Work Intensification: A Lacuna in the Labour Utilisation Literature

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Abstract: The labour flexibility literature has been largely organised around two central forms of labour utilisation: numerical flexibility and functional flexibility. The former denotes the use of a range of different employment forms and working-time arrangements to more accurately adjust labour-use to demand patterns. The latter refers to the expansion of worker autonomy and mobility to allow rapid movement between work tasks. The concepts of numerical and functional flexibility have often been used as defining characteristics of different labour management strategies. However, work is characterised not just by the range and nature of tasks undertaken (functional flexibility) and its quantum (numerical flexibility), but also by its intensity (work effort). Employers can and do adjust effort levels independently of functional and numerical adjustments. Work intensification needs to be recognised as an entirely separate labour adjustment process.

Introduction

Work intensification is a much neglected issue in recent labour-utilisation models which tend to focus largely on numerical and functional forms of flexibility. Yet, evidence is emerging that the process of work reform is increasing the effort levels of employees. This paper examines this issue through a single case study in the public hospital system. The structure of this paper is as follows. The first section provides a discussion of the workplace reform in the public sector and the effects it is having on employees. A case is then made about the inability of labour flexibility literature to capture this workplace phenomenon. The next section presents findings of public hospital cases, and outlines the nature of the hospital and its operating environment, recent government endeavours to increase hospital throughput, and the effects this has had on labour intensity and staff well-being. The conclusion of this paper is that work intensification has been the major form of labour adjustment in the public hospital system.

Public sector reform

In recent years, governments have actively pursued micro-economic reform of the Australian economy. Governments have pursued a range of policies, including market liberalisation, deregulation, privatisation, and workplace reform. One of the aims of micro-economic reform has been to lower costs and improve efficiency in the public sector (Castle and Haworth, 1993). In the health care sector, one of the principal instruments used to improve the efficiency of the health system has been the Medicare agreement between the Federal and State governments.

A main objective of hospital sector reform has been to reduce hospital waiting lists (Butler, 1991: 41) and increase the overall level of efficiency of the public hospital system. Governments, faced with limited resources and expanding demand for health services, have sought a number of ways of improving access while restraining cost of service provision. The Commonwealth government, in particular, has sought to 'promote structural and micro-economic reform in the hospital system'

(Australian Government Solicitor, 1993: 57) by offering the States incentives to improve efficiency and treat more public rather than private patients under the terms of the 1988 and 1993 Medicare agreements. Funds have been made available for the development and implementation of advanced hospital management systems, while additional funds have been made available to increase hospital throughput.

In many areas of public sector reform, however, 'the emphasis is on getting results in the short-term, rather than worrying too much about how they are achieved' (Davis, 1994: 125). This short-term focus may, as Muetzelfeldt (1995: 98) notes, entail a process where technical efficiency improvements are achieved by displacing costs 'off budget' and imposing them on employees. The desire to maintain or increase the level of service delivery at lower cost may be achieved by reducing direct inputs such as labour. Employees, then, may experience intensified workloads and decline in health and well-being. A number of authors have identified that workplace reform in recent years has resulted in increased workloads and stress (Britton, 1995; Face, 1995; Heiler, 1996). Indeed, the most telling statistic in the Department of Industrial Relations' report on enterprise bargaining in Australia in 1994 is that 56 per cent of employees felt that their work effort was greater than 12 months ago. These preliminary findings indicate that employees are increasingly shouldering the costs of workplace reform through increased work effort.

Labour-utilisation models and work intensification

However, the recent labour flexibility models used to conceptualise changes in the organisation of labour and work do not adequately capture this dimension of labour adjustment. Rather, most models tend to be organised around two forms of labour flexibility: functional and numerical. One of the most influential offerings is Atkinson's (1984) 'flexible firm' model of dual labour use strategies: the functionally flexible core workforce strategy and the numerically flexible peripheral workforce strategy. Most other contributions are organised around these two types of flexibility (Horstman, 1988) although some versions extend this dualist framework to include other areas of flexibility (such as procedural and technical-organisational flexibility; see Meulders and Wilkin, 1987; Rimmer and Zapalla, 1988). Work intensification as a distinct form of labour adjustment is entirely absent in these labour utilisation models.

This issue has been only partially addressed in the critical flexibility literature. It has been recognised that labour intensification may be a consequence or undisclosed objective of management flexibility strategies (Pollert, 1991: xxi). Work intensification has been found to be the product of functional flexibility strategies (for instance, Elger, 1991; O'Donnell, 1995; Pollert, 1991; Tomaney, 1990). Similar conclusions have been reached in the case of numerical flexibility (Bagguley *et al.*, 1990; O'Connell Davidson, 1990; Rees and Fielder, 1992; Stubbs, 1991). However, while work intensification may be a by-product of, or ulterior motive for, employers' dualist flexibility practices, work intensification is also a distinct and separate form of labour adjustment.

