

The hidden traps in multi-tasking: The experience of work intensification for personal service attendants in the healthcare sector

Eileen Willis
Flinders University

ABSTRACT

This paper outlines the creation of a new category of worker, personal service attendants (PSAs), through the amalgamation of cleaning, nurse assistant, orderly and kitchen hand tasks. The study focuses on the introduction of PSAs into one public hospital in South Australia between 1996 and 2000. The paper makes three points. First, the creation of this occupational group was not the result of post-Fordist moves to up-skill and multi-skill workers, but was in response to budget cuts that saw the reduction in staff numbers across all occupational and professional groups in the hospital, pressure by the state government to out-source all non-core services and a desire by human resource managers to bring the orderlies under control. Secondly, nurse managers supported the creation of PSAs, despite objections from the Australian Nursing Federation, as it offered an opportunity to shift lower order tasks to this group and thus reduce the work intensification of nurses. Finally, the paper argues that the introduction of this new occupational group did little to alleviate the workload of either nurses or PSAs; both groups experienced work intensification in the period under discussion. However, becoming a PSA did increase work satisfaction for female PSAs.

Introduction

This paper outlines the creation of a new category of worker, personal service attendants (PSAs), through the amalgamation of cleaning, nurse assistant, orderly and kitchen hand tasks. The study focuses on the introduction of PSAs into one public hospital in South Australia between 1996 and 2000. The paper makes three points. First, the creation of this occupational group was not the result of post-Fordist moves to up-skill and multi-skill workers, but was in response to budget cuts that saw the reduction in staff numbers across all occupational and professional groups in the hospital, pressure by the state government to out-source all non-core services and a desire by human resource managers to bring the orderlies under control. Secondly, nurse managers supported the creation of PSAs, despite objections from the Australian Nursing Federation, as it offered an opportunity to shift lower order tasks to this group and thus reduce the work intensification of nurses. Finally, the paper argues that the introduction of this new occupational group did little to alleviate the workload of either nurses or PSAs; both groups experienced work intensification in the period under discussion. However, becoming a PSA did increase work satisfaction for female PSAs.

Work intensification in the health sector in Australia

Over the last decade health professionals in Australia have argued that their work has become more intensified as a result of budget restraint and healthcare reform (White and Bray, 2004; Willis, 2002). Finding the evidence for this work intensification requires understanding the changes that have occurred and the factors that might contribute to work intensification in workplaces such as Westernvale. Two varieties of work intensification are suggested in the literature (Green, 2004:714). These are *extensive* and *intensive* work effort. Extensive work effort refers to working longer hours, while intensive work effort refers to working at a faster pace or with fewer down times. Both these concepts can be elaborated when applied to hospital work that incorporates shift work. In hospital settings the hours of work are non-standard, usually with a reduced number of workers as the shifts move across the twenty-four hour day from morning to night and through the five days of the standard working week to the week-end. In the past this arrangement has assumed a reduction in duties as the day progresses or as the week moves toward Saturday and Sunday. These assumptions are no longer guaranteed although many hospitals still operate according to this model.

In making a claim for work intensification Green (2004) suggests five hypothesis or factors need to be examined. These are; the presence of increased technological and organisational change; the introduction of multi-skilling and functional flexibility; human resource management techniques designed to engender greater worker engagement; increased use of incentives; decreased power of unions; and rising job insecurity. Added to this, he suggests that each of the processes listed above may impact on the other. For example a weak union may precipitate the introduction of new technology, while the threat of redundancies may soften workers up to accept job redesign (Green, 2004). White and Bray (2004:3) add a sixth factor to the list in support of work intensification. They suggest that in many instances it is possible to provide evidence of increased work volume. A seventh factor suggests that if one occupational group makes a claim of work intensification, this is likely to impact on the work of others in the team, especially where multidisciplinary teamwork is required. This paper argues that this is especially so for personal service attendants; a newly created occupational group introduced into a number of public hospitals in South Australia in the 1990s.

