Outsourcing and Downsizing: Processes of Workplace Change in Public Health

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Abstract

Throughout the 1990s, public hospitals embarked on a range of benchmarking exercises for support services, often accompanied by downsizing and, in some cases, outsourcing. These support services included clinical areas such as, radiology, pharmacy and pathology, and non-clinical areas of catering and cleaning, engineering and environmental services. The impetus for this trend was the introduction of the Federal Government's National Competition Policy with its rationale that private sector pressures and competition would make the public sector more efficient.

Through a case study approach, this paper discusses this process at two public hospitals, the aim being to investigate the reasons for outsourcing, outsourcing's interconnectedness with downsizing, and the implications at the workforce level. Workplace issues discussed include consultation between management, unions and employees, changes to employee numbers and work practices, maintenance of workplace condi-

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tions, implications for staff recruitment and retention, and the relative power of management and unions. It concludes that benchmarking, outsourcing and downsizing have all been used to bring about workplace change. Whilst the choice between processes may be dependent on management perception of the workplace environment, implications for the workplace from each process have been similar.

Introduction

The introduction of the National Competition Policy (NCP) in 1995 by the Federal Government provided the impetus for outsourcing, benchmarking and downsizing in the late 1990s. The policy was based on an ideology that private sector pressures and competition would make the public sector more efficient. The Policy stated that 'competition, or the threat of it, can create powerful incentives for management to improve internal efficiency and to become more responsive to customers' (State Government of Victoria, 1996: 5).

The implementation of competitive neutrality principles required that by June 1996, all public hospitals were to identify significant business activities and develop an implementation timetable (Phillips Fox & Casemix Consulting, 1999: 93). However, in adopting NCP there was no compulsion to outsource functions, or indeed, to adopt any particular organisational form. The Health Service Review Discussion Paper (Phillips Fox et al., 1999) stated that by 1999 a considerable proportion of the non-clinical services in public hospitals had been evaluated against competitive neutrality principles. It reported that in some cases outsourcing occurred with resultant savings, but even when internal provision was retained, it provided a means for in-house staff to identify efficiencies and restructure workplaces. Many hospitals also implemented a second phase of competitive neutrality through benchmarking and the possible outsourcing of clinical services, such as pathology and radiology (Phillips Fox et al., 1999: 93).

This paper will investigate how one rural and one city hospital attempted to make changes and improve efficiency by adopting NCP guidelines. But first a review of the literature highlights the reasons for outsourcing, the interconnected nature of outsourcing and downsizing, the use of downsizing to affect the climate and acceptance of outsourcing, and outsourcing's role in reducing employee numbers.

Reasons for Outsourcing

Ang (1994) believes that the main attraction of outsourcing has been the

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relative production cost advantage of using external service providers. The outside provision of services introduces economic efficiencies through the outsourcing vendor's ability to utilise specialist human resources, technologies and physical infrastructure. Such specialisation, it is said, creates economies of scale when the products or services are sold to multiple customers (Lacity & Hirscheim, 1993: 31).

A reduction in wages and other working conditions has been a reason found to account for these cost savings. For example, Domberger (1994), and Milne & McGee (1992), reported that cost savings arising from public sector outsourcing result from associated wage reductions rather than increases in efficiency. Ascher (1987), in a British study, similarly found that reductions in employees' wages and conditions were the result of compulsory competitive tendering, even if the tender was won in-house.

It has also been reported that savings were due to increased flexibility of the labour force which outsourcing produced, although often flexibility and reduction in wages were linked. A Labour Research Department study on the impact of competitive tendering in the British public sector during the mid 1990s reported that the reduction in wages and conditions was linked to outsourcing, and resulted from an increased trend towards the use of part-time labour by contractors (Industry Commission, 1995: 160).

The extensive review of work practices that outsourcing has initiated in government services has also been cited as a reason behind the government privatisation policies (Industry Commission, 1995: E27-28). It was suggested that the mere threat of contracting-out in-house services can lead to improvements in efficiency and productivity (see, for example: Domberger, Meadowcroft & Thompson, 1986; Donald, 1995; Industry Commission, 1995; Sharp, 1995; Hodge, 1996). In this regard, workers are spurred by the threat of outsourcing to adopt more flexible work practices and improve productivity to ensure job security.

Effects of Outsourcing

Other research conducted in private industry and in the public sector has found that outsourcing has increased the expertise of core staff and injected professionalism and skilled personnel, whilst improving access to technology (see, for example: Hoewing, 1992; Rimmer, 1993; Aubert, Rivard & Patry, 1996; Willcocks & Currie, 1997; Industry Commission, 1995).

Despite this, the contention that outsourcing has financial advantages has been challenged. First, it has been argued that cost savings are not

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available over the long-term (see, for example: Evatt Research Centre, 1990; Rimmer, 1993; Willcocks, 1994; Industry Commission, 1995, Domberger, 1994; Quiggin, 1994; Willcocks & Currie, 1997: 45). Secondly, the inclusion of all transaction costs has been questioned (see, for example; Cullen, 1994; DeLoof, 1995, Donald, 1995) and thirdly, it has been suggested that the costs of internal provision have decreased solely with the threat of outsourcing the service without it actually occurring (Donald, 1995; Sharp, 1995; Hodge, 1996)

Questions have also been raised with regard to the effect of outsourcing on quality (Industry Commission, 1995: 102). Other researchers contend, however, that the outsourcing process engages the organisation in setting specifications and monitoring of performance which were previously lacking (Domberger & Rimmer, 1994: 84). If indeed this is the case, then whether quality was measured accurately before outsourcing is contentious.

