

Gendered Relations to Working Time: Enterprise Bargaining Outcomes in Acute Care and Community Nursing Settings in Australia

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In this paper we examine the outcomes of the 2001, 2004, 2007 Enterprise Bargaining Agreements between the Australian Nursing Federation (SA) and the South Australian Government with particular focus on union-based strategies for de-intensifying nurses' labour in the acute and community sectors. Consistent with the theoretical and empirical research on time the strategies employed in the acute sector reflect rational, linear, bureaucratic, logical and masculinist relations to time through the use of computerised time and task measures. Community sector solutions are characterised by cyclical, messy and highly relational feminised approaches to reducing work intensification. We argue that the outcomes of these two approaches are contradictory. The community-based solution of case management is less successful in reducing workload, but maintains worker control over the labour process, while in the acute sector, the highly Taylorist approach is successful in de-intensifying workload but at the cost of reduced control over the labour processes.

Introduction

One of the major objectives of the Australian Nursing Federation (ANF) over the last decade has been to respond to member claims that their work has intensified as a result of hospital restructuring and budget shortfalls that have been part of the health industry landscape since the early 1990s. At the national level the ANF has responded to this through a series of research projects and campaigns, and at the state level the various branches have moved to incorporate strict limits on both the duration and intensity of working time (AIRC 2001a; 2001b; 2001c). This has seen the union move to contain numerical flexibility (shifts, overtime, and leave) and work intensity (patient load per nurse) through the three yearly cycle of enterprise bargaining (EB). This paper explores the outcomes of three EB rounds negotiated between the ANF (SA Branch) and the South Australian Government in 2001, 2004 and 2007 with particular reference to work intensification in acute public hospitals and the community health sector. Achieving some control over work intensification in the public hospitals has been assisted by the presence of a computerised nursing dependency tool; EXCELCARE, which provides clear, standardised information on workload. In the community health sector opportunity for standardisation is confounded by a range of structural and cultural factors including models of care. One way of conceptualizing these differences is through the theoretical lens of gendered time use. The ideal types (Elwell 1996) of masculinised and feminised relations to time (Odih 1999, Bittman 1991), captures much of what presents as problematic for bureaucrats, managers, nurses and the union in seeking to limit work intensification for nurses in the public sector, while maintaining the relational qualities of nursing care.

Data for this paper comes from two sources; the first from ethnographic work done by the first author between 1998 and 2002 in two public acute hospitals in South Australia that explored how time is used as a technique of control over the labour of health professionals, specifically nurses and early career doctors, the second from a research project conducted between 2006 and 2007 by all four authors with a range of community health nurses drawn from both union interest groups and Department of Health managers. The aim of the second project was to gather sufficient data to design a suitable workload measure required as part of the 2005 EB Agreement between public sector nurses working in community health and the State government. Data included focus group discussions with community health nurses, the collection of job diaries over a period of two weeks, investigation of workload measuring tools from interstate and other countries, and the development and trial of a tool for a period

of six weeks including preliminary evaluation of its usefulness. The paper is organised into three sections. Firstly, a brief theoretical discussion of modes and gendered relations to time is provided. This is followed by a discussion of workload measuring tools in both the acute and community sector. In outlining each tool or process we provide an assessment of its capacity to contain work intensification while at the same time ensuring control over the labour process.

Modes and Relations to Time

The theoretical exploration of time has taken numerous directions, two important ones being 'modes of time' (Adam 1995, 2002) and 'relations to time' (Adam 1995, 2002). The most obvious mode of time in health care is bodily time; the time taken for bodies to heal. There is an assumption that bodily time stands in opposition to the rational social organisation of health care, and that nurses (and doctors and allied health professionals) have neither opportunity nor inclination to take account of this time. However, the successful practice of healing is contingent on the use of medical technologies that operate on the basis of biological, physical and metaphysical time. It is simplistic to suggest that bodily time is in conflict with the social and bureaucratic organisation of time in the care of the sick. Nurses and doctors synchronise much of their work and the technology they use with the body's rhythm. For example they rely on routine tests that measure patient responses to drugs or surgery in order to pace treatment. These responses are natured benchmarks for determining the efficacy of medical technology.

