AGREEMENTS IN FIRMS COVERED BY FEDERAL AND STATE AWARDS

MEDICENTRE CASE STUDY

Julian Teicher

WORKING PAPER NO. 45

Melbourne 1996
ISSN 1320 5757

AGREEMENTS IN FIRMS COVERED BY FEDERAL AND STATE AWARDS

MEDICENTRE CASE STUDY

Julian Teicher*

INTRODUCTION

In the 1994 *Enterprise Bargaining Report* (Department of Industrial Relations,1995) one of the issues highlighted was a significantly lower incidence of registered agreements in workplaces which were subject to mixed federal and state award coverage. In order to assist in establishing whether there was a causal link between these two phenomena, the Commonwealth Department of Industrial Relations commissioned the National Key Centre in Industrial Relations at Monash University to undertake four case studies. One of these case studies, of a large South Australian teaching hospital, is presented below. As with the other case studies in the series, Medicentre demonstrates that the absence of formal enterprise agreements is unlikely to result from the phenomenon of mixed coverage. Rather this case highlights the fact that agreements continue to be negotiated at the workplace level and that the degree of formality of agreements will vary for a range of reasons. Some of those reasons will be specific to the particular workplace and others will reflect broader systemic factors. A further feature of this case is the fine line which sometimes exists between an agreement and the exercise of management prerogatives.

The paper examines the negotiation and objectives of unregistered agreements between unions and management which cover staff at Medicentre. These agreements are a means of addressing the needs of particular occupational groups

* Executive Director National Key Centre in Industrial Relations. This research was produced under contract to the Commonwealth Department of Industrial Relations and is published with their consent. It is emphasised that any views expressed are attributable to the author only and not the Department.

whose pay and conditions would be more difficult to deal with through the rules and procedures of what is otherwise a very centralised industrial relations system. They represent an effort by management and unions to overcome rigidities inherent in the award conditions designed to apply generally to a variety of organisational and industrial circumstances. This study is focused on the regulation of the working conditions of two quite different groups of employees: hospital scientists; and the porters, orderlies and cleaners.

The discussion commences by providing a range of background information, including an examination of the organisation and decision-making structure of the hospital and an overview of the workforce and employment structure. The second part provides a review of the organisational changes that have affected Medicentre in the 1990s. Central to the discussion is the negotiating structure which is the subject of the third part. This is followed by an account of the two major unregistered agreements which have developed to meet the needs of the hospital and particular groups of employees and which provide a measure of flexibility which was not available through more formal channels of state public sector industrial regulation.

METHODOLOGY

The study was undertaken with the support of a senior officer in the Human Resources Division of the South Australian Health Commission (SAHC), who provided background on award coverage, negotiation processes and the relationship between the SAHC, incorporated health units such as Medicentre and the wider system of industrial relations in the South Australian public sector. This was followed by interviews with a senior member of staff in the Department for Industrial Affairs, and an official in the Industrial Relations Commission of South Australia who were able to elaborate on the operation of industrial relations in the public sector. At Medicentre a range of discussions were undertaken with management staff and employees in ancillary services. The Senior HRM Consultant - Industrial Relations

(hereafter referred to as the IR Consultant) provided an extensive briefing on the recent history of industrial relations in the hospital. He also provided invaluable background on the development of the Hospital Scientists' Agreement, which he had been associated with in his previous capacity as an official of the Public Service Union which had represented that group since 1978. The IR Consultant arranged discussions with a number of other staff at Medicentre, including the Manager of Patient Services, Director of Finance, shop stewards in the ancillary services area, and a group of porters. Discussions were undertaken with full time staff in the Australian Professional Engineers Association and the General Workers Union. An official of the Hospital Scientists' Association was also interviewed.

The people who contributed to the study offered their support on a confidential basis as many of the matters discussed remain sensitive. For this reason, attribution of information is normally given in a very general manner, such as 'a manager said' rather than being directly attributed. Also the names of unions have been substituted with fictional generic titles. Statistical and financial information was provided by Medicentre, although the financial information was provided on a confidential basis and cannot be reproduced. The hospital's database does not provide a breakdown of staff into those with a non-English speaking background, or whether they are Aboriginal or Torres Strait Islanders. References to gender are estimates.

BACKGROUND

Medicentre was established in 1975, on a site adjacent to a South Australian university. It provides facilities for a wide range of medical services and teaching through the university's faculty of medicine, which shares facilities and staff with the public hospital. The hospital offers a very wide range of medical, surgical and emergency services and has an in-patient capacity of 402 beds. The total number of staff, including teaching staff, is 2316.

While formally operating as an autonomous incorporated unit, Medicentre is largely dependent on the South Australian Health Commission, which is responsible for the management of the public hospital system in South Australia. As a result, many of the administrative systems and procedures used in the hospital reflect the requirements of the SAHC for reporting and control over aspects of the hospital's operations. The regulation of employment is also complicated by legislative and administrative arrangements in a number of ways which are explored in the following sections.

EMPLOYER'S DECISION-MAKING STRUCTURE

The organisational structure of Medicentre has undergone several changes over the years as the organisation has attempted to deal with changing demands on its funding, operations, and services. The present situation is illustrated in Figure 1 which demonstrates that the SAHC exercises a number of general supervisory functions over the operation of Medicentre. The importance of the SAHC in industrial relations is discussed later in the paper.

