Recasting Australian employment law: implications for the health sector

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IN OCTOBER 2004 the Federal Coalition Government was re-elected with an increased majority and, from July 2005, control of the Senate. Between 1996 and 2004, while significant changes were implemented, most "reform" proposals were blocked in the Senate. Now the government intends to implement these Bills and, in many cases, proposes further reforms. These initiatives come at a time when the health care system is experiencing profound pressures for change.[1-3] This article discusses the proposed changes in employment law and the likely impact on the health care sector.

Legacies of the past: the changing balance between contracts, agreements and awards

Until the late 19th century relations at work in Australia were governed by commercial, especially contract, law. If workers attempted to improve wages and conditions collectively they were liable to be prosecuted for conspiracy in restraint of trade — a criminal offence. "Freedom of contract" was highly valued by employers. Among the workers with limited bargaining power there was growing support for a different way of governing workplace relations. Disputes over unions' right to exist and bargain collectively reached a crescendo in the 1890s. Unions were comprehensively defeated in these upheavals and turned to political activity: first they formed labour parties and then these parties, with the support of progressive liberal political forces, introduced systems of conciliation and arbitration to establish a "new province of law and order" in the labour market.[4]

For most of the last century the "Australian way" of setting standards at work has involved a combination of collective bargaining and arbitration. Agreements settled with the strongest unions set new standards that spread to the weaker segments of the workforce through awards made by industrial tribunals. In setting and maintaining awards, industrial tribunals have endeavoured to achieve fair pay and working conditions within and between different occupational groups, providing the basis for stable and efficient wage structures. Over the years the pace setters in the system have changed. Initially located in the traditional blue collar heartlands of metal and engineering, construction, road transport, coal mining and the waterfront, more recently the union heartland has shifted to white collar, public sector workers, especially teachers and nurses.[5] Nursing unions in particular have been very successful in winning major improvements in wages and working conditions on the basis of innovative industrial campaigns and spreading the gains through successful arbitration.

While these have been the basic features of the system for a century, the system has evolved in response to changed economic and political circumstances. The last 20 years, in particular, have been particularly turbulent.[6,7] Rates of unionisation have halved. Even more importantly, the role of awards has declined. Agreements reached between employers and their workers now play a far greater role in setting labour market standards, with awards relegated to a safety net offering inferior standards. Only 20%* of employees are

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totally dependent on awards, and another 20% primarily rely on them and have their pay and conditions supplemented by "overaward" entitlements. While a further 40% of employees are on collective enterprise agreements, nearly all of these agreements build on and do not replace the relevant award. Currently, only 20% of employees are award free and on individual contracts.[8-10]

Work, commerce and the law: a new Australian model†

In May 2005, Prime Minister John Howard made a statement to the Federal Parliament on the government's proposed employment law changes.[12] This primarily codified proposed changes contained in Bills blocked in the Senate and outlined in allied discussion papers,[11,13] with a focus on increasing commercial and contract law visions of work. At its most extreme, the government plans to make it much easier for employers and workers to structure their affairs as "principal–contractor" relations,[13] outside the scope of employment law. Within the realm of employment law the government wants to make it easier for employers and employees to make individual contracts, even if the bulk of the workforce wants a unionised collective agreement. This undermines the rationale for collective agreements (ie, redressing the inequality of bargaining power at work) — something no other western country allows, including the United States of America.

In addition, there is a drive towards centralisation and recasting of employment law with the proposal to displace most state employment law systems. This will mean around 85% of the workforce (ie, anyone working in an incorporated business) will fall within the Federal system. Within the newly centralised system there will be a radical recasting of employment rights and obligations. These initiatives fall into three general categories, outlined below.

Reducing employment standards

The end of the requirement for fair dismissal procedures in businesses with 100 employees or less has received significant media coverage. While this is a major reduction in rights for millions of workers, it is of relatively minor significance compared with proposals to undermine awards. Currently no employer can reach an agreement with an employee or group of employees unless that agreement is at least as good as the award — this is known as the "no disadvantage test". In his statement to Parliament, John Howard reported that future standards (statutory minima) will comprise: basic rates of pay; annual, sickness, paternity and special leave; and a specification of maximum hours of ordinary-time work.[12] Currently, awards offer workers a far greater range of rights, such as overtime penalties, shift allowances, leave and casual loadings. The new statutory minima will provide employers with a major incentive to offer new jobs that are at or just above these bare-bones statutory minima. As these employers gain price advantages in the market for their goods and services other employers will be forced to follow suit. This is what happened under the individual Western Australian Workplace Agreements during the Court era and with individual contracts during Kennett's term in Victoria.[14]

