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**CONTRIBUTED ARTICLE**

**The Variable Impact of New Public Management and Budget Cuts on the Work Intensification of Nurses and Doctors in one Public Hospital in South Australia Between 1994 and 2000**

**Ellen Willis, School of Medicine, Flinders University**

**Abstract**

This paper explores the impact of new public management and budget cuts on the work intensification of nurses and doctors in one Australia public hospital during the 1990s. These were the time-based incentives built into the Medicare Agreements of 1993-1998 and 1998-2003, and casemix Diagnosis Related Groups. These two reforms were part of a broader micro-economic strategy underpinned by new public management processes employed by the state to increase the productivity of health professionals. The impact of these reforms on the labour of health professions was variable, however. Documentary evidence from a study conducted in a public acute hospital in South Australia, called ‘Westernvale’, illustrates that during the period 1994-2001, these reforms resulted in a longer period of work intensification, for the profession of nursing than that of medicine.

**Introduction: Evidence for Work Intensification in the Healthcare Sector**

During the 1990s the Australian government introduced two major funding reforms into the public healthcare system to bring about productivity and efficiency gains. These were incentive based funding linked to the Medicare Agreements and casemix Diagnosis Related Groups (DRGs).

This paper illustrates the impact of these reforms on the staffing levels for doctors and nurses in one public acute hospital in South Australia, called ‘Westernvale’. Data for the paper are taken from a larger ethnographic study conducted between 1997 and 2002 at Westernvale. Data collection included six months participant observation on two wards, attendance at Australian Nursing Federation site meetings over a six month period, interviews with cleaning, clinical, administrative and management staff, participant observation with nursing outreach staff over the five year period and analysis of key in-house and State government documents and relevant evidenced-based literature. The paper is divided into two
sections. Section one provides a brief discussion on work intensification and the reform process, situating the Medicare incentives and casemix DRGs as performance management tools of new public management processes. Section two demonstrates the impact of these reforms on Westernvale staffing levels over the eight year period from 1994 to 2002, arguing that the nursing division experienced a more protracted period of work intensification than other professional groups such as medicine or medical scientists.

Work intensification is not limited to the public health sector; claims are made that it has reached epidemic proportions in a number of industries, with negative impacts on the quality of work, family life and personal health (Burchielli, Pearson and Thanacoody 2005, Green 2004, Pocock, Wanrooy, Strazzari and Bridge 2001). Generally, work intensification is defined as having more work to do than previously, although more elaborated definitions include ‘having extra roles, taking on more tasks with the same staff numbers, or coping with the same or heavier workloads with fewer staff (Allan, O’Donnell and Peetz 1999; Green 2004; Burchielli et al 2005, p. 96). Green and McIntosh (2001, p. 56) suggest that work intensification should be examined firstly in terms of the longer hours worked (extensive work effort) and secondly in terms of the work pace (intensive work effort).

Within the healthcare sector there have been numerous claims to increased workload (Allan 1998, Considine and Buchanan 2000, Willis 2002, White and Bray 2004), but, as White and Bray note, few authors have provided cohesive frameworks for examining these claims. In making a claim for work intensification in the healthcare sector White and Bray (p. 3) suggest that in many instances it is possible to provide direct evidence by comparing shifts in staffing numbers against increases in patient volume. Increases in patient numbers can contribute to either intensive or extensive work effort. This evidence is particularly powerful when it is accompanied by other contributing factors such as increased technological and organisational change; the introduction of multi-skilling and functional flexibility; human resource management techniques designed to engender greater worker engagement; increased use of incentives; decreased power of unions; or rising job insecurity (Green 2004). Added to these factors is a flow on effect; in workplaces were the work is intensified for one occupational group, this is likely to impact on the work of other categories of workers, especially where multidisciplinary teamwork is required.