The present structure emerged from a process of strategic planning which was initiated in 1993 by a former Chief Executive Officer and developed through a residential planning seminar early in 1993 and another in 1994. A major reorganisation of the administration followed which included an upgrading of the management of human resources. In January 1994, a Director of Administration and Human Resources was appointed to provide a more active focus on human resource management. This person reports directly to the Chief Executive Officer. The Director of Administration and Human Resources undertook a review of his department during his first year. This review resulted in upgraded attention to such areas as training and occupational health and safety and the creation of a new position of 'Senior HRM Consultant - Industrial Relations', which was filled in August 1994.

These changes represent a change in the importance attached to human resource management issues. In particular, they indicate an increasing recognition that specialist skills were required in dealing with industrial relations within the hospital, which is the common law employer, while the SAHC is statutorily responsible for determining the framework of working conditions within the public health sector (see below). The hospital is responsible for the day-to-day management of the employment relationship. While the hospital had always had a Personnel Department, that group had been largely restricted to the provision of basic services relating to leave, superannuation and accident claims. Matters of policy were dealt with by the SAHC. The IR Consultant was the first such position in the hospital and reflected the greater importance being placed on human resource management within Medicentre. The position was one requiring considerable skills in dealing with constant industrial incidents and issues. It was filled by a former union official with intimate knowledge and experience of South Australian public sector industrial relations. At a personal level, he also brought a commitment to changing attitudes and behaviour over time.

The approach adopted by the IR Consultant has been to develop a closer and more open relationship with all staff, as illustrated by his practice of holding area meetings to explain management initiatives affecting work arrangements. His approach to managing the employment relationship has been to set the framework within which decisions about employee relations matters are made, rather than leaving them to evolve in response to local emergencies.

THE WORKFORCE

The hospital employs a workforce with diverse skills. The overall composition is shown in Table 1. The hospital does not have specific statistics on gender and ethnicity for all groups of employees, but in the workforce as a whole has more women than men. Women tend to outnumber men in particular occupations such as nursing, clerical and administrative services and cleaning. One Personnel specialist commented that the relatively low proportion of NESB workers reflected the

geographic location of the hospital. This is confirmed by 1991 Census data which show that the area of Adelaide from which the non-medical workforce is mainly drawn tends to be dominated by people born in Australia or the United Kingdom (see ABS 1991 Census Data, Place of birth by Statistical division).

The two groups which are the object of this study are quite distinct. The hospital scientists are university-educated, many with doctoral degrees, and work in an environment where individual autonomy and responsibility are valued. It is one in which individuals can have unique recognition and status within their peer group based on their research and expertise. According to members of the group, women tend to be very well represented in the lower levels of the classification structure, but very poorly represented in the senior levels.

The approach of the hospital scientists to industrial relations is related to their wish to maintain a career structure and working conditions consistent with what they see as their professional status. Their success in gaining the agreement of the Public Service Board in the late 1970s to their claims for a range of special conditions was, in the view of several senior public sector industrial relations officers, a tacit acknowledgment within the public sector that they could be treated in this manner without setting precedents for other areas of professional employment.

The other group of hospital workers discussed in this paper are the porters, cleaners and orderlies. Historically these occupations have operated separately; porters move equipment and laundry; cleaners maintain the cleanliness of wards and other areas of the hospital; while orderlies move patients and cadavers. Although the hospital does not collect detailed figures on gender or ethnicity within these groups, personnel staff believe that the porters and orderlies are both predominantly men, while cleaners are mainly women. In terms of their function, it is important to note that cleaners and orderlies deal directly with patients whereas porters have little or no patient contact.

ORGANISATIONAL CHANGE

Prior to the election of the Brown Government in 1993, there had been a continuing process of review and rationalisation in health services as the previous Government grappled with the increasing costs of health care, new technology and a move to day-care procedures. Such changes had the effect of reducing bed numbers and increasing demands for public health services from hospitals. Hospital administrators in these circumstances found themselves dealing with demands for qualitative changes in the delivery of services without any real increase in budgets and with reducing staff resources.

Under the Brown Government, the focus moved from the previous process of incremental change in the health system, to policies designed to change the structure of the system more fundamentally. This direction was signalled with the Government's policies on Contestability and later on Competitive Tendering and Contracting Out (CTCO) which, together with real budget reductions, opened up the possibility of a partial privatisation of health services. The Government's policies have provided an impetus for Medicentre to move in a direction which reduces its dependence on a dedicated public sector workforce. The availability of generous separation packages in the public sector has been an important mechanism for facilitating these more radical changes.

The impact of change in the health system over a number of years has been to place staff and management under considerable pressure. In the words of one manager:

> it's very wearing ... it's not like you could look on a change and reflect on it, the next one has already started ... you don't get any sense of achievement out of it.

These frustrations were felt throughout the workforce, by management and staff alike. Concern over such experiences, and the difficulty of providing coherent direction in hospital management led the former Chief Executive Officer to initiate the Strategic Management Conference early in 1993. This conference, and a

second in 1994, represented an effort by Medicentre management to cope with the many changes both external to the hospital and in the working conditions and relations within. They were not part of any coherent range of planning initiatives, but might be seen in hindsight as one of a series of attempts to bring some stability and direction to a turbulent operating environment.

The first real intimation of an effort to develop a long-term focus had been the development of a Mission Statement in 1989. This was followed by a variety of policy initiatives and reviews, including a 1991 investigation by international consulting firm, Booz-Allen & Hamilton, aimed at identifying areas for efficiency improvements. The 1994 Strategic Planning Conference identified a need for a change in the light of developments since 1989. These were summarised as :

- Legislation: this included the impact of changing industrial and occupational health & and safety legislation.

