Conflict or cooperation: Industrial relations practice in the Victorian public health sector

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ABSTRACT

This paper reports on a survey of 35 human resource directors from public healthcare facilities in Victoria and explores the character of industrial relations within the four divisions of the Victorian public healthcare sector, particularly the industrial relations climate. This sector is characterised by a traditional pluralist model of industrial relations despite wider Australian trends towards decentralisation and individualisation. Management in metropolitan hospitals rated their industrial relations climate the most cooperative of all four healthcare divisions. Even though there was limited evidence to suggest management hostility towards unions, community health centres rated the lowest in terms of cooperation and highest in terms of hostility. Implications are drawn for the practice of human resource management in a unionised environment.

Introduction

Despite the fact that there is an increasing international interest in health sector industrial relations (Bach and Winchester 1994, Bach 1998, 2000, Thornley 1998, Oxenbridge 1996); until recently in Australia this sector was largely under researched. This is surprising considering that the health industry is labour intensive and one of the more highly unionised industrial sectors, with evidence that some health sector unions are increasing their union membership and density (Stanton. 2002). The health industry is also characterised by a number of different professional groups, each highly educated and skilled with its own history, culture, specialisms and patterns of practice (Duckett 2000). These professions often have different interests and the ability to exercise a certain amount of clinical autonomy and independence (Bach 2000), leading to accusations of rigid working arrangements revolving around professional 'silos' and tribal behaviour between the groups (Hunter 1996). At the same time there is an international shortage of many healthcare professionals and technological innovations which have led to the need for even greater skill acquisition with up-skilling rather than deskilling in many areas (Braithwaite 1997; Stanton 2002). Braithwaite (1997) argued that up to the early nineties industrial relations in the Australian health care sector was largely stable, centralised, award bound and rigid and Bray and White (2003) and Stanton, Bartram and Harbridge, (2004) suggest that despite flirtations with decentralisation through enterprise bargaining, health sector industrial relations in New South Wales and Victoria have remained centralised. One reason for this is that the sector is also largely publicly funded and hence dependent on government policy for direction setting and control. However, as governments have sought more innovative and flexible work practices over the last decade the potential for struggle over contested terrain has increased.

This paper focuses on the public healthcare sector in Victoria, which has been through two different government approaches since 1992, both of which have had a significant impact on industrial relations. The Liberal Coalition government from 1992 to 1999 adopted the approach of New Public Management, which encouraged the decentralisation of pay bargaining, hostility towards trade unions and a ceding of industrial relations powers to the federal level. In contrast, the current Labor government has relied on greater centralisation of industrial relations, particularly in the public health sector, and appears to have adopted a more open relationship with trade unions. This paper reports on a survey of 35 human resource directors from public healthcare facilities in Victoria and explores the character of industrial relations within the four divisions of the Victorian public healthcare sector (e.g., Metropolitan hospitals, the rural base hospitals, district hospitals and community health services). These responses concerned the human resource directors' views and perceptions of the industrial relations climate, formalisation of industrial relations and union-management relations within their organisation.

This survey is part of a larger-scale systematic study into people management practices in the Victorian public health sector undertaken by the researchers. This paper is of significance as there is clear evidence that building a positive industrial relations climate between trade unions and management can be an important starting point for the promoting, adopting and understanding the challenges, constraints and opportunities of workplace innovations such as human resource management (HRM) (Cregan, Bartram and Johnston, 2001; Bartram and Cregan, 2003).

Changing government policy in Victoria

Historically public hospitals in Victoria have been largely independent bodies run by semi-autonomous boards of management, staff were employees of the hospital not of the government. However, until 1992, public health employment in Victoria was centralised in that hospital staff were largely employed on state awards. Industrial processes were conducted centrally with direct state government involvement and employers had to implement these decisions with little input into their negotiation (Fox, 1991). Lin and Duckett (1997:49) argue that the health trade unions, because of their links with the Australian Labor Party, were seen as powerful and had been able to negotiate generous wages and conditions and also able to resist any real reform of work practices. The Liberal Coalition government elected in 1992 attempted to introduce pay decentralisation through the development of enterprise bargaining, at the same time it tried to weaken the power of the trade unions through abolishing union payments at source and by publicly excluding unions from consultation processes. (Stanton, 2002).

