Empowerment or Enslavement?: Lean Production, Immigrant Women and Service Work.

by

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Abstract

This paper examines the application of elements of lean production work organisation to service work. Lean production describes the Japanese car assembly manufacturing system pioneered by Toyota. Proponents of this production system claim that lean production has universal application and will have as dramatic an impact upon the organisation of service work as it is having on work organisation within the manufacturing sector. This paper critically assesses the impact of elements of lean production work organisation upon non-english-speaking-background immigrant women service workers within two New South Wales hospitals. Lean production for these workers involves contradictory outcomes. Increased job satisfaction from greater patient contact on the one hand is constrained by an intensification of work effort, peer group surveillance and pressure to speak english. The paper also argues that trade union support for lean production work organisation may undermine rank and file loyalty to the union.

Introduction

This paper examines the impact of lean production work organisation upon non-english-speaking-background immigrant female service workers. These workers are employed within two New South Wales public hospitals which have undergone a workplace restructuring process analogous to lean production. The paper aims to distinguish the rhetoric of lean production espoused by Womack et al (1990) and Mathews (1992) from the reality of this production regime for these hospital workers. For Womack et al (1990) lean production describes the Japanese automobile assembly manufacturing system developed by Toyota and is more than a system of work organisation. It also involves the relationship between customers, manufacturers, designers and suppliers and aims to guarantee responsiveness to market demands and changing consumer tastes. This paper, however, is limited to the application of lean production to the organisation of service work.

An "ideal model" of lean production in the service sector points to the amalgamation of job functions, the emergence of a new workplace culture through the organisation of workers into self-managing teams, the development of a multi-skilled and functionally flexible workforce, and the emergence of a more 'cooperative' management/trade union relationship (Mathews, 1992: 169-170).

The form of lean production work organisation introduced within both hospitals bears a number of similarities to this "ideal model". Hospital management did not seek to introduce the Toyota production system described by Womack et al (1990) Rather, elements of lean production work organisation were introduced into both hospitals in a piecemeal fashion in response to the threat of privatisation of hospital services. In place of four occupational classifications for cleaners, porters, kitchen staff and ward assistants all jobs have been amalgamated into one, that of a Patient Services Assistant. Management claims this results in a more

multi-skilled and flexible workforce. Prior to introducing the Patient Services Assistant program, management measured the work routines of each group of workers and attempted to eliminate any perceived idle time. Team-working has been introduced into one hospital. Finally, initial trade union opposition to the program has altered to active support.

This paper critically assesses the benefits of amalgamating job functions, 'multi-skilling', team-working, the elimination of 'idle' time and active trade union participation in lean production work organisation for non-english-speaking-background immigrant women workers. It is structured as follows. First, Mathews' (1992) model of lean producion in the service sector is outlined. Second, the critical literature regarding lean production is integrated with an analysis of the impact of the Patient Services Assistant program on the organisation of work in both hospitals and the response of hospital workers and their union, the Health and Research Employees Association of New South Wales. The conclusion suggests an alternative model of lean production work organisation to explain the experiences of non-english-speaking-background immigrant women undertaking service work.

Methodology

Both King and Queen hospitals have a high concentration of non-english-speaking-background immigrant women workers. At King, of 109 Patient Services Assistants 98 per cent comprises immigrant workers of whom 82, or approximately 75 per cent, are women mainly from South America and the former Yugoslavia (Cleaning Services Manager, King, 1994). At Queen, the number of male and female Patient Services Assistants is roughly equal (76 male and 77 female) although 90 per cent of women workers comprises immigrants (69 out of 77) predominantly from South America and the Philippines (Cleaning Services manager, Queen, 1994).

The research for this paper involved interviews with immigrant women workers within their working environment at both hospitals. This form of research methodology seeks to understand the impact of workplace change through the observations of those directly affected by undertaking a substantial number of individual and group interviews (Alcorso, 1991: 115). Such a qualitative approach enables a comprehensive picture of the discrimination and exploitation experienced by immigrant women workers within Australian workplaces to be developed (Alcorso and Harrison, 1991: 58).

In accordance with this methodology, semi-structured interviews were undertaken with Patient Services Assistants on a variety of wards at King and Queen hospitals. The interviews were undertaken in November 1993 with a further round of interviews in February 1994. Patient Services Assistants were interviewed while working on hospital wards or in groups during their lunchbreaks. In total twenty-five Patient Services Assistants on ten hospital wards were interviewed to conduct these interviews; five at King and five at Queen. Nine managers were also interviewed: one senior cleaning services manager overlooking Queen and King; two cleaning services managers (one at King and one at Queen); five Nursing Unit Managers (four at Queen and one at King). An interview was also conducted with the Human Resource Development manager at King. Finally, the Health and Research Employees Association industrial officer and workplace delegates at both Queen and King were interviewed.

