Managing the healthcare workforce: cost reduction or innovation

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Abstract

Labour costs are the largest proportion of total costs in the health industry in developed countries and are a target in health sector reform. The Kennett government in Victoria introduced policies based on competition and cost reduction and the decentralisation of industrial relations through enterprise bargaining. These policies directly impacted on the health workforce leading to work intensification, labour shortages and poor morale. The Bracks government has since returned to centralisation. This paper argues that it is time for a more innovative approach to health workforce management based on recognising staff as an asset rather than a cost.

The context: labour costs in the health care sector

Over the past twenty years, governments throughout the world have become increasingly concerned about rising costs in the health care sector. This concern is due to fears that aging populations, increasing demands for services, greater expectations from consumers and new and expensive medical technologies and treatments will lead to unsustainable healthcare costs (Saltman et al. 1998). The largest component of health care costs in western health care systems is the cost of the labour force. The health sector has a highly educated, labour intensive workforce and in Australia the health care workforce accounts for over 70% of total costs (Duckett 2000).

Labour costs in the healthcare sector can be viewed from two different perspectives. One perspective is that – because it is such a large proportion of total costs – the labour force is a logical target for cost savings and policies must be developed to achieve such savings and reduce such costs (Thornley 1998).

The other perspective is that the health labour force is a major resource for the community, governments and organisations. According to this view, policies that focus on improving service delivery through innovative management practices and greater investment in the workforce could bring great benefit to both employers and employees and provide more effective and efficient services for the community as a whole.

This paper argues that governments have often focused on cost reduction at the expense of innovation and often lack a coherent policy to manage the health care workforce. My paper uses as an example the Victorian experience under the Kennett government between 1992 and 1999.

The Kennett government: a focus on cost reduction

The Kennett government had a philosophical commitment to the free market and introduced health and employment policies reflecting that commitment including privatisation, outsourcing, cost reduction in public services and deregulation of the labour market. The underlying ideology behind these policies is a belief that market forces are the most effective way in which to allocate scarce resources (Alford and O'Neil 1994).

On coming to power in 1992, it can be argued that the Kennett government believed that there were two major problems in the Victorian public health sector. The first problem was how to make the perceived high spending and unaccountable public hospitals more efficient and effective. The second problem was how to tackle the perceived inflexibilities in the health labour force in the face of strong trade unions and professional associations and a centralised and rigid industrial framework (Lin and Duckett 1997; Teicher and Gramberg 1998).

The government's approach was to treat hospitals as independent business units funded by throughput and episode-based funding underpinned by a commitment to pay devolution through enterprise bargaining. In this situation the role of government is to play a steering role through the use of regulatory frameworks and to contract others to carry out the delivery of services (Alford and O'Neil 1994). This 'arms length' approach impacted on the main parties in a number of ways.

(a) The Department of Human Services

Such an approach by its very nature led to strategies that were not managed coherently at the government level and led to long-term problems in workforce management. The government had no long-term strategy or vision for the management and development of the health workforce as according to the philosophies of competition this is an area best left to market mechanisms and according to arms length management workforce issues are the problem of hospital managers.

In the Department of Human Services there was no workforce planning branch. Also, the industrial relations unit, which had previously negotiated directly with unions on behalf of government, was moved out of the DHS and became the independent Victorian Hospitals Industrial Association in 1994 (VHIA 1999). The job of the Department's Human Resources Section became 'managing the industrial relations risk for the government' and was much more internally focused. The Human Resources Section continued the tradition of being quite separate from the Acute Health Division where many of the health policy decisions were made. This separation had the effect that health policy decisions were often made without recourse to the workforce management issues, and the industrial relations decisions were made independently to the policy directions of the Acute Health Division, which was ultimately responsible for funding any new enterprise agreements.

(b) Industrial relations

Another problem with the Kennett government's approach was that, despite the fact that many of its policies were proving to be problematic, the ideological commitment to these policies continued. One such area was in industrial relations. The role of government as funder of the public health system and therefore effective employer of staff was ignored in the drive to encourage enterprise bargaining. The government constantly attempted to keep out of the bargaining process, arguing that as it was not the employer this was not a government role. However, the trades unions, particularly those representing professionals, were able to exercise their power so that the government was constantly pulled protesting into the bargaining process. Actors in this exercise described it as a 'charade' or a 'pretence' or 'grand theatre' and saw it as time-consuming and wasteful (Stanton 2001a). At the same time, despite expressed commitments to autonomy in industrial relations, such autonomy was strictly controlled in practice. If a potential local agreement had cost implications for the government the hospital was told that it would not be funded (Stanton 2001a). Again this constant interference was time-consuming and wasteful. It also undermined local initiatives.

