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Enterprise Bargaining and Work Intensification: an Atypical Case Study from the South Australian Public Hospital Sector

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Abstract

This paper explores the relationship between enterprise bargaining and work intensification through a case study of bargaining between the Australian Nursing Federation and the South Australian Department of Human Services. The third enterprise agreement between these parties, signed in 2000 to operate for three years, included an agreement by the department to staff public hospitals according to Excelcare, a computerised nursing workload program interfaced with rostering and costing products. The outcome was the de-intensification of work for nurses despite shrinking budgets, nursing shortages and the usual understandings that enterprise agreements should increase productivity and efficiency. Central to this atypical case was the process by which nurses and their union learnt from previous experiences with enterprise bargaining and with Excelcare, and the role of middle-level nurse managers, who assisted in the gathering of detailed data that was required to advance the nurses' cause.

Introduction: enterprise bargaining and work intensification

The relationship between enterprise bargaining and work intensification is both important and problematic. Much of the early research on enterprise bargaining in Australia either explicitly argued or implicitly assumed that workers would be worse off because this system shifted the ground for salary increases by linking them specifically to increased effort (Morris, 1996). However, there are few studies that directly investigate the process and outcomes of bargaining and their impact on work intensity. Allan et al., (1999), for example, provide compelling evidence that work intensification is one of three major trends in recent work relations in Australia and that it has increased employee dissatisfaction and stress at work, but they do not address the role of enterprise bargaining in advancing these trends.

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The analysis offered by ACIRRT (1999) suggests that the enterprise bargaining process has not been central to those aspects of work restructuring that might result in work intensification, such as multi-skilling, up-skilling and the reduction in staff numbers. Rather, most enterprise agreements have been confined to negotiations over wage rises and flexible hours of work, not work intensification:

> The restructuring that has been a feature of organisational life for over a decade has largely been achieved outside the formal industrial relations system ... These changes have been introduced by management without the input from external third parties such as unions and the Australian Industrial Relations Commission ... (ACIRRT 1999:54)

These changes have also been brought about with little consultation with workers. Given this, it appears that enterprise bargaining has become an avenue for some workers to negotiate for improved wages and working conditions that might compensate for the fact that they are now working harder.

Research in the health sector about whether or not enterprise bargaining has resulted in increased work intensification, or for that matter productivity and efficiency gains, also suggests problematic outcomes. Stanton (1999), for example, shows that while federal and state governments have seen the enterprise bargaining process as a mechanism for ensuring increased efficiencies and productivity, the outcome has been more complex. Her research on enterprise bargaining in Victorian public hospitals during the Kennett years (i.e. 1992-99) indicates that enterprise bargaining was not itself a mechanism for work intensification but rather it served as a vehicle by which unions tried to win back conditions lost through other cost-cutting processes, such as redundancies, the introduction of casemix forms of funding, real reductions in budgets and the outsourcing of services such as pathology and radiology.

Allan's (1997) research on Queensland hospitals reveals significant work intensification, but again there is little to implicate enterprise bargaining. Rather, governments of both political persuasions endeavored to bring about increased productivity and efficiencies into this sector. The two major vehicles for this were the introduction of casemix forms of funding based on output rather than historical funding models and the various funding incentive measures built into the last two Medicare Agreements (Allan, 1997). In both Medicare agreements, while funding increased, it was tied to performance outcomes such as reducing waiting lists for elective surgery and for patients in causality departments.

Some commentators have even argued that the principles of enterprise bargaining do not readily translate to the public health sector (Harrison and Pollitt, 1994). Enterprise agreements tied to increased productivity and efficiency gains assume a share in generated profits. In the public health care sector what is produced is a service, not a product and staff are increasingly having to deliver this service with capped or reduced budgets (Braithwaite, 1997).

Thus, literature – both within the health sector and more broadly – suggests two conclusions relevant to this paper. First, work intensification has been common during the period when enterprise bargaining has become dominant in Australia and this is detrimental to many employees. Second, mechanisms other than enterprise agreements (especially managerial unilateralism) have been more central than enterprise bargaining itself to the progress of work intensification – indeed, the most likely role for enterprise bargaining is as a potential means by which some employees gain compensation for the work intensification with which they are confronted.