Stanton (2002) exploring industrial relations in the health sector under the Kennett government argued that government policies led to a struggle for control in three areas. The first, between government and employers as employers tried to resist or extend government policy. The second, between employers and their employees as employers tried to implement government policy and, third, between government and trade unions as trade unions tried to resist government policy. Employers believed that industrial action had increased during this period but largely as a response to government policy rather than their own actions.

In 1999 the election of the Labor government led to a return to centralised industrial relations processes in the health sector, with government officials playing a greater role in negotiations, and an increased reliance on the Australian Industrial Relations Commission (AIRC). Stanton *et al* (2004) interviewed key informants from government, trade unions and employers to compare both governments' policies and their impact on the practice of industrial relations in the sector. They found that from the perspectives of the key actors within the system, in practice both governments' approaches to management of the sector have not differed markedly and have been applied with political theatre, a continuance of central-local tensions and an absence of government direction and leadership system wide. While the Liberal Coalition government promoted 'hands-off' managerialism and the employers enjoyed some involvement in the 'enterprise bargaining' process, which promoted limited flexibility for labour utilisation at the local level, the evidence suggests that the process was still largely centralised with strong government involvement and interference in the background. In contrast, the Labor government has openly centralised the bargaining process and in-effect largely removed employers from the bargaining process as unions are negotiating directly again with the Department of Human Services. Evidence from the key informants suggested that there is a lack of consultation with the management and the field. Consequently, it is possible that the complex web of historically ingrained tensions between key actors has been perpetuated and has stifled the renewal of innovations in people management in the Victorian public health sector. The evidence from the key informants suggested that the actions taken at the level of policy and strategy has directly impacted on collective bargaining and personnel policy at the level of the workplace (Kochan, Katz and McKersie 1986). However, we have little systematic data that explores the industrial relations climate and union management relations at the organisational level in the Victorian healthcare sector and what we do know tends to reflect the views of managers from the larger tertiary hospitals. In this study we explore the industrial relations climate from the perspectives of human resource directors in a number of healthcare facilities. In this paper, first, we review briefly the literature on industrial relations climate, second, we outline the sample and method, third, we present the findings and finally we focus on discussion and conclusions.

Industrial relations climate

Organisational climate refers to a variable, or set of variables, that represents the norms, feelings and attitudes prevailing at a workplace (Payne and Pugh, 1976). The concept of organisational climate offers the opportunity to link individual and organisational levels of analysis. Kelly and Nicholson (1980) argue that the application of the climate concept in industrial relations can bridge the theoretical gap between organisational characteristics and industrial relations outcomes such as conflict. Dastmalchain, Blyton and Adamson (1991) suggest that a firm's industrial relations activities generate a characteristic atmosphere within that organisation. This characteristic atmosphere, as perceived by the organisational members, is what is regarded as the industrial relations climate. The concept of industrial relations climate viewed in this way is perceptual rather than objective and is organisational rather than psychological (Payne and Pugh, 1976).

The union-management relationship offers a potentially fruitful area for the exploration of the concept of organisational climate (Dastmalchian, *et al*, 1991). In an effectively unionised organisation that is faced with the challenge of competitive pressures, management has the problem of introducing changes that strike at the heart of collectivism: issues of flexibility include skill definitions, job controls, work intensification, wage rates and job loss. Such issues can be dealt with by collective bargaining with its inherent threat of industrial action. However, if the aim of management is to introduce flexibility yet avoid industrial conflict, there is evidence to demonstrate that, where there is an effective union presence, management often consult with unions to achieve this end (Ackers, Marchington, Wilkinson and Goodman, 1992; McInnes, 1985). In its formal guise, such as joint consultation committees (JCCs), the practice has a long pedigree and has entered the armoury of HRM in the form of participation or employee involvement (EI). Union presence is said to facilitate consultation by providing a ready-made organisational structure among employees (Turner, 1994).

