

# Employment relationships in Victorian public hospitals: the Kennett years

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## Abstract

*From 1992 to 1999, the Kennett government in Victoria moved to competitive market models of service delivery and the measurement of service provision through casemix funding. Public hospital managers were given greater accountability for the costs and provision of service delivery and a new range of service providers, many from the private sector, entered the public health market. The decentralisation of the industrial relations system led to new developments in bargaining that brought both opportunities and problems. In the Victorian public health system there was an increasing emphasis on decentralisation in both service provision and employment relations. In this paper I suggest that there were contradictions in these developments for government, and new challenges and difficulties for employers, employees and trade unions.*

## Australian health policy in the 1990s

The 1990s have seen major changes in the management and organisation of Victorian public hospitals. These changes have been the result of a number of political and economic developments, one of the major factors being change in health policy, which has been a significant focus of both state and federal governments. Fears of increasing costs associated with an aging population, growth in new technologies, increasing consumer expectations, and the need to control supplier-induced demand, have led both state and federal governments to introduce health policies which seek better value for money through more efficient and effective health management systems. This is true not only of Australian governments but also of governments throughout the world (Twaddle 1996, Evans 1995).

At the same time there has been increasing influence internationally of 'neo-liberal' approaches to policy making. This includes a greater reliance on the use of market forces in the allocation of resources, utilisation of corporate sector management models and a decreasing role for government with a consequent cutback in government spending (Gardner, 1997:3).

Health care spending in most western industrialised countries is now a significant proportion of government spending in terms of gross domestic product. However, it is not an industry that is easy to change. There is strong support for universally accessible health care supported by public funds, and governments are susceptible to hostile public opinion in the face of dramatic changes in service delivery.

Western governments have adopted various approaches to health sector reform including increased new systems of funding and the introduction of markets and competition (Saltman et al, 1998:5). These approaches are evident within the Australian health care system where both state and federal governments have introduced policies such as the introduction of casemix funding and an increase in outsourcing of government services. Governments are increasingly withdrawing from direct provision and purchasing services from others. This purchaser/ provider relationship ostensibly separates out the role of government as purchaser of health services from that of provider of health services. Linked to this is the increase in the purchase of core medical services from private providers and the provision of public hospital services by the private hospital sector (White &

Collyer, 1998). Thus in Australia, governments are purchasing services from an increasing range of providers many of them from the private sector and in most states service delivery is measured through casemix funding.

## **Impact of health policy change on the management of Victorian public hospitals**

These policies have had a particularly strong impact in Victoria. The Kennett government was elected in 1992 on a platform of reform that included a commitment to cost cutting and downsizing in the public sector, the privatisation of public utilities and the contracting out of public services to the private sector. Other features of the Kennett government included a commitment to radical industrial relations reform and a sustained drive to reduce trade union power (Teicher & Gramberg, 1998).

The impact of policy change on the public health sector has been substantial. It has led to the restructuring of the sector, with amalgamations, relocation and closure of some health facilities, as well as greater responsibilities for strategic planning, financial control and industrial relations by the management of health organisations (MHPB, 1995) (Stanton, 1997). Victoria was also the first state to introduce casemix-based funding for all its acute hospitals in 1993. This has led to a changing relationship between hospitals and government departments, again placing an increasing responsibility and accountability on managers not only for output but also for a range of other management tasks (Duckett, 1994). The introduction of competitive tendering has led to a number of services being tendered out to the private sector with the consequent impact on the terms and conditions of employment of the workforce as well as staffing levels. These have included 'hotel services' such as catering, laundry, and cleaning and diagnostic and clinical functions such as radiology and pathology (Armstrong 1995; (White & Collyer, 1998).

These changes were introduced at a time of substantial budget cuts to the public health sector, putting health facilities under greater pressures to increase their outputs while coping with declining budgets (Davies 1998). In the late 1990s the Kennett government invited private sector organisations to tender for the provision of core public hospital services. Latrobe Regional Hospital was the first example of a private-for-profit company providing public hospital services in Victoria although not the first in Australia (White & Collyer, 1998). The government was keen to further such developments as part of the Austin and Repatriation Medical Centre/Mercy Redevelopment Project and expressions of interest were sought for the new Knox, Berwick and Mildura hospitals.