Lean Production: an "Ideal Model" for Service Work?

Womack et al (1990) argue in their review of the world automotive industry 'The Machine that Changed the World' that lean production represents a new 'paradigm' in work organisation that supersedes mass production. They consider the Japanese automotive production process pioneered by Toyota lean in comparison to mass production because it utilises fewer workers; makes do with smaller plant; relies on minimal

stock levels; and produces fewer faulty products (Womack et al, 1990; Shadur & Bamber, 1994: 345). Furthermore, Womack et al (1990: 9) contend that lean production can be applied beyond the manufacturing sector and they "... believe that the fundamental ideas of lean production are universal - applicable anywhere by anyone - ". However, they provide little or no evidence to demonstrate the supposed benefits that arise from the application of the key elements of lean production into industrial sectors other than manufacturing.

In Australia this task has been attempted by Mathews. In two case studies (one in the public and one in the private sector), he applies elements of lean production work organisation to service work (Mathews, 1991a, 1992). He argues that lean production "is now sweeping the world in the 1980's and 90s in a fundamental paradigm shift that is changing the face of manufacturing, and will just as surely change the face of service industries, in both the public and private sector" (Mathews, 1991b: 21).

Mathews outlines an "ideal model" of the benefits he expects to accrue from the introduction of lean production into the service sector:

". Such a strategy calls for flexibility of process and adaptation of staff to different tasks, achieved organisationally through programmability of operations (utilising information technology) and through people policies that require commitment, security and multi-skilling;

. A new workplace culture is created, captured most dramatically in the emergence of self-managing teams, which are also adapted to the cellular manufacturing techniques that utilise information technology;

- Broadening of tasks is achieved through the integration of functions previously fragmented, and the building in of functions such as quality assurance to become part of a complete job or process;

- Flexibility demands new management responses such as Just-In-Time operation and Total Quality Management;

- The dependence of the system on staff skill and commitment needs to be complemented by a cooperative approach to industrial relations, by skills-based job classification systems and the provision of genuine career paths for workers.

...*World best practice in services organisations* is now taken to mean a client-focused, team-based, value-adding approach that has striking parallels with the emergence of 'lean production'." (Mathews, 1992: 170)[1].

However, rather than representing an emerging panacea, lean production may prove detrimental to the best interests of both workers and organised labour. The next section integrates a range of criticisms of lean production contained within the literature with the experiences outlined by the non-english-speaking-background female workforce at both hospitals.

Lean or Mean?: Coercion and the Elimination of Idle Time

The introduction of lean production may require considerable coercion from management. For example, the introduction of work teams at General Motors in Van Nuys California was accompanied by threats of plant closure and job losses (Parker and Slaughter, 1988: 43). Therefore, workforce consent to lean production may be less than genuine (Hampson et al, 1994: 239) while the line between consent and coercion can be decidedly thin (Sayer, 1986: 67). Furthermore, worker effort under lean production work organisation is maximised by eliminating idle time in work

routines (Delbridge and Turnbull, 1992: 59) Through Kaizen, or continuous improvement, constant pressure is maintained on both workers and the production system. Fucini and Fucini (1990: 148) observe that workers were "actively engaged" for 57 seconds out of every minute under the lean production system in operation at Mazda's Flat Rock automobile plant. Hampson et al (1994: 238) argue that "lean production's goal is total effort all the time, human physiology notwithstanding". Effort maximisation also results from deliberate understaffing compelling the remaining workforce to do an extended range of tasks (Ewer et al, 1993: 19; Parker and Slaughter, 1988: 4; Williams et al, 1992: 342). Eliminating idle time may also result in the emergence of Taylorist work routines. The lean production labour process corresponds with "classic Taylorist principles" because of its reliance on short, repetitive work cycles and standardised work operations (Berggren, 1992: 30). This outcome contrasts with claims that lean production represents an alternative paradigm to Taylorist mass production.

The patient Services Assistant program was introduced in response to budget cutbacks and threats of contracting out by the New South Wales government. More stringent financial pressure in the form of yearly reductions in both hospitals' operating budgets have been imposed each year since 1988. In the 1992-1993 financial year the cleaning services department budget was cutback by some 2.45 per cent (Senior Manager Cleaning Services Queen and King, 1993). Contracting out of cleaning and related services had been a potential threat since 1989 when the Minister for Health announced that the privatisation of "hotel services" provided by hospitals was government policy unless a viable alternative was developed by hospital management (Compulsory Conference, 3 March 1992). In October 1991 the Eastern Sydney Area Health Service, the Health Administration Corporation, the New South Wales Minister for Health, cleaning services management at Queen and King and the Health and Research Employees Association held consultations regarding

possible alternatives to contracting out (Compulsory Conference, 3 March, 1992). As a result of these deliberations the Patient Services Assistant program was developed.