- Booz-Allen & Hamilton reviews: this consultancy was aimed at identifying and reducing inefficiencies.

- Award restructuring: the process of implementing award restructuring was a continuing preoccupation for managers.

- Budget reductions and ward closures/unit restructuring.

- Proposals for major structural changes.

Action plans were developed in a number of areas of administration, including a greater focus on human resource management issues. The objectives of the human resource proposal were to develop pro-active strategies for dealing with enterprise bargaining and to facilitate the introduction of multiskilling.

The first objective reflected the wish of the newly-appointed Director of Administration and Human Resources to create a more consensual and proactive

approach to change and adaptation within Medicentre. Realistically, this objective would only have been realisable if there was a high degree of trust and mutual respect between management, unions and staff. This was not the case at that time, and the situation subsequently deteriorated with union opposition to the Government's CTCO policy and its more stringent approach to public finance. Examination of internal financial documents reveals that the level of real funding for Medicentre has declined since 1994.

Notwithstanding these objectives, the support staff, particularly porters, orderlies and cleaners, continued to exert a high degree of control over their work situation. Some managers, commenting on the intransigence of these workers when faced with the need to change, suggested that the situation was aggravated by a relatively high turnover amongst management staff. However, the IR Consultant also observed that, at the time of his appointment, he found most managers were unaware of the rules governing their industrial relations and personnel responsibilities, and that many tended to respond to staff difficulties in an ad hoc and inconsistent manner. According to several senior managers, the result has been a lack of clear and cogent management policy on human resource matters, which has allowed authority to drift to the workers themselves. One manager illustrated the way in which work practices had been separated from the normal processes of management using the experience of the Booz-Allen & Hamilton consultants who reported frustration at being unable to penetrate the 'mysteries' of the work undertaken by porters and related groups, because of a refusal by them to cooperate in explaining their work systems.

The second objective of the human resource plan - to build a multiskilled and flexible workforce - was a clear attempt to meet demands for improved service delivery. This had been the intention of the Structural Efficiency Principles of the Australian Industrial Relations Commission (AIRC) but for some public sector groups implementation of those decisions was still being discussed as late as 1995. This was the case with the award covering porters, orderlies and cleaners: the *South Australian Government Health etc, Ancillary Employee Award, March 1993.*

NEGOTIATING STRUCTURE

Decision-making on employment matters at Medicentre is complicated by the legislative framework. While incorporated hospitals such as Medicentre are common law employers, the employment conditions they establish must be approved by the SAHC, which in turn adopts and applies standards contained in the *Public Sector Management Act 1993* as the basis of its approach to Personnel Management. Where awards or industrial agreements are used to determine aspects of the employment relationship, a further complication is added. The right to negotiate conditions of employment and participate in industrial proceedings before State and federal tribunals is reserved by various means, outlined below, to the Department of Industrial Affairs and the SAHC. Behind this formal division of authority there is a less formal, but quite authoritative, level of decision making involving core agencies in the South Australian Public Service. These agencies, the Departments of Premier and Cabinet, Industrial Affairs, Treasury and the Commissioner for Public Employment, maintain a watching brief over all industrial issues, with the objective of maintaining broad standards and financial predicability in industrial relations matters. While each brings statutory authority to their discussions and policy directions, their access to Cabinet ensures that all public sector agencies are expected to work within the parameters set by this group. The situation as it affects the resolution of industrial issues within such bodies as Medicentre is outlined in more detail below.

Employment Conditions

As indicated above, staff at Medicentre are formally employed by Medicentre Board. However, as provided in section 30(1) of the *SA Health Commission Act, 1975*

> The board of an incorporated hospital may appoint, upon terms and conditions fixed by the Commission and approved by the Commissioner for Public Employment, such officers and employees as it thinks necessary or desirable for the proper administration of the hospital.

The role of the Commissioner of Public Employment referred to here has its roots in provisions of the *Public Sector Management Act 1993*, which provides a set of general guidelines for personnel management in public sector organisations. These principles, which cover such matters as equal opportunity and the merit principle, apply to all public sector agencies nominated in the Act including the SAHC. In addition, the Commissioner for Public Employment has developed a number of policies on such matters as overtime, classification standards and redundancy, which are expected to apply throughout the public sector. An agency can only deviate from these policies with the approval of the Commissioner for Public Employment. This leaves a range of issues on which the SAHC itself may formally determine conditions for health sector employees. These matters are formally circulated through Administrative/Industrial Circulars. However, these instruments are normally the subject of consultation required in agreements and awards operating in the public sector. Recently this has been reinforced by a Supreme Court decision, that notwithstanding consultations over outsourcing, the issue is one for the SAHC to determine (decision S5500, SA Supreme Court, Australian Liquor, Hospitality & General Workers Union v South Australian Health Commission).

Responsibility for Awards and Agreements

Section 60(2) of the *SA Health Commission Act*, establishes the SAHC as employer for proceedings before the State Industrial Relations Court or Commission. It states that:

> For the purposes of any proceedings, or any industrial agreement under the *Industrial Relations Act (SA), 1972*, the Commission will be regarded as the employer of all officers or employees of incorporated hospitals or incorporated health centres.

In such cases the Commission generally consults with incorporated units, though they are prohibited from instituting proceedings on their own behalf and are prevented from entering into agreements on their own volition, unless the SAHC has given its consent (section 60(3)). The responsibility for implementation of awards and agreements is, however, placed on the Boards of the incorporated bodies under

section 60(3) of the Act. As a consequence, the SAHC generally controls the industrial relations agenda, while the incorporated body remains responsible for day-to-day management.

