Employee Participation: Case Studies in the Australian Healthcare Industry

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Abstract: This paper explores employee participation based on case studies in three Australian healthcare services. We analyse the views of managers and employees on their understanding and experience of employee participation and the facilitators and impediments to participatory practice. Findings indicate the existence of direct and indirect forms of employee participation including regular OH&S committees and irregular employee user groups. Only one organisation had an ongoing management/union consultative arrangement. However, all organizations had informal arrangements for employee participation in teams or project development. A model of eight pre-conditions to employee participation was used to analyse the data. The main finding is that management support is the pre-eminent pre-condition for employee participation to occur, however this is dependent on management identifying a benefit in employee participation. Implications are drawn for managerial practice and further research.

Key Words: management, unions, employee participation

Introduction
Employee participation is a topical subject in industrial relations and human resource management research and practice (Ackers 2007; Markey and Hodgkinson 2003). It has been linked to improvements in productivity and organisational efficiency (Poutsma, Hendrickx and Huijgen 2003; Appelbaum, Bailey, Berg, and Kelleberg 2000). Although the evidence for this link is mixed (Danford, Richardson, Stewart, Tailby and Upchurch 2004), interest in the area has grown.

Australian healthcare organisations are the focus of this paper. Performance in healthcare is a significant public policy concern and systems redesign has become an international preoccupation as new methods are sought to address its quality and effectiveness (Locock 2003). Although Australian healthcare organisations have adopted major technical changes, they have often been slow to accept improved methods of people management (Bartram, Stanton, Leggat, Casimir and Fraser 2007). Labour in Australian healthcare accounts for 70 to 80 percent of health costs (Duckett 2007) and governments have encouraged workplace reform (Willis, Young and Stanton 2005). Evidence suggests that change has often been imposed on health service staff despite the potential benefits that employee participation in decision making may offer (Stanton, Willis and Young 2005). Healthcare could be the ideal environment for employee participation to flourish as it is highly professionalised, with strong unions and high levels of employment security (Stanton et al 2005). London (2001:133), who surveyed Australian health staff on workplace change, argued “participation in decision making was identified as highly desirable”. However, West, Borrill, Dawson, Scully, Carter, Anelay, Patterson & Waring (2002) argue little employee participation research has been undertaken in hospital and health settings.

Employee participation can be defined as employees exercising some influence over their work and decisions that affect their work and the workplace, however it has a great diversity of meanings, forms and motives (Sirianni 1987). These include worker participation (Sirianni 1987), industrial democracy (Ramsay 1977), self-management (Appelbaum et al 2000), co-determination (Furstenberg 1986) and employee voice (Dundon et al 2004). Lashley (2001)
refers to the ‘involvement continuum’ for worker participation, from autocracy to democracy. Marchington (2005) argues that a problem with employee involvement is that it has no unambiguous definition.

The level of worker involvement in managerial decision making is uneven and the locus ranges from the unit level to the whole organisation (Marchington 2005). Participation is either direct or indirect. Direct participation occurs where “... work is organised to permit front-line workers to participate in decisions ... problem solving or quality-improvement teams ...” (Appelbaum et al 2000:7). These may be informal, short-lived groups, or formalized autonomous work groups in which employees make important production decisions (Markey and Hodgkinson 2003). Indirect participation occurs when workers are represented by others such as trade unions on consultation or collective bargaining committees (Marchington 2005).

In this paper, employee participation includes both direct and indirect processes ranging from problem solving groups and self directed teams to formal employee/union joint consultative committees, but does not include collective bargaining in the Australian healthcare sector which has been analysed elsewhere (Stanton 2007).

This paper analyses three case studies of public healthcare organisations in Victoria, Australia. The aim was to explore the experience of employee participation from the perspectives of key managers and employee focus groups. As part of this, we assess the role of unions and the health employer association and the industrial relations implications. The findings are analysed through the application of a model derived from the literature, which identifies eight pre-conditions of employee participation that should predict its presence. These are management commitment, union presence, perceived benefit, supportive policy, job security, trust, organisational size and participatory ethos (O’Donoghue, Stanton and Bartram 2007; Dundon et al 2004; Poutsma et al. 2003; Appelbaum et al 2000).

