Workplace change and the internal labour market: evidence from the NSW hospital industry

ALEX DE RUYTER

Alex de Ruyter is a Lecturer in the Birmingham Business School at the University of Birmingham, UK.

Abstract

After a decade of labour market reform and workplace change, increasing attention has focussed on public sector industries. In this paper, domestic and maintenance occupations in the hospital industry are examined, as previous work has focussed on nursing, with other occupations being largely ignored. Grimshaw and Rubery's (1998) model of internal labour markets is adopted as the preferred theoretical approach. This model, in acknowledging external factors, the role of workers, and custom and norms within the firm, provides a basis from which to examine labour use practices within the hospital industry.

Introduction

The health care sector contributes significantly towards GDP in developed countries. By the late 1990s health care spending in Australia stood at some 8.6 per cent of government spending, while the USA was the highest spender, at some 15.3 per cent (Stanton 1999). In recent years, it has also increasingly become the focus for neo-liberal reform attempts, mainly through fiscal consolidation and changes to work practices, in Australia and other OECD countries. An important theme has been the demise of traditional internal labour markets. This has occurred as establishments contract out, restrict the activities of trade unions, increase the use of non-standard employees and delayer management hierarchies.

It is evident that considerable change has taken place in the hospital industry labour market in Australia and internationally. From the literature, it appears that one of the greatest areas of workplace change across OECD countries has been in the rise and widespread use of part-time and casual/temporary employment. However, the majority of the literature has tended to focus on individual aspects of workplace change only, such as the rise and rationales for part-time work. The attention of Australian researchers has primarily been focused on the increasing use of private sector practices in the public hospital sector (eg, Patrickson and Maddern 1996; Stanton 1999).

In this paper, the concept of an Internal Labour Market is used to explore workplace change. Internal labour markets are typified by recruitment into a base-grade permanent full-time job, internalised training, job ladders, and protection against arbitrary dismissal. The growth of part-time and casual work at first glance then, suggests a shift away from the internal labour market. However, there has been a paucity of research on the implications of work practices and employment structures for internal labour market theories. Similarly, research has tended to focus on the nursing profession and the public sector (eg, Meagher 1994; Gough and Fitzpatrick 2000). Other occupational groups and private hospitals have been largely ignored. Thus, this research seeks to build upon the results of previous studies into labour use practices by examining internal labour market structures and labour use practices for domestic and maintenance staff within the industry. In particular, the following research questions are explored:

- What internal labour market structures exist for domestic and maintenance staff in the hospital industry?
- How are non-standard (i.e., part-time and casual) employees utilised, and to what extent do they represent a departure from the internal labour market?

The model of the internal labour market used is that of Grimshaw and Rubery (1998). They construct a dynamic framework for the factors that serve to affect the scope and nature of internal labour market structures within firms, reproduced below. Three broad factors affect internal labour markets: the performance of the firm; the firm's customs, norms, and practices; and the influence of the external labour market. This model, in acknowledging cultural and social factors in addition to economic factors, provides a suitable base to examine workplace change and internal labour market structures. Crucially, the model highlights that internal labour markets are not insulated from the external labour market. Rather, they adjust in response to changes in the external labour market. These factors are examined in respect of four stylised aspects of internal labour markets: recruitment into a permanent job, training, promotion, and dismissal.

Method

A case study was conducted in a public hospital ('Public Hospital'), which comprises part of a NSW regional Area Health Service ('Regional Health'). The regional area health service was selected because of the widespread use of non-standard forms of employment: during 1997 non-standard forms of employment comprised nearly 50 per cent of the workforce in Regional Health (Annual Report 1997). In addition, Regional Health is one of the region's largest employers, with over 6,900 full-time equivalent staff during 1996/97 (Annual Report 1997). This translated into some 8,935 employees during 1997/98. Thus, as one of the Region's largest employers, Regional Health has an important role in the wider regional economy and community. The establishment within Regional Health was selected because it demonstrated considerable change in labour use practices and external influences.

The region also contains a significant proportion of disadvantaged people, and a higher proportion of elderly people than the NSW State average, which reinforces the requirement for comprehensive health services to meet their specific needs. Most importantly, the region is perceived as having an attractive lifestyle and is located near Sydney. This serves to potentially increase the number of individuals attempting to obtain work at the hospitals within it, and higher average tenure levels as individuals stay in the area. Thus, case studies conducted in the region allow the state of the local labour market to be considered in analysing how the external labour market conditions shape internal labour market structures.