Prior to the introduction of the Patient Services Assistants program management timed the jobs of each separate classification. Cleaning services management measured cleaners and porters while nursing unit managers measured ward assistants. Management wanted to know precisely when workers were busy and when quiet periods occurred in their daily routines. Management developed a time chart showing the peaks and troughs in the work routine of each classification (Human Resources Development, King, 1994). From this exercise management was able to structure the duties of Patient Services Assistants to ensure that these quiet periods were eradicated. This exercise ensures that Patient Services Assistant's workloads are constant from the start to the end of their shifts (Cleaning Services Manager, King, 1993).

Before the program was introduced hospital management reduced the number of employees undertaking cleaning, portering and kitchen duties by some 60 positions in 1989 (Human Resource Development, King, 1994). Since the introduction of the program at Queen employee numbers have declined from 240 to 159 (a decrease of approximately 34 per cent). A similar outcome has occurred at King (Cleaning Services Manager, King, 1993). Management argues that no retrenchments have resulted from these reduced staffing levels which have been achieved through natural attrition and which have resulted in considerable cost savings. Overall, senior Cleaning Services management estimates that the cost savings have been in the order of $1.5 million per annum (Cleaning Services Manager Queen and King, 1993).

Management argues that entry to the Patient Services Assistant program is voluntary and that employees have not been forced against their will to

transfer from their previous positions. At King, management notes the hospital was faced with imminent closure (ongoing because of the considerable monetary value of the hospital site for residential property development) and unless employees wished to expedite this process they had little choice but to become Patient Services Assistants. Management also argues that resistance to the program could result in widespread retrenchments as the only alternative to the program was the privatisation of hospital services. These arguments were assisted by the proposed closure of the kitchen at King. Kitchen staff displaced by this decision were allowed to transfer to the kitchens at Queen. To remain at King, as most wished to do, meant becoming Patient Services Assistants.

To ensure that workers decided to transfer into the program, management refused to replace staff who left the kitchens at King. It resulted in the remaining "skeleton staff" being massively overworked. Some were responsible for delivering meals to three wards. To serve these meals meant running backwards and forwards from ward to ward "like a yo-yo" (Patient Services Assistants, King, 1994). Ex-kitchen employees claim that this workload was a "...killer" and that they frequently worked without a break. They also insist that their appeals to the Health and Research Employees Association to come to their aid fell on deaf ears (Patient Services Assistants, King, 1994). This strategy was ultimately successful. Ex-kitchen employees claim they literally "...ran from the kitchens" into the program (Patient Services Assistants, King, 1994).

At Queen, a more consensual approach was adopted by management although pressure on employees to become Patient Services Assistants remained considerable. The was influenced by the fact that ward assistants are members of the Nurses' Federation. Management didn't want to antagonise this union and risk jeopardising the program. As a result, it remains genuinely voluntary for these employees to become Patient Services Assistants. To date none have volunteered. This lack of

enthusiasm for the Patient Services Assistant program is also evident among kitchen staff at Queen with few willing to volunteer. Hospital workers who initially agreed to transfer into the program were vilified by other hospital workers as "management crawlers" (Cleaning Services Manager, Queen, 1993). To overcome such resistance at King the General Manager of the hospital would spend his lunch break with new Patient Services Assistants to encourage other hospital workers to enter the program.

'Management By Stress': Work Intensification and Lean Production

Lean production work organisation may result in a considerable intensification of work. This represents the experience of workers under the Toyota production system in Japan (Dohse et al, 1985: 133). As such, it may be more appropriate to label this production system 'management by stress'. Parker and Slaughter (1988: 11)[2] argue that "stress rather than management directives becomes the mechanism for coordinating different sections of the system. The stress throughout tightly links the different parts to make the system 'self - regulating' for management's purposes" (cited in Berggren, 1993: 45). Deliberately stressing both the production system and those workers involved in it represent central methods of lean production work organisation.

Hospital management is aware that Patient Services Assistants complain of excess workloads. Although the Cleaning Services manager at King concedes that the workload of hospital employees has increased he insists he "...only expects eight hours [work per day from Patient Services Assistants], thats all" (Cleaning Services manager, King, 1993). At Queen the Cleaning Services manager is also sceptical of claims of overworking. He argues that under the program's new shift system hospital employees cover a broader span of hours and therefore have more time on wards to do the extra duties required of them (Cleaning Services manager, Queen, 1993). The Human Resources Development manager at King claims that

Patient Services Assistants are busy but not frantic and "...still have time to sit outside and have a cigarette". In short, while management concedes that Patient Services Assistants are doing more, they disagree that the pace of work has intensified excessively or that Patient Services Assistants are overworked.