These two modes of time, bodily time, and the time governing the organisation of health care, interact to maximise health in very concrete ways. Part of what makes for skilful professional care is the ability to keep the technological interventions and when they are delivered (read 'the bureaucratic order') synchronised with the body in ways that do not cause undue distress to the patient. Nature may work without the intervention of the social and technological, but doctors and nurses know that they cannot effectively use medical technology, and the bureaucracy that structures this technology, without tapping into the rhythms of the patient's body. This symbiosis between bodily and technological/organisational time is also played out in patterns of work. As a consequence nurses provide 24-hour care regardless of the day or hour. Nurses take shift work and unsocial rosters as a given. It is premised on the moral imperative to care for the sick 365 days of the year, 24 hours per day (Zerubavel 1979). However, nurses do expect to finish work at the end of the shift and unlike young doctors in the public sector do not have a tradition of un-paid over-time, double shifts, long hours or on-call, despite the fact that in the last decade some of these practices have occurred (AIRC 2001a; Wise 2007). Nurses also require adequate time to care for individual patients. When the pace quickens and this is no longer possible or they feel it is compromised they may leave the profession or suffer from burn-out. There is considerable evidence that this has occurred over the last two decades with even employer groups seeking to find industrial solutions (Buchanan & Considine 1999; Buchanan, Bretherton, Bearfield & Jackson 2004; AIRC 2001a; Wise 2007).

Relational time: gendered time

The second approach to time deals with its relational character. Here social theorists attempt to explore the way in which particular individuals, genders, societies or cultures, use, understand and relate to time; and in turn, how this impacts on the type of people and societies that prevail (Bergmann 1992). Debates on gendered relations to time use in the public or domestic arena oscillate between those who suggest they are fluid (Hearn 1987; Hearn 1992; Odih 1999; Everingham 2002) and those who see time use as fixed (Bittman &

Lovejoy 1993; Bittman & Wajcam 2002). In both cases gendered relations to time are seen as responses to power.

Odih's (1999) exploration is a useful starting point for asking whether or not time use is gendered because she asks a key question about the relationship between gendered work, women, power and efficiency. Odih (1999) presents this dilemma by first stating that work time is neither male nor female, but should be understood as embodied, feminised and relational; or abstract, linear, masculinised and rationalised. Relational time is an experience of time that is contextualised and social rather than internal and individuated. In relational and embodied time individuals may subordinate themselves to the 'other'. However, this should not be understood to be simply women's time or the time of the powerless, but rather the time of those caught up in the feminised discourses of embodied social relations (Odih 1999:21). This relational time is not the exclusive domain of women, but rather a reflection of the power and interpersonal relationships of both sexes. Both men and women engage in masculine or feminine modes of time. This is possible since she claims gender identity is not fixed, but a fluid reflection of social practices, historical circumstances and organisational arrangements (Odih 1999).

Despite Odih's (1999) claim for fluid relationships to time, a number of scholars have suggested clearly delineated gendered differences (Helman 1992, Glennie & Thrift 1996, Bittman 1991, Bittman & Lovejoy 1993, Baxter & Bittman 1995, Bittman & Wajcam 2000; Baxter 2002). The arguments for binary differences move from gendered differences in domestic labour and childcare (Bittman 1991), to leisure (Bittman & Wajcam 2000) to differences in personality, societies, cultures and civilisations (Helman 1992). For example, Helman (1992) makes a claim that Western society is characterised by a determined shift towards linear time, a result of industrialisation, secularisation and rationalisation and that this shift is a reflection of masculine ways of being in the world. Citing Hall (1959) he refers to these gendered differences in individuals as cultural constructions of monochronic and polychronic time, that seep into the pores of individuals as well as the cultures of organisations and their practices.

In his fascinating article on coronary heart disease (CHD), Cecil Helman (1992) linked Friedman and Rosenman's (1959) Type A behaviour to Hall's (Helman 1992) cultural construction of monochronic time. Monochronic time is linear time and should be viewed as a relation to time, rather than a mode of time. For the monochronic individual, organisation or culture, tasks are compartmentalised into shifts, hours, minutes, seconds, and appointments and schedules are taken seriously, independently of context. Bureaucracy and procedures take precedence over relationships. Monochronic individuals, bureaucracies and cultures encourage disciplined organisation whereby time is mentally divided out across the day in detailed half-hour or fifteen-minute segments. When time is wasted or interrupted this is noted and bodily stress may be experienced. When time is well used, pleasure ensues.