Some of the arguments for the greater use of market mechanisms in health care are that managers are made more accountable for cost control, the efficiency of service provision and the quality of the services that they provide (Duckett, 1994). However, others have expressed concern that such approaches lead to sources of tension and conflict as hospitals faced with the need to increase throughput within restricted budgets cut back on resources including staffing levels and seek to minimise salary rates of workers (Braithwaite, 1997:9, Braithwaite and Hindle 1998).

Hindle (2000) argues market competition does not necessarily lead to more consumer-focused and efficient services. In Singapore, corporatisation of public hospitals led to improvements in efficiency but physician fees rose dramatically and there is widespread duplication of high technology and medical equipment and services. In Malaysia, the government had to retreat from a policy of corporatisation following public opposition from professional bodies.

Paton and Bach (1990: 266), commenting on outsourcing in the UK's National Health Service, argued that "... the labour movement's analysis suggests that financial savings are only achieved at the expense of a reduction of staffing levels, worse terms and conditions of employment, and lower standards of service."

The issue of lower standards of service is controversial. There is no agreement as to the impact of privatisation on the quality of service delivery. White and Collyer (1998:488) argue 'that there is a noticeable lack of evidence that the private sector per se, is more capable of providing better services with greater efficiency.' Even the Industry Commission, while promoting competitive tendering and contracting, concedes that '... from the studies that have been undertaken both in Australia and overseas there is little consensus on the impact of

contracting on the quality of publicly funded services' (Industry Commission, 1996:124). Despite the lack of evidence of the benefits of the use of market approaches to the provision of health care services, Victorian health policy under Kennett shifted firmly in this direction.

It is unclear how these developments have impacted on employment relations in Victorian public hospitals. The establishment of the Metropolitan Network Boards in 1995 meant that all public hospitals in the metropolitan region became part of a larger health care network. A number of community health centres also integrated into these networks. In most cases the networks became the employers of staff rather than the individual hospitals and as such are legally responsible for industrial relations and human resource management (Adeney, 1997). The Victorian government has never been the legal employer of hospital staff although it does provide a framework of control through the Public Sector Management and Employment Act 1998.

In the networks, many employees are covered by enterprise agreements, others by existing federal awards and some, but very few, by Australian Workplace Agreements (AWAs). Many hospital services, such as cleaning, catering, laundry, and pathology and radiology have been put up for tender and outsourced in some cases, and the employment relationships of these employees will be governed by an entirely different set of employers, some with no previous health industry experience. Government policy was to encourage a new range of operators to move into the health sector through private sector partnerships. Some of these operators are subsidiaries of major private hospital chains and multinational companies (White & Collyer, 1998).

Thus it has become increasingly difficult in the public health sector to identify exactly what is the enterprise or who is the employer. The identification of the enterprise and the employer is an essential one in employment relations. It is from the relationship of employer and employee that a number of legal and financial rights and obligations flow. At this point, health policy developments and industrial relations changes become interrelated.

## Changing industrial relations structures in the health care industry

Employment relationships in the health sector have been affected by the pressures of globalisation and international competitiveness which have led to microeconomic reform and structural adjustments, with an emphasis on improved productivity and efficiency and the subsequent decentralisation of industrial relations (Rimmer, 1995). The Australian Institute of Health and Welfare states that the health labour force is now more efficient and productive than ever. In 1996 fewer hospital staff treated significantly more patients at a much higher rate of patient turnover and declining average length of stay (AIHW, 1998b:181)

However, industrial relations in the Australian health care sector is poorly researched compared to the manufacturing sector (Braithwaite, 1997:3) so the full extent of such developments is difficult to assess. Apart from some notable exceptions (Fox 1998, McCoppin 1994) until comparatively recently there were few empirical studies.