In the case of nursing, claims to work intensification can be seen to be the result of a number of these factors (White and Bray 2004). Importantly, the nursing case is bolstered by the impact of work intensification on other groups working alongside nurses, be they doctors, allied health professionals or cleaners. In this study, the case of Personal Service Attendants (PSAs) who do ward based cleaning and patient fetch-and-carry activities is used to demonstrate that nurses experienced more protracted work intensification than doctors at Westervale Hospital. PSAs, a newly created occupational group created in 1995 by up-skilling orderlies, kitchen hands, nursing assistants and cleaners, work on the wards doing duties such as cleaning, transporting of patients and serving meals. The decision to create this new occupational group was motivated at Westervale by a State government requirement to outsource all non-core duties. Clinicians felt that to do so would compromise care and argued that a multi-skilled worker assigned to each ward would aid in infection control and the smooth management of patients through the system. PSAs were allocated evenly across all wards and worked under the direction of the senior nurse.

The New Public Management and the Healthcare Sector

‘Reform’ within public health sector impacting on the various health professions is not isolated to Australia (Bach 2000). The trends are global, and the motivation is cost control. Some commentators suggest countries such as the USA, the UK, New Zealand and Australia have been more ruthless and determined in their efforts than many European States (Bosch 1998). The origins of the reforms instigated in the public health sector arose from the belief, held in the early 1980s in many western nations, that the sector underperformed and that a radical overhaul should include incorporating many of the competitive strategies of the market into the public/civil service (Cairney 2002). This belief led to a series of strategies broadly defined as the New Public Management (NPM) (Ferlie 1998). Ferlie defines the NPM under six headings: (1) privatisation of public utilities; (2) the introduction of market-like mechanisms into the public sector; (3) separating core (policy) from peripheral (service delivery) tasks; (4) outsourcing the service delivery, while maintaining government control over policy; (5) more active management such as performance management systems; and (6) labour market flexibility. Added to these is the emphasis on outputs over inputs and the break-up of large, uniform organisations into smaller business units (Bach 2000).

In applying the criteria of NPM to the healthcare sector, the evidence from the UK and New Zealand is more obvious. In both countries, the introduction of quasi markets via the purchaser/provider split that devolved purchasing power down to the level of Trusts or GP fundholders more clearly emulated market mechanisms (Harrison and Ahmad 2000). In Australia, control has remained more obviously centralised both at Federal and State levels. The imposition of the National Competition Policy, however, resulted in the privatisation and outsourcing of many public health services; particularly pathology and radiology, while the Medicare incentive funding and casemix benchmarking meant that State
health organisations were forced to explore labour market flexibility and performance management systems in order to meet new productivity targets.

**Work Intensification Through Performance Management**

According to Morris (1996), in the late 1980s and early 1990s a proliferation of human resource consultants employed by major companies and government instrumentalities recommended outsourcing, downsizing, and a range of workplace activities that encouraged flatter structures, teamwork, the generation of mission statements and increased quality assurance. Whatever approach is taken to increased productivity, be it new technology or restructuring workplace processes, achieving it is problematic. One solution is for employers to supervise or control the activities of employees through direct surveillance, or technology such as production lines or the setting of targets, and to impose penalties for non-compliance. Direct surveillance can be costly and in some workplaces, particularly service industries, neo-Fordist production processes may be inappropriate, outdated or distasteful to the workers’ sense of professionalism and autonomy. A seemingly democratic solution to the problem, which management faces when attempting broad-based control of the labour process and increased control of professional labour, is arrived at by combining ‘best practice’ and ‘benchmarking’ as performance management strategies.