Monochronic cultures are orientated towards the sequencing of tasks—one thing is done at a time—and a high value is placed on speed (duration and rhythm) and efficiency (temporal location, sequencing and meeting deadlines) including achieving more in less time. In Hall's view monochronic time is peculiar to Western societies and represents an attempt to impose order from the outside on the individually chaotic lives of humans (Helman 1992:37). Fast is best, even when it is not synchronised with the message or, in the case of health care, with the processes or relationships needed for healing. As Helman (1992) notes the very personality traits needed for success in Western society produce a relationship to time that is counter-productive to health and well being.

However, while Western society is assumed to be characteristically monochronic, this is not uniform. Since monochronic time is intimately tied to bureaucracy, organisation and economic production, individuals such as women, the unemployed and elderly, often excluded from these, may be less subject to this imposed time order and engage in what Hall refers to as polychronic relations to time (Helman, 1992:38). Polychronic time is cyclical rather than linear; it is not readily experienced as lost or wasted, but is multi-faceted. Individuals and cultures that engage in polychronic time perform multiple tasks with little apparent stress, revealing a *laissez faire* attitude to delayed gratification and as a consequence exposing their social class position. This is because polychronic cultures value relationships, family and human interaction over schedules and organisational demands. From this perspective, while polychronic relations to time may not be conducive to bureaucracy, they may be more suitable in small organisations where relationships are pivotal, or in situations where complex problems must be solved (Lee 1999:17).

Helman (1992:46) argues that behind these characteristics are two moral typologies; the first dealing with values, the second with implications. Monochronic conjures up ideas of the modern, Western, urban, fast, public and profane world of men and money (Helman 1992:47). Without them the world would be primitive and out of date. Conversely, non-Type A individuals are referred to as Type Bs. These people are devoid of ambition, competitiveness and a sense of urgency (Helman 1992:31). They are indifferent to time, friendly, relaxed and satisfied individuals who are patient, other-centred and family orientated. The cultural analogy is the polychronic. Such behaviours and cultures imply a traditional, non-western, rural, slow, sacred, feminised private world in need of redemption to bring it into the modern world. This may be the world of caring relationships, but it is not the world of innovation and sophisticated medical technology that saves lives; nor the world of efficiency and increased productivity in the workplace.

In summary, social theorists of time suggest that individuals, organisations and societies develop a relationship to time that becomes associated with gender or gendered ways of being in the world. However, different societies value different approaches to time. In Western society the time that is valued is monochronic, linear, rational, efficient time; the time of progress, the successful and the powerful male. Non industrial societies are characteristically cyclical, messy, irrational, feminised and now-a-days powerless; and this is both a reflection of, and reflected in their apparent inefficient relationship to time. Whether we take the position of gendered relations as fluid or binary the two approaches are useful for understanding cultural practices associated with either gender. The argument applied in this paper is that the two workload tools outlined below reflect monochronic and polychronic gendered relations to time intensity. However, we argue that the flow of power is more complex than the usual assumptions that feminised time use is less powerful than masculinist time use. For nurses in the acute sector the power of the workload tool, EXCELCARE, resides in its capacity to offer a precise measure of their work intensification, but at some cost to control over the labour process. For community mental health nurses the case management tool offers less control over work intensification, but preserves control over the labour process. The qualities of these two tools are explored below.

The 2001 Enterprise Bargaining Agreement for public acute hospital nurses

The three EB agreements under review are the 2001-2004, 2004-2007 and 2007-2009 Public Sector Agreements between the Australian Nursing Federation (ANF) and the South Australian Government. In the period leading up to the 2001-2004 EB Agreement the union argued the need for a precise measure or tool for controlling work intensification for nurses working in public hospitals. The ANF proposed a nurse-patient ratio formula similar to the

one successfully achieved in the State of Victoria in 2001. Anxious to avoid ratio staffing, the government proposed using the nursing dependency tool, EXCELCARE as a way of measuring and controlling work intensity (AIRC 2001a).

EXCELCARE is not a work intensification tool; it is a computerised nursing dependency costing system or patient classification instrument marketed as a nursing care plan. It was introduced into South Australian public hospitals between 1992 and 1995 following consultations with the ANF. It interfaces with the rostering system so that EXCELCARE calculations, accurately predict the number of staff needed for the next shift. It also interfaces with computerised financial programs. EXCELCARE predicts workload through timing direct and indirect performance of nursing tasks through Taylorist stop-watch tests. Direct time is care which is performed by nurses and can clearly be attributed to a specific patient and a specific task such as putting in a cannula. Each task is referred to as a unit of care (UOC) (SAHC 1995). It also makes provision for direct and indirect/embedded timed activities. Embedded activities within a UOC include writing of nursing notes, or the time spent reading case notes. These embedded activities are incorporated within the UOC that are common to all patients. Indirect times are divided into fixed and variable units of time. For example, a fixed indirect time would be the checking of dangerous drugs at the end of a shift. A variable indirect activity might be equipment checks specific to a ward, for example checking monitors on the cardiac ward.

