

# Searching for the hospital yardstick: A case study of private hospital productivity bargaining

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## Abstract

*The decentralisation of Australia's centralised wage fixation system has been seen as providing opportunities for employers and trade unions to tailor working arrangements to suit the needs of the workplace and to provide better paid long-term jobs. This paper details the productivity bargaining between the Private Hospitals' Association of Queensland and The Australian Workers' Union in 1995–97 in Queensland that led to the introduction of a number of productivity-based enterprise agreements. The case study shows that productivity bargaining in the private hospitals studied remains focused on 'bottom line' issues where cashable savings can readily be generated. The paper concludes with an examination of the lessons drawn from the productivity bargaining process.*

## Introduction

Since the early 1980s, both federal and State governments have actively pursued micro-economic reform of the Australian economy. This has included a range of policies such as market liberalisation, tariff reforms, deregulation and workplace reform. Traditionally Australia has had a highly centralised system for

establishing employment and working conditions through industrial tribunals, at both federal and State levels. The main vehicle through which these tribunals influence wages and employment conditions are awards. These awards specify the basic conditions of employment, including wage levels, that apply within a particular industry or occupation. Awards have the force of the law.

There has always existed, however, an additional tier of negotiation which largely lies outside the formal tribunal system. Since most awards specify only minimum conditions, scope for bargaining by the parties for conditions over and above the specified awards in the form of over-award payments is fairly widespread. Nevertheless, despite this scope for over-award bargaining, award wages have until recently tended to dominate overall wage outcomes.

A major shift towards an enterprise-based bargaining system, initiated by the 1991 National Wage Case, was reinforced in 1993 with the enactment of the Commonwealth's Industrial Relations Reform Act. One of the main aims of this Act was to encourage the spread of enterprise agreements and to put the onus on the industrial parties at workplace level to take responsibility for their own outcomes. A new set of workplace agreements was introduced, offering two basic bargaining models, namely, (i) Certified Agreements (CAs), which must involve a union, and (ii) Enterprise Flexibility Agreements (EFAs), which could be reached through direct negotiation between employers and employees without a direct union role.

Both forms of agreements were closed (that is, could only be varied in exceptional circumstances) and were of a specific duration. Both were subject to a 'no disadvantage test' (that is, the agreement could not have provisions which undermined the relevant award as a package). In addition, the new arrangements focused on a single business and outlawed the making of multi-employer and multi-site agreements. The then Queensland Labor Government adopted these provisions by way of amending the Queensland Industrial Relations Act in 1993, which was subsequently replaced by the Queensland Workplace Relations Act in 1997.

This paper details productivity bargaining in the acute for-profit sector of the hospital industry between the Private Hospitals' Association of Queensland (PHAQ) and The Australian Worker's Union (AWU) during 1995–97. A key feature of this bargaining process was the important role that key performance indicators played in linking wages to workplace productivity. The paper examines the development of key performance indicators and how these were linked to union-employer wage bargaining.

## **Key performance indicators and workplace change**

The impetus towards workplace agreements since 1991 has shifted the direction of wage negotiations towards the workplace level. The agenda for bargaining appears to be largely confined to cost minimisation measures such as hours of work, penalty rates, and so on. For example, the utilisation of key performance indicators in enterprise bargaining as a measure of workplace reform remains largely undeveloped. The 1995 Enterprise Bargaining in Australia Report conducted by the Department of Industrial Relations (1996) surveyed a range of outcomes in the bargaining process. It found that by 1995, 3277 agreements had commenced operation in the federal jurisdiction, covering approximately 61 per cent of employees employed under federal awards. The report went on to find that pay rates were dealt with in 94 per cent of all agreements, working hours in 81 per cent, work practices or work organisation in 65 per cent, penalty rates in 50 per cent and performance appraisal in 45 per cent of all agreements (Department of Industrial Relations 1996, p 106).

In terms of changes in human resource management practices and work organisation, the survey found that quality assurance was dealt with in 28 per cent of all agreements, flexible labour organisation in 23 per cent, introduction of a new classification structure in 17 per cent, team working in 15 per cent, introduction of best practice in 11 per cent, and organisational restructuring in 4 per cent of all agreements (Department of Industrial Relations 1996, p 109).