In Australia benchmarking and best practice as performance management measures were initially private sector strategies, but in 1990 they were introduced into the public sector. Both the Medicare agreements of 1993-1998 and 1998-2003 and casemix are examples of performance management reforms that combined incentive funding with benchmarking as cost containment strategies. The relationship between the drive to increased productivity and efficiencies through performance management and work intensification is rarely acknowledged in the relevant healthcare literature dealing with benchmarking (National Health Ministers’ Benchmarking Working Group [NHMBWG] 1999). When it is, the argument proffered is that labour market flexibility such as up-skilling and multi-skilling or the reorganisation of work processes avoids the obvious pitfalls of work intensification because of workplace innovations or more efficient technology. What is not acknowledged is that the reorganisation of work processes in public acute hospitals is subject to the vagaries of emergency admissions and the complexities of treating human illness and disease, which are neither predictable nor subject to control.

**Benchmarks and Incentive to Change: the Medicare Agreements**

Funding for public hospitals in Australia is through a mix of Commonwealth and State grants. Since the introduction of Medicare in February 1984, the Commonwealth has entered into a range of agreements with the States and Territories in five-year cycles: 1983-1988; 1988-1993; 1993-1998; 1998-2003; and 2003-2008. Over the last fifteen years, one of the most successful ways in which both Labor and Coalition governments have coerced health professionals into engaging in the ‘reform’ process is through the creation of financial incentive or innovation pools. This has been achieved by reducing the Medicare base funding to the States and Territories for the funding of public hospitals and tying additional funds to targets and benchmarks. It was the rationale behind the various ‘demonstration’ programs in the 1990s, including the National Hospital Demonstration Programs instigated by Commonwealth from 1996-2003 and the Australian College of Physicians Clinical Support Systems program (Royal Australasian College of Physicians 2002).

In the 1988-1993 Medicare Agreement, the Federal Labor government established a base Hospital Funding Grant (Senate Inquiry 2000, p. 34). It also made it clear that it intended to move to casemix funding in the future, and began to implement some of the necessary information technology. The 1988-1993 round included additional funding via incentive programs for those States that increased the through-put in palliative care and same-day surgery, encouraged early discharge and aided the implementation of casemix information systems. As the Senate Inquiry into the funding of public hospitals in Australia noted, this ‘provided the opportunity for the Commonwealth to encourage service innovation’ (Senate Inquiry 2000, p. 35).

Significant changes were introduced into the third round of the Medicare Agreement in 1993-1998, also brokered by the Labor government. The principles of Medicare as a universal program, free at the point of service, remained. The base grant, although calculated in the same way, was reduced by $400 million, however. This $400 million was transferred to two bonus incentive pools. Bonus Pool A was for additional public bed-days above a pre-set benchmark set for each State and Territory. If any State’s percentage share of public bed-days was below this benchmark, financial penalties were incurred. Bonus B Pool funds were distributed to those States and Territories that increased their share of public bed-days above a set benchmark, but the incentives were paid only if that State performed better than other States (Senate Inquiry 2000). In effect, this intensified the work of health professionals as States and hospitals competed against each other for funds. For example, if a State or Territory increased its share of public bed-days from 53.5 per cent to 54 per cent, it was eligible for funds from this pool, but not necessarily as much as another State, if the other State’s performance resulted in a higher percentage increase (Queensland Health 1996).

The 1998-2003 agreement brokered by the Liberal-National Coalition
government is known as the Australian Health Agreement. A number of performance targets for elective surgery and Accident and Emergency waiting times were maintained at the levels achieved in the previous Medicare Agreements, although the incentives that pitted States against each other were abandoned. Conflict between the Commonwealth and the States over the base grant for hospitals continued during the 1998-2000 round, exacerbated by the reduction in the number of Australians with private hospital cover and a failure on the part of the Commonwealth to make up for the increase in population load. Principles of time management remained part of the agreement. Clause 13 (2) of the agreement stated that access to public hospital services by public patients must be based on clinical need and within a 'clinically appropriate period', and the benchmarks for this are evident in waiting times for elective surgery and waiting times for emergency admissions (NHMBWG 1999). Clause 20 and 21, Schedule C, committed the States to continuous benchmarking and the collection and sharing of data to achieve this aim; and Clause 67 committed the States to a continuous process of efficiency (Commonwealth Department of Health and Aged Care 2001a).