Unions have optional responses to a consultative relationship. There is a major stream of industrial relations literature that suggests that labour reaps little benefit from consultation per se. In his classic study, Ramsay (1977) argued that "participation is … best understood as a means of attempting to secure labour's compliance" … as a managerial device to ensure "legitimation". As such, it is based on a unitarist concept of "the company". Labour takes part because its objective is "the primacy of democracy itself" (p498). The latter is doomed to be realised in the long term, as managers no longer encourage participation when worker resistance fades. Ultimately, it is a zero-sum game, with management as the victor.

However, different views have been expressed about consultative practices, Batstone (1984) maintained that companies that were making losses 'had a strong incentive to highlight their problems to workers and seek their co-operation in overcoming them' (p261). Bougen, Ogden and Outram (1988) argued that in a situation of competitive pressures, management might need to secure co-operation from workers rather then mere compliance. Moreover, a view has developed that there may be scope for mutual gain from management-union co-operation as managers' search for competitiveness and employees for job survival in a context of global pressures (Guest and Peccei, 2001; Eaton and Voose 1992). Collective bargaining - with its threat of industrial conflict - may be a major impediment to such a goal, so consultation between management and employees has taken on a greater significance in certain situations. That is, consultation can be part of a positive-sum game in which both managers and workers gain. The price for managers is a sacrifice of some of their 'prerogative', and that for workers, a constraint on their capacity to collectively bargain. Recently, however, there has been greater emphasis in the literature concerning management and trade union cooperation (Goddard 2004). Walton (1985) establishes the dominant American managerialist paradigm, indicating that HRM policy choices should be contingent and reflect the interests of a range of stakeholders, including trade unions. Walton (1985) proposes also that 'commitment-based' strategies highlight the mutuality in labour relations planning and problem solving for both trade unions and management. It has also been argued that trade union presence has been associated with a greater sophistication of HRM. In fact, Eaton and Voose (1992) suggest that trade union presence has been associated with greater employee productivity.

The relationship between unions and the employer within the public health sector has had its 'ups' and 'downs', depending on the government of the day, funding arrangements and personal philosophies of the key players within the sector. Much of the attention in the literature has been on the relationship between trade unions and the government, the highly political nature of the sector and the fact that the health industry is seen as an essential service (Fox 1991, 1998, Stanton 2002). Case studies in the sector suggest that management practice and prerogative need to be understood in the wider industrial relations context (White and Bray 2003, Carr 1999). It is clear from the health services literature that it is difficult to understand any developments in the public health sector without considering the highly unionised and politicised industrial relations context.

Sample and methodology

The data used in this paper is derived from a survey of 130 organisations in the public healthcare facilities in Victoria, including metropolitan health services which are the large city based teaching hospitals, the large regional base hospitals, smaller non-teaching district and bush hospitals and community health centres between December 2003-April 2004. Five hundred and thirty six questionnaires were distributed to the CEO, human resource director and two general functional managers (often Directors of Nursing or Medical Directors) per organisation. A total of 184 questionnaires (34 percent response rate overall) were returned including 64 CEOs, 35 HRDs and 85 GFMs (almost 50 percent response from CEOs and an estimated 90 percent response rate from HRDs as all organisations do not have a designated HRD). In this paper HRDs from nine metropolitan hospitals, five base hospitals, 14 district hospitals and six community health centres were used in the analysis.

There were two survey instruments; one directed at the HRD and the second to the CEO and general functional managers of the organisation. The HRDs survey comprised of questions relating to strategic HRM, questions relating to the full range of HRM functions including recruitment and retention and a comprehensive set of HRM outcomes such as industrial relations outcomes, recruitment and selection and turnover outcomes. The CEO and GFM survey contained the same SHRM questions, a less comprehensive set of the same group of HRM functions plus questions pertaining to the organisational outcomes monitored by their organisation. Only the HRDs were questioned about industrial relations since they generally have responsibility for most industrial relations matters.