Another problem that has developed is in the area of workforce management. The management of contract staff, morale of internal staff, equity between contract and internal staff, and trust, motivation and commitment of both internal and contract staff have been highlighted as complex issues by numerous researchers. For instance, Pfeffer (1994: 22-4) believes that contract staff lack loyalty, dedication and firm-specific knowledge. He suggests that they bring problems of reduced productivity and motivation.

In contrast, Pearce (1993: 1093-4) concludes that there is no difference between in-house and contract workers' organisational commitment. Benson (1998: 366) supports the proposition of dual commitment, by suggesting that 'organizations that outsource maintenance functions do not appear to end up with a poorly committed group of contractor employees'. Indeed, it was found that their commitment to the host organisation was often higher than it was to their employer. However, as Benson qualifies, this may be explained by the nature of the relationship between the host organisation and the employer, as these employees were often employed on a relatively stable basis with the contract-labour firm. They were classified as permanent full-time workers, paid award wages and conditions, and identified with the host company as their place of work (Benson, 1998: 361).

Outsourcing's effect on organisational safety has also been raised as an issue (see, for example; Rebitzer, 1991: 3) often explained by the lower commitment levels on part of contract staff and the lack of formal supervision and training offered by the host organisation (see, for example: Kochan, Smith, Wells & Rebitzer, 1994).

Interestingly, Pearce (1993: 1090-3) found employees who worked

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alongside contractors reported less trust in their organisation compared to those where contract workers were non-existent, and suggests that this was due to two principle reasons. First, that employees felt dependent on their organisations to deliver future benefits, which contractors received immediately in the form of increased benefits. Secondly, that the very presence of contractors reminded employees that their organisations were willing to 'take advantage' of them by not offering equivalent benefits (Pearce, 1993: 1085-1086). Furthermore, Ang (1994: 140) has cited research (see, for example: Porter & Steers, 1973; Rotter, 1980; Organ, 1988; Gambetta, 1988) showing the impact of reductions in organisational trust through decreased performance, increased turnover, lack of cooperation, and dysfunctional behaviour, such as lying, cheating, and stealing.

Downsizing

In the same vein, the downsizing literature argues that decreased employee numbers brought on by contracting-out has caused a reduction in trust and co-operation between management and staff. In this regard, downsizing has often occurred with little research into its effect on those remaining. Sharp (1995) states that outsourcing, as part of the downsizing process, is often traumatic for staff, time consuming, costly and disruptive. Zeffane (1995: 45-46) supports this contention, asserting that the inability of managers to address issues relating to staff redeployment, performance appraisal, retraining and strategic human resource planning frequently leaves employees shaken, uncertain and less effective. Amabile and Conti (1999) have cited research where downsizing has been accompanied by a deterioration in communication (Cascio, 1993), a deterioration in trust (Buch & Aldridge, 1991), an increase in fear (Buch et al., 1991), a resistance to change (Cameron, Sutton & Whetton, 1988) and high levels of uncertainty and chaos (Tombaugh & White, 1990).

More indirectly, outsourcing, and downsizing have been shown to confer distinct advantages for certain sectors of the labour market at the expense of others. The expansion of supervisory positions in the field of engineering, for example, has been found to be often at the expense of in-house blue-collar workers (Albin, 1992; Chandler & Feuille, 1991). Contracting has also had detrimental effects on particular ethnic and gender groups within the workforce. In US studies, for instance, the brunt of the downsizing due to outsourcing has been borne by women, part-time workers and African-Americans (Hodge, 1996: 55). This finding is reflected in studies conducted in other countries, such as Britain

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and Northern Ireland (see, for example: Ascher: 1987: 106; Fraser, 1997: 10-2). In Australia it was reported (Fraser, 1997: 40-1) that downsizing through contracting out has had detrimental effects on immigrant, non-English speaking female workers.

In addition, a substantial body of empirical evidence questions the ability of downsizing to increase profits. For instance, Cascio and Young (1997: 1189), in their research of 5,479 cases of downsizing, concluded that 'downsizing may not necessarily generate the benefits sought by management...and that management must be cautious in implementing a strategy that can impose such traumatic costs on employees'. Amabile and Conti (1999) concluded that downsizing produces negative implications for creativity and team stability, and along with the lack of support for economic benefits, decision makers should approach downsizing with extreme caution.

To investigate these issues, this paper turns to two case studies which describe these processes in more detail. Interviews were conducted with hospital managers, staff, union representatives and private sector proprietors between 1999 and 2001. The hospital names are disguised and interviewees were granted confidentiality. The interviewer first contacted and interviewed the hospital chief executive officer, and subsequently arranged interviews with other personnel. All interviews were conducted face-to-face with the interviewee alone at the hospital location. All interviews began with the interviewee asked to talk generally about the workplace changes which occurred throughout the implementation of NCP, with subsequent semi-structured questions focusing on the reasons, processes and effects of such. Interviews were taped and later transcribed. Annual reports, newspaper articles, consultants' reports and other published and unpublished material was used to supplement the interview material.