Case study: personal service attendants as a third level carer

In South Australia personal service attendants (PSAs) were created by amalgamating the occupational groups of nurse assistants, kitchen staff, cleaners, porters and orderlies. Their work mirrors that of personal care attendants (PCAs) working in Nursing Homes but they perform fewer direct nursing tasks, such as dispensing medications, and there is as yet no formal vocational training available for them outside of hospital settings. Previously these occupational groups operated independently of one another with a tendency for men to be orderlies and porters and women to function as nurse assistants, cleaners and kitchen staff. At Westernvale cleaners had up to four weeks formal training with a strong emphasis on infection control, while kitchen staff, orderlies and porters learnt on the job. Around 35-40 percent of PSA's time is spent in cleaning clinical areas such as patient beds, lockers, toilets and showers as well as offices, kitchens and lounges within the wards. Their time is also devoted to a range of tasks known as 'fetch and carry'. This includes transporting patients to and from tests, to home wards or to discharge areas. This takes up to 20 percent of their time. Other duties such as distributing meals, moving beds and lockers around the ward and in some areas shaving patients prior to surgery make up the remainder of their job description. Much of the work involves heavy manual handling and cleaning with the concomitant risk of occupational injury.

While the creation of PSAs in South Australia was a direct result of radical budget cuts instigated by an in-coming Liberal government in 1994 following the collapse of the State Bank, this newly created occupational group is also a belated response to the transfer of nurse education to the tertiary sector and the subsequent loss of cheap, low-grade, student-nurse labour. The shift from hospital-based training to the university sector for nurses was formally ratified in 1990, but for Westernvale began in 1982 because of its close proximity to one of the earliest established tertiary based schools of nursing. Previously, junior nurses in training performed many of the duties now taken up by PSAs such as the cleaning of beds, lockers and ward furniture, the delivery of patient meals, the organisation of ward equipment such as linen and the transport of patients to tests and theatre for surgery. Over the last twenty years many of these tasks, such as delivering patient meals and arranging flowers have been classified by the professional and industrial arms of nursing, as 'non-nursing duties'. Personal service attendants are as a consequence a form of substitute labour as well as a new occupational group created to fill a gap left by the up-skilling of registered and enrolled nurses.

Similar developments occurred in some other states in Australia such as Victoria and New South Wales (O'Donnell 1995) and in the USA, Britain, Canada and Hong Kong (Brannon 1996, Badovinac, Wilson & Woodhouse, 1999, Huston, 1996). O'Donnell (1995), commenting on the employment of PSAs in two large hospitals in New South Wales notes that these women are mainly from non-English speaking backgrounds, with minimal education, but high levels of commitment to the hospital, the nurses and the patients. His research showed that PSAs enjoy their new multi-skilled role and prefer to work as part of the nursing team, rather than under the direction of hospital administrators. However, the PSAs in O'Donnell's study also reported high levels of stress because they worked in self-regulating, non-hierarchical teams where authority structures were unclear, but audit requirements were high and responsibility for performance

or lack of it shared equally by all. Multi-skilling has resulted in work-intensification with few opportunities for down time.

Brannon (1996), commenting of the use of substitute nursing labour in the USA, where both university and college trained nurses work with Unlicensed Assistive Personnel (UAPs), points to the fact that UAPs allowed new models of nursing care to be designed that left lower numbers of registered nurses working on the wards with higher numbers of UAPs, and no support from college trained nurses. The second tier or college trained nurses were laid off from the acute care sector and forced to find work in community and home-based nursing where the unregulated and underfunded nature of their work meant that they worked without direction from a registered nurse. In Brannon's study they reported that they were often required to perform nursing duties, such as the administration of drugs that are legally outside their jurisdiction in a hospital setting. Similarly Badovinac et al (1999) reported increased stress levels for RNs who had to manage their patient load with lower-skilled carers. Interestingly, consistent with Australian figures Badovinac et al (1999) found that over 50 percent of UAPs were 40 years of age or older, while 50 percent of RNs on the wards were under the age of 35 pointing to status differences based on age and education that may contribute to tension between the two groups. Green (2004) reports that in Britain increases in work intensification are more often reported in the service sector, in work done by women and those over 40.