Recognising this lack of empirical research, Braithwaite (1997) disaggregated the health sector data from the 1990 Australian Industrial Relations Workplace Survey and followed it up with two in depth case studies. He found an industry with an unclear locus of workplace managerial control. Although within the workplace the financial, business and strategic performance rests with management, patient care processes rest with health professionals and particularly with doctors (Braithwaite, 1997:129). Unlike their counterparts in manufacturing, managers often had little control over the production process. He also found an increasing adoption of new technologies had affected pace and complexity but had not lead to deskilling, in fact he found the opposite was happening with upskilling and specialisation taking place, thus increasing the potential control of medical specialists (Braithwaite, 1997:128). This trend is borne out by recent evidence from the Australian Institute of Health and Welfare (AIHW, 1998b:181).

Braithwaite (1997:133) also describes an industry in which, for workers and managers, responsibility for industrial relations has traditionally happened away from the workplace. He found working conditions were less flexible and more bound by awards than other industries. He also provides a picture of an industry having to cope with major change due to pressures of increasing demand for services at a time of shrinking resources. He argues that resources were becoming tighter in the 1990s with greater pressure for workplace reform, and health service managers were becoming more strategic and less operational. He also found that health managers were seen by unionists as less likely to consult over change than their counterparts in other sectors.

Braithwaite's research took place soon after the introduction of casemix-based funding and competitive markets, but before the election of the Federal Coalition Government in 1996 and the introduction of the latest round of industrial relations changes. Commencing in the 1980s, a series of legislative change culminating in the Commonwealth's Workplace Relations Act and Other Legislation Amendment Act 1996 has created an industrial relations environment in which centralised systems of decision making are being slowly dismantled and trade unions are no longer seen as an essential part of the process (MacDermott, 1997).

This has had particular implications for Victorian workers. Originally the Kennett government introduced its own form of industrial reform through the Employee Relations Act 1992. This act was far more radical than the model of managed decentralism followed by the Keating Federal Government of the time and abolished state awards replacing them with collective and individual agreements. However, the Kennett experiment floundered when the federal government enacted legislation making it easier for workers on state awards to move to the federal arena (Fox et al 1995). This avenue was utilised by most health unions. Thus the election of the federal Coalition government in 1996 with an increased emphasis on workplace bargaining through the introduction of the Workplace Relations Act 1996 has had a direct effect on health workers in Victoria.

It can be argued that the managers of health care organisations now have greater flexibility to negotiate with their employees (on behalf of their organisations) terms and conditions of staff employment that are 'tailor made' for their situation. According to this premise centralised bargaining should be a thing of the past as bargaining moves to the enterprise level. As the largest single cost of delivering health services is labour which average approximately 70% of costs in the acute sector (AIHW, 1998a:25) these powers should theoretically allow health service managers new freedoms to maximise efficiency and productivity.

## **Decentralisation and employment relationships in the public health sector**

There have been two distinct and clear trends in health policy and industrial relations, both focusing on decentralisation and ostensibly moving the onus of management control to the enterprise level. There are a number of fundamental contradictions with this move from a central to a local focus. The first is an employment relations issue which relates to the relationship between the legal employer and the effective employer. As Fox argues, in the public health sector although the legal employer may be the hospital (or now the network) the effective employer is the funding body - that is, the government. She argues that 'he who pays the piper calls the tune'. Through her analysis of five major industrial disputes in the health sector and the complex relationships between the employers and employees involved in the disputes and the government she concludes that '... centralised bargaining is inevitable when significant financial costs are involved and funding is controlled from a central source, the effective employer, as distinct from the legal employer' (Fox, 1996:27).

It is debatable how much real control the legal (the local) employer has over employment relations. When significant new costs are likely (for example due to a wage demand) there will be pressure to involve the effective employer (the centre). Here lies a contradiction for governments. Universal access to publicly funded health care is highly valued by the general public. If a government keeps out of the bargaining process but still controls the purse strings, it runs the risk of being forced to accept ultimate responsibility as the public comes to believe that the government through its intransigence is undermining their access to health care. If governments enact essential service legislation to prevent industrial action and avoid industrial issues being brought to the attention of the public, they undermine the bargaining power of health workers, and the ability of health workers to negotiate or agitate for improved terms and conditions is constrained. If real collective bargaining is limited and other appropriate industrial relations mechanisms are disbanded the terms and conditions of health care staff are likely to be eroded with a consequent loss of morale and the potential for further political costs. There is an ongoing tension between this central and local relationship. This situation was highlighted in the 1997 nurse's dispute in Victoria, where the ANF won a considerable victory by forcing a reluctant government to the bargaining table (ANF, 1997).