Work is characterised not only by the range and nature of tasks undertaken (functional flexibility) and its quantum (numerical flexibility) but also by its intensity (work effort). Employers can and do adjust effort levels independently of functional and numerical adjustments. Employers may attempt to increase effort levels to accommodate surges in consumer demand or they may seek to intensify work effort to improve productivity through the use of incentive payment systems,

downsizing or management control strategies. Whatever the rationale or mechanism, adjusting effort levels acts as a substitute for quantitative adjustment in labour usage. Work intensification needs to be recognised as an entirely separate labour adjustment process which may or may not be associated with other forms of adjustment. The absence of attention to work intensification as an independent form of labour adjustment is surprising, given the central importance of the concept of a wage/effort exchange in the industrial sociology literature (Edwards, 1986).

As Lloyd and Seifert (1995) demonstrate, the labour adjustment process in the public sector is often a case of increasing effort levels of the existing staff. Undoubtedly, the issue of work intensification is as much a feature of private sector employment as it is of the public sector. The profit motive is a strong incentive for private firms to intensify labour. But unlike the public sector, private firms also have profit incentives to use additional labour to match additional consumer demand. Within the public sector, though, labour utilisation is constrained by budgets such that the provision of additional services will be limited by the elasticity of endurance of the workforce. This characteristic of public sector employment is particularly salient here because workload issues have been one of the most important industrial issues in Queensland public hospitals for decades.

The Queensland public hospital system is a classic example of fiscal strain and the effects this has on effort levels. Unlike other States, Queensland has maintained, at considerable financial cost, a public hospital system since 1944. The commitment to provide universal access has simultaneously created pressure to restrain costs (Scotton, 1995: 83) such that Queensland still boasts the lowest cost hospital system in Australia. Lower costs were achieved through lower salaries and staffing levels (see Table 1). Inadequate staffing levels produced workload pressures which periodically erupted in industrial disputation; most recently in September 1994 (*Courier Mail*, 19 September 1994). Indeed, the first major strike by Queensland nurses in 1984 was a direct result of workload pressures (*Queensland Nurse* (1984) **3**(2): 2-5).

Table 1: Queensland variation from national average for equivalent full-time staff per occupied bed day, acute hospitals, 1987/88, 1989/90, 1990/91

Workforce segment	**1987/88**	**1989/90**	**1990/91**
Medical	–10	–16	–8
Nursing	2	–4	–13
Administration	–33	–35	–36
Allied health, operational and other	–21	–18	0
Total	–12	–12	–11

Note: 1989/90 data exclude NSW except for Total. The allied health, operative and other category data for 1990/91 are not available.
(**Source:** calculated from Cooper-Stanbury, Solon and Cook, 1994; Table 6.1; Gillett, Parslow, Scholes and Renwick, 1991: Table 7.1; Gillett and Solon, 1992: Table 6.1.)

Hospital workers are particularly vulnerable to work intensification pressures. In personal service industries, most forms of industrial action taken by workers will directly affect service users; in this case, patients. The underlying professionalism of health workers can restrain the kinds and extent of industrial action which are pursued to redress workload grievances. While there undoubtedly has been a growth in the militancy of health workers in the last decade (Bessant, 1992; Fox, 1990; Gardner and McCoppin, 1987), industrial action by these workers is still often perceived as unprofessional, unnecessarily harmful to patients and unethical. This problem is

particularly acute for the highly feminised health professions where the dual social stereotypes of 'caring women' and professional care providers are intimately intertwined.
To illustrate just how important it is to recognise work intensification as a separate form of labour adjustment, the following sections will outline the experience of workers in a large public hospital in Queensland.

The organisation: Pubhos

Established in the post-war period, Pubhos is a large Queensland metropolitan hospital offering an extensive range of acute hospital services as well as geriatric and mental health services. It has particular expertise in a number of specialty areas with an international reputation for excellence in some of these areas. The hospital serves a large urban catchment area and is the referral hospital for many smaller hospitals in the outer suburbs and adjoining regions. The hospital admits approximately 60,000 patients a year who are tended by a staff of more than 3,000. It is a major teaching hospital, providing undergraduate and post-graduate medical education. Prior to the transfer of nurse education to the tertiary sector, it was also one of the largest teaching hospitals for nursing in the country.

Financial control and the pattern of labour use

While the daily administration of the hospital is vested in senior managers, many areas of hospital management are either directly or indirectly controlled by the Health Department. Pubhos is but one facility within the network of services provided by the Queensland health system. One of the primary objectives of these Health Department controls has been to contain expenditure, particularly labour costs, which represent a major component of total costs. The nature of these controls has had a major impact on the overall pattern of labour use, including the type of labour, the quantity of labour and the intensity of its application.