Because of lack of central planning, the interrelationship between industrial relations policy and health policy on the ground often had contradictory outcomes. For example, productivity gains through the introduction of casemix funding and budget cutbacks were often clawed back through the enterprise bargaining process. In the 1997 wages round awards were largely rolled over into enterprise agreements so the opportunity for award simplification was missed (Stanton 2001a).

(c) Employees

The government's focus on cost reduction strategies and lack of long term human resource planning were accompanied by a lack of recognition of the effect of such policies on employees and increasing problems of work intensification, labour shortages, and the consequent impact on staff commitment and moral (Considine and Buchanan 1999; Stanton 2000; Weekes et al. 2001). In some hospitals, changing management structures

and practices limited career paths and career opportunities for professionals (Ferguson 1998). In other hospitals opportunities were created as experienced staff left the industry and less experienced junior staff were promoted. Hospitals faced with increasing budgetary problems often cut back first on training and development with little thought about the long term implications of that course of action because long term workforce planning is not often a role of an individual organisation.

(d) Health organisations

The government's twin but unrelated strategies in the health and industrial policy areas led to a continuing contradiction between central and local initiatives. There was a lack of recognition of or concern about the impact of policies on the hospitals themselves. Lack of a central planning framework meant that one of the metropolitan health networks moved further towards the privatisation of services than even the Kennett government would have wished (Harkness 1999). There was no proactive support to hospitals for the management of staff and no government investment in local human resource management. There was no recognition of hospital problems in the staffing area, and no encouragement of training and development of staff (Stanton 2000). Also, because hospitals were still tied to short term funding rounds, long term human resource planning was difficult.

(e) Trade unions

The impact on trade unions was mixed. For unions such as the Health Services Union of Australia representing the hotel service workers, a combination of anti-union policies and budget cuts and outsourcing led to a union that turned in on itself and lost members dramatically. Other unions such as the Australian Nursing Federation (ANF) and the Australian Health Professionals Association grew in membership – and, it can be argued, in strength and influence (Stanton 2001b).

The government's response to the unions was contradictory. On the one hand its rhetoric and much of its legislation was anti union, on the other hand, at times the Kennett government took a more pragmatic view of the health unions. In the ANF's 1997 enterprise bargaining round, the Kennett government refused to become publicly involved in negotiations. However, throughout the dispute it was common knowledge that direct discussions had been taking place behind the scenes between the government and the union. Eventually the ANF intensified their campaign by imposing work bans in what Belinda Morieson, the ANF Victorian State Secretary, described as the most serious dispute since the 50-day strike in 1986. In September 1997, after the ANF voted to extend work bans, the Kennett government finally came publicly to the bargaining table.

The nurses were not the only health union who took industrial action during the Kennett years. The Medical Scientists Association of Victoria (MSAV) entered into their first ever statewide strike by public sector members and found latent power through their presence in key sectors, eventually they too forced the government to become involved. They won wage increases in line with nurses, protection of award entitlements against award stripping, paid maternity leave and a number of other improvements (Bremner and Kelly 2000).

The Australian Health Professionals Association took industrial action in 1997 and won similar wages and conditions and in 1999 forced a reluctant government to arbitration.

A mix of good and bad news

This paper does not suggest that all outcomes from the Kennett government's policies were poor. Measured productivity increased, there was increased accountability to government by hospitals for service delivery, there was some evidence of greater consultation between management and clinicians over work practices and some employers expressed some satisfaction in increases in some aspects of local autonomy (Braithwaite and Hindle 1998; Duckett 1995). However, these achievements must be considered against a legacy of labour shortages and a demoralised workforce that have made recruitment and retention of staff a major problem for Victorian hospitals.