While the report found that enterprise bargaining was increasing efficiency in 62 per cent of workplaces, it also showed that 58 per cent of employees reported an increase in work intensification, 50 per cent reported increased job stress and a majority of employees were more dissatisfied with managerial decision-making. From the perspective of management, only 9 per cent of managers said that productivity under enterprise bargaining had improved 'a lot', whereas 53 per cent reported small gains and 38 per cent reported no change in productivity (Department of Industrial Relations 1996).

Performance indicators were included in 28 per cent of all agreements. Table 1 shows the ranking of performance indicators.

The report found that agreements containing one or more performance indicators were most common in the manufacturing sectors, particularly metals manufacturing where they were included in 50 per cent of agreements. The industry where they occurred least was personal, community and financial services. The survey found that performance indicators were often neglected in favour of 'softer' issues such as changes in hours of work, rostering, penalty rates, overtime and so on, which could yield immediate cost savings.

**Table 1: Performance indicators in enterprise agreements**

<b>Performance indicator</b>	<b>Order of importance (% of agreements)</b>
Quality practices	22
Human resource management issues	15
Output measure	9
Cost control	6
Financial performance	2
Any indicator	28

*Source:* Department of Industrial Relations 1996, p 122, Table 4.5.

In 1997 both the Federal Coalition Government and the Queensland Coalition Government further amended the enterprise bargaining stream by removing the requirement for trade unions to be partners to certified agreements and introducing employer–employee workplace contracts known as ‘Australian Workplace Agreements’ and ‘Queensland Workplace Agreements’ respectively. This paper refers to the formal bargaining structures in place based on the 1993 legislation.

## **Outline of the hospital industry in Queensland**

The hospital industry (providing acute care) can be divided into four broad sectors: the public hospital system, private for-profit hospitals, private not-for-profit hospitals, and smaller specialist for-profit hospitals run either on a stand-alone basis or integrated as part of a broader health service. The acute hospital sector in Queensland is dominated by a large public hospital system, funded through the public sector and Medicare rebates. The for-profit sector is smaller and consists of a number of medium-sized hospitals, however, the industry is dominated by the small number of large integrated private hospitals.

There are a number of competitive push-pull factors at work in the for-profit acute hospital sector. First, the gradual deregulation of the hospital industry in Australia has seen the growth in specialist day surgery performed outside the traditional public hospital sector. Second, there is a growing rationalisation of the hospital industry, with larger multinationals such as Health Care Australia entering the field. Third, there is a steady decline in the conversion rate (that is, consumers who maintain full private health cover) from 66 per cent of Australians being covered by private health insurance in 1982 to only 38 per cent by 1992–93 (Australian Institute of Health and Welfare 1994). This drop has

meant greater competition for funds by the for-profit sector and further squeezing out of smaller operators. Despite this drop in private health cover, the business of the for-profit sector has grown from 20 per cent of admissions in 1982 to about 30 per cent by 1992–93, representing the growing importance of the larger operators (Australian Institute of Health and Welfare 1994).

Fourth, hospitals are large and complex organisations with high technological and operating costs. Labour costs in the hospital industry vary according to size and complexity of hospital (for example, number of beds, mix of acute services provided and technology). In general, labour costs of hospitals are similar to those of hotels and vary between 55 and 65 per cent of total operating costs. Like hotels, hospitals are labour-intensive. Finally, unlike manufacturing, where productivity and efficiency can be measured in a number of ways (for example, number of rejects, quality and customer satisfaction), the introduction of cost minimisation measures in the hospital industry is always constrained by the requirement to meet set (government-imposed) accreditation requirements and clinical accountability outcomes which embrace a general community expectation of what constitutes an acceptable standard of health care.

There is a close connection between the for-profit providers and private health funds. Private providers in the main rely on private health funds for much of their funding. The extent to which costs can be reduced depends on a range of issues. For example, while labour costs are high, these tend to be relatively fixed; that is, the imposition of quality outcomes and health standards (for example, employment of appropriately qualified and trained labour) has limited the ability of hospitals to adopt labour-saving and cost minimisation strategies such as hotels which are able to casualise their workforce and need not provide more than a basic level of skills training.

In 1992 the then Federal Labor Government made changes to the private health insurance legislation allowing private health funds to negotiate directly with private providers to enable health funds to cap costs. This was to be achieved through engendering greater competition in the for-profit sector by allowing private health funds to either strike a better deal with private providers, or allow them to switch financial support from one private hospital to another through the use of annual performance contracts.