This Act is silent on the role of the SAHC in relation to proceedings before the AIRC. Under the *Industrial Relations Act 1988* (Cth), each of the incorporated bodies is regarded as the employer for any proceedings before the AIRC. To avoid anomalies in industrial relations policy, the SAHC approached each incorporated body seeking formal authority to represent them in any proceedings before the AIRC relating to enterprise bargaining and any other industrial matters. All Boards are reported to have agreed to this request. While the legislative framework gives the SAHC authority, the situation is generally regarded positively by hospitals.

Administrative Coordination of Industrial Matters

A final complication in these arrangements needs to be related, as it directly affects the process of enterprise bargaining in the public sector. An Industrial Claims Coordinating Committee (ICCC) set up under ministerial authority has existed since 1975. This committee is made up of representatives of the Departments of Premier and Cabinet, Treasury, Industrial Affairs and the Commissioner for Public Employment, together with three senior public servants drawn from public sector agencies on the basis of their personal experience and knowledge. There is no representative from the SAHC.

According to one of its members, the ICCC has a schedule of regular meetings, which are undertaken on a relatively informal basis. The ICCC provides direction to the Government on the handling of major claims in the public sector and, in the past, has provided the basis for a single approach to national wage cases. In the current circumstances, it is the body which ensures that the introduction of enterprise bargaining in the public sector occurs in a manner which does not create anomalies in conditions of employment for different groups or wage settlements beyond budgeted targets. Decisions of the ICCC are normally reflected in the policies of the Commissioner for Public Employment and in the industrial relations policies of the

Department for Industrial Affairs. The key function of this body is to provide a strategic framework for industrial relations, as distinct from dictating particular conditions. The *SA Public Sector Framework Agreement for Enterprise Bargaining* which is described in the next section was developed through the ICCC.

The legal and administrative arrangements for the regulation of work and industrial relations within the public sector which are described above restrict the ability of Medicentre management to act autonomously on industrial matters. While there is considerable discussion and consultation between SAHC and Medicentre officers, in practice the line of authority remains clear.

Awards and Agreements

Table 2 summarises the awards and agreements applying to Medicentre employees. In general, the awards define specific aspects of the employment contract on basic issues such as rates of pay, classification standards, working hours (including shift and part time work), overtime and a variety of allowances. While there are differences between each of the awards, there are also many similarities which reflect the concern by the employer to avoid anomalies in conditions across the public sector.

The award framework, though occupationally-based, has been simplified considerably since the commencement of the award restructuring process in 1988. The mixture of state and federal awards is historical, though unions respondent to state awards have all recently begun proceedings aimed at a shift to federal award coverage. Union officials explained that these applications were aimed at ensuring access to the most favourable jurisdiction at a time when the State Government was changing industrial relations legislation.

The *Enterprise Bargaining Framework Agreements*, one covering employees under State awards and the other applying to employees covered by federal awards, were established in the closing days of the Bannon Government in November 1993. These documents provide procedural rules for the pursuit of enterprise agreements

in an enterprise or section of an enterprise. The agreements provide a comprehensive framework for enterprise bargaining. They defined the bargaining unit as a Single Bargaining Centre (SBC) which is:

> the management and union representatives established in an enterprise or discrete section of an enterprise (as defined) to develop and negotiate improved productivity consistent with this Agreement.

The agreements define a Single Bargaining Unit (SBU) as comprising the union group representing unions with members within the SBC.

Within the health area, the SBC has been defined as covering all incorporated hospitals and health centres and the SAHC itself. In effect, this SBC covers the whole public health system. It is composed of seven union representatives; the Employee Ombudsman, representing non-unionised groups within the SAHC; three 'other employee representatives', representing diverse groups; and an equal number of managers drawn from the health system. While neither of the State's two largest teaching hospitals is represented directly on the SBC the common interests of the larger hospitals are represented by the inclusion of a member from the Womens' and Childrens' Hospital. The SAHC has consistently maintained that once an agreement is finalised for the whole of the health area, each of its constituent units, including the major hospitals, will be permitted to pursue further agreements within their own organisations, provided that these are consistent with the SAHC Agreements.

The move to enterprise bargaining in the health sector beyond the framework agreements has affected only some employees at the time of writing. Three agreements for groups within the health sector have been finalised applying to nurses, doctors and employees covered by the federal metal trades award respectively. A further agreement covering clerical, technical, trades and allied groups was negotiated, but failed to attract majority approval of the employees covered. This agreement will now be reviewed by the negotiators. The enterprise agreements already concluded, and those under negotiation, follow the occupationally-oriented pattern of the existing award structure.

The framework of public sector industrial relations described in this section has two characteristics which have made it difficult to deal with local issues. First, the system remains centralised, even with the negotiation of enterprise agreements by the SAHC for particular groups. The legal framework ensures that the Commissioner for Public Employment, the Department for Industrial Affairs, and the SAHC are the primary actors in determining what issues may be dealt with at the level of Medicentre, and the way in which particular occupational groups are aligned with one another. Second, awards and agreements each set conditions for broadly defined occupational groups across the public sector. They reduce the likelihood of anomalies across occupational boundaries and across the health sector, though this is expected to be less of concern as enterprise bargaining proceeds.

The framework of public sector industrial relations makes it difficult for particular operating units, such as Medicentre or discrete occupational groups such as hospital scientists, to pursue working arrangements and conditions suited to their particular needs. The unregistered agreements described below are examples of the way in which a measure of flexibility is gained in order to respond to situations which require an expeditious response or which are unsuited to centralised determination.