The overall direction of block grants and incentive funding, however, while requiring clinicians to intensify the pace of their work, did not demand changes to the way they organised this work or to clinical decision-making. Change in the organisation of work was more readily achieved during this time through casemix. This is a refined form of benchmarking and a system for measuring the product mix and the types of patients admitted and procedures performed in hospitals and other healthcare settings. Its implementation had a profound impact on the organisation of hospital work and as a consequence, work intensification.

**Intensifying Day to Day Work Through Casemix**

The introduction of casemix Diagnosis Related Groups (DRGs) into the Australian healthcare system in the early 1990s did not come as a surprise to observers within the system. The idea was floated in the National Health Strategy (1989-1992), and the 1988-1993 Medicare Agreement established the Casemix Development Project. The Commonwealth indicated in the 1993-1998 Medicare Agreement that it would move in the next round to funding all States and Territories through a nationally unified casemix system (Reid, Palmer and Aisbett 2000). Given this, States and individual public hospitals had no choice but to comply.

Casemix classification systems are not restricted to measuring output in public or private hospitals. They are used across a range of settings such as the Resident Classification Scales (RCS) - the basis for funding nursing hours of care for the aged; Ambulatory Patient Groups used for community care; and Diagnosis Related Groups (DRGs). DRGs are the casemix system used to determine the funding of public hospitals in

**Introduction of Casemix into South Australian Public Acute Hospitals**

Casemix funding was introduced into all hospitals in South Australia in the 1994-95 financial year; although the Health Commission had been using it since 1985 as the tool for dealing with morbidity data, established a clinical advisory committee in 1989 and completed the first nursing weights study in 1990. The accelerated introduction of casemix into all public hospitals in South Australia was a result of a change of government. The Liberal party came to office in late 1993 following the collapse of the State Bank. Their resounding win was seen as a mandate to reduce the State debt through curtailing public expenditure. Consequently, casemix was introduced at the same time as the public health sector sustained a budget reduction of $30 million over the three-year period from 1994 to 1996. Fifteen million dollars of this was carried by the public hospital sector; this represented a reduction of 4 per cent in real terms of the total healthcare budget for the State. This was achieved by reducing funding of predicted activity
to below 1993-94 levels (South Australian Health Commission 1995). As a consequence, benchmark prices for each DRG were determined by the available funds, not the real costs (Brooker 1997).

Funding to individual hospitals was negotiated through Service Agreements, which in effect outlined for each hospital its share of the State debt and opened the way for other new public management strategies such as contestability (outsourcing) and the privatisation of non-core activities. Funding to public hospitals in South Australia following the introduction of casemix in 1994 was in three parts: an annual grant, an activity grant and an efficiency/incentive (or service pool) grant. The annual grant was fixed and covered infrastructure, education and research. The activity grant for each hospital was the benchmark price for each DRG, calculated by dividing the available funds for acute admitted patients by the number of weighted separations for that hospital. Initially the length of stay (LOS) remained constant for each DRG, but the reimbursement was reduced, thus producing in-built efficiency. Between 1995 and 1998 the LOS for many DRGs reduced, presumably in response to improvements in throughput, forcing many public hospitals with highly acute and elderly patients that prevented them from reducing LOS to intensify their labour, reduce staffing levels or re-design work processes.

Activity for 1994-1995 for each hospital was set at 1993-94 levels. For some hospitals the budget provided in 1994-1995 was less than they would have received for the 1993-1994 financial year. Where hospitals came in under the agreed target, they had to reimburse funds as if they were a loan where they went over the target they had to fund this activity from within the activity grant, supplemented by a transitional grant (Brooker 1997). The transitional grants were dispensed with by 1996 and were paid at a rate of 50 per cent of the deficit. The Hospital Service Improvements Strategy (South Australian Health Commission 1994, p. 11) notes that 'this differential is a measure of the hospital’s inefficiency. It is expected that all hospitals will operate at the efficient benchmark'.