Government attempts to rein in health costs in areas not controlled by Medicare funding have seen greater importance placed on the role of organisations such as the PHAQ in negotiating contracts with private health funds on behalf of their members. These annual contracts are important in understanding the nature of competition in this sector. Private health funding is largely dominated by the private health insurance funds. The decline in the number of Australians in

private health insurance continues to squeeze the provision of services. Cost control over private health providers has been exercised by limiting the capacity of private providers to charge for health services above the scheduled Medicare fee (for example, prohibiting 'gap' insurance). The Coalition Government elected in March 1996 has foreshadowed a major revamp of health funding to take effect in late 1997.

Changes in funding have also had an impact on public sector health. The former Labor Government sought to use the Medicare Agreement with States as a vehicle to achieve micro-economic reform in public sector health services. According to Allan (1997), the main objectives of the Medicare Agreement have been to reform the hospital sector by reducing hospital waiting lists, and to increase the overall level of efficiency of the public hospital system by offering the States incentives to improve efficiency and treat more public rather than private patients as provided for under the terms of the 1988 and 1993 Medicare Agreements. In this way, the Federal Government has sought to improve access to public health while retaining the cost of service provision (Allan 1997, p 11).

The use of funding as a vehicle for micro-economic reform has had a profound effect on public health services. As Davis observes, the emphasis is on getting results in the short term, rather than worrying too much about how they are achieved (1994, p 125). According to Allan, such a short-term focus entails a process where technical efficiency improvements are achieved by displacing costs 'off budget' and imposing them on employees. The desire to maintain or increase the level of service delivery at lower cost may be achieved by reducing direct inputs such as labour. Employees experience intensified workloads and decline in health and well-being. Lower costs are achieved through lower salaries and staffing levels. Employees are increasingly shouldering the costs of workplace reform through increased work effort (Allan 1997, pp 12–13). The current lively debate about the future shape of the health system and funding arrangements contributes to a view of a health system in crisis.

## **Scope of case study**

The case study in this paper examines enterprise bargaining in private hospitals in Queensland during 1995–97 in the non-nursing sector. The case study sets out the enterprise bargaining method adopted by the AWU and private hospitals, and also assesses the outcomes of productivity bargaining on workplace efficiency. Two approaches to productivity bargaining 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. The case study analysis concludes by assessing the outcomes of enterprise bargaining and the importance of the bottom line.

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 Davis, 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, pp 124–5).

Productivity bargaining in health care therefore assumes greater importance as health services move away from institutional protection and monopolies and are exposed to greater market variation.

## **Defining productivity in health services**

Traditional approaches to productivity in human services have distinguished human services from manufacturing by reference to a number of dimensions such as the nature of the product; the intangibility of the service provided; the lack of inventory control; the inability to use quantifiable performance measures in human services; and the close proximity between producer and consumer services. However, such differentiation is somewhat artificial when compared to human service organisations such as hospitals. Hospitals are often large and technologically complex, store services as inventory in different forms (for example, storage of pharmaceutical, bandages, beds, surgical equipment and cook chill catering), and have close monitoring and quality control procedures.

Hospitals have a defined 'assembly' line or production process which is not that dissimilar to a manufacturing setting. In the case of a hospital, this involves the consumer as the object to be treated as they pass between different stages of interaction (for example, admission, accommodation, surgery, observation, catering, rehabilitation and discharging), depending upon the characteristics of

the patient. The search for productivity measures in such a setting is governed by five key factors:

- chronic illness or injury do not have clearly defined start/stop points for performance assessment
- many consumers of hospital services may have multiple episodes of care
- the quality, integration and coordination of care is important and determined by legally enforceable standards or at common law through a duty of care
- productivity measures do not often reflect the nature of the client community and prevailing community attitudes
- average hospital stays are becoming increasingly shorter as patients are discharged earlier. This places greater importance not only on how well care is delivered during the hospital stay, but also on the extent to which this standard of care is translated into the community, for example, in follow-up services (drawn from National Hospital Outcomes Program 1997).

The utilisation of performance indicators in health services often says more about the philosophies of the people who use them rather than the service being evaluated. For example, historically, hospital performance indicators have tended to focus on narrow technical aspects of health care delivery (such as technical proficiency, number of interventions and surgical procedures). More recently, there has been an attempt to introduce broader 'systems'-based indicators encompassing clinical outcomes, community acceptance of care, critical process measures and cost of care delivery (National Hospital Outcomes Program 1997, p 12).