Shifting bargaining power

Even though industrial action is at an all time low, with less than 3% of workers involved, the Howard government plans to put more restrictions on strikes. Industrial action will be prohibited during the life of an agreement, and industrial tribunals will have increased power to suspend industrial action taken "in concert" across enterprises, and to require secret ballots for strikes. The government is also proposing to allow "third parties" (eg, patients in hospitals) affected by industrial action to apply for the suspension of that action.

* It is important to note that these proportions refer to employees only. These are workers engaged on a contract of service. Around 23% of the workforce are "owner managers". These people are self-employed and many work on a contract basis. See, for example, the latest data on forms of employment.[8]
† This section draws heavily on material and arguments prepared by the author and Chris Briggs published elsewhere.[11]

Reducing the role of industrial tribunals

Traditionally, industrial tribunals have played a central role in setting standards for the labour market. Under the proposed changes the power of the Australian Industrial Relations Commission to set minimum award rates of pay will be removed and given to an Orwellian "Fair Pay Commission". In addition, much of the Commission's dispute settling function will be passed to private mediators. As such, the primary role for the tribunals will be to manage larger scale disputes, which in the end comes down to enforcing stricter controls over unions.

Overall, the effect of these changes will be to weaken the ability of unions and industrial tribunals to improve labour market standards. As the international comparative industrial relations and labour economics literature shows, the inevitable result will be greater wage inequality, longer hours for full timers and more fragmented hours for part-timers.[15,16] In addition, employers will enjoy unparalleled power to reshape work unilaterally. Yet there are some constraints, as the industry and labour market context will limit what is possible.

Health industry and labour market context: deepening skill shortages

Arguably the greatest challenges for the health sector arise from the growing level and complexity of demand for health services. On the supply side, changes in the level and nature of funding are profoundly reshaping the sector and close monitoring and control of health funding has become a particular concern for treasuries and finance departments.[17]

The institutional arrangements which have balanced competing demand and supply pressures have also been changing. Since the late19th century the health system had been primarily organised by, or at least structured in a way that enhanced the power of, the medical profession.[18] This regime of "medical dominance" has been severely shaken with the onset of the new public management in health since the early 1980s.[19] While clinicians, especially doctors, still exercise considerable influence in the system, this power is now often shared with senior health administrators. This arrangement is, however, far from stable, and often dysfunctional.[20]

This industry context has created a situation in which the health system is unable to attract and retain sufficient numbers of skilled workers. While this is commonly referred to as a skill shortage, is it is more accurate to define it as a shortage of "decent" jobs — that is, jobs that are not only well paid, but which have attractive hours of work and offer satisfying opportunities for skilled workers to care for patients and their co-workers. Declining levels of on-the-job training also make health care organisations less attractive places to work. Health workers at all levels are becoming disenchanted with managers and governments exploiting their good will to maintain services. This is leading to deepening disengagement with the system as evidenced by deepening recruitment and retention problems.‡ This situation is not unique to Australia.[26,27]

This creates major pressure to change the sources and division of health labour, with growing reliance on overseas trained and/or agency doctors and nurses. Yet labour from these sources has not been enough to meet demand. Unsurprisingly, there is growing pressure to change models of care, including the skill mix associated with the provision of health services. How will changes in employment law operate in such industry and labour market settings?

Changing strategic options

Predicting future developments is difficult. While laws can change, the parties, through their choice of response, can often negate the reform objectives. Most of the changes noted in the previous section have enhanced the control and influence of governments and health system managers at the expense of clinicians, especially doctors. As a

‡ The best documentation of this problem concerns the nursing profession, but the problem exists for other professions in the sector too. Indicative Australian studies substantiate the assertions in this paragraph.[21-23] Indicative overseas studies of nursing document similar problems.[24,25]

result, government and managers now exercise greater control over funding and workflows, which has resulted in profound increases in productivity defined in financial and administrative terms. For example, the NSW Department of Health reported of nurses in the 1980s and 1990s:

> Acute care hospitals are the major employers of nurses in Australia and patient separations from these insititutions rose by a dramatic 55.6% (from 3.3 million to 5.2 million) between 1986 and 1996. Although the overall numbers of nursing registrations are not declining, these figures mean that patient numbers per nurse are increasing.[28] (page 10)