Unregistered Agreements

As suggested above, the use of unregistered agreements has been an important mechanism for dealing with matters of concern to particular groups of employees. Under the central health sector enterprise agreements for clerical, technical, professional and ancillary staff which are currently being negotiated there is a general undertaking that the

> parties to this agreement agree to give positive consideration to future Enterprise Agreements being developed for individual health units or groupings of health units, (clause 10, Draft Agreement)

Until this agreement is finalised there is therefore little likelihood of agreements at the health unit level being negotiated. The two cases which follow illustrate the way in which unregistered agreements have been used to deal with the needs of small groups of employees in a flexible manner. In one case, the group of employees involved was spread across the system, while in the other case the employees covered were confined to Medicentre.

Hospital Scientists

The hospital scientists' group covers a range of specialist scientific positions providing research and analysis services in public hospitals. Until 1978, their salaries and employment conditions were established by the (then) Public Service Board (PSB), as was the case with many other professional groups. In 1978, they formed the Hospital Scientists Union (HSU) to pursue improved employment conditions. With the assistance of the Public Service Union which had formal coverage of the group, the HSU negotiated an agreement covering salaries and conditions with PSB, and three incorporated health bodies. The agreement was not registered, but the conditions in it were incorporated into PSB determinations and were adopted by the SAHC. The agreement has continued as the basis of employment conditions for hospital scientists since that time and, until recently, the PSU has provided industrial advice and assistance to the group. Earlier in 1996, at a Special General Meeting, the Scientists Union agreed to use another union which is referred to as the union of Professionals and Managers (UPA), to represent it in future negotiations with the SAHC. As the PSU has formal industrial coverage of the group a confused situation has emerged in which two unions are seeking to act as agents for the HSU.

The agreement embodies a number of unique employment conditions. These include five weeks leave to compensate for overtime as required. However, the most significant feature relates to the classification of hospital scientists. The *Hospital Scientists Agreement* made provision for incremental salary advancement in individual cases of excellence as determined by a process of peer group assessment. The peer assessment process is known as the Hospital Scientists

Assessment Committee (HSAC). Benchmark positions are available as a guide for those seeking re-classification. Hospital scientists may also apply for personal reclassification based on professional excellence. While no grounds are specified for such reclassifications, the application form seeks details of the applicant's qualifications, responsibilities, research and teaching experience, and membership of professional bodies. At the higher levels of the structure, members of the group are paid in excess of the rates for equivalent professions.

The hospital scientists have continued to represent an interesting anomaly in a system increasingly regulated by awards. By the early 1990s, public sector industrial relations policy makers in the Department of Industrial Affairs and the SAHC were interested in rationalising this situation, particularly under the impetus of the reviews initiated under the structural efficiency principles of federal and State Commissions in 1988-9. In part this reflected a concern for consistency, as the potential existed for other scientists and professional groups to mount similar claims for special treatment. In 1992, preliminary discussions between public sector unions and the Department of Industrial Affairs for an integrated public sector award covering all clerical, administrative, technical, professional and supervisory employees canvassed the possibility of including the hospital scientists in a proposed Professional Officers stream. However, as one of the people involved in these discussions indicated, it was quickly recognised that any attempt to integrate the hospital scientists would involve a quite detailed review of the relative advantages they enjoyed. It was agreed to postpone such a review until after the new award was in place.

The HSU agreed to defer further discussions of the issue at that time in the knowledge that they would not be eligible for pay rises under the Structural Efficiency Principle (SEP) until they were covered by a relevant award. Following the finalisation of the *SA Public Sector Salaried Employees Interim Award, June 1994*, a second attempt was made to resolve the award coverage situation. This began in 1994 with a comprehensive review of classifications and duties by a joint working party representing the SAHC and with the PSU representing the hospital scientists.

The outcome of this joint review was a clarification of differences between the SAHC and the hospital scientists. While both parties were able to agree that the lower level positions in the structure could be integrated into the Professional Officers stream of the *SA Public Sector Salaries Employees Award*, they disagreed as to the way the upper level positions could be dealt with, as these extended beyond comparable structures. There was also disagreement over the discretion exercised by the HSAC in relation to rewards for excellence. A particular issue relates to the salaries and conditions of senior hospital scientists and their choice of comparators. In developing their current claim, the HSU has used academic salaries and conditions and those applying to staff at the National Health and Medical Research Centre as reference points. Some senior hospital scientists are accorded courtesy titles of Professor or Associate Professor in the teaching hospitals, creating an expectation within the hospital scientists group that some financial equivalence should also be made. Within the SAHC there was a willingness to address the position of senior levels of the group by transferring them to the Executive Officer category. This classification group, which is reserved to the senior levels of management within the public sector, would have implied a range of managerial responsibilities being undertaken by the scientists affected, and the proposal was not therefore seriously entertained by the HSU.

At this time, discussions were suspended after disagreements emerged between the PSU and the HSU over representation of the hospital scientists' interests. As indicated above, the HSU has formally elected to use the UPM for its industrial advice and representation. The SAHC has taken the position that the unions concerned need to develop a common position before negotiations can constructively proceed.