Case Study Hospital One

The rural city in which the hospital is located is the largest in the region. The hospital provides medical, nursing, psychiatric, allied health and health promotion services to inpatients, outpatients, domiciliary care clients and general communities. In addition, support services for purchasing, linen provision and information technology are provided for three smaller hospitals and health-related organisations in its sub-region.

This hospital is one of the region's major employers of labour, with an effective full-time staff level in 1999/2000 of 627.7. In that year it treated 12,823 acute inpatients, 72,500 outpatients and served 254,429 meals. Turnover amounted to $45.2m, with total assets of $55.6m. On 1

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July 1999, it amalgamated with an adjoining regional hospital service to become a regional health care provider, increasing the number of available beds from 179 to 246[1].

The hospital currently outsources pathology, radiology, dental technician, lawn mowing, security and some engineering and maintenance services. In addition, as part of NCP implementation, it has benchmarked hotel and pharmacy services.

Hospital Process of Benchmarking and Outsourcing

Generally, the process involved a benchmarking exercise which included a cost/benefit analysis of outsourcing. In cases where outsourcing was considered viable, information was gathered from staff, unions, other organisations, legal firms and industry experts. On implementation, discussions ensued between management, staff and unions concerning the implications, with the Chief Executive Officer (CEO) depicting this as 'consultation'.

The CEO declared that the rationale expressed to staff was that the hospital's financial position and the Government cuts to health were the impetus for outsourcing. He stated that

> the staff were able to raise questions and have input into the decision, within confidentiality requirements. They were also informed of the final decision... The aim was to take the staff with the hospital so that even if they did not like the decision, they understood it.

As one staff manager stated, 'staff were told as early as possible, but they didn't want to go in and scare people about what might not happen'. Weekly meetings were held over a six-month period with possible outcomes discussed. Although the hospital involved the unions, the manager stated that the consultation was also held directly between management and staff 'to stop misinformation from unions'. He explained that, even though the hospital

> has a good relationship with the unions, the unions have a different perspective. Their job is to generate fear amongst members to ensure they are not seen as unimportant... to try to get the hospital to give more, regardless of how well the hospital is managing the process. Consultation and argument, and even conflict, is positive in bringing issues into the open.

It was reported by a staff manager that initially the staff were hurting,

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angry, upset and disappointed with the changes mooted. Although the staff understood that there was no longer tenure in the public sector, these changes further decreased job security. They argued that if there was money to be made by the private sector in providing the service, then the public sector should also be able to avail itself of it.

Throughout the negotiations, staff became resigned to the changes, especially since downsizing had occurred throughout the 1980s and 1990s, alongside funding constraints, organisational amalgamations, and changes to processes and technology. A staff manager stated that 'the staff understood that change was inevitable, people had seen positive outcomes from change and so outsourcing became just another step'.

Similarly, the CEO stated that the staff realised that the hospital would examine outsourcing, so it was better to work with the organisation to provide a better and efficient service and to ensure its long-term viability. Indeed, 'the outsourcing threat and the Kennett Government factor allowed changes to work practices to occur at a faster pace than would otherwise have happened, sensitising staff to the need to change'.

Generally, the process could hardly be called 'consultation'. Information was called from staff when the decision was made to investigate outsourcing, whereas consultation between management and staff and their representatives was limited to the outcomes, such as the transfer of leave entitlements.

Radiology

The CEO stated that two factors led to the outsourcing of radiology. First, the cost of replacing obsolete equipment was prohibitive. Secondly, the relationship between the radiologists, management and the hospital staff was confrontational, creating conflicts of interest, poor staff morale, management and financial problems. Problems with staff morale were also due to staff reductions as patient examinations declined from 18,500 to 11,000 between the mid-1980s and early 1990s. This reduced the hospital's private revenue, also leading to insufficient funds to replace out-dated equipment.

Management expressed disquiet about staff morale and claimed that the employment of internal staff by the contractor was one of the foremost factors considered in the awarding of the winning tender.

The new service subjected work practices to minimal change. Staff were offered their existing hours as a minimum. However, if this involved a demotion, they were compensated. Retrenchments were also paid for staff wishing to leave. As it was a 'transmission of business', long service leave and annual leave was either paid out or carried for-

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ward. The hospital took out an insurance policy to cover sick leave for one year, and thereafter, the staff were paid for entitlements accrued through working for the private organisation.

The union official confirmed the hospital's concern for the staff, adding that there was a stable union membership at the hospital of around fifty per cent. He claimed contracting out did not disrupt employees, their relationship with the hospital was maintained, they obtained a ten per cent pay increase and their jobs were guaranteed. The private proprietor argued that the pay increase was in lieu of the staff's adoption of a private practice, or more customer focused, mentality towards patients. However, a union official characterised this mentality in a more derogatory fashion as being 'an assembly-line mentality, with a loss of localised departmental leadership'.

The proprietor of the privatised service also asserted that staff recruitment was a problem and that the scarcity of radiology technical staff actually led hospitals to sell off their existing radiology departments as staff attraction and retention was better for larger multi-national companies that could contract across the State.

As the location of the service is the same, the relationship with other hospital employees has been maintained and urgent hospital work still takes priority over private outpatients. However, it was also reported that work has become intense with staff working over breaks to cope with increasing numbers and to satisfy demands of general practitioners. A staff member commented: 'doctors put pressure on staff and take advantage of the situation. They want non-urgent patients tested on the same day and sometimes even at weekends'. Waiting periods have disappeared, and whilst overtime is paid, the viewpoint of the staff is that 'it is now a private department and staff are responsible to the private firm, so if they don't bring in the dollars they would not be happy'.