EXCELCARE provides clear, rational, and standardised information on work intensity. All that is required is for the nurse to key in one of over 1000 UOC (each one meticulously timed and regularly up-dated) into the data-base for each patient per shift for the rostering program to accurately predict the number of staff needed for the next shift. If management fails to staff accordingly a breach of the EB Agreement has occurred. For example, if the UOC equals sixty-four hours then the rostering program will indicate a need for 8 nurses for the next shift. While there may be some variations in timings across hospitals, within sites the timings are standardised and the care plans are tailored to each client upon admission. Providing all else is equal between wards, and nurses assiduously fill in the EXCELCARE data on all three shifts across the 24 hours, workload intensity is reasonably equally distributed.

Despite these strengths EXCELCARE is not without its flaws, two are worth comment. EXCELCARE is promoted as a nursing care plan. While sophisticated, the UOC are predetermined with the care plan limited by the capacity of the tool, or the most recent update of tasks. Timings cannot be adjusted except through formal negotiation. Only UOC contained within EXCELCARE are recorded as nursing work; and while nurses do set up their own nursing care plan it is the EXCELCARE task that is counted as nursing work. EXCELCARE also shapes relational work. This occurs in two ways. Firstly, the focus of a shift becomes the performance of tasks for a set number of clients according to a predetermined EXCELCARE plan; the risk here is that accomplishment is about getting the tasks done, not about establishing a caring relationship. Why this might be so is best explained by the way relational work is calculated. EXCELCARE calculates interactions with clients as timed 15 or 30 minute UOC called '*Dealing with anxiety*'. A standardised time is sometimes attached to this relational task, as if it is a technical event, and the minutes taken to complete it are tallied up. EXCELCARE has replaced the nurse's subjective nursing plan, defining care in terms of direct and indirect, legitimate or not, rational and irrational, real or unreal timed events. It also defines the way in which tasks are put together, structuring for many nurses how they think about their work. At first sight, it promises nurses clear and unambiguous evidence of the intensity of their work; yet they have no control over the timing, and little control over the nursing care plan. It reduces nursing work to detailed tasks performed on patients as if they were products assembled on a production line. Interactions between two

humans—one sick, the other caring—are transformed into the fifteen minute UOC ‘*Dealing with anxiety*’.

The 2004 EB Agreement for community nurses

In the 2004-2007 Agreement the ANF South Australian Branch turned its attention to community health nurses who like their colleagues in the acute hospital sector argued that their work had become increasingly intensified through nursing shortages, vacancies and more complex patient loads, partly the result of earlier discharges from the acute sector. Appendix C of the agreement required both parties to explore an appropriate staffing equalisation tool during the life of the agreement for community mental health and community health nurses (AIRC 2004a). The tool designed by our research team takes a case management approach to work intensification. We were influenced by how the work was organised, but also by an examination of work diaries kept by eleven community mental health nurses over a two week period in 2006. What these diaries exhibited was a non-linear approach to nursing work motivated by the availability of clients, their families, outside agencies, the severity of their current illness episode, issues of housing, employment, the next available work car, or which patient was home at that particular time of the day. The work was not linear, but opportunistic, and given the chronic nature of mental illness, cyclical.

A second major influence on the research team came from work being done interstate and nationally in monitoring nursing workload. The Victorian Psychiatric Service Certified Agreement 2004-2007 (AIRC 2004b) made provision for each service to develop their own workload equalisation tool. As part of our research investigation we contacted a small number of teams in Victoria to find out how and what they had put in place to achieve work equalisation. What became clear was that there was a stronger push to equalise case loads between clinicians, rather than deal directly with work intensification amongst some groups, although others were trialling modified forms of a tool developed by Meldrum and Yellowlees (2000) and the SWIM tool (HACSU 2005). The tool we finally settled on drew heavily on a process for workload transparency developed by the Outer East Area Mental Health Program (Maroondah Hospital), the SWIM tool as well as a range of measurements designed by Meadows and Yellowlees (2000).