The tension between nurses and substitute workers is most evident in Britain where healthcare assistants (HCA) were introduced into public hospitals, or their numbers increased, following the 1980s National Health Service reforms which also brought budget cuts. Their presence has created considerable ambiguity in nursing circles where their introduction has confounded the hopes of many registered nurses that the new Primary Nursing, where one nurse cares for the patient from admission to discharge, would facilitate a post-Fordist climate of task reunification, flexible specialisation and job enrichment (Daykin & Clarke, 2000). Daykin and Clarke (2000) report that Registered Nurses' resistance to HCA arises from the fact that the promise of holistic care has been abandoned. While RNs are relegated to high level technological care and administration - and up-skilled - the day to day lower level, multi-tasked caring work involving patient interactions is performed by HCAs. As a consequence the work of HCAs is routinised and repetitive, while for much of their working day RNs are engaged in paper work rather than direct patient care.

In the Australian context personal service attendants should not be confused with the second level of nurse; the Enrolled Nurse (ENs), although they share some similarities in their relationship to registered nurses as substitute labour. Enrolled nurses are clearly aligned with registered nurses as a second tier nurse. This is despite the fact that in South Australia conflict between these two grades of nurses simmered throughout the 1980s and 90s. This conflict had its origins in the fact that training for ENs, which occurs in the Technical and Further Education (TAFE) sector, was considered inadequate for acute hospital nursing and legislation prevents ENs from working independently of supervision by a registered nurse. Attempts by the South Australian Nurses' Board to bring the practice of ENs under greater regulation peaked in the early 1990s much to the distress of many of these nurses. The Nurses' Board took this action in response to a realisation that many ENs were performing tasks at a level equal to registered nurses and outside the legislation. For many ENs working in public hospitals this led to de-skilling and dissatisfaction with the work they were allowed to perform, yet at the same time other ENs were up-skilled to perform tasks equal to experienced Level 1 RNs, but without adequate remuneration. Following the introduction of enterprise bargaining the Australian Nursing Federation took a more proactive approach to the issue of ENs. The 2000 EB agreement established set ratios for the employment of RNs to ENs at 70/30 thus keeping their numbers low, safeguarding the integrity of the registered nurse role, but making it difficult for managers to employ cheaper qualified/substitute labour. The ANF recognized that despite the legislation and the quota restriction many ENs had been up-skilled to perform tasks equal to that of registered nurses. As a consequence both the 2000 and 2004 EB agreements made provision for an advanced EN grade and role with accompanying salary increases. However the caveat on the ratio of ENs to RNs leaves the way open for the employment of more personal service attendants.

The introduction of PSAs at Westernvale

In 1993 the newly elected Liberal government saw its resounding win over the Labor government as a mandate to reduce the state debt through curtailing public expenditure. The introduction of casemix diagnosis related groups (DRGs), a prospective payment system was accelerated and became the basis for hospital funding while at the same time the hospital sector sustained a budget reduction of 15 million over the three-year period 1994-96 (Brooker, 1997). Funding to individual hospitals was negotiated through Service Agreements and the principle of contestability became mandatory (selected government services had to be put out to tender) along with the privatization of non-core activities. As a result many hospitals were forced to either offer state funded voluntary redundancy packages in order to reduce staffing levels or re-design work processes in order to comply with the principle of contestability. Two areas for privatisation were cleaning services and meal preparation.