The CEO stated that the privatisation process had turned a 'liability into a strength [when] it injected $3m of equipment into the hospital department'. Patient numbers have increased from thirty-five to close to one hundred per day, with consequent increases in staff numbers and morale.

Pathology

The outsourcing of the pathology service was made within the context of a volatile industrial relations climate. The Health Services Union of Australia (HSUA) No. 1 Branch was regarded as powerful, simultaneously pushing up medical scientists' rates of pay whilst resisting the introduction of flexible rostering.

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The process involved lengthy discussions between the union, staff and management at this hospital re transfer arrangements. Voluntary departure packages were clearly set out in the awards. Sick leave was not transferred but a certain proportion of existing credits were underwritten by the hospital. The union official stated redundancy packages were offered to all employees and, as such,

> staff were granted a golden handshake to change their nametags. They were also given access to Retrenchment Benefits from their Superannuation Fund leaving them in a better position than others who in a year's time may resign to go and work interstate or in the private sector.

A director believed a benefit was a reduction in staff management problems, particularly in the areas of selection and rostering, as his role changed to contract supervision. Another director added that, 'although line management control is lost, control still exists by means of the accreditation processes of the hospital and private laboratory'. The staff did not have to apply for their jobs with the private organisation, and, apart from a new laboratory opening in competition, the only other employment prospects were located in the capital cities, both situated over three hundred kilometers from this city. Moreover, union membership did not alter.

Another effect of the privatisation process across the industry, a director believed, was a reduction of union power, as the public sector put off poorer performing scientists.

> This resulted in the unions starting to play ball with work flexibility. The climate allowed productivity gains that the public sector couldn't achieve prior to this process occurring. And privatising decreased the union strength.

In this case, improved flexibility occurred through changes to working hours and shift rosters. Furthermore, pay rises were obtained as the private sector pays two to three percent more than the public sector. Rationalisation of the testing procedure resulted in the transfer and centralisation of some tests to the city laboratory, with the outcome that, initially, staff numbers decreased by four or twenty-two percent, however since having increased.

Engineering and Maintenance

The contracting-out of functions within the Engineering Department,

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which at the time included facilities and maintenance, began ten years ago. Downsizing occurred with this development, and between 1992 and 1997 numbers were reduced from twenty-five to 11.4 effective full time staff which was achieved through natural attrition with no union involvement. Staff were told downsizing was due to financial difficulties, and a manager stated that 'the staff realised their vulnerability as they were viewed as non-core by the hospital and knew that in times of cutbacks the ancillary areas would be first to be looked at'.

In 1997 the consultants' recommendation to outsource was rejected. Instead, changes were made to work practices by improving recording procedures, monitoring job times, and staff involvement in budget preparation. Structural change also occurred with facilities and maintenance functions transferred from the Engineering Department to the Supply Department. The line manager believed that the threat of outsourcing decreased staff morale and increased insecurity. He stated that 'once that idea was 'put to bed' and staff were given more responsibilities and changed their work practices, productivity increased'. By 2000, effective full-time staff numbers increased to 15.6.

Notwithstanding this, both departments used a combination of contractors and internal staff, with most of the specialist engineering functions and repairs to specialist medical equipment being contracted out to Melbourne based organisations due to a lack of local expertise. The relationship with most of these external companies has been long-standing. Furthermore, it was argued that, in some cases, wages earned outside the hospital system are six times higher those earned within, making it impossible to find staff. However, systems such as the Steam Reticulation System used for sterilising, heating and cooling, are maintained by internal staff, as manager stated 'the average plumber would have no idea how to treat it, and it is too far to bring in Melbourne maintenance staff for a four hour job'.

In areas of general maintenance, the line manager claimed that in-house staff perform non-specialised work cheaper than contract staff. In addition, he argued that internal staff produced a better quality product due to his day-to-day control. Managers wanted contractors to perform each job perfectly, not quickly and cheaply, in the manner commonly found in the private sector. The continual movement of patients can be life threatening and so a philosophy of doing it once and doing it really well is imperative. However, another manager believed that the productivity of internal staff and contractors are similar, but 'contract work has advantages as if they don't perform the work they are out'.

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Hotel Service

Continual downsizing has occurred in the Food Services Department with staff numbers falling from 72 effective full-time in 1989 to 35 in 2000. The existing manager was employed in 1989 to introduce change, aiming to increase efficiency and decrease costs. This was achieved by reducing hours, changing work practices, altering the menu system, tendering for dietary supplies and using new technology, all whilst reducing effective full-time staff by around twenty. In 1993, when the Government offered voluntary departure packages, it spurred the manager to again look at introducing new technology. A cook-chill system of food preparation was introduced which allowed for a further reduction in effective full-time staff from 50 to 35. Working hours at penalty rates were reduced, with compensation offered as a regular fixed over-award payment plus a reduction of one hour per shift at paid rates.

In 1997, outsourcing of the food services was considered, on the basis of cost savings and compliance with NCP. The consultant's recommendation to outsource was rejected for a number of reasons. First, the CEO stated that the staff were highly committed, a number having been employed for between twenty and twenty-five years. He argued that these staff were very loyal, not highly paid and lacked transportable skills and had co-operated with management in the past to reduce costs and achieve savings by working with new technology and changing work practices. He stated that

> a country hospital's decisions impact upon a lot of people and we have to bear in mind consequences. The hospital owes a debt of gratitude to them for making these changes, and so does not wish to privatise after the loyalty they have shown.