However the sustainability of this achievement is in doubt. The deepening problems of disengagement among health workers are manifest in deepening recruitment and retention problems. Health workers, especially nurses, have not passively accepted this situation. While many have voted with their feet, nurse unions have led decisive campaigns of collective action to remedy underlying problems. For example, in NSW the Nurses' Association has used the State Industrial Relations Commission to open up collective agreements and arbitrate to dramatically increase pay for public sector nurses (9.5% in 18 months in 2002–2003). Similar methods have been used to increase the pay of aged care nurses by 2004 – 2005.

The Victorian branch of the Australian Nursing Federation very effectively combined community campaigning, industrial action and arbitration to achieve mandatory nurse–patient ratios. These have worked to stabilise deteriorating employment conditions by enabling nurses and nurse unit managers to close beds if there are not enough nurses to provide proper care.[29] Similar successful action on pay and working conditions has also occurred in Queensland, Tasmania and South Australia.

Nursing unions have not achieved these outcomes on the basis of bargaining alone. The activities of industrial tribunals have been central to their successes. Even where "private arbitration" has occurred, as in the case of the Victorian nurse–patient ratio campaign, the Australian Industrial Relations Commission used its structures, especially the award, to shape the intervention.[30] Central to this was the unity of the nursing unions and recognition by industrial tribunals of the legitimacy and importance of maintaining decent standards of work for nursing as a profession.

Most likely impact of employment law changes

The impending changes in employment law have been formulated to weaken the role of awards and unions in bargaining. Traditionally, awards and unions have regulated "industries, occupations and callings" which provided the framework for the recent highly successful campaigns by nursing unions. The implementation of mandatory nurse–patient ratios in Victoria provides a good example of this: the provision of services in pubic hospitals is defined as being dependent on maintaining the profile of a particular class of skilled workers. But the vocational basis for defining rights and obligations at work is about to change. In its place, employment law will work to promote "flexibility" and "tailoring outcomes" to suit the requirements of "particular workplaces and enterprises". In short, weakening of the occupational bases for defining labour market standards will increase management prerogatives considerably.

The role and influence of the skilled clinicians in the system is not about to disappear. Demand for doctors, nurses and allied health professionals will remain, but the division of labour between these groups has never been fixed and is set to change dramatically. As currently structured, the industrial relations arrangements could have helped underpin a new distribution of work roles, but this will be difficult to achieve in the new framework of employment law. Any employer who meets the five minimum statutory conditions will be entitled to recast all other aspects of employment for their workers. As a result the impending changes in skill mix and employment conditions for different classes of health workers is likely to be ad hoc, if not chaotic, in nature. This will affect the staffing profile of particular health services. This trend is already evident in the aged care sector where the registered nurse is

an endangered species of worker. Statutory regulation provides some minimalist protection of service levels. Yet it was only intervention by the NSW Industrial Relations Commission that addressed the inadequate levels of pay which have been identified as a key factor behind the falling skills profile in this sector.

Conclusion: employment law and the broader context

Changes in employment law will complement wider health policies directed at increasing differentiation in the quality and fragmentation of health services. Funding policies in particular are explicitly directed at increasing inequality in the distribution and access to health services. The chaotic realignment of the division of labour within the health workforce will supplement this broader trend. "Up-market" segments of the population in metropolitan centres will get all the doctors and nurses they need, especially in the private sector. Most regional and rural areas and the less prosperous areas of the metropolitan centres will have to rely on services staffed with fewer professionals and a growing proportion of lower skilled health workers.

Employment law will not drive these changes; it will, however, facilitate them. Even more importantly it will work to weaken any opposition to these developments. To date, the most effective opposition to regressive trends in the provision of health services has been organised by increasingly active nursing unions. Their success has been based on combining community campaigning, creative industrial action and arbitration by industrial tribunals. Their capacity to organise so effectively is about to be weakened. History shows, however, that setbacks are not necessarily permanent. While the impending changes undermine unions in the short run, unions are likely to find other ways to respond to what will almost inevitably be a situation of deepening inequality and deteriorating conditions of work. Given the strength and cohesion of unions in the health sector, especially in nursing, some of the most significant and lasting counter-offensives are likely to originate from this sector.

Competing interests

None identified.

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