However, identifying productivity measures in health care remains an elusive task. Different forms of indicators for assessing quality outcomes and care standards continue to be used. In the area of labour relations, management practices and labour use have been early targets for productivity analysis.

## **Efficiency and search for the hospital 'yardstick'**

Historically, 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, p 206). These techniques, based on scientific management, have their origins in the efficiency movement in the United States during the 1900s. This 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. 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 & Arches 1985, pp 176–8). Second, it initiated a growth in functional specialisation of technical and specialist occupations which have made health work increasingly collective and complex (Bellaby & Oribador 1980, pp 300–4; Rademaker 1980).

Initially, scientific management focused on hospital design. Changes in hospital layouts and patient ward structure fostered the more efficient use of nurse time by centralising patient care with tasks allocated between nursing and auxiliary workers. An outcome was to reduce the amount of time nurses spent on each patient and enable patient ratios to be increased. The changes in the physical design were comparable to changes in machine technology: the emphasis was on machine layout and not machine function, whereby nursing and medical wards are segregated along technological lines. The result is that the patient is transferred to various areas of the hospital depending upon the type of treatment and technology required (Reverby 1979).

Scientific management principles were also used to reorganise bureaucratic function of hospital units not concerned with providing direct patient care, for example, hospital laundry, kitchens, clerical and record-keeping, pharmacy, and general 'housekeeping', facilitating the employment of less skilled workers in these areas (Rademaker 1980). Efforts were made to standardise work organisation through the analysis of hospital methods, work organisations and work flow. This was achieved through breaking down work into separate tasks based on industrial methods. These included the use of process charts, flow diagrams, multiple activity and analysis work/task distribution, and work sampling (Rademaker, 1980). Man-machine systems analysis and design was applied to ward layout and work flow. Tasks were standardised and work (nursing) stations could be staffed by fewer nurses and the more routine and menial tasks could be performed by auxiliary health workers (Reverby 1979, p 23). In addition, changes in administration saw clerical workers assuming many routine clerical/record-keeping tasks which had previously been performed by nurses (Rademaker 1980).

More recently, support services such as laundry, waste disposal, food services/catering and cleaning have been systematised in order to standardise the service and maximise output (see, for example, a recent Queensland Health benchmarking project involving operational and food catering services).

Rationalisation of hospital health care also involved standardisation of human resources. Studies of operating (theatre) nursing, post-operative (recovery) and rehabilitation units were undertaken, the aim being to establish a methodology for determining optimum allocation of resources, length of patient stay and bed occupancy rates. The outcome was to subject health occupations such as nursing to greater formalisation – through written rules, regulations, procedures, job descriptions and evaluative mechanisms. Such worker differentiation has increased standardisation of work-related tasks, rules and policies (Timo 1989).

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 systems such as casemix and diagnosis related groups as a more efficient means of allocating and costing resources according to consumer health traits (Davis 1995, pp 129–30). 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 (that is, attempting to achieve cost savings), cut-backs in services and ward closures has again highlighted the growing need for more sophisticated approaches to organisational performance and measurement in the context of enterprise bargaining.

However, the impact of these measures do not flow evenly through the health system. While operational, non-clinical areas and nursing have undergone profound change, the impact on clinical support areas (for example, diagnostics and allied health) is more vexed, as many of these are contracted out to visiting health consultants. This case study focuses on operational areas covering ward support, food services/catering, maintenance, cleaning and laundry in Queensland private hospitals.

## **Industrial relations**

The health industry in Queensland is dominated by two 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 relevant to this case study which the AWU is respondent to is the Private Hospital and Nursing Home Employees Award – State. Other unions include the Australian Services Union covering clerical/administration workers and the State Public Services Federation covering allied health works such as physiotherapists, podiatrists and speech therapists.

Union membership in the industry is broadly divided between the QNU and the AWU, with actual numbers dependent on each hospital. The QNU, in conjunction with the Australian Nursing Federation, has over the past five years sought to introduce a professional career path for nurses. The AWU has concentrated on negotiations for a new industry award with rates of pay drawn from the public sector. The principal awards in the private hospital sector are the Private Hospital Nurses' Award – State (QNU) covering nursing classifications, and the Private Hospitals and Nursing Homes Industry Award – State (AWU) covering all operational classifications (domestic, kitchen, accommodation services, ancillary, technical and paramedical classifications such as theatre assistants). Historically, there has been a close connection between public sector and private sector wage rates for operation employees due to the early influence of the Boarding House Employees Award – State, which was a catch-all award for work that included a domestic and accommodation component. Since the early 1930s, the Boarding House Award has been hived off in favour of making specific hospital awards covering operational employees.