The tool is divided into three components; i) calculating time for case management, ii) case management equalisation, iii) recording the intensity of clinician time spent with a client. Before any decision can be made on case load the array of other duties a particular nurse must perform is estimated and subtracted from his or her case management time. These other duties include health promotion activities, service related organisational duties such as preparing for quality audits, professional duties such as attending to new staff or supervising students. It is assumed that only the clinician and team leader can determine the time allocated to these duties and this negotiation over time available should be conducted on a regular basis three or four times across the year. The second part of the tool deals with a transparent process for case load equalisation. The allocation of clients to each clinician is performed at team patient intake meetings. Equalisation of workload is achieved by openly recording each patient assigned. Once a clinician has achieved their designated number within a six week cycle they cannot take on another client until all other members of the team have also reached their quota. The focus of this process achieves equalisation between clinicians; it does not deal with workload intensity.

The third part of the tool deals directly with time spent on case management and goes some way to addressing the issue of work intensity. Case management is defined as one-to-one therapy, but also the myriad of advocacy work done on behalf of, or with clients and their families such as assisting them to find work, housing, recreation or on-going treatment as well

as researching their conditions through personal reading or discussion with colleagues. It may also be influenced by the models of care practiced. To deal with this a limit to clinician load was initially recommended. These limits range for 20-25 for community mental health nurses to 12 for those dealing with patients in crisis. Similar loads were recommended for nurses dealing with clients with other chronic conditions, but it was clear these recommendations as yet, have little basis in evidence given the variety of models of care practiced across the sector. As a consequence, work intensity is calculated by examining the time spent with the client, the number of interventions over the week, the clinical factors for this client such as the level or risk or comorbidities, the complexity of their social, religious and cultural circumstances and the availability of resources beyond the treating team such as non-government organisations, local General Practitioners and self-help groups; many of which are in short supply in South Australia (SASIB 2007). Population factors such as remoteness from major health services are also recognised as impacting on clinical intensity of the case managers' work and were incorporated into the tool. This aspect of the tool is not a patient acuity rating, but an estimate of the time intensity the clinician commits to the person. The score assigned to this section is not a patient rating, but a subjective measure of the intensity of engagement the clinician has with this client. Hence while the tool has little capacity to predict the volume of work, or estimate the number of nurses needed, it does have the capacity for equally sharing the work through a process of negotiated transparency. In fact it is best defined as a set of transparency processes, rather than a tool.

While the tool is currently being integrated into existing computerised systems, it will never become fully standardised as the calculations of time spent with clients is based on what nurses say they did, not on predetermined timings. The case management tool/process designed for these community health nurses lacks the precision of EXCELCARE used in the public hospital acute sector. The number of hours allocated to case management is determined by the nurse in what is a subjective consultation with the team leader. The amount of time spent with each client cannot be accurately estimated, for the performance of similar tasks may vary between case managers, across regions and from one service to the next. This variation may be the result of nurse's skills, the time they take to deal with the client's anxiety, their interest in this case, and certainly in the way they sequence tasks, organise therapy or the model of care in place. These variations in the labour processes are under the control of the clinician. Variations will also arise from the nature of the client's condition, their compliance, socio-economic background, the availability of other services, family supports or even the amount of traffic on the roads on any given day.

Each of these variations is accommodated in the tool. As a consequence the tool requires constant negotiation to ensure it achieves equality through transparency. The time and intensity of work is not calculated through time and motion studies, but is negotiated between teams and arises out of knowledge of the context. Even if models of therapy were standardised variations would continue to occur between regions and teams because of social factors, or simple factors like early morning traffic, distances between services and client homes or the number of support services available in the surrounding suburbs and towns. The tool recognises that nursing work can be cyclical and multi-faceted and that for community health nurses this work is essentially relational. This approach reflects polychronic relationships to time; messy, cyclical, non-linear, complex, highly contaminated, non sequential and feminised.