The efficiency or service pool grants were drawn from the savings generated and were modelled on the Medicare incentives. There was a bookings list pool, a through-put pool and a primary healthcare incentive pool. In order to access funds from the booking list pool, which was established for teaching hospitals, a hospital had to reduce waiting lists for elective surgery. This basically meant increasing throughput. In the first year of operation, one hospital received 70 per cent of the available funding, leaving the other hospital administrators with a sense that the funds were subject to ‘gaming’ and manipulation (Brooker 1997). Funds were also available for increased activity linked to service improvements such as establishing benchmarks for same-day surgery, reducing readmissions, implementing programs such as Hospital @ Home services that facilitated early discharge, and reducing surgery LOS (South Australian Health Commission 1994). In the first year, money from this pool was spent in the first quarter requiring hospitals to cap productivity for the remaining nine months.

In his independent evaluation of the South Australian casemix program, Brooker (1997) notes that patient separations increased by 4 per cent in the 1994-95 financial year; there had also been a 9 per cent increase on the previous figures in the 1993-94 year, while the available beds reduced by 9 per cent between 1989 and 1995. This was due to a significant growth in same-day surgery, which increased by 13 per cent in 1994-95. The evidence also suggested that the severity and complexity levels of in-patients increased, so that hospitals were now treating these complex cases in a shorter time than they had previously (Brooker 1997). This was particularly so in the larger public acute hospitals, such as Westernvale, that focussed primarily on emergency admissions.

The Impact of Casemix Funding at Westernvale

Westernvale hospital did not come in on budget in the first year of casemix, nor in the subsequent six years. In May 1995, the Chief Executive Officer resigned and the hospital engaged in a program of staff reduction through voluntary separation packages under the Liberal State government’s workforce reduction scheme. In 1995, the annual report noted that the number of redundancies was 255, with nursing and salaried medical staff numbers decreasing by 93 and 19 respectively, and the remainder coming from support staff such as orderlies and cleaners. In 1996, a further 67 staff took packages, and another 15 in 1998 and 1999. Total staff numbers went from 2316 to 2137; a loss of approximately 8 per cent.

The hospital reduced its patient length of stay from 6.0 to 5.1 days in the first year of casemix funding and increased through-put by 20 per cent, gaining funds from the through-put pool; but since these funds were exhausted in the first quarter, subsequent increases in through-put were unfunded. In February 1995, the hospital held a strategic management conference to deal with the implications of casemix and the State debt. Out of this conference came the new management structure of clinical divisions. By 1996, budgets had devolved to the newly created divisions. The new CEO noted in the annual report that ‘clinicians who make decisions that drive our costs also have the authority to manage budgets and staff’ and that the hospital was $97,000 over budget.

In the same year, following the recommendations of a consultancy firm, the catering and general cleaning services were outsourced, along with diagnostic laboratories. The orderlies, ard-based cleaners and kitchen staff were offered either a separation package or training as Personal Service Attendants (PSAs). The 1996 annual report also notes that the hospital took out a loan of $25,601,000 from the Government Financing Authority for debts incurred as a result of the financial stringencies, to be paid back over a
The Variable Impact of Casemix on Health Professionals: the Case of Nursing

The impact of the new funding model on the intensity and pace of work for the various health professionals can be gauged by examining staff numbers against patient through-put demonstrated in Table 1. These figures suggest that the percentage of nursing and hotel staff made redundant was sustained over a longer period than for doctors or medical scientists. Year 1994 is the first twelve months of casemix. The Annual Report (1995) indicates a drop in staff numbers of 90 nurses and 19 doctors. These are 10 per cent and 7 per cent reductions respectively. In 1996, medical staff were further reduced by 48 (20 per cent), but by 1997-98 their numbers increased to 308, with 22 Visiting Medical Officers (VMOs), and by 1999-2000 numbers had increased to 336. This is an increase of 15 per cent on 1994 figures, with only 4 years in which numbers were below 1994 levels. Nursing figures remained at 95 per cent of 1994 numbers until 2002 -9 years, in all. The enterprise bargaining agreement then brought nursing numbers back to 1994 levels. All this occurred at time when the proportion of people with private health insurance continued to go down, putting more pressure on elective surgery lists. Further, as Table 1 demonstrates, the rate of same-day surgery increased significantly while the average length of stay remained relatively constant.