The paper is organised as follows. First, we outline the preconditions to employee participation derived from the literature. Second, we explain the industrial relations and public policy context of the three organisations. Third, we outline our methodology. Fourth, we present findings from the three case studies. Finally, we discuss the findings and draw conclusions. We argue that despite the existence of the pre-conditions, employee participation only occurs where management support exists and the management perceives there is a benefit in the introduction of employee participation.

The Pre-conditions of Employee Participation
A number of factors have been identified as pre-conditions to the introduction and maintenance of employee participation and it is suggested that where these conditions are exhibited, employee participation will occur (O’Donoghue et al 2007). A key theme emerging from the literature is the importance of management support. Strong support and commitment from senior management is seen as vital for employee involvement to take hold and develop (Tesluk et al 1999). There is evidence that participation is more developed in organisations where management are convinced of its strategic benefit (Poutsma et al 2003) and where management is well disposed towards consultation and information-sharing (Cully, Woodland, O’Reilly and Dix 1999).
Trade unions support is a crucial component and evidence suggests that employee participation contributes more to performance in unionised settings than in non-union settings; that is, participatory practices are positively associated with the presence of unionism (Hodgkinson 2001; Cooke 1994). Union involvement leads to improved communication, trust and cooperation (Brewster, Wood, Croucher and Brookes 2007). Organisations do not exist in a vacuum and supportive public policy has been identified as a factor in that governments can support or undermine employee participation through regulation or policy direction (Dundon et al 2004).

Perceived benefit is an important factor. From a management perspective, the benefits of employee participation relate to enhanced productivity, economic outcomes and effective organisational change (Walters and Frick 2000; Ben-Ner and Jones 1995). This is based on the view that employees have greater work related knowledge than their managers and are better able to schedule and arrange work and identify problems and fix them (Cooke 1994). Lawler, Mohrman and Ledford (1998) argue that organisations with high employee involvement perform better than those with low involvement. For workers, employee participation can lead to greater autonomy, job satisfaction, respect and increased power (Pruess and Lautsch, 2002; Appelbaum et al 2000).

Job security, employer – employee trust and size of organisation appear as other important preconditions for successful employee participation. Evidence suggests that workers will react positively to job security (Freeman and Lazear 1995), which is critical to the success of high performing organisations that put a premium on labour force attachment (Brown, Geddes and Heywood 2007; Appelbaum et al 2000). Employer and employee trust in the workplace optimises the existence of successful participatory processes (Suff and Williams 2004). In union management partnerships, high trust is engendered by employee participation (Brown and Oxenbridge 2004). Size of the organisation is positively associated with workplace participation schemes and higher level committees (Brown et al 2007; Bartram 2005; Poutsma et al 2003). However, there are conflicting views, as Heller et al (1998) noted that direct participation is more likely to be evident in small organisations.

We have added a theme, ‘participatory ethos’, which does not appear in the traditional employee participation literature, but does feature in the healthcare literature. Australian community healthcare exhibits specific characteristics that appear to influence human resource management practices and facilitate participation. The participatory ethos in community healthcare and the human resource practices, such as flatter hierarchical structures, encourage participation of staff in the decision making and have been a key feature of policy and practice in this area (Leggat, Bartram, and Stanton 2006; Swerisson 2006; Stanton 2002).

The Context of Healthcare in Australia and Victoria
Australian healthcare is a complex mix of public and private systems and relationships between State and Federal governments (Willis et al 2005). The Victorian Government funds the state healthcare system mainly with funds provided by 5-year agreements with the Federal Government (Duckett 2007). Public healthcare services are government owned, but each organisation acts as “... a separate and discrete employer with its own management structure” (State Services Authority 2009:51). Although the Government is not the direct employer,
decision making is influenced significantly by Government due to its funding, policy administration and regulation (Bray, Stanton, White, and Willis, 2005). While most funding is directed to public hospitals a range of primary health and support services are provided through Community Health Services to meet local community needs. The State Labor Government encourages and supports community involvement and participation in planning, review and evaluation of health services (Leggat et al 2006; Swerisson 2006).