The situation of the hospital scientists indicates that unregistered agreements may be a means of isolating a group whose claims challenge the integrated nature of public service working conditions but who also require careful attention. Although the agreement was unregistered, incorporation of its contents into PSB determinations in 1978 (and later those of the Commissioner for Public

Employment), gave its terms official weight and the agreement became binding within the health sector. However, as other professional and scientific groups become more industrially active, the position of the hospital scientists has become more difficult for the SAHC to sustain. On the other hand, the SAHC is aware that dissatisfaction amongst the hospital scientists could lead to resignations and the loss of people with skills and knowledge who would be difficult to replace[1]. Ongoing discussions over integration of the group into the Professional Officers' structure is a recognition that their position is inconsistent in the long term with industrial relations policies based on consistency between similar groups across the public sector. The care being taken by the SAHC in these negotiations also reflects its recognition of the importance of the group in an effective health system.

Multiskilling of Ancillary Staff

The use of local agreements to facilitate changes in the job definitions of ancillary staff who work in wards exemplifies the manner in which such agreements may be used to facilitate change at the local level.

As indicated above, Medicentre managers have faced increasing pressure to review and rationalise staffing and services within the hospital in recent years. These pressures began with reductions in the real level of budget allocations in the early 1990s and were further heightened by the Brown Government's CTCO policy. This policy included the principle of contestability which provided a means for determining whether selected government services and functions should be put out to tender. Patient services at Medicentre were identified as one area in which external tendering should be initiated. As a consequence of this policy, Medicentre managers saw a need to clearly identify 'core' services that were essential to the effective operation of the hospital. The dispersion of support services in a variety of functional groups left them open to wholesale outsourcing, a possibility which Medicentre managers saw as potentially disruptive and likely to reduce the effectiveness of patient care. This was particularly the case with the large group of

[1] The evidence of the actual level of resignations being experienced is confused. See Sheryl-Lee Kerr, SA's Brain Drain, The Adelaide Advertiser, 8 April 1995.

porters, orderlies, and cleaning staff who performed the more menial but essential support services within wards which kept the hospital's patient care function operating. By defining more clearly the ward and related services, and separating those ancillary staff working in wards from the larger functional grouping of orderlies and porters, the integrity of ward services could be protected.

In early 1994 the Manager of Patient Services proposed the creation of a new group of multiskilled employees at the ward level to be known as Patient Services Attendants (PSAs) who would take over the ward based work of porters, orderlies and cleaners. The IR Consultant took on the task of implementing this proposal. The first part of the strategy was to create a consultative process through which the proposal could be discussed with union and staff representatives. This consultation process was embodied in a formal agreement known as the *Medicentre Workplace Change Agreement.* The agreement, which was made with the GWU, set up a consultative process, the purpose of which was to: 'facilitate an environment to enable workplace change to be undertaken in the Patient Services area of the hospital'.

The Consultative Committee set up by the agreement consisted of four workplace representatives, an officer from the GWU and four management representatives, of whom one was to be a senior manager. The GWU representatives were to be shop stewards drawn from the work areas concerned, while management representation included the Manager of Patient Services, IR Consultant and Director of Administration and Human Resources. The tasks to be undertaken by the Committee, as outlined in the Workplace Change Agreement were to:

- oversee the process of contestability (as defined) and its impact on employees;

- establish and maintain effective consultative and participative processes that deal with the real barriers affecting efficiency;

- resolution of these barriers by way of redefining and reorganising the way work is performed and breaking down functional barriers;

- facilitate a cultural and attitudinal change between the parties leading to a climate of cooperation and trust;

The IR Consultant saw the agreement as a means of breaking down the entrenched attitudes and industrial behaviour which pervaded the hospital, as well as achieving the immediate objective of creating the PSA group. The agreement was negotiated without the prior consent of the SAHC and was therefore in breach of the previously outlined restriction on the capacity of Medicentre to negotiate an agreement. SAHC officers expressed concern as to whether this statement could be interpreted as implying that Medicentre management had authority to change such conditions. As the agreement was of a limited term, and dealt essentially with one area, they refrained from any formal challenge to its validity.

In addition to the consultations, which then took place on the basis of this agreement, the IR Consultant also undertook discussions with other unions with members operating at ward level. These included the Nursing Union (NU) and the PSU.

From the outset, the IR Consultant was surprised at the cynicism of workplace union officials when he outlined the PSA proposal. According to one of the managers present, a shop steward from the porters' area listened patiently to the proposal and then responded with the simple statement that 'it won't happen'. It later emerged that this attitude reflected the state of workplace relationships in which informal work practices had become an important element in the administration of many hospital services. According to some managers, in the past unions had largely run the hospital. This view suggests an 'indulgency' pattern[2] in which the failure of management to provide a coherent approach to human resource management leads to worker-initiated rules. This partly resulted from the low status of human resource

[2] Alvin Gulden, (1964) Patterns of Industrial Bureaucracy, Free Press.

management at Medicentre before 1994, but also reflected the relative power of unions while Labor was in office. A consequence of this situation was that ancillary staff exercised considerable discretion over their own working arrangements and practices.

The use of the Consultative Committee to develop an agreement with the new multiskilled workers was a tangible illustration of a more conciliatory management approach. However their efforts to discuss the problems facing the hospital and its staff broke down. The IR Consultant later described the approach taken by union representatives in the consultative process as filibustering over new demands.

While employees were cynical about the intentions of Medicentre management, the attitude of GWU officials was consistent with their distrust of management initiatives. This distrust followed from the more hostile industrial relations environment created by the Government's outsourcing policy and its approach to industrial relations at Medicentre. The officials raised questions over the classification, level of supervision, and training of the people who would fill the new PSA positions. Union concerns might have also reflected the potential loss of members arising from the fact that multiskilling would open up the possibility of poaching by other unions.