Secondly, it was broached by the line manager, that most hospitals did not want to contract-out because they would lose management control. As such, their decision was not based so much on public interest, as self-interest. 'If the service is outsourced, the manager gets the sack so it is really about protecting their own jobs'.

Thirdly, there were questions raised about the costing of the consultant's proposal by the line manager and director, who both found inadequacies in the report in relation to staffing and meal costs. They further determined that outsourcing would make no savings.

Despite the recommendation not been accepted, the effect on the staff was still apparent. When outsourcing was initially proposed, staff were concerned as the hospital had outsourced other services. Even though the line manager was told that it was only an exercise in assessing the possi-

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bility of outsourcing, he also saw it as a real threat. He stated that: 'he felt he was "kept in the dark"'.

A union official supported the proposition that the threat of outsourcing can change work practices by stating: 'in smaller hospitals, outsourcing was not used as often, but was used as a threat in order to introduce private sector efficiencies by benchmarking internal costs against private sector costs'. The Government he believed, gave hospitals a choice to outsource or reach benchmarks, but whichever process was used, downsizing was a consequence.

Overall, across the hospital, a director stated that as the department heads knew their areas were being benchmarked they tightened up their processes. 'They had a tendency to keep increasing staff, which doesn't occur now'.

Case Study Two

The case study hospital was founded in 1871. It has forty-two clinical units, providing all forms of medical treatment, except for obstetrics and paediatrics. In 2000, more than quarter of a million inpatients were treated. Four hundred and fifty beds are funded at this hospital.[2] The staffing level prior to outsourcing was approximately 3,100. Approximately four hundred and fifty staff were employed in the areas contracted-out.

During the early 1990s, each of the support areas were subjected to a best practice survey with the assistance of external consultants. In food services this resulted in a reduction in effective full-time staff of approximately eighty. Staff savings were made through changes in work practices, such as reducing the number of staff on meal breaks at one time and reducing downtime. The hospital also injected one million dollars of capital to improve dishwashing facilities. Inefficiencies were attributable to poor processes, rather than employee laziness. A staff manager argued that 'this process assisted the staff in looking at better ways of doing things. It wasn't that they weren't busy, but they were busy doing the wrong things and with outdated equipment and systems'.

During 1998/99 the hospital market tested support services in accordance with the Government's Competitive Neutrality Guidelines (Annual Report, 1998/99: 35), resulting in all the support services of catering, cleaning, security, ward support, distribution, and gardens and grounds being outsourced as a single contract. The contract cost amounted to $11.8m in 2000/01, being the largest outsourcing health contract in Australia at the time.

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A director discussed the reasons precipitating the outsourcing decision in terms of ideology and trends. He indicated first, that the decision was made when the Kennett Liberal Government was in power, with its general philosophy of involvement of the private sector in public sector activities. Secondly, that New Zealand had led the way in outsourcing, particularly of hotel services, and there was 'a bit of a trend or fashion' to, at least, market test these services. A third factor was the strong philosophy of the Network Board, which supported the involvement of the private sector. The Board supported a bid from the in-house team, with the belief that the contestability process

> would, at worst, encourage the in-house team to carefully review work processes, practices, efficiencies and quality, and inject a little enthusiasm into their work and, at best, you might get some quantum gains in work process.

Although the policy supported an internal bid, another director stated that

> in adopting it with such enthusiasm, there was obviously a view that the private sector was a panacea to the perceived problems of quality and change management that existed with in-house provision. There was an aim to break the stranglehold of the HSUA.[3]

This was linked to financial reasons for outsourcing, as the viewpoint was that the private sector could perform the work cheaper, due to different industrial agreements. However, with the eventual 'transmission of business' case through the Australian Industrial Relations Commission, terms and conditions of employment were maintained.

However, some managers discounted the strength of the union movement, believing that industrial activity was not regarded as a significant threat as in the event of stopworks or bans, management and other staff could operate the service. A director explained that 'although the HSUA can be disruptive and unpleasant the hospital can continue to work'. Furthermore, it was contended that the HSUA had minimal political sway with the Kennett Government at the time.

Outsourcing Process

Probity auditors were appointed to ensure, as the CEO stated, 'that the process was transparent and that staff did not view the process as an attack on them, as opposed to a means for determining value for money'. He explained their stated rationale:

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> we put it under the guise of the Government's Competition Policy. So it wasn't an internal decision, but we were compelled to comply. We felt that it was in their interests that they went through the process, as if they were successful it would give them some security of tenure.

Consultants were used to assist the in-house team however their bid was unsuccessful and the staff felt extreme disappointment. Several directors described the price gap between their bid and the winning bid as huge. But another questioned this, especially taking into account the fact that the winning bid was under-priced. 'The gap was more about non-financial matters as the in-house team was not seen as having the level of management skill required to deliver the service.' He added that, as their bid was dependent on further re-structuring to achieve its financial targets, there was degree of reluctance on the part of the assessors to accept it.