On the other hand, Patient Services Assistants at both hospitals argue that the amalgamation of cleaner, porter, kitchen staff and ward assistant classifications has resulted in a massive intensification of labour and increased work related stress. At Queen, on top of their previous duties of cleaning, Patient Services Assistants now have to serve food, make beds, deliver messages, and fetch blood samples and medicines from the pharmacy. One Queen Patient Services Assistant commented that "...you never stop" during your shift (Patient Services Assistant, Queen, 1993). At King, the intensity of work is, if anything, more extreme. Here Patient Services Assistants work without ward assistants and have to heat as well as serve meals to patients (Patient Services Assistants, King, 1993). They also have to transport patients about the hospital. Moreover, cleaning is more arduous because of the age of the floor surfaces. Former kitchen staff at King say that they endure "...three times as much work" as Patient Services Assistants than when they worked in the kitchens. Other immigrant woman Patient Services Assistants argue that the intense nature of work "kills us sometimes" and that at the end of a shift they are invariably "stuffed" (Patient Services Assistants, King, 1994). Another female Patient Services Assistant claimed that you had to be "young and fit" to survive the pace of work and when carrying linen bags she felt obliged to take two or even three bags at one go to save time (Patient Services Assistants, King, 1994). The level of stress experienced by Patient Services Assistant's has also increased because of the pressure they are under to get the job done. One immigrant woman Patient Services Assistant at King reported collapsing on the ward and having to be taken to casualty because of the constant pressure and

intensive nature of work (Patient Services Assistant, King, 1993). The intensified pace of work is compounded by interruptions from nursing staff with requests to undertake frequent errands (Patient Services Assistants, Queen and King, 1993).

Furthermore, the burden of work falls most heavily onto immigrant women hospital workers, contrary to the intention of the program to reduce the division of labour along gender lines. Prior to the program both occupational segregation and a sexual division of labour was established orthodoxy. Male porters undertook the "heavy" work of transporting patients, while women were restricted to cleaning, preparing meals and making beds. By becoming Patient Services Assistants women workers are, in theory, provided with access to a range of duties previously the preserve of male hospital employees.

At Queen, Patient Services Assistants work in pairs (often one male and one female) and male workers have actively resisted undertaking duties such as cleaning and changing beds (Patient Services Assistants, Queen, 1994). If male Patient Services Assistants do clean they only undertake certain tasks such as polishing which is relatively easy. They also avoid the "heavy" work involved in vacuuming, mopping floors and cleaning toilets because they argue that this is "women's" work (Patient Services Assistants, Queen, 1994). One immigrant woman commented that this represents "...the number one complaint" of female Patient Services Assistants at Queen. The net result of these actions is a major inequality in work distribution between male and female Patient Services Assistants at Queen with cleaning accounting for approximately 60 per cent of the overall Patient Services Assistant workload. Furthermore, female Patient Services Assistants argue that Cleaning Services management "...sides with the men" in the allocation of work tasks at Queen (Patient Services Assistants, Queen, 1994). Cleaning Services argue male workers are primarily placed on wards to undertake portering duties. Female Patient

Services Assistants, who in any case "...make better cleaners than men", are expected to get on with cleaning duties (Cleaning Services Manager, Queen, 1993). Instead of overcoming the previous sexual division of labour, working in pairs at Queen has entrenched these divisions.

At King, a substantially different picture emerges. Here immigrant women Patient Services Assistants contend that the male members of their teams do a "terrific job" undertaking cleaning duties without complaint (Patient Services Assistants, King, 1994). However, there is often solely one man on the ward with five or six women. Male Patient Services Assistants at King are in a far less powerful position to dictate which tasks they will and won't do.

The range of duties undertaken by Patient Services Assistants includes heavy lifting of patients and linen bags. New technology, in the form of new trolleys, have been introduced in an attempt to overcome potential occupational health problems that may arise. The new 'blue' trolleys have sides that lift out, reducing the height linen bags have to be lifted, and aim to reduce the potential for back strain (Cleaning Services Managers, Queen, King, 1993). But, the new trolleys are only effective after the linen bags have been removed from their original containers and it is difficult for many immigrant women workers to lift full linen bags over the rim of these containers. One female Patient Services Assistant at King noted "sometimes you lift a bag and don't know how you did it". Back strain is also caused by transferring patients by wheelchair. Adult patients, many recovering from heart operations and often overweight, have to be transported between wards at King by Patient Services Assistants. But, the hospital grounds are spread out, slope towards the sea and wheelchair access to many buildings is via a ramp. All three circumstances create the potential for occupational injury (Patient Services Assistants, King, 1993).