Managers and clinicians at Westernvale argued that to privatise the services of kitchen staff, cleaners, orderlies, porters and nursing assistants would jeopardize quality care particularly in the area of infection control. One way of preserving this workforce as 'core' was to roll the occupational groups up into one, re-classify them as personal service attendants and allocate them to individual wards. This included shifting them from supervision by the centralized human resource managers to that of the ward clinical nurse consultants. An argument in support of this proposal was that once attached to a ward, PSAs, could respond immediately to nurse or doctor requests for test results to be collected, patients to be moved or beds to be cleaned following patient discharge. Previously when nurses wanted these tasks done they had to contact centralised services and wait for orderlies to arrive; sometimes up to half an hour, or in the case of cleaning tasks, wait until cleaners had finished in other areas or do it themselves. Managers could see the advantages of this newly multi-skilled workforce attached to specific wards who could respond 'just in time' to requests that facilitated patient through-put on wards in a hospital that had recently reduced both nursing and medical staff as a result of budget cuts. The re-organisation of the hospital into divisions, or the Johns Hopkins model of devolution, following the logic of casemix DRGs, facilitated this move. Budgets were devolved to divisional clinical managers. This included an allocation of PSAs for each ward. A secondary motivating factor was the fact that many of the female cleaners and kitchen staff believed the new occupational group would provide them with more interesting and meaningful work, although the male porters and orderlies were less sure.

The introduction of PSAs into Westernvale was not achieved without considerable opposition from the Australian Liquor, Hospitality & Miscellaneous Worker's Union (LHMU); the union representing the various occupational groups. Prior to the Liberal Government reform, hospital managers at Westernvale had attempted to negotiate with the LHMU for the creation of a multi-tasked occupational group. A number of the managerial staff were of the view that the union was resisting the need to comply with the 1980s Structural Efficiency decisions of the Australian Industrial Relations Commission to build a multi-skilled and flexible workforce. This was particularly so for the orderlies. Managers found it difficult to bring these worker under control, to get them to outline their duties or to respond to the change in work design that was occurring throughout the hospital as a result of staff cuts and the need to increase productivity and efficiency.

The LHMU initially resisted the Liberal Government reforms, specifically competitive tendering, by invoking the 1994 Enterprise Bargaining clause, which required hospital managers to consult with unions on workplace change. In 1996 the union's challenge to the principle of competitive tendering was overturned in the Supreme Court as not a violation of the 1994 EB agreement. This, coupled with the fact that the offer made to workers was financially attractive; all were appointed at a higher classification level, moving them from level one and two to three, along with the belief by many of the female cleaners and kitchen hands that this work would be more interesting given its multi-skilling and closer relationship with nursing staff, meant that the union was forced to withdraw its opposition. The newly created PSAs were given one weeks training; three weeks short of what was previously offered to cleaners and they were assigned to the wards. It is at this point that any argument for multi-skilling or up-skilling falls down. A more accurate description is that PSAs were now multi-tasked.

As previously stated the response of the ANF and nurse managers to this newly formed occupational group was positive in the light of a reduction of over 100 effective full-time nursing

staff between 1994-1996. Nurses believed that the PSAs would alleviate work intensification on the wards, although they were suspicious of encroachment by these workers into areas deemed 'nursing duties'. These suspicions continued over the following four years and were a constant agenda item at site union meeting, but tended to be isolated to specific wards, such as Accident and Emergency, where the role of PSAs was more ambiguous. Across the hospital it became mandatory for PSAs to attend handover each morning for the first shift of the day, an essential task if they were to know which patients were booked for surgery and needed to fast or which patients needed to be delivered to laboratories for tests, rehabilitation classes or discharged. In organising their day PSAs needed to arrange cleaning and meal delivery around the needs of the patients as well as respond to nurse and doctor requests to pick up drugs from the pharmacy or retrieve equipment loaned to other wards. Many of these tasks were previously done by nurses assigned to the ward or kitchen staff, cleaners and orderlies working under the centralised human resource departments. An assumption was that they would reduce the burden of work for nursing staff. This assumption is explored below, along with the impact on their own labour.