Industrial relations in Australia, including Victoria, has been characterised by compulsory conciliation and arbitration and ‘centralised’ wage determination practiced by quasi-legal tribunals (Willis et al 2005). In public healthcare, employee conditions of employment are regulated by sector-wide agreements achieved through centralised bargaining in which government and state trade union officials play a strong role (Stanton and Bartram 2005). However, despite this centralised industrial environment, healthcare organisations do have a significant amount of control over their own human resource policies and practices (Stanton, Young, Bartram and Leggat 2010).

The industry is complex and dominated by influential groups; particularly the State Government Department of Human Services (DHS), the health service employer organisations and unions (Bray et al 2005). The principal employer organisation, Victorian Hospitals’ Industrial Association, deals with industrial relations, government relations, policy and funding matters (Bray et al 2005). The workers have strong, well organised professional groups and trade unions (Stanton and Bartram 2005). The three principal unions are: the Australian Medical Association (AMA) represents industrially medical specialists and salaried doctors; Australian Nursing Federation (ANF) represents nurses industrially and attends to some professional issues; such as training and accreditation; and the Health Service Union (HSU) is a composite union comprising five branches representing an array of employee categories: allied health professionals, such as physiotherapists, medical imaging technologists and pharmacists; psychiatric care and disabilities; managers; and non-professionals, such as cleaners, porters, patient assistants, food handling and administration (Willis et al 2005).

In healthcare, collective bargaining is sector-wide and “...has remained centralised, with state government officials and state trade union officials continuing to play a strong bargaining role.” (Stanton and Bartram 2005:270). There are several reasons for this. First, the state governments are effectively the employer, due to their funding role, and centralisation enables them to exercise better control of wages. Second, the sensitivity to industrial disputes in health results in the government seeking to influence outcomes. Third, the unions are strong and prefer to maintain centralised processes for bargaining (Stanton and Bartram 2005). However, since the mid-1990s, employers have made widespread efficiency gains “... introduced largely through managerial prerogative rather than collective bargaining” (Bray et al 2005:86); including outsourcing, changes in work practices and working hours.

In 1999, a Labor Government was elected in Victoria. Its industrial relations policies promote a partnership approach and consultation between management and unions; thus fostering employee participation, particularly on workplace change (Industrial Relations Victoria 2006). Also, the guidelines for capital development in healthcare require the establishment of employee ‘user groups’, which contribute to workplace design (Department of Human Services 2001). Though
this mandates participation it does not mean it is practiced, as Dundon et al (2004:1168) argue “...managers remain strategic policy actors whatever the state of the legislation or public policy prescription ...”; that is, managers have a key role in interpreting and adopting policy.

Methodology
This is a qualitative study based on case studies in three different Victorian healthcare organisations – the emergency department in a large metropolitan hospital (MetroED), a mid-sized regional hospital with a large aged care function (Regional Health), and a community health service (Hillside). The organisations were purposively selected for feasibility of access to sites, interviewees and archival material and their willingness to participate in the study. Interviews were conducted with the CEO and the Human Resource Director (HRD) at Regional Health, the CEO at Hillside and the General Manager Human Resources of Suburban Health (HRD) and the Director and Nurse Unit Manager (NUM) for MetroED. These were followed by focus groups with non-management staff at each organisation and an additional group at Regional Health, the employee union representatives on the Staff Consultative Committee (SCC).

For these interviews and focus groups, semi-structured questionnaires were used to allow more flexibility in questioning and openness of responses from the respondents. All interviews were recorded and transcribed then analysed and the observations drawn. From these, separate sets of comments were derived: general observations on the overall responses, the participant’s perspective of employee participation, why it works, the impediments to successful participation, and the views the informants had of themselves and the other parties. Much of the data was captured as direct quotations, which enables the participant’s view of their world to be represented accurately (Ezzy 2002; Patton 1990).