Perhaps the last point to make here is that it should come of no surprise that the application of competitive policies to the health sector would lead to perverse and contradictory outcomes. The literature relating to market failure and health care quite clearly demonstrates the importance of government intervention. Health care is a

service not a commodity and consumers are not customers able to exercise consumer sovereignty in their choices in order to maximise their satisfaction. There is an imbalance in health information provided to consumers by health professionals that impacts on their choices of treatment, and suppliers can influence the demand of consumers through diagnosis and referral (McGuire et al, 1988). Health economists focus on rational planning through the use of economic evaluation techniques such as cost-benefit analysis rather than leaving allocation of scarce health resources to the market.

Assumptions underlying enterprise bargaining are that these enterprises are independent firms competing in the market place. Public hospitals are not independent firms trying to maximise profits: in fact they have no revenue stream that is independent from government.

Even in areas where there are independent firms competing in the market, there is not one model of enterprise bargaining. Rather enterprise bargaining structures vary from industry to industry and firm to firm, and there is no one size that fits all (Arsovska and Callus 2000). Evidence from other industries demonstrates that a move to enterprise bargaining was often the choice of managers who saw advantages in the process for their organisations (Wooden 2000). There is no evidence in the public health sector in Victoria that the move to enterprise bargaining was employer-driven. Rather it was government-driven and while some employers welcomed it others were less enthusiastic (Stanton 2001a).

The experience of other countries taking the same the same policy path could have identified potential problems. In the United Kingdom, attempts to decentralise industrial relations in the health sector had led to higher transaction costs, and lower levels of trust between managers and staff. These attempts were finally abandoned by the Blair government soon after it took power (Loewenberg 1996; Thornley 1998 Bach 1998). In Singapore, the corporatisation of public hospitals led to improvements in efficiency in the short term, but in the longer term higher physician fees and duplication of expensive medical equipment and high-technology services have led to the Singapore government to conclude that the policy '… was an example of market failure' (Hindle 2000).

In New Zealand, similar policy directions have similar outcomes and there is evidence that the creation of competitive models of service delivery led to less collaboration and sharing of information amongst health professionals (Malcolm et al, 1996). Southon and Braithwaite (1998) argue that market models of service provision undermine the autonomy of the health professional leading to decreasing commitment and poorer standards of service. According to Hunter (1996) there is a danger that such models lead to a 'contract culture' that replace 'high trust' relations with 'low trust' relations thus fundamentally transforming the notion of professionalism. Recent developments in the health care sector have emphasised other ways to achieve change in work practices, especially in difficult areas such as medicine. For example clinical governance strategies attempt to engage clinicians in restructuring clinical processes strengthening accountability and developing clinical practice guidelines in order to improve service delivery.

The Bracks government: clearing up after the night before

The Bracks government victory in 1999, while unexpected, was seen by many health workers in Victoria as an opportunity to right some of the wrongs done to the public health system. The new government inherited an industry that was in poor shape and its response has been to put more money into the sector, to re-emphasis planning including establishing a workforce planning section, put a greater focus on quality and not just efficiency, and on collaboration rather than competition. These are all policies to be welcomed.

However, there has also been a return to centralised industrial relations processes in the health sector and the government has been keen to allow the Australian Industrial Relations Commission to decide solutions to difficult problems. There can be some sympathy for the government's position. One difficult problem was the dispute over nurse-patient ratios in early 2001. This dispute was foreseeable but not easily preventable. Years of budget cutbacks and consequent work intensification under the Kennett government had led to a nursing workforce that was tired, demoralised, angry and in short supply.

The 2000 enterprise bargaining round with nurses came all too quickly and the last thing the new government wanted was a big fight with one of the groups it had wooed while out of office. At the same time there were

other groups of workers both in the health sector and in the public sector at large waiting their turn, and Treasury was not keen to allow wage increases that set precedents for others.

The ANF's industrial strategy of closing beds has the advantage of being effective in the pressure it places on hospital managements and government while at the same time able to be presented to the public as the union protecting the quality of service delivery. This strategy also put the government under great pressure from the community to act quickly to protect services.

The Bracks government reacted by passing on the issue to the Australian Industrial Relations Commission and the nurses did get a good deal from the commission in terms of the total remuneration package. However, the commission also handed down nurse-patient ratios, which although welcomed by the union were always going to be a problem for employers and the government. For many employers this judgement represented a return to a centralised industrial response linking employment with service delivery issues.