In the 1990s, the Health Department introduced two major measures to improve the efficiency of the public hospital system — despite having the lowest cost hospital system in Australia. First, central agencies have imposed direct budgetary cuts on the health system. The cuts have either been in the form of general cuts to operating grants or specific cuts to induce efficiency savings in areas such as administration and hotel services.

The second measure used to induce efficiency gains has been the introduction of activity targets for hospitals. As part of the Medicare agreement, effective 1 July 1993 to 30 June 1998, the Commonwealth government offered incentive money to increase the level of hospital activity and so reduce waiting lists. Queensland agreed to participate in the scheme in 1993/94 and set activity targets for each hospital in terms of admissions and occupied bed days. This was the first time that activity levels were set by the central office.

The expansion of surgical activity commenced in early 1993/94 with the employment of additional surgeons and some nurses. Over the course of 1993/94, there was an 8 per cent increase in the number of theatre cases compared to 1992/93. The number of emergency cases increased by 16 per cent and the number of booked theatre cases increased by 4 per cent.

Between 1992/93 and 1993/94, admissions increased by 8.5 per cent, the average daily number of in-patients increased by 6 per cent, the occupancy rate increased from 86 to 92 per cent and the average length of stay fell by 14 per cent. The increase in utilisation was due to an increase in both surgical and medical patients.

Productivity indicators

The major effect of this expansion of activity was to significantly increase the intensity of labour. Some indication of the increases in productivity can be gained from changes in static labour productivity. Static labour productivity is a crude input-output indicator which measures the ratio of average daily in-patients to effective full-time staffing positions. This indicator thus provides a static or 'stock' measure of productivity, which abstracts from case complexity and flow measures of productivity.

Table 2 indicates the percentage increase in total labour productivity for the period 1991/92 to 1993/94. As can be seen, there have been significant productivity increases, particularly in the areas of allied health and nursing. As can also be seen, these increases in labour productivity pre-dated the efficiency drive of 1993/94, with significant increases also recorded in 1992/93.

Table 2: Annual labour productivity increases for 1992/93 and 1993/94 and total labour productivity increase from period 1991/92 to 1993/94, Pubhos (per cent)

Segment	**Annual increase 1991/92 to 1992/93 %**	**Annual Increase 1992/93 to 1993/94 %**	**Total increase from 1992/92 to 1993/94 %**
Allied health	25	1	26
Nursing	6	15	22
Medical	6	7	14
Administration	–5	4	0
Operational	8	–8	–1
Total	7	7	15

Note: errors due to rounding.
(**Source:** calculated from *Annual Reports.*)

Using data for 1992/93 and 1993/94 it is possible to show how effort levels varied on a monthly basis for 1993/94. This can be seen in Figure 1, which shows that with the exception of September 1994 — when a strike took place — effort levels were consistently equal to or higher than for the preceding year, with significant variations from month to month.

Declining staff well -being and morale

Workload pressures had been building in the hospital system for some time and really came to a head with the significant expansion of hospital activity in 1993/94: employees took industrial action in September 1994. At one public hospital, striking health workers were distributing leaflets to the passing public asking them to join them in a campaign to save the public hospital system from

chronic understaffing and excessive demands on staff.

Some indication of the effect of these workload pressures can be gained from Figure 2. Measures of staffing counselling, sick leave, quit rates, incident reports and workers' compensation claims all indicate a deterioration of the health and well-being of staff at Pubhos.

The highest growth rate was recorded for staff counselling services. This indicator was based on the average number of staff counselling services per day. From July 1992 to November 1994, the average number of staff counselling sessions rose from approximately five per day to 11 per day. In January 1992, the average number of sessions was two per day. Approximately two-thirds of presenting cases were for depression, stress and anxiety and for relationship difficulties with co-workers and supervisors. By 1993/94, one in five staff members were using counselling services.