Useful data was obtained from documents in each case study, such as annual reports. This provided background and descriptive material; including, the nature of each organisation; governance structures; and the range of their services and statistical data on budgets and staff. Also, some documents specific to participatory processes were collected; such as descriptions of occupational health and safety committees and the SCC at Regional Health and minutes of meetings.

The case studies were preceded by a literature review of employee participation with a focus on the healthcare industry. Earlier research by the authors provided an industry perspective based on a survey of senior public health managers and interviews with key health sector. This found substantial support for employee participation across the system, although support was weakest at the largest healthcare services, and a preference for unstructured processes (O’Donoghue et al 2007). From this, a general research proposition was developed: where there is evidence of the pre-conditions in an organisation, employee participation will occur. Further, without management support, even if other preconditions are evident, that employee participation will not succeed. In essence, management support for employee participation is necessary, but is not a sufficient condition for employee participation to exist and be viewed as successful.

The Case Study Organisations
Regional Health is medium-sized with 550 staff and a significant aged care service. Two ongoing participatory forums were observed:

- the Staff Consultative Committee (SCC) that comprised the CEO, other Directors and workplace union representatives; and
- the Occupational Health and Safety (OH&S) committee that involved the HRD, other senior managers, and staff nominees from each department.

Also, two irregular forums existed:

- continuous improvement groups comprising staff from different levels and work units including allied health and nursing; and
- user groups of staff to contribute to the aged care redevelopment.

Hillside is a small community health service based at two sites serving separate communities. It employed 90 staff who were predominantly female and many were part-time. Hillside has no formalised staff participation except the OH&S Committee. The participation was mainly informal and the arrangements included staff forums and workshops, site meetings, and professional staff groups in which they contributed to design new projects or programs. Also, staff had established a forum, ‘What’s in Staff Heads’, to identify issues to raise with management. During the rebuilding of Hillside’s Head Office in 2000, there was a formal staff user group.

‘MetroED’ is a component of ‘Suburban Health’; one of the largest of Victoria’s 18 public health services. Apart from an OH&S committee, there were no other continuous formal consultative arrangements at Suburban Health. During the redevelopment of MetroED, user groups were set up, but there was uncertainty if they conformed to DHS requirements. Participation by staff was mainly informal and occurred through general staff meetings; team meetings; email communication from the Director; and a suggestion scheme.

**Analysis of the Case Studies: Providing the Organisational Perspective**

The three case studies were compared and analysed to attain an organisational perspective of employee participation. Views of managers and employees were elicited about their organisation, the pre-conditions for employee participation and factors that discouraged this. The discussion is focused on two points:

1) The common features among the case study organisations,

2) An assessment of the pre-conditions in the case studies.

**Common Features of the Case Study Organisations**

The case studies differed in size, location, range of services and their participatory experiences, but a number of similarities in the services were identified. First, all managers interviewed were positive about employee participation; arguing that it provided opportunities for employee input and was a sign of good management. However, they believed that it had to have strategic value to sustain support. For example, at MetroED, the management recognised the link between employee involvement and successful change.
Second, all the employee focus groups regarded their organisation as good place to work. They expressed affinity for their work colleagues and to serving the community. In particular, Hillside was described as having a ‘family’ feel.

Third, despite support for employee participation, the managers stated that they reserved the right to make decisions, which they exercised regularly, including at key points of organisational change. For example, the Regional Health CEO acknowledged that she made decisions without consulting staff and this impeded employee participation.

Fourth, each service had one example of a formal on-going participatory forum; an OH&S Committee that comprised management and staff representatives. Also, during major redevelopments, each health service established formal user groups of staff to elicit their suggestions on proposed designs and plans. Regional Health had a formal staff management consultative committee.

Fifth, each organisation had informal mechanisms through which employees could contribute. At Regional Health, staff participated in cross service ‘continuous improvement’ committees and on projects and program delivery at Hillside.

Sixth, the focus groups recognised that they had made a positive contribution to management decisions on redevelopments and influenced the design of programs. At MetroED, they stated that the new facility was a better place, partly due to their contributions to the design of the building and the type of equipment to be used. Also, at Regional Health, benefit had been generated in the site consolidation project and the development of the expanded aged care facility.