Copious amount of discussion ensued between the HSUA and management. At the time, the 'transmission of business' case had not been tested outside psychiatric services, hence, uncertainty and a lack of clarity surrounded the maintenance of working conditions. Once internal staff realised that their bid was not accepted, industrial activity occurred, which took the form of extensive work bans over three weeks plus a number of strikes. The industrial negotiations resulted in an agreement, which contained a clause covering organisational change and outsourcing. The CEO explained that their decision making was very reactive due to their lack of experience in structural change processes.

The new contract positions were published and staff were asked to submit an 'expression of interest'. Direct employment was offered, with around seventy-five per cent of four hundred and fifty staff transferring to the contractor. Around twenty were redeployed and eighty took departure packages. The packages offered financial payouts of between eighteen and thirty thousand dollars. Upon accepting new positions, long service leave could be cashed-in whilst all other entitlements were transferred. Pay rates remained similar due to the 'transmission of business' ruling.

Notwithstanding the emphasis on risk management and evaluation of proven performance, the hospital parted company with the contractor after fourteen months. Although the details of this process are confidential, a director did state that the hospital had concerns about the contractor's ability to deliver against the contract and to deliver at the price.

The re-tendering process was performed over six to eight weeks. On re-awarding of the contract, similar specifications were used, but the

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price the hospital was willing to pay was reviewed. A director argued, in relation to the importance of matching the contract price with the required service, that

> there was a common belief amongst those in the public sector at the time that if you screwed these organisations really hard at contract negotiation, they would just have to wear losses.

Post Outsourcing

Financial savings amounted to twenty per cent of the contract price of $11m. Although savings also eventuated in the management of industrial relations, a director qualified this by arguing that 'although the hospital would spend significantly less time on managing industrial relations issues, it is not a complete risk transfer to the private contractor as any resultant industrial activity from disputation effects the hospital, and still requires management intervention'.

Another benefit was the introduction of detailed specifications, which often produced changes in work practices. Additionally, changes to work practices came from the introduction of new technology by the contract company. Food was produced off-site initially using a cook-chill system to reduce staff, save on penalty rates, and operate within core hours Monday to Friday. However, on-site fresh cooking was re-instated shortly into the operation of the second contract due to problems with quality.

In order to save costs, working conditions were also altered especially in after hours work with the reduction in cooking shifts from fifteen to four. In addition, six management positions were made redundant. A manager of the contractor stated that 'the staff are working harder because there are less of them ... they have to work faster and harder'.

It was proposed by a number of managers that changes, such as removing accrued days off and changing rosters could have been achieved without outsourcing, but as the CEO stated, 'these sorts of issues are 'sacred cows', and they become very difficult to change, due to their emotive nature'.

In evaluating the success of outsourcing, a director regarded the working relationship between the contract and internal staff as an important consideration. He stated that

> the contract staff often have intimate contact with clinical service staff, so if things weren't going right the internal staff would get down in the dumps and angry and frustrated, which in turn has

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> downstream effects on what the patients and family experience.

Co-existence between the internal and contract staff was also regarded as important by the shop steward who works as a patient care assistant. He explained that operationally, on a day-to-day basis, he answers to the nurse manager on the ward, but ultimate responsibility falls to the Project Manager of the contract organisation.

In general, the whole process has produced a detrimental effect on staff morale. A staff manager, in describing the feelings of the staff, stated that they were 'frightened that the private operator would treat them differently and sack them if they didn't do the right thing'. A director explained: 'the reality is those staff still work here … they still walk in the front door, they're still part of the place and yet for a long time after the event they felt they'd been sold out'.

Furthermore, this spread to other sections of the hospital, such as radiology and pathology, who saw themselves as the next in line to be subjected to the outsourcing process. Others, such as those involved with direct patient care, had the view initially that

> it was not going to happen to them and anyway, this was going to deliver better quality services, so therefore, it must be a good thing. The savings could be put back into core services. However, after problems arose with quality, the realisation came that this panacea was suddenly not true and sympathy emerged.

A director argued that the breaking up of an organisation into parts produced a set of problems inherent in trying to establish an espirit de corps amongst the staff when they are beholden to different organisations. 'At the end of the day they are still part of the hospital, and, as a patient, if the service is poor you blame the hospital, not the private contractor'.

The union organiser claimed that the relationship between the private and public employees within the hospital is difficult, with the 'private sector employees feeling like second-class citizens as they no longer worked for the hospital'. A manager of the contractor also argued that there is still resentment from some quarters in the use of contractors and that the contract staff are not perceived as part of the team.

> The accepted standards of health care maintain that all services should be involved in continuous improvement, but this ethos stops when it comes to non-clinical support services at this hospital. For example, no training is offered to these staff, nor are apprentices or trainees employed. In the first two and a half years of

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> contracting, the contractors were not included in the Occupational, Health and Safety Committee.

But this attitude seems to have changed more recently and there is a move to a greater involvement of contract staff, as evidenced with their inclusion in hospital committees.

In contrast, the CEO contended that the culture clash occurred internally within the contract organisation with assimilating the public sector employees into their organisational culture. A director explained that he thought the private organisation did not do enough to imbue staff with their vision and objectives.

A manager of the contract organisation expanded and reasoned that the upheaval in employment from the hospital to the first contractor, and then to another, within a couple of years imbued in workers a feeling that

> we mightn't be all here tomorrow, so we better use up our sick leave, our annual leave. There was a whole change of management staff, conditions and uniforms with a lot of union trouble as well. It is now starting to sink in that we are here for the long haul and the relationship is getting more comfortable.