There can be sympathy for the employer's position. Nurses as well as other health workers are overworked and there is a need to control workloads. However, centrally determined nurse-patient ratios are a crude measure, not sensitive to patient acuity and not allowing for any discretion by nurse unit managers. In the really acute wards, one nurse to four patients is not enough; in others, it is not always warranted, depending on the patient mix.

To make matters worse, the ratio formula was handed down at the same time as a government review was taking place addressing nurse shortages. There was little consultation with the industry by the Commission and the question of how to fund the ratios also proved difficult. The Department of Human Services tried to find a path between the demands of Treasury for cost containment and those of the hospitals for greater numbers of nurses to meet the ratio targets. Some hospitals recruited more nurses to meet the ratios than the Department was willing to fund. In such a highly technical as well as contested area, it was inevitable that this process would lead to conflict.

At the same time, a crisis loomed in the aged care sector as nurses moved from there to the acute sector for better wages and conditions. Even the private sector is affected in the battle to recruit and retain nursing staff.

While the origins of this dispute were not with the Bracks government, there are some lessons that can be learnt. The Kennett government had ignored central government planning in favour of a reliance on market forces. What we have seen in this dispute is the logic of leaving workforce planning to market forces, and not just in nursing – radiographers and pharmacists are in critically short supply in the public health system. A workforce planning strategy for the health sector and a radical improvement in the way the many agencies of government work together on industrial issues are urgently needed. Those agencies also need to be working with employers and trade unions. Leaving conflicts until they turn into industrial disputes and then trying to resolve complicated problems in heated situations hardly ever leads to either the cheapest or the best solutions.

The need for innovation

Health policy and employment strategies based on cost reduction and competition can undermine innovation and creativity and lead to a demoralised and overworked health workforce. An alternative approach is to recognise the potential of the health workforce as a valuable resource that can be nurtured rather than a cost to be curtailed. This workforce comprises of highly educated, professional, and committed groups of people, and strategies that focus on working with these groups rather than against them are an investment for the future. However, for a government to invest in a workforce in this way is costly and therefore risky and can only come about if there is a vision and a commitment to the view that the long-term benefits in such investment will outweigh the initial costs.

Long-term investment does not mean just throwing more money at the industry. A more strategic response to managing the health care workforce is needed. Such a response would link workforce management and planning directly with the strategic health policy directions of both state and federal governments. In order to do this the different government departments involved in the process would need to work together.

A strategic response would also recognise the constraints of providing a publicly funded service and being honest about that. In a publicly funded service the government is the effective employer, and employment solutions that require extra money and resources are always going to come back to government for support. Why pretend

it is anything different? Instead, it would make sense to seek out new ways of dealing with central issues such as wages and conditions outside of the heat of an industrial dispute rather than during one. Working with the trade unions and professional associations could identify other models of decision making such as Pay Review Boards, or could take some labour utilisation issues out of the central bargaining process to be dealt with more flexibly at a local level perhaps within centrally determined guidelines.

An innovative strategy could encourage autonomy in areas that make sense – for example, in local human resource management functions. Such a strategy could support the development of strategic human resource management at local level rather than undermining it. Government officers could work with local health organisations to identify and support areas of best practice and promote them throughout the service delivery system.

The increasing emphasis on quality management in health care and clinical governance provides an opportunity to identify new ways of working together. However, it is difficult to sustain small islands of innovation in a sea of hostility or even indifference, and central encouragement and support of local people management initiatives can be of enormous value. Recognising that staff satisfaction is an important component in providing a quality service and that people are motivated by a range of factors not just money can have valuable results. Research from the private health care sector demonstrates that innovations such as the development of participative decision making can increase staff satisfaction and commitment but can be undermined by the same organisation introducing cost-cutting policies (Scott-Ladd 2001).

Similarly, recognising that some government policies can have a perverse effect on human resource management practices leading to undesirable outcomes means that such policies can be identified and contradictions resolved.

Finally, a comment from a human resources director of a large metropolitan network sums up the sentiment expressed in this paper.

> *'I think that the whole government's structure for health has been basically driven by accountants. It's basically around dollars and cents and that is not what is required to get reforms in the health sector. It's about partnerships, it's about relationships, and it's about getting learning processes established in the workplace. Its about people, it's about more effective problem solving. When you get those things happening I think that the dollars and cents will look after themselves. There's been a series of signals and a series of sort of management parameters that take the system in a particular direction and it's not the direction that it needs to be going in'.*

Footnote

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