Seventh, the participants recognised that hierarchies were present that adversely affected the capacity of each organisation to instil participatory processes. At Regional Health, the CEO was described as autocratic and the medical staff did not engage in any of the formal processes. At MetroED, the Director consulted separately with medical staff as they were not involved in other informal processes.

An Assessment of the Pre-Conditions in the Case Study Organisations
Management and the focus groups were questioned on their perspective of each of the preconditions and the data presented a mixed picture across the case studies. In this paper, the preconditions job security, employer and employee trust, and size of organisation are not discussed due to their lesser importance in the experiences of each case study organisation.

Management Support
Support from management for employee participation was expressed, although less emphatically at MetroED, as it enhanced the manager’s understanding of what is happening at work, assisted in the implementation of decisions and generated motivation. This support appeared to be linked to recognition of the strategic value of employee participation. The Regional Health CEO stated her commitment had decreased over time, as the SCC had lost strategic emphasis and was resistant to change. All managers reserved the right to make decisions, sometimes without consultation. After the MetroED redevelopment, a ‘hands off’ approach was adopted and
participation diminished; evidenced by the unannounced decision of management to build another facility. This denied the staff the opportunity to influence the decision.

Union Presence
The only collaborative union presence occurred at Regional Health where the unions were involved in formal participatory arrangements. The CEO and HRD stated that union support was constructive and they consciously engaged unions, as they considered better outcomes were achieved. However, they believed that unions sometimes impeded participation, arguing that they lacked a strategic outlook, pursued their own agendas, were insular and resistant to change. At MetroED there was no systematic involvement of unions and virtually no union presence at Hillside. At MetroED and Regional Health, in some instances, the staff failed to influence management through participation and engaged unions to achieve their goals through adversarial bargaining. In these instances, employees reported that benefits had been generated, which strengthened their perception of having an effective voice.

Perceived Benefits of Employee Participation
All participants believed employee participation was positive and identified a range of common benefits. For management, the benefit was staff contribution to change; such as problem identification, improving the quality of the decision, increasing ownership or reducing resistance to implementation. Also, staff involvement enhanced communication and sharing information, assisted in aligning staff with the organisational direction, and contributed to worker identification and commitment. For the HRD of Suburban Health, one tangential benefit was that he believed employee participation reduced union membership.

For employees, the opportunity to contribute their knowledge and experience to shaping management decisions was the key reason for their participation. This linked to achieving better outcomes, resolving problems, encouraged staff to get ‘on board’ with changes, improved morale, respect and friendliness in the workplace, increased organisational understanding of staff, and made the management’s work easier in the long run. The MetroED employees were most critical, but they considered the redeveloped department was improved due to their contributions.

Policy and Regulation
Each organisation responded to the requirements of government policy and regulation on participation in three ways. First, well functioning OH&S Committees existed in each organisation. Second, at times of major development, user groups were established, as required by government. Third, under Victorian Government Industrial Relations Policy, employers are encouraged to collaborate with relevant unions (Australian Labor Party 2006). However, this did not appear to influence practice strongly and collaboration only occurred at Regional Health. Unions were involved through adversarial bargaining at MetroED. The Hillside CEO acknowledged that the absence of union involvement was a gap in practice.

Participatory Ethos
Hillside exemplified the high levels of support for employee participation in community healthcare. Management was accessible and the focus groups reported that they had many opportunities to participate and influence management decision making. Though focus groups at
Regional Health and MetroED expressed their desire to serve to their communities; arguably this commitment is different to the participatory ethos in community healthcare.

**Discussion and Conclusions**

The participants in this study considered that employee participation had value and potential to contribute to improvements in their organisation and workplace. The findings show that the participation takes a number of forms; either direct, such as project work; and indirect, such as OH&S or organisational change committees. They have formal employee participation; specifically, OH&S committees, and staff user groups in large capital works redevelopment projects. However, the focus groups believed that this is not always done well, not very extensive and largely takes the form of consultation after decisions have been made. Other than the OH&S committees, there was limited evidence of regular participatory practices, particularly formal arrangements such as joint consultative committees. The exception was the Regional Health SCC. As Levine (1995) suggests substantive employee involvement remains the exception.