He claimed that as these divided loyalties are starting to break down, trust is returning which the private organisation has assisted by issuing each worker with $1,000 worth of shares. The shop steward explained, that in being given the shares, 'it is a big incentive as you have to hold them for two or three years ... you're not a worker any more, you're a partner'. In addition, the career structure for contract staff has improved, as they are now able to transfer between contract sites, rather than being limited to the one hospital site.

However, the contractor's line manager qualified this when he stated that 'as the contract is up for renewal soon for one additional year, staff are feeling insecure again'.

The union membership density is around seventy per cent, having fallen from a high of ninety per cent two years prior. The contractor's line manager stated that the initial transfer from in-house to contractor status produced intense fear as 'they just didn't know what was going to happen to them and so there was a mass signing up with the union'.

A director argued that they should have had the opportunity to stop the process, if the changes made by staff were of such a magnitude prior to leading up to the decision. He added that another model of restructuring that has produced similar savings at other hospitals has been one of empowering management and giving them a brief to work with

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staff and unions to achieve change and reach benchmarks, without the threat of outsourcing.

He added that 'the HSUA is less volatile than it was in the past, and enterprise bargaining agreements lock staff in ... but even after all the changes and disruption, workers are back to where they were in the 1980s – lowest paid in the place with little opportunity for training and advancement'.

In conclusion though, one director 'sees outsourcing as a change management mechanism. The process produces change, but it is not necessarily that the private sector does things better or smarter'.

Discussion

This paper has outlined the processes of benchmarking, downsizing, outsourcing and the introduction of NCP at two public sector hospitals. The first case study hospital benchmarked hotel services and outsourced the two clinical areas of pathology and radiology and the non-clinical area of engineering and maintenance. The second hospital outsourced all support services of catering, cleaning, security, ward support, distribution and gardens and grounds. In both hospitals downsizing and changes to work practices occurred alongside outsourcing, and even where outsourcing was rejected, its threat provided the impetus for similar changes.

Prior to outsourcing in the early 1990s there were numerous examples of downsizing and changes to work practices as government and private revenue decreased. At hospital one, staff numbers were reduced in radiology as patient numbers declined, in engineering and maintenance as specialist functions were contracted-out, and in hotel services as new technology was introduced and changes were made to work practices. Hospital two also reduced staff, as systems were updated and work practices were changed. However, over time in hospital one, staff numbers increased in the privatised radiology and pathology services as patient numbers rose and in engineering and maintenance with improved productivity and the subsequent transfer of some maintenance functions back in-house. Notwithstanding this, the whole process resulted in decreased staff numbers, increased productivity, altered work practices, increased numerical and functional flexibility, alongside increased staff vulnerability and decreased staff morale, thereby supporting the contentions raised in the downsizing literature (see, for example, Sharp, 1995; Amabile & Conti, 1999). Costs of operations also decreased but whether it was solely due to downsizing is questionable, as the process included changes to work practices and technology. Researchers have found simi-

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lar results. For instance, Hartley & Huby (1986: 293) contended that cost savings were the result of a combination of factors such as reduced employment, increased use of part-time workers, use of modern equipment and better management practices.

Boards and executive management drove changes such as these, with information being provided to staff about the rationale and the progress of the exercises. Once outsourcing was considered viable, negotiation between management, unions and employees tended to focus on the transfer process. None of this could be regarded as consultation, rather it was patriarchal in nature, with management telling the workers that change was needed and outlining the method of implementation. Such a lack of communication has been cited by researchers (see, for example, Cascio, 1993) as problematic.

In implementing NCP, outsourcing was investigated as an option at hospital one, whilst at hospital two it was considered to be the sole option. Indeed, at hospital two the board of management, complying with government ideology, mandated that outsourcing be used as the change mechanism, whilst there was a lack of evidence of any consultation with line managers, staff or unions concerning any other methods. In contrast, hospital one rejected outsourcing in support areas as management questioned data that consultants used to support their recommendations. Instead change was implemented through alterations to organisational structure and work practices. This occurred with the support of line managers who actively lobbied against outsourcing's introduction. Similarly, directors and managers at hospital two believed that rather than outsource, other change mechanisms could have been used, which included empowering line management to work with staff and unions to investigate other methods. Hence, at this hospital, the approach could be classed as giving in to "bandwagon pressure". Walston, Kimberly and Burns (2001) argued that in times of uncertainty, the probability of hospitals adopting new structures and practices increases substantially when others have used them. They furthermore argued that superficial implementation, although it may lead to external legitimacy, in effect fails to focus the effort needed for radical improvement.

The lack of availability of expert staff in the rural area was a consideration in the decision to outsource radiology and pathology at case study hospital one. Similar considerations were apparent in the selective outsourcing of engineering and maintenance functions. Indeed, staff and line managers claimed that an advantage of outsourcing such services is that problems of staff selection and control were reduced. Rural areas suffer from both a distance and expertise disadvantage. The distance to major cities, and thus other sources of labour, makes it difficult to gain

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numerical flexibility at short notice by using contract labour. In addition, it is often problematical to attract skilled expertise in rural areas, especially if the complexity of the task is not consistently high.