The intensive nature of the workload undertaken by Patient Services Assistants is compounded by pressures from management to develop verbal and written english language skills. Patient Services Assistants have to respond to instructions from Nursing Unit Managers, other nurses and doctors. They also have to interpret signs over patient's beds when distributing meals. Some patients receive special diets or no food at all if they are about to have an operation. Patient Services Assistants also have to leave notes for one another regarding duties completed and those that remain outstanding. All communications are in english and few concessions are made for those employees whose proficiency at english is poor. As a result meals, are sometimes delivered to the wrong patient. Nursing Unit Managers contend that Patient Services Assistants distribute according to the bed numbers and not by the names of patients or the signs over patients beds. But beds are sometimes alternated. In response to these pressures Patient Services Assistants with poor english literacy skills have developed an array of coping mechanisms to overcome this problem. For example, some Patient Services Assistants recognise that a patient is fasting because the black and white sign over their bed is removed. Others are able to distribute menu cards correctly by matching the day of the week to the colour of the card (Human Resource Development, King, 1994).

Teamwork: 'Management by Blame' and Peer Group Surveillance

The introduction of team working is central to the organisation of work under lean production. According to Womack et al (1990: 99) "... in the end, it is the dynamic work team that emerges as the heart of the lean factory". Mathews argues that when organised into self managing teams employees are provided with considerable autonomy over the allocation of tasks cementing a spirit of cooperation amongst the workforce (Mathews, 1991a: 14). Furthermore, Mathews insists that "such an approach would introduce a healthy degree of competition between teams..." (1991a: 34). Mathews argues that these teams result in greater

customer satisfaction, product quality, employee morale and productivity (1991a: 15). He presents team work as a panacea for both management and workers

However, team working has been widely criticised. Work teams seek to tap the tacit skills or knowledge of the production process possessed by shopfloor workers in order to further rationalise production (Wood, 1989: 454; Sayer, 1986: 52). This places greater pressure on workers in teams to reduce the time available to workers to rest between tasks. This process transfers pressure to meet production quotas directly to workers who may feel a greater "collective responsibility" for their work performance (Wood, 1989). Also, it may lead to workers monitoring one another's work performance (Dohse et al, 1985: 132). As a result, team working may result in considerable peer group surveillance or 'management by blame' (Delbridge and Turnbull, 1992: 65). This peer pressure may involve "a substitution of horizontal social control for traditional hierarchical means" (Oliver and Davies, 1990: 562). Organising workers into teams may result in intense peer group surveillance facilitating management control and fracturing collective worker solidarity.

Hospital management argue that team working introduced at King is working successfully. Human Resources acknowledge that initially teams experienced teething problems. Alongside personality conflicts, some male team members refused to undertake duties that they perceived to be "women's work". Where personality problems persisted Cleaning Services management removed one or both workers from the team (Human Resources Development, King, 1994).

However, Patient Services Assistants argue that team working at King has led to the emergence of peer group pressure and increased conflict between workers. Patient Services Assistants are organised into teams of

approximately seven on each ward. No team leaders are appointed because of the potential for these workers to abuse their powerful position (Human Resources Development, King, 1994). Because of the intensive nature of work Patient Services Assistants need to co-ordinate duties and assist one another as much as practicable. Where this works smoothly the team can expedite their duties with a minimum of conflict (Patient Services Assistants, King, 1994). But, within each team tensions frequently arise because of suspicions that one or more workers are not pulling their weight. Where this occurs it can effectively "double the work" for other workers (who have to do that person's duties as well as their own). It also increases the stress on all Patient Services Assistants on the ward with the team collectively blamed by their Nursing Unit Manager for any tasks not completed during the shift (Patient Services Assistants, King, 1994).

The team responds in two ways. Initially the person perceived to be at fault is taken aside and one or more of their colleagues "tell them straight" to improve (Patient Services Assistants, King, 1994). Alternatively, the team may collectively tell the person(s) concerned to improve their work performance. Patient Services Assistants insist that this is done in a "friendly" rather than aggressive manner. Nonetheless, they concede that those at the receiving end of this "friendly" criticism "sometimes get upset" (Patient Services Assistants, King, 1994). The second method is to inform Cleaning Services management or their Nursing Unit Manager about the problem. But, Patient Services Assistants are reluctant to "dob in" fellow workers and if they adopt this course they prefer to inform the Nursing Unit Manager (Patient Services Assistants, King, 1994). Therefore, team working at King results in increased policing by Patient Services Assistants over one another's workloads fracturing worker collectivity and facilitating management's control over labour, as fellow workers rather than management, reprimand those workers whose performance is deemed sub-standard.

Lean Production Skill Formation: Multi-skilling or Multi-tasking?

Claims by management that lean production results in a 'multi-skilled' workforce moving flexibly between tasks, may obscure a reality of multi-tasking. 'Multi-skilling' for many unskilled workers may merely enlarge the range of mundane tasks to be performed (Child, 1985; Fieldes and Bramble 1992: 570). Berggren (1992: 44) argues that "for most workers, the demands of flexibility mean they are alternating between similar repetitive tasks. This is multitasking rather than multiskilling". Multi-skilling may also result in a reduction in the workforce with tasks redistributed among the remaining "flexible" employees (Child, 1985: 127).

