Letter from . . . Australia

Victorian nurses' strike

JOHN KNIGHT

On the Friday before Christmas the nurses went back to work in Victoria after a strike lasting 50 days. As the employers—effectively the Victorian government in the shape of the minister for health, Mr David White—seem to have conceded almost everything that the Royal Australasian Nursing Federation (RANF) had been requesting for months before the strike did the health care services in Victoria have to be disrupted?

The answer may lie in economics. When hospitals are not paying nurses and not taking in patients, who have to be fed and given clean linen as a minimum, they should cost less to run. The Australian Labour party (ALP) state government, like the ALP federal government in Canberra, has accepted that the current economic crisis in Australia can be overcome only by cutting government expenditure.

If the federal government is cutting spending the states have to do likewise because most of their funds come from the federal government. Cutting spending on health in the states means cutting spending on hospitals. In 1975 the federal government started providing half the operating costs of state hospitals. After two years and a change of government the arrangement was not renewed and the seeds of the recent nurses' strike were sown. In 1977 the Victorian government introduced staff ceilings in all government hospitals. Those ceilings are still in force today despite changes in technology and workload in the past decade. During this period the nursing shortage has steadily increased helped by the inadequate rates of pay, which positively penalise anyone making a career out of bedside nursing.

Some years ago there was a dispute about non-nursing duties, which was settled by the provision of ward clerks and bed makers. Two years ago in an effort to get extra staffing for intensive care units there was a period of no elective admissions. This brought some hospitals almost to a close. The result of that action was a small improvement in the staffing ratios but no extra money to pay the nurses.

New wage rates but not enough money

In the middle of 1985 the health department and the RANF started discussions about new pay rates and a new career structure that would encourage nurses to stay in nursing at the bedside. The federation wanted to discuss the two subjects separately but the government wanted to link them. Eventually the new scheme and the new wage rates, which offered nothing to the student nurses nor to the first year nurses and \$A 450 a week to the non-existent directors of nursing of hospitals with over 1000 beds, was unveiled in June 1986. The next step was to classify every job so that the

wages could be paid. This is where the snake slid out of the grass. The government had made much of its determination to find an extra \$A 50 million for the increase in nurses' wages. What it had not made public was that the money was not enough to pay the rises using the existing staff structure let alone a staff structure designed to pay long serving (more than five years) nurses more to encourage them to stay in nursing. To avoid exceeding the money available the health department downgraded most nurses. The charge sister in my anaesthetic department found herself an associate charge sister as did almost all theatre charge sisters. In Victorian hospitals there is usually at least a charge sister for each operating theatre with a supervisor and assistant supervisor in overall command. The new dispensation was one charge sister in each department and operating suites are just another department to the bureaucrats at the health department. The result was that many people who had been charge sisters for years were downgraded. In many cases this downgrading was the final straw and resignations went in. As well as cutting down the supervisory staff most nurses were classified as grade 1, as if they had just qualified, however long they had been nursing. One nurse who had been in charge of an ear, nose, and throat theatre in the United Kingdom and qualified for 10 years found herself a grade 1, admittedly after only a year in Australia. Certificate pay disappeared and even with the rises promised many nurses would be worse off after the new pay scale was introduced. One of the problems with the health department is that there are few administrators with experience of health matters and almost no doctors.

Protests were, of course, made to the health department, but the minister would not enter into discussions with the RANF as there was not a dispute. He had been highly regarded as a successful minister on the basis of his handling of the energy portfolio. His great achievement had been to increase the output of brown coal briquettes. His predecessor, Mr Tom Roper, had been moved out of the health portfolio after a mediocre performance that saw the waiting lists rise rapidly. This was not entirely his fault as the federal government had introduced Medicare, which made free public hospital admissions available to all, during his tenure of office. This meant that many people transferred from the private hospital system to the public one by dropping their insurance cover. Mr White, who started by announcing that he would see waiting lists reduced, has made an even greater mess of things than Mr Roper ever did. The no elective admissions dispute and a full blown nurses' strike has meant vastly increased waiting lists.

Large majority vote to strike

The RANF eventually got fed up with being stonewalled. By this time the claims had gone before the state industrial commission. In Australia each state and the commonwealth of Australia has an arbitration system for settling disputes but a dispute must exist before arbitration can start. This is usually achieved by the unions claiming all sorts of things that they know the employers will not give and the employers doing the same. Then both sides go before the commission; the horse trading starts and both sides yield from

East Melbourne, Victoria 3002, Australia

JOHN KNIGHT, FFARCS, specialist anaesthetist

Correspondence to: 80 Wellington Parade, East Melbourne, Victoria 3002, Australia.

their prepared positions. During the strike the RANF was accused of being industrially naive. But it only asked for what it had been asking for over a year. After a few weeks of no progress in the industrial commission the nurses voted, by a large majority of those at the meeting, to strike. Perhaps they would have been wiser to have put in their resignations en masse or to have banned elective admissions again.

Once the strike started Mr White refused to hold discussions on the grounds that he was legally unable to do so as the matter was before the industrial commission. No such claims had ever been advanced when dealing with the Australian Railways Union. He maintained this pose for three weeks before agreeing that there was no such legislation. The state secretary of the RANF is a member of the Socialist Left (the left wing of the ALP) and the ALP government had no compunction in making sexual innuendoes about her and her left wing male friends. It struck me and many of the commentators that the government acted much more brutally towards the nurses than they did to the railway unions. This may have been because it was dealing with women and expected them to crack.