The case study follows the method used by Allan (1996). In Allan's research, employment information was used to construct cohorts for which employment trends could be adduced. This was followed by interviews with a HR Officer, a CEO, and four domestic and maintenance managers (unfortunately, no employees or union officials were available). This approach can overcome the restrictions of using self-administered questionnaires and enables a greater understanding of the idiosyncrasies and undercurrents in each enterprise (Burgess et al 1994). The 1995 Australian Workplace Industrial Relations Survey (AWIRS) was used as the template for the questionnaire, in order to provide rigour and sophistication (Stoecker 1991).

Public Hospital is a 107-bed hospital incorporating a centre for bone and joint disorders, and serves as a teaching hospital for the local university (Establishment Profile). It provides a number of specialist services, including orthopaedics; rheumatology; rehabilitation medicine; and a range of outpatient services (1997/98 Annual Report). Allied health services such as physiotherapy, occupational therapy, speech therapy, and social work are also available at the hospital. Total Employment at Public Hospital stood at some 571 persons during August 1999, which in turn comprised 421 females (74 per cent) and 150 males (26 per cent). The workforce is long established, with a considerable number of employees having at least 10 years continuous service with Regional Health (29.5 per cent of females, and 34.5 per cent of males). Lengthy service is particularly evident in support occupations for males, and in support and administrative jobs for females.

Domestic and maintenance include cleaning and kitchen staff, orderlies and tradespersons. The gender balance is relatively even, with males comprising some 44 per cent of the total domestic and maintenance workforce. Segregation within is evident however, with males predominating in support and maintenance jobs, and females predominating in domestic jobs. As a heterogeneous group, it is not surprising that some cohorts should exhibit

a high incidence of non-standard employment, while in others it is non-existent, as seen in Table 1 and Table 2. This area in turn can be divided into four major groupings: Cleaning (which comprises cleaning, linen, and waste management), Catering, Maintenance, and Theatre Support. The majority of the 31 cleaners in Cleaning are Hospital Assistants (Grade 2) who can operate cleaning machinery and climb ladders, whilst the one Hospital Assistant Grade 1 does not (Manager 6).

Table 1: public hospital, domestic and maintenance staff, female, August 1999

Staff type	Employment type					
	FT	TFT	PPT	PT	TPT	Total
General Admin Staff	6	-	-	-	-	6
Aide	3	-	7	1	3	14
Hospital Assistant	22	4	9	4	14	53
Chef – Grade C	1	-	-	-	-	1
Total	**32**	**4**	**16**	**5**	**17**	**74**

Source: Regional Health, Employment Data

Findings

Recruitment into a permanent job

The case study findings suggest considerable departure from the traditional internal labour market. Being a heterogeneous area, considerable differences arise as to whether people can secure permanent employment. Trades appointments are on a full-time permanent basis (with the exception of apprentices) and entirely male, which is reflected in a stable workforce. These employees essentially form a 'core' that can be supplemented by contractors when major projects arise. Informal agreements with unions entail that when a position becomes vacant it be filled. At a Regional Health level, there appear to be no moves to scale down the number of workers in this occupational group.

Table 2: public hospital, domestic and maintenance staff, male, August 1999

Staff type	Employment type					
	FT	TFT	PPT	TPT	PT	Total
General Admin Staff	3	-	-	-	-	3
Hospital Assistant	12	2	2	7	1	24
Linen Foreperson	1	-	-	-	-	1
Wardsperson	1	-	-	-	-	1
Boiler Attendant	1	-	-	-	-	1
Gardener	1	-	-	-	-	1
Motor Vehicle Driver	1	-	-	-	-	1
Plumber	3	-	-	-	-	3
Carpenter	3	-	-	-	-	3
Electrician	4	-	-	-	-	4
Painter	2	-	-	-	-	2
Apprentice	-	4	-	-	-	4
Total	**32**	**6**	**2**	**7**	**1**	**48**

Source: Regional Health, Employment Data

FT = permanent full-time, TFT = temporary full-time, PPT = permanent part-time, TPT = temporary part-time,
PT = part-time (penalty loading but no pro-rata benefits, casual under ABS definition)

Cleaning and Catering, in contrast, display a high usage of non-standard employees. In Cleaning there were 10 temporary employees as at November 1999, of which six were regular (fixed-term) employees who were working 40 hours a week and thus were full-time, and four were 'casual' (sic. irregular). Cost is a major factor in using permanent part-time employees. In Cleaning, part-timers were perceived to be ideal, as the rosters were constructed so that the work would only need be done from four to six hours per day (Manager 6). In Catering, part-time employment is also perceived to be cheaper.