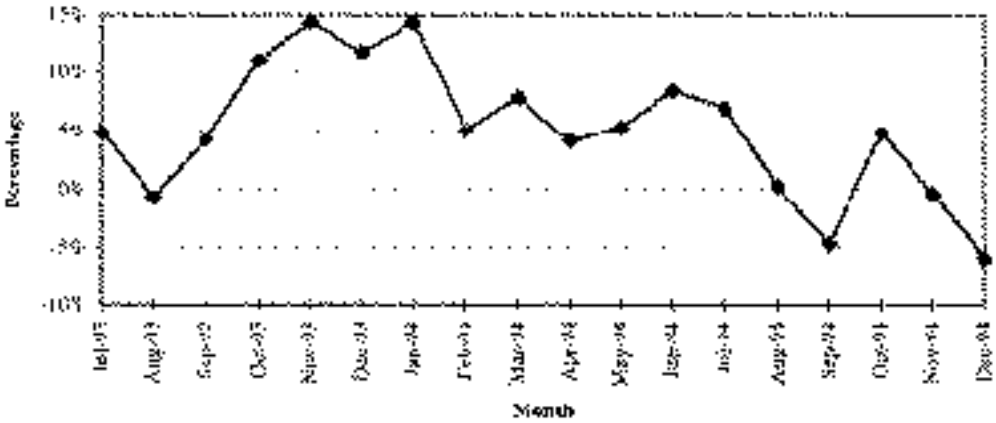

Figure 1: Total static labour productivity increase by month, July 1993 to December 1994 (using 1992/93 as base), Pubhos (per cent)

Note: slightly exaggerated as excludes nursing agency usage.
(**Source:** calculated from financial reports.)

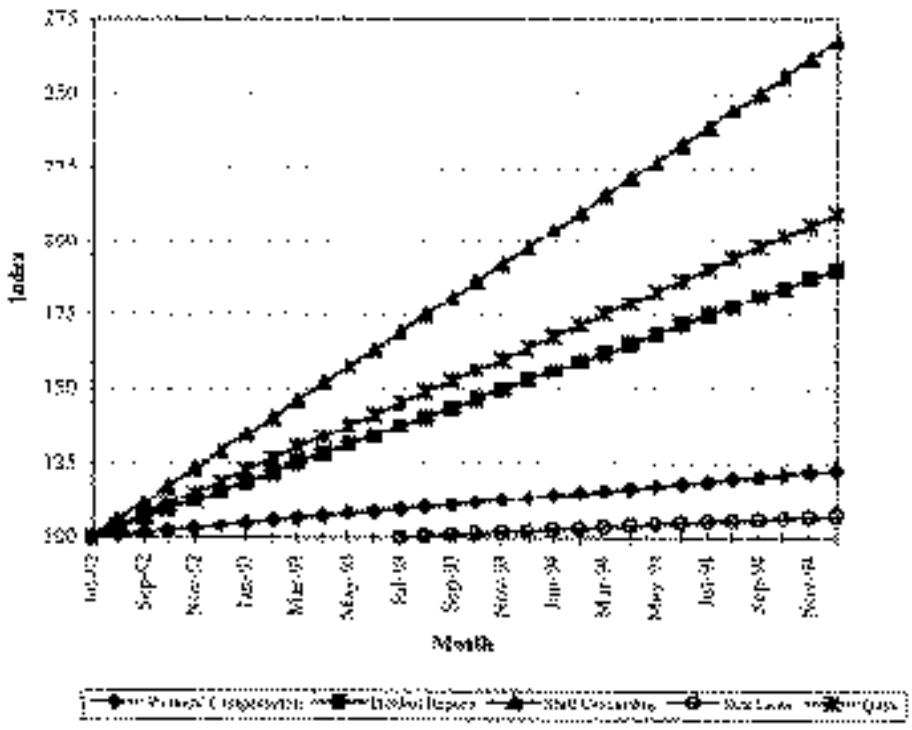

Figure 2: Trends in various measures of worker well-being, Pubhos, July 1992 to December 1996 (as a ratio of effective full-time staffing)

The next highest indicator is the quit rate. The number of quits has risen from 20 per month in January 1992 to 50 per month in December 1994. By 1993/94 one in five staff members were leaving the organisation per annum. In areas such as nursing, the turnover rate was 30 per cent. Also showing strong trend growth was the number of reported incidents at work. Reports incidents include injury to both personnel and equipment, although the vast majority of reports pertain to personnel injury. Some care should be exercised in interpreting these data, as not all incidents result in working days lost or compensation claims. Nevertheless, the upward trend is clear and escalating. The other two measures shown in Figure 1 are workers' compensation claims[1] and sick leave. Neither of these measures show the same dramatic growth rates as the other indicators, although both are nonetheless increasing.

Conclusion

What these case study data indicate is that one of the primary mechanisms used to increase the throughput of hospital services in recent years has been variation in the workload of hospital employees. Hospital workers have laboured more intensely and their health and well-being has deteriorated accordingly. Yet, despite the obviousness of these empirical findings, the labour utilisation literature provides very little conceptual purchase on this kind of labour adjustment process. Clearly, we need to move beyond the limitations of the flexibility literature and develop more adequate models for understanding the labour utilisation process.

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1 The workers' compensation data should be interpreted with caution as these data only provide a measure of the number of claims, not the severity of claims or duration of injury, illness or disease.

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