems among many professions, leading to

grave staff shortages in many outer suburban, rural and remote areas; and international shortages of a number of key professional groups. The question is — are further reforms in the industrial relations system that are designed to free up the labour market and increase productivity likely to provide solutions to any of these problems?

A starting point would be to identify the key features of health sector industrial relations. In the mid 1990s the industry was described as rigid, award-ridden and rule-bound.<sup>2</sup> Since that time the industry has been subjected to the same pressures for workplace reform and decentralisation of industrial relations as other sections of Australian industry. Bray et al,<sup>3</sup> comparing the experiences of New South Wales, South Australia and Victoria, concluded that despite attempts to introduce decentralised bargaining and the flurries of activity that took place around it, the industrial relations systems of all three states has remained largely centralised. They argued that unlike other industries the coverage of collective bargaining in the health sector is almost universal, with most public health sector employees continuing to be covered by collective regulation in the form of awards and certified agreements. They suggested that the bargaining process has remained centralised, with state government officials and state trade union officials continuing to play a strong bargaining role. They also found that the scope of bargaining had actually increased as trade unions had managed to incorporate new provisions, such as nurse–patient ratios, into enterprise agreements. At first glance it could be argued that a new wave of reform is needed.

On further analysis however, it becomes clear that the atypical nature of the health care industry argues for a different focus of reform, for several reasons. First, state governments play an important role as the funder, and therefore effectively

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the employer, in the sector, and while governments publicly might extol the virtues of decentralised wage bargaining, in private they are anxious to control their wage bills and they have a wider agenda in setting public sector wages. In the public sector, some kind of centralised wage agreements often make sense. Second, the sector is highly political with industrial disputes quickly becoming front page news. Nurses closing hospital beds, using the argument there are not enough staff to provide a quality service to patients, can easily move from being the problem of the individual hospital employer to a major embarrassment for a minister. Third, the trade unions have particular strength and work to keep bargaining centralised.<sup>3</sup> Further, unions such as the Australian Nursing Federation are adept at utilising the enterprise bargaining process as an organising tool to recruit new members and increase the strength of the union.<sup>4</sup>

This is not to say that workplace reform has not taken place in the health care sector. It has, but largely outside of the industrial relations process. White and Bray<sup>5</sup> argued that changes to work practices in NSW hospitals emerged out of budget cuts and increased managerial prerogative and were not the results of bargaining. Stanton<sup>6</sup> argued that workplace change in Victorian hospitals was the result of the introduction of casemix funding, outsourcing and budget cuts. So change has taken place — in fact the evidence suggests that the health care workforce is more productive than ever, but often in spite of and not because of industrial relations.

The evidence also shows that there is a cost of workplace reform. These costs include work intensification, higher labour turnover and a loss of workforce morale.<sup>7</sup> All of these costs contribute to and exacerbate the problems facing the industry today, and another wave of reforms may just add to this effect.

The implication of all of the evidence is that action at the system level focusing on further industrial relations reform is neither desirable nor likely to achieve much. Being part of the national system has achieved little in the Victorian health care sector, enterprise agreements might be

signed at the enterprise level but they are still funded by the state government and contain largely the same provisions. Reduction of the powers of the AIRC means little if the trade unions are strong and united and the government is vulnerable to bad press. In the health sector these reforms, if carried through with enthusiasm, stand to waste a lot of time, energy and goodwill and do nothing to deal with the real issues of labour shortages and high labour turnover, to say nothing of the quality of service provision.

A more fruitful approach to achieving workplace change in the health care sector would be to support employers to engage with employees at the organisational level to find ways of making the provision of health care services better for staff and patients alike. It is time to develop policy that is based on evidence and experience and can actually solve problems, rather than policy based on misplaced ideology. Bartram et al<sup>8</sup> surveyed 130 public hospitals in Victoria and found a number of system-wide concerns that impacted on the performance of hospitals, particularly in terms of a range of human resource management (HRM) outcomes (eg, indicators like staff turnover; number of grievances lodged; number of stress-related leave episodes; number of incident reports lodged; number of hours lost through injury, etc.). A lack of systematic practice of strategic HRM (the integrative use of HRM functions linked with organisational strategy) was associated with poorer performance on the HRM indicators listed above. Furthermore, when chief executive officers, human resource directors and general functional managers were quizzed about the barriers to improving the people management at the organisation, industrial relations and unions were seldom raised as an impediment. In contrast, issues such as inadequate managerial skills, difficulties with the use and understanding of formal people management systems and processes, and inadequate government funding were seen as the major impediments to the more effective use of human resources.

More detailed examination by Bartram et al<sup>8</sup> found that health care organisations in the sample often had limited or conflicting understanding of

strategic human resource management, did not place a high priority on the outcomes of their HRM practices, and did not understand the value of collecting, analysing and linking data on HRM outcomes to organisational performance. For instance, chief executive officers and HR directors were generally very positive concerning the use of strategic HRM within health care organisations. However, many general functional managers reported difficulties in understanding exactly what HRM was, its role within the organisation and their front-line people management responsibilities. The HRM literature and acknowledged best practice in management highlight the central importance of middle and line management in the translation and operationalisation of HRM plans and strategies at the workplace level. From the sample in this study, public health care facilities might be having difficulties in operationalising HRM and therefore actually practising it, despite wide-scale evidence of the positive impact of HRM on organisational performance from the “Magnet Hospital” studies,<sup>9</sup> high performance work systems research<sup>10</sup> and the exploratory results of Bartram et al.<sup>8</sup>

The study also demonstrated limited performance monitoring throughout the Victorian public health sector. The sector reported a strong focus on financial, activity and patient satisfaction measures, with limited reporting on HRM measures. It is acknowledged that effective management requires appropriate performance measurement, and the mechanisms to translate data into knowledgeable actions — neither of which were strongly demonstrated in this study. Thus, the strategic human resource management paradigm is “lost in translation”, and, consequently, opportunities to understand and develop the link between people management practices and improved organisational outcomes are missed.

It is clear that the difficulties faced by the public health sector are extremely complex and require sophisticated and cooperative responses from the main stakeholders including employers, managers, clinicians, unions and governments. Further deregulation of industrial relations and

attempts to reduce union power will be met with significant opposition, particularly by many clinicians, unions and even some employers, possibly diverting already scarce resources away from improving management processes. In the case of the public health care sector, we argue that deregulation of industrial relations could be seen as a simplistic response to complex challenges of cost containment and effective management of a highly skilled workforce.

There is little theoretical or empirical evidence to suggest that the forthcoming industrial relations reforms will improve the quality of people management in the public health sector, or that they will provide solutions to measurement and monitoring of people management systems and processes. Neither will they improve communication throughout the organisational hierarchy, nor enhance management's knowledge, skills, and abilities to better use scarce resources and subsequently improve the quality of patient care. The public health sector needs governments prepared to facilitate debate and possible solutions concerning many of the issues raised in this paper with representatives of all of the key stakeholders in the sector. All of the stakeholders bring valuable perspectives and possible solutions. Given the complex and interdependent nature of the sector, solutions to these people management challenges can only be successfully achieved through standing together, unified around the key aim of improving the quality of care within the community, rather than ideologically driven and divisive industrial relations reforms.

## Competing interests

None identified.

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