Prior to the introduction of the Patient Services Assistant program hospital workers received little or no training and performed a range of lowly skilled tasks. The Patient Services Assistant program seeks to change this through a structured training course which aims to multi skill trainee Patient Services Assistants. A pilot Patient Services Assistants training program was initially introduced. The trade union, which was initially hostile to the program, was allowed to choose the wards for this pilot program and picked those wards where the relationship between nursing management and hospital workers was most antagonistic (Human Resource Development, King, 1994).

The current training program runs for 20 days. It involves two work shop days at the beginning of the program with 18 days allocated for on-the-job training. (Human Resource Development, King, 1994). The two days of class room briefing are intensive. On the first day, Patient Services Assistants are taught how to transfer patients on wheel chairs, cleaning (stripping of floors and polishing), how to minimise the risk of infection, how to serve food and how to lift patients correctly. On the second day, they are trained in team work as part of both hospitals' quality customer program. They are also informed of the life support procedure in case of

patient emergency, and fire safety (Human Resource Development, King, 1994).

Nevertheless, Patient Services Assistants are critical of the training that they received. They consider that too little time is spent in class room training and that their trainers were ignorant about certain elements of their duties. For example, trainers knew little about kitchen duties with ex-kitchen employees themselves having to explain these tasks to other trainee Patient Services Assistants. Moreover, they knew little about the ordering of stores. Ex-ward assistants, whose responsibility this had previously been, had to inform other trainees. Finally, Patient Services Assistants claim that over time the standard of training declined markedly. While initial training courses were both rigorous and intensive, "...like the army", with trainees having to satisfy each stage of the course to pass, with increasing numbers entering the program these standards slackened. They contend that trainees were being pushed through the course with only the briefest of instructions as to their duties and are then expected to pick it up on the ward (Patient Services Assistants, King, 1994). However, because of staff shortages it is often difficult to allocate a "buddy" on the ward to demonstrate duties to trainee Patient Services Assistants (Health and Research Employees Association Delegate, Queen, 1993).

As a result, many Patient Services Assistants are sceptical of management claims that they are now "multi-skilled". Ex-kitchen staff concede that their knowledge is no longer restricted solely to the operation of the kitchens and they can now undertake cleaning duties and order for the ward's storeroom. But many argue these tasks merely involve some commonsense and use skills hospital employees already possessed (Patient Services Assistants, King, 1994). Ex - cleaners asserted that there is "no difference between [being a] Patient Services Assistant and cleaning" while others insist that there is not really all that much skill involved in ordering stores. One Patient Services Assistant

commented that the only real skill she learnt was how to use the polishing machine (Patient Services Assistant's, Queen and King, 1993). Multi skilling for these employees is limited to learning a range of lowly skilled tasks many of which they were already familiar with.

Despite these negative consequences, changes in the organisation of work at both hospitals have resulted in a range of positive outcomes for Patient Services Assistants who concede that the program has increased job satisfaction. At Queen, one Philippino Patient Services Assistant noted that being a Patient Services Assistant is "a little [more] dignified than just cleaning". Patient Services Assistants contend that they find the increased range of work more satisfying than the monotony of merely cleaning and many at King prefer the new rotating shift system in operation. It ensures that they have a different range of duties to perform each week. Also, Patient Services Assistants experience increased job satisfaction from being based permanently on wards. They are more integrated with nursing staff (for example attending morning tea), whereas previously they floated between wards and their contact with nursing staff was more limited. Patient Services Assistants are also more involved in patient care and have new uniforms and job titles. Finally, all those Patient Services Assistants interviewed prefer the new supervision regime that has accompanied the program. Nursing Unit Managers are perceived as providing Patient Services Assistants with greater autonomy. Many also see them as more understanding of the pressures that Patient Services Assistants are under.

A further benefit for non-english-speaking background immigrant hospital workers is the comprehensive english language education that accompanies the program. English classes cover both trainees and Patient Services Assistants already allocated to a ward with an accredited teacher employed to conduct these classes (Cleaning Services Manager, Queen, 1993). Classes take place half in the employees' and half in work

time. This ensures a motivated and committed class room (Health and Research Employees Association, Industrial Officer, 1993). In 1993 four classes were run. They took place twice a week and lasted for four hours for approximately five months at intermediate and advanced level. The classes are tailored to the specific needs of those attending, alternately focusing on writing or speaking skills. Patient Services Assistants may repeat the classes, if the teacher feels that they require extra tutoring, or may progress to the advanced class. These english classes represent an ongoing process open to all Patient Services Assistants to brush up on their english language skills (Cleaning Services Manager, Queen, 1993). Non-english-speaking-background immigrant women hospital workers regard the opportunity to attend these classes as a positive innovation (Patient Services Assistants, King, 1994).