This paper presents a case study that questions these two points. Nurses working in public hospitals in South Australia (and particularly in one hospital) have been able to reverse the trend towards work intensification and they have used the enterprise bargaining process to achieve this end. Furthermore, the story of these events in South Australia suggests two broader factors that may shed light on the problematic outcomes of enterprise bargaining. First, while enterprise bargaining might well disadvantage many employees, this is not an inevitable outcome. In particular, there may well be a learning process by which employees take time to learn how best to advance their interests using enterprise bargaining. Embedded in this factor is the realisation that as the workplace continuously changes new areas for negotiation emerge. This is particularly so for public hospitals given the federal government has allocated significant amounts of funding for innovative forms of service delivery through the National Demonstration Hospital Program (NDHP). It is the innovations introduced through programs like the NDHP that have invariably led to new ways of working and work intensification – and to new opportunities for employees to renegotiate their lot.

The second factor concerns the (often contradictory) role of middle management in the relationship between enterprise bargaining and work intensification. While middle-level managers may often work with senior managers and contribute towards work intensification, the opposite can also happen. Indeed, in the case study presented in this paper there is evidence of opportunistic action taken by middle management in the interests of workers. This role for middle management may be predictable in the health sector, given that middle managers invariably come from within nursing, medicine or allied health occupations and in most instances maintain strong loyalties to their professions (Harrison & Pollitt, 1994), but it may also be more widespread than the existing literature suggests.

Data for this paper are drawn from a larger ethnographic project conducted between 1997 and 2000 in a major public acute teaching hospital in South Australia, called Western. The research project included six months of intensive fieldwork on two wards, interviews with key informants over the following two years and attendance at on-site union meetings over a six-month period in 1998.

Excelcare: measuring the nursing workload

Excelcare is one of probably hundreds of nursing workload products, which vary from those that focus on "dependency levels" as the basis of their calculations to those – like Excelcare – that use timed "units of care" (UOC) or measure "patient acuity". Despite these differences, the basic approach is similar. The workload and staffing is calculated by multiplying the range of nursing tasks by the number of minutes required and then by the number of patients. Weights are apportioned to each task/indicator and the average time for completing these tasks is built into the computing system. The underlying assumption is that shift-by-shift reporting of the timings allows management to reorganise staffing to cope with changes in the intensity of the work, but also to develop refined benchmarks for staffing. Nurse managers use Excelcare to predict staffing levels on a roster-by-roster basis, as well as in response to seasonal changes in illness patterns.

The timings in Excelcare are determined through time and motion studies, with clear guidelines on when to start the stop watch and how the task should be recorded. Each UOC has a precise time attached to it. For example, the UOC "removal of cannular" is seven minutes, while a blood transfusion is 32 minutes. Nurses may "time-adjust" where there is clear evidence that in performing a task more than the allocated time has elapsed, but this is generally discouraged. The time allocated to a task is further divided by who performs it; if an Enrolled Nurse (EN) completes the task, it is cheaper than the same task done by a Registered Nurse (RN). Nurses are allowed three minutes to key in each patient's units of care and nurses have a personal password that allows them to enter the program and key in the data. This allows management to know who is delivering the UOC. As a consequence, Excelcare is also a quality assurance tool that provides detailed data on the care planned and delivered. It is possible to do a retrospective audit on which nurse provided adequate care over the three daily shifts for a patient's episode of care and pinpoint problems. This allows a multiplicity of nurses to care for any one patient, but for the detail of each nurse's care to be available.

Enterprise bargaining and Excelcare in public hospitals in South Australia

Excelcare was introduced into the fifteen major public hospitals in South Australia in 1992 under a "Heads of Agreement" between the South Australian Health Commission (as it was then known) and the Australian Nursing Federation. The union's support for the agreement was premised on transparent research that secured accurate timings and a belief that the product would provide rational and equitable staffing based on the evidence. On the Health Commission's side, the introduction of Excelcare, which was part of a wider Information Technology strategy, was motivated by the recognition that nursing salaries constituted one-third of public hospital budgets in the state and the need to achieve efficiencies and savings through better nurse rostering and clinical management practices (SAHC Report 1995). The Heads of Agreement committed the hospitals to achieving a two percent salary saving over the five years of the project life, based on 1991/92 costs (SAHC 1995). This was achieved at Western by 1995. The

SAHC Report (1995) notes that Excelcare enables time saving in the production and review of nursing care plans and saves time through standardisation of plans. What the trial and agreement also attempted to achieve was standardisation of staffing across all the major state-funded hospitals.

Nurses in South Australia subsequently engaged in three rounds of enterprise bargaining, with the resulting enterprise agreements spanning the years 1996-1998, 1998-2000 and 2001-2004. In all cases, agreements have been state wide rather than site specific. While hospitals were common law employers, any employment condition negotiated with the various professional and occupation groups had to be consistent with the *Public Sector Management Act* of 1993. As a consequence, the right to negotiate was centralised and bargaining took place between the relevant unions and the Health Commission, or more recently the Department of Human Services (DHS). All three enterprise agreements included provision for the management of change in order to achieve increased productivity and efficiencies, although given that the agreements covered nurses working across the entire sector, the desired changes are not specified. Rather, the agreements focused on salary increases and working hours, leaving efficiencies to be resolved locally.