"…. you don't have meal breaks, and you don't need as many staff. There's less sick leave, and less accidents because people aren't as tired and you don't have to cover for meal breaks" (Manager 22).

The only disadvantage of using permanent part-time employees was perceived to be administrative, in that it increased the amount of rostering (Manager 22).

Temporary full-time and temporary part-time staff can be used to fill in for absences, and for positions where a permanent appointment has not been made, say during a staff freeze: fulfilling a similar role to casuals (except apprentices). A major disadvantage of using temporary part-timers (sic. casuals) perceived by managers is that they are 'sectorised', in that they can work for more than one hospital within Regional Health. Hence, a temporary part-timer might not be 'available' when a manager requires them as they might have already taken a more 'choice' shift at another establishment (Manager 22).

In Cleaning, the six temporary employees who had been employed on an ongoing basis had experienced multiple contract renewals: generally on a three-month basis. However, with the hospital shutting down for four weeks over Christmas, their contracts had recently been renewed for only one month. A manager explained (Manager 6) that the reduction in the length of contract was to match the downtime in demand and the uncertainty for staffing requirements this imposed, as patient numbers would be reduced during this period. However, it was notable that as these employees had worked more than 13 weeks continuously, they would be viewed by the Health and Research Employees' Association (HAREA) as warranting being appointed on a permanent basis (Manager 6). Indeed, after the period of analysis, temporary employees of more than 13 weeks' tenure were converted to permanent employment contracts as part of the new award.

Within the domestic and maintenance area, Catering has been the subject of considerable workplace change in the last 10 years; linked to a shift in the industrial relations (IR) culture. Prior to 1990, all the work was full-time, except for base grade 'casual' (i.e., temporary) positions. The Catering manager asserted that

"ten years ago if you had said the words 'part-time' in this kitchen, it would have emptied: they would have all gone out on strike. This kitchen was the worst in NSW, and now it's probably the best" (Manager 22).

"… it used to be males doing heavy-duty tasks, and they controlled the union. The first day I walked in, I was told to get my f——–g head out of the kitchen because there was still five minutes' changeover time. Now it's changed. In the old days one of the things they'd do to anybody who didn't do as they were told, was to spray their car with duco oven cleaner. That was a sign to tow the line" (Manager 22).

Indeed, in this area, a shift in attitudes has occurred with a 'generation' transition. Many of the older staff who opposed the use of part-time work took redundancy packages circa 1990. The younger employees are

"only interested in coming to work, getting their job done and getting home. They'll do extra for you if you accommodate them - they're more willing to make changes and adapt" (Manager 22).

No areas appear to have been contracted out to private contractors. Some discussion was made a number of years ago to introduce contracting out in the provision of cleaning, for example. However, the union (HAREA) opposed the measure. It was also found that the in-house providers could provide a better service, at a lower cost (Manager 6). In cleaning, private providers were perceived to cut corners in providing a lower-cost service. As one manager explained,

"… contractors were brought into the Royal North Shore, and it was dirty. They put the people in to do the work, but as their contracts went through, they put the people off. So, they had fewer people to do more work. It wasn't like here where you've got eight hours to do the work" (Manager 6).

"A contractor might only have four hours to do the same amount of work, so they have to cut corners. I think when they start out they have lots of people and they run at a loss to get the contract renewed. Once they have

the contracts renewed, they might have that contract for another four years. So, they don't need as many people because they have their contract. They put employees off, but they still expect the same amount of work to be done. So you can't do it – it's just physically impossible to do it" (Manager 6).

The absence of a shift to contracting out signifies one area in which workforce developments have run counter to neo-liberal lines.

Training

Public Hospital has its own Staff Development Unit, which provides training in a number of basic areas, including OH&S and staff induction programmes. In addition, there is a Staff Education Centre at Regional Health level, which provides courses in areas such as IT. However, there is a perception that not all employees would have the same access to training – casuals and temps for example. While temps get the same access to in-house programs, the issue is not as clear where an expense on the part of the hospital is incurred. As one manager explained,

"well, I'd have to look at how regular they are how often they come in: are you going to get that investment back?" (Manager 12)

The domestic staff areas have undergone changes in skill requirements that have led to the need for staff to be more trained. Previously in some areas, there were hospital assistants who couldn't even read or write (Manager 22). The impact of technology through the introduction of cook-chill heating of prepared food has done away with the need to have chefs in hospital kitchens. It has also enabled hospital assistants to undertake a greater range of duties, which has increased their training requirements. The Catering manager noted that

"cook chill has changed how people do their duties. We've always employed people that never had to have a school leaver's certificate, or an intermediate certificate. They just had to come to work and be able to read – but their reading skill was never tested. Now, hospital assistants are regenerating the food: they're acting in a sense as a chef. Food has to be calibrated and Quality Assurance has come into the system. All of that has to be done with the documentation, and they have a clerical demand on them and an accuracy demand, that they've never had before" (Manager 22).