Industrial Relations: 'Cooperation' versus Adversarialism

Lean production requires an emasculated response from trade unions to succeed. Hampson et al (1994: 240) argue that "organized labour's weakness is a necessity for the full flowering of this mode of production organization". In Japan a more cohesive management/union relationship emerged from the defeat of militant trade unionism in post World War II Japan (Dohse et al, 1985: 135). For example, at Toyota, management used both threats of dismissal and promises of job security to reduce the power of the Toyota trade union (Berggren, 1993: 27). Berggren (1991: 14) observes that initial trade union cooperation with lean production, to ensure secure jobs were not threatened, resulted in a strong backlash from shopfloor workers resentful of the changes in work organisation that lean production involved. It led to the incumbent trade union being overturned and the election of a much more militant workplace trade union leadership.

Before the introduction of the Patient Services Assistant program authoritarian control by Cleaning Services management at King resulted

in a history of highly conflictual industrial relations. Management/trade union relations at Queen, while less antagonistic, remained adversarial (Human Resource Development, King, 1994). With the introduction of the Patient Services Assistant program at both hospitals it is possible to discern both adversarialism and a movement towards greater 'cooperation' in the management/trade union relationship. Such 'cooperation' appears to be more resigned than voluntary, however. The union's industrial officer argues that it was unable to oppose the introduction of the Patient Services Assistant program at Queen and King hospitals because of a broad banding exercise in 1980 which simplified the classification structure contained in the Hospital Employees Award and for which hospital workers received a $20 a week pay increase. In introducing the Patient Services Assistant program management is merely moving all hospital workers onto grade two of that award while making maximum use of the flexibility and range of tasks it outlines.

Health and Research Employees Association's rank and file membership initially resisted the introduction of the program, especially at King. Hospital workers were angered at an outcome providing them with more work for no increase in pay. In January 1992 the Health and Research Employees Association sub-branch at King endorsed a motion condemning the program and refusing to work in accordance with it (Compulsory Conference, 2 March 1992). The union issued a notice, pursuant to section 25A of the Industrial Arbitration Act 1940, that it was in dispute with the Eastern Sydney Area Health Service. This resulted in the New South Wales Industrial Relations Commission holding compulsory conference proceedings on 29 January 1992 and on site at King on 11 February 1992 to consider the workforces' concerns regarding the program.

Contradictory evidence was presented to the Industrial Commissioner who felt compelled to recommend that the union sub-branch accept the

program. Of the six Patient Services Assistants who presented evidence, two argued in favour and four against (Compulsory Conference, 3 March 1992). The Commissioner contended that the alternative, contracting out, would threaten the job security of hospital employees and observed that "It is not a glib statement to say that unless the current classification continues the Area Health Service will have no alternative but to call for tenders as originally proposed by the Minister for Health..." (Compulsory Conference, 3 March 1992: 1). The union's sub-branch ultimately accepted the Commissioner's findings and dropped its opposition to the Patient Services Assistants program.

The day to day monitoring and negotiation over the program is conducted by the union's delegates at King and Queen. Management prefers to keep negotiations over the operation of the program "in house" (Cleaning Services Manager, Queen, 1994). Both delegates consider that the program is operating relatively smoothly, although they concede initial problems with Nursing Unit Managers overworking their members (Health and Research Employees Association delegate, King, 1993). The union delegate at King sits on a hospital panel which promotes the virtues of the Patient Services Assistant program to visiting delegations from hospitals in rural New South Wales, Victoria and Western Australia.

Adversarialism remains strong despite such cooperation with management in the promotion of the program. The union's delegates are actively involved in policing the operation of the program. They have ensured that Patient Services Assistants do not undertake duties beyond grade two of the Hospital Employees Award. At King, delegates were able to resist management's attempts to have Patient Services Assistants shave and feed patients (Cleaning Services Manager, King, 1994). At Queen, delegates are currently negotiating with management over reports that Nursing Unit Managers are getting Patient Services Assistants to do the duties of ward assistants whenever they are away doing messages.

Delegates insist that this is outside the scope of the agreed duties for Patient Services Assistants at Queen (Cleaning Services Manager, Queen, 1994).

The unions support for the program has alienated a significant number of Patient Services Assistants at Queen and King. These are highly critical of the Health and Research Employees Associations about-turn from initial opposition to acceptance of the Patient Services Assistant program and are critical of the lack of pay increase for all but former cleaning staff. They also argue that union meetings are held at mid day when they cannot attend as this is when they have to feed patients (Patient Services Assistants King, 1994). Moreover, few immigrant women Patient Services Assistants interviewed attend union meetings. One female Patient Services Assistants commented that she learns little at these meetings; "...you come away feeling more confused than before" (Patient Services Assistants King, 1994).