The experience of Western was typical of the process by which the agreements were implemented. Following the 1996 agreement, for example, senior management at Western established working groups to facilitate the management of change. Meetings of these groups were regularly reported in internal newsletters at Western, but staff argued that they had little impact on the change process. This may well be because a more powerful process was at work. The casemix model of funding was introduced into all South Australian public hospitals in 1994 with a $15 million reduction in the public hospital budget (Brooker, 1997). At Western, over one hundred nursing positions were lost in the first twelve months following the shift to casemix, although not all of those positions were clinically based. Coupled with this was a more concerted shift by the state government to reinforce the Medicare incentive-based funding model, which tied access to additional funds to reduced patient length of stay, waiting list times for elective surgery, waiting times in Accident and Emergency and increased patient throughput. Set targets based on the 1994/95 output were established and funded at 1992/93 rates (Brooker, 1997).

The 1998 public hospital enterprise agreement for nurses dealt with a range of work-time issues, including the question of work intensification. Work-time issues are very clearly delineated for nurses. While some nurses might work a double shift and it is rare for staff to complete all the work for the shift exactly to the hour, the fact that the shift is handed over to another team of nurses restricts overtime. However, getting the work done on time is a major issue and this was the consistent subject of monthly union branch meetings, along with the discrepancies in Excelcare staffing ratios. As a consequence, the enterprise bargaining negotiations were taken very seriously. When agreement was not reached with the DHS, industrial bans were imposed for five days, with the union ordering skeleton staff; i.e. night duty staffing numbers only. Over the

five days of the dispute one in five beds was closed each day of the work to rule before the DHS agreed to union demands (ANF Bulletin, 1998).

The resulting enterprise agreements produced a number of benefits for nurses, including:

- salary increases that brought South Australian nurses into line with their counterparts in Victoria,
- maternity leave,
- additional payments for those nurses in rural areas who were required to be on call,
- new arrangements for paid days off,
- directives for meal breaks,
- additional days of leave to care for sick children and other family members, and
- a complex arrangement for those staff who found themselves working on public holidays. (ANF Campaign, 1998)

All these gains were introduced at least partly in response to work intensification, although they clearly dealt more directly with the number of hours worked rather than the intensity of the work effort. In this way, the 1998 enterprise agreement failed to establish a precise procedure for avoiding work intensification. The agreement dealt with days off work as a solution to work intensification rather than addressing the issue directly. To the extent that it regulated them, staffing levels were provided for under s.10.11, details of which were outlined in appendix C of the agreement:

> 1. The parties are committed to ensuring that, wherever possible, sufficient numbers of appropriately qualified nurses are available to meet the assessed needs of patient/clients.
>
> 2. Accordingly the parties agree that for the life of the agreement staffing arrangements should, where possible, vary in accordance with the number and type of clients receiving care. (Australian Industrial Relations Commission, 1998)

This aspect of the agreement, however, became impossible for the union to enforce because of the excusing phrases "where possible" and "wherever possible".

By the time negotiations began for the third enterprise agreement, the ANF had gathered substantial evidence from nurses to negotiate increases in staffing. This evidence was Excelcare data, precisely and systematically gathered by nurses across a number of sites. The union used these data to good effect, achieving increased staffing levels in the new agreement, which took a two-staged approach. In the first instance, the Department of Human Services had to guarantee 200 extra nursing positions immediately for public hospitals but, more importantly, they agreed to staff according to Excelcare timing, or any product that would replace it (ANF Bulletin, 2000). Section 8.6 (iii) (a) of the agreement read:

> Hospitals to staff in accordance with Excelcare ... and (ii) following implementation of the new system in August 2002, health units are to staff according to the staffing plans

generated under the new system. (Australian Industrial Relations Commission, 2000)

The agreement was implemented immediately with the new product to be introduced in August 2002. In the meantime, all hospitals were committed to staffing according to Excelcare timings.