The decentralisation of industrial relations in the health sector is problematic. If government is the effective employer of an essential service it has to have some control. Devolving all powers particularly remuneration to the enterprise level may only create more problems in the long run. Britain has discovered this in relation to the NHS Trusts. The Blair Government has signaled its intentions to return to a system of national pay

determination matched with local flexibility over human resource issues rather than have a myriad of complicated relationships (Government Stationary Office Ltd, 1997:50).

It is not the first time that the centralisation of industrial relations in the health sector has come under scrutiny. In the early eighties Sethi and Dimmock examined the centralisation of industrial relations systems in relation to the U.K. the U.S.A. and Canada. They concluded that the largely centralised (at that time) National Health Service in the UK was developing some flexibility at local level and the largely decentralised systems of North America were becoming more centralised. They concluded that ‘... although collective bargaining in the health sectors started off by being decentralised in North America and centralised in Britain both are moving towards a similar state of fairly centralised bargaining with accommodation of local needs’ (Sethi & Dimmock, 1982).

There is a similar contradiction in relation to service delivery at the enterprise level. On one hand, the Kennett government wanted less control and an arm’s length approach to service delivery (‘steering not rowing’ (Osborne & Gaebler, 1992:30)). The developments around competition emphasis this approach: providing services becomes the job of someone else at a more local level, while the government develops the framework for service delivery. Ostensibly it would appear that the developments in relation to privatisation lead to less government control as more enterprises with aims and objectives relating to profit making rather than universal access to health care move into the provision of services. However, it can be argued that the government actually wants and needs more control and the developments around casemix funding emphasis this, as it seeks greater accountability for public spending. This is particularly true in the provision of clinical services. While the largest occupational grouping in the health sector is the mainly female nursing profession, the most powerful group is the predominantly male medical profession (Braithwaite, 1997:10). The medical profession in particular is able to initiate demand for its services and largely controls the production process in health organisations. Developments in the area of economic evaluation, clinical practice guidelines, best practice and performance indicators are all examples of governments seeking greater control not only of expenditure but also of the production process. Better understanding of the production process in health care will enable government to have greater control of expenditure.

Employers are faced with similar contradictions. Much of the debate around the new industrial relations environment revolves around the opportunities for greater efficiency and productivity through the adoption of efficient and flexible work practices by agreements being tailor-made to particular establishments. One of the main benefits for employers is the potential for greater flexibility in the deployment of staff, new shift patterns, multiskilling, broad job categories, performance based pay and individual contracts (AWAs) for particular individuals and groups. However, these take time, money and expertise to negotiate. Coupled with the potential for greater conflict over remuneration, and over control of the production process, it may be that the transaction costs of local bargaining outweigh any productivity and efficiency gains. Again the experience in the UK is pertinent; the reluctance to inaugurate local bargaining by many NHS Trusts and particularly with doctors would suggest this to be the case (Loewenberg, 1996).

Similarly the contracting out of services might be beneficial to an employer. It means that they are no longer responsible for the terms and conditions and the day to day management of a group of staff. Instead they are concerned that the agreed levels of service delivery and the quality of that service delivery are maintained. However, the monitoring of these contracts and the cancellation of unsatisfactory contracts can be time consuming and costly thus counteracting any benefits in the long run (Paton & Bach, 1990:266).

For employees, the benefits of more flexible working conditions and the opportunity to have an input into the development of their own agreements might be outweighed by less experienced people bargaining on their behalf or the difficulties of bargaining for themselves. They may find greater job insecurity, poorer terms and conditions, less equity in the workplace and poorer standards of occupational health and safety. The experience in New Zealand identified by the New Zealand Nurses Organisation would support these contentions and the Australian Nursing Federation has been instrumental in bringing these concerns to the attention of its membership (Blake, 1997).