In this paper Dastmalchian, *et al*'s (1991) 35 item measure of industrial relations climate was used. Five components of industrial relations climate emerged following a principal components factor analysis of [eigen values > 1 retained and the factor solution rotated using the varimax orthogonal method]. Reliabilities and standard deviation are presented of the five factors: cooperation between management and trade unions (alpha=.78, mean=10.2, S.D.=3.2, items=5); management hostility towards trade unions (alpha=.89, mean=7.8, S.D.=2.7, items=4), formalisation of the industrial relations system (alpha=.84, mean=25.9, S.D.=3.0, items=6); union support in organisation (alpha=.73, mean=11.1, S.D.=1.7, items=3); and employee perceptions of fairness of the industrial relations system (alpha=.73, mean=9.1, S.D.=2.4, items=3). One-way ANOVA tests were conducted to ascertain the extent of differences in management perceptions of the industrial relations climate across the health services divisions. From an examination of the one-way ANOVA tests, a number of possible climate dimensions that reflect the various aspects of the union-management relationship in Victorian public health facilities can be identified.

Results

First, means of the components of industrial relations climate are reported. Overall, it is apparent that the HRDs rated cooperation with trade unions as generally favourable, despite the large standard deviation. Moreover, HRDs across the four divisions rated highly the extent of formalisation of industrial relations processes. Employee support for trade unionism was also rated quite highly by the HRDs and promoting hostility with trade unions was rated low by the HRDs.

TABLE 1
Descriptive statistics

Variable	Mean	Standard Deviation
Cooperation	17.79	3.28
Formal IR systems	25.88	2.96
Hostility	7.82	2.68
IR system fair	11.09	1.67
Employee Support union	9.06	2.42
n = 34		

Second, One-way ANOVA tests found statistically significant differences between the health services divisions in relation to cooperation [F=4.775, p=.008] and hostility [F=2.494, p=.080] between trade unions and management. More specifically, HRDs in metropolitan hospitals perceived that they possessed the most cooperative industrial relations climate in comparison to community health centres - with least cooperative industrial relations climate (see Table 2). In terms of hostility between management and trade unions, the means were low indicating management reported an absence of hostile views towards trade unions. Moreover, HRDs in base hospitals reported that their organisation was the least hostile towards trade unions and community health centres the most hostile towards trade unions. Results also indicate the high level of formalisation of industrial relations systems and processes 25 and above. Despite not being statistically significant human resource directors view employee support for unions within the organisations highest in the metropolitan hospitals and lowest in the community health centres. Moreover, HRDs perceived that employees viewed industrial relation systems and processes fairest in the metropolitan hospitals.

TABLE 2
ANOVA of industrial relations climate for HRDs

Variable	Mean (Division 1)	Mean (Division 2)	Mean (Division 3)	Mean (Division 4)	F
Cooperation	19.78	16.20	18.86	15.00	4.76***
formal IR systems	26.56	25.20	25.31	26.67	.67
Hostility	8.89	8.00	6.38	9.00	2.49*
IR system fair	12.11	10.80	10.76	10.50	1.69
Employee Support union	10.44	8.80	8.69	8.00	1.56
n = 34					
df=33					
* p< 0.10					
** p < 0.05					
*** p < 0.01					

Third, further analysis was carried out using one-way ANOVA on the individual items of the cooperation and hostility factors. HRDs had largely neutral views concerning joint management-union committees achieving success across all of the four divisions. Metropolitan hospitals held the most positive views concerning a great deal of concern for the other parties' point of view in management-union relations. HRDs in the other divisions held quite neutral views. Significant differences were found between the divisions concerning the statement shop stewards are treated with respect at the organisation [F=6.10, p<.002]. HRDs from the metropolitan and district hospitals had higher means compared to HRDs from community health services. Once again in terms of parties freely exchange information - metropolitan hospitals rated 'agree'. HRDs in the other divisions rated this statement as neutral. Significant differences were found between the divisions concerning the statement management often seek input from the union before initiating changes [F=3.19, p<.04]. HRDs from metropolitan hospitals had higher means than the HRD from community health services. With reference to the hostility items HRDs across the divisions tended to disagree with the statements (see Table 3).