Excelcare and work intensification at Western

Excelcare was introduced at Western after 1992, as it was at the other South Australian hospitals. Its implementation required RNs to type up a care plan on Excelcare for each patient at the time of admission. Towards the end of the shift, each RN keyed in Excelcare timings for the patient under his or her care. This was done three times in the twenty-four hour period. When nurses did not get their Excelcare timings in by the designated hour they risked losing staff to another ward. Compliance rates for each ward were published on a monthly basis and nurses were reminded regularly at ward meetings to get the data in on time to ensure adequate staffing. By 1995, however, it became clear that wards were consistently under-staffed according to the Excelcare data. When ward nurses complained about this, nurse managers argued that Excelcare was too generous in its allocation of hours. This was despite the fact that the allocated minutes had been arrived at through rigorous time and motion studies, regularly up-dated at Western. Contrary to this, most ward nurses felt that the product under-estimated the time needed to adequately care for patients and they attempted to illustrate this by precise and accurate recording of the units of care. This only reinforced the view of nurse managers that Excelcare was too generous.

Claims that Excelcare was now "too generous" despite the rigour of the time and motion studies led the Clinical Nurse Consultant (CNC) on the cardiac ward at Western to keep detailed notes that allowed her to compare staffing allocations against the Excelcare predictions. This exercise was instigated in 1997 as a result of her observations that nursing work had intensified. At the end of each shift, once all the nurses had completed filling in the UOC, she instructed the nurse coordinator to manually check the staffing allocated against the computerised prediction and to ring this through to the nurse manager, pointing out any discrepancies. The assumption was that extra staff would be allocated to the next shift. Staff on the ward saw this as a strategy instigated by their CNC in their interests. It was a public statement that revealed that these nurses knew their ward was consistently understaffed, and it acted as a buffer against management claims that they needed to work harder or were responsible for errors.

At the time, there appeared to be little done about the fact that additional staff were rarely rostered. The database acted merely as local information for staff morale and as a justification for their claims to over-work. However, it is clear that by 2000 the experience of the cardiac ward at Western became part of a larger set of data gathered by the ANF which enabled nurses to be confident in their claims that managers were not staffing according to Excelcare timings. The contradiction between the precise Excelcare

staffing predictions and the number of staff actually rostered onto the ward can be gauged by examining data from this ward outlined in Table One. For example, data for 1-3 April show clearly that management were able to alter staffing levels as the work intensified, although even here there is a deficit of 5.1 staff over the three days. By 4 June, the deficit over a three-day period rose to 23.65 equivalent staff, partly explained by winter flu but also by management's failure to adjust staff levels. Given that the deficit was never addressed, many nursing tasks were not completed or nurses were forced to worked overtime, to increase their pace or to take fewer or shorter breaks.

Table 1: Excelcare project figures, Western Hospital, 1-6 April 1998.

Date	Shift	Enrolled Nurses	Registered Nurses	Total projected time	Projected staff needs	Actual staff rostered	Difference
1 April	1	32. 17	35. 44	68. 02	8. 4	8	0. 4
	2	19. 30	32. 41	52. 90	6. 4	6	0. 4
	3	14. 29	22. 15	36. 44	4. 4	3	1. 4
2 April	1	32. 28	34. 13	66. 41	8. 2	8	0. 2
	2	22. 13	33. 54	56. 07	7	7	0
	3	18. 11	23. 53	42. 04	5. 2	4	1. 2
3 April	1	31. 23	36. 32	67. 55	8. 2	8	0. 2
	2	19. 10	31. 57	51. 07	6. 3	7	+0. 7
	3	15. 36	25. 45	41. 21	5	3	2. 0
Total							-5. 1
4 June	1	34. 06	40. 38	74. 44	9. 3	8	1. 3
	2	22. 45	40. 59	63. 44	7. 9	6	1. 9
	3	17. 11	30. 36	47. 47	5. 9	3	2. 9
5 June	1	37. 22	41. 11	78. 33	9. 79	5	4. 79
	2	N/A	N/A	N/A	N/A	N/A	N/A
	3	18. 10	31. 21	49. 31	6. 16	3	3. 16
6 June	1	35. 04	43. 25	78. 30	9. 7	5	4. 7
	2	23. 15	42. 23	65. 38	8. 2	6	2. 2
	3	16. 37	29. 30	46. 07	5. 7	3	2. 7
Total							-23. 65

During the negotiating round for the third enterprise agreement in 2000 senior nurse managers were perceived to be part of employer's negotiating team. In discussions with the Department of Human Services, they in effect revealed that under-staffing was widespread when they indicated that in order to staff according to Excelcare timings additional funding was required. They agreed to the union offer on the understanding the DHS would provide this additional funding. During this negotiating period, as nurse managers sat around the table with the DHS, they also learnt that there were wide

variations in the timings for UOC between hospitals. These variations were apparently a result of timing mechanisms which had been set in 1992 and not altered significantly despite shifts to casemix funding in 1995 and because some smaller hospitals did not have the resources for periodic up-dates. This meant that budgets allocated for the employment of nursing staff differed from hospital to hospital.