It was also evident that in retaining non-specialist maintenance and hotel functions in-house, the local availability of blue-collar workers was a factor. Such low skilled workers were readily available in the labour market, and the managers believed that the local community would view their replacement by those from outside the region unfavourably. Furthermore, the flexibility of staff in having made changes to work practices, their loyalty and the close relationship between the rural community and the hospital were regarded as primary motivating forces in retaining the services in-house. Despite hospital two's outsourced workforce being comprised of similar low skills, these were not factors considered important. In both cases the workforce had been employed over a long period, but the relationships with the hospital management differed. At the rural hospital a number of managers discussed the workers in terms of their loyalty, in contrast to the city hospital where the relationships between management and workers were never discussed. Indeed, the major human resource consideration in relation to outsourcing support functions at the latter hospital was the transfer of industrial relations risk to the contractor.

Increasing union power was an impetus for outsourcing of pathology at hospital one and support services at hospital two. Escalating rates of pay and resistance to flexible rostering, both being subject to negotiation at the time of outsourcing, were regarded as a direct cause of the outsourcing of pathology right across the health industry. In contrast, low-paid workers staffed the support services at hospital two, with conflicting opinion regarding the union's strength. But it was clear that the union lacked government support. In general, the right wing ideology of the government viewed the whole union movement unfavourably, hence, the blue collar areas were often subjected to the first wave of outsourcing in an effort to further decrease their power, as well as being seen as one of the easier areas to privatise. Similarly, the government viewed the professional union of medical scientists negatively due to the union's industrial muscle. Notwithstanding this strength, the unions could not prevent the move towards outsourcing. Such industrial relations imperatives have been cited extensively in the literature as an impetus for outsourcing, especially in blue-collar areas or where extensive industrial disputes have occurred (see, for example: Kochan, Smith, Wells & Rebitzer, 1994; Benson & Ieronimo, 1996).

The transfer of internal staff to the contractor provided for the retention of firm-specific knowledge, although it made cultural change diffi-

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cult to achieve. Staff simply changed their employer, but continued to work with their peers at the same location. Hence, the ability of staff to change their commitment from the hospital to the contract company has been slow.

Culture clash at hospital two was evident, both between internal and contract staff and within the contract organisation. Staff were unsure of who bore ultimate responsibility for their work, as they answered to both contract management and nursing staff. However, improvements in trust between the parties began to emerge as the contract organisation and the hospital both made an effort to improve communication. In addition, hospital management, in realising the importance of a team-based approach, has begun to include contract staff in hospital meetings and staff functions. So even though organisations use culture to control the behaviour of employees, in an outsourced arrangement the building of relationships and alliances is also important (Sharma, 1997).

This fact has often been overlooked when organisations have outsourced, in the belief that the management of staff can simply be passed to a third party. The very nature of the location, with both sets of workers working along side each other, makes it imperative that the working relationship between them is based on effective communication and clear accountability.

Decreased staff morale was evident at both hospitals as staff were subjected to the benchmarking process, did not win the tender and were transferred to the contractor. At hospital two, the trust and motivation of staff working alongside contract staff in other departments decreased as well. Industrial relations unrest was also evident as part of the transfer process although it has decreased subsequently. In addition, the taking of all accrued sick leave has been a problem, as the staff still feel insecure about their long-term future.

Conclusion

This research points to the complex interrelated nature of the use of downsizing to change worker's acceptance of change, which includes outsourcing, and use of outsourcing to reduce employee numbers. The discussion has highlighted important workplace issues, such as consultation between management, unions and employees, changes to work practices, maintenance of conditions, staff recruitment and retention and the relative power of management and unions, which have emerged from such changes to processes.

Whether outsourcing was used as a process of workplace change was dependent, in an economic sense, on the control that the hospital re-

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quired, the cost and availability of specialist labour, and the quality of work required. In addition, non-economic considerations highlighted outsourcing being promoted ideologically by the government and the board of management, its use in transferring management and industrial relations problems to a third party and in decreasing the power of the union. The effect of the outsourcing process had been to initially, decrease staff numbers, change work practices, and introduce new systems and technology, resulting in decreased morale and trust. In addition, benchmarking exercises were used to change work practices and decrease staff numbers through the threat of outsourcing, also resulting in reduced morale. The culture of change has been gradually introduced at both hospitals with employees under no misapprehension about their lack of tenure, job insecurity and future changes. Hence, benchmarking, downsizing and outsourcing have all been used in this sector to bring about workplace change, and whilst the choice between processes may be dependent on management perception of the workplace environment, the implications for the workplace have been similar.

Further research is warranted in areas which this research has raised but are outside its scope. These include, first, the effects of downsizing and outsourcing on workforce flexibility. Secondly there are workforce management issues surrounding outsourcing, such as contract workers' occupational health and safety requirements, training needs and career structures. Finally there is the measurement of quality of service provision. This article has indeed highlighted the problematical relationship between the cost of service provision and quality, and has illustrated that the specification of service standards solely on an output basis do not always provide enough control over quality which a mixture of performance standards and output measures would offer. Hence, the third area of further research is the measurement of service quality in times of outsourcing and downsizing. And finally, the relationship between internal and contract staff especially in organisations using team-based structures is worthy of additional research.

Notes

1. This information was sourced from the Hospital's Annual Reports. These are not cited fully in the reference list to maintain anonymity and confidentiality.
2. This information was sourced from the Network's Annual Reports. These are not cited fully in the reference list to maintain anonymity and confidentiality.
3. The HSUA branch referred to here is the number three branch.

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