The Queensland private health and aged care employers are 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 two principal employer groups are the Aged Care Association of Queensland and the Private Hospital Association of Queensland (PHAQ).

The PHAQ was formed in the 1930s as the Private Hospital Association representing a diverse group of charitable (religious and denominational) as well as for-profit providers. By 1996, the PHAQ had 39 member hospitals out of a potential membership of 48. The PHAQ membership is diverse, with the denominational and religious hospitals making up the largest membership group. The PHAQ has traditionally focused on industry representation with government and has played a reactive role in industrial relations matters.

The PHAQ has traditionally sought to avoid the industrial limelight, focusing mainly on award matters and representational issues before the Queensland Industrial Relations Commission. This reactive approach changed during the early 1990s with the QNU campaign for the introduction of the 38-hour week in 1991 and the AWU pursuit of a new industry award in 1993. In relation to nurses, the PHAQ and the QNU reached agreement on a new award that allowed particular matters to be bargained at workplace level by PHAQ members. The AWU claim for a new award with the PHAQ was bound up as part of broader enterprise bargaining negotiations. This study focuses on the

processes involved in negotiating the new AWU award which was linked to the development of key performance indicators under enterprise bargaining. Under enterprise bargaining, the PHAQ has taken a more proactive role, seeking to achieve increases in efficiency and to implement the Coalition industrial relations reforms.

## **The AWU approach**

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 to which employees would be translated. Upon application by the Crown, this remuneration standard was approved by the Queensland Industrial Relations Commission on 3 July 1991, taking effect from 1 July 1991. These rates of pay were seen by the AWU as appropriate for the private sector, returning parity of wages between public and private sectors which was lost during the 1980s as a consequence of the decline in the use of comparative wage justice.

Following 12 months of negotiations, the AWU reached agreement with private hospitals through the 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 on 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 making 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 overseen 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 wage 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 process
- measures to ensure certainty in employment
- accommodating the needs of workers with family responsibilities.

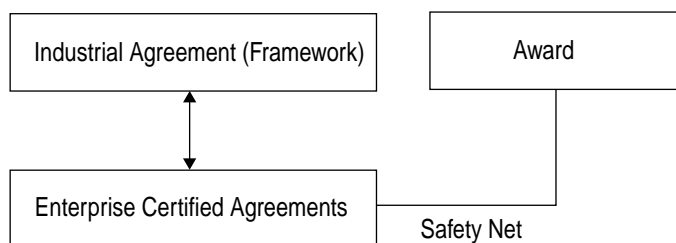
The industrial agreement was important to the overall success of the bargaining by providing a framework which:

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

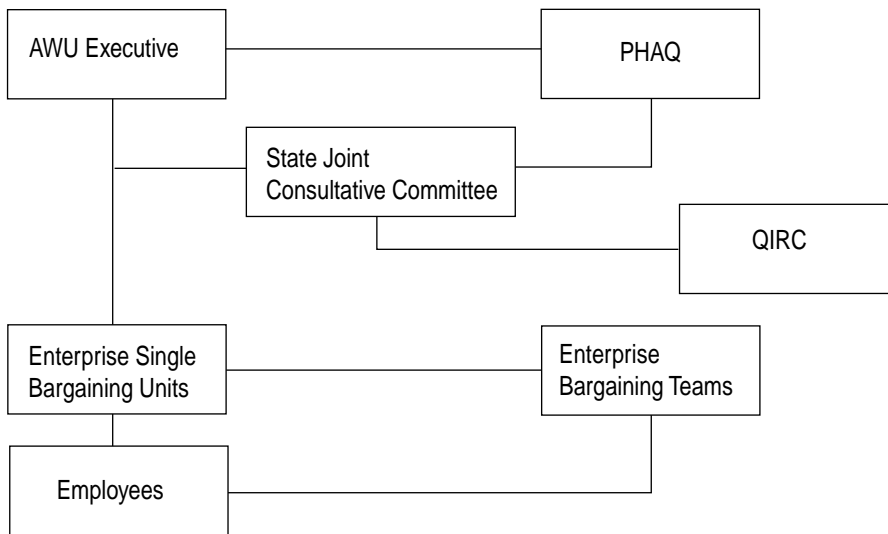
Figure 1 shows the relationship between the new Private Hospital and Nursing Home Award and Framework Agreement.