Work intensification: the process of extensive and intensive work effort

Two qualities of work intensification are increases in the pace of work and extension in the time worked. In the hospital sector this can be extended to include the impact of shift work. Shift work incorporates non-standard and non-social hours as well as the idea that as the day or week progresses the pace of work reduces consistent with the patient load. These arrangements governing shift work are no longer accurate for many wards in public hospitals in Australia. The drive for productivity and increased efficiency, increases in private health insurance, the shift in the bulk of same day surgery to the private sector and the reduction in elective surgery in the public sector due to the increase in emergency admissions has led to many work re-design innovations. As a result, patients may return from surgery, not on Wednesday ready for discharge on Friday, but on Friday needing intensive care over the weekend. Not all patients return from surgery by early afternoon, settled and comfortable by 9pm, when the skeleton night duty staff come on duty; some return as late as 9 pm in need of intensive observations every ten to fifteen minutes throughout the night. In both cases these patients return to wards staffed with fewer nurses and PSAs than the morning or weekday shifts and fewer doctors available to check out concerns. These factors are part of the extended and intensive work burden of work for PSAs.

At Westernvale in October 1996 the Liquor Hospitality and Miscellaneous Workers' Union conducted a mass meeting at the hospital following complaints from its members about working rosters. When the PSAs were cleaners and kitchen hands they had worked a rosters of 152 hours across a 28 day cycle with fixed and predictable days off each month. Under the new arrangements they now worked a similar shift pattern to nurses. This was a three by seven-day variable rotation per month of either an early (7am to 3pm) or late (1pm to 9pm) shift. Only one PSA was rostered on in the hospital for night duty. The difficulty with these arrangements for PSAs was that the number rostered per ward was considerably fewer than nurses. Usually three PSAs were on duty for the morning shift and two for the late shift. The majority of PSAs were older women in their 40s and 50s and they found the seven continuous days arduous, given that much of the work involved heavy manual handling tasks. Because of their fewer numbers they were unable to negotiate changes to their roster to deal with their fatigue, although some dealt with this by using morning and lunch breaks to lie down in empty rooms or spend time by themselves.

This issue came to a head in 1997 when many nurse managers reported they were regularly forced to work outside the agreement by altering rosters and requesting part-time PSAs to work because of the injury rate amongst full-time staff. By May 1997 the injury rate amongst PSAs was 4.3 percent per year, compared with the overall hospital rate of 2.5 percent for other staff. This number rose to 6.6 percent in 1998, despite the fact that it remained stable for all other professional and occupational groups. Workcover claims rose by almost 50 percent in the same year to 27; up from 14 in 1995. This resulted in an added burden to those able to work, lower standards in cleaning and low morale. In 1999 nurse managers performed a detailed task analysis of PSA duties. The outcome of this task analysis was a reassignment of PSAs more equitably across the wards, but their numbers did not increase.

Impact of Multi-tasking and the reduction of idle time

While PSAs remarked that multi-tasking made their work more interesting they had to manage the variety of tasks from their position of subordination. Refusing to do a task or follow a request from a nurse or doctor was not an option for PSAs, except where it contravened the orders of the senior nurse in charge of the ward. Their access to doctors is negligible, while their access to the senior nurse is restricted by their awareness of the work load these nurses carry and the seemingly trivial nature of their concerns about cleaning and meals. One of the major difficulties reported by PSAs is completing all the cleaning, but at the same time responding 'just in time' to the requirements to have patients delivered to rehabilitation classes or medical tests. When PSAs leave their cleaning work to respond to a nurse request, on return to the ward they must begin their cleaning work again, rather than take up where they left off, because cleaning agents must be freshly applied. Added to this, they must organise their work without disrupting medical rounds or treatment regimes performed by allied health staff and nurses. Nor can cleaning be performed during patient meal times. This work requires complex juggling, and ensures negligible down-time as there is always cleaning work to be done.

Human resource audit

While PSAs work without direct supervision, at Westernvale their cleaning work is audited on a three monthly basis by an independent company contracted by hospital management. Following each audit, wards are assigned a score, which becomes public knowledge and discussed amongst PSAs at morning tea, in the lifts returning to home wards and at handover. The scores are aggregated for each site visit and for the year, as well as benchmarked against other public hospitals around the country and state. The scores contribute to the hospitals' initiatives in maintaining accreditation. Accreditation is a major benchmark for hospital quality assurance and has become increasingly important over the last few years as the evidence of the risks associated with hospitalisation becomes more public. In cases where the cleaning scores are low PSA staff are urged to intensify their effort and bring the score into line with the needs of accreditation and the hospital benchmark. O'Donnell (1995) notes in his study of PSAs working in public hospitals in New South Wales that the burden of maintaining standards where work is performed by a self-monitoring team, with no one in charge, creates work intensification for some workers. Responsible, competent and fit workers end up carrying the load for those who are not well or incompetent or when staff numbers are reduced due to injury or illness.