However, it is evident that the pre-conditions of management support, compliance with government policy and regulation and perceived benefit exist. Also, union presence was evident, but inconsistent. This aligns with earlier research into Victorian healthcare, which identified three pre-conditions of employee participation: management support, union presence and policy and regulation (O’Donoghue et al 2007).

A clear issue emerging from this study is the role of management; consistent with literature that identifies the importance of management to the success of employee participation (Marchington 2005; Dundon et al 2004). To be successful, senior management needs to be committed to make employee participation happen; for example, exhibiting openness, communicating regularly, ensuring representatives have time and resources for participatory responsibilities, possess the requisite skills for participatory decision making and responding positively to employee input. Through leadership, support and encouragement, participatory practice can cascade down the organisation to create the climate or culture that is conducive to successful employee participation (Cabrera, Ortega, and Cabrera 2003; Cully et al 1999; Tesluk et al 1999).

Employees were sceptical about the level of management commitment and support. First, they reported that ideas that they had contributed were not accepted and that communication and feedback was poor. Second, some were cynical of management’s motives and stated that participation occurred only to allow the CEO to claim that government policy objectives were met. Third, at Regional Health, some claimed that the management had created an image of participation in order to achieve their own ends (Brown and Oxenbridge 2004; Farnham et al 2003); a problem identified in other parts of Victorian public healthcare (O’Donoghue et al 2007).

The absence of continuous and committed management support, as evidenced at MetroED, may diminish the ‘participatory climate’ (Miller and Monge 1986) and lead to less rather than more participation. As Milkman (1998) states, a huge gap has emerged between the rhetoric of participation and the reality at the workplace. This may be due to indifference, rather than deliberate, as the value of participation is not greatly appreciated among managers (Bar-haim 2002). Also while the employers organisation (VHIA) does espouse support for employee
participation (O’Donoghue et al 2007), there was no strategy evident that would provide support for individual employers to instil this at the workplace. The lack of local leadership may reflect the absence of sector wide institutional support for a participatory approach. In the case studies, there was no evidence of involvement from VHIA, which is focused on industry-wide collective bargaining; thus, industry leadership is lacking.

Union involvement is important for the success of employee participation (Brown et al 2007) and can improve communication, trust and cooperation (Brewster et al 2007). The unions expressed support for the concept of employee participation (O’Donoghue et al 2007). However, this did not extend to active support in the workplace, except at Regional Health. There, the management generally saw union support as constructive and consciously engaged the unions. They considered better outcomes were achieved with a union presence, which is consistent with other findings (White and Bray 2005). With co-operative labour-management relationships, employee participation is easier to adopt (Brown et al 2007). However, even at Regional Health, the unions eschewed collaboration to pursue key objectives related to nurse staffing ratios and change proposals through bargaining and advocacy in the Industrial Relations Commission. Also, at MetroEd, the unions did not collaborate; rather they adopted an interventionist approach to security arrangements for front office staff and to nurse staff levels. This meant the industrial relations environment was more adversarial than collaborative, supporting the contention that strong union presence is associated with direct negotiation, not participation (Cully et al 1999).

Of interest, unions and employees were involved in OH&S processes and committees. However, they did not view this involvement as employee participation and did not leverage from this to broader participatory involvement.

Only MetroED management expressed any antagonism to unions. The HRD of Suburban Health believed that employee participation was beneficial as it reduced union involvement; in effect, a union substitution strategy. This could explain the lack of union involvement as the real motivation of management would engender suspicion and lessen union inclination (Brown et al 2007; Cooke 1994), discourage union collaboration (Milikan 1998) and diminish trust (Brewster et al 2007; Brown and Oxenbridge 2004), which was an issue at MetroED. Unions will only enter into participatory processes if there is a benefit (Stepp and Schneider 1997) and loss of members does make participation problematic for unions (Ackers 2007; Bartram and Cregan 2003). Only Hillside management viewed the absence of strategic union involvement as an inhibitor to employee participation. However, the industrial relations environment at Hillside was benign, as opposed to MetroEd and Regional Health where a level of antagonism existed and adversarialism was evident.