Table 1: Activity data and staffing numbers 1994/95-1999/2000 Westernvale Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Occupancy (%)</th>
<th>Same-day</th>
<th>Cost per separation</th>
<th>Nursing staff</th>
<th>Hotel staff - PSAs</th>
<th>Medical staff/ VMOs*</th>
<th>LOS days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>N/A</td>
<td>13,186</td>
<td>$3,029</td>
<td>922</td>
<td>314</td>
<td>292/26</td>
<td>5.10</td>
</tr>
<tr>
<td>1995</td>
<td>86.9</td>
<td>14,232</td>
<td>$2,782</td>
<td>833</td>
<td>200</td>
<td>273/n/a</td>
<td>5.22</td>
</tr>
<tr>
<td>1996</td>
<td>87.8</td>
<td>N/A</td>
<td>$3,417</td>
<td>857</td>
<td>180</td>
<td>238/n/a</td>
<td>5.30</td>
</tr>
<tr>
<td>1997/8</td>
<td>88.3</td>
<td>16,553</td>
<td>$3,790</td>
<td>882</td>
<td>146</td>
<td>308/22</td>
<td>5.01</td>
</tr>
<tr>
<td>1998/9</td>
<td>87.3</td>
<td>17,860</td>
<td>$2,505</td>
<td>918</td>
<td>150</td>
<td>324/21</td>
<td>4.72</td>
</tr>
<tr>
<td>1999/2</td>
<td>95.40</td>
<td>20,035</td>
<td>N/A</td>
<td>881</td>
<td>144</td>
<td>336/21</td>
<td>5.10</td>
</tr>
</tbody>
</table>

*Visiting Medical Officer

Table 1 also contains the category hotel staff (orderlies, kitchen staff) or Personal Service Attendants (PSAs). The category 'hotel staff' decreased by 22 per cent over the period from 1994 to 1999, with Westernvale's own annual report of 1998 indicating a reduction of 9 per cent to 122 in that year (Effective Full-time). Their number continued to decrease despite an internal review held in 2002 - the result of high levels of injury amongst these workers. The review resulted in a redistribution of PSAs across the wards according to work intensity, but no increase in staffing levels. This occupational group comprises mainly middle-aged women, except for a small number of former orderlies. The data in Table 1 do not include cleaning staff who deal with the public areas of the hospital. These cleaning duties were outsourced to a private company, as was the preparation of meals, and, as previously noted, pathology services.

In the evaluation of the introduction of casemix into South Australian hospitals Brooker (1997, p. 67) notes a drop in overall numbers of inpatients and nursing staff, but an increase in the acuity of the patient load. He suggests that:

Despite the reduced number of bed days, nursing workload can be regarded to have increased ...there has been a trend to treating more complex patients and towards shorter hospital stays. Reducing the length of stay increases the average intensity of nursing care, as the later days of a patient's stay usually require less nursing care than earlier days.

The increase in same-day surgery also gives an indication of increased work intensity. Brooker makes no critical comment about the increase in medical staff numbers, which is a state-wide trend, except to indicate that there had been a 14 per cent increase in medical services and to point out that the reduction in hotel staff may also be a result of contracting out these services. He does note the following percentage changes in medical (+6 per cent), nursing (-13 per cent), hotel (-29 per cent) and scientific and technical (+1 per cent) staff across the State between 1989 and 1995 (Brooker 1997, p. 108). There is, however, little evidence to suggest that an increase in the work of doctors is not also an increase in work for nurses. Any increase in patient load is an increase to both groups; their work is interdependent.