Evidence of increased load

There is no doubt that those PSAs who up-tasked from previous occupations as cleaners or kitchen staff enjoy their work, however, they were soon reporting that their working day was more intense than previously. At Westernvale senior administration employed some workload measures to calculate the number needed in each division, but as mentioned above their introduction was motivated by a desire to avoid out-sourcing what the state government bureaucracy defined as non-core activities and recognition of the need to reduce the work load for nurses. Not all cleaners or orderlies transferred to the newly created positions in 1996, significant numbers took redundancy packages so that while PSAs were trained to perform the range of tasks once restricted to narrow occupational groups, the pool of staff was reduced by 30 percent. This was a 9 percent reduction in the overall workforce.

The significance of this reduction in numbers can be gauged by examining Table 1, taken from the Westernvale annual reports for 1994 through to 2000. In 1994 the complement of hotel staff, the category assigned to PSA previous occupational groups was 314. By 2000, the number was reduced to 144 representing a 45 percent reduction in staff numbers over the eight-year period, although it needs to be stated that some of this work was out-sourced to private companies employed to clean the public areas in the hospital. At the same time the number of registered and enrolled nurses dropped from 922 in 1994 to 833 in 1995 and remained below 1994 figures until 2001 when the EB agreement between the ANF and the Department of Human Services brought nursing numbers back up above 1994-5 levels. Given that the table shows clearly that hospital occupancy increased, the number of same day procedures intensified and the length

of stay remained relatively stable, the work of PSAs like that of nurses, intensified. It is not surprising that by 1998 PSAs and nursing staff were reporting several difficulties with this new occupational group.

TABLE 1
Activity data
and staffing
numbers
1994-2000
Westernvale
Hospital

Year	Occupancy (%)	*Same-day	Nurse Nos.	PSAs and hotel staff	*LOS days	No. Bed days
1994	N/A	13,186	922	314	5.10	402
1995	86.9	14,232	833	200	5.22	402
1996	87.8	N/A	857	180	5.30	413
1997/8	88.3	16,553	882	146	5.01	427
1998/9	87.3	17,860	918	150	4.72	437
1999/2	95.40	20,035	881	144	5.10	402*

* Number of patients admitted and discharged on the day of their surgery.

** Length of stay in days.

Average number of beds available across the hospital

Discussion and conclusion

This paper has provided a case study in work intensification for personal service attendants working in one hospital in South Australia. The study demonstrates that PSAs experience both intensive and extensive work intensification. Changes to the work of PSA's included radical job redesign to create a new occupational group, changes in duration and timing of their shifts and less flexibility in their working hours. While PSAs found the multi-skilling and up-skilling made work more satisfying, responding to the tasks 'just in time' resulted in increased job stress and to a reduction in the 'porosity of the working day' (Green 2004:737). It is not surprising that PSAs, many of whom are women in their late 40s and 50s sought a quiet room during tea breaks for a rest. PSAs also experienced considerable pressure as a result of increased work surveillance through the pervasive human resource technique of the quarterly cleaning audits, and the move from centralised control to the immediate supervision of nursing staff. The quarterly audit activity, while effective in bringing scores up to the benchmark, often meant that some PSAs were forced to carry the work of incompetent, sick or injured workers. While they were theoretically under the supervision of the senior nurse of the ward, they rarely brought their problems forward given that they regarded their complaints trivial. This left them to work on problems amongst themselves with little authority to find solutions other than work harder. The case study also provides evidence of increased work volume with virtually no idle time. This includes increases in same day surgery and reduction in patient length of stay, along with a reduction in nursing numbers.