As a consequence, some Directors of Nursing immediately ordered re-timings of the Excelcare UOC in the light of new medical technology, occupational health and safety legislation and the overall design and lay-out of the hospital. This required the standard time and motion studies involving a range of nursing staff from CNCs to ward nurses. The Director of Nursing at Western argued that the expected introduction of the new rostering product – anticipated in the enterprise agreement – offered an opportunity to gain additional funding for nursing services. She acknowledged the strange mixture of loyalties, stating: "if we don't increase the timings the union will be cross, if we do the DHS will be cross; we're caught". Despite this conflict, the re-timing exercise was conducted under rigorous conditions with up to 200 UOC being re-timed and subjected to evidence-based critique. Some UOC did have increases in the time allocated, but others did not. This Director of Nursing did not know what new product would be installed, but she was prepared to have firm evidence once this information was available. Whatever it was, she saw this as her one chance to argue for a higher nursing/patient ratio.

Despite this optimism, by mid-2001 some nurse managers were claiming that there were insufficient funds to staff according to Excelcare and, ironically, not enough nurses. This resulted in the closure of beds during the winter months of 2001. The union also imposed work bans at some sites in response to management not meeting agreed staffing levels. Telling nurses that Excelcare was too generous was no longer an option given the enterprise agreement and their involvement in the re-timing exercise. In discussions with senior nurse managers, they indicated that when the enterprise agreement was signed they had made it clear to the DHS what additional resources would be needed to adhere to the agreement. They did this in good faith, assuming the DHS would provide the funds. It did not. At Western the enterprise agreement required an additional one million dollars, but only $500,000 was received, making it difficult for the hospital to maintain the agreement. Now the DHS argued the Excelcare timings were too generous and that nurse managers needed to refine them and bring the times into line with the existing budget. This made the re-timing exercise an ambiguous one for nurse managers. As one nurse manager noted:

> Excelcare timings add up to more than eight hours work per nurse. This is often due to the fact that some tasks are done simultaneously so that hospitals get caught presenting two or three sets of timings. This provides the funding body with room to quibble over all the figures and to insist that the timings be adjusted to the budget.

Discussion and conclusion

The case study presented in this paper is atypical in two ways. First, it shows that nurses in South Australia have been able to reverse the trend experienced by many nurses – and many employees from other industries around Australia – towards work intensification. Second, the nurses and their union used enterprise bargaining to achieve this outcome.

Part of the explanation for the nurses' achievement involves them and their union learning how to "play the enterprise bargaining game". They learnt from their experience of the second enterprise agreement that ambiguity in the wording of agreements could defeat its effect. They therefore knew that the provisions in the third enterprise agreement to tie staffing levels to Excelcare had to be precisely worded in order to ensure compliance by governments and management. The nurses' familiarity with the computerised workload product, Excelcare, acquired over several years, also meant that they were well placed to use it to achieve their objective. This did not mean that nurses believed Excelcare, or the replacement product, accurately predicted the number of nurses needed at any one time over the 24 hours period. Rather what they pragmatically sought was, first, a commitment to use the product as it was intended and, then, they undertook the detailed data gathering that was necessary to make the best of the system. The role of the ANF in working closely with members to develop strategies and to compile the necessary information and resources was also important not only in developing the enterprise agreement in the first place, but also in giving ward nurses the confidence to bring on industrial bans once there was a threat by hospital managers and the DHS to break the agreement after it came into operation.

Another important explanatory factor in the case study was the role of middle-level nurse managers. They were clearly concerned about work intensification and they were central to gathering the data necessary to mount the nurses' case for reducing work intensity. This is perhaps a predictable action by nurse managers. Consistent with the analysis offered by Harrison and Pollitt (1994), nurse managers' loyalties are often directed towards the profession rather than the government or hospital management when the opportunity avails itself. There was no evidence that nurse managers and ward nurses worked together with the union in compiling the evidence, but it is clear that nurse managers hoped to capitalise on it and that all nurses could benefit.

There are clear limitations to what can be generalised from this case study. For example, it should be recognised that the data collected from nurses on the wards at Western may not have been duplicated at other hospitals – or, for that matter, in other wards at Western – in exactly the same way as outlined here. Nor should it be presumed that these actions provided the only data known to the union in making its case. Nonetheless, the case provides a useful illustration of how enterprise bargaining can be used to stem the tide of work intensification and raises important questions for future research.

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