Patient Services Assistants response to the program has taken both collective and individual forms. Collectively, female Patient Services Assistants at King have vocally and persistently complained to both management and union delegates about the excessive weight of the patients they have to transport. In response, the union delegate at King has imposed a 70 kilogram limit on the weight of patients that these women are permitted to transfer. Management has conceded to both union and Patient Services Assistants demands. Presently, three motorised wheel chairs are on order and will soon be in operation at King in an attempt to overcome this problem (Manager Cleaning Services, King, 1994). The individual response by Patient Services Assistants to the program involves taking sick leave or going on work cover. Ex-catering staff, who have found adjustment to the cleaning duties most difficult, often go on work cover claiming back strain (Health and Research Employees Association Delegate, King, 1993). Moreover, their is

considerable individual resistance from among ex-ward assistants who represent a sizeable portion of employees going on work cover, sick leave, or reporting absent (Cleaning Services Manager, King, 1993). Many migrant women do not regard leaving their current jobs as an appropriate response. They contend that in the present labour market they would struggle to gain alternative employment (Patient Services Assistants, King, 1994). The Patient Services Assistants program, however intense, is preferable to no job at all.

Conclusion

The form of work organisation evident at both hospitals demonstrates the need for an alternative model of lean production and service work to that outlined by Mathews (1992), particularly where it affects marginal workers such as non-english-speaking-background immigrant women. An alternative model of lean production work organisation in the service sector, consisting of six elements, is suggested[3]. Firstly, lean production work organisation may produce a range of beneficial outcomes for labour. Patient Services Assistants enjoy increased job satisfaction through greater patient contact, new uniforms, improved integration with nursing staff and english language classes. Secondly, lean production may require coercion from management to succeed. The introduction of the program at King was accompanied by management threats of hospital closure, with many kitchen workers entering the program in order to escape oppressive working conditions. Thirdly, lean production in the service sector may lead to considerable work intensification. The elimination of idle time and amalgamation of job functions prior to the beginning of the program has laid the basis for a maximisation of worker effort (Parker and Slaughter, 1988; Delbridge and Turnbull, 1992), increased stress, occupational injury, pressure to speak english and the reinforcement of a gendered division of labour. Fourthly, lean production work teams may result in 'management by blame' (Delbridge and Turnbull, 1992: 65) or horizontal social control (Oliver and Davies, 1990).

The introduction of teams at King has resulted in considerable peer group surveillance (Sewell and Wilkinson, 1992). Fifthly, the promotion of 'multi-skilling' by management as a significant benefit for workers may obscure a reality of multi-tasking (Berggren, 1993). 'Multi-skilling' at Queen and King involves training in a number of lowly skilled and labour intensive tasks requiring more commonsense than skill. Finally, trade union responses to lean production work organisation which fail to constrain its more detrimental outcomes for workers risks undermining shopfloor solidarity and loyalty to the union.

End notes

1. Mathews advocates a similar model of lean production "as an ideal form" in his analyses of Colonial Mutual and Ford (Mathews, 1991a: 43-44, 1991b: 21). In a later study Mathews concedes that lean production may create a range of problems for workers and organised labour, however the earlier "ideal model" remains unrefuted (Mathews, 1993).

2. Womack et al (1990) analysis of lean production has been criticised for providing "no analysis of the academic debates about 'intensification' and no evidence on the behavioural reaction of workers to Japanese style management inside and outside Japan" (Williams et al, 1992).

3. The framework developed on the strength of this case study, based on the responses of management and labour at only two hospitals, is unrepresentative and therefore not amenable to generalisation. Nevertheless, idiosyncratic case studies are useful in that they facilitate the process of theory building (Mitchell, 1983).

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Senior Cleaning Services Manager, Queen and King, November, 1993
Cleaning Services Manager, Queen, November, 1993; February, 1994
Cleaning Services Manager, King, November, 1993; February, 1994
Leading Hand, Cleaning Services,Queen, November, 1993
four Nursing Unit Managers, Children's Wards, Queen, November, 1993
Nursing Unit Manager, Delaney Ward two, King, November, 1993

Patient Services Assistants (King and Queen)

Cardiology Ward, November, 1993; January, 1994
Cardiothoracic Surgury, November, 1993
Spinal Injuries Ward, November, 1993; January, 1994
Delaney Ward two, November, 1993
Marks Pavillion, November, 1993
Children's Wards 1,2,3,4, November, 1993
Dickinson Geriatric Unit, January 1994

Health and Research Employees Association

Industrial Officer, November, 1993
Delegate, Queen, November, 1993
Delegate, King, November, 1994