The evidence for job insecurity is ambiguous. Prior to the formation of the occupation a number of cleaners, orderlies and kitchen hands took redundancy packages, and it is also true that those who sustained an injury had difficulty returning to the wards given the heavy nature of the cleaning and transport of patients involved, although the majority were permanent employees. Job insecurity did exist at certain times throughout the 1990s, but it was not sustained, although there was certainly an ethic amongst the nursing staff that those who could not take the pace should resign. Whether this spilt over into the PSA ranks is not clear. The case study provides insufficient evidence to suggest that the union's power has diminished or that new technologies have impacted on their work, although Green (2004) includes new managerial strategies under this factor given that information technology allows remote control, but closer surveillance of work. What is clear is that as the numbers of PSAs reduced so too did those of nursing staff, despite close observation by the union. A key process contributing to work intensification is the increased pressure placed on groups of workers, when other occupational or professional groups in the team are under pressure.

In this study, one of the most significant factors of work intensification for PSAs is related to work intensification experienced by the nurses. When nurses are under pressure, much more of the mundane cleaning, patient retrieval and domestic work is left to PSAs. This increased work volume is in turn exacerbated by the reduction in PSA numbers which in turn impacts on stress levels and as the evidence suggests, increases the injury rate. In 2000 the EB agreement covering nurses brought their staffing numbers back to 1994 levels, no such increase was achieved for PSAs. However, by 2004 PSAs had achieved a separate EB agreement from administrative professionals in the sector.

There has been considerable increase in work intensification in the health sector. It has not been restricted to nurses or doctors, but is system wide and, as a consequence, is doubly intensified for health professionals and occupational groups given the high demand placed on them all to integrate their work in order to ensure efficient work practices are in place in what is increasingly becoming a multidisciplinary arena. PSAs may be at the bottom of the health occupational hierarchy, but this does not mean that their dedication to the care of sick patients as well as their commitment to the nurses and doctors, is diminished. Re-working the tasks of cleaning, patient transport and feeding requires more than creating new work arrangements. It requires maintaining staffing levels or increasing them, where productivity levels increase and systems of work are redesigned. It also demands recognition that the intensity of work for one occupational group will impact on other groups where the work is highly structured around teamwork and where all are committed to the service of care.

References

- Badovinac, C. Wilson S and Woodhouse, D. 2002 'The use of unlicensed assistive personnel and selected outcome indications, *Nursing Economics* 17(4)194-200.
- Brannon, R. 1996 'Restructuring hospital nursing: reversing the trend toward a professional workforce', *International Journal of Health Services* 26: 643-654.
- Brooker, J. 1997 *An evaluation of casemix funding in South Australia 1994-95*, Adelaide: Casemix Development Program; Commonwealth Department of Health and Family Services and the South Australian Health Commission.
- Daykin, N. and Clarke, B. 2000 "'They'll still get the bodily care'". Discourses of care and relationships between nurses and healthcare assistants in the NHS', *Sociology of Health and Illness* 22: 349-365.
- Green, F. 2004 'Why has work effort become more intense?' *Industrial Relations*, 43(4) 709-741.
- Houson, C. 1996 'Unlicensed assistive Personnel: a solution to dwindling healthcare resources or the precursor to the apocalypse of registered nursing?' *Nursing Outlook* 44: 67-73.
- O'Donnell, M. 1995 'Empowerment or enslavement? Lean production, immigrant women and service work in public hospitals', *Labour and Industry* 6 (1995) 73-94.
- Stanton, P. 2002 *Changing Employment Relations in Public Hospitals 1992-1999* School of Public Health, Faculty of Health Sciences, La Trobe University, Bundoora.
- White N. and Bray, M. 2003 'The changing role of nursing unit managers: a case of work intensification, *Labour and Industry* 14(2) 1-20
- Willis, E. 2002 'Enterprise bargaining and work intensification: an atypical case study from the South Australian Public Hospital Sector' *New Zealand Journal of Industrial Relations* 27(2) 221-232.