Promotion

Vertical job ladders traditionally characterised employment at Public Hospital. However, promotion into higher positions is no longer automatic for the next employee in line. Promotion to a higher job means competing against external applicants. Hence, promotional opportunities are more likely to occur through horizontal job ladders. Job ladders are less in evidence for lesser skilled positions, for example, in cleaning where the chain runs from hospital assistant to leading hand to manager. However, they are still present, with hospital assistants for example having a three-tiered job ladder.

Arbitrary dismissal

Protection against dismissal varies by employment type. For fixed-term employees there is no compunction for contract renewal upon expiry, while casual temps work by the hour, under the premise of a 'contract of casual employment', with both having limited protection against unfair dismissal. The perception for permanent employees however, is that a job with Regional Health is 'a job for life', and dismissal procedures are lengthy. Management stresses a policy of not using forced redundancies to adjust staff numbers downwards, preferring voluntary redundancies (sic. 'natural attrition'). In contradistinction to traditional internal labour markets, no policy of 'first on, last off' is in evidence. In some areas where voluntary redundancies were offered, more experienced staff tended to take them (Manager 22).

Case study summary

It is evident then that extensive workplace change has taken place across Public Hospital throughout the 1990s. The greatest departure from the traditional internal labour market has been the increased use of non-standard employment over the last 20 years. The use of part-time and casual employment in turn has been driven by increased pressure to meet budgets in the face of funding uncertainty. Accompanying this shift has been a

decline in trade union presence at the workplace level. Unions traditionally were instrumental in upholding the standard employment model, as evidenced by the opposition to part-time employment in the domestic and maintenance area 10 years ago. However, employee turnover and a rising proportion of younger, non-standard employees with little identification to union concerns, or solidarity, has hampered union presence on the ground and accelerated shifts away from traditional work practices.

Factors shaping internal labour markets

Apparent from the case study findings is that domestic and maintenance positions display significant variation from traditional internal labour markets. This is evident particularly for low-skilled domestic areas, which are highly exposed to the external labour market. Job ladders in these areas are little in evidence. Substantial change has occurred in the dynamics of work practices within the hospital. What pressures have contributed to the reshaping of internal labour markets in Public Hospital?

Performance of the Organisation

In Public Hospital the major factor determining labour use practices is the need to reduce costs. In practice means the need to meet budgets set by the NSW Department of Health, a problematic area given that governments have generally sought to reduce expenditure over the 1990s (Walker 1998). Case-mix funding is extensively utilised: payments prescribed according to predetermined prices for cross-boundary flows – that is, hospitals should be paid the same amount for the same product (Hindle et al 1998). Given that staffing comprises more than two-thirds of the hospital budget, a deterioration in the balance sheet is perceived to be most easily met by adjusting staff numbers/hours. The cost imperative has lead to the increased use of part-time and casual work. However, pay structures for domestic and maintenance employees have not deviated from the scales set in State awards. A move to enterprise bargaining occurred circa 1994, but was discarded soon after as the unions continued to bargain for pay and conditions on an industry-wide (that is State-wide) basis. This provides a contrast to the UK, where National Health Service (NHS) restructuring has resulted in pay and conditions being largely determined at local (hospital) level (Grimshaw and Rubery 1998).

New management practices such as multiskilling have had an impact on work in domestic and maintenance occupations. It is in the domestic occupations that the most significant departures from the traditional internal labour market are evident. An emphasis on cost reduction has driven the shift to hospital assistants performing a greater range of duties, and reducing the number of qualified chefs in kitchens. It has also led to rationalising food production to a central unit in Regional Health, with food re-heated on site through cook-chill, for Public Hospital.

Influence of the external labour market

The link between the external labour market and employment is most evident in the domestic and maintenance occupations, which tend to be low-skilled and relatively un-insulated from the external labour market. In the domestic sectors, demand for services follows a regular pattern of peak hours in the mornings and evenings, with relatively quiet periods through the rest of the day. Thus, a high degree of part-time and casual/temporary work is utilised. Coupled with a high unemployment rate for the Region (particularly for low-skilled and younger individuals), little pressure existed for management in the hospital to offer permanent full-time work to such individuals.