The GWU used a variety of arguments to frustrate discussion of the multiskilling proposal. It was portrayed as a dilution of skills and an attempt to impose higher workloads on their members. However, the union was particularly concerned over the implications for staffing levels, which was the area in which the proposal offered the opportunity for savings to the hospital. As the union remained intransigent for much of the negotiation, management turned directly to the staff affected through their shop stewards. In a series of local meetings with the staff and their shop stewards, the IR Consultant forged agreement on many of the detailed matters associated with implementing the proposal. In this way the union's ability to stall the implementation of the PSA proposal was undercut and eventually the GWU gave its approval informally. Essentially staff agreement to the new classification was facilitated by the simultaneous offering of Targeted Separation Packages (TSPs) which were to be offered to those uninterested or unsuccessful in obtaining a PSA

position, who consequently became surplus employees. The enthusiasm of staff for TSPs cleared the way to implementation of the new system late in 1995.

The new PSA positions were advertised internally and, at the same time, expressions of interest in TSPs were sought. Management undertook the process of selection for the TSPs. The classification of the PSAs was fixed through a classification review process already in existence and the positions were fixed at level 3 in the ancillary staff structure. Most porters and cleaners were at the time classified at level 1 and in some cases level 2.

Some comment needs to be made about the negotiation process used in this situation, as it illustrates the difficulty faced by the new management in attempting to negotiate change. The consultative arrangements did little to foster the common interest sought by management. Employee representatives were predominantly the shop stewards who had been at the heart of the old pattern of relationships, while many of the management members showed little commitment to the process. Their failure to attend meetings was usually explained away by reference to the pressures of other management tasks, but for the employee representatives it reinforced their suspicion of management appeals to cooperation. Union officials claim to have experienced many instances of what they describe as 'management duplicity' in the past.

The Influence of Union Decision-Making Structures

The decision making structures of unions influence the degree to which members in particular workplaces or occupational groups can exercise control over the way their industrial interests are represented. In this study the GWU faced the issue of a division of opinion between members' needs and union policy. The role taken by the GWU organiser illustrates the way that such issues were dealt with. While the organiser provided advice and leadership in negotiation for the WCA, he also acceded to the views of local members who sought outcomes which differed from his preferred position. His views reflected union policy that reorganisation proposals involving staff reductions should not be accepted. However, faced with the reality

that members were happy to enter such arrangements, the union could do little more than state its position and allow members to make their own decisions.

The activities of the hospital scientists described above illustrate another aspect of union decision making. According to an executive member of the HSU, originally most of the hospital scientists were also members of the PSU. Although the PSU represented the interests of the group in negotiating the original agreement, some hospital scientists believe that PSU officials subsequently took little interest in the group. One hospital scientist reported that a PSU official regarded them as a self-interested elite. This situation underlies the decision by the HSU to seek representation through UPM. Further, it is evident that although the issue of legal coverage is unclear, by acting as an independent and coherent group the hospital scientists have been able to retain control over their own interests in the negotiating process.

CONCLUSIONS

The agreements discussed in this case study indicate the existence of unregistered agreements outside the context of the normal bargaining arrangements within the SAHC. These agreements result principally from a need to deal with the particular needs of groups of workers within the system, without incurring a precedent for the conditions or rights of other employees. In both cases senior industrial relations officers in the Department for Industrial Affairs and in the SAHC had some misapprehension about the arrangements.

In the case of the Workplace Change Agreement negotiated at Medicentre, the SAHC effectively turned a blind eye. SAHC officers expressed the view that the agreement could be tolerated because it did not involve substantive changes in working conditions. In the case of the Hospital Scientists Agreement, SAHC industrial staff express no urgency about resolving the issue, although they are keen to put in place a more formal arrangement, and one more consistent with their other policies on industrial relations. In both cases these unregistered agreements have

been a means of allowing flexibility in an otherwise centralised approach to industrial relations.

BIBLIOGRAPHY

Department of Industrial Relations (1995), *Enterprise Bargaining in Australia: 1994 Annual Report*, AGPS.