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

The above framework for negotiations guided the enterprise bargaining and workplace change process for private hospitals during 1995–97. 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 due to threatened



**Figure 1: Agreement making process**



**Figure 2: Structure of bargaining**

changes to aged care funding following the election of a new Federal Government. This left private hospitals as the only employer group involved in the bargaining process. This position also 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 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. Table 2 shows the size of the hospitals.

Private hospitals in Queensland are generally large (over 51 beds). Most private hospitals also provide a full range of services as described in Table 3.

## Productivity enhancement measures

One of the difficulties in determining performance indicators for hospitals is the lack of agreement and data on hand to compare performance. According to a report, the *First National Report on Health Sector Performance Indicators: Public Hospitals: The State of Play* (National Health Ministers' Benchmarking Working Group 1996), there is an absence of appropriate data on hospital performance. While a number of indicators exist, they often lack a clear breakdown of the elements used or are not integrated with other hospital objectives, such as service delivery and quality, and other hospital activities.

**Table 2: Hospital size**

Number of beds	Number of hospitals	Percentage
>200	5	12.5
101–199	13	32.5
51–100	10	25.0
21–50	7	17.5
1–20	5	12.5

The report, however, provided a list of the performance indicators which could serve as a benchmark. Table 4 summarises these indicators.

### **Performance indicators drawn from case study**

In relation to the case study, by the end of September, 40 performance agreements had been reached at local hospital level. Each contained a range of performance increases to be applied locally. These are grouped thematically and ranked in importance in Table 5.

As shown in Table 5, the main emphasis by private hospitals is associated with reducing operation costs and waste (ranked first and fifth). Patient/consumer satisfaction, best practice, staff training and labour flexibility ranked sixth, seventh, eighth and ninth 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 advanced by management was the desire of hospitals to keep trained staff rather than rely on casual and irregular labour. However, in practice, private hospitals have restructured their workforce by gradually shifting the work effort from permanent employees 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 enterprise bargaining pay increase) suggested an attempt to deal with this problem.

**Table 3: Sample of hospitals (n = 40)**

<b>Hospital</b>	<b>Number</b>
Surgical/Medical/Maternity	11
General Medical/Surgical	8
Surgical/Medical/Obstetrics/Psychiatric	17
Surgical/Medical/Obstetrics/Intensive and Coronary Care	4

**Table 4: Summary of hospital performance indicators**

<b>Category</b>	<b>Indicator</b>
Efficiency	Cost per casemix-adjusted separation
	Cost of treatment per outpatient
	Average length of stay for top 20 Australian national diagnosis related groups
Productivity	User cost of capital (depreciation + opportunity cost) per casemix-adjusted separation
	Ratio of depreciated replacement value to total replacement value
	Total replacement value per casemix-adjusted separation
	Labour costs per casemix-adjusted separation
Quality	Rate of emergency patient readmission within 28 days of separation
	Rates of hospital-acquired infection
	Rate of unplanned return to theatre
	Patient satisfaction
	Proportion of beds accredited by Australian Council on Healthcare Standards
Access	Waiting times for elective surgery
	Accident and emergency waiting times
	Outpatient waiting times
	Variations in intervention rates
	Separations per 1000 population

*Source:* First National Report on Health Sector Performance Indicators: Public Hospitals: The State of Play 1996, p 21.



**Table 5: Ranking of performance indicators**

<b>Performance indicator</b>	<b>Percentage</b>
Operational costs/energy savings (meet budget target)	39.4
Waste	29.5
Occupational health and safety/work-related injuries	21.3
Accreditation/quality standards	19.7
Absenteeism/turnover	19.7
Patient satisfaction/customer focus	19.7
Best practice/organisation effectiveness/TQM	18.0
Staff development/training	16.4
Labour flexibility/new work practices	14.8
Extra services/access	9.8
Mission and values/organisation 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 key performance indicators process was six months.
2. Operational costs include telephone, chemical costs, service delivery, stock control and energy use.
3. Waste include general and medical waste.
4. Occupational health and safety (OH&S) issues include OH&S training, knowledge of OH&S procedures, compliance with OH&S guidelines, workers' compensation premiums.
5. Labour flexibility include new work practices, rostering, multi-skilling, greater work effort.
6. Sample of key performance indicators: 164.
7. Percentages are based on the number of references in the sample agreements.