Public Hospital displayed an excess of labour supply for relatively unskilled positions. In this context managers were acutely ware of the relative abundance of potential employees, enabling them to utilise temporary employees to work regular shifts. Managers were thus able to identify temps that expressed a distinct willingness to work whatever shifts were available, and use them in preference to other temps who were not as amiable.

Using the same temporary employees meant that they built up familiarity with cost centre practices and hence provided managers with the benefits of permanent employees regarding loyalty and productivity. The need to have reliable and regular employees meant that temps were effectively performing work that could be deemed as permanent. Temps in turn were aware of their employment insecurity and noted that management didn't even have to dismiss them – they could just not be called in. While temps are less likely to be given training, where

a specific skill is deemed necessary, regular temps can be provided with the necessary training. The investment in the temporary employee was not 'rewarded' with permanent work because the risk of 'losing' the employee is relatively low. It was this practice that led the HAREA to seek conversion to permanent employment for 'regular' temps.

Customs, norms and practices

In common with the occupational groups, the award system has been the major determinant of employment practices and internal labour market structures. As with the other cohorts, awards (in both public and private hospitals in NSW) are arbitrated at state level. Awards set floors for employment entitlements, and set limits on the use of casual and temporary employees. Indeed, as seen in the public hospitals, the union (HAREA) was able to amend the award concerned to restrict the use of temporary employment contracts to employees with less than 13 weeks' service. The consequence of this was that a number of temporary employees were converted to permanent employment (after the time of the case study).

Traditionally, unions have been strongest (and most militant) in the domestic and maintenance occupations. Union power at the bargaining table was complemented by a highly organised and active delegate system. However, in Public Hospital, union activism has declined in recent years, although membership levels remain high. Largely, this can be linked to a generation turnover at the hospital, with older highly unionised workers retiring, and being replaced by younger workers who have little inclination to become active in the union movement. Union presence at local delegate level is now weak to non-existent in Public Hospital, with many employees not even being aware of whom their local representatives are.

Thus, it is evident that an award system arbitrated at State level can offer little respite against an inappropriate exercise of managerial prerogative at the ground level. Compliance with award clauses depends on effective enforcement – i.e., a strong union presence (Campbell 1996). While some temporary employees have been converted to permanent employment, it is quite possible that in future, Public Hospital could make use of intermittent, short-term casuals to avoid the 13-week rule of conversion to permanent employment. The implication of this is that awards only set proximate guidelines for work practices. Hence, they can be circumvented. Whilst unions possess considerable clout at the bargaining table, if their presence is weak at delegate level, then their ability to 'police' awards is reduced.

Conclusion

The case study presented in this paper suggests that the internal labour market for domestic and maintenance positions differs significantly from traditional internal labour markets. However, it does not appear to have been subject to the same degree of neoliberal policies evident in other Australian states and OECD countries.

The greatest departure from traditional internal labour markets is that part-time and temporary employment was widely used on a regular basis. Indeed, temporary employees faced long spells of regular employment, generating long tenure, but without many of the benefits of the internal labour market (Grimshaw and Rubery 1998). This situation was recognised by the union, which was able to have many temps converted to permanent contracts. Permanent part-time work is also used – but with virtually the same benefits as working full-time, in contrast to simple dualistic models of the labour market, which posit part-time work as a secondary form of employment. Permanent part-time work is compatible with an internal labour market framework.

The Grimshaw and Rubery model captures the various influences that shape internal labour market for domestic and maintenance staff. It amply underlines the need to move beyond solely ascribing the existence of internal labour markets to technical or efficiency factors having arisen in a socio-political vacuum, and vice-versa. It shows how employer prerogatives and demand pressures interact with the IR system to shape work practices. Indeed, in this study, the IR framework can be seen as providing a brake on managerial prerogative and pressures to externalise the workforce. However, there is a need to further identify how the various influences interact – can any one of them be given primacy over others? Are there causal relationships between them? From this study, it appears that the state of the external labour market is the major factor that will influence internal labour markets. Indeed, it demonstrates how internal and external pressures mutually interact to shape employer practices and the relative labour market position of employees (Grimshaw and Rubery 1998).

Whether neoliberal pressures on internal labour market structures will intensify in the future is unclear. Managers in Public Hospital suggested there was no desire to increase the number of temporary employees or casuals, for example (the accuracy of management perceptions aside). Studies on other hospital occupations would show whether neoliberal pressures have manifested in the erosion of internal labour market structures elsewhere.

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