The existence of perceived and real benefits to management and employees is a positive factor in management facilitating opportunities for involvement and employees taking these up (Pyman, Cooper, Teicher, and Holland 2006; Brown and Oxenbridge 2004; Poutsma et al 2003). For management, the benefit was of staff contribution to change; such as improving the quality of the decision or reducing resistance at the implementation stage. At Regional Health, management considered that staff involvement assisted the process of change, enhanced communication and sharing of information; benefits found in other participatory experiences (Narine and Persaud 2003; Pruess and Lautsch 2002). The Hillside CEO believed that staff would have more
ownership of change decisions and their participation assisted in aligning staff with the organisational direction, contributing to worker identification and commitment (Newell 2002; Appelbaum et al 2000). At MetroED, management recognised that staff input identified problems in management proposals, improved decisions and assisted with implementation. In essence, these views recognised the link between workplace consultation and successful change (Narine and Persaud 2003).

The public policy context and regulation is a key influence to the presence of employee participation (Dundon et al 2004). This was evident in the case studies in the OH&S committees and the redevelopment User Groups. However, except for the HRD at Suburban Health, none of the managers or employees explicitly identified the OH&S committees as a form of employee participation. Also, the resort by employees at Regional Health and MetroEd to industrial agitation conflicts with the State Government policy on collaboration. However, this mirrors the nature of Australia’s industrial relations, as legislation reinforces union centred bargaining, rather than direct workplace participation (Gollan 2002).

Community healthcare has a history of participation (Stanton 2002) that is reflected in human resource practices and encouraged by flat hierarchical strategies (Leggatt et al 2006; Swerisson 2006). Community healthcare reported the highest levels of support for employee participation in Victorian healthcare, particularly informal processes (O’Donoghue et al 2007). Hillside exemplified this participatory ethos. Employees reported that they had many opportunities to participate and influence management decision making through project groups, program planning and staff meetings. Though employees at Regional Health and MetroED were committed to their services, this is arguably different to the ethos that underpinned participatory processes in community healthcare.

Impediments to Employee Participation
According to the participants, several impediments were identified. These represent challenges and contribute to the difficulty to establish and maintain employee participation; as observed elsewhere (Milkman 1998).

First, the health sector is hierarchical in nature, such as between and within professions like doctors and nurses (Duckett 2007). This affects management style and leadership and can contribute to autocratic decision making, as was alleged at Regional Health and MetroED. This is consistent with the findings of Danford et al (2004) who identified management resistance to the principles of worker participation and any constraints on their perceived prerogatives. In part, this explained why some employees viewed management as autocratic, or even dictatorial. The willingness to exercise managerial prerogatives is common to the experience of public healthcare (Bray et al 2005), and represents top down hierarchical management (Duckett 2007). The support of management appeared to be linked to recognition of the strategic value to them of employee participation (Poutsma et al 2003), but this was neither pervasive nor continuous. All managers placed limitations on the extent of employee involvement and reserved the right to make decisions, sometimes without consultation. This is consistent with much of the employee participation literature that assumes managerial prerogative (Farnham et al 2003; Marchington 1992).
Second, some managers attributed the lack of success of participatory arrangements to negative union attitudes and actions. Management at Regional Health regarded that the value of the SCC was reduced due to the inflexibility of union representatives. Preston and Crockett (2004) and Levine (1995) argue that workers may be less flexible after they have had some input. At Suburban Health, the HRD considered the unions lacked a strategic view of participation and the Nurse Unit Manager at MetroED was antagonistic to union involvement. By contrast, the CEO of Hillside considered the absence of unions may have diminished the success of participation and represented a missed opportunity.