## Training

A majority of agreements appeared to place importance on training. However, such training remains generally firm-specific for operational employees, as illustrated in one hospital agreement.

### ***Clause 2.5 – Training***

*To assist the attainment of the objectives, it is agreed that further training will be provided to employees so that they are able to contribute to the objectives through improved skills as required to meet the changing needs of the hospital.*

*Experienced employees in each functional area will assist in training their fellow employees on-the-job and will participate in being trained in on-the-job training skills.*

The extent to which training and skills are regarded by managers as central to the success of the organisation remains questionable. If one accepts that the linkage of formal training to pay and promotion is an indicator of the importance placed on skills, the ranking of skills and training as being eighth in importance suggests that skill and training is not rated highly or, alternatively, skill formation is not seen as a priority.

## Work organisation

Most agreements saw improvements in work organisation in the construct of achieving lower operational costs and reduction in wastage and achieving quality standards. The introduction of productivity enhancement measures such as multi-skilling, training, job rotation and so on was not a key issue. It suggests differences between public and private sector health care delivery. Whereas public health has sought to achieve cost savings through effort-shifting (increased work effort and reduction in staffing), the development of cost accounting information systems in the private sector is more closely related to cost and activities. There is a stronger 'bottom line' profit measure in the private sector, as suggested in Table 5.

## Labour flexibility and working time flexibility

The introduction of labour flexibility and flexible working hours were ranked ninth in importance. It suggests that numerical flexibility is not a major issue. Private hospitals have already restructured their workforce with the most appropriate mix of weekly, sessional part-time and casual staff. Absenteeism is

a major concern and has been identified as a key area for activity. Employee consultation did not rate highly, perhaps due to the fact that each agreement was negotiated through an established consultative committee at workplace level.

## **How are the key performance indicators to be achieved?**

Almost all agreements contained provisions for monitoring the key performance indicators. Targets were often set at six-monthly intervals over a period of two years. Measurement techniques remained underdeveloped at the time of the approval of the agreement as these would be developed later. Indicators such as OH&S, turnover and training were to be measured on the basis of the number of staff undergoing training or upgrading, and the reduction in OH&S incidents. Overall, this aspect of the process remains to be developed.

In terms of specific targets not being met, most agreements contained the following clause:

### ***Wage increases***

*In the event that specific target performance indicators are not achieved; in the instances of the third and the fourth wage instalments, the Parties will meet to discuss and propose a wage increase or performance indicator adjustment, which takes into account all factors affecting the progress made toward achieving these targets. However if agreement cannot be reached between the 'Parties' on an appropriate wage increase, the matter shall be referred to the State Joint Consultative Committee for resolution. During this process, each party reserves their right to have the matter referred to the Queensland Industrial Relations Commission.*

*In the event that all performance indicators are achieved after the two year period, any shortfall remaining between what was paid for the third instalment and its maximum amount of 2.0% will be paid.*

As required by the then *Queensland Industrial Relations Act 1990*, each agreement provided for a grievance handling and disputes resolution procedure.

## **Discussion**

One of the primary objectives of private hospital 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 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. The focus is on identifying and reducing push-pull factors affecting operational costs. Despite the focus on cost reduction, the negotiation over performance measures did raise the awareness by hospital management of the importance of organisational performance.

However, the objectives in service delivery for hospitals cannot be simply defined and measured at point of delivery. Health service delivery and the hospital organisation represent a very complex service requiring care and quality issues to be paramount. Parts of this complexity relates to the routine of the input where service delivery needs to be tailored to the care of the individual. Thus a number of unique constraints on performance and efficiency outcomes in hospitals can be identified such as:

- *External factors:* These include demographic trends, morbidity, population characteristics, community perceptions and expectations.
- *Regulatory framework:* The health system is regulated by a complex matrix of laws and regulations covering educational standards (for example, medicine), occupational registration boards, legal controls over patient care, service delivery and funding.
- *Health insurers:* In private health, the financial dependence on health insurers determines which services will be provided and those that are not.
- *Bureaucratic:* Hospitals are large bureaucratic organisations involving a range of professions and occupations. Each is a stakeholder in the system.