Figure 1: Medicentre Organisational Structure, 1995

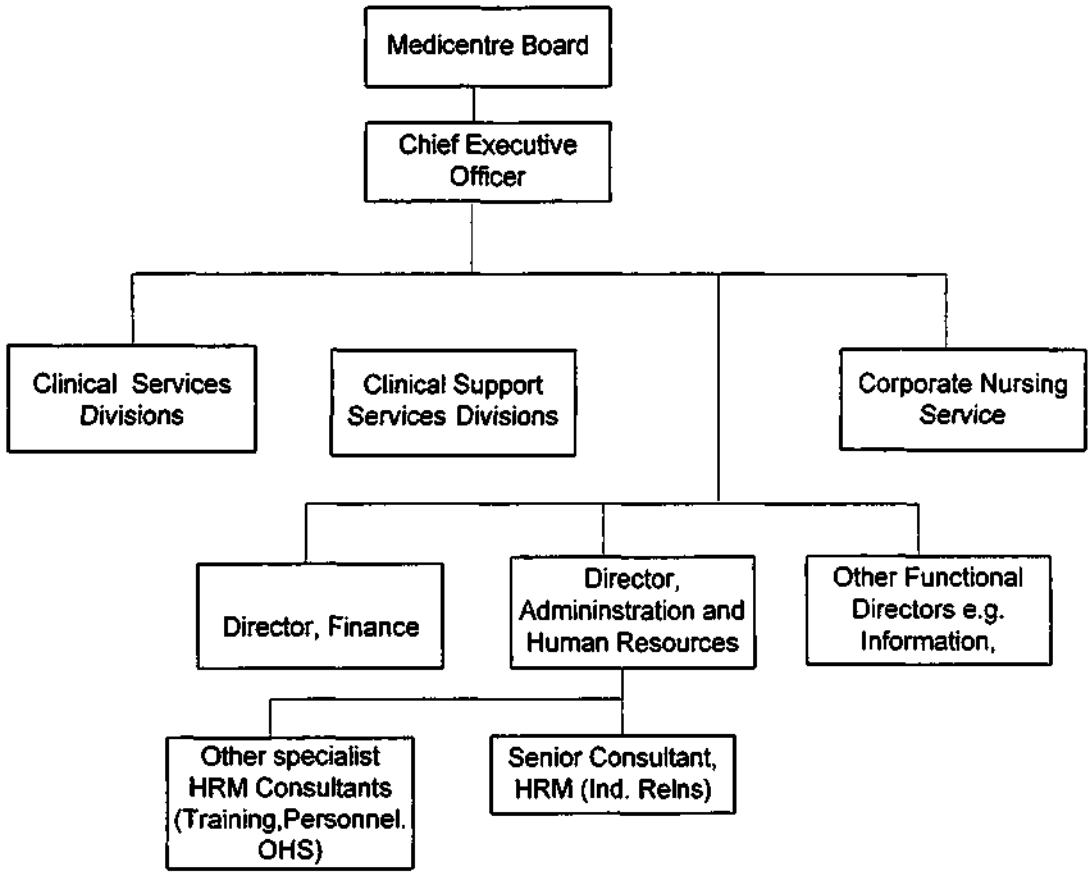

Table 1: Workforce Composition, Medicentre

Group	Staff Numbers (EFTS)
Nursing	922.2
Administrative & Clerical	355.5
Medical support services	348.7
Dental	7
Hotel Services	314.8
Maintenance	49.3
Medical	292.7
Sessional Medical	25.8
TOTAL	2,316

Source: Annual Report, Medicentre, 1995

Table 2:Awards and Agreements covering employees of Medicentre

Nature of Award or Agreement	Nature of Award or Agreement
Framework Agreements	Enterprise Bargaining Framework (State) Agreement, November 1993 Enterprise Bargaining Framework (Federal) Agreement, 1993
Federal Awards	Nurses (South Australian Public Sector) Award 1991
State Awards	The South Australian Government Health etc, Ancillary Employees Award, March 1993
	The SA Public Sector Salaried Employees Interim Award, June 1994
	Metal Trades (SA Government departments and Instrumentalities) Award, 1985
	South Australian Government Building Trades Award, May 1994
	The South Australian Medical Officers Award, February
	Plumbers & Gasfitters (South Australia) Award
	Government Stores Employees Interim Award, 1992
Enterprise Agreements	SAHC (Federal) Enterprise Agreement 1996 for Metal Trades Staff.
	SAHC (State) Medical Officers Enterprise Agreement, 1996
	Nurses (SA Public Sector) Enterprise Agreement 1996
Unregistered Agreements	Medicentre Workplace Change Agreement
	Hospital Scientists Unregistered Agreement

National Key Centre in Industrial Relations

The National Key Centre in Industrial Relations was established at Monash University in 1989, with core funding provided by the Commonwealth Government. The Key Centre aims to:

* offer a quality graduate studies programme in industrial and employee relations with a strong emphasis on current issues facing practitioners at the workplace;

* conduct research on industrial relations, particularly aspects of workplace industrial relations such as enterprise bargaining and best practice; and

* provide advice and assistance to industry on a fee-for service basis, utilising the expertise of the Centre's full-time staff.

The Centre has undertaken a wide range of important research and consulting projects. These projects have included leading-edge research in the fields of award restructuring, remuneration, enterprise bargaining, benchmarking, the family and work, training and best practice. The findings of these studies are incorporated into the teaching programme.

National Key Centre in Industrial Relations
Monash University, City Campus
8th Floor
30 Collins Street
Melbourne, Victoria 3000
AUSTRALIA

FAX: +61 3 9903 8710
TEL: +61 3 9903 8700

Recent Working Papers And Monographs

Working papers

39. *The End of Standard Working-time? Working-time Arrangements and Trade Unionism in a Time of Transition*, Iain Campbell

40. *The Process of Enterprise Bargaining in Context: A Case Study*, Rowena Barrett & Cheryl Mutabazi

41. *Participation in Labour Adjustment Assistance: The Regional, State and Local Agency*, Michael Webber, Sally Weller & Phillip O'Neill.

42. *The Decline of Australian Union Density - A Review*, Gerrard Griffin & Stuart Svensen

43. *Casual Employment, Labour Regulation, and Australian Trade Unions*, Iain Campbell

44. *Labour Market Outcomes Among Retrenched Workers in Australia: A Review*, Michael Webber & Iain Campbell

45. *Agreements in Firms Covered by Federal and State Awards: Medicentre Case Study*, Julian Teicher

46. *The Impact of Workplace Reform on Occupational Health and Safety: A Study of Five Workplaces*, Malcolm MacIntosh, Richard Gough, Julian Teicher, Andrew Smith & Wayne Mortensen

Monographs

No. 6.
Industrial Relations in New Zealand: Five Years of Deregulation, Gerard Griffin (ed.)

No. 7.
Contemporary Research on Unions: Theory, Membership, Organisation, and Non-Standard Employment, vol. 1., Gerard Griffin (ed.)

No. 8.
Contemporary Research on Unions: Theory, Membership, Organisation, and Non-Standard Employment, vol. 2., Gerard Griffin (ed.)