Third, women are disproportionately over represented among short tenured and part-time employees (Brown et al 2007) and part-time and female employees were less involved in either direct or indirect employee participation (Markey and Hodgkinson 2003). Fourth, the time poor nature of healthcare was reflected by the absence of budgeted time, inconvenient meeting times, and lack of notice to staff, which reduced the capacity to contribute. In this environment, some managers pay “lip-service” to worker involvement, creating a feeling of participation rather than real practice (Howcroft and Wilson 2003).

Fifth, most groups characterised the processes as information sharing, rather than participation in decision making and asserted that information was provided after a decision had been made, thus, limiting staff involvement to the implementation. This view is echoed in some literature (Hodgkinson 2001; Lashley 2001) and represents a missed opportunity to make constructive suggestions on work place design (Pruess and Lautsch 2002). For the participants in formal processes, this was a source of frustration and contributed to cynicism, as they felt bypassed when decisions were made, leading to failure of participation (Ackers 2007). However, based on employee comments on the value their involvement made to improvements at work, this appears somewhat misguided. In many instances, participation occurred before the decision. For example, at Regional Health, the participation influenced decisions on the site consolidation and the aged care redevelopment. Similarly, at Hillside, staff regularly contributed to the development of programs and, at MetroED, staff stated that their contributions led to improvements in the new facility. Staff clearly had the opportunity to contribute and influence the formulation of management decisions.

Conclusions
From the discussion, we make the following conclusions. First, the preconditions of management support, policy and regulation, and perceived benefit are necessary to ensure formal OH&S committees and user groups are established. All case study organisations had formal participatory OH&S committees and user groups. Second, union involvement is required for formal participatory arrangements to be established, other than OH&S committees, but this only occurred at Regional Health, which had the SCC. The key difference was the active presence and support of unions at Regional Health for employee participation. There, the unions were engaged collaboratively with management and a continuous formal participatory process existed; that is, the SCC. Third, managers have a key role in interpreting and applying policy and regulation and, even where employee participation is mandated, it does not mean it is applied. For example, MetroED and Hillside management determined not to involve unions as part of change processes despite Government Policy. Similarly, at Regional Health, it was the CEO who initiated the original staff consultative committee, because she perceived a benefit in doing so.
The case study managers reported that OH&S Committees were valuable arrangements; that is, they perceived a benefit from these. The combination of management support, perceived benefit and compliance with policy and regulation has led to the establishment of ongoing OH&S committees as formal participatory arrangements. However, it is feasible to contemplate that if management did not value the OH&S committees, they would exercise their prerogative not to initiate or to discontinue them, as they had done with union involvement and formal consultative arrangements. This highlights the power of management to determine whether or not there will be employee participation and, if so, the nature of this. In essence, this makes the management the sole decision maker.

In the case of the research model, management support is a necessary pre-condition to the establishment of employee participation and this would occur only where the management perceives a benefit in establishing a participatory arrangement. In the light of this, when considering the research model, in the case studies, all of the other pre-conditions that facilitate and sustain employee participation are subordinated to management support and perceived benefit. Given the recognition of the importance of management support (O’Donoghue et al 2007), it is likely that this conclusion from the case studies could be generalised to Victorian healthcare. That is, management support and perceived benefit are the eminent pre-conditions that determine whether or not employee participation will occur.

**Implications for Future Research**

These observations raise challenges that should be considered for further research, for government policy and practitioners who wish to institute participatory practices in the workplace. These are beyond the scope of this paper, but indicate that many topics on employee participation in public healthcare are open to research. First, given the limited spread of participation, is there a qualitative difference between public healthcare in Australia and other industries that inhibits the spread of employee participation? Second, why do Victorian healthcare services comply with OH&S regulation to set up OH&S committees, but mostly ignore industrial relations policy obligations? Exploring this may assist in explaining the managerial behaviour and develop a more supportive framework to initiate and embed employee participation. Third, why are unions not more involved in participation in public healthcare? Understanding union motivations may identify strategies to increase their engagement; such as training programs in alternative dispute settling and collaborative interest based bargaining to alter the adversarial culture. Also, what occurs in community healthcare, built on a participatory ethos, may provide a useful paradigm within which unions could address employee participation.
Bibliography