## **Complications for stakeholders**

The introduction of enterprise bargaining in 1991 in Australia has forced employers and trade unions to seek wage increases at workplace level. The 1995 Enterprise Bargaining Survey shows that achieving cost minimisation through changes in working hours, penalty rates, work organisation, overtime and so on has led to increased work intensification and job-related stress. The adoption of key performance indicators was shown to be underdeveloped. For management, cost minimisation measures remain attractive as they can be translated quickly

into cashable savings. The introduction of performance indicators requires a realigning of human resource management systems and practices at both organisational and workplace level. To be effective, human resource management practices would need to be 'tuned in' to overall organisational performance extremes. This may require changes to training systems, recruitment and selection practices, planning, performance appraisals, communication, and a decision-making structure which is more democratic and participative.

The case study of productivity bargaining in private hospitals shows that management, at least in this industry, remains focused on 'bottom-line' issues where cashable savings are capable of being generated.

For employees, the benefits of bargaining remain vexed. In the present case study, the union played a key role in ensuring that a workplace consultative structure was in place within an overall industry level bargaining framework. This has the effect of shielding employees from the effects of concession bargaining.

The focus of the bargaining process on efficiency and productivity has meant that other important issues such as elimination of discriminatory workplace provisions (for example, equal pay), advancement opportunities, low pay, job insecurity, and occupational health and safety remain unaddressed in workplace bargaining. The introduction of even greater flexibility through the use of individual contracts under a Federal Coalition Government, which are effective from March 1997, suggests that management will continue to focus on bottom line bargaining as this has proven so successful in the past.

## **Conclusion**

This case study has attempted to provide a glimpse of workplace bargaining in private hospitals in Queensland. The process has been described and the performance discussed. In the private sector, the development of cost accounting systems are more related to cost and activity. This is illustrated in a cost minimisation approach to bargaining. This places a greater emphasis on bottom-line profit measures and provides a picture of strategies and imperatives in performance measurement and organisational change in private sector health.

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## References

- Allan C 1997, 'Labour utilisation in Queensland hospitals', unpublished PhD thesis, Griffith University, Brisbane.
- Australian Institute of Health and Welfare 1994, *Australia's Health: the Fourth Biennial Report of the Australian Institute of Health and Welfare*, Canberra.
- Bellaby P & Oribador P 1980, 'Determinants of the occupational strategies adopted by British hospital nurses', *International Journal of Health Services*, vol 10, no 2, pp 291–309.
- Davis A 1995, 'Managerialised health care', in S Rees & G Rodley (eds) *The Human Cost of Managerialism*, Pluto Press, Sydney, pp 121–35.
- Department of Industrial Relations 1996, *Enterprise Bargaining in Australia: 1995 Annual Report*, Australian Government Publishing Service, Canberra.
- Green R 1993, 'Analysis and measurement of productivity at the workplace', *Labour and Industry*, vol 5, nos 1 and 2, pp 1–15.
- Hall R & Harley B 1995, 'The Australian response to globalisation: Domestic labour market policy and the case of enterprise bargaining', in P Gollan (ed) *Globalisation and its Impact on the World of Work*, ACIRRT Working Paper no. 38, Sydney, pp 71–96.
- McKinlay J & Arches J 1985, 'Towards the proletarianisation of physicians', *International Journal of Health Services*, vol 15, no 2, pp 161–95.
- National Health Ministers' Benchmarking Working Group 1996, *First National Report on Health Sector Performance Indicators: Public Hospitals: the State of Play*, Australian Institute of Health and Welfare, Canberra.
- National Hospital Outcomes Program 1997, *Quality and Outcome Indicators for Acute Healthcare Services*, A Research Project for the National Hospital Outcomes Program Health Service Outcomes Branch, Australian Government Publishing Service, Canberra.
- Queensland Nurses Union 1995, *Measuring Productivity in Health Care*, Queensland Nurses Union, Brisbane.
- Rademaker A 1980, 'Technology, skill and social organisation in registered nursing', Unpublished PhD thesis, State University of New York, Binghamton.

Reverby S 1979, 'The search for the hospital yardstick: Nursing and the rationalisation of hospital work', in S Reverby & D Rosner (eds) *Health Care in America*, Temple University Press, Philadelphia, pp 206–25.

The Australian Workers Union 1995, *Key Performance Indicators and Enterprise Bargaining for Health Workers*, Brisbane.

Timo N 1989, *The Labour Process, Technology and Work Organisation: A Study of Nursing and Health Work*, unpublished M. Phil thesis, Griffith University, Brisbane.