There are similar concerns in relation to the contracting out of services. Trade unions have consequently negotiated agreements with the Health Care Networks that lay ground rules for the contracting process and protect the jobs and terms and conditions of existing staff (AHPA, 1998).

For trade unions the issues are about survival. They were operating in an environment with extremely hostile state and federal governments. Have they become less relevant as more and more individuals and groups bargain for themselves? Does bargaining with a constantly increasing group of employers become physically impossible for them as more and more services are moved to the private sector and the industry becomes more decentralised? This is a particular risk if they lose their membership base and therefore their revenue declines. Or have they become more relevant as people realise the difficulties of bargaining for themselves and value the expertise of experienced outsiders and the strength of collective rather than individual action. This is even more likely for employees who are facing employers who are under intense and continuing pressure to reduce costs and increase productivity and possibly make a profit, and rather less pressure over the quality of care produced and less concern for the wellbeing of their staff.

There has been a low level of take-up of individual agreements in the form of AWAs in the public hospital sector. Out of 195,800 employees in the Victorian health and community services sector (ABS, 1998) in the period from March 1997 to June 1998 only 48 AWAs covering 30 workplaces were registered with the Office of the Employment Advocate. Of these only 24 AWAs in 10 workplaces were in the public health sector. The majority of these agreements covered either managerial positions or maintenance jobs. Research currently being undertaken on unpublished data from the Office of the Employment Advocate indicates there is no evidence at the moment that they will be utilised on a large scale by nurses, doctors or allied health professionals. Whether this is due to employees being influenced by their unions arguments based on New Zealand experience or whether it is employer resistance to the time consuming processes involved in negotiating and administering AWAs is not known.

## Conclusions

The present system of employment relations in the public hospital system in Victoria is complex. Whether it is likely to increase in complexity in the near future depends on the direction of the new state government in relation to health and industrial relations policy.

Evidence from overseas and interstate, and comment from Victorian trade unions, would suggest that decentralisation and privatisation are detrimental for employees. Also, while there may be an increase in control and flexibility of employment relationships for employers, the increased responsibility for cost control and increase in transaction costs might undermine any benefits that could be gained.

Trade unions in the health sector will face new challenges, particularly if new players (many from the private sector) increase their share of the public health market. These new players might become involved in a process of pattern bargaining as unions make agreements with one set of employers and seek to replicate those agreements across the state. On the other hand, new employers might take a more adversarial approach to labour relations, refusing to recognise existing agreements and insisting on the development of new enterprise agreements or AWAs which extract increased concessions from staff in the search for greater productivity. Although the new government is no longer encouraging AWAs in the public service, there is no barrier to public and private health employers moving further down this path.

However, the new government may prefer to revert to a more centralised process, with (say) the Department of Human Services and the employers' industrial group (the Victorian Hospitals Industrial Association) playing a central role. The VHIA has claimed that it '... played a far more significant role in the enterprise bargaining "experience" of 1997 that anyone was prepared to acknowledge in early 1997' (VHIA, 1998). The role of the VHIA might be to negotiate core agreements that become a framework for more localised bargaining around their particular implementation. This would not be too different from what has happened in reality and is similar to the process envisaged in the United Kingdom. Another important advantage of such a centralised approach by 'legal' employers is that it gives collective strength for the lobby of the 'effective' employer, that is government, for further funding through an industrial organisation with expertise and experience.

Regardless of the scenario that eventuates, governments will remain the funders of public health services and therefore in effect have ultimate control over the provision of services. The effects on employment relationships therefore depend on developments in health policy. In Victoria, these policies have led to a tangled web of

public and private health care providers, and the new government might discover the costs of trying to manage this process outweigh any benefits gained.

The impact of the previous government's policies on employment relations in the public health sector is unclear and needs further research. However, it is clear that the tension between central and local relationships in the health care sector will continue until addressed by health and employment policies that are based on the understanding of the real issues and needs in the health care sector. Such policies would need to take into account not only the needs of governments, employers and employees but also of consumers who are the recipients of health care and are often absent from this discussion. Only time will tell if the new government is able to take on this challenge.

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