From standardised monochronic to messy polychronic nursing work

This paper has made a series of observations about the outcomes of union endeavours to contain work intensification for nurses in the public acute and community health sectors

through Enterprise Bargaining Agreements. These observations suggest that a particular tool or technology and the associated practices it throws up may shape the way an organisation, and its staff, relate to clients. We suggest that EXCELCARE is a tool reminiscent of monochronic time that engenders a particular way of being a nurse - one with an eye to the clock and the task; one that calculates interactions as UOC. This is not to suggest that all nurses working in acute hospitals are monochronic type personalities. What is suggested is that the technologies guiding practice go some way to shaping how individuals work and view this work. It could be said there is a monochronic ether in the air. We also noted that in the acute sector EXCELCARE successfully provides a mechanism for careful calculation of nursing intensity because the tool measures the nursing task in minutes built up over a series of evidence-based time and motion studies. The work is carefully defined, but as a consequence, nursing control over the labour process (what the work is, how it is done and organised) is compromised. The analogy here is that while the nurses can control the pace of the production line by knowing what time is needed to perform the tasks and as a consequence have enough nurses working alongside them, they do not have control over the tasks to be performed. These are predetermined through the 1000+ units of care built into the EXCELCARE product. They can of course do more for the patient, but these additional tasks are not counted as 'work' nor is time assigned for these other incidents of human caring. There is a tendency not to perform these additional tasks since the synchronisation of EXCELCARE to the rostering program PROACT is highly refined; the minutes and hours calculated by EXCELCARE predict with exquisite refinement the number of staff available per shift reminiscent of a well oiled production line.

When nurses find themselves enjoying interactions with patients they question their caring and healing capacity, asking themselves *is this work?* At other times competence is defined by those who can perform relational tasks in 15 minutes, rather than 30, or patients are assigned a UOC '*Dealing with anxiety*' according to where they are on a clinical pathway as if emotions or pain always conform to the days in the week. Legitimate work is limited by the UOC recorded on the system so that incidental caring work is missed, but so too is work that engages the nurse in professional judgment as individually tailored care plans give way to EXCELCARE. Reminiscent of monochronic practices with its tight sequencing of tasks and the value it places on time and efficiency, EXCELCARE imposes an order on nursing work from the moment of the UOC '*Admission of patient*' to the UOC '*Discharge*'. Despite this it has the capacity to predict in hours, minutes and seconds nursing intensity and as a consequence delivers its industrial promise to deal with work intensity. The tool predicts the need for additional staff, and budget considerations aside, agency or casual staff can be assigned to a ward to meet demand. A recent announcement by the South Australian government that EXCELCARE, the current acute sector workload tool will be replaced in 2009 (Johnston 2008) is in our view unlikely to alter the capacity of the tool to do anymore than record work intensity.

The community mental health tool is based on subjective, but transparent discussion of workload with acknowledgement of the messiness of social and cultural issues outside hospital walls, as well as the chronic nature of illness for many patients cared for in the community. It lacks precision, cannot control or predict work intensity except after the fact, and must rely on the nurse to provide the measures. The order it creates over time use is a negotiated one, subject to variation, conflict, disagreement and abuse, and highly dependent on good-will. This tool is polychronic and messy and requires managers to calculate workload through repeated acts of transparency and negotiation. It is not a tool that pre-determines the tasks to be done, or times them and allocates nursing staff accordingly. It is a set of processes that negotiates the assigning of a patient load or number to be case managed, and then

provides a mechanism for ensuring each clinician's work intensity is roughly similar, and decidedly transparent. From this perspective it allows individual nurses as case managers, to maintain control over how they organise and sequence their work, what tasks they do, what order they do them in, how much time they assign to them and when they do them. The focus is transparency and equity between clinicians.

Concluding Comments

We have noted above that the ANF has attempted in the last 10 years to deal with work intensification using the EB process. Under the 1996 Workplace Relations Act the 20 allowable matters provided a framework for controlling hours worked, but not work intensification (Australian Government 1996). The union has used workload ratios and workload tools, such as computerised care plans like EXCELCARE or Nursing Hours per Patient Day (NHPPD) formula to deal with work intensification in the acute sector. The ANF is acutely aware of the limitations of this approach seeing the ratio staffing achieved in Victoria as preferable to EXCELCARE or NHPPD, but has been unable to achieve it in other states (AIRC 2001c). Research by the AIRC in Western Australia shows that when NHPPD formula is converted to ratio staffing it is less favourable than the Victorian ratio staffing agreement (AIRC 2001b; 2005). Importantly, ratio staffing does not have the same in-built risks as task-based formulas, allowing like case management, a more holistic approach to planning patient care. But as we demonstrate case management approaches likewise have limitations in controlling work intensification. Their strength lies in confirming the relational aspects of nursing work, not in controlling the work intensification

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