Eventually the Australian Trades Union Congress (ACTU) held discussions with the nursing federation and presented its case to the government. According to the ACTU the government agreed to settle the dispute on the ACTU terms, which had been approved by the RANF. The government offer, however, was less than had been agreed, which given the history of the dispute was to be expected. It was nearly Christmas, the nurses had been out for 49 days, and several had been starved back to work so the vote to accept the government's offer should not have been the surprise it was. Among the conditions was a review of the classification of nurses.

The really surprising thing about the dispute was the support that the nurses got. Furthermore, there were no reports of people dying for lack of treatment. The government made great play of the fact that the striking nurses could be sued by patients or relatives for not giving care and the media ran stories about how patients waiting for cardiac surgery would die while waiting for the strike to end. It was not surprising that the public hospital system carried on coping. The RANF made quite sure that there were enough staff for casualty and intensive care units and for caring for patients who could not be sent home. Only in the last days of the strike were people walking out of casualty departments and threatening to close down intensive care units. The nurses in my hospital did not go on strike; they just worked half shifts. The effect was to close the hospital to elective admissions, but the list of acceptable emergency procedures included any cancer surgery.

The nurses went on strike because they thought that they were being overworked and had no chance of improving the position. Many had left nursing for better pay, reduced hours, and often less

responsibility. The result had been more work for those remaining as hospitals have been chronically underestablishment for years. The new career structure, with its increments of skill and service, was seen to be the only way of breaking the vicious circle. When the health department downgraded most of the nurses and many charge sisters this was seen as the last straw. When discussions about the problems could not even be started the strike was inevitable. It is a sad fact about Australia that governments listen only to arguments that are backed by industrial muscle. The federal government, with the aid of the state government, provoked a doctors' strike in New South Wales in 1984 when Medicare came in and were willing to go to the negotiating table only when it was obvious that the Victorian doctors would join the strike unless the government agreed to talk to the Australian Medical Association.

Minister let off the hook

Mr White wants hospitals to provide the same and preferably more services as in the last financial year with a 1.5% cut in income. The services provided will be less than last year; the nurses' strike has seen to that and so Mr White has been let off the hook. What he does not seem to realise is that health expenditure is very much like railways expenditure. To provide any service at all costs a lot of money. The overheads are high. The railways cost the state government over \$A 400 million a year more than they bring in. Perhaps Mr White will follow Mr Roper to the transport portfolio and make room for some new minister interested in people rather than in briquettes.

For reasons that are quite beyond me hospitals in Victoria usually get their budget figures for the financial year, which is July to June, in September or October of that year. This year my hospital had not had its budget by Christmas. The budget is not an income and expenditure budget. It is solely an expenditure budget. If for some reason the hospital treats more private patients than usual and so makes more money than expected the health department cheque the next month will be that much smaller. All this combined with the inane government system of one year budgets that must be spent by the end of the financial year means that the Victorian public hospital system is deteriorating faster than ever. Patients are treated as well as possible but more and more by people who are fed up with working, even part time, in overloaded, underfunded, understaffed hospitals run with constant interference from the health department, which seems to consider that industrial peace with hospital cleaners is more important than providing enough nurses to open all the beds that are closed for lack of staff.

I suppose that things are much the same in the National Health Service.

What are the long term effects, if any, of vasectomy? Is there any risk to the cardiovascular system?

Vasectomy as a method of birth control has become increasingly popular in the United Kingdom over the past 20 years. The advantages of local anaesthesia, outpatient treatment, and absence of serious or life threatening complications have added to the attractiveness of vasectomy as opposed to sterilisation of the woman. A follow up questionnaire of 1508 men by the Crediton project,¹ more than six years after vasectomy, showed that the men and their wives had found vasectomy to be a satisfactory method of contraception, contributing to a more contented marriage and sex life. In the later 1970s primate studies suggested that vasectomy increased the severity of atherosclerosis. Since that time much clinical and epidemiological research has failed to show any association whatsoever between vasectomy and atherosclerosis in man as manifested by cardiovascular disease.²⁻⁵ A comprehensive study with the longest average follow up to date (15 years), sponsored by the National Institute of Child Health and Human Development, is particularly convincing.⁶ Of the nearly 5000 men in this study almost 1400 had had a vasectomy, some as long as 37 years ago with 29%

having had a vasectomy more than 20 years ago and 15% more than 25 years ago. All men had 12 lead ECG examination with multistage treadmill testing and measurements of heart rate, blood pressure, and ECG responses. The conclusion reached was of no increased risk of coronary heart disease in vasectomised patients including men with raised concentrations of anti-sperm antibody in their blood streams. This agrees with all previous studies in man with the advantage of a longer period of follow up and serves to strengthen the statement that vasectomy does not predispose to atherosclerosis or subsequent coronary heart disease in man.—J C GINGELL, consultant urologist, Bristol.

- 1 Jackson LN, Avant P. Vasectomy: a follow-up of 2000 men. *J R Coll Gen Pract* 1982;32:172-3.
- 2 Walker AM, Jick H, Hunter JR, et al. Vasectomy and non-fatal myocardial infarction. *Lancet* 1981;i:13-5.
- 3 Wallace RB, Lynch CF, Pomrehn PR, Criqui MH, Heiss G. Vasectomy and coronary disease in men less than 50 years old: absence of association. *J Urol* 1981;126:182-4.
- 4 Goldacre MJ, Holford TR, Vessey MP. Cardiovascular disease and vasectomy. Findings from two epidemiologic studies. *N Engl J Med* 1983;308:805-8.
- 5 Walker AM, Jick H, Hunter JR, McEvoy J 3rd. Vasectomy and non-fatal myocardial infarction: continued observation indicates no elevation of risk. *J Urol* 1983;130:936-7.
- 6 NIH. Long term vasectomy shows no association with coronary heart disease. *JAMA* 1984;252:1005.