What is clear in this case study is that the re-organisation of healthcare had a differential impact on health professionals. Overall, the numbers of doctors employed in public hospitals in South Australia, and at Westernvale, between 1994 and 2000 increased, with a dip in 1994-95. This was not the case for the profession of nursing. It was not until 2001 that nursing numbers across the State and at Westernvale returned to pre-1994 levels, and only then as a result of an enterprise bargaining agreement that tied staffing levels to productivity outcomes. The numbers of PSAs remained well below the previous levels for orderlies, cleaners and kitchen staff. The number of medical scientists, who work closely with doctors, remained stable until 2001, then decreased due to a round of redundancies following increased hospital debt. These
data suggest, in the absence of any ameliorating factors such as radical job
re-redesign or labour substitution, that the pace of work for nursing staff was
exacerbated over a longer period than that of doctors.

Discussion and Conclusion

This paper provides evidence of work intensification of nursing staff as a
result of significant reduction in staff numbers during a time of increased
patient acuity, rising rates of same-day surgery and reduced patient length
of stay. As Brooker notes (above), all of these factors exacerbate the workload
for all staff. The figures do suggest, however, that the burden fell on nursing
staff and lower level workers such as the PSAs over a longer period of time
than on medical staff or scientists, although during the period 1995-1996
the reduction in medical staff was more extreme. How these figures can be
generalised to other hospitals in the State is a moot point. While the evaluation
carried out by Brooker (1997) suggests that work intensification did occur for
all occupational groups, not all hospitals applied the same internal reforms.
Hotel and cleaning services were not outsourced in all hospitals, nor did all
hospitals introduce PSAs. Some maintained cleaning services or outsourced all
kitchen and cleaning activities. Brooker’s data do show, however, an overall
State reduction in nursing numbers during this period.

Critics could argue that work intensification includes extensive work loads
as well as intensive work effort and that there is ample evidence that doctors,
especially early career doctors, have experienced considerable increase in
working hours over the last decade (AMA 1998, 2001). Finding evidence in
support of this at the individual hospital level is difficult, requiring longitudinal
or retrospective studies. What is clear is that, in workplaces where the work is
intensified for one occupational group, this is likely to impact on the work of
other categories of workers, especially where all groups are required to work
closely together or some duties are interchangeable as is the case between
nurses and PSAs and between doctors and nurses. It is not surprising that
the Australian Nursing Federation was able to reverse the staffing levels at
Westernvale once the nursing shortage became a national phenomenon (Willis
2002); or that the major South Australia hospitals find it difficult to attract
sufficient junior medical staff. Nor is it surprising that the rate of injuries
for PSAs rose dramatically over this period (Willis 2005). Where work is
intensified, staff who can will vote with their feet, while those who cannot
will become sick.

There is now a general agreement in South Australia that casemix was
introduced along with real budget cuts, so that the DRG price per patient
LOS was reduced to below the previous year’s benchmark (Brooker 1997).
This was an additional factor contributing to work intensification. The
re-organisation of administrative functions to medical and surgical divisions
that included devolved budgets threw the onus for achieving these targets
on to clinicians as part of the process of establishing internal markets, while

the Medicare benchmarks for elective and emergency admissions assumed
that rational responses could be provided for what are unpredictable illness
events. What was required was a set of highly coordinated interactions
that enabled beds to be emptied ‘Just In Time’ and re-made ready for the
dozens of patients in Accident and Emergency or waiting for elective surgery.
Failure to speed up this process meant that the hospital was not eligible for
incentive pool monies and lost out. All staff at Westernvale experienced work
intensification, but it appeared that nurses’ work was intensified over a longer
time frame than that of doctors.

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