TABLE 3
ANOVA of cooperation and hostility for HRDs (individual items)

Variable	Mean (Division 1)	Mean (Division 2)	Mean (Division 3)	Mean (Division 4)	F
Joint management-union committees achieve results	3.67	3.00	3.50	3.00	.713
Great deal of concern for the other parties point of view in management-union relations	3.78	2.80	3.07	3.00	1.46
Shop stewards are treated with respect here	4.00	3.40	4.21	3.29	6.10***
Parties exchange information freely	4.00	3.20	3.64	3.43	1.42
Management often seeks input from the union before initiating changes	4.11	3.60	3.79	2.86	3.19**
Management often opposes changes advocated by the union here	2.56	2.00	1.86	2.57	2.31*
Union-management relations in this organisation can be best characterised as hostile	1.89	2.20	1.62	2.29	1.56
Parties regularly quarrel over minor issues	2.44	2.80	1.86	2.47	
Best way to get anything accomplished here is for the parties to report to aggressiveness	2.00	2.00	1.36	2.00	.018**
n = 34 df=33 * p< 0.10 ** p < 0.05 *** p < 0.01					

Discussion and conclusions

Overall the picture that emerges of the industrial relations climate in Victorian public healthcare facilities is one of cooperation between management and trade unions, a fairly formal system of industrial relations in a non-hostile environment where there is a perception of employee support for unions. However, when this is broken down further into the four divisions of the Victorian public health system the evidence suggests that there are in fact heterogeneous industrial relations climates, management perceptions and possibly even industrial relations approaches. Based on the proceeding analyses there is some evidence to suggest that HRDs in the metropolitan hospitals surveyed are more likely to promote cooperate strategies relative to the other divisions, followed by the largely rural district hospitals, then by the large rural base hospitals and lastly the community health services. It is unclear from the data as to why this is the case. It could be that trade union density within metropolitan hospitals is likely to be larger relative to the other divisions, not only because of their size but also because of their relative importance within the industry however, the rural base hospitals are also large and have importance in their

community. It could be that trade unions in rural areas are not as welcome to employers as in the city however, this would not explain why the largely rural district hospitals promoted cooperative strategies. It might be that in the smaller rural district hospitals, which often have limited human resource departments unions might also provide important management and communication functions. However, community health services are generally much smaller organisations with have a limited human resource function and these organisations also rated the lowest in terms of cooperation. Community health services have many of the features of a small business and their managers might prefer a more direct relationship with their staff without the involvement of unions. The industrial relations process might be seen as an outside third party rather than a stakeholder in the organisation.

Despite the metropolitan and to a lesser degree district hospitals pursing industrial relations strategies of cooperation with trade unions, results indicate that HRDs did not strongly favour the benefits or outcomes of workplace innovations such as joint-consultation committees with trade unions. In contrast, HRDs across all of the divisions strongly favour traditional mechanisms of dispute resolution and negotiation in accordance with legislative requirements (e.g., collective bargaining, informal meetings and the AIRC). These results confirm the case study of a Victorian regional public hospital's approach to industrial relations (Bartram and Cregan, 2003). The results also confirm Carr's (1999) case study findings in Britain that change was taking place but largely through a shift towards a more consultative style within a traditional industrial relations framework rather than a human resource management approach. Despite trends of the growth of individualisation and decentralisation of Australian industrial relations (Deery and Walsh, 1999; Mitchell and Fetter, 2003) the evidence in this study tends to support the continued existence of a traditional industrial relations system within the Victorian public health system – a pluralist model of industrial relations that is highly centralised, unionised and formalised – similar to Bray and White's (2003) findings in NSW. This is despite, or perhaps even because of, the largely government inspired enterprise bargaining battles of the past decade. The pluralist model of industrial relations has enormous implications for the introduction and growth of HRM particularly in terms of Kessler and Purcell's (1996) notion of strategic choice. This paper supports Bach (1998) in arguing that an understanding of the wider constraints in health sector industrial relations is essential, if organisations try to re-direct their approach in a context that is inextricably linked with a wider complex web of regulations, relationships and restrictions. In such an environment there is no benefit to employers in promoting conflict and hostility towards trade unions and professional associations. Rather a co-operative approach is more likely to achieve results.

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